

TRADITIONAL HEALTH-RELATED PRACTICES OF RUSSIAN-SPEAKING  
IMMIGRANTS RESIDING IN THE UNITED STATES

by

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and approved by

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## **ABSTRACT OF THE DISSERTATION**

Traditional Health-Related Practices of Russian-Speaking Immigrants Residing In The

United States

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Dr. Teri Lindgren

The population of Russian-speaking immigrants is growing in the United States. Like many other immigrants, Russian-speakers (born in the former USSR) present with a number of health concerns. Many of the health conditions pertinent to this population are highly manageable and/or preventable. Empirical literature indicates low engagement in health-promotion, health maintenance, and screening behaviors in this group of immigrants. There is also an indication of a gap in research addressing culturally-based beliefs and behaviors of Russian-speakers in the US.

To address a gap in empirical literature, a qualitative ethnographic study was conducted on the East coast of the United States. Twenty participants ages 36 to 83 years were interviewed along with participant observation at community events and analysis of documents (visual and print media).

Data analysis revealed perceptions of health and illness to be influenced by perception of healthcare, and these findings subsequently guide health-related practices of Russian-speaking immigrants. The study also identified transnational socio-cultural

connections to influence beliefs and practices of the immigrants who came to the United States after the USSR dissolution.

Further research is recommended to examine the factor of transnational socio-cultural connections in greater details, and to explore diverse groups of Russian-speaking immigrants residing in various areas of the US.

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## CHAPTER 1.

### INTRODUCTION

The population of foreign-born residents continues to grow in the United States (U.S. /US) (Camarota and Zeigler, 2015). Immigrants often suffer from poorly managed chronic medical problems, untreated communicable diseases, and neglected health conditions (Kemp and Rasbidge, 2004). Due to the stress of immigration, lack of social and economic resources and language barriers, health-related problems of the immigrants are frequently not adequately managed in the United States (Kemp and Rasbidge, 2004, Retrieved from <http://www.womenshealth.gov/minority-health/immigrant-migrant/>).

With the increased number of immigrants in the US, the health problems of this aggregate become a matter of public health importance. Many immigrants and refugees come to the U.S. with multiple health issues, including, but not limited to communicable diseases and untreated chronic medical conditions (Kemp and Rasbidge, 2004). Foreign-born adults are less likely to engage in screening behaviors, participate in health-promoting activities, and are more likely to have chronic unmanaged health issues than their counterparts who were born in the US. Lack of resources, communication barriers, stress of relocation and exposure to infectious agents in the country of origin may negatively affect the health status of the immigrants (Retrieved from <http://www.womenshealth.gov/minority-health/immigrant-migrant/.gov/minority-health/immigrant-migrant/>).

Due to the magnitude of social and economic issues faced by immigrants, many often neglect their health care needs. In most cases shelter and employment are higher priorities than health for immigrants and refugees (Kemp and Rasbridge, 2004). Barriers,

such as limited knowledge of laws and healthcare policies may prevent immigrants from accessing quality healthcare services. Some immigrants, especially who are undocumented, delay seeking health care in fear of being reported to the government officials or even deported to the country of origin (Kemp and Rasbridge, 2004).

The CDC has established health screening guidelines for refugees and immigrants entering the United States. These guidelines include a physical exam, mental health assessment, and immunization screening, general blood work and screening for some of the most common communicable diseases (Retrieved from <http://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html>). Although most immigrants undergo a health screening process prior to entering the U.S., some unregistered immigrants enter the country without being screened (Kemp and Rasbridge, 2004). Not all immigrants come from the areas with adequate epidemiologic control. Some might experience multiple health issues including infectious diseases that could potentially be transmitted to others.

Depending on the country of origin, some immigrants may suffer from malnutrition, hepatitis, intestinal parasites, sexual transmitted diseases, malaria, dental caries, tuberculosis, and post-traumatic stress disorders (Kemp and Rabridge, 2004). Every immigrant has his or her life story before they came to the United States. Some people move to the United States looking for better economic opportunities, while others are forced to leave their countries looking for safety, or to escape from war and violence. In contrast to US immigration patterns in the late 19<sup>th</sup> and early 20<sup>th</sup> century, today some immigrants never travel back, while others keep close connections with their homeland (Lipson, Weinstein, Gladstone, and Sarnoff, 2003). These connections could be both

detrimental and facilitative to immigrants' acculturation process, and influence their health beliefs and practices (Miller, Sorkin, Wang, Feetham, Choi, and Wilbur, 2006).

Research shows that some immigrants demonstrate the “healthy immigrant effect”, where health status of new immigrants was found to be better than health of native-born population of the same ethnic and cultural group (Noymer and Lee, 2013). However, this perceived advantage has been found to decline over time, a phenomenon referred to by some as the “trajectory of health” (Acevedo-Garcia and Bates, 2008; Kim, Carrasco, Muntaner, McKenzie and Noh, 2013). Alternatively, Corlin, Woodin, Thanikachalam, Lowe and Brugge (2014), relate better health status of immigrants compared to native born population to factors as selection bias, undiagnosed medical problems, healthier lifestyle behaviors, and the practice of immigrants returning to their native countries to seek medical and end of life care.

### **Population of Interest.**

One of the largest populations of immigrants in the U.S. are those born in the former Union of Soviet Socialistic Republics (Soviet Union / USSR) (Ivanov, Hu, and Leak, 2010). Established in 1922, the USSR included nearly 60 cultural groups, and consisted of 15 republics: Russia, Ukraine, Belorussia (Belarus), Moldavia (Moldova), Georgia, Armenia, Azerbaijan, Tadzhikistan, Turkmenistan, Kirgizia, Uzbekistan, Kazakhstan, Latvia, Lithuania, and Estonia (Bazilevich, Bakhrushin, Pankratova and Fokht, 1947). Historically the population of the Soviet Union spoke Russian as their primary language (Duncan and Simmons, 1996; Resick, 2008). In 1991, 74 years after its formation, the USSR collapsed, leading to a political and social restructuring of the country (Schmemmann, 1991). The collapse resulted in a mass migration to the U.S. Over



734, 000 residents of the former USSR migrated to the United States between 1990 and 1997 (Ivanov, Hu, and Leak , 2010). According to Evanikoff del Puerto and Sigal (2006), about 500,000 Russian-speaking immigrants arrived to the United States between 1985 and 1998. Immigration from the former USSR to the U.S. has continued, and has increased dramatically in the past few decades (Retrieved from [http://factfinder.census.gov/faces/nav/jsf/pages/community\\_facts.xhtml](http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml)).

Almost one million U.S. residents were born in one of eight of the fifteen former republics of the USSR (Retrieved from [http://factfinder.census.gov/faces/nav/jsf/pages/community\\_facts.xhtml](http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml); Trouth Hofmann, 2011). The immigrants from the former USSR represent a cohort of individuals united by the common history, traditions, beliefs, and practices established in the Soviet Union. One of the most distinct characteristics of this aggregate is a common language – Russian, the primary language of USSR (Duncan and Simmons, 1996). Even today, after the dissolution of the USSR and independence of Soviet republics, many residents of the areas of the former Soviet Union speak Russian as their first or second language. According to the U.S. census bureau, in 2010 about 854, 955 people in the United States spoke Russian as their primary language, making Russian the 12<sup>th</sup> most spoken language in the country (Retrieved from [http://factfinder.census.gov/faces/nav/jsf/pages/community\\_facts.xhtml](http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml)). In 2017 the numbers changed to 936,344, ranking Russian 9<sup>th</sup> most spoken foreign language (Retrieved from [https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_17\\_1YR\\_B16001&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_B16001&prodType=table)).

The population of Russian-speaking immigrants in the U.S. is growing. Yet very little is known about the population of Russian-speaking immigrants in the United States (Hoffman et al. 2006; Tselmin, Korenblum, Reimann, Bornstein, and Schwartz, 2007; Ivanov et al., 2010; Mehler, Scott, Pines, Gifford, Biggerstaff and Hiatt, 2001). The population of Russian-speaking people has been described as a highly educated, mostly urbanized multiethnic group (Tulchinsky and Varavikova, 1996). According to Evanikoff del Puerto and Sigal (2006), more than 40 % of Russian adults have university and college degrees, and many Russian-speaking immigrants are trained professionals, including physicians, nurses, teachers, musicians, and engineers.

Russian immigrants in the US should not be considered a heterogeneous group. In the past century five main waves of Russian immigration to the United States took place (Evanikoff del Puerto and Sigal, 2006). The first waves of immigrants in the early 20<sup>th</sup> century consisted mostly of political and religious refugees and those fleeing war. The next, 1971-1991, immigrant movement consisted mostly of Jews escaping political and religious persecution. The most recent wave has occurred since 1991, after Mikhail Gorbachev initiated *glasnost* (openness) and *perestroika* (restructuring) movements leading to the dissolution of USSR (Evanikoff del Puerto and Sigal, 2006). Thus the population of Soviet immigrants shifted from Jews seeking religious freedom in the 1970's to the current population of immigrants who seek better economic and occupational opportunities in the U.S., and is not limited to people of the Jewish faith (Hoffman, McFarland, Kinzie, Bresler, Rakhlin, Wolf, and Kovas, 2006).

The earliest waves of Russian-speaking immigrants consisted of people born and raised before the establishment of the Soviet Union, who had very little or no experience

with a socialistic lifestyle. Many of the latest waves of immigrants were born during the Soviet era. Their formative years were spent in the USSR. Some of those immigrants encountered political and social changes related to dissolution of the USSR, while others left USSR before 1991, when it was still one country.

Some distinctions were identified among sub-groups of Russian-speaking immigrants of different waves (Amburg and Lindgren, 2013). Those who left the USSR before 1991 have tended to be more assimilated and associate themselves more with the U.S. than those who immigrated after USSR dissolution, where they had more freedom to connect to the “old country” without the inference of the Soviet government. The main focus of this research study was the concerns of the Russian-speaking immigrants, who moved to the US after the dissolution of the USSR and experienced changes in the social and political structures of their home country (Evanikoff del Puerto and Sigal, 2006; Bazilevich, Bakhrushin, Pankratova and Fokht, 1947; Schmemann, 1991).

### **The concern to be addressed.**

Very few studies have addressed the health needs of the immigrant population from the former USSR (Ivanov, Hu, Pokhis, and Roth, 2010). The absence of information on the health status of these immigrants can be explained by the prevailing restrictive political environment of the USSR. Historically, up until 1991 (the year of the USSR dissolution), research of the health status of Russians was controlled by the government, and data was not readily available to the public. The government falsified statistical reports, making it almost impossible to get accurate information on the population’s health status (Duncan and Simmons, 1996). Thus, the health status of persons, who migrated to the U.S. from USSR before 1991, is not likely to be adequately described and

addressed. Subsequently, the infrastructure of healthcare services after 1991 was based on the needs identified by allegedly false records prior to 1991.

Despite poor documentation of Russian speaking immigrants' health status, there is ample evidence of unhealthy lifestyles and health-related consequences in this population. A decline in the health status of the former USSR residents, increased disability rates, poor management of chronic conditions, and decreased life expectancy have all been identified after the dissolution of the Soviet Union (Mamedov, Sharvadze, Poddubskaya and Didigova, 2011, Roberts, Stickley, Balabanova, Haerpfer, and McKee, 2012).

Noymer and Lee (2013) report immigrants from the former USSR are likely to perceive their health as poor or fair in general. Contrary to the notion of "healthy immigrant effect", the immigrants from the former USSR generally have poorer health than the non-immigrant population (Davidovich, Filc, Novack, and Balicer, 2013). Trouth and Hoffmann (2011) reported that Russian-speaking immigrants have the worst health indicators of the developed world; many of these indicators are based on deleterious behaviors, including smoking, lack of exercise, alcohol consumption, and unhealthy dietary choices. The genetic background and lifestyle of this population predisposes many Russian speakers to hereditary chronic conditions, such as obesity and high levels of cholesterol (Duncan and Simmons, 1996; Tselmin, Korenblum, Reimann, Bornstein and Schwartz, 2007). Moreover, the lack of government regulations concerning environmental and occupational safety in the former USSR likely exposed Russian speakers to harmful substances in the environment (Lukjanova and Popova, 2011).

### **The phenomenon of interest.**

Poor health indicators and multiple medical problems notwithstanding, Russian-speaking immigrants generally exhibit low rates of engagement in health promotion and screening behaviors (Ivanov, Hu, and Leak, 2010; Duncan and Simmons, 1996; Tselmin, Korenblum, Reimann, Bornstein and Schwartz, 2007). Underutilization of healthcare services and low levels of engagement in health promoting behavior are problems among Russian-speaking immigrants (Ivanov, Hu, and Leak, 2010; Ivanov, Hu, Pokhis and Roth, 2010; Aroian and Vander Val, 2007). Historically and culturally, Russian speakers do not engage in preventive health services, and little is known about their beliefs and behaviors related to health maintenance (Ivanov, Hu, Leak, Pokhis and Roth, 2010; Duncan and Simmons, 1996). Health promotion in Russian-speaking populations was historically viewed as the government's responsibility (Lipson, Weinstein, Gladstone and Sarnoff, 2003). Although Russian-speaking immigrants value health, and view it as an absence of disease, the concept of "being healthy" is not perceived as a priority in the immigrant population (Resick, 2008). Data suggests many Russian-speaking people do not believe in the necessity of disease screening and only address health problem when they have symptoms (Roberts, Stikley, Balabanova, Haerpfer, and McKee, 2012).

Previous experiences, along with communication barriers, are believed to impact underutilization of health-related services by this immigrant population (Ivanov and colleagues, 2010). Russian-speaking immigrants may lack the appropriate knowledge and experience of healthy behaviors (Ivanov, Hu, Leak, Pokhis and Roth, 2010), and socio-economic factors might not be the main reasons preventing Russian-speaking immigrants from adequately utilizing health resources (Davidovich, File, Novack and Balicer, 2013).

Cultural beliefs influence health behaviors of Russian-speaking immigrants (Ivanov, Hu and Leak, 2010), yet very few studies have been conducted to investigate health-related practices of Russian-speaking immigrants (Ivanov, Hu, Leak, Pokhis and Roth, 2010).

### **Foundational assumptions.**

The empirical literature yields a variety of theories exploring the phenomenon of health practices (HP). The term “health practices” is often referred in the literature as “health behavior(s)” (Baban and Craciun, 2007), “health promotion” (Harris and Guten; 1979, Pender, 2011), or “health-related behavior(s)” (Ioannou, 2005). Health practices of individuals are guided by the background, life experiences and personal perceptions and attitudes related to health and include positive and negative behaviors and actions.

Positive health practices (PHP) are geared toward health promotion, disease prevention and upholding of personal wellness, promotion, improvement and maintenance of health, performed by a person (Harris and Guten, 1979), whereas negative health practices (NHP) include behaviors leading to health destruction, disability, and death (Ioannou, 2005). Harris and Guten (1979) identified health-related practices as activities directed toward promotion, improvement and maintenance of health, performed by a person regardless of the actual or perceived health status, as health-protective behavior. In 1983 the phenomenon of positive health practices (PHP) was conceptualized by Muhlenkamp and Brown as a multidimensional phenomenon consisting of various areas of health practices, including exercise, relaxation, nutrition, safety, substance use, and health promotion (Muhlenkamp and Sayles, 1986).

Many scientific inquiries addressed this phenomenon in light of positive, health promoting behaviors that lead to improvement and maintenance of health and wellbeing.

Pender, (1982), and later Walker, Sechrist and Pender (1987) identified general health, nutrition, physical and recreational activity, sleep, stress management, self-actualization, sense of purpose, relationships with others, environmental control, and use of health care resources, social support, sleeping, eating, physical activities and avoidance of harmful substances as the indicators of PHP (Seichrist and Pender, 1986; Walker and Hill-Polerecky, 1996).

Yarcheski, Mahon, Yarcheski, and Cannella, (2004), conducted a meta-analysis, and identified loneliness, social support, perceived health status, future time perspective, self-efficacy, depression, self-esteem, hope, perceived stress, education, age, marital status, income, and sex, as antecedents of PHP. Additionally, it was noted that traditions, acquired by people in the native countries, can influence their current health perceptions and practices (Kleinman, Eisenbers and Good, 2006).

Originated in 1990 and revised in 1996, Pender's Health Promotion Model (HPM) (Appendix A), focuses on complex processes influencing individuals' engagement in PHP, highlights the importance of personal factors, such as age, gender, culture, and socioeconomic status in health-related behaviors, and stresses the importance of the comprehensive assessment of these variables in their influence on health outcome through the lifespan (Pender, Murdaugh, and Parsons, 2011). HPM model identifies the connection between prior life experiences, personal characteristics of the individuals, and behavioral outcome manifested by the engagement in health-related practices. Thus, the importance of socio-cultural characteristics in individual health-related practices cannot be underestimated.

### **The significance of the study.**

Enhancing the health status of people and communities has always been a public health priority (Carreno, Vyhmeister, Grau and Ivanovich, 2006, Tselmin et al., 2007). There is a gap in empirical literature addressing the needs of this diverse population (Torrens and Swan, 2009). The gap highlights the need for research addressing culturally diverse aggregates against the mainstream population (Hsuen-Fen S. Kao, Min-Tao Hsu and Clark, 2004). It is important to address the needs of the immigrant population and recognize the trend toward health disparities among subgroups of immigrants in the US (Martin, 2009).

The paucity of accurate information on the health status and needs of Russian-speaking immigrants influences planning of care and allocation of resources for Russian-speaking aggregate. Very few studies have been conducted to investigate health-related practices of Russian-speaking immigrants (Ivanov, Hu, Leak, Pokhis and Roth, 2010). Additionally, the US healthcare providers are not equipped with adequate knowledge of culturally appropriate care for these immigrants (Lipson, Weinstein, Gladstone and Sarnoff, 2003; Resick, 2008). The review of the research reveals many gaps in knowledge regarding the specific health beliefs and practices of Russian-speaking residents of the US (Benisovich and King, 2003; Resick, 2008; Ivanov et al., 2010). Missing from the literature is empirical knowledge that spells out the meaning of health, traditional patterns, attitudes, and behaviors related to health of Russian-speaking immigrants.

The purpose of the study is to address this gap in empirical literature by examining health-related practices of Russian-speaking immigrant population in the United States. Additionally, the aim of this research is to identify patterns, meanings,



beliefs and attitudes of Russian-speaking immigrants towards health and related activities. The study addressed the segment of USSR-born residents of the United States, who had experience living in the former Soviet Union up to its dissolution. The research will also address transnational connection of this population with the “old country” and the influence of such connections on current health practices of this population.

## CHAPTER 2.

### REVIEW OF THE LITERATURE

Large numbers of immigrants from all over the world arrive in the United States annually (Retrieved from <http://www.dhs.gov/immigration-statistics.gov/immigration-statistics>). Immigrants constituted about 13 percent of US population in 2012-2013 (Retrieved from <http://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states-2#1>). Along their diverse cultural heritage, immigrants bring their health issues with them to the United States making immigrants' well-being a major public health priority (Retrieved from <http://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html>; Kemp and Rasbidge, 2004).

Immigrants may suffer from many health problems ranging from neglected chronic conditions to communicable diseases (Kemp and Rasbidge, 2004). The stress of immigration, coupled with a lack of resources, socio-economic issues, and language barriers may prevent immigrants from receiving adequate health monitoring and management (<http://www.womenshealth.gov/minority-health/immigrant-migrant>). One of the largest populations of immigrants in the U.S. is the aggregate of people born in the former Union of Soviet Socialistic Republics (Soviet Union / USSR) (Ivanov, Hu, and Leak, 2010). Former USSR immigrants are united by common history, culture, and use of Russian language for communication (Duncan and Simmons, 1996; Resick, 2008). Immigration of the former USSR residents to the United States is ongoing, and has increased considerably in the past few decades (Retrieved from [http://factfinder.census.gov/faces/nav/jsf/pages/community\\_facts.Xhtml](http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.Xhtml); Retrieved

from [https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_17\\_1YR\\_B16001&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_B16001&prodType=table)).

Despite the growing numbers of Russian speaking immigrants in the United States, few studies have explored this population in depth (Ivanov et al. 2010; Duncan and Simmons, 1996; Hoffman, McFarland, Kinzie, Bressler, Rakhlin, Wolf and Kovas 2006; Tselmin, Korenblum, Reimann, Bornstein, and Schwartz 2007; Ivanov, Hu, and Leak 2010; Mehler, Scott, Pines, Gifford, Biggerstaff and Hiatt, 2007). There is evidence of unhealthy lifestyles among USSR born populations, including unhealthy diet, sedentary lifestyles, heavy smoking and alcohol intake, leading to premature mortality, trauma, and increased morbidity (Perlman, Bobak, Steptoe, Rose, and Marmot, 2003; Ott, Paltiel and Becher, 2009; Tselmin et al., 2007; Duncan and Simmons, 1996; Barr and Field, 1996; Eberstadt, 2006; Levintova and Novotny, 2004; Saburova, Keenan, Bobrova, Leon, and Elbourne, 2011; Ryan, 1988). High prevalence of cardiovascular diseases, hypertension, various types of cancers, diabetes, obesity, communicable and sexually-transmitted diseases, and frequent dental problems and mental-health disturbances were reported in Russian-speaking population (Hundley and Lambie, 2007; Duncan and Simmons, 1996; Kemp and Rasbridge, 2004; Duncan and Simmons, 1996; Evanikoff del Puerto and Sigal, 2006). Cultural beliefs were identified as influencing factors in health-related behaviors of Russian speakers, yet little is known about the beliefs and behaviors related to health maintenance in this cultural group (Lipson, Weinstein, Gladstone, and Sarnoff, 2003; Resick, 2008; Ivanov, Hu, Leak, Pokhis, and Roth, 2010; Duncan and Simmons, 1996). There is a limited information in empirical literature addressing health-related practices of Russian-speaking immigrants (Benisovich and King, 2003; Resick ,

2008; Ivanov et al. 2010). The purpose of this chapter is to review existing empirical literature on this population and identify the gaps in research addressing health-related practices of Russian-speaking immigrant population.

### **Background of the phenomenon of health-related practices.**

A review of the empirical literature yields a number of studies examining the phenomenon of health-related practices. Harris and Guten (1979) identified health-related practices as activities directed toward promotion, improvement and maintenance of health, performed by a person regardless of the actual or perceived health status, as health-protective behaviors. Some empirical literature refers to health-related practices as “health-related behaviors” and “health promotion”. Many scientific inquiries addressed this phenomenon in light of positive, health promoting behaviors that lead to improvement and maintenance of health and wellbeing.

In 1983 Muhlenkamp and Brown conceptualized positive health practices (PHP) as a multidimensional phenomenon consisting of various areas of health practices, including exercise, relaxation, nutrition, safety, substance use, and health promotion (Muhlenkamp and Sayles, 1986). Pender, (1982), and later Walker, Sechrist and Pender (1987) identified general health, nutrition, physical/recreational activity, sleep, stress management, self-actualization, sense of purpose, relationships with others, environmental control, and use of health care resources, social support, sleeping, eating, physical activities and avoidance of harmful substances as the indicators of PHP. In their 2004 meta-analysis Yarcheski, Mahon, Yarcheski, and Cannella identified loneliness, social, support, perceived health status, future time perspective, self-efficacy, depression,

self-esteem, hope, perceived stress, education, age, marital status, income, and sex, as antecedents of PHP.

Originating in 1990 and revised in 1996, Pender's Health Promotion Model (HPM), focuses on complex processes influencing individuals engagement in PHP. Pender argues the applicability of the HPM to examine populations through the life span, and identifies the importance of individual characteristics and actions in engagement in health-promoting activities (Pender, Murdaugh, and Parson, 2010). Pender's health promotion model highlights the influence of personal background, which includes socio-cultural characteristics, on individual health-related practices. Pender identifies direct connection between previous life experiences, culturally established beliefs and behaviors, and behavioral outcome, as it is defined by engagement in health-related activities. Pender's model emphasizes the influence of personal characteristics (age, gender, culture) on behavioral outcome (health promotion).

The HPM also demonstrates the connection between personal characteristics and behavior-specific cognition, evident by interpersonal influences such as family, peers, models, and norms. Carreno, Vyhmeister, Grau, and Ivanovic (2005) found individual experiences, behaviors and attitudes towards health acquired from family and religious practices in the early stages of an individual's development, to be predicting of behaviors and attitudes towards health promotion later in life, making socio-cultural characteristics important factors affecting health-related practices.

#### **Related phenomenon: Culture.**

O'Mahony and Donnelly (2007) identified traditionally-established beliefs and practices as some of the main factors guiding individual health-related behaviors. The

importance of prior family and cultural experiences, including those related to health, cannot be underestimated. Sanchez-Birkhead, Kennedy, Callister, Miyamoto (2010) identified the cultural traditions and family values to influence individual health beliefs and behaviors.

Lee, Kim and Han (2009) identified cultural attributes and acculturation as essential factors affecting immigrants' behaviors. Chouliara, Papadioti-Athanasidou, Power, Swanson (2004) conducted a cross-cultural study of attitudes towards health promotion, and identified culture as one of the key factors affecting health-related practices. Culture was found to play a major role in guiding health-related behaviors and self-care activities (Baheiraei, Mirghafourvand, Mohammadi, Nedjat, Chrandabi, Rajabi, and Majdazabeth, 2011; Bahar, Okcay, Ozbicakci, Beser, Ustun, and Ozturk, 2005; Moscardino, Nwobu, and Axia, 2006; Hjelm, Nyberg, Isacson, and Apelqvist, 1999)

Pender defines culture as race and ethnicity, and attaches culture to personal psychosocial factors related to acculturation, education, and socioeconomic status (Pender, Murdaugh, and Parson, 2010). Kao, Hsu, and Clark (2004) identify one of the most common bias of connecting culture to ethnicity, and the subsequent inappropriate measurement of culture as a research variable; they see culture as a broad concept and propose its integration into a socio-economic-politic-cultural context.

The concept of culture is not universally defined or conceptualized (Kao, Hsu, and Clark, 2004). The definitions of culture vary between anthropologists, sociologists, psychologists and health-care providers. Emde (2006) defines culture as a meaning shared by a group of people and views culture as a dynamic, subjective entity that guides and influences an individual. Keesing (1974) proposes the definition of culture as a set of

socially transmitted behavioral patterns serving humans in their abilities to communicate in the ecological setting.

The founder of transcultural nursing theory, Madeline Leininger (1988), defines culture as learned, shared, and transmitted values, beliefs, norms and practices guiding people's decisions and actions. In her Theory of Cultural Care Diversity and Universality, Leininger connects nursing to folk and professional health-care systems, and includes cultural and social dimensions, such as technology, religion and philosophy, kinship, cultural values, political, educational and economic factors, in core dimensions influencing care, health, and wellbeing of individuals, families, and groups. Giger and Davidhizar (2002) stress the importance of culture and conceptualize cultural uniqueness in their Transcultural Assessment Model, consisting of biological variations, environmental control, time, social organization, space, and communication.

Despite the need for further exploration of health-related practices in relationship to individual cultures, the phenomenon of positive or negative health-related practices of Russian-speaking population is not well explored in the literature. There are no empirical studies guided by Pender's HPM that address the population of Russian-speaking immigrants residing in the United States.

### **Literature review.**

Being born and raised in USSR, the author became interested in exploring the population of Russian-speaking immigrants after her personal experience of working with this aggregate in community settings. The author's non-Russian-speaking colleagues verbalized difficulty caring for Russian-speaking immigrants and lack of understanding of some health-related practices of this cultural group. Russian-speaking patients in the

United States are often viewed as attention-seeking, manipulative and abrasive, and some health behaviors of this group are perceived as odd and even dangerous to Western healthcare providers, while the same activities are considered socially-accepted norm by Russian-speaking immigrants (Duncan and Simmons, 1996).

The author witnessed healthcare professionals complain that Russian patient are non-compliant with prescribed treatments and even utilize unusual modalities to maintain their health. For example a homecare nurse reported that her client contacted a healer in Brazil who was claiming to perform distant surgery by using a person's photograph. This client was so convinced that she had had surgery performed by this long-distance healer that she became physically ill and felt like she was going through a post-operative period. This and many other cases, shared by colleagues, inspired the author to research health-related practices of Russian-speaking immigrants and identified a strong need to address the gap in current knowledge of the Russian immigrant population in the United States. In addition, the author holds a degree as a physician's assistant from the Ukraine as well as a nursing degree in the United States. This allows her to examine this population from multiple perspectives, as she understands the immigrants' background and shares many life experiences with this cultural group.

The literature search was conducted through the academic libraries, CINAHL, PubMed, Web of Science, Scopus, DynaMed, Clinical Key, Essential evidence plus, Ovid Medline, BioMed central, Science Direct, and supplemental Internet resources using key words: "Soviet", "USSR", "Russia", "Russian", "Russian-speaking", "health" and "immigrants". The search was set from 1922 to 2015. The starting search year of 1922 was based on historic documentation of USSR formation. The initial search results



were reviewed by the author, and only publications in English and Russian languages were accepted for further examination. The primary investigator (PI) speaks and reads Russian fluently. Hence, she was able to analyze publications in Russian independently, and include them in the literature review. Inclusion criteria were based on PI's determination of relevance to the topic of interest (Russian-speaking people, Russian-speaking immigrants in U.S., and immigrants to non-USSR countries).

The results identified from the initial search were carefully reviewed by the author for more in-depth assessment. In the second phase, the author reviewed and analyzed in great detail the publications addressing health-related issues of Russian-speaking populations residing in countries of the former USSR as well as outside of USSR. Identified publications were divided into three main categories: studies addressing historic documentation of life in USSR, lives of current residents of countries of the former Soviet Union, and Russian-speaking immigrant population in the United States and other non-USSR countries. In the third phase of the literature review, the author supplemented the search by supportive literature exploring the patterns that emerged in the previous review phases. Final results of literature review were organized in the following categories: I. Historical context of USSR, with subcategory of healthcare system in USSR; II. Health status and issues of current residents of the former republics of USSR countries, with subcategories of Life expectancy indicators, Health-related behaviors and practices, and Health-seeking practices; III. Russian-speaking immigrants from USSR in the United States and other non-USSR countries with subcategories of emigration, common health issues of Russian-speaking immigrants in non-USSR

countries, Russian-speaking immigrants in the United States, and transnational connections.

### **I. Historical content of USSR.**

The Union of Soviet Socialist Republics (USSR), led by the communist-socialistic party, was established in 1922 and dissolved in 1991 (Columbia Electronic Encyclopedia, 2013; Hosking, 1993; Sakwa, 1999). The territory of the former USSR, overlapped two continents, covered some 8,650,000 square miles or an area one and a half times larger than United States of America, with the capital city Moscow (now the capital of Russia), and consisted of 15 republics: Armenia, Azerbaijan, Belorussia (now Belarus), Estonia, Georgia, Kazakhstan, Kirgizia (now Kyrgyzstan), Latvia, Lithuania, Moldavia (now Moldova), Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan (Ryan, 1988; Retrieved from [http://www.Retrieved from http://www.britannica.com /place/Soviet-Union .com /place/Soviet-Union](http://www.Retrieved from http://www.britannica.com/place/Soviet-Union .com /place/Soviet-Union) ). During this time period, the communist government was in control of allocation and planning of agriculture, military, education, healthcare and other social resources for Soviet people (Columbia Electronic Encyclopedia, 2013; Hundley and Lambie, 2007).

The Soviet government maintained strict control over the everyday lives of the citizens. Many religious institutions were destroyed and theological practices were considered illegal during early Soviet years (Columbia Electronic Encyclopedia, 2013; Hosking, 1993). Dissidents and opponents of the Soviet administration were suppressed and persecuted by the government (Columbia Electronic Encyclopedia, 2013). Those who criticized the Soviet government were arrested, and some confined to prisons, insane asylums, and internment camps (Sakwa, 1999).

Very little objective information is available on the lives of the Soviet people before 1991. While under the governance of Communist party, information on life in Soviet Union was not readily available to the rest of the world. The Soviet government controlled the healthcare system, including all health records and vital statistics data (Duncan and Simmons, 1996).

**Healthcare system in USSR.** The structure of healthcare delivery system in the USSR was instrumental in guiding health beliefs and behaviors of people in USSR (Barr and Fields, 1996; Eberstadt, 2006; Levintova and Novotny, 2004). Historically, healthcare services in the countries of the former Soviet Union were the government's responsibility (Barr and Fields, 1996; Lipson, Weinstein, Gladstone, and Sarnoff, 2003; Yarova, Krassen Covan, and Fugate-Whitlock, 2013). Established in the 1920's the socialized healthcare system was centralized, organized, standardized, and bureaucratized (Barr and Fields, 1996).

USSR healthcare services were free and accessible to everyone in the country (Tulchinsky and Varavikova, 1996). The centralized health-care system in USSR included assigned district physicians, who coordinated the care of the population in the specific geographical area and referred patients to specialty providers based on their health needs (Sheiman, 2013). Health promotion and disease prevention were not common practices in USSR. The health-care system in the former Soviet Union was described as "illness" rather than "health-gaining" oriented with weak rehabilitation care, unnecessary long hospital stays, and limited primary care services (Sheiman, 2013).

Despite being free to the public, Soviet healthcare was inadequately funded by the government. Healthcare providers were poorly paid, which resulted in low morale and a

culture of bribery and corruption (Eberstadt, 2006). Although “tipping” the providers for services in form of gifts and money was a custom in USSR, some healthcare professionals demanded to be additionally compensated by patients for their care (Barr and Field, 1996; Tulchisky and Varavikova, 1996).

While the government had total control, the economic and social structures in USSR began to crumble by the 1980’s (Columbia Electronic Encyclopedia, 2013). During this time the USSR had the lowest gross national product in industry and agriculture compared to the seven most developed countries, including USA, Germany, and Japan (Sakwa, 1999). The destruction of the government structure extended to the USSR healthcare system, resulting in poor quality services, such unsafe hospital environment, deficiency of sterile supplies and surgical instruments, lack of basic medications (Eberstadt, 2006; Barr and Field, 1996). In addition to poor quality of care, medical advancements in USSR were in the state of stagnation. During the Soviet era, the responsibility for medical education shifted from academia to freestanding medical institutes whose main focus was on specialization with a lesser focus on research (Tulchinsky and Varavikova, 1996). The culture of bribery spread also to academia, leading to lower quality of healthcare providers (Barr and Fields, 1996; Tulchiskyand Varavikova, 1996).

Before 1991, research on the population’s health’s status was controlled by the Soviet government, and accurate statistical and epidemiologic data was kept secret from the public (Duncan and Simmons, 1996; Tulchinsky and Varavikova, 1996). Many Soviet people were poorly informed of their exposure to various occupational and environmental hazards due to unregulated air pollution and poor enforcement of workplace safety

(Duncan and Simmons, 1996; Lukjanova and Popova, 2011; Eberstadt, 2006). The overuse and misuse of pesticides and fertilizers, and careless disposal of industrial waste of heavy metals and radiation in the environment as well as poor safeguards of nuclear facilities were common in USSR (Eberstadt, 2006). In some cases, the government knowingly withheld the information on environmental exposure to hazards from the public (Columbia Electronic Encyclopedia, 2013).

The country was in the state of crisis. In an attempt to rescue a sinking USSR, the country's leader, President Mikhail Gorbachev, criticized the communist regime, and in 1985 proclaimed the country's new approach of *glasnost* ('openness') and *perestroika* ('restructuring') (Columbia Electronic Encyclopedia, 2013). Shortly after the declaration, Gorbachev's notion of openness was challenged on April 26, 1986. A nuclear reactor in the Ukrainian city of Chernobyl accidentally exploded, spreading hazardous radioactive materials into environment (Remennik, 2002; Retrieved from <http://www.nrc.gov/reading-rm/doc-collections/fact-sheets/chernobyl-bg.html>; Evangeliou, Balkanski, Cozic, Hao, and Moller, 2014). Initially the government was not forthcoming in disclosing the information on Chernobyl's explosion to the public. However due to Gorbachev's proclamation of *glasnost* and pressure by neighboring countries that were impacted by the spread of radiation, such as Sweden, the Soviets were forced to disclose the ecological catastrophe to the public, and people in the USSR found out about their exposure to high levels of radiation (Columbia Electronic Encyclopedia, 2013).

The Soviet government waited three weeks to disclose the information on the nuclear plant explosion to the public. Due to the government initial attempt to cover up

the Chernobyl explosion, preventive measures and crucial early interventions were delayed, leaving millions of people exposed to high doses of radioactive products in the environment (Remennick, 2002). Gorbachev denied an attempt to cover up the disaster, and explained the delay in alerting the public by the need for an additional investigation. Followed by reports of radiation in Sweden and forced by Western criticism, Gorbachev opened media access to Chernobyl area, and allowed unlimited exploration of the extended of disaster (Retrieved from [http://www.nbcnews.com/id/12403612/ns/world\\_news-europe/t/chernobyl-cover-up-catalyst-glasnost/#.VsJtRvkrKM8](http://www.nbcnews.com/id/12403612/ns/world_news-europe/t/chernobyl-cover-up-catalyst-glasnost/#.VsJtRvkrKM8)).

Despite the revelation of information about the disaster, there was still inadequate guidance on health-protective measures against radiation. Thousands of people were forced to evacuate from the affected areas with very little public health information guiding them on the government controlled Soviet media (Hosking, 1993; Remennick, 2002). The government's poor response to the accident created continuous exposure to radiation in many areas of USSR. Some people were left for years under chronic secondary exposure to radiation through contaminated food and water (Remennick, 2002).

The Chernobyl disaster was a turning point in Soviet Union (Hosking, 1993) leading to the revelation of the Communist regime failure (Remennick, 2002). Like a tumbling snowball Chernobyl events exposed other government's inadequacies to Soviet people. With *glasnost* they learned about Soviet poverty, inappropriate use of country's resources by the government, and the truth about the Afghan conflict (Columbia Electronic Encyclopedia, 2013). *Glasnost* destroyed the Soviet Union, as the people

“opened their eyes” and saw the truth about their country (Retrieved from [http://id/12403612/ns/world\\_news-europe/t/chernobyl-cover-up-catalyst-glasnost/#.VsJtRvkrKM8](http://id/12403612/ns/world_news-europe/t/chernobyl-cover-up-catalyst-glasnost/#.VsJtRvkrKM8)).

Realizations of declining social and economic status of USSR led to disappointment and frustration of its citizens, and subsequent demands of the union republics to separate from the USSR (Columbia Electronic Encyclopedia, 2013). In 1991 the USSR dissolved, dividing what was once the largest country in the world into 15 newly proclaimed countries (Columbia Electronic Encyclopedia, 2013). Upon dissolution of USSR, each of the 15 republics became an independent country with its own policies, laws, and regulations.

The collapse of USSR created chaos and disruption of the socialized healthcare system. Exacerbated by economic and political issues, healthcare shifted from socialized to a private care model, somewhat of a “market”- driven system with questionable quality of care, poor physicians’ competency and limited quality control (Barr and Field, 1996). Due to insufficient government funding, healthcare facilities in countries of the former Soviet Union lacked adequate supplies and treatment materials. Patients in the former Soviet Union were expected to bring their own basic medical supplies, such as linen, pillows, surgical gloves, wound suture supplies, and syringes, to the hospitals and clinics where they were treated (Yarova, Krassen Covan, and Fugate-Whitlock, 2013).

## **II. Health status and issues of current residents of the former USSR countries.**

While searching the literature, readers can often get tangled up by the names of newly established countries of the former Soviet Union, and not realize the connection between Armenia and Russia, Moldova and Belarus, etc. The research of Russian-

speaking population is often complicated by the compounding of cultures in the countries of the former Soviet Union (Hundley and Lambie, 2007). Some current studies address one or more of a few former USSR countries, but none explore all 15 republics of the former Soviet Union due to the geographical inaccessibility, separatist administrations, and military actions on some territories of the former USSR (Roberts, Gilmore, Stickley, Rotman, Prohoda, Haerpfer, and McKee, 2012; Mir, Roberts, Richardson, Chow, and McKee, 2013). Despite these limitations, some scarce information providing light on the health status of Russian-speaking population is available.

**Life expectancy indicators.** High infant mortality rates and low life expectancy in countries of the former Soviet Union are documented in empirical literature (Eberstadt, 2006; Barr and Field, 1996; Tulchinsky and Varavikova, 1996; Levintova1 and Novotny, 2004; Ryan, 1988). Due to the questionable validity of morbidity and mortality rates in the USSR, one cannot determine the change in vital statistics in countries of the former Soviet Union, yet some researchers report deterioration of health indicators. According to Ryan (1988) average life expectancy in USSR from 1938 to 1986 was 65.9 years. Although the accuracy of life expectancy data in Soviet times is questionable, life expectancy of Soviet men was reported to have decrease to 59 years soon after collapse of the Soviet Union (Tulchinsky and Varavikova, 1996). Current average life expectancy in countries of the former USSR reported by World Health Organization (WHO) is 71 years. Estonia has the highest indicator of 76, yet this number is still lower than average life expectancy of 78.5 years in the United States (Retrieved from [http://www.who.int/gho/mortality\\_burden\\_disease/life\\_tables/en/](http://www.who.int/gho/mortality_burden_disease/life_tables/en/)) (Appendix B).



**Health-related behaviors and practices.** Empirical literature yields data of unhealthy lifestyles of the USSR born population, which are believed to lead to high morbidity and mortality (Perlman, Bobak, Steptoe, Rose, and Marmot, 2003; Ott, Paltiel and Becher, 2009). Traditional Russian cuisine is rich in red meats, sugar and polysaturated fats (Ott, Paltiel and Becher, 2009). Tselmin et al. (2007) have addressed the associated hypercholesterolemia, hyperlipidemia, and obesity in Russian speakers, with dietary habits and sedentary lifestyle.

Historically, Russian-speakers engaged in poor lifestyle habits, such as heavy smoking and alcohol intake (Duncan and Simmons, 1996; Ryan, 1988). Many deaths in Russian-speaking populations are related to trauma, poisoning, and respiratory diseases, often associated with smoking (Barr and Field, 1996; Ryan, 1988). Premature mortality in Russian-speaking men has also been related to heavy alcohol consumption, which was a common problem in the former USSR (Eberstadt, 2006; Levintova1 and Novotny, 2004; Saburova, Keenan, Bobrova, Leon, and Elbourne, 2011). Vodka and *samogon* (Russian moonshine) are excessively consumed by Russian-speaking people and are related to many accidents (Eberstadt, 2006; Ryan, 1988). Preexisting risk of cardiovascular diseases combined with heavy drinking is linked to many deaths in Russian-speakers (Eberstadt, 2006). Indeed, there is an epidemic of alcoholism in the countries of the former USSR (Barr and Fields, 1996). Drinking while working and operating heavy machinery was a common practice and socially acceptable in the Soviet Union (Eberstadt, 2006). Certain professionals, such as plumbers, mechanics, and carpenters were reimbursed for their work by alcohol and some workplace areas

encouraged drinking habits in Russian-speaking countries (Saburova, Keenan, Bobrova, Leon, and Elbourne, 2011).

