Russian-speaking Newcomers in San Francisco: A Community Assessment Report

A Project of the Newcomers Health Program
of the
San Francisco Department of Public Health
in collaboration with
International Institute of San Francisco
and
Bay Area Community Resources

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September, 2002

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I. Acknowledgements

The Newcomers Health Program of the San Francisco Department of Public Health would like to sincerely thank the Russian-speaking community members (whose confidentiality we must maintain) who generously gave their time to participate in our health education surveys, interviews, and focus groups. The co-authors would also like to extend their appreciation to the health and human services providers for kindly sharing with us their time, advice and experiences (see Appendix J). We also want to acknowledge the support of the California Department of Health Services, Refugee Health Section, which provided us with the funding to compile this report.

In addition, the co-authors want to acknowledge our staff, interns and those individuals who assisted in the development, implementation and writing of this community assessment through its various phases. Their support, time, expertise, resources and feedback were invaluable and greatly appreciated. We apologize for inadvertently omitting any others who supported this project and are not included here.

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This report is made possible in part by funds received from the California Department of Health Services, Refugee Health Section, under grant number 01-90-4467-01A.

II. Executive Summary

The Russian-speaking newcomer community is one of the fastest growing communities in the San Francisco Bay Area. The current wave of newcomers from the former Soviet Union include many individuals who have left their homeland due to an increase in the incidence and virulence of anti-Semitic activity, or to escape communism. Thousands left the former Soviet Union when it was experiencing economic and social upheaval. One goal they all have in common is their pursuit of a better life in the United States for themselves and their families.

Russian-speaking newcomers include people with different immigration statuses, some are refugees, others are asylees or parolees and some are immigrants with no special status. Due to the difficulty of sub-categorizing this community and for purposes of inclusiveness, this assessment encompasses newcomers from the former Soviet Union who have arrived in the past fifteen years, regardless of their immigration status.

In order to better understand and help Russian-speakers deal with resettlement, trauma and stress, health care and social service providers can benefit by having additional information about them. A community assessment, such as this one, which includes various methods of gathering information is a good tool for beginning to identify community assets, socio-cultural and health beliefs and practices, community needs and gaps in services. This assessment, undertaken by the Newcomers Health Program, a program of the San Francisco Department of Public Health in collaboration with the International Institute of San Francisco and Bay Area Community Resources, attempts to present a baseline picture of the Russian-speaking newcomer population in San Francisco County. The goals of this assessment were fourfold:

1. To document the basic demographic characteristics of the Russian refugees who came to San Francisco, including information on general health issues, employment and education, resettlement resources and challenges, and overall well-being.
2. To begin a process of networking with community members and enhancing community capacity so that Russian-speaking newcomers in San Francisco have more resources available to help themselves.
3. To seek information to guide us in determining future directions and collaborations for Newcomers Health Program.
4. To compile and produce a report, and share findings related to information obtained on this community by the Newcomers Health Program.

Due to resource limitations, this assessment is primarily descriptive and qualitative in nature. The assessment utilized the following methods which are summarized in this report:

1. a literature and data review;
2. analysis of billing data from public health primary health care clinics of the San Francisco Department of Public Health;
3. analysis of refugee initial health assessment data from the California Department of Health Services;
4. patient health education assessment survey at Refugee Medical Center;
5. key informant interviews with health and human service providers who work with Russian-speaking newcomers;
6. focus groups with Russian-speaking newcomer adults and youth, and visiting Russian businessmen.