**Health-seeking practices.** In the face of documented poor lifestyle habits in Russian-speaking people, the empirical research provides scarce reports on customary and culturally-established health-related and health-seeking practices in this population. The literature search reveals data on the use of multiple modalities, including scientific and allopathic, and folk modalities to improve and sustain health status in this population. After the dissolution of USSR and the collapse of government controlled healthcare system, many people turned to mystic healers and psychics. Alternative modalities were not openly used by Soviet people before 1991. Empirical research lacks adequate exploration of the use of alternative and folk modalities in Soviet Union as those practices were not well described in the literature before the USSR collapse. However, there is current evidence of the use of allopathic and home remedies by the residents of the former USSR (Yarova, Krassen Covan, and Fugate-Whitlock, 2013; Brown, 2008). Alternative modalities vary from mineral springs and mud baths to use of supernatural forces, like “magic and charms” (Hundley and Lambie, 2007).

Brown (2008) surveyed 177 physicians 23-75 years of age practicing medicine in 3 large academic hospitals in St. Petersburg, Russia, on the use of alternative medicine and complimentary modalities. One hundred percent (100 %) of the respondents reported the formal use of at least 2 types of such therapies with their patients. The range of modalities varied from massage, phytotherapy (plant-derived medicines), cupping, vitamins, and herbs to the use of hypnosis, urine therapy, znakharstvo (Russian folk healing), faith healing, and low-intensity laser. Although the study was limited to only 3

hospitals in one Russian city, and 64 percent of the respondents were females, this research highlights the extent of involvement of alternative modalities in patient care in the former USSR countries.

There is also evidence that Russian-speakers prefer to use home remedies before seeking professional help and favor taking as few medications as possible (Yarova, Krassen Covan, and Fugate-Whitlock, 2013). In a mixed method study comparing 15 female residents of Ukraine to 15 Russian-speaking immigrants in the United States, and 10 American women, Yarova et al., (2013) reported that Russian-speaking immigrants and residents of Ukraine believe herbs to be safer than synthetic drugs. The respondents explained their preference of nature-derived remedies over prescription drugs due to the lack of commercial drugs in Soviet Union, especially after WWII.

In absence of an adequate supply of manufactured prescription medications, some residents of the former USSR turned to occult healers for alternative treatment modalities, such as exorcism, urine therapy (drinking and applications of urine), and bio-resonance therapy (Osborn, 2010). Televised healing séances became very popular in the countries of the former USSR in mid-1990, and some of the proclaimed healers were reported to counsel political leaders, movie stars, and presidents. They claimed to heal cancer, allergies, sexual problems, and even AIDS (Associated Press, 1995; Katell, 1994). Interestingly, some of these healers were supported by the government in parts of the former USSR. Some Russian-speaking healers even extended their services outside of the countries of Soviet Union, including the United States (Hundley and Lambie, 2007).

### **III. Russian-speaking immigrants from USSR in United States and other non-USSR countries.**

**Emigration.** Political and economic instability in USSR and its subsequent dissolution prompted some of its citizens to leave the country. The destinations of Soviet emigrants varied from Europe to Asia and Americas (Heitman, 1991). Each group of immigrants was guided by different reasons for leaving the country. Some were looking for religious freedom or escaping social instability and ethnic violence, while others were seeking better economic opportunities (Goldberg, 1990; Heitman, 1991; Lazin, 2005).

The most recent waves of migration from USSR took place in 1970's and 1990's (Lazin, 2005). These waves were guided by political, economic, and religious ideas. The immigration of 1970's consisted largely of Jews escaping political and religious prosecution (Heitman, 1991). Social and political instability of the country made many people fear for their lives. Jews were often segregated and persecuted in pre-Soviet Russia with continuation of anti-Semitism in many areas of USSR (Benifand, 1991).

Immigrants of 1970's were fleeing totalitarian state (Lazin, 2005; Heitman, 1991; Benifand, 1991). Speaking with the Soviet immigrants from that the 70's era, the author learned that many of them could not contact their friends and family in USSR, as their loved ones left behind could have been arrested or expelled from universities and work places. One of the immigrants recalls her grandfather publicly criticizing and condemning his son for leaving USSR, as the grandfather was threatened to be fired from his job as a newspaper editor in the 70's. Other Russian-speaking immigrants reported similar experiences where Soviet emigrants were pronounced public enemies and their relatives were denied job promotions and admissions to universities.

With perestroika and restructuring of the country, the government control over lives of soviet citizens diminished (Goldberg, 1990; Heitman, 1991; Lazin, 2005). In the

1990's rapid deterioration of standards of living, paralyzed Soviet economy, unemployment and growing crime rates produced a new wave of immigrants (Benifand, 1991). Those immigrants were not limited to Jews and many left the country looking for better economic opportunities. Unlike those who left in 70's, the newer wave of Russian-speaking immigrants were not limited in their contact with country of origin. The investigator recalls many immigrants visiting their family and friends after the dissolution of USSR.

Notwithstanding the individual destination and motives for leaving USSR, the population of Soviet immigrants represents people with a long history of fear of injustice and persecution. Years of living in a society where government had total control over lives of its people, and fear of bigotry and persecution cannot be dismissed from lives of the former Soviet citizens.

**Common health issues of Russian-speaking immigrants in non-USSR countries.** Along with culture and previous life experiences, Russian-speaking immigrants bring a number of health issues to their new home country. Preexisting health problems of this aggregate are carried along and often exacerbated during the immigration and readjustment process (Ivanov, et. al., 2010; Tselmin, et. al., 2007; Resick , 2008). Life expectancy of Russian-speaking immigrants in Europe is significantly lower than in the native European population (Zatonski and Bhala, 2012). Russian-speaking immigrants can suffer from infectious and communicable diseases that are uncommon, and may even be unknown in U.S. and Europe, as well as poorly managed chronic health issues (Kemp and Rasbridge, 2004). Russian-speaking immigrants have a high prevalence of hypertension, cardiovascular and heart problems

(such as CAD and HTN), breast cancer, diabetes, and frequent dental problems, and are at high risk of complicated cardiovascular diseases, various types of cancers, obesity, tuberculosis, depression, and sexually-transmitted diseases, such as HIV, gonorrhea, and syphilis (Evanikoff del Puerto and Sigal, 2006; Kemp and Rasbridge, 2004; Duncan and Simmons, 1996).

Russian speakers are prone to stress-related mental health disturbances such as alcoholism, depression, anxiety, and Post Traumatic Stress Disorders associated with the threat of political imprisonment in the former USSR (Hundley and Lambie, 2007; Blomstedt, Johansson and Sundquist, 2007). Psychological and physiological issues in immigrant populations are often related to prior stressful life events and experience. Many Russian-speaking people experienced chronic traumatic life events prior to their immigration (Remennick, 2002). Historically, total government control over lives of Soviet citizens, the Chernobyl disaster, economic and political turmoil, and the subsequent USSR dissolution, are just a few traumatic occurrences experienced by Soviet people. (Columbia Electronic Encyclopedia, 2013; Hosking, 1993; Sakwa, 1999; Barr and Fields, 1996; Remennick, 2002; Retrieved from <http://www.nrc.gov/reading-rm/doc-collections/fact-sheets/chernobyl-bg.html>; Evangeliou, Balkanski, Cozic, Hao, and Moller, 2014).

The influence of previous experiences cannot be underestimated in its effect on physical and mental health of the immigrants, yet there is a stigma associated with mental-health services. Psychiatric services in Soviet Union were often used as a tool to control rebels and protestors of Soviet regime (Hundley and Lambie, 2007). Some people were declared insane and institutionalized in psychiatric facilities because of their

political and religious beliefs (Spencer, 2000; Sakwa, 1999; Hundley and Lambie, 2007). The Committee of State Security (KGB) used psychiatrists to proclaim radicals as mentally unstable, and diagnose them with “creeping schizophrenia”, characterized by “poor adaptation to the social environment”, and “paranoid reformist delusions” (Hosking, 1993).

Despite the high prevalence of cardiovascular, endocrine diseases, cancers, communicable and sexually-transmitted infections, dental and mental health problems, underutilization of healthcare services is evident in Russian-speaking immigrants (Wu, Tran and Khatutsky, 2005; Ivanov, Hu, and Leak, 2010; Ivanov, Hu, Pokhis, and Roth, 2010; Aroian and Vander Val, 2007; Hundley and Lambie, 2007, Duncan and Simmons, 1996). Notwithstanding reported multiple health problems, former USSR immigrants have poor rates of engagement in health promotion and screening behaviors (Duncan and Simmons, 1996; Tselmin, Korenblum, Reimann, Bornstein and Schwartz, 2007; Wu, Tran and Khatutsky, 2005; Ivanov, Hu, and Leak, 2010; Ivanov, Hu, Pokhis, and Roth, 2010, Aroian and Vander Val, 2007).

**Russian-speaking immigrants in the United States.** Russian-speaking immigrants in the United States have not been well explored; their health and health needs and behaviors are poorly documented (Ivanov et al. 2010; Duncan and Simmons, 1996). The Russian-speaking population is perceived as an “invisible immigrant group” due to the close physical resemblance to the general U.S. population of white Judeo-Christian group (Bagdasarov and Edmonson, 2013). There is a deficit in the empirical literature addressing health and health-related practices of Russian-speaking immigrant populations in the United States. Despite the documentation of common health issues of

Russian speakers found in the literature, health beliefs and behaviors of this population are not well examined.

Many former residents of USSR describe their health as fair or poor in general (Duncan and Simmons, 1996; Gilmore, McKee and Rose, 2002). Russian-speaking people believe in addressing health problems only when they already have symptoms (Roberts, Stikley, Balabanova, Haerpfer, and McKee, 2012). While Russian speakers value health and view it as an absence of disease, it is not viewed as a priority in this immigrant population (Resick, 2008).

Russian-speaking immigrants are often stressed by unfamiliarity with the healthcare system in the United States (Resick, 2008). Communication with healthcare providers is an important factor guiding health-related practices of Russian-speaking immigrants (Shpilko, 2006). The role of healthcare providers in the United States can be perceived differently from the same in the former USSR. Russian-speaking immigrants might not always trust American physicians, can be skeptical of the media as a source of health-related information (Benisovich and King, 2003), preferring home remedies over professional medical care (Yarova, Krassen Covan, and Fugate-Whitlock, 2013). Some immigrants might negatively perceive psychiatrists and social workers due to the social stigma (Shor, 2007).

A qualitative pilot study exploring traditional healthcare practices of Russian-speaking immigrants residing in the United States was conducted in New York and New Jersey in 2013, and examined 8 Russian immigrants ages 43-86 years (Amburg and Lindgren, 2013). (Appendix C) The study identified the importance of family, the value of food, the use of vodka, historic perspective, and expectations of healthcare providers,



all of which influenced the perception of health maintenance. The perception of “healthy food” in Russian-speaking immigrant population differed from that in the United States and the knowledge of use of food-derived remedies were transmitted from one generation to another. The perceptions of vodka’s relationship to health were diverse. Some viewed vodka as harmful, while others believed in its healing powers, using vodka as a remedy. A positive and trusting relationship between patients and healthcare providers was found to be important. Russian-speaking immigrants expected physicians to take their time, listen, and hear patients out.

Amburg and Lindgren (2013) also identified the value of family in Russian-speaking immigrants in the U.S. as an incentive to stay healthy. Russian-speaking immigrants wanted to stay healthy for their families and not to burden families with their care.

Strong family connections with close ties to extended families are historically evident in Russian-speaking immigrant communities (Bagdasarov and Edmondson, 2013; Hundley and Lambie, 2007). A communal lifestyle and crowded living conditions were customary and widespread in Soviet Union (Duncan and Simmons, 1996; Bagdasarov and Edmondson, 2013). It was not uncommon in USSR for multiple generational family members to share the same household (Hundley and Lambie, 2007). Traditional family structures are challenged during immigration. In the absence of the immediate family during the immigration process, friends often substitute for family among Russian-speaking immigrants, and become a primary support system (Hundley and Lambie, 2007). Thus, further examination of the “family and friends” influence on health-related practices of Russian-speaking immigrants is needed.

In the process of data analysis, Amburg and Lindgren (2013) noticed the difference between Russian-speaking immigrants from 1970's and newer wave of the immigrants, those who came to the United States following the dissolution of USSR. Those who emigrated during USSR times were more integrated into American lifestyles and voiced their appreciation of the services available to them in the United States. Although the recent group of immigrants valued their lives in the U.S. as well, they were still more connected to their country of origin than long-time residents of the United States. More recent immigrants seemed to be more connected to both countries, whereas immigrants from the 70's had lesser connections with the former USSR.

In the process of data analysis of the 2013 pilot study Amburg and Lindgren became interested in the influence of transnational connections on health-related practices of Russian-speaking immigrants in the United States. There was some evidence of the participants' strong connection with the countries of the former Soviet Union, yet the literature search revealed very scant data on transnational connections, and the need for further exploration of this phenomenon in Russian-speaking immigrants was identified.

**Transnational connection.** Connection with the country of origin seems to be important for the former residents of Soviet Union. Unlike immigrants who fled USSR in the 70's, and were not able to communicate freely with their family and friends left behind, the post-USSR collapse immigrants have various opportunities to maintain connections with the "old country". Following USSR's dissolution, government control over the lives of the citizens had decreased, which promoted transnational connections and interactions. Russian-speaking immigrants keep close ties with the "old country", and some travel back and forth (Lipson, Weinstein, Gladstone, and Sarnoff, 2003).

In addition to the political changes, technological advances introduced communication between the two worlds. Media, such as television and newspapers, and maintaining contacts with friends and relatives provided immigrants with the information and resources from the home country (Hundley and Lambie, 2007). Television and radio stations began broadcasting programs in Russian language in the East coast area of U.S; a number of newspapers and magazines became available to the immigrants in their native language. According to V. Melnik, the marketing manager of Russian Media group, R. Chernina, an executive director of Be Proud Foundation, a non-profit organization, providing services to Russian-speaking immigrants in New York, corroborated by A. Sirotin (Lakhman), journalist and Russian media reporter in New York, as well as the Internet search, the author learned the first radio station serving Russian community to launch in 1980, while the first television network (RTN, WMNB) was found by non-Russian-speaking rabbi Mark Golub and began broadcasting in Russian language in 1991 (personal communication, December 15, 2015; www.Retrived from <http://www.russianmediagroup.com/standard-5.html>). According to V. Melnik, Russian Media Group currently includes 15 television channels available through satellite and major cable companies, broadcasting various programs for the former USSR audience currently residing in Russia, Ukraine, Belarus, Israel, and the United States. Additionally, basic web search revealed a number of Internet Russian television services available in Russian language. Thus, technological progression and political changes enhanced Russian-speaking immigrants' access to various media resources, including those from the "old country".

With technological advances and help of the Internet, Russian-speaking immigrants were able to access media resources from the countries of the former USSR, and some healers and alternative health-care providers were able to offer their services to Russian-speaking immigrants in the United States (Hundley and Lambie, 2007). Notwithstanding reported skepticism of the media (Benisovich and King, 2003), televised healing séances were very popular in the former USSR (Osborn, 2010, Associated Press, 1995; Katell, 1994). Thus, it is not clear to what extent Russian-speaking immigrants utilize media as a health-related resource. Additionally, despite the evidence of existing transnational connections, the influence of such communication on health-related practices of Russian-speaking immigrants is not well examined and researched.

#### **Summary of the literature search and need for further research.**

The population of Russian-speaking immigrants in the U.S. is growing rapidly, yet a few studies have addressed health beliefs and health-related practices of this population (Hoffman, et al. 2006; Tselmin, Korenblum, Reimann, Bornstein, and Schwartz, 2007; Ivanov et al. 2010; Mehler, Scott, Pines, Gifford, Biggerstaff and Hiatt, 2007; Duncan and Simmons, 1996; Gilmore, McKee and Rose, 2002).

Empirical literature identifies a number of health issues affecting the health and wellness of Russian-speaking immigrant population. Russian-speaking immigrants were found to be at high risk of cardiovascular, diseases, various types of cancers, diabetes, communicable and venereal diseases as well as mental health disturbances, including alcoholism, depression, and post-traumatic stress disorders (Wu, Tran and Khatutsky, 2005; Ivanov, Hu, and Leak, 2010; Ivanov, Hu, Pokhis, and Roth, 2010; Aroian and

Vander Val, 2007; Hundley and Lambie, 2007; Duncan and Simmons, 1996; Tselmin, Korenblum, Reimann, Bornstein and Schwartz, 2007; Wu, Tran and Khatutsky, 2005).

Many of the health-related issues in Russian-speaking immigrant population are associated with stress, sedentary lifestyles, dietary preferences, and other modifiable behavioral factors. Notwithstanding reported potentially preventable health problems Russian-speaking immigrants in the United States do not have high engagement in health-promoting and screening behaviors.

Theoretical framework of Pender's Health Promotion Model identifies the connection between socio-cultural characteristics and prior experiences, and health-promotion (Pender, Murdaugh, and Parson, 2010). Thus, cultural background and previous life occurrences play an important role in the individual health-maintenance behaviors. Literature review addressing Russian-speaking immigrants identified a pattern of cultural beliefs threaded through many studies as an influencing factor of health-related behaviors of Russian speakers, yet many health care providers are not equipped with adequate knowledge of culturally appropriate care for this group of immigrants (Lipson, Weinstein, Gladstone, and Sarnoff, 2003; Resick, 2008).

It is unclear what guides the immigrants from the former USSR in their health-related behaviors. It is also unclear which health-related resources are utilized by Russian-speakers. There is an evidence of transnational connection, but it is not clear how much transnational connections are influencing health-related practices of Russian-speaking immigrants. There is a gap in empirical literature addressing health-related practices of Russian-speaking immigrants. Further research is recommended to address

customary and culturally-established health-related practices of Russian-speaking immigrants residing in the United States.

### CHAPTER 3.

#### METHODOLOGY

One of the increasing foreign-born populations in the US is the aggregate of people born in the former Union of Soviet Socialistic Republics (Soviet Union / USSR) (Ivanov, Hu, and Leak, 2010). Often referred to as “Russians”, the immigrants from the former USSR represents a cohort of individuals speaking Russian as their primary language, and united by common history and culture. According to the 2010 US. Census bureau, about 854, 955 people in the United States speak Russian as their primary language (Retrieved from [http://factfinder.census.gov/faces/nav/jsf/pages/community\\_facts.xhtml](http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml)).

Empirical literature identifies a number of health issues affecting the health and wellness of the Russian-speaking immigrant population. There are socio-culturally defined unhealthy behaviors and lifestyles, such as unhealthy diet, heavy smoking and alcohol intake in this population, resulting in premature mortality, trauma, and increased morbidity (Perlman, Bobak, Steptoe, Rose, and Marmot, 2003; Ott, Paltiel and Becher, 2009; Tselmin et al., 2007; Duncan and Simmons, 1996; Barr and Field, 1996; Levintova and Novotny, 2004; Saburova, Keenan, Bobrova, Leon, and Elbourne, 2011; Eberstadt, 2006; Saburova, Keenan, Bobrova, Leon, and Elbourne, 2011). Russian-speaking immigrants have a high prevalence of cardiovascular diseases, hypertension, and various types of cancers, diabetes, and obesity, communicable and sexually-transmitted diseases, along with frequent dental and mental-health disturbances (Hundley and Lambie, 2007; Duncan and Simmons, 1996; Spencer, 2000, Sakwa, 1999; Hosking, 1993; Kemp and Rasbridge, 2004; Evanikoff del Puerto and Sigal, 2006).

Cultural beliefs are threaded through many studies as an influencing factor in health-related behaviors of Russian speakers, yet many health care providers are not equipped with adequate knowledge of culturally appropriate care for this group of immigrants (Lipson, Weinstein, Gladstone, and Sarnoff, 2003; Resick, 2008). Notwithstanding documented health problems and risk factors, the health beliefs and behaviors of Russian-speaking immigrants in the United States have not been well explored, and their health needs and behaviors are poorly documented (Ivanov et al. 2010; Hoffman, McFarland, Kinzie, Bressler, Rakhlin, Wolf and Kovas 2006; Tselmin, Korenblum, Reimann, Bornstein, and Schwartz 2007; Ivanov, Hu, and Leak 2010; Mehler, Scott, Pines, Gifford, Biggerstaff and Hiatt, 2007; Ivanov, Hu, Leak, Pokhis, and Roth, 2010, Duncan and Simmons, 1996). Therefore, the purpose of this study is to examine traditional health-related practices of Russian-speaking immigrants in the United States. In this research, the word “traditional” denotes common or customary, culturally-established health beliefs and behaviors, and includes allopathic as well as alternative, and folk practices related to health and wellness.

Various philosophical approaches have guided scientists in their exploration of health-related practices. Positivists viewed this phenomenon as a stable, directly measurable entity, the concept as absolute truth, where the reality is uniformly accepted (Mackenzie, 2011; Rubin and Rubin, 2012). The naturalists believed in the exploration of the concept through the lens of the researchers’ personal values, beliefs and experiences, with the perception of the world as “is”, not as it “ought” to be (O’Shea 2010; Rubin and Rubin, 2012). Positivists looked for direct measurement of the phenomenon and the associated connections, whereas naturalists explored the perceptions, beliefs, and specific



actions. Because there was a limited exploration of the health beliefs and practices of Russian immigrants a qualitative (naturalistic) approach was chosen to examine the phenomenon.

Qualitative approaches allow the researcher to achieve profound understanding of the phenomenon (Creswell, 2013), and permit exploration of the subjective view to guides the theory development (Burns and Grove, 2001; Hammersley and Atkinson, 2007). It is a useful approach to explore a phenomenon that is not well defined, such as health-related practices. The phenomenon of health-related practices of Russian-speaking immigrants was not well examined and defined in empirical literature. With a qualitative inquiry the researcher studies subjective experiences and attempts to get closer to this population. Qualitative methodology allows the researcher to recognize his/her personal values and beliefs and apply them to understanding the beliefs and practices of the population of Russian-speaking immigrants in the United States.

The epistemology of a qualitative inquiry involves close connection with the participants (Creswell, 2013) and assumes researcher's direct contact and involvement with the population of interest. The ontology of qualitative inquiry allows the researcher to embrace the idea of multiple realities, multiple viewpoints, uses multiple forms of evidence to explore the phenomenon (Creswell, 2013), and requires a comprehensive assessment of the phenomenon from multiple perspectives. According to the axiological assumption of qualitative inquiry, researcher's personal values evolve (Creswell, 2013), allowing the investigator to discover oneself through the prism of research. In examining traditional health-related practices of Russian-speaking immigrants, the investigator

positioned herself in the role of an observer and an interpreter, exploring the meaning and defining the evidence (Creswell, 2013).

An ethnographical methodological approach was used to guide this qualitative examination. The choice of ethnography was supported by the inquiry addressing cultural beliefs and health-related practices of Russian-speaking immigrants. Unlike grounded theory, concentrating on human processes, actions and interactions, ethnography allowed the researcher to explore the rationale behind the actions in the forms of beliefs, feelings, and emotions (Creswell, 2013; Corbin and Strauss, 2008; Charmaz, 2006).

Ethnography is a useful approach for exploring health practices in light of feelings, beliefs and behaviors of the population (Hammersley and Atkinson, 2007). Hunter (2012) called ethnographic research both holistic and contextual, which requires inculcation, emotional connection, and fosters relationships. Ethnography is described as a “window to the world” of a culture, which allows the exploration of “truthful” accounts of people’s life stories and understanding of their beliefs and behaviors (Schembri and Boyle, 2012; Cruz and Higginbottom, 2013). Ethnography permits interpretation of contexts, making connections, and embracing meaning, instrumental in researching people’s actions and accounts in everyday contexts rather than their responses to the specific circumstances (Hunter, 2012; Hammersley and Atkinson, 2007). The ethnographical methodology allows the researcher to learn the reasons and meanings of human actions, as a result of historically and culturally established behaviors.

Application of ethnographical methodology consisted of three strategies of data collection: interviews, participant observation, and collection and analysis of documents, where the researcher played a role of uninvited “professional stranger” (Cruz and

Higginbottom, 2013). Being a part of a Russian immigrant community the principal investigator had an opportunity to immerse herself in the cultural environment and explore the phenomenon from the “inside”. The researcher, however, faced a challenge of placing herself in the position where the “professional stranger” safely connects with the “insider”. The researcher had to take a number of steps to isolate her personal beliefs and practices from the population of interest. To achieve this isolation, she had documented her own beliefs in a reflective journal prior to the start of the study and continued recording her feelings, emotions, and beliefs continuously through the study to isolate personal beliefs from the collected data.

Since the principal investigator was personally and professionally familiar with the population of interest, a focused ethnographic approach guided the study. Focused ethnography was useful in narrowing the focal point of exploration when the researcher had intimate familiarity with the phenomenon of interest (Taylor, Rush and Robinson, 2014), and when the study is conducted within the researcher’s environment (Higginbottom, Pillay, and Boadu, 2013). Application of focused ethnography was valuable in researching distinguishing contextual or shared experiences in inimitable culture, sub-culture or in specific setting (Cruz and Higginbottom, 2013; Higginbottom, Pillay, and Boadu, 2013). Unlike a traditional ethnographic approach, focused ethnography was more concentrated, involving background knowledge, and insightful data analysis (Knoblauch, 2005). The use of focused ethnography has been very instrumental in exploring small elements of society, or sub-groups as part of the larger group (Cruz and Higginbottom, 2013).

Unlike classic ethnography, focused ethnography concentrated on a specific phenomenon within a culture or subculture (Higginbottom, Pillay, and Boadu, 2013). One can call focused ethnography clustered and problem/phenomenon-driven. Higginbottom, Pillay, and Boadu (2013) identified the distinctive characteristics of focused ethnography in studying a specific aspect of the social field, having background knowledge of the research question, intermittent and purposeful field visits, and often have the observer-as-participant role of the researcher.

### **The study.**

A focused ethnography approach was used to explain the traditional health-related practices of Russian-speaking immigrants in the United States. This research was built upon a previously conducted pilot study (Amburg and Lindgren, 2013), addressing traditional health-related practices of Russian-speaking immigrants residing in the United States. The pilot study took place in Monmouth and Middlesex Counties of New Jersey and Kings County of New York States, and was limited to 8 participants. The results of the pilot study identified a need for further research of the population of Russian-speaking immigrants residing in the United States with an 1) an expansion of the size of the sample and 2) focusing on a more diverse population, including non-Jewish Russian-speaking immigrants and people with limited marriage and childrearing experience to achieve diversity of the sample. Results indicated a difference between Russian-speaking immigrants from the times from before and after the dissolution of the USSR. Those who immigrated when the USSR was one country were more integrated into the culture in the United States, whereas more recent immigrants were somewhat more associated with the “old country.” Those who left the USSR in 1970’s were more assimilated in the US and

had less transnational connections than Russian-speakers who immigrated from the time after the dissolution of the USSR.

Following the pilot study, a research was conducted targeting larger sample of representatives of the Russian-speaking immigrant community. Prior to the recruitment of participants, the approval from Rutgers University's Institutional Review Board was obtained. The study employed a diverse sample of Russian-speaking immigrants, and was conducted in the states of New York and New Jersey, but was also opened to residents of East Coast of the United States. The participants were recruited with help of the key informants and service providers who had access to Russian-speaking immigrant community. The primary investigator met with each participant in New York or New Jersey at a location of the participants' preference. Each participant was interviewed once by the principal investigator for approximately 60-90 minutes. The interview guide included demographic queries and inquiries on the participants' health-related practices. The demographic inquiries consisted of participant's current age, gender, highest achieved education in the former USSR and US, marital status, years in the United States, years spent in USSR, and the date the individual left the USSR (Appendix D).

Data collected during the interviews was triangulated with participant observation and review of documents (newspapers, magazines, televised programs, and other publications addressing the population of Russian-speaking immigrants) pertinent to the research interest. The data collected from multiple sources was continuously analyzed by the principal investigator and co-principal investigator (dissertation chair).

### **The Sample.**

The limitations of the 2013 pilot study identified the need to recruit more non-Jewish participants, people with limited marriage and childrearing experience, and those who arrived in the United States after the dissolution of the former USSR. The majority of the pilot study sample was representatives of Jewish denomination, who had marriage experience and at least one living child at the time of the interview. Since the category of the role of the family emerged in the pilot study, the principal investigator wanted to achieve more diversity of the sample by examining the representatives of different religious faiths, as well as those who were not married and did not have children, as religion and having children might play a role in the importance of family in health related practices. However, during the sampling process it became evident that most participants were at the age when they already had some marriage experience, and most of them already had children. The goal of broadening religious diversity was achieved; however recruitment through contacts limited the representation of Muslims in the study.

The choice of the states of New York and New Jersey was determined by the convenience and accessibility to the population of interest. However, the study was opened to Russian-speaking residents of East Coast of the United States who were traveling or temporarily residing in New York or New Jersey.

The investigator was interested in the sample of Russian-speaking immigrants who were influenced by the USSR dissolution, and lived in the territories of USSR during the period of Mikhail Gorbachev's appointment as a leader of USSR in March 11, 1985, and USSR dissolution on December 25, 1991 (Retrieved from <http://www.britannica.com/place/Soviet-Union.com>; Retrieved from <http://www.history.com/topics/cold-war/fall-of-soviet-union>).

Potential participants had to be born no later than December 25, 1979, and had to be no younger than 12 at the time of the USSR collapse. The age limit of 12 years was based on the Piaget cognitive developmental theory. According to Piaget, after 11 years of life, the child enters the formal operational stage, and begins processing manipulative ideas and abstract reasoning in his head (Retrieved from <http://www.simplypsychology.org/piaget.html>; Piaget and Inhelder, 1959).

The cut-off time for the immigration after 1991 was based on historic events in the former USSR. The immigrants of the years 1991-present were exposed and potentially influenced by changes in the USSR politics, and the introduction of *perestroika* and *glasnost*'. This group of people lived through the political changes, restructure, and the eventual dissolution of their country. Thus, the focus of the following study was on Russian speaking immigrants who left the former USSR territories during Gorbachev's time or later. The age of the potential participants was no younger than 36 years of age by December 25, 2015, and a US resident for no more than 24 years by December 25, 2015.

The snowball approach was utilized to recruit for the study. The participants were enrolled for the study from New York and New Jersey with assistance of a variety of key informants and by direct communication with the principal investigator. The key informants included members of the Russian-speaking immigrant community as well as the healthcare and education professionals connected with the former USSR residents. A total of 30 participants inquired about taking a part in the study but 10 did not meet the inclusion criteria or decided not to participate.

A total of 18 interviews were conducted with 20 participants representing the sample. Two families independent from each other requested both spouses to be interviewed together. The sample comprised 9 males and 11 females. The range in age was 36 to 83 at the time of the interview (See Appendix E).

In addition to the interviews, participant observation and analysis of documents were utilized to achieve the triangulation of data. The participant observation was conducted in public places, known to have a large congregation of Russian-speaking immigrants. The author (the principal investigator/PI) attended various community events, such as ethnic festivals affiliated with religious as well as secular entities, New Years' community celebrations in New York State, and "Your Highness Grandma" event in Brooklyn, NY, where she observed the behaviors of Russian-speaking immigrants, paying particular attention to their interaction with each other, and family relations. In addition to the events, the PI visited a number of neighborhoods populated by Russian speakers. These visits included visiting stores and pharmacies selling ethnic products from the countries of former USSR.

The principal investigator also examined Russian media and publications containing information on health and health-related practices. These magazines include the following periodicals: "The Folk Doctor", "The Healthy Way of Life", and "Health." Some of the periodicals are distributed exclusively in the United States, while others are published and sold in both the US as well as some countries of the former USSR.

The investigator also watched various televised programs targeting Russian-speaking audience that included health related issue. The programs included but were not limited to those dedicated to health, such as a popular Russian TV show "*Zdorov'e*"



[“Health”], and “*Zhit’ zdorovo s Elenoy Malyshevoy*” [Living [healthy] is great with Yelena Malysheva”].

Over and above the participants’ observations and analysis of documents, the researcher kept a journal of the field notes collected during the interviews. Field notes supplemented the findings and described the investigator’s observations during data collection. Along with the field notes, a reflective journal was kept by the investigator to evaluate her personal feelings and beliefs and exploring how these feelings might influence the interpretation, thereby controlling bias (Patton, 2002).

### **Inclusion Criteria.**

The inclusion criteria include: 1) being born no later than December 25, 1979; 2) immigrating to the United States after December 25, 1991; 3) ability to speak, read, and write Russian; 4) living in the USSR for at least the first 12 years of life; 5) ability to participate in a 60-90 minute interview, and 6) current resident of an East-coast community in the United States. The participants had to be physically located in the states of New York or New Jersey at the time of the interview in order to be interviewed face-to-face.

### **Exclusion criteria.**

Exclusion criteria include: 1) date of birth on or after December 25, 1979; 2) emigrating from the former USSR before their 12th birthday; 3) immigrating to the United States before December 25, 1991; 4) inability to speak, read, write Russian, and/or having any limitations restricting the participation in a 60-90 minute session, or 5) not residing in the East Coast of the United States.

### **Protection of Human Subjects.**

Prior to the data collection, the principal investigator explained the study procedure to the participants. Participants were informed of the voluntary nature of the study and were made aware that there are no adverse consequences for their refusal to participate or to complete the interview. There was a minimal risk to the participants. There was a potential that participants might have become fatigued during the interview or that the interview questions could have brought up unpleasant memories. In either case the participants were informed of their right to stop the interview and/or to withdraw from the study. The principal investigator obtained the informed consent from the prospective participants before conducting the interview as an indication of their agreement to take a part in the research.

All the interviews were confidential. Participants' identifying information was kept separately from the interview data. The interviews were transcribed into the password-protected computer by the principal investigator. Audio-recorded files with the interviews were erased from computer and audio recorder upon transcription and verification of the transcript accuracy. Transcribed interviews only contained an assigned participant's code, and did not include their names and/or personal identifying information. Access to the data was limited to principal and co-principal investigators.

### **Recruitment and Procedure.**

Following the approval of Rutgers University Institutional Review Board, the recruitment took place in various communities highly populated by Russian-speaking residents and /or places commonly used and visited by Russian speakers. Previous experience of posting flyers advertising the study in areas of the residence and congregation of Russian-speaking immigrants did not return positive results (Amburg and

Lindgren, 2013). In response to more than 50 posted flyers for the pilot study only one participant contacted the investigator, and this person ultimately did not meet the inclusion criteria.

While conducting the pilot study, the principal investigator was advised by Russian-speaking immigrants and community informants to use the “word of mouth” as this was a more efficient recruitment tactic for this population. This “snowball” approach returned more positive recruitment results (Amburg and Lindgren, 2013). Hence, the snowball approach was the first choice for participants’ recruitment in this study.

The “snowball” recruitment began with key informants or representatives of the Russian-speaking community. Amburg and Lindgren (2013) pilot study identified the need to recruit religiously diverse sample, as the majority of the pilot study participants represented the Jewish faith. The key informants consisted of representatives from religious as well as secular organizations of Russian-speaking community. They included Russian-speakers of various religious denominations and affiliations. The key informants were provided with the overview and goal of the study and were asked to “spread the word” about the research addressing health-related practices of Russian-speaking immigrants. The key informants were asked to refer potentially interested participants to the principal investigator, and to disseminate the contact information for the principal investigator.

“Snowball sampling” reported to encourage key informants and involved participants to invite other participants, and the participants to invite their acquaintances to take part in the study (Holzemer, 2010). Although the snowball sampling was useful in recruiting representatives of the specific social groups, there could have been a potential

bias in recruitment since the participants were not independent from one another (Burns and Grove, 2001). To limit these bias, the principal investigator utilized various sources and a variety of key informants as the “starting point” of the snowball sampling to reduce the interconnectedness of potential participants. The “starting point” key informants included community health nurses working in Brooklyn, NY, physicians and pharmacists working with Russian-speaking patients in central area of New Jersey, the owners of a Russian food store and an accountant from the Middlesex County in New Jersey. Another key informant was a dentist from Monmouth county of New Jersey, who was actively involved in the Central New Jersey Russian-speaking community life.

In addition to the key informants, the principal investigator communicated with healthcare service providers in the Russian community and made them aware of the proposed study. The category of healthcare service providers included any professionals providing health-related services in Russian-speaking communities or working closely with the population of the immigrants from the former USSR. Unlike the key informants, the healthcare providers did not have to be a part of the community of interest, but had to be familiar with the community from the point of professional interaction.

Communication with service providers was an efficient technique to recruit Russian-speaking participants for the study (Amburg and Lindgren, 2013). The providers were informed of the purpose of the study, voluntary enrolment, and confidentiality of participation, and, like the key informants, were asked to “spread the word” about the research. Service providers informed the prospective participants of the study, and offered them the PI’s contact information. The contact information included PI’s name, phone number, and her e-mail address. Some participants requested that the principal

investigator contact them directly. In this case, the initial referral source obtained verbal permission and contact information from the participants to be contacted by the researcher.

Once permission was obtained, the potential participants were contacted regarding taking part in the study. The principal investigator reached out to the potential participants and explained the purpose of the study. After initial verbal agreement was obtained, the principal investigator set up a meeting with the potential participants at the place of their preference. The participants were asked to pick a place of their choice that had minimal distractions for the interview and where the participants' confidentiality was ensured.

At the face-to-face meeting, the principal investigator clarified any issues/concerns brought up by the potential participants, explained the study in greater detail and informed the participants that there are no consequences if they desired not to participate in the study. Based on the participants' language preference, a written and verbal explanation of the study in Russian or English were provided. Before the start of the interview the principal investigator reviewed the informed consent and had the participants sign it as an evidence of their agreement to participate in the study. Each participant was given \$10 as a thank you for the participation in the study.

**Setting.**

The study was open to the residents of any East coast state of the United States temporarily or permanently residing or visiting New York (NY) or New Jersey (NJ). Most of the recruitment and interviews took place in the states of NY and NJ-both highly populated by Russian-speaking immigrants. Some of the common catchment areas were

residential settings of New York City, Kings and Richmond Counties, such as Bensonhurst and Coney Island, parts of Brooklyn, South Beach and Midland areas of Staten Island, and Monmouth and Middlesex counties of New Jersey. These areas were chosen due to the high population density of Russian-speaking immigrants. All of the interviews took place in NY or NJ at places of the participants' preference. Some interviews took place at the participants' residence or places where they stayed while visiting their families and friends, while others preferred to meet at the public places, such as the area around their work. It was expected that most of the participants were also coming from these states, as NY and NJ were known for their high numbers of Russian-speaking residents.

### **Data Collection.**

Guided by the ethnographical approach, the principal investigator utilized interviews, participant observation, and collection and analysis of documents to gather the data (Cruz and Higginbottom, 2013). Data collection coincided with the continuous analysis until the saturation was reached.

### **1. Interviews.**

Twenty Russian-speaking immigrants were interviewed before saturation was achieved. Each participant was interviewed once by the investigator. All the interviews were audio recorded and subsequently translated from Russian, and transcribed in English. The first 10 transcribed interviews were read by the primary investigator and co-investigator, the dissertation chair and the faculty advisor Teri Lindgren, RN, PhD, to ensure the rigor. The data analyses were reviewed and discussed at regular meetings. The data was revisited and re-analyzed, and coded repeatedly. Frequent communication was

established between the principal investigator and the faculty advisor during data collection and analysis. Reflections on the process as well as emerging theme were kept and these reflective notes, in combination with the interviews, participant observations, document analysis and discussion with advisor enhanced the credibility and trustworthiness of the final product (Creswell, 2013).

In addition to interviewing Russian immigrants in New York and New Jersey, the PI reached out to healthcare professionals and social service providers practicing in Russian immigrant communities. Additionally, the principal investigator contacted Russian media representatives, a politician serving in Russian community, as well as community events organizers to collect their perception of health-related practices of Russian-speaking immigrant community. The outreach to the politician returned no results but others were willing to casually discuss the topic. Despite the lack of politicians' direct participation in the interview, a great amount of data was collected from the other service providers working with Russian-speaking immigrants. Some of the resources included but were not limited to currently practicing and former physicians working with Russian-speakers, practicing registered nurses, pharmacists, former and current employees of the Russian TV stations in New York. These informants shared their perceptions as well as anecdotal stories describing Russian-speaking immigrants. The information collected from these resources was used to validate and support the data collected by interviews and participant observation and provided the researcher with a more comprehensive understanding, an "outsiders'/insider's view" on health-related practices of Russian immigrants, and ensured triangulation of data (Holzemer, 2010).

**2. Participant observation.** Participant observation allowed for data collection in the natural setting (Hammersley and Atkinson, 2007). The participant observations were conducted in public places of common congregation of Russian-speaking immigrants. The principal investigator positioned herself in the areas of congregation of Russian-speaking immigrants. During these events, she observed participants' interaction with one another, such as sharing a meal, playing games, talking to one another, or celebrating some kind of event as a group. Having prior knowledge of Russian immigrant community life in the United States, the researcher understood that many of the community events were attended by families. The researcher sought to gain a perspective of the participants' behavior in the community. These observations were captured in field notes for analysis.

**3. Collection and analysis of documents.** The principal investigator examined Russian media and publications containing information on health practices. The researcher was interested in exploring the role and influence of the media in the lives of Russian-speaking immigrants in the United States.

By reading Russian newspapers and magazines and watching televised programs, addressing health and wellness of Russian-speaking population, the principal investigator hoped to explore the concept of media/public presentation of health-related practices in Russian-speaking community.

Being fluent in Russian, the principal investigator recalls a televised show on one of the largest Russian TV channels describing the use of a hot brick in treatment of thyroid nodule or utilization of leeches in treating common cold. In one popular Soviet movie, sciatica was treated by bee stings and hot stone applications. In casually talking with Russian-speaking immigrants in the United States, the PI learned that health-



dedicated TV programs in Russian are popular among the immigrants, and are being watched by many. Therefore, exploring how media influenced health-related practices of Russian-speakers was important.

### **Field notes and Reflective Journal.**

During, and after the interviews as well as during participant observation the principal investigator kept two separate field notes: 1) field notes captured during participant observation and from exploring Russian focused media (visual and print) and 2) field notes related to observations during the interviews. Field notes described the investigator's observations during data collection, including the interview environment and behaviors of the participants. Field notes documenting the environment observation and media included data pertinent to health-related practices of Russian-speaking immigrants, and any environmental factors and objects used by this population to improve and enhance their health.

A reflective journal supplemented verbal clues gathered during the interview process. Unlike field notes, focusing on the observations and beliefs, reflective journal helped the investigator to evaluate and explore her own feeling, emotions, and verbalize her personal beliefs. The reflective journal supplemented the data collected during interviews and helped the principal investigator situate herself within the collected data. This reflexivity was a continuous and comprehensive process in the study, allowing the researcher to realize his or her subjective role and improving the transparency and rigor of the study (Darawsheh, 2014).

### **Data Analysis and Validation.**

The interviews were transcribed verbatim by the investigator. Interviews conducted by the PI in Russian or English, as per request of the participants. The oral interviews were transcribed and simultaneously translated to English by the PI and a research assistant for data analysis. The investigator transcribed and translated the interviews directly, and validated the accuracy of translated material by discussing small segments or single words and parts of sentences with Russian speaking healthcare professionals. The data for translation verification was presented in the small fragments to protect participants' confidentiality. To ensure the validity of translated data, the principal investigator transcribed portions of the interviews in Russian and translated them to English.

Moreover, the principal investigator presented translated portions of the data to healthcare professionals fluent in Russian and English for back translation. None of the pieces of data submitted for data verification contained demographic characteristics or any information that could have potentially identified the participants.

Data analysis included the analysis of the transcribed and translated interviews, analysis of documents, and analysis of field notes and reflective journal. The analysis of the data involved continuous dissecting the data and deciding where the data fit and/or identification of the need for an additional data (Hammersley and Atkinson, 2007). The process of continuous analysis of the data enabled an ongoing discovery of new themes and patterns. Transcribed data was read and re-read repeatedly. This process enabled "getting to know the data" (Hammersley and Atkinson, 2007). Initially each segment (paragraph) of the interviews was coded by the principal investigator. Guided by the faculty advisor/dissertation chair, the principal investigator searched for patterns in the

data. Close interaction with the data facilitated generation of concepts (Hammersley and Atkinson, 2007). The data patterns were later coded. Small codes were connected to the larger codes, and eventually formed into categories. These codes and categories later merged into themes and patterns. Large categories were evaluated for their interrelationship. At the final stage of the analysis, the data was mapped, displayed in the diagram, and the nature of the connections was visually displayed (Creswell, 2013; Corbin & Strauss, 2008).

Through continuous data analysis, the principal investigator collaborated with her dissertation chair and faculty advisor Teri Lindgren, RN, PhD. Peer research and interpretation of data at different time and location was found to improve the validity and dependability in qualitative research (Golafshani, 2003; Noble and Smith, 2015). Working on data analysis with the faculty advisor improved the validity of data and limited some of the personal bias, which could have potentially influenced the analysis. Noble and Smith (2015) argued for the importance of acknowledgement of personal bias and meticulous record keeping that demonstrates a clear decision trail in improving the validity of the qualitative data. Thus, in order to improve the validity, the principal investigator continuously documented her personal beliefs and bias to prevent contamination of data.

After the initial coding and data analysis, 24 themes were identified. They included: 1) being healthy/view on health, 2) being sick/unhealthy/view on illness, 3) health maintenance/health promotion, 4) health management/disease management, 5) health promotion and maintenance in the former USSR, 6) health maintenance in US, 7) experience with healthcare system in the former USSR, 8) experience with healthcare

system in US, 9) differences between healthcare in the former USSR and US, 10) stimulus/motivation to stay healthy, 11) sources of health-related information, 12) transnational connection, 13) expectations of healthcare and providers' qualities, 14) factors affecting health, 15) complimentary/alternative and non-traditional remedies/practices, 16) view on vodka, 17) historical aspect of living in the former USSR, 18) religion, 19) family role, 20) life satisfaction, 21) immigrants from the former USSR, 22) food and health, 23) current state of countries of the former USSR, and miscellaneous 24) "do not know where it fits in the data" (Appendix L) .

The above 24 themes were organized in the table with 24 rows. When saturation was reached in each of the themes, the summary of the category was conducted. For example, the summary of being healthy/view on health theme revealed the following results: *"Health is everything. Being physically and mentally well"*. The health maintenance/health promotion theme identified the following results: *"Maintaining health related to exercise and healthy diet"*.

Although, the initial stage of data analysis revealed large number of themes, and saturation of data was evident in many but not all of the identified categories, the data was lacking connection and organization. That is when it was brought to the next level of analysis. In that stage, the primary investigator and the dissertation chair combined some of the related themes and discarded the themes where saturation had not been evident. At that stage of data analysis the following 18 themes along with brief working descriptions were isolated (Appendix M):

1. Meaning of health and being healthy. Health is everything.

2. View on illness and being sick. Sickness (un-wellness) – not being able to enjoy life.
3. Health maintenance. Health promotion. Maintaining health is related to exercise and healthy diet.
  - A. Health maintenance in the former USSR.
  - B. Health maintenance in the US.
  - C. View on healthy food.
4. Health management. Practices related to illness. If sick-try home remedies first.
5. Experience with healthcare system in the former USSR. Crowded hospitals.  
Culture of bribery.
6. Experience with the US healthcare. Overall good healthcare system.
7. Differences between the US and the USSR healthcare. No health culture in the USSR
8. Stimulus/motivation to be healthy. To be healthy-to be able to care for self, to be independent and not to be a burden to the family.
9. Sources of health-related information. Younger respondents seek information online.
10. Transnational connections. Although some subjects deny having direct transnational connections, they read the news and books, watch TV and online programs from the former USSR.
11. Expectations of the healthcare providers. Qualities of the healthcare providers:  
Empathy, making patients feel important, ability to listen, see a patient as a human being and not just based on his/her insurance.

12. Factors affecting health. Stress, worries. People want more than they need. The calmer you respond to the stress the better your health is.
13. Alternative modalities. Many use home remedies, teas, milk. Some herbs such as plantago, chamomile, common yarrow. Buteyko's method. Various rinses
14. View on vodka. It is used to relief stress. Occasional use of alcohol is not seen as harm.
15. Historical aspect of living in the former USSR. In the USSR some people were persecuted for their political views.
16. Spirituality/religion. Cultural beliefs including superstitions along with formal religion.
17. Family role. Family members are expected to take care of sick relatives.
18. Unique qualities of Russian-speaking immigrants. Immigrants are stressed because of the unknown.

At the next step of analysis, the researchers reviewed each of the 18 categories for evidence of saturation. The themes lacking adequate saturation were eliminated. Some themes were revisited for their belonging to other categories, others were combined into new categories. Following this level of data analysis the following eight new categories were identified: 1) perception of health, 2) perception of illness, 3) what to do when sick, 4) health promotion and disease prevention, 5) stimulus to stay healthy, 6) transnational connections, 7) perception of healthcare systems, and 8) expectations of qualities of healthcare providers.

Upon completion of this stage of analysis the investigators listed main categories in order to identify their connections. Later the themes were collapsed into categories, and

sub-categories (Appendix F). At the final stages of data analysis the themes were organized into Core and merged into the Core model (Figure 1, Core model, Appendix G). The emerging of the Core model was guided by the theoretical framework of the Health Promotion Model. The themes were organized into Cores based on their relationship and interconnectedness.

### **Rigor.**

To further validate the data, a triangulation approach was utilized. The validation of data by triangulation involved the comparison of data addressing the same phenomenon collected from different sources (Hammersley and Atkinson, 2007; Golafshani, 2003; Noble and Smith, 2015). The researcher compared the interviews, field notes and reflective journals with participant's observations and collection of documents. Each source of data supplemented the others. The use of multiple approaches, such as observation, interviews, and recordings facilitated validity of the qualitative inquiry (Golafshani, 2003). The themes emerged during data collection as well as any questions and concerns related to the data were clarified and verified with representatives or Russian immigrant community.

The principal investigator conducted an ongoing data analysis to ensure triangulation and comparison of the emerged themes with the data collected from multiple sources. To assure the rigor, the investigator and her advisor continuously revisited gathered research material to ensure fluency and familiarity with the data (Hammersley and Atkinson, 2007).

To increase the rigor, the "thick description" technique was utilized. Thick description approach involved the exploration of behaviors along with understanding of

the meaning and rationales related to the individual actions (Ponterotto, 2006). In investigation of Russian-speaking immigrants' behaviors, the researcher looked into this aggregate's perceptions and experiences, examining views on health, illness, and healthcare along with health-related practices.

The purpose of this chapter was to describe the research methodology for the study aiming health-related practices of Russian-speaking immigrants. Empirical literature lacks adequate exploration of health-related practices of this population. Qualitative methodology allowed extensive examination of the phenomenon. Ethnographic inquiry guided the study and enabled comprehensive assessment of this population from multiple perspectives.

The data was collected through interviews, participant observation, and document analysis. Subsequently, the data was triangulated to ensure rigorous analysis and comprehensive views on health-related practices of Russian-speaking immigrants in New York and New Jersey. The results of the data analysis are presented in the next chapter.



## CHAPTER 4

### DATA ANALYSIS

There is evidence in the empirical literature identifying a gap in the exploration of practices related to the health of immigrants from the former Soviet Union (USSR), also known as Russian-speaking immigrants (Hoffman, et al. 2006; Tselmin, Korenblum, Reimann, Bornstein, & Schwartz, 2007; Ivanov et al. 2010; Mehler, Scott, Pines, Gifford, Biggerstaff & Hiatt, 2007; Duncan & Simmons, 1996; Gilmore, McKee & Rose, 2002). Despite the prevalence and increased risk of cardiovascular diseases, cancers, diabetes, communicable and sexually-transmitted infections, as well as mental health disturbances, including alcoholism, depression, and post-traumatic stress disorders in this population, it is unclear what factors guide Russian-speaking immigrants in their engagement in health-related activities (Wu, Tran & Khatutsky, 2005; Ivanov, Hu, & Leak, 2010; Ivanov, Hu, Pokhis, and Roth, 2010; Aroian & Vander Val, 2007; Hundley & Lambie, 2007; Duncan & Simmons, 1996; Tselmin, Korenblum, Reimann, Bornstein and Schwartz, 2007; Wu, Tran & Khatutsky, 2000). Cultural is found to influence health-related behaviors of Russian-speaking immigrants, yet many health-care providers are not equipped with adequate knowledge of culturally appropriate care for this group (Lipson, Weinstein, Gladstone, & Sarnoff, 2003; Resick, 2008). The purpose of this study is to focus on the gap in the empirical literature addressing health-related practices of Russian-speaking immigrants residing in the United States.

Due to the nature of the inquiry, a qualitative ethnographic methodology was chosen to guide the study (Creswell, 2013; Corbin & Strauss, 2008; Charmaz, 2006, Hammersley & Atkinson, 2000; Hunter 2012; Schembri & Boyle, 2012; Cruz &

Higginbottom, 2013). Since the principal investigator was personally and professionally acquainted with the population, a focused ethnographic approach was utilized to explore health-related practices of immigrants from the former USSR (Taylor, Rush & Robinson, 2014; Higginbottom, Pillay, & Boadu, 2013; Cruz & Higginbottom, 2013; Knoblauch, 2005). In order to ensure comprehensive data collection, the study consisted of three strategies for gathering the evidence: interviews, participant observation, and the collection and analysis of documents, including, but not limited to media and periodicals (Cruz & Higginbottom, 2013).

### **The Description of the Sample.**

A total of 18 interviews were conducted with 20 participants representing the sample. Two families independent from each other requested that both spouses be interviewed together. The sample is comprised of 9 males and 11 females. The range in age was 36 to 83 years at the time of the interview. The majority of the sample (60 %) was married, 45 % were Jewish, and 45 % Christians, 5 % Muslim, and 5 % were mixed. The average number of children was two, with the range from 0 to 5. Eighty percent of the participants came from the European part of the former USSR (Russia, Ukraine, Belarus), and the remaining 20 % came from Uzbekistan and Georgia. The range of years spent in the former USSR was from 18 to 62 years, whereas the number of years spent in the United States ranged from 4 months to 26 years. All participants received some schooling in the former USSR with 70 % of the sample having a bachelor's degree or higher education in the former USSR. In contrast, only 50 % of all participants received some form of education in the United States (See table in Appendix E).

### **Themes, Cores, and Categories.**

The data analysis identifies five main themes with multiple related categories. The themes subsequently merged into three overarching Cores. Core 1 is titled established views based on previous experiences, and includes themes of perception of health and perception of illness. Core 2 is named modifying views and factors, and is comprised of the theme of perception of healthcare. Core 3 addresses behavioral outcome, and reflects health-related practices.

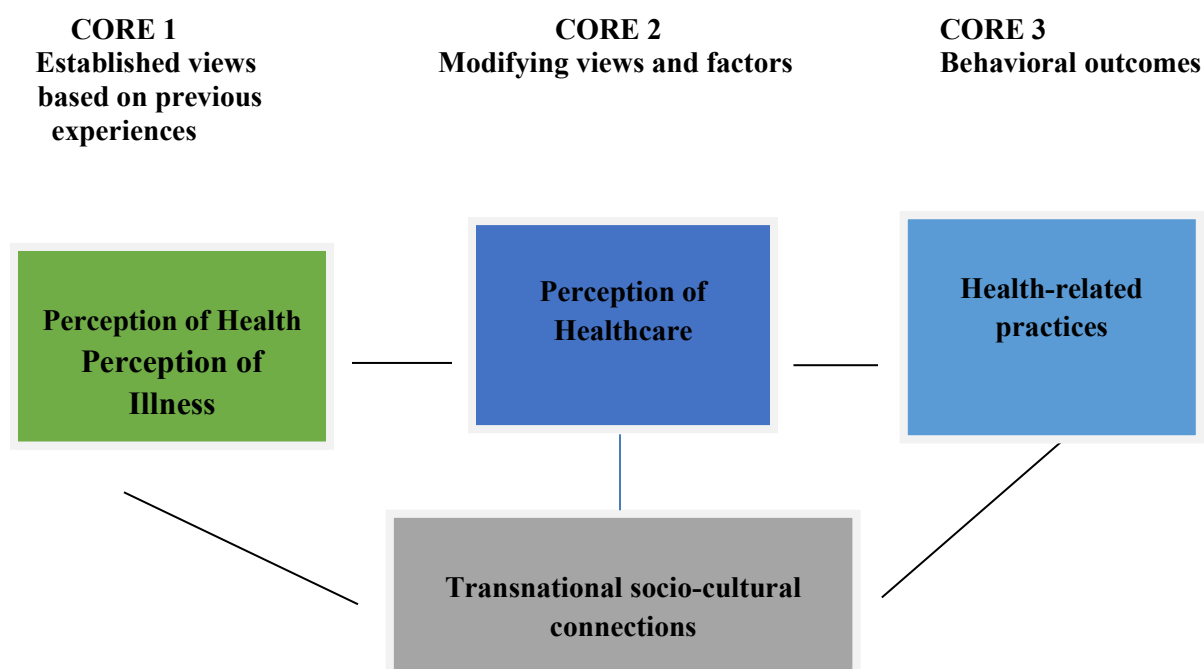
Core 1 consists of culturally based values and beliefs that are established by spending formative years in the former USSR. These values are pertinent to the aggregate of Russian-speaking immigrants, who share similar culture and values. Core 2, focuses on the modifying views that are shaped by various factors and encounters with health-care systems in the former USSR and the United States. Core 3 is influenced by Cores 1 and 2, and concentrates on the behavioral outcomes manifested by health-related practices. These practices are based on culturally established beliefs and modified by experiences with healthcare.

Although independent, all three Cores are inter-related and mutually influencing. The interaction of the Cores is an ongoing process that includes reshaping of perceptions and behaviors as they are affected by experiences. The Cores indicate the relationship between the views established by one's upbringing in former Soviet Union and the factors related to various life experiences before and after immigration, leading to the outcome manifested by health-related behaviors.

The theme of transnational socio-cultural connections is freestanding and does not fit within the Cores. Although this theme is not a Core, it underpins all three Cores and is closely connected with all the themes and categories as it influences multiple aspects

related to health of Russian-speaking immigrants in the US. Transnational socio-cultural connections enhance the experiences and modify views, and behaviors related to health of Russian-speaking immigrants residing in the United States (Figure 1, Core model, Appendix G).

*Figure 1. Core model.*



### **Core 1. Established views based on previous experiences.**

This core emerged in response to questions related to health and illness. The participants were asked to explore what it meant to them to be healthy and what it meant to be sick. In the process of the interview, it was noted that when asked about their view on health, many Russian-speakers referred to their personal motivators to stay healthy. As a result, the theme perception of health evolved into the exploration of stimuli to stay healthy.

**Theme 1. Perception of Health.** Russian-speaking immigrants in the United States value health stating: “Health is everything. No health-no nothing.” Health is viewed as an “absolute harmony” and the absence of pain or any type of discomfort: “Don’t think you have a body part... nothing bothers you.” “Being healthy-feel good.” Being healthy is living life to the fullest: “Full [healthy] life-nothing bothers you, nothing hurts, no fatigue.” Being healthy also refers to getting all that life has to offer: “Healthy-live life to the fullest...You can drink, eat, [and] enjoy life”.

Physical activity is closely related to health. Being able to move around without limitations is often referred to as being healthy: “Health is the ability to move.” The ability to enjoy life and socialize is also a part of being healthy: “Being healthy-being active, walking, having a social life, going to the theater, meeting with friends and family.” Being healthy involves independence in physical activities: “Healthy-living normally, run, jump, understand surrounding, [and] not suffer in pain.”

Russian-speaking immigrants view health as a combination of physical and psychosocial stability and include it in their overall meaning of health. They believe that psychological and emotional distress could lead to disturbances in physical health: “Being healthy/being physically and psychologically well...Bad thoughts lead to sickness.”

One of the participants stated: “To be healthy is to be morally and physically healthy.” Interestingly, the word “moral” used by Russian-speaking immigrants has a “psychological” meaning. When asked about components of health, a participant stated: “...If a person [is] morally [mentally/psychosocially] healthy, his thoughts are thinking in a good way...and physically healthy.”

Health is a valuable asset in Russian-speaking immigrants in their personal lives and the lives of their families. Many participants mentioned their families while talking about their own health. As a result, family as key stimulus to stay healthy emerged as a new category.

***Stimulus to stay healthy.*** “Grandkids stimulate [me] to be healthy.” Families motivate Russian-speaking immigrants to stay healthy: “Want to be in shape to help the kids.” The family was recognized by multiple participants as an important motivator for maintaining health.

***Role of the family in being healthy.*** Family plays an important role in the lives of Russian-speaking immigrants. Some participants stated that it was important for them not to burden the family with their care, while others stated that it was important for them to stay healthy in order to support their families. Regardless of the reasoning, the family was identified as the main stimulus to stay healthy.

There are family roles and expectations in Russian-speaking immigrants in the United States. Family members are anticipated to support and help each other: “But he [the father] lived with me. I cared for him, watched after him. Even tried to feed him when he was coming home after work.”

A family often includes extended family members. In the absence of immediate familial caregivers, extended family members take responsibility for the care of those who are in need, even if they do not get along. One participant shared his experience of taking care of the grandfather’s sister:

... She was never married, and we took care of her. She had a bad personality...  
She wasn’t my grandma. She was my grandfather’s sister... Yes, she lived at

home, but we [provided] everything that she needed. Before she died we hired a woman. She took care of her. Simply it was impossible to live with her...

Russian-speaking immigrants have a negative perception of long-term care facilities and feel strongly about placing their family members in nursing homes: “How can one place a mom in a nursing home?” Adult children are expected to support their parents physically and financially. One of the participants described his observation of an American family:

When I worked in the store there [came] a simple woman and her son. It was here. 35-40 years [old son]. They bought coffee. And the son paid for coffee separately; mom paid for coffee separately. Such things amazed me. So pay. How much there is? One dollar-two dollars? I don't understand this. [It is very] difficult to understand. She paid for her coffee; he paid for his. How to ask him not to place his mom [in a nursing home]? In our [country] parents live in the same home with grandkids, family.

Observations of the participants and in reviewing Russian media and news publications, the importance of family was apparent. Many community events involved multiple generations. It was noted that family members put a great emphasis on taking care of each other. The principal investigator attended an annual community event “Your Highness Grandma” contest in Brooklyn, New York. This contest includes women self-identified as grandmothers to compete with each other in singing, dancing, and other talents. The Bklyner, the Brooklyn-wide news site describes this event: “The grandmothers used the spotlight to celebrate their grandchildren, as well as America, the adopted home of each contestant. They honored their American patriotism with traditions of

their Eastern European cultures” (Retrieved from: <https://bklyner.com/everyone-winner-15th-annual-highness-grandmother-pageant-sheepshead-bay>).

During this event, the principal investigator observed Russian-speaking immigrants of different ages gathering while family members of different generations interacted and supported each other. Grandmothers were performing for their children and grandchildren. Children of various ages danced ethnic dances to show their respect and to honor their families.

In attendance of other religious and secular ethnic festivals in New York and New Jersey, the unity of the families, and intergenerational communication were evident among the immigrants from the former USSR. Regardless of the Soviet republic of origin, the immigrants from the former USSR were showed family connections along with a desire for preservation of ethnic and cultural traditions.

In communicating with young and middle-aged Russian-speaking adults the principal investigator noticed a pattern in this cultural group of making living arrangements to be near their elderly relatives. For instance, a number of families were staying in apartment buildings in Brooklyn to make sure that they were close to their parents whose health was declining. They believed that the infrastructure and amenities of a big city, such as Brooklyn, were more suitable for their parents and grandparents. Although the adult children had the option of moving to the suburbs of New Jersey, they preferred to stay as close to their parents as possible.

It is not unusual for the extended families to settle close to each other and help in caring for the elderly and unwell. After interviewing various Russian-speaking immigrants, it became evident that there are several generations of a family living



together. The grandparents are helping to raise the children, while young and middle-aged adults are taking care of the elderly. Many of the interviewed participants reported living with their extended families upon initial entry into the country; some were still living and taking care of family members at the time of the interviews. Family members assist newcomers in their settlement process in a new country and try to place them in the same neighborhoods:

We came. We were... I, [my] husband and aunt, [the] father's sister. We came, lived [with a cousin] for 3 weeks. During that time we found an apartment...and moved there. My [cousin's daughter's] husband all helped us move and we settled there...The aunt lived nearby...That is why I went to her often and she stopped by, at my [home] with her helper...We were very close. She helped me all [her] life; I [helped] her. So...She was like a mother [to me]...When she was sick I was coming to her...

Despite the cultural expectations that family members care for one another, Russian-speaking immigrants prefer to be independent and do not want to burden loved ones with their care. Many participants stated that they wanted to stay healthy to protect their families from the burden of caring for an ill relative: "To be healthy-to take care of myself, be independent, not be a burden, not for the family to take care of me...Want to be able to help." Personal independence was noted to be an important part of being healthy: "To say honestly, [I] do not want to be a burden to someone. That is, [I] don't want for someone to [take care] of me..." Therefore "being healthy" is to be independent of being cared for by others: "Don't want to depend on anyone. Person exercises to be in shape and not be bedbound and incontinent".

Besides not being a burden to the family, Russian-speaking immigrants want to stay healthy to be able to support their loved ones: “I have to be healthy to work and keep the job. Being sick with an ulcer-not being able to work-not able to pay bills.” One of the participants stated: “The stimulus is mostly wanting to raise the kids because I see what now, I am almost 45 years old, and I see that I still need [my] mom...That is why [I] want the kids to have parents. To support them, morally [psychologically] and financially.”

Russian-speaking immigrants view a person as healthy if they are free of pain or any kind of limitations of daily activities. Since being healthy means absence of any form of restrictions, the presence of a chronic condition is perceived as a sign of illness. The need to take medications to support one’s health is viewed as an alteration of health: “Being healthy-not need medications.” If one is prescribed medications and needs adjustment of dosages, such a person is viewed as being ill.

**Theme 2. Perception of Illness.** Contrary to the perception of health being the absence of physical and psychological disturbance, the perception of illness includes the presence of pain, discomfort and any type of irritation: “Sick [is] when [it] hurts and discomfort.” Any limitation in daily activities and the inability to get the most out of life was perceived as an illness by the respondents: “Not being able to enjoy life, not being able to do what you want to do.” Being sick is viewed as a constraint of living: “Sick-unable to get all that life has to offer.”

Similarly to the perception on health as a combination of physiological and psychological well-being, the perception of illness includes disturbances of these aspects

of life: “Sick-cannot walk [move] and think.” Cognitive instability or any type of emotional disturbance is also viewed as a sign of illness:

There are different unhealthy people, and physical traumas are there, and some [overcame] surgeries; there are people I saw, I worked with them, they are simply like psychologically unstable. The person is healthy, but [you] can’t tell that he is healthy...

Any sign of unwellness is viewed as an illness in the Russian-speaking immigrant population. There is little difference between chronic and acute conditions. Any indication of disturbance from the norm is perceived as a sign of illness: “Sick-chronic problems, pain. Discomfort is the indication of something. Not well with a sore throat, coughing, fever, bronchitis.”

Interestingly, medical attention is viewed primarily as a sign of unwellness. Some participants reported seeking professional medical care when ill: “Went to the doctor because had problems... [I am] taking medications to stay healthy.” Although taking medications was viewed by some as a sign of illness, others saw taking medications as a health-improving activity. Participants identified the need to take medications to stay healthy, yet once their health was improved, there was no more need to take medications.

The need for medications and medical care follow-up were closely connected to being ill: “Being dependent on the medications [is] being sick... Not having control over your medication dosages.” One participant stated: “Sick person is the one not being able to function without medications.” Being under regular medical monitoring was also seen as a sign of illness: “If need to go to the doctor/hospital frequently-you are sick.” A participant reported: “If you go to the doctor, you are sick.”

There was no perception of the health-care providers as promoters of health. Health-care professionals were seen as those who mostly manage diseases. Seeking medical attention indicated having an existing health problem. There was no stated difference between chronic and acute health issue. In the perception of illness, healthcare providers were given a dominant role, while a patient has very little control over his/her health and has to accept his/her destiny: “Sick-not good. You need to go to the doctor, run tests, and accept it.” Russian-speaking immigrants seem to trust their health to physicians and accept that the patient is not in charge of their treatment plans.

Along with a perception of illness, the participants reported their activities related to disease management. A variety of health improvement modalities were reported. They ranged from scientific approaches to traditional and/or alternative health-related interventions. When talking about illness, the participants referred to a variety of remedies used to manage unwellness. Subsequently these inquiries led to an additional subcategories of what to do when sick, and remedies to illness.

***What to do when sick?*** Naturally, when talking about health disturbances, the participants addressed various approaches to health management. When asked what they do when they are sick, Russian-speaking immigrants provided diverse responses. Some referred to a variety of home remedies and natural products: “If sick do nothing or if have a cold-lemon.” Some respondents preferred not to seek medical attention when they were sick: “If sick, [I] stay home. Rarely go to the doctor.” There were even those who sought a combination of the scientific and folk approaches: “If sick-antibiotics or home remedies. Throat rinses, rubs.” One participant stated: “If sick, [I] take care of myself. Or

[I go to] doctors to run some tests.” In general, there was a peculiar combination of utilization of home remedies and scientifically established health-care services.

Some respondents openly talked about using the combinations of the scientific-based and non-allopathic modalities. Others denied any use of home and/or folk remedies and only reported to utilized physician-prescribed treatments. Intriguingly, those who directly denied using folk remedies indirectly reported utilization of some non-allopathic methods in maintaining their health. For example, a participant reported being advised by a family member to use liquor as a home remedy. It was only due to no liquor being handy that prevented the participant from using it. Although the same participant denied using non-scientific modalities, the use of the recommended remedy was strongly considered. One can conclude that Russian-speaking immigrants might not differentiate between non-scientific and allopathic modalities.

*Remedies to illness.* Many of the home remedies, used by Russian-speaker in the US, were learned in the former USSR and handed down from one generation to the next. Participants reported that their parents and grandparents practiced similar approaches to health management: “Some things I ask [my] mom or grandma...” Some participants reported that mostly older immigrants utilized folk remedies “Although it is controversial, older people still use old remedies.” Yet, younger respondents admitted to using non-scientific modalities as well: “I drink tea with ginger and make the kids drink [tea]. I buy ginger root, I peel it, [and] I cut it into small pieces in the cup...to improve the immunity.”

Home remedies included foods and natural products, such as vegetable buds: “In the United States still doing boiled potatoes, breathing birch buds. [Drink] Milk if

someone has a cold.” The use of various hot [boiled] drinks, such as teas, infused with herbs and roots is believed to help fight colds and boosts immunity:

From non-traditional, the only thing that I can say is what my mom believes...she gives it to me occasionally. She absolutely believes in ginger.... [My] mom buys a lot of ginger, squeezes it through a juicer, [and] mixes it with honey and lemon. This jar is usually stored; this mix is stored in the fridge... Practically...I add a couple of [tea spoons of mixture] to tea. It adds a little spice. I believe that it thins the blood; I believe that it boosts immunity.

Russian-speaking immigrants believe in enhancing immunity with home remedies and prophylactic measures to prevent diseases:

I drink, I give the kids to drink, when [they have] colds, there is [herbal] remedy. When [cold only starts] I give it to adults, can give to kids too. It has no alcohol... There are also some herbs that I give to the kids simply for prophylactics once a day.

The word “prophylaxis” is commonly used by Russian-speaking immigrants in reference to preventing diseases, yet, it was not clearly connected with the concept of prevention. There is no clear definition and/or structured activity to prevent health disturbances. “Prophylaxis” is mostly used in terms of improving the overall health status, yet there was no universal guidance to such practice.

Russian-speaking immigrants refer to a variety of remedies, which are believed to improve their well-being. One of the participants reported using herbs to promote wound healing and valerian roots for sleep, despite her family objecting it: “I like folk medicine and try it myself... The family is not supportive of this... Plantago for wounds. It helps

wounds heal fast. Boiled plantago. Castor oil for skin, Valerian, hawthorn brewing. Valerian for sleep.” This participant indicated the importance of having faith in using various remedies: “A person has to believe in something.”

One family reported the use of a variety of naturally derived remedies for management of different health alterations: “Tea helps with conjunctivitis. Some ingredients in tea are antiseptics... Lavender and plantago heal.” They believe in the power of alternative modalities as they were historically established, and they advocated for providers to combine scientific and traditionally established treatment modalities: “Use methods of the ancestors... The ideal doctor would use both methods: one that is established by generations, and the other based on scientific discoveries.” Alternative natural modalities are well accepted by many Russian-speakers: “Acupuncture, herbs. Better than pills. Shamans, voodoo, exorcism are bad, but natural remedies are welcomed.”

In conversing with a number of Russian-speaking immigrants, including those in the medical profession, the Principal Investigator noticed some patterns of use of alternative modalities in disease management. For instance, there were reports of using Eastern herbalists to help with chronic and even terminal health issues. The choice of modalities could also include spiritual interventions. There was a report of some people going to small distant villages of the former USSR to meet with spiritual folk practitioners to help with their health issues, believed to be caused by evil spirits.

There is a great belief in the healing powers of nature in Russian-speaking immigrants. One participant even reported using urine to treat infections: “Urine, in nature, is sterile. Plus there are salts. It does [burns/irritates], but it kills bacteria.”

Wounds were reported to heal faster with the use of natural ingredients: “This wound heals simply with sugar.” A participant reported mixing sugar and egg shells to treat his mother’s bedsores. Another participant reported lemon rinses to help with symptoms of scarlet fever, “garlic wicks” for nose problems, coltsfoot for the common cold, yarrow, plantain, hypericum, chamomile for stomach, nettle, burdock, coconut oils for hair, coconut oil for face masks, and boric acid for ears and eczema. This participant reported: “Russian medications are more natural.”

In general alternative modalities are well accepted by Russian-speaking immigrants. Some of the modalities were developed and presented by medical professionals in the former USSR. One of the popular alternative approaches in health management in the former USSR was reported to be a Buteyko Method, also called “trained breathing.” It was developed by a physician from the current territory of Russia. Some of the interviewed participants reported great improvement in their health after using the Buteyko Method. They described that approach to be based on asceticism, limiting overdoing, and over consuming: “Don’t overeat, don’t over love...” The principal of the Buteyko Method, a trained breathing approach, was described as controlling breathing patterns, and utilizing natural forces to manage one’s health...”

In reviewing popular periodicals and media in the Russian language one can find a variety of so-called “home recipes” to improve and sustain health. Russian-speaking immigrants can find “advice” on how to manage a health problem using various, sometimes even unusual, home remedies. The modalities include using herbs, berries and food products to manage a variety of health problems. Interestingly, none of the “recommendations” were supported by solid scientific research. Very few articles have a



reference from a physician or expert in the field. It was unclear if any of those health-care providers were licensed to practice medicine in the United States. The topics published in the magazine varied from polycystic ovarian syndrome to depression, dental care, and herbal remedies. There was no indication that the editor, authors or publisher had any kind of medical background and/or credentials.

One of the articles found in a magazine under the “expert opinion” column provides an interview with a healer claiming to “reverse biological clocks” and rejuvenate a body using knowledge gathered from ancient healers; Tibetan, Chinese, Arabic and European doctors along with shamans. This healer claims to be a surgeon with about 50 years of experience. In the same magazine, there was also a column on herbal treatment where an herbal pharmacy compounder gives advice on management of asthma. This herbalist claims to treat asthma with herbal tinctures.

The Russian health magazines have a large number of advertisements for a variety of medical services in the United States and countries of the former USSR. There were the advertisements for dental care, neurology, family medicine along with laser liposuction and podiatry care, physical therapy, medical supply companies, and pharmacies. Along with health-focused articles, there are advertisements for mediums and fortune-tellers.

The readers’ columns vary from asking the magazine to address a specific health issue to sharing home remedies and alternative modalities used by the readers. One of the readers highly recommends using turmeric for people of advanced age to improve their memory and cognitive abilities. This reader states that turmeric “blocks the action of proteins that destroy brain neurons.” The same person claims that turmeric decreases

inflammation, helps with stress reduction and diabetes. She also reports that cinnamon decreased blood sugar and [LDL] cholesterol levels as well as blood pressure. While there are studies on certain spices and herbs that indicate their potential effectiveness on promoting health, (Khan, Safdar, Ali Khan, Khattak, Anderson, 2003), the reader giving advice on health maintenance did not provide any scientific support for the assertions on cinnamon or turmeric, nor provide their credentials or education.

Some readers just talk about their families and tell their life stories to the editor. Others share their health problems and ask for advice. In most cases, the editor recommends seeking professional medical advice and comprehensive evaluation of their health conditions.

Also in the periodical, there is a section titled: "Without medications". Here an author of unidentified professional background advises readers on remedies to alleviate white coating on the tongue. The author provides 7 different remedies that include salt, spices, baking soda, yogurt, aloe vera, and even glycerin. There was no scientific reference indicating the effectiveness of these approaches.

Inside the magazine, there is an advertisement of an herbal therapist from Georgia. This woman claims to have been raised by nuns in a monastery. According to the ad, the nuns passed down their knowledge on the treatment of cancer (including metastasis), HIV and AIDS, diabetes, colitis, eczema, and many other health problems with herbs. On the bottom of the page, this therapist states: "If you have health problems do not rush into taking pills and [other medications], try natural remedy given personally by nature".

In communicating with Russian-speaking immigrants who read Russian health magazines in the United States, the PI learned of an example of recommendation on using vodka soaks to relieve pain in the feet. There was no additional information or a specific guide provided on the utilization of this modality.

Although some of the interviewed participants reported using vodka to maintain their health, the general views on the benefits of vodka varied between the participants:

Vodka. Alcohol, in principal, not healthy, harmful to the liver, but wine helps alleviate stress. There is a belief that you have an upset stomach as a result of infection you have to drink a shot of vodka. [I] tried it, but it did not help.

Another interesting observation is that Russian-speaking immigrants often alternate the use of scientific and non-scientific modalities. Some will mix medications, prescribed by healthcare providers, with home remedies if they are not happy with their response to prescribed medications: “I try a mixture that [was] prescribed, and that is so drowsy that I...or with some Codeine that I can’t function, I only sleep all day, I will try, for example, drink herbs. For a cough, for example, coltsfoot.” It is, however, unclear if the instances of such combinations of treatment approaches were reported to health-care providers. It is also unclear if they were taking these remedies simultaneously.

Having medical coverage allows Russian-speaking immigrants to utilize health-care services in the United States and seek the help of health-care professionals: “Since [we] have insurance-go to the doctor.” The pattern of using herbs, supplement, and other non-traditional modalities was noted in all the participants regardless of their age, education, socio-economic status, the presence of medical coverage, and access to health-care services in the United States.

Due to the common use of the alternative modalities, Russian-speaking immigrants prefer providers who include folk and non-scientific remedies in their treatment plans: “In US good healthcare system... Big choice of doctors, very competent doctors... My physician prescribes antibiotics right away... American doctor does not offer herbs... American treatment modalities are faster and stronger... But Russian modalities, which are often used, are natural.” Russian-speaking immigrants prefer “natural” modalities over health-care systems based approaches. The perception of the health-care system plays an important role in guiding participants’ decisions regarding their health management. Their previous and current experiences and expectations guide them in seeking professional medical care or using non-traditional modalities.

### **Core 2. Modifying views and factors.**

Core 2 has been established based on the inquiries related to living in the countries of the former Soviet Union and the participants’ experiences with health-care systems in their country of origin as well as in the United States. During the interviews, some participants identified the differences in health-related services in the USSR and the United States, and shared their experiences with encounters with both systems. As a result of such interactions, the participants developed a number of expectations of health-care providers, and rated their experiences based on those expectations.

**Theme 3. Perception of Healthcare.** The perception of the health-care systems was divided into three categories: perception of the healthcare system in the former USSR, perception of healthcare in the United States, and expectations of healthcare providers. These experiences play a vital role in Russian-speaking immigrants’ perceptions on health and disease management.

***Perception of the healthcare system in the former USSR.*** Regardless of the country of origin in the former USSR, most participants reported negative experiences with the health-care system in the former Soviet republics. Crowded hospitals, outdated technology, and lack of attention from health-care providers were identified: “In Russia crowded hospital rooms.” The comments included incompetence of healthcare providers in the former USSR: “Russian doctors have a gap in assessing their patients.” Lack of support and resources to treat patients in the former USSR was addressed: “In former USSR doctors have fewer resources.”

In the former USSR healthcare for the citizens was a government responsibility. The historic structure of healthcare in the former USSR included regional clinics, called polyclinics. Citizens of the former USSR were assigned to residential and/or work-based health-care providers. One of the participants noted: “In USSR [I] was assigned to the polyclinic to a regional doctor. Had one regional internist... [I] went to the regional doctor to get a note for work when was sick. Another doctor made house calls.” In addition to the neighborhood physicians, some workplaces provided health-care services to their employees. One of the participants stated: “In USSR workplaces provided health monitoring of their workers. It was a government responsibility.” Workplaces also provided vouchers to health-based resorts [sanatoriums] for their employees: “Sanatoriums were provided by the workplaces to maintain the health of the workers.” Although the word “sanatorium” has a negative connotation in the United States, in the former USSR, sanatoriums were widely utilized as resorts for health and disease maintenance.

Although such a system was convenient, the patient lacked the freedom to choose a physician: “In the former USSR was no choice of provider.” Interestingly, the polyclinic was seen as a resource for taking care of illness rather than a source of sustaining wellness. Polyclinic services were mostly utilized when people were sick rather than as a health maintaining or a disease prevention entity. “[I] used to go to the gynecologist in USSR. Rarely saw the doctor in USSR.” Such views on health-care services are consistent with their perceptions on illness and health, where seeing a doctor was perceived as a sign of illness.

Due to the lack of government resources and inadequate compensation for health-care providers, a culture of bribery was reported in the former USSR. Doctors working in the private sector were reported to give more care and attention to their patients, while government-based physicians were perceived as less attentive: “[In former USSR] doctors make little money and do not really care about patients. However, in private clinics, you can get enough attention for the money.” Interestingly, private care services in the former USSR republics were reported to be better than the same in the United States: “Simpler to get private care in Belarus than in the US. More accessible care in Belarus than in the US... If you pay in Belarus-don’t have to wait to get care.”

There were no official prices for health-related services in the government based facilities, yet, in order to get quality care, one is expected to “bribe” the providers: “Healthcare in Ukraine is based on bribery. You have to pay to get care. Have to pay for supplies there.” Currently in certain areas of the former USSR not everyone is able to afford quality medical care: “It is very hard to afford healthcare in Ukraine for a regular person. No way without money in Ukraine. Everything is expensive.” There is a lack of

equipment in health-care facilities, where the family members are expected to purchase necessary supplies, including but not limited to medications, wound care material and linens for the hospital bed. “Family had to bring it all.” Medical care in the former USSR is based on the financial abilities of the patient. “In Russia there is everything, but one needs the money.”

Several participants reported that even money does not guarantee health-care services for the elderly. Age was one of the determining factors of health-care provision: “In Russia, they look at your age. If you are old, you will not be cared for. In Russia even [if] you have the money but you are old you will not get a quality care.” The neglect of the needs of the elderly was reported: “Elderly are not treated because people over 70 [years old] are expected to die soon. Grandma was refused treatment in the former USSR.” Health-care providers were expected to be paid upfront to care for an elderly patient: “Health-care workers were waiting for the bribe, wanted to push her out-home to die...Refused to do a surgery, did not want to give her medications or even bedpan.”

Although the majority of participants reported negative interactions with the health-care system in the former USSR, some believed that health-care providers in the former USSR were forced to do their best with minimal resources:

Russian doctors did not have the technology. They were forced to think. In the former USSR doctors are not machines. They believed in patients’ uniqueness. No “brushing by one comb”. In Russia people went into medicine by calling...More levels of creativity in the former USSR. Today doctors are blind executors...

The Principal Investigator had a random and unusual encounter with a group of Russian-speaking immigrants who came to the United States as scientists. These professionals come from elite families from the former USSR. Their parents were scientists, physicians, and ministers in the Soviet government. These immigrants reported having access to privileged health-care services in the USSR. Such services were available to the government officials and their families only. When they were informally asked about their experiences, these immigrants reported having great resources and access to the most advanced technology in the country. They were disappointed when the USSR collapsed and they no longer had such privileges.

***Perception of the healthcare system in the United States.*** The experiences with the health-care system in the United States varied among participants. Interestingly, older immigrants verbalized the most satisfactory experiences with health-related services in the United States, whereas younger Russian-speakers reported negative encounters related to the cost of American health-related care. Presumably, older immigrants had lower medical costs or even free government-based medical coverage, while younger participants were paying higher amounts for health-related services. This difference in cost influenced the participants' perceptions as well as their expectations of the health-care system in the United States. Those who have medical insurance were more optimistic about healthcare in the United States: "Everything is affordable in the US... If you have insurance, you can afford care." One participant stated: "American healthcare is so advanced and all care was paid for by Medicaid." However, not all the immigrants from the former USSR have adequate medical coverage when they move to the United States: "In US most cannot afford to pay themselves for healthcare."



The participants over the age of 65 with a government-issued healthcare coverage reported positive experiences in general with the health-care system in the United States:

[I am] very satisfied with healthcare in the US. Very attentive, treat you with care, listen to you. [I] never had any problems. You get treated with a great care by the doctors. Good doctor-listens to me, [runs] tests, calls the pharmacy, writes prescriptions. Care was greater than in Russia. It is [in Russia] like a factory.

Unlike limited services for the elderly in the former USSR, in the United States the quality of care and timely services are available to everyone regardless of age. One of the participants stated: “In US surgery was done immediately. Helped grandma with eye problems right on the spot, and her eyes never bothered her again.”

American health-care providers are viewed as detail-oriented and found to be patient- centered according to the participants in the study: “In US doctors are very thorough... Check everything.” One of the participants reported: “Patients get a lot of attention from the providers.” American health-care providers are perceived as focused on solving patients’ health-related problems: “The difference between Russian and American practitioners is that in America providers want to investigate the problem, unlike Russian physicians who try to dismiss the issue and not to focus on it.”

Some younger respondents, however, feel that physicians in the United States do not pay enough attention to their patients: “Doctors have to immerse in your problem... They don’t listen... Nobody pays attention... No one wants to immerse themselves in your problem.”

Generally, the rating of health-care services in the United States is higher than the same care in the former USSR. However, younger participants verbalized some issues

related to their experiences in the United States. Many participants perceived health-care services to be money -driven and focused on profits: “Doctors want more; make more...In USA pharmaceutical monopoly. Profit-chasing, government controlled.” Some believe that insurance companies influence the quality of care: “Doctors are pressured by the insurance companies.” Pharmaceutical companies were believed to suppress natural treatment modalities: “Propaganda of pharmaceuticals... Media is a part of the propaganda. People with money rule... Vaccines became business. People get over-vaccinated and get sicker... Homeopathy is suffocating...”