Some General Findings from the Assessment

1. *Diversity:* There are many differences in the waves of Russian speakers who live in the San Francisco Bay Area. There are subgroups based on the country of origin, religious practice, immigration status, age and socio-economic status.
2. *Physical health issues:* Chronic diseases such as hypertension, diabetes and heart disease are very common. Diseases of the musculoskeletol system and connective tissues, diseases of the nervous system and sense organs, and rheumatoid arthritis are also common. Some of these are most likely related to lifestyle, diet and tobacco use.
3. *Mental health issues:* Loss of country, work and status cause many Russian-speaking newcomers to feel depression and stress. Many of the elderly have feelings of depression and become isolated due to a lack of English language skills. Some do not seek assistance in health care because they are uninformed about services available or due to the stigma associated with mental health.
4. *Employment opportunities:* Most Russian-speakers are well-educated and well-trained. However, due to language limitations or lack of current technology skills many are unable to get work or earn a substantial wage for the high cost of living in San Francisco.
5. *Supportive services:* One of the most frustrating areas for these newcomers is the lack of qualified Russians-speaking interpreters and service providers at many health centers and social service agencies. Many Russian-

speaking newcomers expressed their appreciation for the health care providers at the Refugee Medical Clinic, Mt. Zion Hospital and San Francisco General Hospital.

6. *Housing:* The high cost of housing in San Francisco is a major concern for many Russian-speakers. Many fear homelessness. We are seeing a larger population settling in unsafe neighborhoods such as the Tenderloin and the Western Addition. Others move out of the city to suburban areas such as Daly City, Richmond, Walnut Creek and even to Sacramento where there is a large Russian population.
7. *Youth issues:* Youth tend to acculturate faster into the community than the older generations. Many don't want to speak Russian and this causes a communication problem with elderly family members who may only speak Russian. In addition, some Russian service providers perceive that Russian-speaking youth have a much higher smoking prevalence rate than American teenagers. If this is true, tobacco-related diseases will continue to affect this community at higher rates than the general population.
8. *Great strengths:* Russian-speakers know how to "find their way" in the culture and have a desire to work and become successful in the new environment. They are resourceful, resiliient and developed skills in their homeland for getting around obstacles. They have a strong sense of family and a very good work ethic.

Recommendations

We based these suggested recommendations on the information gathered in this assessment. We believe that these actions could significantly and positively impact the health, well-being and resettlement experiences of Russian-speaking newcomers in San Francisco.

1. Increase access to health care services by providing the newcomers with an extensive orientation to the health care system in the U.S. (and more specifically in San Francisco) so they will better understand the process and be able to utilize services.
2. Develop health education prevention programs such as hypertension management, diabetes management and healthy eating programs that are culturally and linguistically appropriate. Use bilingual, bicultural staff to conduct outreach and implement activities.
3. Implement cultural competency training at all levels of service provision. Provide funding for more native language brochures, one-on-one education and native language videos.
4. Increase the availability of interpreter services and Russian-speaking providers throughout the health and social services arena.

5. Conduct social support groups for Russian-speaking newcomers citywide and develop mental health services that specifically meet the needs of older Russian-speaking community members. Identify and outreach to sub-groups that are not seen as well as those that are more visible by their presence in the various assistance programs offered by service agencies. Very often those that are the least visible are, by definition, the ones that need the most attention from social service agencies and others in the community.
6. Develop youth and intergenerational programs to enhance family connections and build on cultural strengths.
7. Incorporate alternative medicine, stress reduction and coping strategies into more traditional health and social services model that are common in the United States. This idea is based in part on models practiced in the former Soviet Union, thus it is not only culturally appropriate but would also build trust in the community.
8. Increase the number of vocational training and job placement programs that serve Russian-speakers with limited English skills.

III. Introduction

Purpose of this Community Assessment

From 1999 to 2002 Newcomers Health Program implemented several assessments of the Russian-speaking immigrant and refugee population in the San Francisco area. We decided to compile information from these smaller assessments into one comprehensive report with information on the current status, strengths and needs of Russian-speaking newcomers in San Francisco County, to highlight programs and services which have proven helpful, and to identify gaps in services.

The primary goals of this assessment were to:

1. To document the basic demographic characteristics of the Russian refugees who came to San Francisco, including information on general health issues, employment and education, resettlement resources and challenges, and overall well-being.
2. To begin a process of networking with community members and enhancing community capacity so that Russian-speaking newcomers in San Francisco have more resources available to help themselves.
3. To seek information to guide us in determining future directions and collaborations for Newcomers Health Program.
4. To compile and produce a report and share findings related to information obtained on this community by the Newcomers Health Program.