It is believed that physicians are forced to act according to certain guidelines to protect themselves from legal actions:

Doctors prescribe antibiotics because they are afraid the body is too weak. A doctor is the last instance...Side effects are harmful but many people do not know about them. Some procedures are not necessary. Doctors force procedures on patients. A person is not given an option. Doctors want to do expensive procedures. Doctors are afraid to be sued.

The health-care system in the former USSR was part of the government services and was free to the public. Therefore, the money-driven, health-care system in the United States is negatively viewed by some Russian-speaking immigrants. “Healthcare is business. [It is] all about the money. Surgery-money. If people are disabled someone makes money off it.” Some Russian-speaking immigrants perceive American doctors more as business people than those who provide care: “Healthcare is related to money. Doctors care about your insurance before they care about your health. Doctors are businessmen. If you don’t have the money-“Be healthy.”

Some participants seem expect more attention from their health-care providers since they have to pay for care:

In the US doctors are not interested in your health. Appointments are too short.

Diagnosticians are good but treat you poorly because of the money. In America, focus is on money, not on patient's health... Doctors do not allocate enough attention.

There was an interesting pattern in a choice of health-care providers by Russian-speaking immigrants. Participants who were not fluent in English and not technologically advanced preferred convenient Russian-speaking providers. Some listened to the Russian radio for recommendations:

I used to listen to the radio...And this doctor who I went to, was speaking on the radio...He answered asked questions very interestingly. He had a program where the radio listeners asked him questions and he was answering. And he advertised himself at the same time, that he had to open an office in Brooklyn...It was next to the place where we lived.

Younger and more computer savvy participants used Internet resources to choose a provider. "Hospital recommended an affiliated physician. Despite hospital recommendations [I] checked the MD rating independently." Since health-care system in the former USSR was government controlled and a patient had very limited choices of health-care providers, Russian-speaking immigrants like the opportunity to learn about the providers before they choose the specialist that best fits their needs: "In US you know more about your doctor before you see them." Although some might ask friends and family to recommend a provider, others refer to the Internet as the main source of their

information about healthcare providers. “How else I will know the doctor? Unless I know him? Unless I know a person, I have no other choice but to use agents like Yelp or any other rating service, to read what other people said.”

The reputation of the provider and medical facility are important to Russian-speaking immigrants: “Better to go to a specialist in the area in a reputable hospital”. The reputation of the provider is as important as the personal qualities. Russian-speaking immigrants have specific expectations of those who deliver care to them. They are used to unconditionally trust their doctors and they expect the providers to meet a number of important criteria.

***Expectations of healthcare providers.*** Russian-speaking immigrants identified a number of important qualities of health-care providers. Personal attention from the provider is valued a lot by Russian-speaking immigrants: “Need to allocate at least 30 minutes per patient, read the whole chart.” A participant reported: “Doctor called [me over the phone] herself. Russian doctor working for a prestigious hospital was personable...” Knowledge of current research is also essential for this population. One of the participants described their experience with an American doctor: “The doctor knew about research in that area. The doctor conducted a comprehensive exam and did not rush. Doctor also paid attention to the other medical problems.”

Russian speakers believe that attention to details is very important in health-care providers: “Health-care providers have to hear you [out]. Providers [have] to listen to their patients. Lead the patient to the end. Give them answers.” Physicians are expected not to be tainted by the pharmaceutical companies: “Do not just prescribe corporation-guided medications. They get percentages from prescribed medications.”

There is a necessity for a great level of trust in the provider: “Russian immigrants are very trusting of physicians. They will do what the doctor says. The doctor is the person who will save me and make me healthy. We trust doctors completely.” Physicians often are viewed as the main source of health-related information. They are expected to guide their patients in their health-related activities: “People from [the former] USSR are not educated about their health. In US doctors are expected to [educate] enlighten patients.” Doctors are seen as saviors with a high authority, whose recommendations are accepted without any reservations.

Individual attention to each patient is one of the main qualities that most participants looked for in health-care providers. “Internists were attentive, listened. I have no complains about healthcare workers.” Some believe that Russian-speaking immigrants are spoiled in their longing for attention: “Russian immigrants are spoiled in getting more personal attention from the doctors...People from [the former] USSR want more attention from the doctor.”

There seems to be a diversity in priorities of choosing health-care providers among Russian-speaking immigrants. Some respondents believed in the importance of personal attention by those taking care of them: “Care and attention. A person does not just walk into a clinic: they have many questions bothering them.” Other participants believed the competence of the provider to be paramount whereas personal qualities were secondary: “Providers’ ratings are important in choosing one...Pick doctors with good outcomes. Personal qualities are irrelevant. [I] do not have to live with the doctor. Need good results if sick.” Knowledge and skills are crucial qualities of the healthcare professionals: “Doctors have to be knowledgeable and skilled. Experience is more

important than age. Diagnostic abilities of providers are important. Doctors need to know the side effects of the prescribed medications.”

Although some younger participants had expertise as a priority preference of providers, they felt that the personable approach was also important:

Honestly, when I read reviews, I read if the doctor was able to help or was not able [to help]. I look at accreditations of the doctor, on which college he completed...When I had to go to a vascular doctor I went to the doctor who graduated from Harvard Medical School. Somehow you trust. I understand that this is a very strong doctor and that if he said that-that I have it. Like more trust, if you see a super respected school... And super respected hospital where this doctor works...An impression that he is ...impersonal...Does not talk to you about your lifestyle, not getting into [details], not trying to be friendly... That particular doctor, at least...They are impersonal. They look more into a computer than at you, because they fill out questionnaires and applications, etc. But overall they know what they are doing, and they know which tests need to be ordered. And I have more trust to those doctors then those who sit somewhere in Russian neighborhoods, and their clients/patients are elderly people.

Although younger respondents preferred the providers educated in the United States, there was a trust of physicians who graduated from reputable schools in the former USSR and those who did not put profit before the quality of patient care. “My internist, in fact, is very personable, who did not study in America, but she graduated from Leningrad [current St. Petersburg] Medical School. I am absolutely convinced that

there the diplomas were not purchased [sold]... She is a very [honest] person. That is why she drives [the car], Kia.”

Despite the trust of Russian-speaking providers, in serious cases, Russian-speaking immigrants place competence and qualifications before personal qualities of health-care providers. A participant reported: “Nevertheless, I think, if there was anything serious, that I would have gone for a second opinion to an American doctor.”

The choice of healthcare providers varied from convenience to published ratings. There seemed to be no uniform pattern in choice of the primary providers. However, the choice of a specialist was based on recommendations rather than on convenience: “Initially chose doctors ... [who were] “Not foreign” [familiar, in relation to patient’s personal cultural experiences]... Later used recommendations.” Some reported choosing their primary doctors based on convenience, yet the choice of the specialists was based on recommendations. “Prefer regular doctor based on convenience, location. If need a specialist-look for recommendations from people.” Older participants preferred to be seen by Russian-speaking health-care providers and receive ancillary health-related services in the Russian language as well. Younger respondents had no language preference of the provider.

Interestingly, when asked about healthcare providers, most participants talked about physicians with a few comments about nursing care. Nurses were not really perceived as independent practitioners. There seems to be a lack of knowledge about the advanced nursing scope of practice in Russian-speaking immigrants. Most respondents could not clearly distinguish nurse practitioners from physicians: “Nurses nourish. A nurse is more like an assistant to a physician.” One of the participants stated: “The first

element of helping a person is a well-educated nurse. Nurses [are] to use alternative methods and to “screen” patients if they really need more serious treatment.” Nurses are viewed as a kind person who gives people hope. “Nurses relate to patients as their relatives... Kindness... A nurse is like a savior... Giving people hope... A good word is half of health, half of the treatment.”

Previous experiences and perceptions of health-care systems and services lead to the behavioral outcome of the health-related practices. All of the health-related activities were guided by the socio-cultural backgrounds of Russian-speaking immigrants and modified by their experiences with health-related services before and after their immigration.

### **Core 3. Behavioral outcomes.**

This core emerged as a result of the inquiries addressing health-related practices in the former USSR and in the United States. The participants were asked to talk about their health-related actions in both countries. Additionally, the responders were asked to describe which practices were kept post immigrating to the United States, and which activities were no longer practiced. The participants were asked to talk about the factors affecting their practices in the United States.

**Theme 4. Health-related practices.** Health-related practices in Russian-speaking immigrants were closely connected with previous life experiences and perceptions on health and illness. The concepts of health-promotion and disease prevention were not clearly defined by Russian-speaking immigrants. None of the participants mentioned engagement in disease screening activities as part of their health-related practices. Those



who described their encounters with healthcare providers were focused on disease-related events.

Some practices were adjusted since the immigration, while others were preserved as part of their cultural heritage. Yet, when referencing their experiences with health-care systems in the United States, the participants did not mention health promotion or disease prevention activities.

***Health-related activities in the former USSR.*** Although there was no specific concept of health-related activities, government-based organizations had established health-related services at schools and workplaces. A participant reported having “prophylactic [activities]” at schools and reported that schools screened the students for dental problems and scoliosis. Such government-mandated health-related practices, however, were not always well accepted by the citizens of the former USSR:

The culture of taking care of your health is different...In the Soviet Union at that time, this culture, in my opinion, was not developed at all. Although, doing sports did exist. But on the other hand that was like...It looks to me like it had more like a social tone, in a group [commune/team], but not in relationship to your health. Although, I remember now, in our school [we] were doing some exercise. There was a period when [students] were doing exercise [with] the entire school in the morning. But it is like this initiative was gone fast.

Another participant indicated that health promotion was not a priority for people in former USSR: “People were [more] preoccupied with life routine than health.” Although physical activities were reported to be connected to health, there was no specific pattern of such behaviors. Sports were more for recreation than for health:

“Was going to the gym when [I] was young. Was physically active.” One participant reported playing soccer with a friend in the former USSR as part of the healthy lifestyle.

Traveling and staying in health resorts was also described as a way to maintain health in the former USSR: “To stay healthy I went away camping, spent time with friends and family, went to the sea resort, traveled.” Government-based workplaces provided their employees with vouchers to sanatoriums [health resorts]:

The only [thing] I never went to sanatoriums [to improve my health], the only things, in the 70s there were organized camping resorts. Our factory was not big... We had a base [resort area] on the coast of the sea... and we, as a rule, spent two weeks there in the summer. Alone or with the kids...

Citizens of the former USSR reported utilizing food and natural remedies to maintain their health. Natural food products, clean air, and sun were believed to improve health: “[We] grew own our fruits and vegetables... [We] drank fresh milk straight from the cow, breathed fresh air.” Sunbathing and tanning were related to health in people living in the former USSR: “Always tanned-sign of someone healthy.”

***Health-related activities in the United States.*** Health maintenance in the Russian-speaking immigrant population in the United States is related to diet and exercise. The respondents reported modifying their lifestyles since the immigration.” [I have] tried to stay healthy.” Ways of life were modified by the information gathered from TV and other media. “In the US you are educated. You get the information from the media in the US about health. You see people taking care of their health. In the USSR not educated.”

*Diet.* Russian-speaking immigrants reported trying to eat healthier in the United States by limiting junk food and carbonated beverages among other things. One participant reported drastic changes in her diet since the immigration:

I want to say what [it] changed a lot. When we [first] came with mom and grandma here... we continued cooking what we cooked there. These were [potato pancakes, hamburger meat, French fries]. We never made fresh salads. It was not included in our ration. [Now] Like, [because] of my husband, who likes vegetables, and likes salads, we have almost not one dinner when we at least do not cut tomatoes, cucumbers, avocado, and do not eat some amount of vegetables a day. Started cooking less Russian food and much more what is some neutral food, [such as] chicken baked in the oven, again, organic etc. Organic eggs, organic milk. I do not know how much it helps, but...

Many report their eating habits have changed since their immigration. “When [we] first came to the US were eating the same way as in [USSR]... Did not eat vegetables much... Now I know which foods are healthy. Don’t eat salami, canned food, [and] processed food, do not add salt, [and] do not eat “harmful” food. Do things right.”

Russian-speaking immigrants gather information on a healthy diet from the media, Internet and their personal surroundings. “[I] was inspired by the co-workers to start eating healthy. Educated people in the office started avoiding products with GMO, [they] do not use plastic containers, [and] people bring their own [homemade] food to the office.”

The perception of a “healthy diet” in Russian-speaking immigrants includes fruits, vegetables, and limited sugars. “Right food [is] fruits and vegetables, not cookies and ice

cream.” Traditional foods from the former USSR have been modified and adjusted to be healthier food choices. Culturally established foods are believed not be healthy.

“[Cultural] food is fattening, very saturated, high calories. What was considered normal in [former USSR] is not normal here now.” Some diets were adjusted due to the aging process. A participant stated: “I eat everything and I feel fine. [Now eating healthy] more vegetables. Vegetables fix stomach problems. With age certain foods cause problems.”

Many Russian-speakers prefer organic food as it is believed to be healthier. “To me very important is a healthy diet. To me to be healthy means eating healthy food, rich in vegetables and fruits, preferably, organic food...I am obsessed with healthy diet. I am simply obsessed...”

Homemade organic foods rich in greens, grains, and dairy products are believed to have a positive influence on health:

I go on vacation I carry...food. For example, cottage cheese, salad...We just had lunch... [We ate] the plate of [greens]. That is...I...every morning we eat a plate of oatmeal...I make two types of grains.

Organic food is believed to help in disease management. A participant stated: “[We] prefer organic food. No GMO. Food can help with some diseases.... Vegetables, salads.... Less Russian food...Watching sugar content.... Limit bread, consuming fewer flour products....Many things have changed.”

Although many participants referred to organic food as a healthy option, when asked about their personal opinion of the difference between organic and non-organic, some respondents did not see a strong connection between food and health: “No difference between organic and non-organic food. No specific connection between food

and health. If a person is healthy he can eat anything.” A participant believes organic products to be a marketing strategy:

And what is the organic food? We even saw organic vodka. Like...Ok, how vodka could be organic? The wheat is organic or what is...I think that now it becomes a selling point. So, they could get the same product. Don't know if this is controlled by someone or is not controlled. What is organic? ... But simple in your head you think that it will help you.

Organic food is often purchased just because it is believed to be better:

I will take organic simply to... you know, just because. Nothing. Simply [psychological].

For example... [I] recently took tofu which is organic. It is really tasty. It is not only tasty. By quality it is...better quality. It does not fall apart, does [not look like a sneeze]. Again, all depends on the producer. How you will say it or not say it. I, likely, relate it to taste. Yes. Not more with health, more with taste.

Interestingly, although the respondents verbalized the list of healthy food choices, many of them reported not always adhering to a healthy diet: “One weekend, one, other, another, worked late, four days in a row ate pizza at 10 pm or something else. Chocolate donuts in the morning, pizza in the evening, and went somewhere on the weekend.” Even those who have to follow a strict diet based on medical recommendations, admit cheating on their diets when they are outside of their homes:

Unfortunately, when I end up in a restaurant I eat like all the other people. The only thing is maybe where there is a choice on the table; I will not reach for salty fish, such as smoked fish. I know that [I] do not eat it and [do not crave it].

Like...but other things I eat. I understand that they are more seasoned than what I need to eat.

Another interesting aspect is that despite the attempts of keeping healthy diets at home, children of Russian-speaking immigrants do not have the same dietary preferences, and act like most children in the United States. “The kids are trying to resist it a little bit...Once a week [I] allow [them] to buy whatever junk they want at school. Whatever they want they can buy. They go, buy pizza, chicken nuggets, waffles, I don’t know, something...” Despite the parents’ attempts to modify culturally-established foods and make them healthier, their children often refuse to eat it: “The kids could try a little. Some do not eat at all. Because they are influenced by American food culture, and they prefer local food...it is more interesting.”

Along with modification of diet, Russian-speaking immigrants reported exercise to be a part of their health maintenance approach. They believe that their health-related activities should include exercise.

*Exercise.* Russian-speaking immigrants believe physical activities improve their physical and psychological well-being. One participant stated: “Running helps stay healthy... Running helps physically and mentally... Running outside helps boost immune system and some little things stop bothering [you]...”

Similarly to the modification of diet, physical activities were adjusted after immigration to the United States as well. “[I] was never into sports in [former USSR]”. When asked what they do for health, many participants reported exercising for health. Some participants reported going to the gym and engaging in structured exercise

programs, others believe that being physically active in general was a part of maintaining a healthy lifestyle. “Moving is the most important. Walking. Get out [for a walk]...”

In addition to life adjustments and assimilating into life in the United States, Russian-speaking immigrants maintain various degrees of connection with their country of origin. These connections guide them in their health-related practices and even serve as resources to health-care services and information. The importance of transnational connections in Russian-speaking immigrants in the United States cannot be underestimated.

**Underpinning Theme 5. Transnational socio-cultural connections.** This theme emerged as result of the investigator inquiries and analysis of the data related to the interactions of the participants with countries of the former USSR. Some of the participants identified the influence of transnational connections during their interviews. Other respondents were asked to describe their interactions with countries of the former USSR. Although some reported having direct and frequent contacts, others denied having ongoing connections with the country of origin, yet, all of the participants had current knowledge of events, political and social, in the former USSR.

Regardless of the number of years spent in the United States, Russian-speaking immigrants had some form of connection with their counties of origin. The type of transnational socio-cultural connection depended on whether the participants has friends and family currently living in the former USSR. Some denied having anyone to connect with back home. “All friends left. There is no one to connect with.” Other participants reported frequently traveling to their country of origin or communicating with friend and family by phone or the Internet:

We talk every day through Skype, or if cannot talk through Skype, if oversleep, because we always call in the morning, then communicate through the Whatsapp and Viber. Every day. We don't have a day that we don't talk to them. Because the ties are very close.

Some transnational socio-cultural connections were affected by political changes in the country of origin. The decision to stay in the United States was influenced by the turmoil in the former USSR:

We thought that we would work here for 3-4 years, save something, and will return home. Later we realized that all is not like that because [we are] wanting very much to help the kids, and the situation in Ukraine, so far, financially is very difficult, and we want to be here.

In addition to communicating with friends and family, some participants even reported reaching out to health-care professionals in the former USSR for consultations. When they cannot find answers in the United States, the immigrants ask health-care professionals in the former USSR for medical advice:

I look for acquaintances, this girl... [In former USSR], she has a friend, I hope to transfer these X-rays, and will sit down, and specifically will look at them for 30 minutes. Will need to pay-I will pay as much as needed...here...nobody gave me the answer. I suffer from it. It tortures me wildly. I can't find any help here.

One of the participants reported a situation where his infant son was sick and health-care professionals in the United States could not figure out the cause of the problem: "I called [the doctor in Russia]. He told me: "He [my son] does not have urinary tract infection. Take a baby, and run from the hospital."



The concept of transnational socio-cultural connections was not directly identified by the participants of the study. Some of them even denied having any connections with the countries of the former USSR. However, a covert pattern of socio-cultural transnational connection was noted in all the participants. Some stated that they never travel back to their country of origin, yet they stay current with the events happening in the former USSR by contacting their friends and/or through the media.

Most participants reported and were observed to have Russian television channels at home. Those who did not have Russian channels on their TV utilized the Internet to access information in Russian. The principal investigator reviewed the variety of televised programs from the former USSR. There are a number of programs addressing health-related issues. Some programs are led by medical professionals to educate the audience on diagnostic and treatment modalities. There were also segments addressing health in some news programs as well. In searching the Internet one can find lots of information on non-traditional modalities in the Russian language. Some of those resources come from the countries of the former USSR; others are developed in the United States and published in the Russian language. Some magazines are strictly dedicated to health while others have health-related columns.

There are a few health magazines available in the Russian language in the United States. Some magazines are published in the United States by Russian-speaking immigrants, while others are available for purchase in the former USSR and in the United States.

In visiting the neighborhoods of common residence of immigrants from the former Soviet Union one can find a number of stores selling culturally based products.

The types of products vary from foods and souvenirs to books, remedies, and medications. One of the largest Russian bookstores in Brooklyn had an entire section of books on health. Those books could also be purchased online and delivered to any part of the United States. The books on health could also be found under the category “Healthcare” on the store’s website. The subcategories of these books include books on diets, alternative modalities, beauty and health, medical dictionaries and references, and books on healing by nature. Some books were written by physicians, others were not. The store’s website also had a section called “Health”. This section contains products for saunas and massage therapy. Although products for sauna were included in health section of the ethnic store, the use of sauna was not identified in the interview data in relation to health. This could be related to the perception of saunas as social rather than health-related activity that includes drinking alcohol and eating dry salty fish between staying in steam rooms.

Among other ethnic stores, there are great numbers of pharmacies in New York and New Jersey selling herbs and remedies used by Russian-speaking immigrants. One of the interviewed participants demonstrated a variety of herbs and remedies stored in her kitchen. When asked about the place where she got them from, the participant replied:

In Russian pharmacy, right by us...I bought it there...I went to the pharmacy and asked from this list what I should buy. And there was also Senna, something else on the list. And they said: “No need”, and these four herbs, which I marked by crosses next to them. Here I have them: chamomile, this is plantain, hypericum, and common yarrow...

The principal investigator visited one such pharmacy and found an entire section of herbs and medications from countries of the former USSR. During her visit to the pharmacy, the principal investigator observed Russian-speaking immigrants asking for some of the medications from the former Soviet Union. The pharmacist, who spoke Russian, was advising customers on their choices of herbal remedies.

Interestingly, various herbs, lotions and teas from the former USSR could also be found in a large Russian supermarket in New Jersey. This store opened in 2016 and provides a variety of ethnic foods to the community. The store has a selection of herbs available for purchase; yet, there is no pharmacist to guide the customers.

In observing the Russian-speaking immigrant community during a variety of community events, the principal investigator learned the importance of cultural traditions in this population. Regardless of the time spent outside of the country of origin, Russian-speaking immigrants preserve some of their traditions and maintain a connection with their culture. Russian-speaking immigrants like to congregate at home and gather around the dinner table: "...You unite at the table, cook and eat..." Food has great value in this community. Although the immigrants have adapted to American food, some ethnic foods are still part of their menu and are an important part of celebrating holidays and special life events.

An example of this is the celebration of New Year's, the biggest former Soviet holiday. New Year's Eve is one of the strongest connections with the life "before the immigration." It involves many cultural traditions. Despite traditional holiday meals, many Russian-speaking immigrants connect with their friends and families from the former USSR to wish them a good year. This holiday is a family event.

Russian-speaking immigrants invite family and friends to their New Year's celebration. If the actual New Year's Eve is not spent with family, Russian-speaking immigrants call their loved ones immediately after the stroke of midnight to wish them a great year. If not physically present, the family is always a part of the celebration and family connections are included in this tradition.

New Year's Eve involves giving gifts, eating, drinking, and wishing each other all the best in the New Year. There is a belief about this holiday in the former Soviet culture that the way you spend New Year's holiday reflects the way the rest of your year will be. Russian-speaking immigrants do their best to have a great time on New Year's Eve. They dress up in their best outfits, dance, and laugh, eat and drink for a good year.

The traditional dishes on the New Year's table include a potato salad with a French name called "*Oliv'e*". Another former Soviet tradition for New Year's is to eat tangerines. Due to the scarce food choices in the former USSR, tangerines were only available during the winter. They were very expensive at that time and were often given as a holiday gift to kids. Although today anyone can afford to buy tangerines at any time during the year, this tradition is still preserved.

At the most recent observation of New Year's, the principal investigator had an opportunity to witness a congregation of about 700 immigrants from the former USSR. Multiple generations gathered to celebrate their biggest holiday of the year. The organizer of this event brought her own family, consisting of her husband, son, daughter-in-law, granddaughter, brother, sister-in-law, nephews, and her elderly mother. They all sat at one table enjoying each other's company.

A number of groups came with their extended families. One could observe parents, grandparents and children having fun with each other. One person stated that about 30 people consisting of his family and friends came to the New Year's celebration this year. In the hotel lobby, a group of grandparents with their adult and teenage children and grandchildren were spending time together. It is not unusual to see people of different generations closely interact with one another.

Russian-speaking immigrants are all about traditions. Speaking with the immigrants who came to the United States as young children, one can notice the influence of culture on their behavior. Culture plays a vital role in guiding activities of the immigrants from the former USSR. Dietary preferences are no exception.

Although the traditional Soviet and post-Soviet cuisine consists of foods high in fats, cholesterol and sugars, culturally established foods often prevail over healthy food choices. For example, the above mentioned famous New Year's dish "*Oliv'e*" consists of boiled potatoes, eggs, carrots, canned peas, pickles and mayonnaise. Most Russian-speakers also add bologna or chicken to this dish. There are other traditional foods that vary from one former USSR republic to the other. For example, middle-Eastern and Caucasian republics of the former USSR are famous for their shish kebabs. Although, the size of the portion and content of spices vary between the republics and even cities in the former USSR, in general this dish is high in fat and cholesterol. Middle-Eastern regions of the former USSR are known for their pilaf. There is an entire tradition of cooking this dish. Although, almost every person from the former USSR tries to make this dish at home, the people from Uzbekistan, Kyrgyzstan, Tadzhikistan, Turkmenistan, Kazakhstan, and even Caucasian countries, are the best cooks of pilaf. This dish requires

a lot of preparation and includes lots of meat, fat, rice, carrots, garlic and a variety of spices. In speaking to just a few immigrants from the former Uzbek republic, the principal investigator learned that the recipes vary between the cities within the country.

One of the participants stated:

In Uzbekistan there are different types of pilaf, depending on the region. In Tashkent looked differently, Samarkand differently, Bukhara differently, Kharesma [the name of the region] differently. Something different is used. There is another rice, some special rice or there is... For example, in Samarkand and Bukhara there is a custom that carrots and meat are not mixed with rice. In our [tradition] the other way around. We can't... Even before [serving] someone, before starting eating... they mix, but not Samarkand. They... [Prepare] separately rice, carrots, separately meat, etc.

Although, each region is using different ingredients to make the pilaf, this dish in general is high in fat, carbohydrates, and cholesterol. A participant stated: "I wanted to point to the moment, Uzbek's food it is a very fattening in many cases, very saturated, [highly] caloric, and this moment it changed very much, by the way. What we considered normal in Uzbekistan now we consider not normal."

Another example of culturally established food choices is evident in immigrants from Belarus. In this country potatoes were one of the main parts of the diet. In speaking with the immigrants from the former Belarusian republic of USSR, the principal investigator learned about a popular Belarusian restaurant in Brooklyn. This restaurant is decorated like a house in a Belarusian village. The restaurant's website contains a number

of pictures of foods made out of potatoes. One can also find photos online of the waiters wearing traditional Belarusian outfits.

In general, Russian and/or former Soviet republic ethnic restaurants are favored by the immigrants from the former USSR. A participant stated: “At least once every two weeks [we] go to Uzbek restaurant.” The menus in those restaurants contain a variety of meats, fried foods, potatoes, pickled foods, pastries, including crepes and pancakes. Although the food choices are often high in fat, cholesterol and sugars, Russian-speakers find comfort in this nostalgia.

Despite the differences between dietary choices in different regions of the former USSR, Russian-speaking immigrants have a number of common traditions and practices. Those traditions unite the former USSR residents and define them as a cultural group. Described above New Year’s celebration is just one of the examples of the strong cultural traditions in the Russian-speaking immigrant population. Even though, many Russian immigrants in the United States are able to identify the difference between health and unhealthy food choices, when it comes to traditional meals, the cultural preference wins.

The importance of culture in health-related practices of Russian-speaking immigrants cannot be taken lightly. Culture is guiding perceptions of health and illness, modifies perceptions of health-care systems, and directs the behaviors of this population. The themes that emerged in this study identify the importance of previous socio-cultural life experiences on perceptions of health and illness in Russian-speaking immigrants. Family plays an important role in shaping those views and perceptions. Culturally established perceptions are modified by encounters with health-care systems in the former USSR and the United States, leading to expectations of health-care services and

health-care providers. Subsequently, these encounters lead to health-related behaviors of Russian-speakers in the United States. Health-seeking and health-maintaining behaviors are directly related to given (culturally-established) and modified (shaped by experiences) factors. All of these aspects are additionally influenced by the transnational socio-cultural connections. Transnational socio-cultural connections are present in the lives of all Russian-speaking immigrants in the United States. Although the degree of such connections could vary between the immigrants, the influence of these relations is undeniable.

Russian-speaking immigrants in the United States have culturally established beliefs about health and illness. Such beliefs are built during their formative years spent in the former USSR. In general Russian-speaking immigrants believe that health is a state of physiological and psychological stability. Any disturbance in one's mental or physical state, the presence of any visible symptoms or pain is considered as unwellness. Based on these beliefs the immigrants from the former USSR determine the need to engage in health-related practices to improve or maintain their health. Health-maintenance or health improvement activities of Russian-speaking immigrants vary from utilizing non-traditional and alternative modalities to seeking professional medical care. No specific patterns were identified in the immigrants' choices of allopathic or non-allopathic approaches to remedies to illness.

Perceptions of health and illness in Russian-speaking immigrants in the United States are shaped by their experiences with healthcare systems in the former USSR and the United States. Such experiences guide the immigrants and mold their expectations of health-care providers. A combination of perceptions of health and illness, influenced by



experiences and expectations of health-care systems, and health-care providers, lead to the outcome of health-related behaviors of Russian-speaking immigrants. Health-related behaviors of Russian-speaking immigrant population include their beliefs in diet and exercise as the main determinants to health. Although, the immigrants from the former USSR can recognize healthy food choices, they admit following traditional Soviet cuisine on many occasions, where many of the food choices were reported to fall into the “unhealthy” category.

Last, but not least, a factor uniting the immigrants from former USSR was found to be their transnational socio-cultural connections. These connections vary in degree and frequency, yet are very influential in guiding perceptions and behaviors of Russian-speaking immigrants residing in the United States.

## CHAPTER 5

### DISCUSSION OF FINDINGS

There are increased numbers of immigrants entering the United States. One of the largest populations of the immigrants in the US are Russian-speakers, born in the former Union of Soviet Socialistic Republics (Soviet Union / USSR) (Ivanov, Hu, and Leak, 2010). Like many other groups of immigrants, those from the former USSR were found to have a number of health concerns. There was a reported evidence of cardiovascular diseases, cancers, diabetes, communicable and sexually-transmitted infectious as well as mental health disturbances, including alcoholism, depression, and post-traumatic stress disorders in this population (Wu, Tran and Khatutsky, 2005; Ivanov, Hu, and Leak, 2010; Ivanov, Hu, Pokhis, and Roth, 2010; Aroian and Vander Val, 2007; Hundley and Lambie, 2007; Duncan and Simmons, 1996; Tselmin, Korenblum, Reimann, Bornstein and Schwartz, 2007; Wu, Tran and Khatutsky, 2005).

Notwithstanding identified public health concerns in Russian-speaking immigrant population, this aggregate had not been well explored in terms of their health-related activities, health promotion and health-maintenance behaviors (Ivanov, Hu, Pokhis, and Roth, 2010; Hoffman, et al. 2006; Tselmin, Korenblum, Reimann, Bornstein, and Schwartz, 2007; Mehler, Scott, Pines, Gifford, Biggerstaff and Hiatt, 2007; Duncan and Simmons, 1996; Gilmore, McKee and Rose, 2002). The empirical literature provided the evidence of cultural factors influencing behaviors of the Russian-speaking aggregate in the United States, and identified a great need of exploration of this group of immigrants. Despite the importance of culture in health-related behaviors, many health care providers

were reported not to be fluent in culturally appropriate care for this group of immigrants (Lipson, Weinstein, Gladstone, and Sarnoff, 2003; Resick, 2008).

### **The study.**

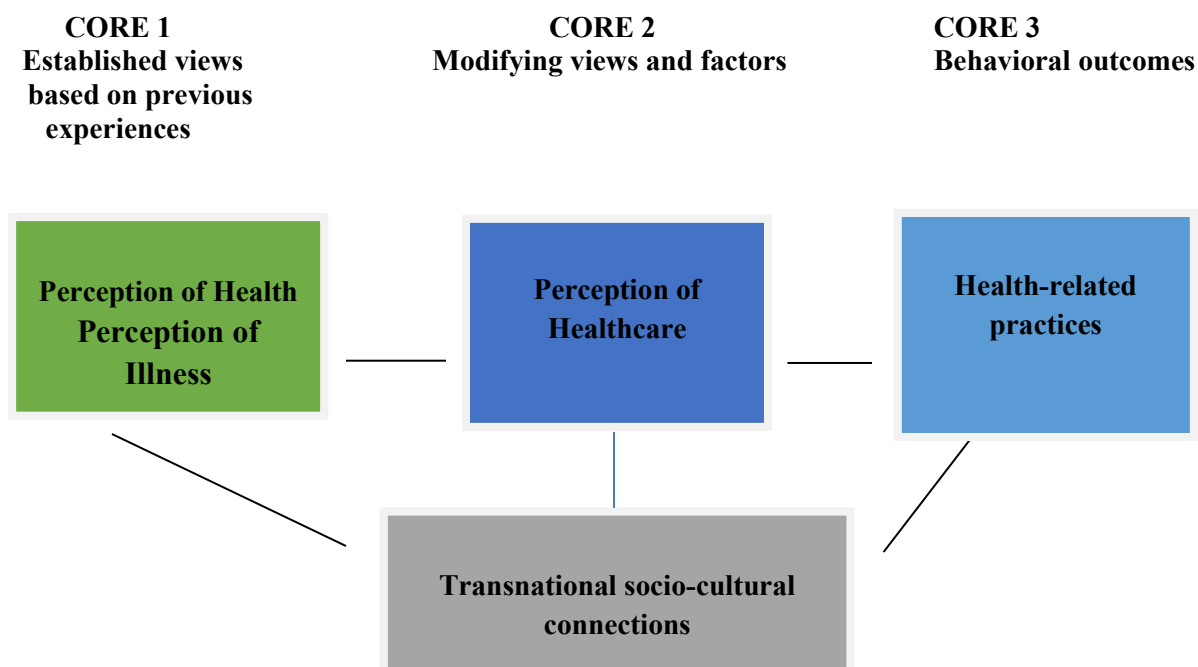
To address the gap in empirical literature a qualitative ethnographic study was conducted to explore the factors affecting health-related practices of Russian-speaking immigrants residing in the United States (Creswell, 2013; Corbin and Strauss, 2008; Charmaz, 2006, Hammersley and Atkinson, 2000; Hunter 2012; Schembri and Boyle, 2012; Cruz and Higginbottom, 2013). Twenty representatives of Russian-speaking community in the United States, ages 36 to 83, were included in the study. (Appendix E). The sample comprised of the immigrants, whose formative years (first 12 years of life) were spent in the USSR, and who immigrated following USSR dissolution, after December 25, 1991. Previous research address Russian-speaking immigrants in general without consideration of the time spent in the United States. The pilot study by Amburg and Lindgren (2013) identified the differences between cohorts of Russian-speaking immigrants from before and after USSR dissolution. As a result, the need to explore Russian-speakers, who were raised in the Soviet Union, and affected by the USSR collapse, became apparent (Retrieved from <http://www.britannica.com/place/Soviet-Union.com>; Retrieved from <http://www.history.com/topics/cold-war/fall-of-soviet-union>; Retrieved from <http://www.simplypsychology.org/piaget.html>; Piaget and Inhelder, 1959).

### **Results of the study and Analysis of findings.**

The interviews were conducted by the principal investigator, transcribed, translated and subsequently analyzed with guidance of the principal co-investigator. In

addition to the interviews, participant observation and review of media, visual and print, were utilized to ensure the triangulation of data. The data analysis revealed 5 main themes with related categories and subcategories. The main themes were: perception of health, perception of illness, perception of healthcare, health-related practices, and transnational socio-cultural connections. The themes were subsequently organized into three overarching Cores. Core 1, established views based on previous experiences, included the themes of perception of health and perception of illness. Core 2, modifying views and factors, was represented by the theme of perception of healthcare. Core 3, behavioral outcomes referred to the theme of health-related practices. The final theme of transnational socio-cultural connections was freestanding, as it did not belong to a specific Core; yet, it was influencing all three Cores, and their corresponding themes (Figure 1, Core model, Appendix G)

*Figure 1. Core model.*



The Cores of the model are interactive and interconnected. Core 1 reflects the views established by previous life experiences which frame Russian-speaking immigrants' perceptions of health and illness. This core is the foundation of the model, yet it is flexible and prone to reshaping. Since individual experiences evolve over time, the views on health and illness have a potential to be modified by the variety of interactions. Such interactions include transnational socio-cultural connections and encounters with healthcare systems.

Encounters with healthcare systems are positioned in Core 2, reflecting modifying views and factors. Core 2 is the mold of Core 1, where views on health and illness of Russian-speaking immigrants are shaped by interactions with healthcare systems in the US and the former USSR.

While Core 1 is the origin of views that guide behaviors, and Core 2 reflects the experiences with healthcare that modify the views and health behaviors, Core 3 defines the behavioral outcomes as evident by health promotion and disease prevention practices of Russian-speaking immigrants in the United States. All three Cores are influenced by the phenomenon of transnational socio-cultural connections. These ongoing connections affect perceptions of health and illness, perceptions of healthcare, and health-related activities of Russian-speaking immigrants in the US. Transnational socio-cultural connections theme underpins the Cores without being a Core by itself.

### **Application of results to Pender's Health Promotion Model.**

The subsequent analysis of the Core model uncovered the connections with the Pender's Health Promotion Model (HPM) (Appendix A). Elements of the Core model are found to correspond with some components of the HPM.

In her Health Promotion Model, Pender isolates three dimensions: individual characteristics and experiences, behavior-specific cognitions, and behavioral outcome. The HPM illustrates the connections between the dimensions, and demonstrates the influence of various factors on the behavioral outcome as manifested by health promoting behaviors (Pender, Murdaugh, and Parsons, 2011). The influencing factors are presented by subcategories comprising the dimensions. The dimension of individual characteristics and experiences includes prior related behavior and personal factors, including biological, psychological, and socio-cultural characteristics. The behavior-specific cognitions and affect dimension includes perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal and situational influences. The commitment to action connects the dimension of behavior-specific cognitions and affect with behavioral outcome. Subsequently, the behavioral outcome is evidenced by health promoting behavior, and is directly influenced by immediate competing demands and preferences. In the Health Promotion Model, Pender demonstrated behaviors and cognitions influencing individual characteristics and experiences, leading to the health promoting behavioral outcome.

Similarly to the HPM, the Core model illustrates personal characteristics influenced by the variety of modifying factors, and leading to health-related practices of Russian-speaking immigrants residing in the United States. Although, some aspects of the models seem similar, not all the parts of the Core model fit into Pender's HPM.

#### **Transnational socio-cultural connections theme in relation to the HPM.**

Transnational socio-cultural connections theme is freestanding, yet, strongly influencing the Core model. In comparing this theme with Pender's model one might find difficulty

placing it within the HPM dimensions. Transnational socio-cultural connections could partially fit under Pender's dimension of individual characteristics and experiences, the subcategory of personal factors that includes socio-cultural characteristics. It could also partially be placed under the dimension of behavior-specific cognitions and affect subcategory of interpersonal influences. Despite the parts of the factor of transnational socio-cultural connections finding their places within Pender's model, this category could not be positioned in its entirety in any specific section of the HPM.

Transnational socio-cultural connections are unique but not exclusive to the aggregate of Russian-speaking immigrants. Lipson, Weinstein, Gladstone, and Sarnoff (2003) report some immigrants traveling back to the country of origin, while others never go back due to political and safety issues. This situation applies to the immigrants from the countries of Soviet Union. Unlike the previous waves of Russian-speaking immigrants, those who left the USSR after its dissolution, were looking for better economic opportunities (Hoffman, McFarland, Kinzie, Bresler, Rakhlin, Wolf, and Kovas, 2006; Evanikoff del Puerto and Sigal, 2006). The post-USSR collapse immigrants were not escaping political prosecution, and could freely travel back to the country of origin to maintain connections with friends and family outside of the United States.

The pilot study by Amburg and Lindgren (2013) identified the differences between the immigrants of the waves from before and after USSR collapse. The immigrants from the wave of 70's were escaping the political regime of USSR, and limited their connections with countries of the former Soviet Union as these contacts could have caused government persecutions of the family and friends left behind. After

the dissolution of the USSR, the newer wave of immigrants felt safe to keep in touch, and even travel back to their country of origin.

This study found additional difference in transnational connection within the group of post-Soviet immigrants. All of the participants report communicating with family and/or friends outside of the United States. Those immigrants who still had families and/or friends in the countries of the former Soviet Union demonstrate the strongest transnational connections compared to those who had no remaining ties to the former USSR. Although some Russian-speaking immigrants deny having direct transnational connections, there is evidence of Russian-speakers in the United States having some form of contact with countries of the former USSR.

All the participants in the study demonstrate the up-to-date knowledge of the events in the former USSR. It was evident in the study that Russian-speaking immigrants are also keeping connected with Russian-speaking community through media and Internet. Although some respondents deny watching TV or reading newspapers in Russian, they are cognizant of what is happening in their native countries.

Modern technologies have played a significant role in maintaining connections with the country of origin. Empirical literature indicates that technological advances enhance transnational connections and transform immigrants' acculturation process (Son, 2015).

Some participants keep close contact with relatives and friends in the former USSR, and report communicating almost on a daily basis through social media and various Internet resources. With advances in technology such connections have become stronger and more frequent.



Technology also allows the immigrants to get health-related information from the country of origin. This information includes advice on health improvement and maintenance. While some immigrants are seeking virtual advice from healthcare providers in the former USSR others travel to the former Soviet republics to receive healthcare services there. In some cases Russian-speaking immigrants in the United States use medications from the former USSR as these medications are more affordable and familiar to them.

Russian-speaking immigrants do not have to travel back to the former Soviet countries to get the medications. Some medications and supplements are available for purchase in ethnic stores in the United States. Since the data was collected in the East coast of the United States in the places highly populated by Russian-speaking immigrants, it is unclear if Russian-speakers have access to same variety to medications in other parts of the US. Even though it is possible that some Russian-speaking immigrants might not be able to buy familiar medications and herbs in “Russian stores”, there are Internet websites and online stores selling medications from the former USSR. It is, however, unclear if the US providers are familiar with these medications, or even aware of their Russian-speaking patients’ use of them.

Transnational socio-cultural connections of Russian-speaking immigrants include a number of key elements. This group of immigrants has a freedom to travel back to the country of origin, as the political climate has changed since the dissolution of the former Soviet Union. The immigrants have access to resources and services from countries of the former USSR. Additionally, modern technology allows direct and virtual communication with friends, family, as well as healthcare providers outside of the US.

Despite the importance of transnational socio-cultural connections in this population, these links are not addressed in empirical literature. The concept of transnational connections was scarcely explored in other cultural groups of immigrants. Mwikali Kioko (2010), in her dissertation, examined 38 Kenyan immigrants residing in NJ, and found all of the participants to have maintained transnational connections via Internet resources, telephone conversations, and participation in cultural activities in the United States. Afulani, Torres, Sudhinaraset, and Asunka (2016) identified the relationship between cross-border connections and health status of sub-Saharan African migrants in France. Son (2015) examined 27 Korean American women residing in the United States, and reported the majority of the participants to use “virtual connections” to maintain their ethnic identity.