Newcomers Health Program is a community-based refugee health program that has provided services to refugees and immigrants in San Francisco for over 20 years. It is a collaborative program of the San Francisco Department of Public Health, International Institute of San Francisco and Bay Area Community Resources. The programs instituted by the Newcomers Health Program include clinic-based services such as medical interpretation, comprehensive health assessments of newly arriving refugees, health education, referrals, and case management at primary health clinics of the San Francisco Department of Public Health. Newcomers Health Program also conducts community-based health programs designed to improve community well-being and enhance community capacity. Current programs include the Bosnian Community Wellness Program administered in collaboration with the International Institute of San Francisco, and the SUNSET Russian Tobacco Education Project administered in collaboration with the Bay Area Community Resources. Newcomers Health Program continuously plans and develops

programs based on information gathered from assessments such as this one.

Definition of the Community

The terms "Russian-speaking immigrants" or “Russian-speaking émigrés” are often used in literature as umbrella terms inclusive of all arrivals (immigrants, refugees, asylees and parolees) from the former Soviet Union. For the purposes of this report, we will use the term Russian-speaking newcomers. The specific focus is on Russian-speaking newcomers who arrived in the United States within the last fifteen years.

The United States Refugee Act of 1980 defines refugees as "persons outside their own countries of nationality who are unable or unwilling to return because of persecution or well-founded fear of persecution." In order to resettle refugees and promote their self-sufficiency, the Refugee Act authorizes financial assistance by the federal government in cooperation with state and local government and voluntary agencies (General Accounting Office, 1990). Benefits for refugees include eight months of Medi-cal Insurance and Temporary Aid to Needy Families payments. Individuals who come to the United States as visitors but do not return to their country of origin can apply for asylum status, and if it is granted they are referred to as asylees. There are Russian-speaking asylees in San Francisco who are entitled to the same benefits as refugees (General Accounting Office, 1990). Parolees are granted this special immigration status in the former Soviet Union by the United States government and are entitled to some of the same benefits as refugees once they arrive here. Immigrants who choose to leave their countries of origin to migrate to another country for reasons not associated with persecution, usually in search of improved quality of life, are not eligible for as many benefits as refugees, asylees and parolees.

Limitations

As with all newly arriving immigrant groups, it is a challenge to paint a comprehensive and accurate portrait of the Russian-speaking newcomer community. First of all, there are limited sources of secondary data. Because Russian-speakers are often aggregated under the category of “white”, often with no differentiation by language or country of origin, it is often complicated to examine county or other public data. Data sources about immigrants do not usually differentiate between refugees and other immigrants, and there is limited census data from the 2000 census. Other sources of information, such as schools,

community colleges, refugee and immigrant service providers, and health clinics have limited information or data that is not easily accessible. Even initial resettlement figures on refugees available from the U.S. Department of State and the resettlement agencies are not considered accurate in estimating refugee population sizes because of secondary migration into and out of San Francisco, in addition to the fact that these numbers only include refugees, and not asylees, parolees or other immigrants.

There are also limitations specific to the analysis of the San Francisco Department of Public Health primary care clinic patient utilization data. Using administrative datasets for these purposes is often problematic because they are set up for billing and not research purposes. Therefore, some Russian-speaking newcomers may have been inadvertently excluded from the dataset.

There were considerable time, funding, and staff constraints in completing this assessment. Newcomers Health Program staff had limited time to commit to this project and there was little dedicated funding. Consequently, sample sizes for focus groups, refugee interviews, and surveys were smaller than we would have liked. Language issues posed some challenges for non-Russian staff analyzing the interview and focus group data.

It may be difficult to generalize the findings of this assessment to the general population of Russian-speaking newcomers in San Francisco, or to the general population of Russian-speaking newcomers in the United States. Our information was primarily obtained from service providers our program has connections with, and from patients of three public health clinics in San Francisco and Newcomers Health Program clients, who may be different from other Russian-speaking newcomers. The focus of this assessment is on Russian-speaking newcomers over the age of eighteen. While this is in many ways appropriate, it is important to remember that newcomer children have unique needs and concerns that should not be overlooked by service providers.