While ethnic identity was not a focus of this study, what is clear is that the ability to talk to and see family members and friends reinforced socio-cultural perspectives on health and illness, expectations and usage of health services and health practices of Russian-speaking immigrants in the US. It is evident in empirical literature that transnational socio-cultural connections are not uncommon in immigrant population; yet, their importance in lives of immigrants is not well recognized.

Transnational socio-cultural connections play an integral role in maintaining and supporting health beliefs and practices of Russian-speaking immigrants and their health care in the US. The influence of transnational connections on perceptions on health and illness, as well as the perception of health-related services, with the subsequent influence on health-related behaviors of Russian-speaking immigrants in the United States cannot be underestimated.

**Core 1. Perceptions of Health and Illness themes**

In this study Russian-speaking immigrants perceive health as a combination of physical and mental wellbeing. A person is viewed as healthy if there is an absence of any evident signs of distress, discomfort, or chronic disturbance. Being healthy is viewed as the ability to “enjoy life to the fullest” without any limitations. Family is identified as the primary motivator to stay healthy; either because of the need to work to support for family or because the respondents did not want to burden the family. Family members motivate Russian-speaking immigrants to stay healthy. Additionally, the participants identified strong expectations that family members take care of each other, and are against placing elderly family members in long-term care.

Regardless of the reasoning, staying healthy for the family and expectations of the family members to take care of each other is a general premise of perception of health in Russian-speaking immigrants residing in the United States. Russian-speakers often adjust their personal and work schedules in order to care for other family members. If unable to provide direct care, the participants report making arrangements to ensure that their elderly and unwell relatives receive proper attention. The empirical literature supports the notion that long term care placement of the loved ones is not valued by Russian-speaking immigrant in general (Evanikoff del Puerto and Sigal, 2006).

Some Russian-speakers even report settling in the same neighborhoods with the immediate and/or extended family members who need care. These findings are supported by previous studies of Russian-speaking population. The empirical literature provides historic evidence of people born in the former USSR having strong family connections

with their immediate as well as with their extended families (Bagdasarov and Edmondson, 2013; Hundley and Lambie, 2007).

This study also found Russian-speaking immigrants not only prefer to settle near their relatives, but sometimes even share the household with multiple generations of the same family. Such findings are consistent with reports of communal lifestyles and overcrowding being a norm in the former USSR (Duncan and Simmons, 1996; Bagdasarov and Edmondson, 2013; Hundley and Lambie, 2007). Historic overcrowding in the former Soviet Union could have been related to the socio-economic barriers and lack of adequate housing in the country; however, even after immigrating, and regardless of the economic status, Russian-speaking participants indicate that they prefer to stay close to each other in the United States.

Although important in the perception of health of Russian-speaking immigrants, family as health motivator is not unique to this aggregate. Bhattacharya and Shibusawa (2009) report very structured cultural beliefs and roles within the family in population of immigrants from India in the United States. Afulani, et. al. (2016) suggest family separation to have negative impact on sub-Saharan African migrants in France, indicating the importance of family in health of this group of immigrants.

As oppose to perception of health being the absence of any physical or psychological limitations and/or disturbances, illness is viewed as any form of distress. A person is believed to be ill when they require regular medical attention or interventions to support their health. Any form of psychological (mental) or physical restrictions and/or instability is a sign of illness in Russian-speaking immigrant community.

Russian-speaking immigrants view any chronic condition as a sign of illness. A person is believed to be ill if they require medical care or need to take medications to maintain their health, therefore taking a lot of medications is not desired. Yarova, and colleagues (2013) reported similar findings where Russian-speakers favored taking as few medications as possible.

Since Russian-speaking immigrants report a preference of not taking medications to maintain their health, a subcategory of what to do when sick emerged. In illness Russian-speaking immigrants often rely on a number of approaches, including scientific, folk, non-allopathic, and complimentary modalities. The study found uneven patterns of utilization of scientifically-based health-related services and non-allopathic approaches. Some Russian speakers openly talk about frequent use of herbs, folk remedies and alternative modalities, while others state that they seldom use them. Despite the difference in frequency, all of the participants report utilization of some types of non-allopathic methods in their health-related practices or illness care. Although, there is no consensus in their approaches to illness management, the participants express the use of non-allopathic remedies to illness, including herbs, and cultural foods.

There is evidence in empirical literature describing the use of non-allopathic and home remedies by the residents of the former USSR (Yarova, Krassen Covan, and Fugate-Whitlock, 2013; Brown, 2008). The variety of modalities reported in the literature ranges from massage, phytotherapy (plant-derived medicines), cupping, vitamins, and herbs to the use of hypnosis, urine therapy, *znakharstvo* (Russian folk healing), faith healing, low-intensity laser, mineral springs and mud baths, to the use of supernatural forces, like “magic and charms” (Brown, 2008; Hundley and Lambie, 2007, Associated

Press, 1995; Katell, 1994). Although the study participants did not mention all of the non-allopathic approaches found in the literature, they did not reject the idea of including complementary and alternative modalities in their treatment plans. Many of them stated that they preferred trying home remedies before seeking professional medical care and allopathic treatments. In some cases, Russian-speaking immigrants, report seeking attention of healthcare providers only in serious and urgent situations. Yet, it is unclear how the seriousness of the situation is assessed.

This study finds Russian-speaking immigrants utilizing variety of approaches to manage their health. Some refer to acupuncture and Eastern herbalists; others use food, herbs and teas to manage health disturbances. Some of the examples of home remedies include boiling potatoes to treat colds, plantago for wounds healing, and ginger for immunity boost.

Russian-speaking participants demonstrated a great faith in nature-derived and folk-based health maintenance approaches. They believe that historically-established approaches proved themselves to be beneficial to health, and they value the “knowledge of the ancestors”. The knowledge of folk modalities is transferred from one generation in the family to another. The participants learn about certain modalities from their parents and grandparents. In addition to the intergenerational transfer of knowledge, Russian-speaking immigrants in the United States gather information on alternative modalities from Russian language media. Media resources, both visual and print, that are available in the United States, strongly advocate for the use of alternative modalities in treatment of various health conditions. A number of health magazines, focusing on folk and alternative modalities in Russian language, are available for purchase and subscription in

the United States. These magazines contain classified advertisements for healers, herbalists, mediums, and other alternative providers along with those of licensed healthcare providers. In addition to health magazines, Russian speakers living in the United States have access to books on alternative medicine, and can purchase herbs and remedies and over the counter medications from the former USSR in stores and pharmacies located in areas of residence and congregation of Russian-speaking immigrants.

These findings are consistent with the research documentation of Russian-speaking immigrants showing a preference of home remedies over professional help (Yarova, Krassen Covan, and Fugate-Whitlock, 2013). Such phenomenon could be related to Russian speaker's stated preference of nature-derived modalities and the historic lack of medications in the former USSR.

There is a great emphasis on organic food use for health and disease management in the Russian-speaking immigrant community in the United States. Natural and organic foods and herbal remedies seem to be valued over allopathic medicines by this population; yet, the participants cannot explain what exactly makes organic products better than non-organic.

The data gathered in the study showed inclusion of alternative modalities along with allopathic approaches in disease management in Russian-speakers residing in the United States. However, it was still unclear what guides them in their choices of one approach over the other. Nor it is clear, if there is co-use of allopathic and non-allopathic remedies. Additionally, it is undetermined if they discuss those remedies with healthcare providers.

**Perception of Health and Illness in relation to the HPM.** Upon initial analysis of the Core model connection with the Pender's HPM one can find the similarities between Core 1, established views based on previous experiences, and Pender's dimension of individual characteristics and experiences. Core 1 addresses perceptions on health and illness. Pender's dimension focuses on personal factors and prior related behaviors. Although not all the pieces of both models can be aligned, there are undeniable similarities. Both models address culturally-established beliefs, experiences and practices and their influence on formation of views on health and illness. Pender's subcategory of personal factors focuses on biological, psychological, and socio-cultural characteristics.

In the study of Russian-speaking immigrants residing in the United States, the perceptions of health and illness are influenced by spending formative years in the former USSR, and are shaped by being a part of the Soviet culture and subsequent immigration to the United States. As the culture evolves over time and communication with friends and family in the country of origin continues, transnational socio-cultural connections have a potential to continue influencing individual perceptions on health and illness.

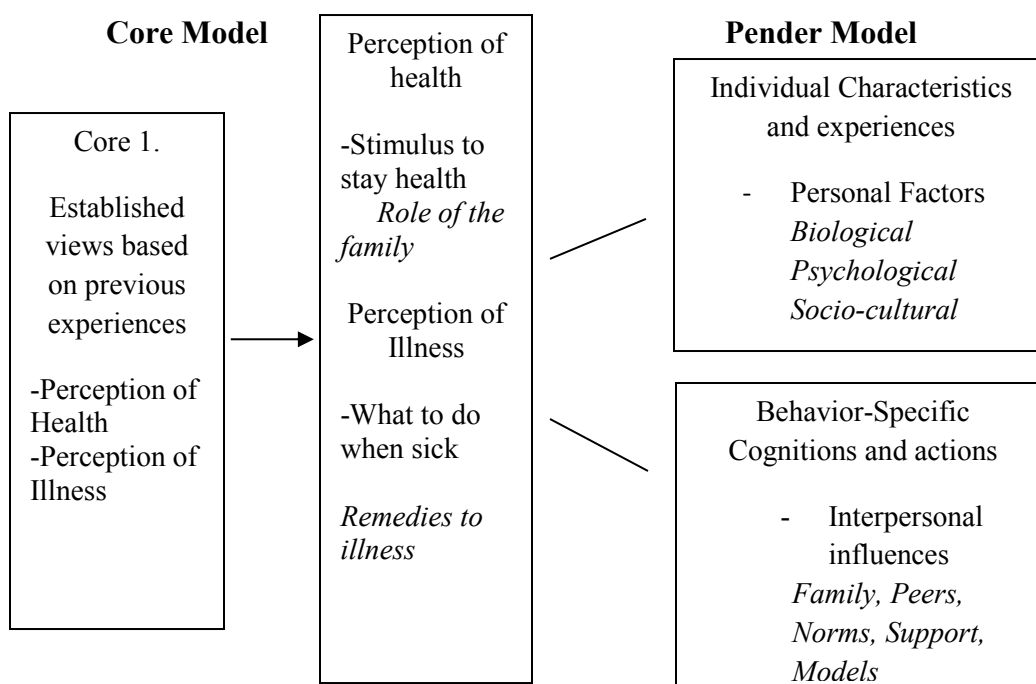
The theme of perception of health of Core 1 corresponds with Pender's dimension of individual characteristics and experiences, more specifically under personal biological and socio-cultural factors. In the study of Russian-speaking immigrants family played a formative role of views and perceptions and was more aligned with Pender's dimension of individual characteristics and experiences. Although the role of the family is identified in both models, Pender's model positions family in the behavior-specific cognitions and affect, under the category of interpersonal influence, along with a source of support and



models for behaviors. Thus, the category of the stimulus to stay healthy and related subcategory of role of the family can find their place in Pender's behavior-specific cognitions and affect dimension under the category of interpersonal influences, connecting Core 1 with two dimensions of the HPM.

Since the theme of perception of illness with its related category of what to do when sick and subcategory of remedies to illness involves cognitive processing and behavioral response, it could be connected with the dimension of behavior-specific cognition and affect of the HPM. However, the conceptualization of the theme of perception of illness involves cultural influence, connecting this theme to Pender's dimension of individual characteristics and experiences dimension. Thus, as well as the theme of perception of health, the perception of illness simultaneously ties Core 1 with two dimensions of the HPM. Consequently, Core 1 is connected with behavior-specific cognitions and affect in addition to the individual characteristics and experiences dimension of the HPM (Figure 2, Core 1 connection with HPM, Appendix H).

*Figure 2. Core 1 connection with HPM.*



## **Core 2. Modifying views and factors.**

Core 2 addresses shaping factors that could potentially alter established views, such as perceptions of health and illness. Perception of healthcare was identified as the theme of Core 2, modifying views and factors. It appears that perception of healthcare systems influences existing views on health and illness. Their views on healthcare are based on combination of culturally-established views and interactions with health-related services both in former USSR and in the US. Although culturally established, the perceptions of health and illness could be modified by experiences and encounters with healthcare systems and healthcare providers. As a result of such interaction established perceptions are shaped and re-shape.

The theme perception of healthcare includes three categories: perception of healthcare system in the former USSR, perception of healthcare system in the US, and expectations of healthcare providers. Each category looks into historic and present interactions with the healthcare systems in different countries, and addresses the expectations of health-delivery services that are based on previous experiences and established views.

**Perception of the healthcare system in the former USSR.** In discussing experiences with the USSR healthcare system, participants noted the lack of resources, hospitals overcrowding, and the expectation of bribery to receive services. The findings of the study are similar to previous reports of the poorly funded healthcare services in the former USSR, resulting in low morale, corruption, and a system of bribery (Eberstadt, 2006; Barr and Field, 1996; Tulchisky and Varavikova, 1996).

When talking about healthcare before USSR's dissolution, the participants describe government run and controlled health-related services. These reports are similar to the empirical documentation of the Soviet healthcare system being free, yet strictly controlled by the government, where the citizens of the former USSR had very little control over choice of providers or care they received (Tulchinsky and Varavikova, 1996, Sheiman, 2013).

While the participants describe lack of resources and lack of adequate equipment in the former Soviet public healthcare facilities, interestingly they report better quality of care in the former USSR republics for patients who pay out of pocket. Some of the respondents describe receiving medical care in countries of the former Soviet Union since their immigration to the US. These participants recount receiving high quality, timely care and extra attention of healthcare providers in the former USSR once they paid privately.

The concept of "medical tourism" was addressed in empirical literature in relation to other groups of immigrants. Horton and Cole (2011) report Mexican immigrants crossing the border to receive medical care in Mexico. The authors identify a number of reasons guiding the immigrants' "medical returns" to Mexico. These immigrants sought care in Mexico as they perceived healthcare services there to be personable, speedy, less expensive, and culturally familiar, compared to the same in the United States (Horton and Cole, 2011). Similarly to the immigrants from Mexico, Russian-speakers residing in the United States seek health-related services in countries of the former USSR due to the lower cost, timing, and familiarity with culture.

The participants, however, do highlight the age discrimination in relation to care in the former USSR. They describe experiences of the lack of adequate care for elderly patients as their life expectancy was perceived to be limited. It was unclear if health-related services for the aging population have improved for patients paying privately. One participant describes positive experience with care for a physically independent person of advanced age while visiting a healthcare facility in the former USSR since their immigration. However, this person does not report any serious medical conditions requiring complicated care. In another instance a participant described overall poor care for the elderly in countries of the former USSR regardless of the patient's/family ability to pay. A third participant reports healthcare providers refusing to perform a surgery on her elderly relative due to the advanced age. When the same relative came to the United States, an American physician successfully operated on her, and alleviated her chronic health disturbance. The participants, however, overall state their satisfaction with healthcare services for the elderly in the United States, as oppose to the countries of the former USSR.

**Perception of the healthcare system in the US.** When talking about healthcare system in the US, this study demonstrated age differences in the perception of the healthcare system in the United States. Younger respondents verbalize dissatisfaction with the cost of care, stating that healthcare system is based on a business model that supports use of costly treatments and medications. Such views are consistent with previously addressed theme of the perception of illness, where Russian-speaking immigrants prefer to use as few medications as possible, and perceive a person who needs to take medications as unwell.

Unlike younger respondents, older representatives of Russian-speaking immigrant community in the United States are mostly satisfied with the US healthcare system. Such difference could be related to the presence of the government-sponsored insurance plans for the aging population where older immigrants receive Medicare and Medicaid coverage with minimal or no cost to them.

**Expectations of healthcare providers.** Regardless of age, the expectations of the healthcare system include receiving extra care, as evident by time and attention of physicians, as the patients are paying for services with insurance premiums. These views could also be linked to their experiences with healthcare system in the former USSR, where paying cash or giving a bribe granted patients' additional privileges.

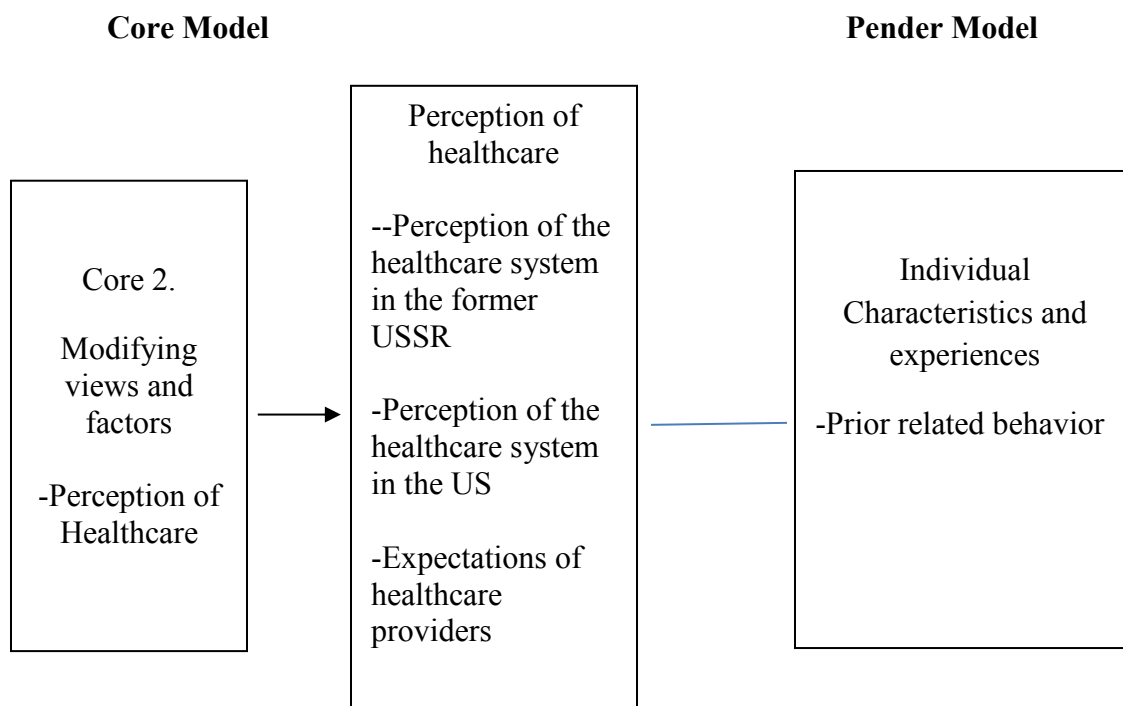
Choosing a healthcare provider also shows generational differences. Younger, computer savvy Russian-speaking participants choose their providers based on published reviews with no preference of the provider's language or personal characteristics. Older, and perhaps less acculturated, participants prefer conveniently located providers who speak Russian and share similar cultural values. Younger representatives of Russian-speaking immigrant community rely on reported qualifications and education of healthcare providers, whereas older participants form their opinions based on provider's attention to them and their health needs.

Overall, regardless of the age, Russian-speaking immigrants want providers to pay attention to their individual needs. Some younger participants report the importance of professional qualifications of healthcare providers over their personal communication skills. Yet, individual attention of healthcare providers is highly valued by Russian-speaking immigrants.

There is a perceived authority of healthcare providers by Russian-speaking immigrants. This aggregate is fully trusting of physicians and expects the providers to educate and guide their health-related activities. The participants acknowledged that they learned about health from healthcare providers in the former USSR. Although, a lot of health-related information is delivered by the media in the United States, Russian-speaking immigrants still expect their healthcare providers to educate them about health and disease management. These findings support empirical literature reports of healthcare services in the countries of the former Soviet Union being the government's responsibility with very little involvement of Soviet citizens in their care management (Barr and Fields, 1996; Lipson, Weinstein, Gladstone, and Sarnoff, 2003; Yarova, Krassen, Covan, and Fugate-Whitlock , 2013).

**Perception of Healthcare in relation to the HPM.** The theme perception of healthcare reflects perceptions and views on healthcare both in the former USSR and in US. In connecting the Core model with the HPM one could tie Core 2 with the dimension of individual characteristics and experiences under the category of prior related behavior. Prior related behaviors include previous interactions with healthcare system(s) and healthcare providers. Based on such interactions Russian-speaking immigrants form and shape their perceptions and attitudes towards health-related services (Figure 3, Core 2 connection with HPM, Appendix I).

Figure 3. Core 2 connection with HPM.



Culturally-based expectations of healthcare and expectations of providers lead to the pattern of health-related activities of the population of Russian-speaking immigrants in the United States. Health-associated behaviors of this population are the outcome of perceptions of health and illness and encounters with healthcare systems, leading to Core 3, behavioral outcomes.

### **Core 3. Behavioral outcomes.**

Core 3 includes the theme of health-related practices of Russian-speaking immigrants. The Core model demonstrates the influence of Cores 1 and 2 on Core 3. Consequently Core 3 is manifested by health promoting, disease preventing, and screening activities. Health-related practices of Russian-speaking immigrants in the

United States are divided into two categories: the activities related to health practiced in the former USSR, and health-related activities in the United States.

**Health-related activities in the former USSR.** When talking about health promotion in the former USSR, the participants do not address organized or individual activities; rather they talk a lot about relaxing and vacationing in sanatoriums, “health resorts”, where they were exposed to fresh air and healthy food. There is no indication of activities aimed at disease prevention, including vaccinations. It is also not clear in this study if vaccinations beyond the mandatory childhood immunizations are included in health-related practices of Russian-speaking immigrants.

When talking about some disease screening, the participants discuss limited work and school-based screenings, primarily for tuberculosis. Disease screening was initiated by the government, but there was no expectation of ongoing services. Since such activities were government controlled and mandatory, they were not well received by the public. Such findings are consistent with empirical literature indicating low engagement in health-promoting and disease-preventing activities by Russian-speaking immigrants in the United States (Ivanov, Hu, and Leak, 2010; Ivanov, Hu, Pokhis, and Roth, 2010; Duncan and Simmons, 1996).

**Health-related activities in the US.** Following the immigration to the United States, Russian-speakers adjusted their health-related practices, and became more involved in taking personal responsibility for health. The participants stated that they were more educated about their health in the US. Unlike the USSR, in the US health education is delivered by media and observation of other people’s activities. When talking about health-related activities in the United States, the former residents of the



Soviet Union mostly talk about diet and exercise. However, despite knowing about these health-related practices, many of them admit to not engaging in regular exercise, nor to adhering to a healthy diet to maintain their health.

Conceptualization of a healthy diet is often viewed as low in sugar, reduced fat and limitation of processed foods. There is a general belief that nature-derived products are beneficial to health. When talking about diet, the participants indicate that diet in the former USSR was not favorable to health. The food choices in the USSR were based not only on preference but on the scarce availability of certain food products in the former Soviet Union. In general, the traditional diet of the former USSR contains large amounts of sugar, fats, and cholesterol. Many traditional dishes consisted of highly salted pickled foods, potatoes, processed meats, such as salami, and smoked fish. These findings are consistent with empirical literature indicating unhealthy dietary styles in the former USSR (Ott, Paltiel and Becher, 2009, Tselmin et al., 2007).

Some of the respondents report adjusting their diet to healthier choices in the United States. Despite having more knowledge about healthy diet in the US, Russian-speaking immigrants admit to eating unhealthy ethnic foods, particularly during holidays or major events.

Another interesting aspect is related to the dietary choices of children of Russian-speaking immigrants in the United States. Russian-speaking children who were born and/or raised in the United States prefer “American food”, such as pizza, pasta, and chicken nuggets over the food preferences of their parents and grandparents. Fildes, Jaarsveld, Llewellyn, Fisher, Cooke, and Wardle (2014) identify the influence of genetic as well as environmental factors on individual food preferences. The researchers found

the environment to dominate the choices of snacks, dairy, and starches, whereas genetic factors establish preferences of fruits, vegetables, and protein. Park, Quinn, Florez, Jacobson, Neckerman, and Rundle (2011) examined food preferences of Hispanic female immigrants, and identified the presence of the farm market to determine the consumption of fresh produce by this group of immigrants. Thus, one can identify the importance of the social and economic environments in dietary preferences of the immigrant population.

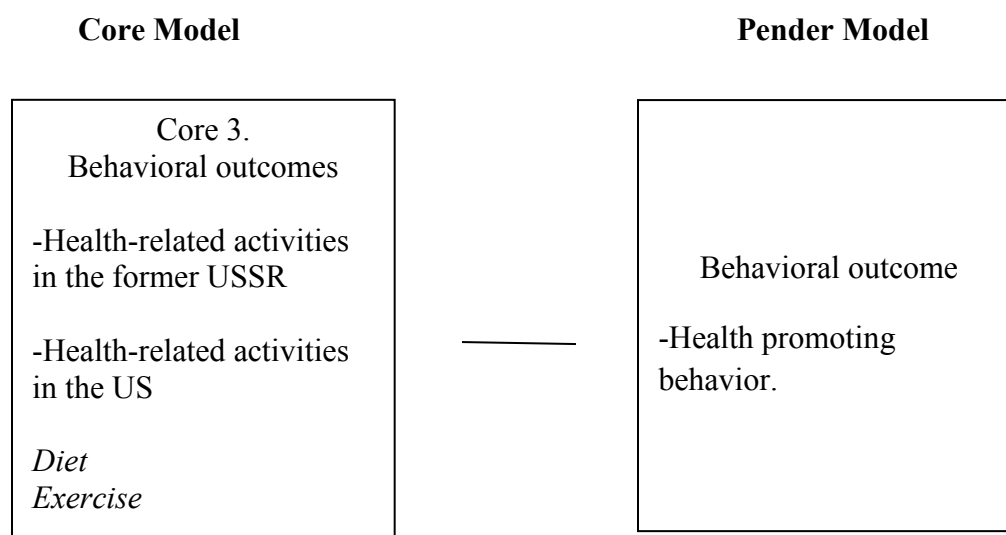
In addition to the diet, the participants include exercise in their health-related activities. Russian-speaking immigrants in the United States report engaging in physical activities in general to improve their health, yet there are no specific details of such activities defined by the respondents. Athletics in the former USSR were reported to be more recreational rather than health-related, and were not a part of structured health-related activities.

When speaking about health promotion, Russian-speaking immigrants rarely, if ever, address health screening or structured health promotion. There are reports in empirical literature indicating underutilization of healthcare services by Russian-speaking immigrants and poor engagement in health promotion and screening behaviors (Wu, Tran and Khatutsky, 2005; Ivanov, Hu, and Leak, 2010; Ivanov, Hu, Pokhis, and Roth, 2010; Aroian and Vander Val, 2007; Hundley and Lambie, 2007, Duncan and Simmons, 1996; Tselmin, Korenblum, Reimann, Bornstein and Schwartz, 2007). This perception could be related to previously mentioned perceptions of health and illness. If a person is not perceived to be sick, there is no proactive engagement with healthcare facilities. These findings are similar to empirical evidence of Russian-speaking people believing in

addressing health issues only when they had symptoms (Roberts, Stikley, Balabanova, Haerpfer, and McKee, 2012).

**Health-related practices in relation to the HPM.** In comparing the Core model with the HPM, Core 3 corresponds with Pender's dimension of behavioral outcome. Although, the terminology sounds similar, Pender's model focuses on health promoting behaviors whereas Core 3 targets multiple types of behaviors, including health promotion, health maintenance, and disease prevention (Figure 4, Core 3 connection with HPM, Appendix J).

*Figure 4.* Core 3 connection with HPM.



In summarizing the comparison of Pender's HPM with the Core model one can identify correspondence and even overlap of cores with Pender's dimensions. Core 1 correlates with two dimensions of the HPM: individual characteristics and experiences, and behavior specific cognition and affect. Core 2 connects with Pender's dimension of behavior specific cognition and affect, and Core 3 finds its link with the behavioral outcome dimension of the HPM. The theme of transnational socio-cultural connections is

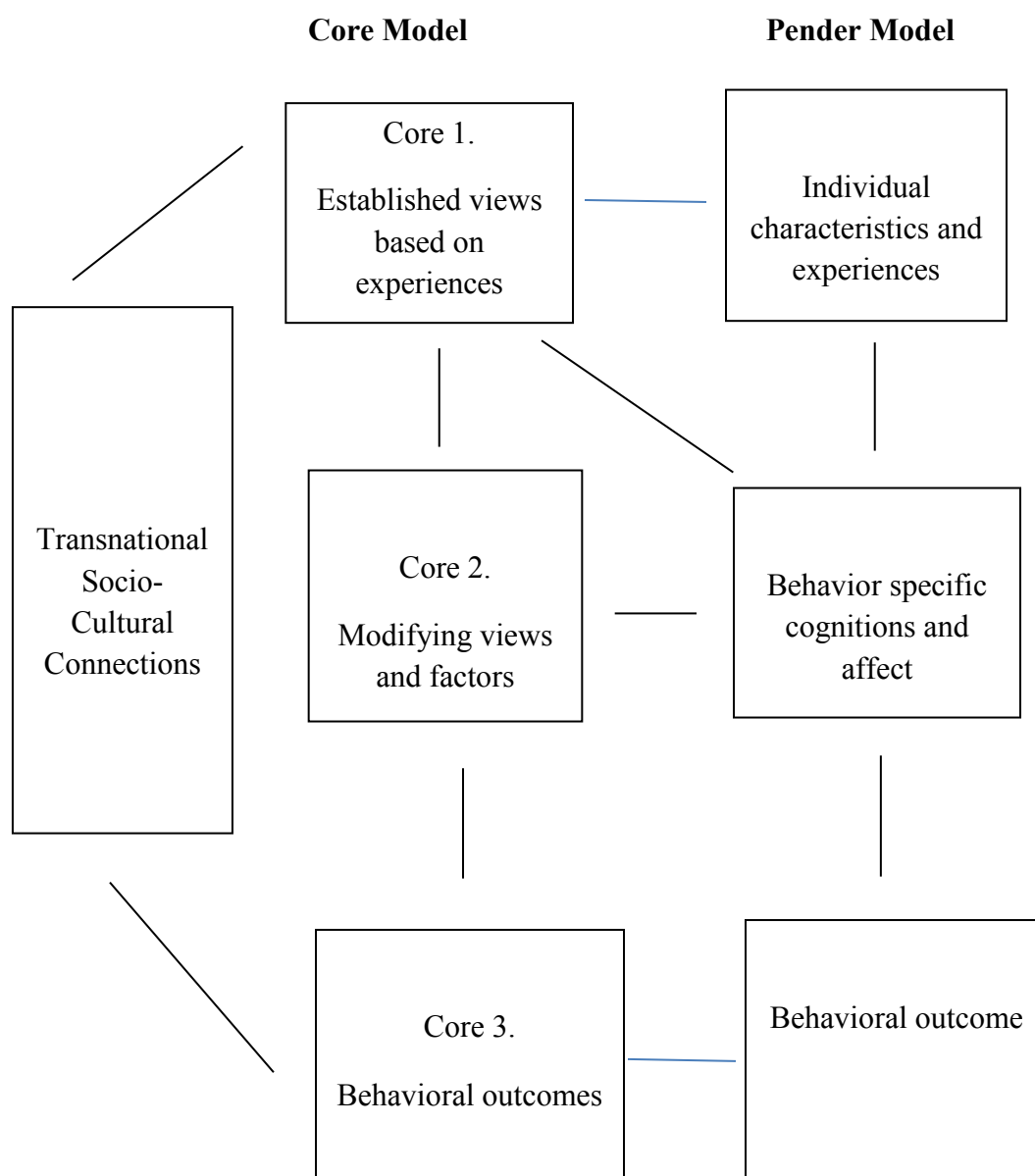
identified in the Core model as influencing factor; yet, it could not be directly connected with the HPM, making it a unique factor pertinent to health-related practices of Russian-speaking immigrants residing in the United States.

In initial comparison of the HPM and the Core model, one can identify the connections between the dimensions and Cores. However, more detailed examinations of themes and categories of the models reveal partial connections between some but not all elements of the model. The main factor that could not be placed within the Cores and could not be directly connected with the HPM was the theme of transnational socio-cultural connections. This distinguishing characteristic positions the aggregate of Russian-speaking immigrants away from the mainstream population (Figure 5, Core model connection with HPM, Appendix K).

The HPM addresses a variety of aspects related to health promoting behaviors of individual, and embraces biological, cognitive, and behavioral aspects of health. However, the HPM focuses on general population, and does not address specific characteristics of immigrants with current connections to the country of origin.

The factor of transnational connections deserves an additional attention and investigation. Although it is not exclusive to the population of Russian-speaking immigrants in the US, the practices related to health resulting from these connections are distinctive and pertinent to this group of immigrants. Thus, their importance cannot be minimized and ignored in assessing health-related practices of the immigrants born in the former Soviet Union.

Figure 5. Core model connection with HPM.



### Conclusion.

There is evidence in empirical literature identifying a gap in exploration of traditional health-related practices of Russian-speaking immigrants. Previous research studies identify a number of health issues in this population. There is also data on

underutilization of health-related services in Russian-speaking immigrant population. Despite the reports of existing health issues and poor engagement in health maintenance, health beliefs and behaviors of this population were not address well in empirical literature.

To address this gap, a qualitative ethnographic study was conducted in East coast of the United States. The study identified five main themes and underlining categories related to health practices of Russian-speaker in the US. The themes identified in the study were subsequently merged into the Core model, and later connected with the HPM.

This study identifies the connection between culturally-established beliefs, experiences with healthcare systems, and behaviors of Russian-speaking immigrants in the United States.

Additionally, the study points out the importance of transnational socio-cultural connections in health practices of this population. Although, the concept of transnational connections is somewhat mentioned in empirical literature in relation to other groups of immigrants, it has not been identified as a factor in Russian-speakers residing in the United States. The uniqueness of the phenomenon of transcultural connections is in this feature's transformation over time and political changes in the former USSR and the US. These connections are more relevant to the newer waves of Russian-speaking immigrants. With fall of the Soviet Union and reduction of government's control over lives of the citizens, the residents of the former USSR obtained the freedom to travel and keep contacts inside and outside of the former Soviet republics. This freedom leads to establishment and/or maintenance of social connections as well as allows access to health-related information, resources and services. These links between the nations are

strengthened by technological advances. It has become easier and cheaper to communicate with friends, family, and health-care providers in the former USSR leading to reshaping of the established views and behaviors.

The factor of transnational socio-cultural connections cannot be ignored in planning care and services for Russian-speaking immigrant population. The providers have to keep in mind the origin of those immigrants, and take their previous life experiences into consideration.

This qualitative ethnographic study exploring the population of Russian-speaking immigrants in the United States is a stepping stone in further exploration of the former citizens of USSR. Additional research of this group of immigrants is recommended for a comprehensive understanding of factors influencing their health views and health-related behaviors.

## CHAPTER 6.

### SUMMARY, CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS

In the past few decades, the populations of the immigrants born in the former Union of Soviet Socialistic Republics (Soviet Union / USSR) have increased in the US (Ivanov, Hu, and Leak, 2010). Like many other groups of immigrants, Russian-speakers in the United States present with a number of health issues (Hundley and Lambie, 2007; Duncan and Simmons, 1996; Kemp and Rasbridge, 2004; Duncan and Simmons, 1996; Evanikoff del Puerto and Sigal, 2006). Although many of their health conditions are preventable and/or manageable, there are reports of unhealthy lifestyles, and poor engagement in health maintenance in this group of immigrants (Perlman, Bobak, Steptoe, Rose, and Marmot, 2003; Ott, Paltiel and Becher, 2009; Tselmin et al., 2007; Duncan and Simmons, 1996; Barr and Field, 1996; Eberstadt, 2006; Levintova and Novotny, 2004; Saburova, Keenan, Bobrova, Leon, and Elbourne, 2011; Ryan, 1988). There is also a lack of evidence of culturally appropriate care for this group of immigrants (Lipson, Weinstein, Gladstone, and Sarnoff, 2003; Resick, 2008; Ivanov, Hu, Leak, Pokhis, and Roth, 2010; Duncan and Simmons, 1996; Benisovich and King, 2003; Resick, 2008; Ivanov et al. 2010).

To address identified gaps in the empirical literature, a qualitative ethnographic study was conducted with a convenience sample of 20 Russian-speaking immigrants aged 36 to 83, residing in the East coast of the United States (Appendix E). The study utilized face-to-face interviews along with participant observation, and analysis of documents. The documents included televised programs, magazines, and other media, visual and print resources, targeting the population of Russian-speakers in the United States.



In the participant recruitment process the “snowball approach” was used. This procedure was chosen as a result of recruitment for the pilot study, where the “word of mouth” worked well for recruiting Russian-speaking immigrants in the US (Amburg and Lindgren, 2013).

The main inclusion criteria focused on Russian-speakers whose formative years (first 12 years of life) were spent in the USSR, and who immigrated following USSR dissolution, after December 25, 1991 (Retrieved from <http://www.britannica.com/place/Soviet-Union> .com; Retrieved from <http://www.history.com/topics/cold-war/fall-of-soviet-union>; Retrieved from <http://www.simplypsychology.org/piaget.html>; Piaget and Inhelder, 1959).

The inclusion criteria were based on results of the pilot study by Amburg and Lindgren (2013). The pilot study explored health-related practices of Russian-speaking immigrants, and identified differences between the Russian-speakers of different immigration waves. Those, who came to the US in 1970’s were escaping political and religious persecutions, and their contacts with the former USSR were not as pronounced as in those who came after the dissolution of the USSR. The immigrants from the wave of post-USSR collapse had more connections with their country of origin, and even reported traveling back, unlike the earlier cohorts of the immigrants. There were no previous reports exploring health-related practices of the post-Soviet Russian-speaking immigrants in the United States prior to this study.

### **Summary.**

The study identified Russian-speaking immigrants to have culturally established perceptions of health and illness. These perceptions include viewing health as absence of

visible or perceived signs of distress and discomfort. Family was the main motivator to stay healthy. As opposed to health, illness is viewed as presence of chronic pain, limitations, and the need to support health by medications. Russian-speaking immigrants prefer not to take medications to support and maintain their health. In case of illness Russian-speaking immigrants refer to a variety of non-allopathic along with allopathic modalities. Yet, there was no consensus on the use of these specific modalities as well as it was not clear if healthcare professionals were aware of these approaches to illness and health maintenance.

The perception of healthcare modifies the established views on health and illness in Russian-speaking population. Overall, Russian-speakers had negative experiences with healthcare services in the former USSR. However, some of the Russian-speaking immigrants reported positive healthcare encounters in the former USSR when they paid for services privately.

Although, healthcare system in the United States was overall highly rated, younger Russian-speakers were unhappy with the cost of care, and they expected extra attention of healthcare providers as they paid for the health insurance premiums. There was a general expectation of personal attention of healthcare providers in Russian-speaking immigrants.

Established perceptions, modified by encounters with healthcare, determined health-related practices of Russian-speaking immigrants. Health-related activities of this population included diet and exercise. Despite the perception of traditional Soviet dishes being unhealthy, Russian-speaking immigrants prefer eating their ethnic foods on major holidays, and while celebrating important life events.

Exercise was perceived more as a recreational activity rather health practice in this immigrant population. There are no specific physical activities that guide health-related practices of Russian-speaking immigrants in the United States.

Health-related behaviors of Russian-speaking immigrants do not include screening and health-promoting practices. Moreover, health monitoring experiences in the former USSR were perceived negatively as they were mandatory and government-initiated. Intrinsically, proactive engagement in screening, such as mammography or colonoscopy, is not common. It is, however, unclear if physician's authoritative advice could persuade Russian-speaking immigrants to participate in these diagnostic activities.

The main factor influencing perceptions and behaviors related to health in Russian-speaking immigrant population was the phenomenon of transnational socio-cultural connections. Although, these connections were not always evident; they were pertinent and influential in lives of Russian-speakers in the United States. These connections varied from communication with friends and family, obtaining goods and services from the country of origin, to getting actual and virtual medical care in the former USSR. Technological advances and change in the political climate in the former Soviet Union and the US enhanced these connections.

The qualitative ethnographic study revealed 5 main themes: perception of health, perception of illness, perception of healthcare, health-related practices, and transnational socio-cultural connections. The original themes subsequently merged into three overarching Cores: Core 1, established views based on previous experiences, consisted of themes of perception of health and perception of illness, Core 2, modifying views and factors, comprised of the theme of perception of healthcare, and Core 3, behavioral

outcomes, and addressing the theme of health-related practices. The theme of transnational socio-cultural connections was the underpinning phenomenon influencing all three Cores and themes (Figure 1, Core model, Appendix G).

The subsequent application of the core model to the theoretical framework identified the Core model's connection with Pender's Health Promotion Model (HPM). Core 1 related to Pender's dimensions of individual characteristics and experiences and behavior specific cognition and affect. Core 2 was connected with behavior specific cognitions and affect dimension, and Core 3 linked with Pender's dimension of behavioral outcome. The theme of transnational socio-cultural connections is an underpinning factor that did not fit within any Core, nor did it have a straight connection with the HPM (Figure 5, Core model connection with HPM, Appendix K).

### **Conclusions.**

Health-related practices of Russian-speaking immigrants residing in the United States are the result of perceptions of health and illness influenced by interactions with healthcare, and transcultural connections. Perceptions of health and illness of this population established during the formative years in the former USSR, and subsequently shaped by life experiences, including the immigration to the United States. Encounters with healthcare involve experience with healthcare systems in countries of the former USSR and in the United States. The consequences of these encounters shape previously established perceptions, and lead to behavioral outcomes manifested by health-related practices of Russian-speaking immigrants in the United States.

In application of the HPM, some elements of the Core model were not aligned with the themes of the study. Yet, not all parts of the Pender's model connected with the Core model. In her model, Pender, does not account for the factor of immigration and acculturation. As such, the element of transnational socio-cultural connections could not be directly connected with dimensions and categories of the HPM.

The phenomenon of transnational socio-cultural connections is not unique to the post-Soviet waves of Russian-speaking immigrants. The empirical literature provides evidence of such connections in other groups of immigrants. However, there is limited exploration of this factor in Russian-speakers. Moreover, transnational socio-cultural connections are more prominent in the immigrants from the post- Soviet era. The dissolution of USSR gave the former Soviet residents freedom to keep in touch with their country of origin. Additionally, technological advances enhance these connections, making them stronger and more frequent. Although the degree and frequency of these contacts varies from person to person, transnational socio-cultural connections influence perceptions and subsequent behaviors related to health of Russian-speaking immigrants.

### **Strengths and Limitations.**

The strength of the study addressing traditional health-related practices of Russian-speaking immigrants is in its methodological approach. Focused ethnography was chosen to guide the study as the principal investigator was familiar with the population, and personally belonged to the community of Russian-speaking immigrants. The investigator had access to the population, and was fluent in communicating with the study participants.

Another strength of the study is in its rigor. The trustworthiness of data was assured by close collaboration with the graduate advisor, Dr. T. Lindgren, and independent data analysis with the subsequent comparison of results. Additionally, triangulating participant observation and review of media resources with interviews promoted thick description of participants' perspectives.

Prior to this research, the population of Russian-speaking immigrants from the post-Soviet era was minimally explored. The factor of transnational connections in Russian-speaking immigrants was not examined as well, and barely acknowledged in empirical literature.