Despite these limitations, we hope this assessment will serve as a valuable tool for service providers in identifying means to better work with their Russian-speaking newcomer clients.

IV. Background and Literature Review

The Waves of Soviet Immigrant and Refugee Groups into the United States

History

The majority of recent Russian-speaking immigrants to San Francisco have been Russian-Jewish people who suffered a unique history in the former Soviet Union. They have been persecuted, marginalized and massacred throughout the centuries. Manyy have been scapegoated for social ills during periods of political and social turmoil. Pogroms (government-sanctioned reigns of terror) have often resulted from this scapegoating. In the 1800's, Russian-Jewish people were restricted to certain regions of the country, excluded from most occupations and subjected to violent attacks. These conditions led many Jewish people to migrate (Gold and Tuan, 1993).

Many Jewish people who stayed in the former Soviet Union, hoping to improve their chances for survival, supported social reform movements such as the Revolution. Their involvement in these movements was often significant, and many of those in Lenin's Politburo were Jewish in origin. By the 1920's, Jewish religious practice was banned and Jewish people were prevented from maintaining links with relatives abroad (Gold and Tuan, 1993).

The common method of describing the Russian-speaking immigrant and refugee population is to divide it into "waves" according to periods of arrival, reasons for persecution, and immigration status. These categories influence access to health and social services, and indirectly affect prospects for long-term well-being.

1. *Those who immigrated to America shortly before 1900*: This group includes those escaping the Jewish pogroms. The children and grandchildren of this group (second generation) may also be included in this group as they represent a well acculturated and integrated, although aging group.
2. *Those who immigrated shortly after World War II*: This group, which includes those who fled from the Ukraine, Russia and Belarus, is now aged and may be vulnerable to health and social problems.
3. *Those who came to the United States in the 1970's and 1980's*: There have been two distinct flows of Russian-speaking migrants into the United States since the early 1970's. One group was from the Jewish population of the former Soviet Union. They were forced to leave the Soviet Union to escape anti-Semitic based persecution. The other group, arriving from 1972-

1986, left to escape communism in the Soviet Union.

4. *Those who arrived since 1986:* This group is the focus of this assessment and is comprised of people from all the former Soviet Republics. Since the disintegration of the Soviet Union, extreme nationalist policies and sentiment in the republics resulted in discrimination and retribution of ethnic Russians living in those areas. Thousands of newcomers left the former Soviet Union when it was experiencing economic and social upheaval alongside increasing freedoms. The largest percentage of the newcomers leaving the former Soviet Union after 1986 were Jewish people from Russia, Ukraine and other republics. Other large groups of former Soviet Union newcomers entering the United States are Armenians and Pentecostals (Gold and Tuan, 1993).

Culture, Language and Ethnicity

The former Soviet Union consists of over one hundred distinct nationalities, sixteen autonomous republics and thirty autonomous areas. To attempt to characterize Russian-speaking culture would be even more difficult than to characterize American culture. While there are cultural similarities and common experiences that Russian-speaking people from the former Soviet Union share, there are many differences such as ethnicity, history and background, social class, language, religion, and numerous other factors.

In Russian culture the strength and importance is in the community, not the individual; belonging to a community equals survival. Despite communism, life in the former Soviet Union was very stable. Many people lived, went to school, worked and died in the same place they were born. Virtually everything was done together without competition.

However, in an effort to end what they called tsarist Russia's "prison of nations" and to promote the Soviet Union as a family of friendly nations, the Communist regime used propaganda, slogans and forced resettlement to promote a unified Soviet culture. The Communist government held grandiose patriotic and folkloric festivals to promote a unified culture. They mandated assimilation and attempted to wipe out distinctions among cultures, undermined social values, forbade all religions, and extinguished dialects and languages other than Russian. Despite these efforts a homogenous culture was not developed (Hartman, 1999).

The official language of the former Soviet Union was Russian. Many of the native languages were forbidden in the former Soviet Union. Yiddish and Ladino were spoken by the older generation, and only at home or with very close friends.