Despite a number of important findings revealed in this study, there are limitations. Since the study utilized the convenience sample and was limited to 20 respondents from two states of the East coast of the United States, the results may not be transferrable to the population of the Russian-speaking immigrants in the United States.

Eighty percent of the sample came from the European part of the former USSR (Russian, Belarus, and Ukraine) with a small representation of Georgia and Uzbekistan. There was no representation of subjects from Baltic republics (Latvia, Lithuania, and Estonia), most of the Caucasian (Armenia and Azerbaijan), middle-Eastern republics (Kazakhstan, Turkmenistan, Tadjikistan, Kyrgyzstan), and Moldova. The majority of the sample consisted of self-identified Jewish and Christian (Russian orthodox and Catholic) representatives. There was a limited representation of Muslims, other Christians, and no variety of other religious groups.

Despite the fact that there was uneven representation of all the former Soviet republics, there were apparent differences in cultural backgrounds of the respondents.

Some of the examples were evident in family and generational relations of the subjects from different parts of the former USSR. There was more focus on older family members having extra privileges and being very respected by the rest of the family in representatives of the Middle Eastern (Uzbekistan) and Caucasian (Georgia) regions of the former USSR. Although, all of the participants reported providing care to their elderly relatives, those from the Middle East and Caucasia demonstrated additional respect of their elders by referring to them in extra polite manner while speaking Russian. However, this pattern was evident in only 3 participants due to difficulties recruiting participants from all parts of the former Soviet Union. Hence, this pattern needs further exploration of differences in cultural perspectives of the immigrants from the former USSR.

All the participants reported speaking Russian, yet, some admitted speaking Russian as their second language and speaking a language of the former USSR republic as their native tongue. Interestingly, regardless of the attempt by Soviet government to unite all residents in the former USSR into one cohort with the same culture, beliefs and traditions of each of the republics has evolved into their own distinct subcultures. The patterns of subcultures are evident by cultural traditions, cuisine, and language differences. This aspect of cultural diversity within the cohort cannot be ignored and could not be adequately explored in this study due to the recruitment restrictions.

Another limitation of the research was in deficient exploration of the factor of acculturation of the sample. The length of stay of the participants varied from a few months to over 20 years. This time spent living in the United States could have potentially affected quantities and qualities of experiences with healthcare services.

There was also a limited exploration of socio-economic status of the sample. There was a lack of the adequate assessment of the reasons behind each interviewee's immigration to the United States. Those factors could have potentially influenced the participants' views and behaviors.

Another limitation deserving attention is the diversity in age of the respondents. Although, the inclusion criteria for the study identified anyone who spent their formative years in the former USSR, the generational differences of the participants could not be dismissed. Some respondents were greatly affected by political changes and repressions in the former USSR immediately after World War II. Their perception of the government's influence on the USSR citizens could vary from the same of those who were young adults just before the USSR dissolved.

### **Implications and Recommendations.**

The study addressing traditional health-related practices of Russian-speaking immigrants identified the connection between the formative beliefs and life experiences in their influence on health-related practices. This research identifies the role of the family in health-related activities of the individuals from the former USSR. Thus, including families in planning care for this aggregate could have potential influence on behavioral outcomes.

There are some differences in family relations, especially, in respect for the elderly, among the representatives of the former Soviet republics. Hence, an additional investigation of sub-cultural characteristics of the former USSR immigrants is necessary to achieve comprehensive understanding of the family roles within this aggregate.



Health was perceived as a combination of physical and psychological wellbeing. Any distress, discomfort or need to take medications was perceived as a sign of illness. In managing health disturbances, Russian-speakers often refer to non-allopathic and alternative modalities, along with taking medications from the former USSR instead of or in addition to the treatments prescribed in the United States. Health-care providers need to keep in mind the possibilities of interactions and additive effects of such remedies. Additionally, further exploration of specific non-allopathic approaches is warranted in this population.

Previous experiences with healthcare guide Russian-speakers in their engagement in health-related practices. This group of immigrants has a set of expectations of healthcare providers. Such expectations include perceived total authority of physicians, preference for fewer medications, and expectations of extra attention by healthcare providers, especially, if patients pay for their services either directly to a provider, or through their health insurance premiums. Such expectations could be detrimental in delivering care to this population.

There is evidence of poor engagement in health screening and health-promotion activities in this aggregate. Previous experiences and established perceptions guide this group of immigrants in their health-related behaviors. It is essential for healthcare providers to be aware of Russian-speakers' beliefs associated with health and disease management. Additionally, an investigation of whether using the perceived authority and trust in physicians can increase screening and other health promoting behaviors in this population is warranted.

The study also identified the importance of on-going transnational socio-cultural connections in lives of the immigrants from the era of the post USSR dissolution.

Although, the factor of transnational connections was previously mentioned in the literature, the exploration of this phenomenon in the population of Russian-speaking immigrants is not sufficient. Thus, further research addressing transnational socio-cultural connections of Russian-speaking immigrants in the US is highly recommended.

The findings of the study were organized in the Core model. This model demonstrates the connections of established views based previous experiences, modifying views and factors, and behavioral outcome. The subsequent connection of the Core model with the HPM identified Cores connections with the dimensions of the HPM. However, additional analysis of this connection demonstrated that not all categories of the HPM could be connected with the Core model. Consequently, an additional exploration of connections between the HPM and the Core model is recommended.

Currently there is no comprehensive exploration of the HPM application in Russian-speaking immigrant population. It is highly recommended to utilize quantitative methodology to examine health-related practices of Russian-speaking immigrants with guidance of Pender's HPM.

This study looked into Russian-speaking immigrants who came to the United States between the end of 1991 and present time. It focused on those immigrants who were affected by the USSR dissolution. However, the study did not look into the factor of acculturation, and did not take the length of stay in the US into consideration. Further research exploring the influence of acculturation on health-related practices of Russian-speaking immigrants in the US is needed.

Notwithstanding the fact that the purpose of this study was the exploration of Russian-speaking immigrating to the US after USSR dissolution, there is still a great need for an additional examination of Russian-speakers of various immigration waves in terms of differences and similarities of their views and behaviors. Comparative research and more detailed examination of different immigration waves are necessary for comprehensive analysis of this group of immigrants. There is a potential diversity among those who moved to the US immediately after the breakup of the Soviet Union and those who have more recently left the areas of the former Soviet republic. One cannot deny the potential influence of political and socio-economic changes in the world since 1991.

The study sample largely consisted of the immigrants from European parts of the former USSR, and included mostly self-identified Jewish and Christian representatives. There is a potential that religion could influence perceptions and practices related to health in the population of Russian-speaking immigrants residing in the United States. Thus, the factor of religion deserves an additional examination.

There is also a need to examine diverse representatives of Russian-speaking immigrant community. There are potential distinctions between the former USSR cultural subgroups. As was evident in the study, some cultural perceptions and practices varied between the representatives of the former Soviet republics. More research is needed to examine and compare the immigrants from all 15 republics of the former USSR.

The study addressing traditional health-related practices of Russian-speaking immigrants was conducted on East coast of the United States, and included the respondents residing in the states of New York and New Jersey. There a great need to expand the research to other parts of the United States and study Russian-speaking

immigrants residing in different areas of the US. It is possible that access to ethnic resources in various parts of the country could potentially influence utilization of health-related services and transnational socio-cultural connections of his aggregate.

Due to the nature of the inquiry the qualitative ethnographic approach was utilized to guide the study. For further exploration of the phenomenon of health-related practices of the population of Russian-speaking immigrants, the use of quantitative and mixed methodologies is recommended.

With the increased numbers of immigrants, arriving and settling in the United States the healthcare needs of this population become a matter of public health importance. Healthcare professionals encountering the immigrants often face cultural barriers, where immigrants' health practices differ from the same of the mainstream. Knowledge and receptiveness to the diversity of culturally established health behaviors guides practitioners in delivering quality care.

The study addressing traditional health-related practices of Russian-speaking immigrants in the United States equips healthcare providers with more insight into the factors leading to the specifics of health-related behaviors of Russian-speaking immigrants. To care effectively for this group of immigrants, healthcare professionals need to take into consideration the aggregate's prior experience with health-related services and keep in mind the role of their culturally based beliefs and views on health and illness management.

An essential factor to remember when planning and delivering care for Russian-speakers is the importance of transnational socio-cultural connections. These connections might vary from seeking advice to taking medications from the countries of the former

USSR. Although, this might not always be evident, the presence of transnational connections plays a vital role in health beliefs and practices of this population.

The population of Russian-speaking immigrants in the United States is increasing and evolving. As evident in empirical literature, many of the health-related issues of Russian-speaking immigrants can be preventable and/or manageable, yet there are numbers of barriers disconnecting this population from health interventions. Culture plays a vital role in guiding health-related beliefs and behaviors of Russian-speaking immigrants. The detailed exploration of the culturally established practices will ensure the knowledge base of this population, and will enhance safe and quality care delivery to this aggregate.

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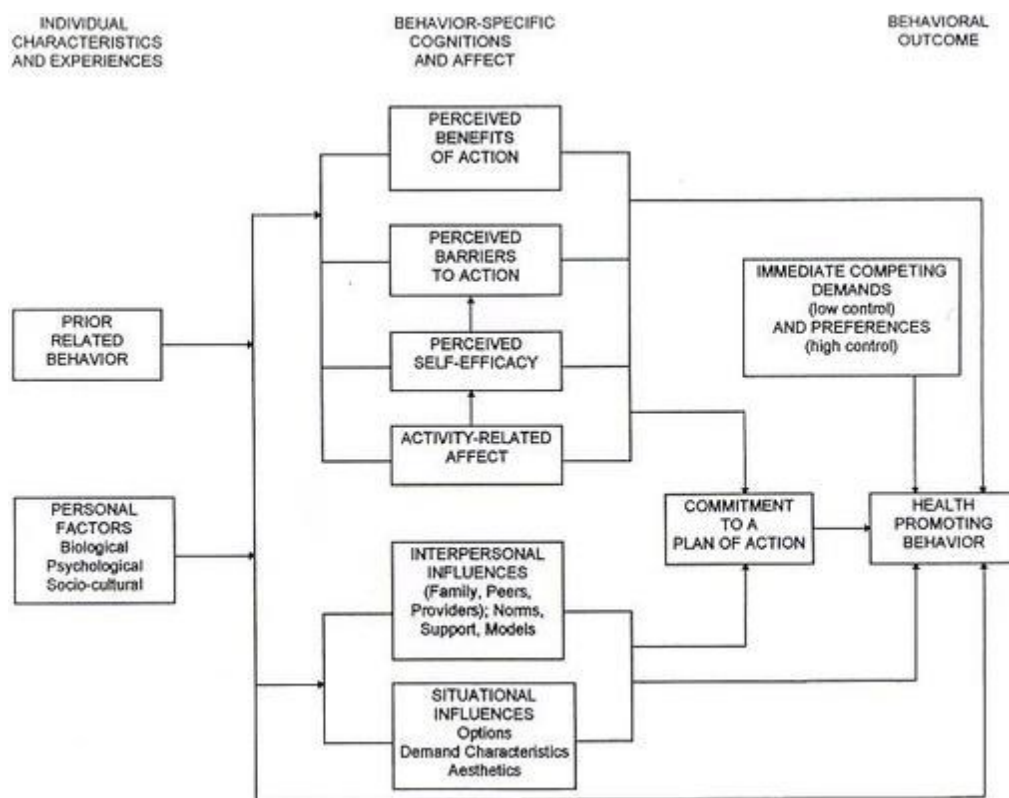
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## Appendix A.

**Pender's Health Promotion Model.**

**2012 Life Expectancy Report in the Countries of the Former USSR.**

**Source: World Health Organization. Retrieved from**

**[http://www.who.int/gho/mortality\\_burden\\_disease/life\\_tables/en/](http://www.who.int/gho/mortality_burden_disease/life_tables/en/).**

<b>Former Soviet Republic</b>	<b>Life Expectancy for Males</b>	<b>Life Expectancy for Females</b>
Russia	67	75
Ukraine	66	76
Belarus	67	78
Moldova	66	75
Georgia	70	78
Armenia	67	75
Azerbaijan	69	75
Latvia	69	79
Lithuania	68	80
Estonia	71	81
Kazakhstan	63	72
Tajikistan	67	69
Turkmenistan	60	67
Kyrgyzstan	66	73
Uzbekistan	67	72

## Appendix C

**Amburg and Lindgren 2013 Pilot Study Demographics.**

Participant#	Sex	Age	State of Residence	Children Total (Living)	USSR Republic of Origin	Highest Level of Education in USSR	Highest Level of Education in USA	Marital Status
1	F	76	NY	2	Uzbekistan	Master's Degree	None	W
2	F	82	NY	2	Ukraine	Technical college	None	W
3	M	86	NY	2 (1)	Ukraine	Middle school	None	M
4	M	43	NJ	2	Russia	Bachelor's degree	MBA	M
5	F	72	NJ	4 (2)	Russia	Some college	None	W
6	M	49	NJ	2	Russia	Master's degree	Some college	M
7	F	45	NJ	2	Belarus	Master's degree	None	M
8	F	60	NJ	2	Ukraine	High School	None	W



### **Demographic Questionnaire.**

Age  
 Gender  
 Marital Status  
 Number of children (if applicable)  
 USSR Republic(s) of origin and residence  
 Years lived in USSR  
 Years lived in United States  
 State of U.S. residence  
 Highest level of education in USSR  
 Highest level of education in United States

### **Interview Guide.**

1. "How do you evaluate your overall health status?"
2. "What does being "healthy" mean to you?"
3. "What does being "sick" mean to you?"
4. "What do you do to stay healthy?"
5. "What do you do when you get sick? How do you care for yourself?"
6. "How did you take care of yourself in USSR if you were unwell?"
7. "How did you keep yourself healthy in USSR?"
8. "Do you still do those things? Which ones?"
9. "Which health-related activities that you practiced in USSR are difficult for you to practice in the United States?"
10. "What can you say about the differences in health-related practices between those that you practices before and after leaving USSR?"
11. "Where do you refer for information related to your health?"
12. "What kind of connection do you have with your country of origin?"
13. "How often do you re-connect with the "home country"?"
14. "What would you like healthcare providers to know about health-related practices that are important to you?"

## Appendix E

## Demographic Characteristics of the Sample

<b>Variable</b>	<b>Total number</b>	<b>Percentage</b>	<b>Mean</b>	<b>Median</b>	<b>Range</b>
<u>Age</u>	N/A	N/A	56	N/A	36-83
<u>Gender</u>			N/A	N/A	N/A
Male	9	45 %			
Female	11	55 %			
<u>Marital Status</u>			N/A	N/A	N/A
Married	12	60 %			
Divorced	3	15 %			
Widowed	5	25 %			
Single	0	0 %			
<u>Religion</u>			N/A	N/A	N/A
Jewish	9	45 %			
Christian	9	45 %			
Muslim	1	5 %			
Mixed	1	5 %			
Number of years in US	N/A	N/A	N/A	N/A	4-26
Number of years in the former USSR	N/A	N/A	N/A	N/A	18-62
<u>Place of origin in USSR</u>			N/A	N/A	N/A
Russia	4	20 %			
Ukraine	6	30 %			
Belarus	6	30 %			
Uzbekistan	2	10 %			
Georgia	2	10 %			
<u>Education completed in US</u>			N/A	N/A	N/A
Associate degree	1	5 %			
Bachelor Degree	2	10 %			
Master's degree or higher	4	20 %			
Some schooling	3	15 %			
None	10	50 %			
<u>Education completed in the former USSR</u>			N/A	N/A	N/A
Associate degree	3	15 %			
Bachelor Degree	3	15 %			
Master's degree or higher	11	55 %			
Some schooling	3	15 %			
None	0	0			
Number of children	N/A	N/A	2	2	0-5

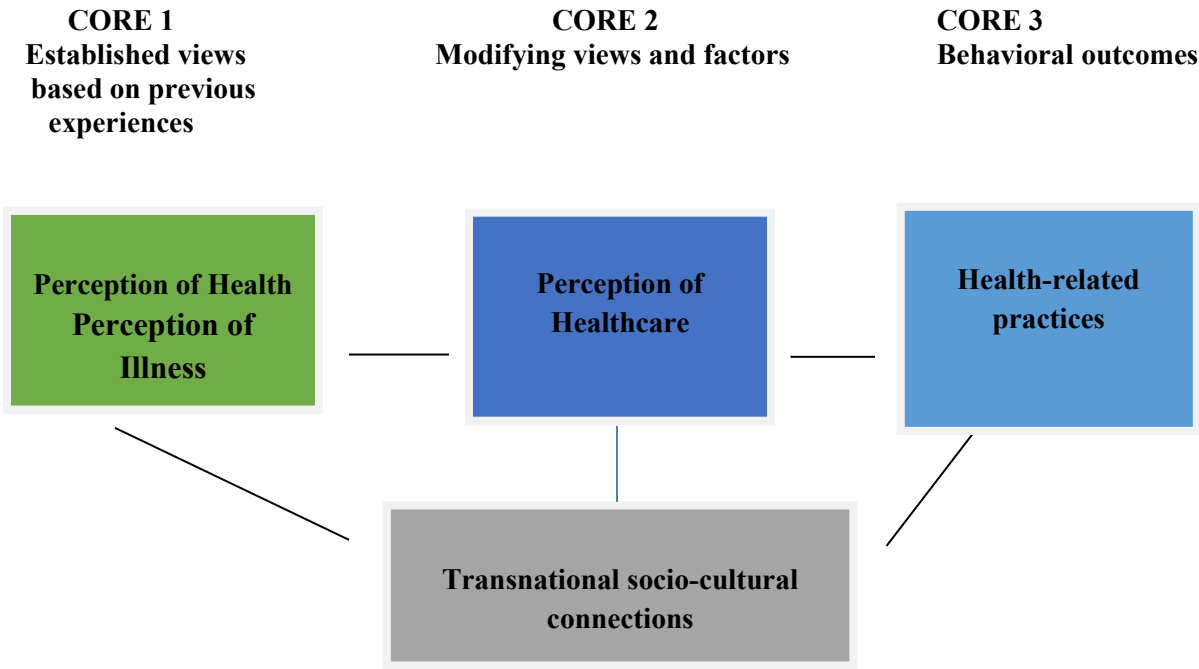
## Appendix F

## Themes and Categories

**Core 1. Established views based on previous experiences****Theme 1. Perception of health***Stimulus to stay healthy**Role of the Family in being healthy***Theme 2. Perception of illness***What to do when sick**Remedies to illness***Core 2. Modifying views and factors****Theme 3. Perception of the healthcare***Perception of the healthcare system in the former USSR**Perception of the healthcare system in the US**Expectations of healthcare providers***Core 3. Behavioral outcomes****Theme 4. Health-related practices***Health-related activities in the former USSR**Health-related activities in the US**Diet.**Exercise.***Theme 5. Transnational cultural connections**

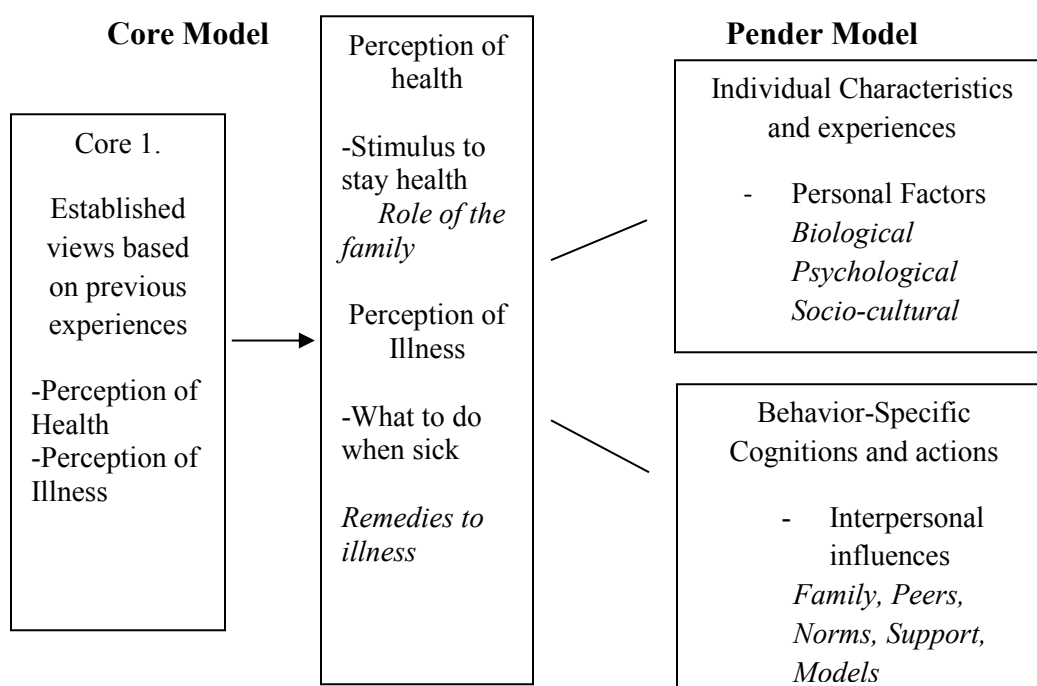
Figure 1. Core model.

Figure 1. Core model.



## Appendix H

Figure 2. Core 1 connection with HPM.



## Appendix I

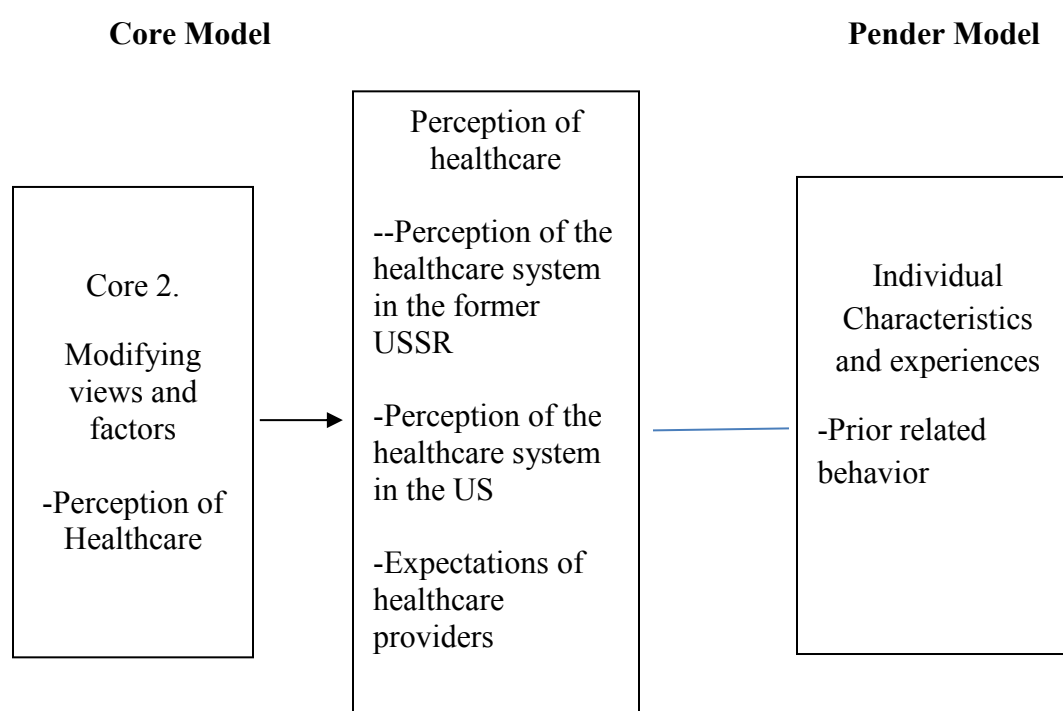
*Figure 3. Core 2 connection with HPM.*

Figure 4. Core 3 connection with HPM.

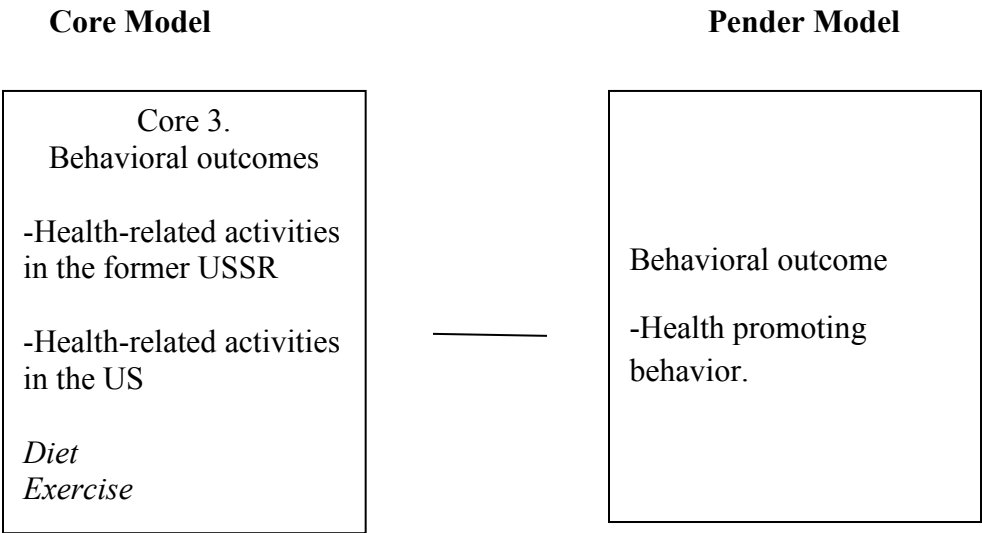
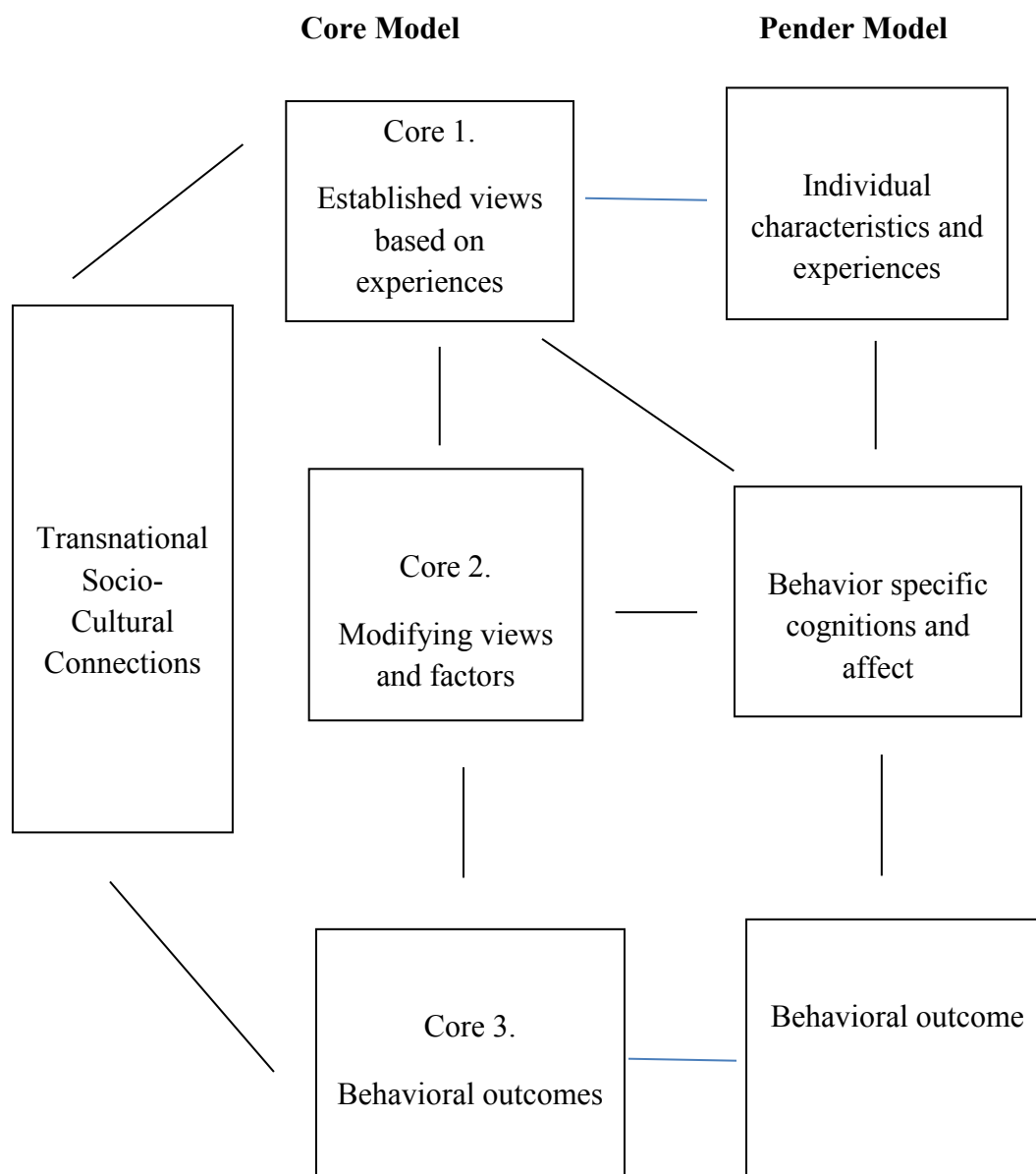


Figure 5. Core model connection with HPM.





## Appendix L

## 24 Initial Themes

CATEGORY	DESCRIPTION
Being healthy / View on health	<p>1. Absolute harmony. Don't think that you have a body part. Nothing bothers you. Being healthy-absolute harmony. Nothing bothers you.</p> <p>2. Healthy=active. Healthy diet and exercise. Being healthy-being active</p> <p>3. Healthy-being able to move. Healthy=active. Never sit down. Diet</p> <p>Health is ability to move. Healthy diet-not fried, fruits, vegetables, no meat.</p> <p>Being healthy-eating right. Eating fruits, vegetables, no meat, no fried foods.</p> <p>5. Health is everything. No health-no nothing. Healthy-living normally, run, jump, understand surrounding, not suffer in pain. Healthy-live life to the fullest. Full(healthy) life-nothing bothers you, nothing hurts, no fatigue. You can drink, eat, enjoy life.</p> <p>Health is everything, living life to the fullest, enjoy life when nothing bothers you, no pain, no fatigue</p> <p>6. Being healthy. Good health is inherited. Family relations influenced health. Good health and luck helped get strong through life turmoil. Faith gave me health. Healthy roots, heritage. Tough life makes you stronger.</p> <p>Active I was lucky with my health. Look like I inherited a healthy body. There was a good relation of the adults in the families. Thanks to health I lived to this age. Had no help. Attributes good health to luck and staying strong through life turmoil. Faith gave me health. Healthy roots, heritage. Tough life made stronger. Was lucky that had a good family. Lucky to little encounter healthcare. Kept busy. I lived a life practically without parents, and all, you understand, there was some living strength. I was not the only one, but one of not many who lived to this age, understand, that I was preserved because of those who surrounded me. If I stayed at the orphanage, I could have died during war. So happened that I was lucky. So...who knows. Was it luck or what? Or payback for the sorrow was given to me at that early childhood.</p> <p>7. Healthy as long as labs are good. Could have been worse.</p>

	<p>Thinks she is healthy because her labs are good. Does not take recent injury into consideration because it could have been worse.</p> <p>9. Health-not sick. Young-automatically healthy. Healthy-not sick. Young-automatically healthy.</p> <p>12. Being healthy: Physically and psychologically well. Thoughts. Being healthy-being physically and psychologically well. Bad thoughts lead to sickness.</p> <p>13. Health perception. Being healthy: Being healthy-being active, walk, have social life, go to the theater, meet with friends, family.</p> <p>16. Being healthy. Being healthy-feel good.</p> <p>17. Being healthy. No needing medications. Being healthy-not need medications.</p> <p><b>SUMMARY: Health is everything. Harmony. Being active=healthy. Being physically and mentally well. Being able to enjoy life. Young people are expected to be healthy. Health is inherited, given by ancestors. Being active. Not need medications. Young people are expected to be healthy.</b></p>
Being sick/unhealthy/ View on illness	<p>1. Not being able to enjoy life, not being able to do what you want to do. <i>Being sick is associated with pain.</i></p> <p>Being sick-pain, no enjoyment in life.</p> <p>2. Illness related to mental state, state of depression, fatigue, tiredness, pain, apathy.</p> <p>Being sick-mental and physical component. Pain is related to illness. Emotional (mental) state are related to illness.</p> <p>3. Inability to get from life what it gives me.</p> <p>Sick-unable to get all the life has to offer.</p> <p>5. Sick-not living life to the fullest. Existing but not living. Illness-inability to live life to the fullest. Existing but not living.</p> <p>6. Constant pain. Changes in personality and behavior. Unhealthy-constant pain that affects personality and behavior. State of the nervous system affects health.</p> <p>8. Chronic conditions (ex. Ulcer), pain, discomfort, sore throat, coughing, fever, bronchitis.</p> <p>Sick-chronic problems, pain. Discomfort is the indication of something. Not well with the sore throat, coughing, fever, bronchitis.</p> <p>9. Pain, discomfort. Bad when it hurts, good when it doesn't. Sick when it hurts. Sick when hurts and discomfort. Why be sick if you can be not sick? Bad when it hurts, good when it doesn't.</p>

	<p>13. Perception of illness: Being sick. Sick-not good. You need to go to the doctor, run tests, and accept it. Must do what the doctor says.</p> <p>16. Being sick. Balance of mind and body. Sick-cannot walk (move) and think. Psycho-emotional condition could harm person's health. Placebo effect.</p> <p>17. Being unhealthy: Being dependant on the medications, doctors, hospitals. If you go to the doctor-you are sick. Being dependant on the medications-being sick. Not having control over your medication dosages. If need to go to the doctor/hospital frequently-you are sick. Sick person is the one not being able to function without medications. If you go to the doctor-you are sick.</p> <p><b>SUMMARY: Sickness (un-wellness) –not being able to enjoy life. Sickness involves pain and mental state of depression. Physical and emotional connection with pain. Being sick-have chronic problems, discomfort. Need of medical care. Being dependant on doctors/hospitals, medications. Psycho emotional conditions affect a person.</b></p>
Health maintenance /Health promotion	<p>1. To be healthy-exercise and eat right. Healthy foods: low fat, low cholesterol, no junk food</p> <p>Health maintenance is associated with healthy diet and exercise.</p> <p>Was healthy as a child. When you are young no chronic diseases. In US two opposites: going to the gym and eat right or "live like I want". When you are young-you are expected to be healthy. Start thinking about health later in life.</p> <p>Young people are expected to be healthy. No chronic diseases are expected in young. Thinking about health later in life.</p> <p>2. Healthy diet: fish, fruits and vegetables, no dough and meat. Healthy-exercise and healthy diet. It is important to have psychological wellbeing.</p> <p>To stay healthy one needs to eat right, exercise, and have psychological wellness.</p> <p>3. To maintain health not to over abuse anything. Restrain self (from temptations). When you are young-nothing hurts. When it starts hurting-need to take care of self and lead healthy lifestyle. Go to bed on time. Don't watch TV constantly. I watch TV when I move. Do something and listen for TV. Moving is the most important. Walking. Get out (for a walk). Need to do something. Create projects for myself.</p> <p>When you are young-nothing hurts. Young people are expected to be healthy.</p> <p>Self-limitation for health.</p> <p>Limit personal temptations.</p>

	<p>Keep self busy.</p> <p>4. Ancient knowledge Simple life, simple food, natural selection. Utilize the knowledge of previous generations. Organic natural treatments. Do not throw yourself into food. Knowledge from the ancestors, Knowledge of health from ancient times. Utilization of resources given by ancestors. Utilize modern knowledge, knowledge from the ancestors. Eating simple, working physically, but not in the gym. Chopping wood, walk, eat simple foods, like ancestors did. Utilize knowledge from the previous generations. Many deny knowledge of the ancestors. There are nature-derived products to heal. Modern philosophy often ignores/denies this knowledge. Mold was used to heal wounds-penicillin was discovered. Organic remedy. Now new treatments are being synthesized and people develop resistance. Balance in reality. Natural selection. We save weak lives. We are going against nature.</p> <p>People who are sick keep producing weak/sick kids. Natural selection. Strongest survive. Use ancient knowledge in organic way to correct human body. Person is prone to disease. There will never be healthy people. People will get sick and will die.</p> <p>Health of ancestors. Strongest survive. Today people are weaker, less prepared by the nature. Traditions of ancestors. Ancient traditions. Sages used to say like: "To breathe through the mouth is the same as to eat with the nose." Simple things are justified.</p> <p>Eggs do not raise cholesterol-your body does. Ancient books believe eggs are harmless.</p> <p>Food has to be simple. Do not throw yourselves into food. Vegetarianism decreases respiration. We were vegetarians and our health deteriorated. Ancient knowledge Ancient traditions for health. Old tradition. Ancient knowledge.</p> <p>There are two types of people. Those who worry about their health and run to the doctors, those who listen to everything doctors tell them to do.</p> <p>The other group of people are those who are thinking about the consequences of interventions.</p> <p>Understanding your problem. Look for treatment solution in ancient history. Fractures-see the doctor</p> <p>No option (infection) take antibiotics</p> <p>Homeopathy healed the allergy in a 4 year old</p> <p>Pill is not in your hand-it is in your head.</p> <p>No need to keep teeth and tonsils as they are the source of infection. They do not have a blood supply. Toothless smile.</p>
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	<p>No need to fix teeth. Tooth infection does not go away. Tooth infection does not go away. It destroys the person.</p> <p>We are what we eat. Eat and drink according to self. Do not over do things. Do not overeat, do not over love. Limited portions.</p> <p>If the doctor prescribed you medications-take twice as less".</p> <p>Always cut the dose it two...</p> <p>Natural forces of healing. Own experiences. Personal responsibility, personal knowledge.</p> <p>Self-healing, self-maintaining.</p> <p>Do not use role models. Do not go to the gym</p> <p>You unite at the table. Have so many chairs but do not use them. At the table you cook and eat, like it used to be. People do not cook at home anymore.</p> <p>5. When travels back to Belarus gets together with friends and compete in performing exercises, measure each other's fitness. Friends in former USSR stopped drinking.</p> <p>To be healthy don't drink a lot, don't smoke, ride a bike, sports, don't eat "filth". "Filth"-foods that poison my body. Junk food.</p> <p>To be healthy: exercise, avoid "fitly"-junk food that poisons you, do not smoke, and do not drink A LOT.</p> <p>Friends in former USSR support health maintenance. In US exercises almost every day, goes to the gym, but not regularly. Job pays for the membership. For disease prevention: bike riding, proper diet, healthy weight, healthy lifestyle, not necessary to take supplements.</p> <p>In US health maintained by active lifestyle. Although has gym membership-does not really go there.</p> <p>8. Healthy diet, exercise. Healthy diet: fruits, vegetables, grains, less chemicals, good for kids and environment</p> <p>I exercise too little, little active. Health=diet, eating healthy food, rich in vegetables and fruits, organic food preference, less chemicals, less harm to the environment and kids.</p> <p>9. Exercising, eating right. Healthy diet includes fruits, vegetables, not cookies and ice cream. Not overeating. Older person has more resources to take care of health. When young less opportunities to take care of health. Better to prevent than to treat later. Exercise sometimes for health. Once in a while. Try to eat right Eating right-limit what you eat, not overeat, eating right food. Right food-fruits and vegetables, not cookies and ice cream. When the person is older-more money, more opportunities. At young age you have nothing and have fewer opportunities to buy healthy food and exercise. Better to prevent than to treat later.</p>
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	<p>10. Lifestyle changes since the immigration. Modified diet. Tried to stay healthy. Lifestyle is modified by the information gathered from TV, media in US. Local culture influences dietary choices. Certain foods still eat as part of the culture, but trying to eat less fat, less harmful substances. Trying to eat healthier in US, limit junk food and carbonated beverages.</p> <p>11. Health practices in United States. Diet. Exercise. Genetics. Organic products are preferred. Health status depends on the exercise. There is a genetic problem that could not be fixed. Did not expect to have problems with blood pressure because is not overweight and is not at the age when the problems start. Running helps stay healthy. Running helps physically and mentally. Running outside helps boost immune system and some little things stop bothering. "I feel broken" Get up and run to prevent problems such as early arthritis that the mom has. Sees changes with exercise. If runs does not get sick. Some people revise their diet completely after serious diagnosis, such as cancer. Certain things, such as Japanese straitening is very unhealthy and dangerous because of the use of chemicals. Certain foods could prevent cancer while others could cause it. Healthy diet can change genetics. Want to know more about it. Diet, genetics, exercise.</p> <p>Health-related practices in former USSR. Did not practice healthy lifestyle. Was never into sports in Belarus. Now I know which foods are healthy. Don't eat salami, canned food, processed food, do not add salt, do not eat "harmful" food. Do things right.</p> <p>12. To stay healthy: Exercise, healthy diet, consisting of vegetables, grains, soups. Homegrown vegetables. Exercise to be healthy. Cooking healthy food, walking, eating healthy. Food choices: vegetables. Son was raised eating good food: soups, vegetables, grains. People grow their own vegetables. Grow own food.</p> <p>13. Health maintenance. Things done to stay healthy: Exercises to stay healthy, walking. Was operated by a good doctor, got great care and attention. Do not overstress self, moderation; watch what goes into your body. Exclude alcohol, eat in moderation. Your body sends you signals. If stomach bothers you-you should not be eating that. Uses art for distraction.</p> <p>Changes in diet/lifestyle since immigration: Eating more vegetables here. United States offers more services for the elderly, such as home attendants, more availability of everything in the stores. In America-I do not deny myself anything. If I want to drink - I have a drink. Could not buy</p>
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	<p>everything he wanted in Belarus because had young kids. Kids are older-you can buy anything you want.</p> <p>17. Health maintenance in US: Self-control, limitation of the food intake. Taking vitamins hoping that this will help. Self-control. Limit food. Take vitamins (hoping that they will help you).</p> <p><b>SUMMARY: Maintaining health related to exercise and healthy diet. Diet includes fruits, vegetables, less meat, grains, more organic, less chemicals, fish, less meat, no dough, cookies, ice cream. No overeating. Eat in moderation. Eating more vegetables, grains, soups. Home-grown food. Organic. Young people are expected to be healthy, but have fewer opportunities to afford healthy lifestyle. Friends provide support of the active lifestyle. Eating simple. Lifestyle changed since the immigration. Health practices had been modified. Diet and exercise adjusted. Did not practice healthy living in former USSR. Do not overstress. Listen to your body, it gives you signs. Being under medical care. Art of distraction. Self-control. Taking vitamins hoping they will help. Limit food.</b></p>
Health management/ Disease management	<p>1. If sick-severe pain ER, if long-term problem-specialist. Pain killers. <i>Being sick is associated with pain.</i></p> <p>If one gets sick acts based on condition. In serious cases ER, otherwise manage by home remedies.</p> <p>2. If sick-take care of myself. Or doctors to run some tests. If sick-take care of myself. Self-care first. If need some tests – doctors.</p> <p>5. If sick do nothing or if have a cold-lemon. Don't want to sick about serious problem (avoidance?).</p> <p>If sick mildly-ignore or use lemon for colds, but afraid to think about serious illness.</p> <p>9. If sick-stay home. Rarely goes to the doctor. If sick-stay home. Rarely go to the doctor.</p> <p><b>SUMMARY: If sick-try home remedies first. In serious cases doctors or ER.</b></p>
Health promotion and maintenance in former USSR	<p>1. Prophylactic at school. Schools used to send students to dentist and screened for scoliosis. In USSR no preventive services focusing on health. <i>Interestingly, there were some screening services in schools, but not really primary preventions.</i> Sport more for recreation than health. Schools were doing morning exercises but no initiative for exercise. There were some screening services established through schools, but no focus on health promotion. Sport-recreation, not health-related activity</p>

	<p>2. To stay healthy played sports, worked out. Sports and physical activities help in health maintenance. In USSR only doctors because was not educated about health. Had no health knowledge-went to the doctor. Going to the doctor to get health-related knowledge. Doctors to educate people about their health.</p> <p>3. In USSR was moving always, but did not eat right. Movement=healthy. In USSR maintained health by moving. Diet was not healthy, but motion compensated for that.</p> <p>5. In former USSR for health played sports. Did not play videogames like kids do today. . In former USSR had friend to play soccer with. Not the same in US. If had the friends here to offer to play sports-would have done the same thing. In former USSR maintained health by sports. Friends were supportive. Active lifestyle, no videogames.</p> <p>6. Spending time vacationing in resort cities. In USSR had assigned regional internist. Doctors made house calls Lived in resort city, climate. Spent 2 weeks in the summer by the sea. Went to resort with the husband. He received voucher at work.</p> <p>7. Health maintenance-traveling, going on vacation. Drink fresh milk, eating natural foods, breathing clean air. To stay healthy went away camping, spent time with friends and families, went to the sea resort, traveled. Traveled to the place where they drunk fresh milk straight from the cow, breathed fresh air. When economy had declined traveled to the same area to trade goods and to make some money. Wanted to dress nicely-that was the vacation. Grew own fruits and vegetables. Always tanned-sign of someone healthy. But that was youth.</p> <p>9. Was going to the gym when was young. Was physically active. Another stage of life. Less prevention in USSR. People were preoccupied with life routine than health.</p> <p>10. Cultural traditions related to health. No preventive care. Uzbek tradition to take care of the problem when it starts (NO preventive care).</p> <p>11. Health-related practices in former USSR. Did not practice healthy lifestyle. Was never into sports in Belarus. Now I know which foods are healthy. Don't eat salami, canned food, processed food, do not add salt, do not eat "harmful" food. Do things right.</p> <p>13. Health management in USSR. If were sick: In former USSR if not well-doctor. Did not feel well-went to the doctor. Worked and tried not to catch anything to stay healthy in Belarus.</p>
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	<p>16. Health promotion and health practices in former USSR. No identified practices. Working-being active to stay healthy. No health maintenance in former USSR. Worked in former USSR to be healthy.</p> <p>17. Health promotion in former USSR: Going to the doctor when sick only. Young people are expected to be healthy. Not doing anything for health when young. (No concept of seeing providers for preventive care) No health promotion/prevention of illness in Russia. In Russia was young. Young people are expected to be healthy.</p> <p><b>SUMMARY: In former USSR maintained health by being active and engagement in recreational activities, spending time outdoors, by the sea, in resort cities, breathing fresh air. Being active was more important than eating right. Doctors are seen as being responsible for health education. Although, there was no formal primary prevention, many places, such as schools provided screening and promotional programs (ex. exercise). Some insurance companies required annual physicals after USSR dissolution, but not all had insurance coverage. No preventive care otherwise. Take care of the problem when it starts. Did not have much information on health management in USSR. Working and trying to stay healthy, seeking medical care if unwell. No concept of health promotion. Young people are expected to be healthy.</b></p>
Health maintenance in US	<p>1. In US still doing boiled potatoes breathing, birch buds. Milk if someone has cold. Although it is controversial older people still use old remedies. Many of USSR home remedies are still practiced in US. Although not without controversy.</p> <p>2. In US you are educated. You get information from the media in the US about health. You see people taking care of their health. In USSR not educated. Because was young? Was not educated in USSR. In the United States media provides health-related information. Education helps maintain health.</p> <p>3. In US-doctor if sick. In US-seek professional medical care if sick.</p> <p>6. Good care in US. Affiliated with the hospital. Primary doctor. Going to the Russian-speaking doctor who has an office in the neighborhood and who advertized on Russian radio. Went to the doctor because had problems. Taking</p>

	<p>medications to stay healthy. Regular doctors' appointments. Good care in the nursing home.</p> <p>Takes medications to stay healthy. Gets help in America. All of this because of America. In US was affiliated with the hospital. Went to the primary doctor. Husband was sick. Did not like the hospital. They did not do anything for me. Just a dietitian recommended losing weight. Went to the doctor who was speaking on Russian radio. Russian speaking doctor opened the office in the neighborhood. Went to him because had some health problems. Doctor did the blood work, comprehensive exam and prescribed medications for pressure and cholesterol. Was going to him once every six month for checkups. Doctor was recommending Calcium supplements and increase in antihypertensive medications. Went to the GYN because had some problems. Additional Calcium supplements were prescribed, but not sure if they work as she does not feel anything. I say it to the internist. He is like that...dos not encumber with medications. Going to an eye doctor every 4 month.</p> <p>9. Very conscious about own health. Understand that have to support self. Simply no time for health. Wavy relationship. Starts exercising when gains weigh. At that time health becomes a priority. Going to the gym every day to lose weight when there are visible signs. Due to the lock of time exercise is not a priority.</p> <p>10. Healthcare practices in US. Tried to stay healthy, living healthy lifestyle. Playing sports with the kids. Wife as a doctor cared for the family, friends from the medical field gave advice, and the family used medications from the Uzbekistan until got adequate medical coverage. Uzbek tradition to save money and "stock-up", including the medications. Once got the insurance went to the doctors. Leading healthy lifestyle to prevent diseases.</p> <p>Tried to live healthy lifestyle. Spouse is a doctor. Brought medications from Uzbekistan "just in case". Had enough medications until the next trip to Uzbekistan. Traditions of Uzbek people to stock up and save. This applies to the medications. Stock up medications and save money. Friends and family, who are in the medical field, give advice about medications. It is cheaper to buy medications there. Lately practically do not use medications from Uzbekistan.</p> <p>Although under certain rare circumstances might use some medications if they are not expired yet. Since have insurance-go to the doctor. To be healthy have to be active, play sports, play sports with kids. Leading healthy lifestyle to prevent diseases.</p>
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	<p>16. Health management in US. Diversion. OTC meds, rest. Not complete following prescribed treatment regimen. If not feeling good take Aspirin and go to bed. Go to bed or divert the attention from the problem. Despite doctor's advice does not take all the meds.</p> <p>17. In US try to control eating habits.</p> <p><b>SUMMARY: Some practices from former USSR are still used in US. People are more educated about their health in US. Media provides more health-related information in US. Used medications from former USSR. Stock-up on the medications. If don't have insurance use medications from former USSR. If have an insurance-go to the doctor. In US try to adjust eating habits. Taking OTC medications and trying to divert the attention from the problem (mind-body).</b></p>
Experience with healthcare system in former USSR	<p>3. Still remembers experience with appendectomy in Russia from many years ago. In Russia 40 people in one hospital room. Had an appendectomy at the age of 17. (57 years ago). Here they ask you for detailed history even if you come with a simple question. In Russia there is a gap... Brother in Russia gets treatment from private clinics, not the government. Doesn't trust government clinics. Russian book about doctors. How doctors are immersed in their work in Russia. Likes watching movies about medicine. Doctors are humans too. Medical TV shows are showing how doctors relate to their patients. They live for the profession. Not anybody can be a doctor. They see human suffering. Sometimes you forget about yourself. If cannot take it need to leave the profession. Russian healthcare workers used to wear white coats. Now they wear scrubs. Compensating doctor is inseparable part of care. Thanking doctors. But there has to be a limit. Money-bribery in healthcare. In Soviet Union giving box of chocolate was customary. Hippocratic oath. Doctors from villages are less spoiled: They see more and give of themselves. Mother in law was a dentist in the military clinic. Doctors in USSR were human-like. You are human, not simply a robot. Human qualities. Used to wait to be seen by doctors in USSR. Here also have to wait to be seen. In USSR could get a referral for sanatorium. Went to the sanatorium almost every year during Soviet times. In USSR health clinic was affiliated with factories and monitored health of workers. Diets were different than in US. Pureed soup. Hated the diet, but now like it. In Russia crowded hospital rooms. Russian doctors have gap in assessing their patients. No trust in government clinics in today's Russia.</p>

	<p>Russian media portrays doctors as very dedicated in their profession and live for the profession. Not anybody can be a doctor. Have to be ready to see human suffering. Selfless doctors, who forget often about their own needs. Yet there are some doctors chasing bribes. Compensation is good but there has to be limit. Spoiled doctors. Less spoiled in villages. Doctors have to have human qualities, but not everyone can be a doctor. Human qualities of doctors. Not like a robot. Healthy diets differ between Russia and US. In Russia they were pureed soups which were not liked by younger people but appreciated with age.</p> <p>Waiting for the doctor is the same in USSR as US.</p> <p>In USSR workplaces provided health monitoring of their workers. It was a government responsibility.</p> <p>Sanatoriums were provided by the workplaces to maintain health of the workers.</p> <p>In USSR if sick-doctor. Doctors made home visits.</p> <p>Workplace physicians.</p> <p>Doctors made home visits in USSR. Physicians were available at the workplace. Government-provided healthcare.</p> <p>4. Doctors were forced to think. Believed in uniqueness of each person. More creative doctors. Russian doctors did not have technology. They were forced to think. In former USSR doctors are not machines. They believed in patients' uniqueness. No "brushing by one comb". In Russia people went into medicine by calling. ... More levels of creativity in former USSR. Today doctors are blind executors.</p> <p>In former USSR used more creativity. Generations of immigrants from former USSR had changed. Different types of people are coming. We were thought to think, not to trust the doctors 100 %.</p> <p>5. In USSR was not important how much time doctors spend with patients. In former USSR (Belarus) doctors make little money and do not really care about patients. However in private clinics you can get enough attention for money. Simpler to get private care in Belarus than in the US. More accessible care in Belarus than in US. If you pay in Belarus-don't have to wait to get care.</p> <p>In former US care is more accessible with money. Doctors do not care about you because they do not get well compensated. But if you pay-you get better care.</p> <p>6. Attended a few doctors before coming to US. In USSR was assigned to the polyclinic to a regional doctor. Had one regional internist. Went to the regional doctor to get a note for work when were sick. Another doctor made house calls.</p>
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	<p>Used to go to the gynecologist in USSR. Rarely saw the doctor in USSR.</p> <p>7. Getting medical care in Ukraine ( Former USSR). Culture of bribery. Unaffordable. If pay-get service.</p> <p>If sick-antibiotics or home remedies. Throat rinses, rubs. Kids got sick from school. Healthcare in Ukraine is based on bribery. You have to pay to get care. Have to pay for supplies there.</p> <p>It is very hard to afford healthcare in Ukraine for a regular person. No way without money in Ukraine. Everything is expensive. Don't miss the government, but miss our land. In Ukraine without the money you are nobody. A person with a hip fracture in Ukraine became completely disabled because the family could not afford the care, whereas the subject's mom recovered because the money was sent from US to pay for care in Ukraine. Have to pay for everything. People work all their lives in Ukraine but still cannot afford healthcare.</p> <p>Doctors came home and were paid for visits in Ukraine.</p> <p>Ukraine is technologically behind. Life expectancy in Ukraine after oncologic surgeries is poor. People are better off getting care in US than in Ukraine. Even doctors cannot help their family members in Ukraine get as good care as in US.</p> <p>8. Doctors were not very good. Patients pay for everything. In Ukraine doctors were not very good. In Ukraine pay for everything. In Ukraine pharmacies make profit on charging full price.</p> <p>Went to doctors if had scarlet fever or other serious problems, otherwise used home remedies.</p> <p>Often had scarlet fever and had to do to the doctors.</p> <p>Otherwise was managed at home with healthy foods and home remedies.</p> <p>9. In former USSR doctors have fewer resources. In former USSR was no choice of provider. You were assigned doctor by the polyclinic according to the region in the neighborhood. Polyclinics had surgeons too. The choice of the providers was fewer in former USSR. Doctors were assigned by the polyclinics. Fewer choices of providers. Now they have options. If you have money-you can afford care. If you do not have the money-there is government-based healthcare. Was going to the gym when was young, was physically active.</p> <p>Difference between US and former USSR in age, another stage of life. Did less prevention in former USSR. In former USSR people were more preoccupied, busier with other things related to health. Not a lot of experience with providers in former USSR. No difference between providers in US and</p>
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	<p>former USSR. This was before the Internet. Cannot compare there and here back at that time and now. People in former USSR live the same as here. They have access to activities, vacations. Two systems of healthcare: government and private. People who have no money can still get care. People have even some money can afford good care. They have everything for the money. Resources are there but cost money.</p> <p>10. Health-related practices in former USSR. Family of doctors. Inherited culture of health from the family. Came from the family of doctors. Father used to be a dentist, mom used to be physician assistant. (Although such specialties are not considered are physicians in US were considered to be doctors in Uzbekistan). “Inherited the culture of health” Went to the doctors as soon as the problems started. Were “ahead of time in terms of teeth”. In Uzbekistan all happened by connections. Recommendations are reliable and cheaper. If you go to the doctor who you don’t know you are risking it. They might rip you off. If you go to the doctor with mutual connections he will relate to you better. Was convenient to have a father as dentist. There were doctors at home. Dental care in former USSR. Golden crowns are the sign of wealth. It was a sign of wealth to have golden crowns. Some installed them without actual necessity. It was fashionable and popular. Father was a dentist. Had good access to the best materials and service. Mother had golden crowns as a “dentist’s wife”.</p> <p>11. Healthcare system in former USSR. Behind the US 100 years. Elderly are not treated as they are expected to die. Culture of bribery. In former USSR they did not even try. Former USSR healthcare is behind USA about 100 years. Elderly are not treated because people over 70 are expected to die soon. Grandma was refused treatment in former USSR. In USSR her life was prolonged 20 years. In US she was treated regardless the age. Although genetics cannot be changed certain things could be modified (lifestyle) to improve health. In former USSR doctors believed that nothing could have been done with genetics. In former USSR doctors did not want to treat grandma. Refused to do surgery, did not want to give her medications or even bedpan. Family had to bring it all. Healthcare workers were waiting for the bribe, wanted to push her out-home to die. In Russia they did not even try. In former USSR was told that will have difficulty getting pregnant but in reality there were no problems at all in US.</p> <p>13. Healthcare in former USSR. In USSR ambulance took patients in urgent cases, neighborhood nurses and doctors.</p>
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	<p>16. Healthcare in former USSR: In former USSR people do not recover as well as in US after surgical procedures.</p> <p>17. Healthcare in former USSR: Money-driven. Old people are not expected to get care. People who don't have the money utilize home remedies. In Russia there is everything but one needs the money. In Russia they look at your age. If you are old-you will not be cared for. In Russia even you have money but you are old you will not get the quality care. If people do not have the money for healthcare they utilize home methods.</p> <p><b>SUMMARY: Neighborhood providers. Crowded hospitals in former USSR. Culture of bribery. Two options of care: government and private. If you have money-you can afford better care. It is customary to thank doctors/providers with some gifts. Doctors had fewer resources in former USSR. Fewer choice of providers. Doctors were assigned based on the region of residence. Doctors were making home visits. Many people cannot afford good healthcare. Everything is expensive. Culture of health is inherited. Needed connections. Dental care was a sign of wealth. Not all could afford good care. Healthcare in former USSR is 100 years behind. Doctors refused to treat elderly patient as she was expected to die. Family had to bring supplies to the hospital. Poor quality women's care. Money driven healthcare in former USSR. Old people are not expected to get a quality care. Poor post-surgical care.</b></p>
Experience with healthcare system in US.	<p>3. In the United States they check everything, trying to figure out everything. Liked rehab center in US. Good care for patients. Not afraid of anything. Liked nurses in the US. Does not like when they don't care if you sleep or not. Lights are on, doors are open. Nurse ready to carry me in her hands. Good impression of nurses. Healthcare workers attentive, caring. I like hospital. I like to be hospitalized. I am happy with everything. Healthcare workers will come 150 times to check on patients. Gets treatment from Russian physician. At times went to another (non-Russian doctor) but liked him too. American cardiologist wants to figure out the cause of the problem, whereas the doctor in Russia was advising not to worry and not to focus on taking blood pressure often. Qualities of doctors: professionalism. I don't see negatives here. I like everything here. Nurses are always in a good mood. You don't see behind the scenes action. Nurses are friendly, always smiling, check on patients in need. Nurses were caring regardless of nurse's nationality and/or origin.</p>

	<p>Relate to patients well. In ER: First time saw a drunk in US in the hospital. Takes long time to get a room in the hospital. Take a lot of blood. Many doctors are coming to check on the patient.</p> <p>In US doctors are very thorough. Check everything. The difference between Russian and American practitioners that in America providers want to investigate the problem, unlike Russian physicians trying to dismiss the issue and not to focus on it.</p> <p>American healthcare is very much liked. Nurses and doctors are attentive regardless of their ethnic and cultural backgrounds. A lot of work done behind the scenes without involving patients. Patients get a lot of attention from providers. Nurses are always smiling. Patients are not affected by nurses' personal and/or work issues.</p> <p>4. Healthcare is business. All about the money. Doctor is an executor. Business. Propaganda. Suffocating alternative medicine. People do not think; like zombies. Hospital misdiagnosed the baby. Healthcare is business. Surgery-money. Herbs instead of surgery. If people are disabled someone makes money of it.</p> <p>Doctor is an executor. All are measured on the same scale. Doctors are pressured by the insurance companies. Doctors want more, make more.</p> <p>Vaccines became business. People get over vaccinated and get sicker. Some diseases are still around, have not been eradicated.</p> <p>In USA pharmaceutical monopoly. Profit-chasing, government controlled. Propaganda of pharmaceuticals. People are like zombies.</p> <p>Homeopathy is suffocating.</p> <p>Media is part of the propaganda. People with money rule. Doctors prescribe antibiotics because they are afraid the body is too weak. Doctor is the last instance.</p> <p>Media propaganda to make money. Doctor is expected to solve all the problems. Norms gets tighter and tighter so medications could be prescribed. Side effects are harmful but many people do not know about them.</p> <p>Some procedures are not necessary. Doctors force procedures on patients. Person is not given an option. Doctors want to do expansive procedures.</p> <p>Doctors are afraid to be sued. Propaganda. Plastic surgeries.</p> <p>5. In US doctors are not interested in your health. Appointments are too short. Diagnosticians are good but treat you poorly because of the money. In America focus on money, not on patient's health. In America people take better</p>
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	<p>care of themselves than in former USSR. There are people everywhere who take or not take care of themselves. Doctors do not allocate enough attention. Profit is not primary. Tablets are created by corporations. People go for medical degrees not because of calling but because of “big bucks”. Doctors only care about the money. In China doctors were helping prevent diseases and were fired if person got sick. They want you to be sick here because they can bill your insurance. In USSR doctors chose the profession based on calling. In USSR poor but talented doctors. In US rich but talentless doctors. Doctors have to immerse in your problem. Difficult to find a good doctor here. I can’t find an answer in America. Doctors do not spend enough time. They don’t listen. Nobody pays attention. No one wants to immerse in your problem. When can’t find answers in US seeks help in former USSR.</p> <p>In US healthcare providers are not interested in your health. They care about the money. People in America take better care of themselves than people in former USSR. Doctors in US do not allocate enough attention. In USSR poor but talented doctors. In US rich but talentless doctors. Doctors have to immerse in your problem. Difficult to find a good doctor here. Nobody wants to immerse in your problem. If can’t find answers in US seek them in former USSR.</p> <p>6. Very good care in the nursing home, could not have done the same at home. Despite hearing complaints from other people on how bad nursing homes were still thinks the care was good considering husband’s condition.</p> <p>8. American pediatrician recommended nose flushes. Nose flushes and rinses. Doctor (pediatrician) recommends it. Antibiotics make you feel better faster so you do not miss days from work. But I go to work anyway. Good healthcare system. Very competent doctors. Doctor prescribes antibiotics right away. Big choice of doctors. Everything is affordable in US. If you have an insurance-you can afford care. Respect the doctor. American doctor does not offer herbs. American remedies are stronger. American doctors are good diagnosticians.</p> <p>In US good healthcare system. Big choice of doctors, very competent doctors. My physician prescribes antibiotics right away. Doctor prescribes antibiotics and medications make you drowsy. Everything is affordable in US. If you have an insurance-you can afford care. Qualities of providers: competence, experience, compassion. Respect the doctor as she is competent. American doctor does not offer herbs. American treatment modalities are faster and stronger. But</p>
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	<p>Russian modalities, which are often used, are natural. American doctors are good diagnosticians. They have tests, blood works and many other ways to diagnose.</p> <p>9. In US you know more about your doctor before you see them.</p> <p>10. Healthcare system in US. Not affordable to everyone. Low income insurance gets little respect and not always great healthcare services. In US most cannot afford to pay self for healthcare. When came to US had insurance for low income families (Medicaid). The rules had changed and adults lost coverage. Kids were still covered. When had no money was given Medicaid. Now have coverage through the job. Physician preference initially was based on insurance allowance.</p> <p>Perception of healthcare in US. Here is a capitalism. Doctors often pass the ball on Medicaid patients. Doctors treat fast. Clean supplies. The patient is always right. Get medications by prescription in the US. In some cases wife as a doctor recommends medications from home. Went to the hospital. Hospital recommended affiliated physician. Despite hospital recommendations checked the MD rating independently. The doctor was in insurance network. Good specialist, although works in a small private clinic. Medicaid limits you in choice of the doctor. Doctors often pass the ball on Medicaid patients. Hard to find the doctor accepting Medicaid. It is easier with private insurance. Was speedily evaluated by the doctor Care was done without pain or unpleasant feeling. Treated fast. No pain during procedure. Was amazed by how clean and neat supplies and materials were. In Uzbekistan it is not like that. Not always clean. In Uzbekistan now commercial healthcare in addition to the free services. It is better in Uzbekistan now. Here is capitalism. The client is always right. In US had kidney problems. A little different for those with Medicaid.</p> <p>11. Healthcare in US. Immediate care. No discrimination when it comes to age. Advanced care. Top of the line technology. In US surgery was done immediately. Helped grandma with eye problems right on the spot and her eyes never bothered her again. American healthcare is so advanced and all care was paid for by Medicaid. Russian doctors speak different language from American doctors “literally and figuratively”. Prefers American doctors who work in highly respected hospitals. That is the first choice. Trusts one Russian doctor because she is a decent person. Reads reviews about the doctors before choosing them. Mom was under care of Russian doctor. Lived in Belarus during Chernobyl</p>
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	<p>explosion. Russian endocrinologist had multiple specialties. There was a question of his competency. Better to go to a specialist in the area in a reputable hospital. Good hospital made speedy appointment due to the seriousness of the matter. Good hospital all computerized. Doctor called herself. Russian doctor working for a prestigious hospital was personable and knowledgeable of most current research. Top of the line technology. Doctor knew about research in that area. Doctor conducted a comprehensive exam and did not rush. Doctor also paid attention to other medical problems. Hospital does not trust just any results. Some tests needed to be repeated because they were not done in reputable places. High level of care. All in computer. Timely, efficient. Doctor knows latest studies, not just what she learned in medical school. Spoke in a way that mom understood. "It reached her".</p> <p>13. Healthcare in US: Got help in US. Very satisfied. Has an assistant. Very satisfied with care. Doctors and nurses were prepared and treated with care. Under close care of the doctor. Went to the doctor because had pain in the stomach. No drugs besides those prescribed by the doctor. If doctor feels I need it he writes a prescription. Very important job of healthcare professionals who run tests. . Under regular care of the nurse from the home care agency. Very satisfied with healthcare in US. Very attentive, treat you with care, listen to you. Never had any problems. You get treated with great care by the doctors. Good doctor-listens to me, takes tests, calls the pharmacy, writes prescriptions. Care was greater than in Russia. It is like a factory. Was in discomfort after the surgery, but all is well so far.</p> <p>Was in discomfort after the surgery, but all is well so far. Russian healthcare services in US. Uses Russian pharmacy. Russian pharmacy writes instructions in Russian for easier understanding. Most doctors are Russian-speaking. American doctor, but the nurse is Russian. She takes good care.</p> <p>16. Healthcare in US. Strict protocols based on technological advances. Good surgical care but problem with therapeutic diagnostics. In US doctors cannot divert from their protocols because of the fear of lawsuits. In former USSR healthcare is not business, in US it is business. Doctor mostly prescribes medications to take care of hereditary problem. Knew that he had a family issue of high blood pressure and expected to be prescribed medications. In US top surgical care. Not so good therapeutic diagnostics in US.</p> <p>17. Healthcare in US: Money-driven. Doctors are businessmen. They care about your insurance before they</p>
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	<p>care about your health. If no money –“Be healthy”. It is“luck” to get a knowledgeable doctor to establish the diagnosis. Healthcare related to money. Doctors care about your insurance before they care about your health. Doctors are businessmen. If you don’t have the money-“Be healthy”. Have to have luck to get a knowledgeable doctor who could establish right diagnosis.</p> <p><b>SUMMARY: Overall good healthcare system. Doctors are thorough, good diagnosticians, big choice of providers. Although some negatives, such as healthcare as business. Not everyone can afford care in the US. Low income insurance does not provide quality services. Here is capitalism. The client is always right. Immediate care. No unpleasant feelings. Speedy appointments, modern technology. Very satisfied with US healthcare. Older immigrants prefer Russian medical services. Doctors care more about your insurance than your pain. Doctors are businessmen. Have to have“luck” to get a knowledgeable doctor. Good surgical care, not good therapeutic diagnostics. Technology-dependent. Doctors are “afraid of lawsuits”.</b></p>
Differences between healthcare in former USSR and US	<p>1. In US two opposites: going to the gym and eat right or “live like I want”. System of drug therapy in US. Medications are being prescribed for everything. No variety of pills in USSR. Different culture of taking care of health. Not developed health culture in Soviet Union. Healthcare in US is business. USSR system was different. In USSR people went to healthcare because of the calling. Here for money. In US-automatic, robot-like, all about the money. Grandparents never took medications. Nobody took a lot of medications. Here people take a lot of medications. Perhaps taking medications improves life expectancy? Mom is bothered that she had to take medications. Does not like to take medications.</p> <p>Healthcare in US a business. Many doctors are in for money. <b>In USSR no culture of health.</b> In US people take many medications. People from USSR don’t like to take pills.</p> <p>2. In USSR you got sick-doctors came to you. Some practice in Brooklyn offers those services here. You stay home and doctor comes to you. Very convenient-you sit home, and doctor comes to you. Level of care in US is higher than USSR. Healthcare is at the very high level in US. Alternative medicine is not part of the healthcare.</p> <p>In US-higher level of healthcare.</p> <p>Doctors making home visits in USSR.</p>

	<p>Alternative medicine is not included in US healthcare.</p> <p>7. Getting medical care in US. Primary care. Wishing some procedures were not required to be waited.</p> <p>In US has a primary doctor to handle health issues or to refer her for the specialist. Cons of healthcare system is the need to await procedures. Wishing some procedures were done sooner rather than later. In Ukraine you can get help faster but have to pay money. Waiting for the oncologic surgery for a month is too long. Daughter was crying and kissing her child awaiting the result of biopsy.</p> <p><b>SUMMARY: No health culture in USSR. In USSR doctors used to make home visits. Some doctors in Brooklyn do it. In US healthcare is business. Level of care in US is higher, but there is no alternative medicine in US healthcare system. USSR healthcare is 100 years behind the US. Russian and American doctors speak different language. Literarily and figuratively.</b></p>
Stimulus/motivation to stay healthy	<p>1. Start thinking about health later, when something happens to someone.</p> <p>Seeing something happening to others makes one start thinking about their health.</p> <p>3. To be healthy-to take care of myself, be independent, not be a burden, not for the family to take care of me. To be on my feet at all times. Not to have a worst health than now. Important to run and jump (physical activity). Don't want to walk with a cane. Want to be able to help. Want to travel, to see the country. If I want this-I am still alive.</p> <p>To be healthy-to be independent, not to be a burden. I am alive as long as I am independent and free in motion(travel).</p> <p>5. Everyone wants to be healthy. To be healthy is to exist normally and adequately react to the surrounding. Personal wish to do things for health. Internal motivation. People do not like sluggish and tired (sick) people. When you are vigorous and happy-you are pleasant to everyone.</p> <p>Stimulus to be healthy: people do not like unhappy (sick) people. Everyone likes happy (healthy) people. Internal motivation for health maintenance.</p> <p>7. Stimulus for staying healthy. Family. Not to be a burden. Grandkids stimulate to be healthy. Want to be in shape to help the kids. If a person is healthy he will be able to work, make money, help the kids. To be healthy-not to be a burden. To bring happiness to the family.</p> <p>8. Being healthy-being able to work and pay bills. If you have health-you can earn the rest.</p>

	<p>I have to be healthy to work and keep the job. Being sick with the ulcer-not being able to work-not able to pay bills. Health is the most important. If you have health-you can earn the rest.</p> <p>9. Family. Being independent, not being a burden. Family is the stimulus to be healthy. Don't want to depend on anyone. Person exercises to be in shape and not be bedbound and incontinent.</p> <p>10. Stimulus to be healthy. To provide for the family. To be able to support the family. As a head of the household have to provide. Man is responsible to support the family. Very important to be healthy to be able to support the family. Very traditional Uzbek culture. There were no high expenses in Uzbekistan. In US it is not easy to survive on one income. Being healthy to be longer with the family, live longer and be healthy.</p> <p>11. Stimulus to stay healthy: Family. To support them mentally and financially, not being a burden. Stimulus to be healthy-the kids. "I am almost 45, and I still need mom" Wants the kids to have parents. To support the kids mentally and financially. Not to be a burden. "Don't want someone to take care of me".</p> <p>12. Stimulus to be healthy: Family, not being a burden. Wanting to be with the family for a long time. Son and the family as a stimulus to be healthy. Want to be with the son for a long time.</p> <p>13. Stimulus to be healthy: To be healthy-not to bring grief to children, to live without inflicting pain. To feel well, to have an appetite.</p> <p>16. No stimuli.</p> <p>17. Stimulus to be healthy: Being healthy to enjoy life. The quality of life. To be healthy-to be able to enjoy life. Quality of life.</p> <p><b>SUMMARY: Usually people do not think about their health until something happens. To be healthy-to be able to care for self, to be independent and not to be a burden to family. Healthy-independent, being able to work, to travel, to pay bills. To provide for the family, to be able to support the family. Live longer to be longer with the family. Not to bring grief to the children. To be well, to have an appetite. To live without inflicting pain. To enjoy life. The quality of life.</b></p>
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Source of health-related information	<p>1. Health-related information is gathered from the Internet. Younger people refer to the Internet for health-related information. Older people read magazines with home remedies and recipes shared by other people.</p> <p>2. Main source of health-related information computer. Internet. Internet is the resource for health info.</p> <p>3. Health-related information is gathered through local health magazines. The magazines provide health recommendations from lay people. Family does not support her reading those magazines. Health-related information is gathered from health magazines, although the family is not supportive of that.</p> <p>4. Old traditions. Books on alternative approaches to health.</p> <p>5. YouTube and Internet.</p> <p>6. Family (daughter-in-law). Daughter-in-law is the source of health-related information.</p> <p>8. Internet. Mother. Mother learned through the word of mouth. Mother recommends remedies. Mom learned about remedies through the word of mouth. Health-related information-online.</p> <p>9. Google. Review sites. Google as a source of information. Yelp reviews of the doctor are determining factors of choice of provider.</p> <p>10. Source of the information. Internet. Internet as a resource. Internet influences lifestyle modifications. Read posts on Facebook and other sites to learn new information.</p> <p>11. Source of health-related information. Internet. Reading articles as a source of information. Facebook. Look into credible sources for health-related information, such Mayo clinic. Learned a lot from online posts. Started reading labels. Stopped buying frozen pizza, high sodium foods. Follows the topics related to cancer and those of interest of her friends. Cancer is scary. Looks for a reliable sources.</p> <p>12. Source of health-related information: Internet as a source of health-related information.</p> <p>13. Source of health-related information: Health-related information is given by the doctor. Doctor approves all treatments and medications. Doctor says-I take it. I won't decide anything by myself. Always ask the doctor. You have to do what they tell you.</p> <p>16. Doctor as a source of health-related information.</p> <p>17. Source of the health-related information: Internet. Internet is the source of health-related information.</p>
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	<p><b>SUMMARY: Younger respondents seek information online. Internet, Facebook. Younger adults look for reliable sources. Older respondents read health magazines, get information from the family members, doctors. Some information is learned from family traditions (knowledge of the ancestors).</b></p>
Transnational connection	<p>1. Older people read Russian health magazines. The magazines contain some health advices and recipes from other people (not always healthcare professionals). Older relative travels back to Russia and even sees physicians there. Younger subject does not consider having connection with former USSR.</p> <p>Older people travel back to former USSR. Younger people not associate themselves as being closely connected to the country of origin.</p> <p>2. All friends left. There is no one to connect with. Friends establish connection. No friends-no connection.</p> <p>3. Reading books in Russian, watching Russian TV shows. Occasional travel to former USSR. Relatives still live there.</p> <p>4. Consulted physician from former USSR on family member's health.</p> <p>When the son was born sought help of Dr. Buteyko from former USSR. Doctor from former USSR stated this was not an infection without physically examining the baby. Russian doctor suggested to elope (AMA) from the hospital. Used to consult the doctor over the phone from US to Russia.</p> <p>5. Visits friend and family in Belarus.</p> <p>6. Still keeps in touch with some family members in former USSR.</p> <p>7. Transnational connection. Very close connection as the part of the family is still in Ukraine. Political issues are influencing connections.</p> <p>Was not planning on staying in US but changed her mind because of the political conflict in Ukraine. Uses technology to connect with her family in Ukraine. Had to cancel Russian TV due to political issues between Russia and Ukraine. Don't read books because we work. Taking care of the family (granddaughter) takes a lot of time. Keep up with news from the homeland through the Internet. Ukraine is our country, we are from there. It worries us. Very close connection because part of the family is still there. Wising family to reunite in US. See how people live in America and have perspectives.</p>



	<p>8. College friends. Communicate home remedies with friends from former USSR. But it is hard to understand certain things those friends do.</p> <p>Connection with a college friend from Ukraine. I kept the contact when the kids were born, and that she was saying, how to say this, I do not understand, we do not have it here.</p> <p>9. Went back more than 10 years ago. Seldom keep in touch. Sometimes phone calls. Connect via Internet, reading news. but it is difficult to understand lifestyles there. No attachment to any culture. The entire family is here and nothing connect to the former USSR.</p> <p>Time is a factor, not the location. Healthcare progressed and evolved over time. Went back to former USSR more than 10 years ago. Sometimes calls people from the homeland. Mostly connects through the Internet. Reads news sometimes. Some things that take place in former USSR are difficult to understand now. Does not attach himself to any culture. I have my life, my views. They have their views, their problems. Hard to understand their lifestyles. The entire family is here. No interest to travel back. Nothing connects him anymore.</p> <p>10. Transnational connections: Frequently goes back to visit the family. Close family ties.</p> <p>11. Transnational connection. Keeps in touch with some friends, but prefers to see them in Europe. Not interested in Russian media. This is not our reality. Does not miss Belarus. Prefers to meet old friends in Europe. Husband does not like Russian media. American TV programs are at much higher level than the same in former USSR. Cannot relate to Russian shows. "This is not our reality". Not interested in Russian press.</p> <p>12. Transnational connection. Family lives in Georgia.</p> <p>16. Family in former USSR.</p> <p>17. Transnational connection: Close ties as there are relatives there. Close connection with Russia. Lots of friends and relatives are still there.</p> <p><b>SUMMARY: Although some subjects deny having direct transnational connections they read the news and books, watch TV and Online programs from former USSR. Those who have family members and friends in the country of origin travel back. Subjects whose entire family left former USSR usually do not associate themselves with having transnational connections. "This is not my reality".</b></p>
Expectations of healthcare and	<p>1. Important qualities of healthcare provider: empathy. Feeling of being important to the doctor. Important to</p>

<p>providers' qualities</p>	<p>establish a contact with physician. Important for doctor to see a person not the money they will get from the insurance. I am human. Share problems with the doctor. Compassion, participation.</p> <p>Healthcare provider qualities: empathy, listen to the patient, compassion, participation.</p> <p>2. People from USSR are not educated about their health. In US doctors are expected to educate (enlighten) patients. Healing modalities were transferred from one generation to the next. Information is transferred from one generation to another.</p> <p>Russian immigrants are spoiled in getting more personal attention from the doctors. Genuine care of the patients. People from USSR want more attention from the doctor. Russian immigrants are very trusting to physicians. They will do what doctor says. Doctor is the person who will save me and make me healthy. We trust doctors completely. Doctors' role is to educate people about health. There is a transgenerational transmission of health-related information. Russians are spoiled in getting personal attention. Want attention from the doctor. Trusting physicians completely.</p> <p>3. Good relationship between doctors and patients is important. Kindness is an important quality in doctors. Qualities of doctors: unselfishness person is full of senses. Help should not be profitable. Doctors need to have a heart. When you are indifferent-you don't belong in healthcare. Professionalism. Healthcare providers: good, kind, unselfish, attentive, work without regard of the profit. Doctors have a heart.</p> <p>4. Nurses nourish. Well educated nurse-first element of helping people. Separate self to help others. Become a nurse by calling. People in healthcare worsen condition. Healthcare professionals make it more complicated. Comfortable living, not curing the disease. Nurses nourish. Nurse is more like an assistant to a physician. First element of helping a person is well educated nurse. Nurses to use alternative methods and to "screen" patients if they really need more serious treatment. Nurses cannot be completely kind as they will destroy self to serve others. Separate self. People have to become nurses by calling.</p> <p>5. In healthcare providers' important attention to details. Not focused on money. Healthcare providers have to hear you. Providers to listen to their patients. Lead the patient to the end. Give them answers. Do not just prescribe corporation-</p>
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	<p>guided medications. They get percentages from prescribed medications. Need to allocate at least 30 minutes per patient, read the whole chart.</p> <p>Health providers should be attentive to details, listen to their patients, lead them to the end, allocate at least 30 minutes of their time.</p> <p>6. Attentive. Internists were attentive, listened. I have no complains about healthcare workers.</p> <p>7. Qualities of healthcare workers. Kindness. Giving hope to people.</p> <p>Healthcare workers-kind people. Nurses relate to patients as their relatives. Kindness. Nurse like a savior. She was not angry because she had taken care of the difficult patient. Giving people hope. Good word is half of health, half of the treatment.</p> <p>9. Good reviews based on outcomes and competence. Personal qualities are irrelevant. Providers' ratings are important in choosing one. Pick doctors with good outcomes. Personal qualities are irrelevant. Do not have to live with the doctor. Need good results if sick.</p> <p>10. Physician preferences. Convenient and closer. Now recommendations. Initially looked for familiar, not foreign. Once had coverage had more options and choice a doctor with modern set up and equipment (environment) . Were not treated well because had Medicaid. "Uzbek mentality-closer and convenient". Now, that have a choice use recommendations. Initially chose doctors from India as lived there himself and was familiar with the country. "Not foreign". Later used recommendations. Stayed with the doctor because she is a good specialist and likes their kids. Changed doctors because doctors made them wait for a long time. Doctors were not relating to them well because they had Medicaid. Doctors did not answer questions because of the Medicaid. Were treated poorly because they had Medicaid and not treated them well. As soon as got private insurance switched the doctors. Not treated well as immigrants.</p> <p>Expectations of healthcare providers. Relating good. Good doctor, good equipment. Wanted doctors to relate good to us. It is important to have good doctor, good equipment, modern set up.</p> <p>13. Qualities of healthcare professionals: Attentiveness, treating with care-qualities of healthcare workers. . Care and attention. A person does not just walk into a clinic: they have many questions bothering them.</p> <p>16. Qualities of healthcare providers. Knowledge, expertise. Diagnostic abilities not based on technology. Doctors have to</p>
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	<p>be knowledgeable and skilled. Experience is more important than age. Diagnostic abilities of providers are important. Doctors need to know the side effects of the prescribed medications.</p> <p>17. Healthcare provider preference. Any spoken language. Primary doctor preference based on convenience. Specialist choice is based on recommendations. Prefer regular doctor based on convenience, location. If need a specialist-look for recommendations from people. . No preference of the language spoken by a provider. Healthcare provider qualities: knowledge and not voicing their personal opinion. Experience. Main qualities of the doctor: knowledge and not give unsolicited advice. Doctor has to be knowledgeable, yet satisfy patients' expectations/needs. Doctor has to evaluate the problem, not to voice his personal opinion. Knowledge depends on a person. Young doctor was not as experienced as a nurse</p> <p>View of the healthcare providers: They are expected to be perceived as an authority figure. At the same time Russian-speaking doctors think they can act like that and they perceive themselves as an authority to the patient, so they are allowed to state statements like: "Dump the girl" or "Change the doctor".</p> <p>View on NP. Not a clear opinion of NP as it was not clear if the subject was comparing NP to MD or RN to MD. Young doctor was not as experienced as a nurse (Not clear if that was an RN or NP).</p> <p><b>SUMMARY: Qualities of the healthcare providers: Empathy, making patients feel important, ability to listen, see a patient as a human being and not just based on his/her insurance. Attentiveness, treating with care. Trusting the provider completely. Providers have to be unselfish. There should be a calling in the healthcare profession. Doctors are expected to educate. Personal attention. Kindness, professionalism. Providers are expected to communicate. Doctors have to be competent. Nurses are expected to nourish. Nurses are seen as more non-traditional providers, who could suggest alternative interventions, not always based on the medical model. Nurse like a savior. Prefer convenient and closer location, technologically advanced, familiar doctors, not foreign. Want the doctor to relate good to us. Experience and knowledge are important. No unsolicited advice from the doctor. View of NP is not clear. For general practitioner convenience is preferred, for the specialist choice is based</b></p>
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	<b>on recommendations. Knowledge, expertise, diagnostic abilities.</b>
Factors affecting health	<p>2. Nervous, worried about the family, kids, sick relative. Family stress affects one's health. Stress, being nervous affects one's health. Stress related to the family needs. Family influences health.</p> <p>4. Source of health misbalance. People harm self. People want more than they need. People get sick when they go against nature. Abusing our bodies. When people give up their responsibilities for health, education. Person harms himself. All problems are from the head. People want more than they actually need today. People want things not thinking if they even need them. Believe that the son developed allergy as a result of misdiagnosis and infusion of unnecessary antibiotic as a baby. Testicles are outside of the body to keep sperm colder than the body temperature. Diapers can cause fertility problems in boys. We ourselves make the kids sick. Diapers are against nature. Women who overdo with exercises have problems with childbirth. They become men-like. Woman becomes a man with exercise. Men, if lead sedentary lifestyles become women-like. Abusing your body. After certain age you have to take things easy. Today people are thinking shallow. Low fat diet is a tragedy. Never-ending process. Cultured milk products and fat are important. Fat free products change chemical structure of food. Starch, garbage in the store. Allergy might be related to the ingredients in the product rather than the product itself. Natural product. Amish sour cream. Straight from the cow. Natural made sour cream is harder. Cultured cream through fermentation. Beautiful bacteria, no corn starch. Fat free-bad, harmonized. People develop intolerance because they do not eat natural products. Natural products are healthier. Too many unnatural products approved by the government. Food could be cooked at home, no need to buy already made food. Patient does not have responsibility for own health anymore. Some people become addicted to plastic surgeries. Sex propaganda. Like a machine. Like a sport. Formal education substitutes parental role. Parents remove themselves from the role of educators. Health is inherited. Health of the ancestors. Mentally healthy. Understanding own body. Health is inherited. People survived 300-400 years ago without research. Tools for being healthy exist for many years. Health is given by nature. Health of ancestors. Strongest survive.</p>

	<p>Today people are weaker, less prepared by the nature. Health not pharmaceutical. Traditions of health</p> <p>6. Nervous system influences health. Stress affects health. Age is expected to influence health status. Genes and nature affect health. Nothing you can do with declining health. Could have been worse. Keeping emotions to self and not upset those around you. Handling stress in individual and something one is born with. It is costly to self to worry. Staying away from the negatives.</p> <p>When you are not nervous-you are healthy. Genes/nature affects health. Understand that the age takes its turn. Energy is leaving. I cannot walk fast. I consider that in my age something has to be. Now treatment no longer helps as much as it used to. Hearing is decreasing. Nothing you can do. Health problems are present but not as scary as could have been. I have age-related problems. Try to adjust nutrition but it affects the taste. Stress as a result of husband's death. This stress affected the taste. . After he died had no appetite. Does not feel hunger. Has body demand to eat, but no hunger. When the husband died did not drop a tear. All sorrow went with him. The most important not to get nervous, of course...Not to have various unpleasant situations...</p> <p>Unfortunately, our life cannot be built like that, of course. Resistance, I consider. Everyone has his own. Some has to pour (it) out of them. If some misfortune to talk (to others about it). I am not. I never poured out. I lived through (feelings) from the inside. And here. Maybe such organism. And that I consider, perhaps, was positive, that I did not pour out my negative emotions regardless if it were kids or husband... this is a personality like that. This is a nature...Not something I raised in myself. I think that this is a given. Because, especially, I consider that various unpleasant events reflect on health. Health...Living...Some relationships. I never, you know, did not take part in any fights, some this...Related positively. If did not like a person I simply did not communicate with him. And all. If needed in relation to work-that is another story, this was work... And to start a close relationship, of course, only with those who were pleasant, and who had an appropriate reaction response. See....I consider that it is all, you know, given by mom and dad. So given to a person from birth. Not to waste self for nothing. Because if you start stress because of little things-this leads to nothing. And now, after the husband, I decided that I cannot resist anything, and I have to accept as (given). Broke something, missed something...Did not do something. I do not blame myself. I understand that it the age and has to</p>
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	<p>be. You know...household routine also poisons. When something does not go right, and all...poisons life for you and surrounding, and all. I try not to pay attention to that. Because you spoil people's lives and your own...Your own is more expensive. You stress more. That is why...(I) Consider... It all came with life experience. (I) understand that when I was younger, especially when (had) a family and all, and related work, I was more principled. I considered that had to be done this way only, and not differently. And now I am like if not like that, that is...I accept that. That is why. It is costly for self when you start worrying. There were different mishaps, I am not saying now, when I was younger, I later worried more because I disagreed with someone or argued about some issues...Of course, maybe this is not very good, but maybe it is a feeling of self-protection. Maybe was lucky...Because my relation was like that, that I was lucky for good relationship from...team, from the side of co-workers. At school, college. Of course, there were different (situations). I consider health to base on the condition of the nervous system. I was lucky that, perhaps, I am a calm person, respond calmer...Because you understand that in life I met, when close (relatives) and friends...some mishap happened. That was a disaster. Constantly talked about that. A person could not keep it inside. By this he not only did not calm himself down, but wind up himself and others around. I keep everything inside. If I had any, of course, there could not have not happened, in relation to work, or, for example, with kids, when they were sick, also could have been difficult situations, I kept it all in me. Never poured it on the kids, stated, not on the husband. For all this calm...Type of personality. When I lived in uncle's family, I came to him, at the age of 14. As a result of life circumstances that suffered a fiasco, he was very nervous sick (person). It manifested itself if anything was not right, he started stating about it in the family, and, of course, it was good that his wife understood that. She was a pediatrician. She understood his condition. She did not reply to him. She did not argue with him. I, of course, even less...And he needed to speak up, and became calmer. And that was this...And maybe this was established in me, not to give out, not to give out, not to pour out of self if you are not happy, and all. Meaning, if it is useless, when need to make a decision, and all...this is another story. But simply pour out your (own) misfortune on someone else, could have been pricier for me more. I understood that. It was better to live it inside of self, and all...This was my approach.</p>
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	<p>Keep it to self. Do not pour emotions. Do not talk back. Do not pour out if you are unhappy.</p> <p>7. Stress impairs health. Family problems leading to stress and health problems. Healthy spirit-healthy body. Connection between mind and body.</p> <p>Healthy-physically and morally. Stress causes illness. Stress of family separation and stress of war. Was stressed because was worried for the family causing blood pressure to raise, joints to hurt. A lot of people are sick mentally. People who are sick physically and those who are sick psychologically. Example of someone who focuses on little issues (like having obsession with cleanliness), causing them to have psychological distress=illness. Healthy spirit-healthy body.</p> <p>12. Life expectancy and factors affecting it: Stress, instability, civilization, poor air quality. Food causes cancer. No more long-livers in Georgia. People lived longer in USSR. Once the republics achieved their independence life expectancy dropped. "People are so worried about their future now. "Afraid of tomorrow". People lose their mind in Georgia. Many people have cancer in Georgia. Food causes cancers. Used to have lots of Russians in that town of Georgia, but not anymore. The relations with Russians were good... People do not live as long as they used to because of civilization. There was fresher air and people were calmer, food was very good.</p> <p><b>SUMMARY: Stress, worries. People want more than they need. The calmer you respond to the stress the better your health is. In Georgia people used to live long. No long-livers anymore because of civilization stress, poor air quality, instability, stress, bad food.</b></p>
Complimentary/ Alternative and non-traditional remedies/ practices	<p>1. 1. In USSR-folk remedies. Steam feet, breathe over potatoes, tea with milk. Serious illness-hospital. <i>If sick-home remedies. Hospital in serious cases.</i></p> <p>Home remedies include steams, tea, and milk.</p> <p>3. I like folk medicine and try it myself. A person has to believe in something. Family is not supportive of this. Folk remedies: plantago for wounds. It helps wounds heal fast. Boiled plantago. Castor oil for skin, Valerian, hawthorn brewing. Valerian for sleep.</p> <p>Folk remedies are widely utilized. A person has to believe in something.</p> <p>4. Alternative modalities. Self-maintenance. Pills in your head-not in your hand. Take twice less pills than prescribed. Toothless smile. Eat according to self. Do not overdo things. Homeopathy. Personal knowledge. Urine therapy. Salt. Tea for conjunctivitis. Herbs, Bilberry, Lavender, plantago. Sugar</p>



	<p>and egg shells for wounds. Pepper applications, fire cups. No role models. Self-regulation. No gym. Cook at home. Family traditions. Too many chairs.</p> <p>Tea helps with conjunctivitis. Some ingredients in tea are antiseptics.</p> <p>Urine is sterile. Salts kill bacteria.</p> <p>Commercial salt without sodium. Dirty salt Minerals. If lacking minerals-lick salt from the mountains, dirty salt.</p> <p>Human stopped eating normally. Refined salt is nothing.</p> <p>Can't eat white iodized salt. Original (dirty) salt. Animals lick the salt. Humans develop mixes to get the same content.</p> <p>Lavender and plantago heal.</p> <p>Wounds could be healed with sugar. Like preserving fruit.</p> <p>Bacteria does not live in lots of sugar.</p> <p>Herbs. Alternative treatment. Method of distraction. People are weaker today, more susceptible to infections. Build up resistance in kids. Use methods of the ancestors. Although use alternative methods still leave the possibility of scientific methods. Collaborations between traditions and modern science. Traditions. Ideal doctor would use both methods: one that is established by generations, and the other based on scientific discoveries.</p> <p>More health food products. Herbs. Normal collaboration between a doctor and a nurse. Patient takes responsibility for his own treatment. Responsibility for life. Noninvasive modalities to be suggested by the nurse first. Pepper applications, fire cups, bilberry, vitamins, herbs to boost the immune system.</p> <p>Wounds could be healed with sugar. Natural remedies. Mix of eggshells, sugar (tasty to eat) help heal wounds.</p> <p>Old method. Self-regulation.</p> <p><b>BUTEYKO METHOD.</b></p> <p>Trained breathing. The longer you can hold your breath-the healthier you are. Breathe through your nose. Training breathing could cure diseases. Do things in moderation. Do not overdo things. Asceticism. Importance of O<sub>2</sub> exchange.</p> <p>Two-legged idiot.</p> <p>A human like a human</p> <p>Human breathing. We do not pay attention on how we breathe. Breathe through your nose.</p> <p>Longer you breathe through the nose-healthier you are.</p> <p>Claims to cure asthma with breathing methodology.</p> <p>Dying people are grasping for air.</p> <p>Change of breathing pattern is one of the first signs of dying.</p> <p>Rule of 10 fingers. Doing things not fully: no fully sleeping, not fully eating, work up the sweat...</p>
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	<p>Buteyko method-asceticism.</p> <p>Breath is more important than food and water.</p> <p>The longer you can hold your breath-the healthier you are. The longer you can hold your breath-the better your health is.</p> <p>Living method of Buteyko method. Doctors gave up on him but breathing method saved him.</p> <p>Be a person-human being.</p> <p>Scientific conclusions to the breathing method.</p> <p>Nose is more important in breathing than the mouth. Nose has filters. All junk goes through the mouth.</p> <p>We need CO<sub>2</sub>. Pure oxygen burns. Need balance of O<sub>2</sub> and CO<sub>2</sub>. CO<sub>2</sub> is as important as O<sub>2</sub>. We need sufficient amount of CO<sub>2</sub>. Fetus develops without oxygen. Sufficient CO<sub>2</sub> can be obtained if breathe through the nose and not deep breathing. Breathing calmly.</p> <p>Body parts are created in a certain way. Air goes through the passages and gets cooled off.</p> <p>Breathing should not be seen. It is an intimate process. No deep breathing.</p> <p>Deep breathing by Buteyko.</p> <p>Hyperventilation deprives of oxygen.</p> <p>When you breathe through your nose you have time to think before you speak. Breathing through the nose helps with mental health. "Control your idiot, breathe through the nose."</p> <p>If you walk and you can't breathe through the nose anymore-you are going too fast.</p> <p>Exercise breathing.</p> <p>5. Positive view on alternative modalities. Used acupuncture. Take herbs rather than chemical pills. Nontraditional treats by nature. Medicine is not developed. Traditional medicine-prescribes tablets, non-traditional-herbs, but have the same purpose. I am against chemistry, use it as a last resort. Don't like the pills. Against shamans, voodoo, exorcism. Drink valerian instead of chemical.</p> <p>Alternative modalities are well accepted. Acupuncture, herbs. Better than pills. Shamans, voodoo, exorcism are bad, but natural remedies are welcomed.</p> <p>6. Did not encounter non-traditional medicine.</p> <p>8. Rinses with lemon for scarlet fever. Garlic wicks for nose problems. Nose flashes. Ginger tea to boost immunity.</p> <p>Ukrainian drops for nose and throat. Eucalyptus. Some home remedies are bought in regular food stores and Russian pharmacy in US. Using herbs for prophylaxis. Home remedies from former USSR. Using home remedies at work.</p> <p>Herbal-not really non-traditional, more home remedies, over</p>
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	<p>the counter medications. Taking herbs before prescribed medications. Coltsfoot for cold. Common yarrow, plantain, hypericum, chamomile for stomach. Brewing herbs. Nettle, burdock, coconut oils for hair. Coconut oil for face masks. Boric acid for ears and eczema. Russian medications are more natural.</p> <p>Rinsing with lemon for scarlet fever. Garlic wicks in the nose. Drinking tea with ginger. Brewing ginger. Remedies to improve immunity. Herbal remedies for kids and adults. Going to Whole foods. Kids take herbs for prophylaxis. Uses some remedies from Ukraine. Drops for the throat and nose. Eucalyptus. Use remedies at work. Uses flashes at work. Herbal is not really non-traditional, more home methods. Prefers Ukrainian medication over American. Over the counter medications over prescription drugs. Will be taking antibiotics plus other remedies. Took herbs instead of prescribed medications first. If they do not help-prescribed medications. Coltsfoot for cold. Common yarrow, plantain, hypericum, chamomile- this collection for upset stomach. Russian pharmacy in NJ supplies herbs. If overate and had stomach problems drink herbs for 2 weeks. Brew herbs and it helps. Pharmacist also recommends herbs. Chamomile, plantain, hypericum, common yarrow. If eat sporadically and have stomach problems-drink herbs. Coltsfoot for cough. Drunk herbs and felt better after not feeling good after eating junk food. Russian medications are more natural. Burdock and coconut oil to make hair thicker. Uses coconut oil for face mask. Burdock oil helps prevent grey hair. Nettle for hair. Boric acid for ears. Boric acid for ears helped eczema. Q-tips irritate skin.</p> <p>11. Non-traditional. Ginger. Discovered by mom, verified by literature. Supplements are disgusting. Mom believes in ginger. She mixes ginger with honey and lemon and it is believed to help boost immunity. Mom gathers her information from TV, Russian media. Mom heard of ginger being good for health. "I (verified)" by English articles. It was written everywhere in the credible sources. Supplements are disgusting.</p> <p>12. Health-related practices: Grandma's recipes. Granma's recipes for health.</p> <p>Non-traditional modalities: Herbs, folk remedies, grandma's recipes, wine. Herbs, folk remedies. Raspberry leafs for blood sugar. Mint leafs help with blood pressure. Some people do something with wine for health.</p>
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	<p>13. View on non-traditional modalities: Not supporting non-traditional modalities. Doctors have greater knowledge. Not interested in non-traditional medicine.</p> <p>16. Non-traditional practices. Using science to maintain health. “Sanitizing” water with silver. Healers, bio-field, energy, D’arsonval. Physiotherapy. Believes in silver to clean/sanitize the water. . Proven by science that silver kills germs. Scientific explanation of silver ionized water. Use of scientific knowledge. The power of belief. Post-Soviet healers. Many people believe in them. Bio-field. It exists but each person’s spectrum is different. Healing by energy. Bio-field is affected by age. It is a part of non-traditional modalities. Physiotherapy. Using physiotherapy to treat a number of diseases. Scientifically-based modality. Believes in extrasensory. The strength of the bio-field. A co-worker had an extrasensory abilities and could diagnose a person by just looking at them. Combination of extrasensory abilities with technological advances. Extrasensory interventions helped heal a person. Energy, spectrum, frequencies. Some might even have negative effect. There is no perfect approach in extrasensory methodology. Some people could have negative influence. Acupuncture-energy channeling. Could help or harm a person. Encountered Reike when wife was sick. Not every person with extrasensory abilities could heal conditions and create permanent positive change. Very strong people can remove the cause of the problem.</p> <p>17. Non-traditional remedies: Tea for cold, steaming feet, fire cups. Valerian root. Herbs, tincture, ointments. Healers. Duck breathing in the throat helps dissolve the bone. Frogs applied to skin help with warts. “Squeezing tonsils”, vodka rubs, Tea is used for cold, steam feet, fire cups. Some even go to the healers. Duck breaths into the throat to dissolve the (fish) bone. Frogs can help warts disappear if placed on the skin. Valerian root. They try herbs, tinctures, ointments. Pushing/pressing tonsils. Subject was exposed to the same as a child as well. If tonsils are inflamed and a child runs a fever pressing tonsils, squeezing pus out supposedly helps them heal. The tonsils are squeezed with a finger wrapped in gauze and soaked in vodka, oil and/or lugol. Later tonsils are rinsed with salt. The child did not like her tonsils squeezed but did not want to be sick for a few days and let her mom do it. Doctor does not know about such practice. Don’t even go to the doctor with tonsils. Uses steroids for cough. Interesting combination of modern medicine and folk methodology. Rubbing a child in vodka when she has a fever. Vodka is not</p>
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	<p>helpful if consumed inside but good for the sanitizing purposes. It also helps with fever. Vodka rubs.</p> <p><b>SUMMARY: Many use home remedies, teas, milk. Some herbs such as plantago, chamomile, common yarrow. Ginger to boost the immunity. The information is provided by elders but verified by youngsters in finding supportive research. Buteyko method. Various rinses. In general many admit using alternate modalities and welcome them in health-related practices. Grandma recipes. Herbs, wine, Raspberry leafs for blood sugar, mint leafs for blood pressure. Valerian root, vodka rubs, “squeezing tonsils”, teas, herbs, tinctures, ointments. Duck to dissolve a (fish) bone, frogs to treat warts. Not all are interested in alternative modalities. Using scientific knowledge in combination with historically-established treatment modalities. Energy channeling, bio-field, healers, physiotherapy. The power of believing (mind-body).</b></p>
View on vodka	<p>5. Vodka is normal in small portions, no harm in vodka as long as it does not turn a person into an animal. Vodka is good in small portions. Grandfather has a tradition of drinking vodka with dinner but no more than 2 shots. Vodka is good in moderation. Family tradition of drinking 2 shots of vodka a day is perceived like healthy.</p> <p>8. In principal harmful, but helps relieve stress. Had an experience with alcohol not helping with stomach infection despite the belief that it helps kill the infection.</p> <p>Vodka. Alcohol, in principal, not healthy, harmful to the liver, but wine helps alleviate stress. There is a belief that you have an upset stomach as a result of infection you have to drink a shot of vodka. Tried it but it did not help.</p> <p>9. Overall alcohol is not good. Occasional use. Seldom uses alcohol. Overall alcohol is not good for health. Occasional beer and wine, cannot tolerate vodka, sometimes cognac.</p> <p>11. View on alcohol. For social interaction, but not really related to health. Alcohol is viewed as a medium for social interaction. Some people believe in red wine being good for health, but cannot relate to that.</p> <p>12. Alcohol. View on drinking. Drunk is a drunk.</p> <p>13. Alcohol and health: Doctor said to drink red wine. Stomach works better after wine. Vodka for social interaction.</p> <p>16. No specific opinion. Supposedly has to help with some problem, but does not always help.</p>

	<p>17. Vodka for consumption is not good. Vodka rubs are used for fever.</p> <p><b>SUMMARY: Vodka, although is considered harmful, alcohol helps in moderation. It is used to relief stress. Occasional use of alcohol is not seen as a harm. Alcohol is used for socializing. Doctor recommended red wine. Vodka is not good if consumed, but used as a home remedy. Supposedly could help with some problems but does not always work.</b></p>
Historical aspect of living in former USSR	<p>6. Historical aspect of living in former USSR. Political life influenced life choices, such as place of residence and carrier. Jews were not allowed to work in certain areas. Despite life turmoil people still believed in Soviet regime.”Lucky to be living in USSR”</p> <p>Born during war. Was forced to live in different places. Political issues of the country influenced the choice of education and profession. As a child whose parents were politically prosecuted had limited carrier options. Mom was arrested in front of her eyes. Neighbors placed her in the orphanage. Some family members were considered “not reliable” to take the child home. Parents considered a great luck to move to USSR from former parts of Romania. The entire family was affected by political persecution. Uncle lost his job, aunt was arrested for trying to clear the good name of arrested relatives. Aunt could not find a job as a Jew. No information on parents’ faith was known. Was forced to move to another family member because the family where she lived had housing issues. Was forced to move to different family members because they had better living conditions. People sought (living) in Soviet Union, believed. Did not know the faith of the parents until almost after USSR collapsed. The information on political arrests was not available. Government poorly compensated for innocently killed parents. Here is the faith of the people. A relative by marriage who grew up with the father tried to put a good word for him but got arrested herself for protecting politically arrested person. Political repressions ruined families. Former political prisoners were not allowed to live in big cities, such as Moscow. Despite being persecuted by the government people still had strong beliefs in Soviet regime. defendants of Soviet regime despite political persecution.</p> <p><b>Political life and persecutions negatively affected health of people living in USSR.</b></p> <p>Relative survived Soviet political camp, but was completely disabled. Those who were affected by political repressions</p>

	<p>died young. Was afraid to share her parents' faith. Used to say that had no parents. Other family members were affected by political repressions. Choice of profession was limited to less "stricter" educational organizations. Perhaps life could have been different if the parents were not arrested.</p> <p><b>SUMMARY: Historically living in former USSR was influenced by political changes. In USSR some people were persecuted for their political views. People were arrested and executed. Their entire families were affected by those persecutions. Children and close relatives were limited in their carrier options. People's health was harmed as a result of political repressions. Despite those persecutions, some people still believed in Soviet regime, considered great fortune to be living in USSR.</b></p>
DO not know WHERE IT fits in the data	3. Life is needed for something: Life is needed for something.
Religion	<p>4. Religious. From religious standpoint. All done by the Creator. The main source is the Creator. The spirit of life is in your nostrils.</p> <p>7. Spirituality/religion.</p> <p>Thanking G-d for people in their lives. Going to church to ask for their health.</p> <p>8. (Spit-spit-spit)-superstition. <b>Superstitions.</b> (Spit-spit-spit), knocking on wood.</p> <p>Spit-spit-spit, knocking on the wood -superstition.</p> <p>10. Religion. All Muslims are different. Some traditions might vary. Asking Allah for all to be good.</p> <p>13. Role of religion: Thanking G-d. Living in religious neighborhood does not have any affect. Eating everything, not only Kosher.</p> <p><b>SUMMARY: Superstitions along with formal religion. Traditions vary from region to region.</b></p>
Family role	<p>6. Family roles. Family took care of an orphan child. Family took care of and elderly and disabled relatives. Keeping family together. Helping children raise their kids. Now that the grandkids grew up need their protection. Older family members help young, while those young help eldest when they grow up. Grandchildren, although have more opportunities, also face hardships with life demands.</p> <p>Family took care of sick relative. Daughter in-law is the source of health-related information. When the husband was</p>

	<p>sick was mobilized. Used to visit him in a nursing home. Had to retire to take care of the granddaughter. Considered that the mother had to work, while she helps with the baby. When the family split did not want to lose a granddaughter. Kept a relationship with ex-daughter-in-law and her parents, even visited them in Israel where they moved. Interaction with grandkids is always nice... the first granddaughter will always be that feeling. I rarely see them because they grew up and do not need our protection. Moreover I need their protection. Now, of course, I understand that conditions of our grandkids, completely different. They are growing in completely different conditions when we were used to many hardships, many... And raised own kids like that because simply did not have material opportunities to satisfy all the demands they could have had... although they have jobs, houses, have what they want, travel when they want, and all, what they have, all of this comes not easy for them. This you know for yourself, from life how is here. Here is different. Now is a different life, different opportunities. If different opportunities-there are different wishes, and all. When husband got sick considered her duty to stay with him. Was visiting him every day to feed lunch, dinner, and help nurses with medications.</p> <p>7. Female/interfamily roles. Dedication to the family. Female sacrifices her career to help the kids. Young family members are taking care of the elderly. Dedicated her life to the family. Sacrificed her career. Kids have advanced degrees. Son takes care of the elderly grandmother. Wanted to help the kids. If mom tells you she has a problem-you drop everything and go there. Family is separated. Dreaming of the family reuniting.</p> <p>8. Family view and influence on health maintenance. Children are used to using home remedies. Kids are resisting to follow healthy diet exclusively. Husband did not like grains because they were not used in his home. Health maintenance learned from the family. Mom cooked at home, had no choice but to cook. Mom keeps healthy diet, but resists medications. Children are used to this approach to treating runny noses. Some remedies are learned from mother and grandmother. Mom learned about remedies through the word of mouth. Kids are resisting eating healthy all the time. They are allowed to buy "junk" once a week at school. Husband does not like grains because his mom never cooked them at home. Mom cooked at home. Had no choice to buy made food as it did not exist. Had to cook everything in former USSR. Mom</p>
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	<p>keeps healthy diet. Mom eats healthy and overall healthy except of bone density loss. Mom does not do anything to help the bone density loss. Does not take medications because they make her feel bad. Protests medications. Mom tries to eat foods rich in Calcium but it does not really help. Mom cannot drink a lot of milk because she gets constipated.</p> <p>10. Family structure. Family value. Uzbek culture-arranged marriages. Preferred to have a wife with medical degree. Important, but not required to of kids to marry someone from the same culture. Job required to be married. Respect of the elders. In Uzbek culture marriages are often arranged. Wanted wife with a “medical degree”. It is necessary to have a doctor at home. Because was raised by the family of healthcare professionals it was necessary to have someone who understand medications etc. “Let the girl be with medical education”. Early marriages. Job required to be married. Got married by arrangement, but will not require it from kids as they are growing in a free country. However, would prefer someone from the same religion. We are not religious people but would like someone from our culture or religion. Not filling up full cup of tea is a sign of respect. Respect to the elders.</p> <p>Raising kids. Kids adapted American food and prefer healthier food. Teaching kids to be active, play sports. Kids are trying to eat healthy as well. Kids adapted more American food. They prefer more the type of food that is served at the school. As a child also liked school food more than the same at home. Family tries to serve the kids food of their choice, more American-type. Although the parents prefer more traditional food, they will cook for kids their favorites. Teaching kids to stay active, participate in sports. Controlling kids’ health habits, such as dental care. In term of food the kids control their own choices as they prefer healthy food.</p> <p>11. Family role in health. Family is supportive of lifestyle modification. Family is supportive of diet modification.</p> <p>12. Family role. No culture of nursing homes. Family is expected to take care of sick relative regardless of the relation and family dynamic. Parents live with kids and grandkids, although nowadays some youngsters are trying to live independent from parents. Family took care of the sick relative. How can one place a parent in the nursing home? Placing elders in the nursing home is a betrayal. Family took care of a relative despite her bad personality. She had hellish personality but we could not place her in a nursing home. Even though she was not close relative family had to provide care. Parents live with kids, grandkids. Kids help parents.</p>
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	<p>New generation-another mentality. Youngsters are trying to live separately. Nursing homes are not common.</p> <p>13. Family: Kids are accomplished. Grateful to kids who brought him to the doctor for care.</p> <p><b>SUMMARY: Family members are expected to take care of sick relatives. Older family member help raise younger while those young are expected to help elderly, protect them. Females are usually dedicated to their family. Women often sacrifice their carriers. Health-related traditions are transferred from one generation to another. Dietary preferences are established by the family traditions. In Uzbek culture arranged marriages. Prefer the children to marry someone from the same culture/religion. Respect of the elders. Raising families: trying to pass on tradition. Children adapt American lifestyle. Family is supportive in lifestyle changes. No institution of nursing homes in Georgia. Family is expected to take care of their sick relative regardless of the family dynamic. Although, younger people try to live separately.</b></p>
Life satisfaction.	<p>6. Life satisfaction. Work. I am happy with what I have. I cannot demand different from life. Wishes to be more fluent in English.</p> <p>I consider that I worked successfully. I was satisfied because I was doing what was taught, and worked according to my specialty. Worked for 32 years at the same place until the retirement. I am happy with what I have. I understand that physically and (financially) I cannot, so to say, demand different from life. Deprived of being fluent in English. Huge minus in my life.</p> <p>View on America and living in US. People seem happier in US. New life in America. More free in America. It is calmer in America. People laugh in America. Everybody smiles in America.</p>
Immigrants from former USSR	<p>7. View on immigrants from the former USSR. Stress of unknowing, especially in recent immigrants. Confused. Fear of unknown.</p> <p>Russian-speaking immigrants have some kind of nervousness in them. Stress of not knowing the language. More recent immigrants are lost, confused, fear of unknown. In Ukraine there is not a lot of technology. Advanced technology might scare the immigrants.</p>

	<p>Social support in immigration. Immigrants support each other.</p> <p>Importance of having good people to help in case one needs assistance. People helped find good doctor. Waiting for results to confirm possible oncology was a tragedy. People (other Immigrants from former USSR) helped with apartment. Boomerang principle. People helped and they should be rewarded for their good deeds. Got support from Mexican immigrants.</p> <p>9. Immigrants have no resources. Start caring about health when life is established. Russian-speaking immigrants use homeopathic remedies, which do not always work. Do not understand if person does not eat meat. See healthcare providers less than other American-born people. Russian-speaking immigrants are used to being patient. Walk it off. No annual physicals. No preventive health. They have different expectations of the healthcare providers, but should adjust to the rules of the country of the residence. Doctors have to do their job and not listen to different cultures. New immigrants have no resources. When life was already established started thinking about diet and exercise. Immigrants from former USSR uses a lot of homeopathic remedies which do not help. Windex for wounds. But they swear by it. Do not understand people who do not eat meat. Guilt trip if you do not eat meat. Completely different culture. Family gives hard time a member who does not eat meat. Not acceptable in former USSR. People pick on that family member. People from former USSR go to the doctors less often. Annual physical is not a routine for them. There is nothing preventive. Russian-speaking immigrants are used to be patient. Walk it off. Russian-speaking immigrants should follow the rules of the country of residence. Do not put your five cents in. People like to talk; confuse place and time. Need to relearn new place. Doctors do not have to listen to some cultures; they have to do their job. If trying to please everyone-never will end the treatment.</p> <p>10. Immigration: Immigration was difficult. Had to leave jobs and school behind. Financial difficulty. Friends helped. Could not work based on specialty. Another culture. Another food. "Not habitual". Won a green card Came with the family. Third child was born in US. "It is all from G-d" Wife was a doctor. Dropped out of the PhD program to come to US. Immigration was difficult. Could not work according to the specialty. Financially difficult. Had difficult time financially when came to US. Friends helped. Sent money to friends</p>
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	<p>before coming to US. With job was difficult. Another culture, another food. "Not habitually"</p> <p>11. View on Russian-speaking immigrants. Different types. Those who care about their health, and those who don't. Education is important. There are different types of Russian-speaking immigrants. Some are educated integrate into American life, others work for cash. There are health-conscious Russians and those who will eat everything without regard to health. This does not depend on age, but rather on education. Not interested in going back to former USSR.</p> <p>17. View on Russian-speaking immigrants: Take their own medications. Some stores sell Russian meds. Believe that Russian meds are less toxic. More customary. When sick-nobody runs to the doctor. Russian-speaking immigrants do not believe in chemicals. When sick-nobody runs to the doctor. Russian medications are more appealing to their taste. Home remedies first, later doctor. Russian-speaking immigrants in the US do the same things they did back at home. They take their own medications. Some stores even sell Russian meds. When sick-nobody runs to the doctor. Old generations get the same treatment as they did before, in Russia. All believe that it helps you. It is less toxic. Many immigrants do not believe in chemicals. Nobody wants injections. Trying to find something that will not harm you as much. Although no one knows. It is simply psychological. Using Russian medication because of the taste. There is the same medication here but it tastes different. American medication gives the kids rash. This is what we are used to. If one gets sick trying rubs, compress and other home remedies first. If it does not help-go to the doctor.</p> <p><b>SUMMARY: Immigrants are stressed because of the unknown. Immigrants support each other. Immigrants have no resources, their expectations are of healthcare providers are different. Russian-speaking immigrants are spoiled. Immigration was difficult. Not habitual. Could not work according to the specialty. New culture, new food. Financial difficulties. There are different types of immigrants: Those who are educated and care about their health, and those who don't. Nobody goes to the doctor. Take their own medications (creatures of habit). Use home remedies first. If don't help-the doctor.</b></p>
Food and health	<p>8. Food and health. Green leafs, oatmeal, grains, fruits, vegetables. Salads help with constipation. Healthy diet is attempted to follow on vacation and bring to work. Seeing co-workers keeping healthy diet makes you eat healthy.</p>

	<p>Obsessed with healthy diet. Cottage cheese, green leafs, oatmeal every morning. I make 2 types of grains. Butternut squash. Variety of fruits and vegetables, soups, breadless hamburgers, baked chicken, creeps with cheese and meat. I cook a lot. Brings food on vacation. Gives kids food to school. Working at the pharmaceutical company many co-workers bring home made “healthy” foods to work. Looking at other people makes you want to eat that too. Salad leafs, soups, green smoothies help digestion. Grains for kids. Salads help with constipation.</p> <p>10. Traditional food. Fattening. Lots of traditions related to food. Uzbek food is fattening, very saturated, high calories. What was considered normal in Uzbekistan is not normal here now. Many traditions related to the food. Such traditions vary by region. Prefers food cooked by the people from his region.</p> <p>Those who lived in Uzbekistan can distinguish good from bad. They know their food. “We are spoiled clients”. Prefers authentic Uzbek food. Lives in the Uzbek community. Uzbek people from many other countries. Uzbeks are very traditional people.</p> <p>11. View of food. There is “harmful food”. Prefer organic food. No GMO. Food can help with some diseases. Vegetables, salads. Eating habits changed since the immigration. Less Russian food. Husband stopped eating “harmful” foods. Buying organic foods. Watching sugar content. Many things have changed. Was inspired by the co-workers to start eating healthy. Educated people in the office started avoiding products with GMO, do not use plastic containers, people bring their own (homemade) food to the office. Limit bread, consuming less flour products. Food can help with some diseases. “I know my own diet”. “I watch my husband’s diet”. We do many things right. Eat salads, vegetables. At the restaurants eats just like everyone else, but tries to avoid very salty foods. Rarely eats at the restaurants. Eating habits changed since the immigration. When first came to US were eating the same way as in US. Did not eat vegetables much. Husband likes vegetables and started eating more vegetables. “Started cooking less Russian food”. More organic food.</p> <p>13. Health and diet. Role of food. I eat everything and I feel fine. Healthy eating more vegetables. Vegetables fix stomach problems. With age certain foods cause problems. . Likes to eat vegetables, grains, soups.</p> <p>16. Food and health. Healthy person can eat anything. No difference between organic and non-organic food. No specific</p>
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	<p>connection between food and health. If person is healthy he can eat anything. No difference between organic and non-organic food.</p> <p>17. View on food. GMO foods are bad. Organic foods are more expensive, yet, it is not clear if they are better. It is more psychological, in “your head”. Selling point. There is a difference in taste, but not a huge difference. Now many foods have GMO. Food influences your cholesterol, blood pressure. Organic foods are more expensive, yet, not clear if they are better. Organic vodka is a joke. Organic is a selling point. There is no clear definition of organic. It is more in your head that organic is better. Some organic foods are better tasting. Depends on the producer. (Does not seem like there is a huge difference between organic foods and non-organic foods). Organic is more attractive if it tastes better. The difference is not big. Simply just because. Simply don’t know that. There were no business studies.</p> <p><b>SUMMARY: Food is directly related to health. Organic food. Fruits, vegetables, grains, soups, etc. Traditional food is fattening. Diet had been modified since the immigration. Watching food choices, less harmful food. Homemade food is better. There is not a big difference between organic and non-organic food. Mostly psychological. Not clear if organic food is better. Mostly psychological.</b></p>
Current state of countries of former USSR.	<p>10. After USSR dissolution private insurances paid for a better care but not everyone had an insurance. Private insurances required annual physicals. Have to have connections in order to get care. After USSR dissolution Uzbekistan introduced healthcare insurance. Private healthcare is better than free healthcare in Uzbekistan. Job insurance required annual physicals. Insurance paid for the private clinics. All problems were taken care of immediately. Took the kids to the doctor in a timely manner. Mostly went for annual physicals. The exam was required by insurance. The physical included general screening (urine, blood work), did not go for problems. In Uzbekistan the same healthcare system as used to be in USSR. The healthcare services are based out of polyclinics assigned by the residential region. You go to the doctor who is assigned to your region. Since parents worked in healthcare had better connections Went to “our own people”. During childhood parents controlled health-related activities. Parents recommended familiar physicians. Generally was healthy. The only encounter in Uzbekistan was with teeth. Recommendations.</p>

	<p>12. Healthcare system in former USSR nowadays: Mostly negative view. Human life costs nothing. Proprietary with poor quality doctors. There is no culture of health. Government healthcare. Bribes. It is difficult to find a good doctor in Georgia. Fee for healthcare. Hospitals are not comfortable. Doctors have no responsibility. Human life costs there nothing. Doctors could not diagnose pregnancy. Though that it was in her mind. Was taking potentially harmful medications during pregnancy because doctors missed the pregnancy. Difficult to find a doctor. There is no culture of healthcare there. Money related to healthcare. People have no money to care for health. Doctors lie. They milk you for money. Healthcare related to money. Georgia introduced insurance but it was stopped because people had no money. Government healthcare. People die because they have no money to pay the doctors. People paid a lot of money but could not save the relative. Doctors did everything because they were paid. People do not go to the doctor, afraid to go. Health-seeking behaviors: People avoid going to the doctors. People share medications. Take medications not prescribed by the doctor. People seek care only when they are sick. People go to the doctors late. Do not go until they are very sick. Horror. People have no money to go to the doctor in periphery. Is someone feels good taking some medication other people take the same medication because it helped someone. Some patients could come and ask for medications to be administered without doctor's orders.</p> <p><b>SUMMARY: After USSR dissolution the structure of the healthcare system failed. People are not seeking medical care because they do not have the money. People seek advice of non-medical professionals to save money. Insurance programs do not work as were intended. Need connections to get care. The system is similar to former USSR but it gotten worse. It is difficult to find a good doctor. Bribery. No culture of healthcare. Poor women's healthcare.</b></p>
Lifestyle modifications since the immigration.	<p>10. Lifestyle changes since the immigration. Modified diet. Tried to stay healthy. Lifestyle is modified by the information gathered from TV, media in US. Local culture influences dietary choices. Certain foods still eat as part of the culture, but trying to eat less fat, less harmful substances. Trying to eat healthier in US, limit junk food and carbonated beverages.</p> <p>11. Eating habits changed since the immigration. When first came to US were eating the same way as in US. Did not eat</p>

	<p>vegetables much. Husband likes vegetables and started eating more vegetables. "Started cooking less Russian food". More organic food.</p> <p>13. Changes in diet/lifestyle since immigration: Eating more vegetables here. United States offers more services for the elderly, such as home attendants, more availability of everything in the stores. In America-I do not deny myself anything. If I want to drink - I have a drink. Could not buy everything he wanted in Belarus because had young kids. Kids are older-you can buy anything you want.</p> <p><b>SUMMARY: Lifestyle had been modified since the immigration. Trying to eat healthier in US. More choices and affordability</b></p>



## 18 IDENTIFIED THEMES (2<sup>nd</sup> Step).

1. Meaning of health and being healthy. Health is everything. Harmony. Being active=healthy. Being able to enjoy life. Young people are expected to be healthy. Health is inherited, given by ancestors.
2. View on illness and being sick. Sickness (un-wellness) –not being able to enjoy life. Sickness involves pain and mental state of depression. Physical and emotional connection with pain. Being sick-have chronic problems, discomfort.
3. Health maintenance. Health promotion. Maintaining health related to exercise and healthy diet. Diet includes fruits, vegetables, less meat, grains, more organic, less chemicals, fish, less meat, no dough, cookies, ice cream. No overeating. Eat in moderation. Young people are expected to be healthy, but have fewer opportunities to afford healthy lifestyle. Friends provide support of the active lifestyle. Eating simple.
- A. Health maintenance in former USSR. In former USSR maintained health by being active and engagement in recreational activities, spending time outdoors, by the sea, in resort cities, breathing fresh air. Being active was more important than eating right. Doctors are seen as being responsible for health education. Although, there was no formal primary prevention, many places, such as schools provided screening and promotional programs (ex. exercise)

- B. Health maintenance in US.** Some practices from former USSR are still used in US. People are more educated about their health in US. Media provides more health-related information in US.
  - C. View on healthy food.** Food is directly related to health. Organic food. Fruits, vegetables, grains, soups, etc.
- 4. Health management. Practices related to illness.** If sick-try home remedies first. In serious cases doctors or ER.
  - 5. Experience with healthcare system in former USSR.** Crowded hospitals in former USSR. Culture of bribery. Two options of care: government and private. If you have money-you can afford better care. It is customary to thank doctors/providers with some gifts. Doctors had fewer resources in former USSR. Fewer choice of providers. Doctors were assigned based on the region of residence. Doctors were making home visits. Many people cannot afford good healthcare. Everything is expensive.
  - 6. Experience with US healthcare.** Overall good healthcare system. Doctors are thorough, good diagnosticians, big choice of providers. Although some negatives, such as healthcare as business
  - 7. Differences between US and USSR healthcare.** No health culture in USSR. In USSR doctors used to make home visits. Some doctors in Brooklyn do it. In US healthcare is business. Level of care in US is higher, but there is no alternative medicine in US healthcare system.
  - 8. Stimulus/motivation to be healthy.** Usually people do not think about their health until something happens. To be healthy-to be able to care for self, to be independent and not to be a burden to family. Healthy-independent, being able to work, to travel, to pay bills.

- 9. Sources of health-related information.** Younger respondents seek information online. Older respondents read health magazines, get information from the family members. Some information is learned from family traditions (knowledge of the ancestors).
- 10. Transnational connections.** Although some subjects deny having direct transnational connections they read the news and books, watch TV and Online programs from former USSR. Those who have family members and friends in the country of origin travel back. Subjects whose entire family left former USSR usually do not associate themselves with having transnational connections.
- 11. Expectations of the healthcare providers.** Qualities of the healthcare providers: Empathy, making patients feel important, ability to listen, see a patient as a human being and not just based on his/her insurance. Trusting the provider completely. Providers have to be unselfish. There should be a calling in the healthcare profession. Doctors are expected to educate. Personal attention. Kindness, professionalism. Providers are expected to communicate. Doctors have to be competent. Nurses are expected to nourish. Nurses are seen as more non-traditional providers, who could suggest alternative interventions, not always based on the medical model. Nurse like a savior.
- 12. Factors affecting health.** Stress, worries. People want more than they need. The calmer you respond to the stress the better your health is.
- 13. Alternative modalities.** Many use home remedies, teas, milk. Some herbs such as plantago, chamomile, common yarrow. Buteyko method. Various rinses. In general many admit using alternate modalities and welcome them in health-related practices.
- 14. View on vodka.** Vodka, although is considered harmful, alcohol helps in moderation. It is used to relief stress. Occasional use of alcohol is not seen as a harm.

- 15.      Historical aspect of living in former USSR.** Historically living in former USSR was influenced by political changes. In USSR some people were persecuted for their political views. People were arrested and executed. Their entire families were affected by those persecutions. Children and close relatives were limited in their carrier options. People's health was harmed as a result of political repressions. Despite those persecutions, some people still believed in Soviet regime, considered great fortune to be living in USSR.
- 16.      Spirituality/religion.** Superstitions along with formal religion.
- 17.      Family role.** Family members are expected to take care of sick relatives. Older family member help raise younger while those young are expected to help elderly, protect them. Females are usually dedicated to their family. Women often sacrifice their carriers. Health-related traditions are transferred from one generation to another. Dietary preferences are established by the family traditions.
- 18.      Unique qualities of Russian-speaking immigrants.** Immigrants are stressed because of the unknown. Immigrants support each other. Immigrants have no resources, their expectations are of healthcare providers are different. Russian-speaking immigrants are spoiled.