Although the Soviet government denied Jewish people (and all citizens) the right to practice their religion and promoted a homogenous culture, outsider status was imposed on Jewish people by being branded "Jew" as their nationality on Jewish citizens' passports, regardless of where they were born or resided (Gold and Tuan, 1993). Jewish people, a national minority in the former Soviet Union, are comprised of two ethnic groups: Ashkenasim (European Jewish) whose language is Yiddish and Sephardim (Mountain Jewish) whose language is Ladino. Both groups also speak Russian. Ashkenasim newcomers arriving in the United States are from former Soviet republics along the European border and Sephardim newcomers are from Azerbaijan and Uzbekistan (Elaysberg, 1996).

Russian-speaking Jewish people practiced Orthodox Judaism openly prior to the Revolution. With the arrival of communism, the practice of religion was forced underground. The communist denigration of religion was so effective in the Soviet Union that now it is primarily the elderly, who learned traditional Judaism before the Stalinist crackdowns in the 1930's, who maintain contact with their religion (Gold and Tuan, 1993). Many of the Jewish people aged 30 to 50 only have a secular knowledge of Judaism and are atheistic. Newcomer youth have been exposed to contemporary American Judaism through religious activities and scholarships to Jewish camps and schools that have been made available to them as part of resettlement programs. This generational variation in religious upbringing and belief can be a source of conflict for newcomer families (Gold and Tuan, 1993).

Russian-speaking Newcomers in the United States and San Francisco Bay Area

According to the 2000 Census reports, there are 27,243 (3.5%) Russian-speakers from Russia and the Ukraine in San Francisco, and 3,545,136 (1.2%) in the United States (United States Census Bureau, 2000). The long form of the 2000 Census asks questions that quantify data on foreign-born newcomers. The questions concern ancestry or ethnic origin, any spoken language other than English, and country of birth. According to data collected almost 700,000 new immigrants flocked to the nine-county (San Francisco Bay area) region between 1990 and 2000 and of those there are an estimated 31,250 Russians and Ukrainians. (Hendricks, 2002). Sacramento and Yolo counties vied with Los Angeles for the most concentrated Russian and Ukrainian communities (Gaudette, 2002). Refugees from the former Soviet Union represent one of the largest groups of legal refugees to the United States in the past decade. Close to half a million were resettled in the United States from 1983-1999, with over 86,000 of them resettling

in California (Office of Refugee Resettlement, 1999). In San Francisco specifically, information from the California Department of Social, Refugee Programs Branch data show that 13,348 refugees from the former Soviet Union resettled here. The same data source documents that from 1997-2001, an additional 1,870 refugees came to San Francisco from this region of the world. In total, these number equal over 15,000 refugees in San Francisco. The exact number of refugees who came into the county are difficult to estimate because of secondary migration in the United States after initial resettlement and due to difficulty in capturing data on immigrants in general. Based on these various data sources we estimate that San Francisco County is home to 25,000 to 32,000 Russian-speaking newcomers.

The United Socialist Soviet Republic consisted of fifteen ethnic republics and spoke over 100 languages. The majority of Russian-speaking newcomers in San Francisco come from either Russia or the Ukraine. They also come from areas of the former Soviet Republic which are now independent countries: Belarus, Moldova, Kazakhstan, Uzbekistan, Azerbaijan, Armenia, Kyrgyzstan, Latvia, Georgia, and Turkmenistan.

Russian-speaking newcomers in San Francisco are an "older" group of immigrants, considered by many to be the oldest immigrant community in the United States (Zinchenko, 2001). The average age of these immigrants is mid-thirties. About 15% of Russian-speaking newcomers are of retirement age and only about half of them are of employable age (Galperin, no date). The intact family is often the unit of immigration, and grandparents frequently migrate with their families and live in the same household upon resettlement. In many newcomer households the grandparents speak only Russian and the grandchildren speak only English (Gold and Tuan, 1993).

Because most Russian-speaking newcomers come from their homeland educated, skilled, and often familiar with urban life, they have been characterized as being well-equipped for adjusting to American life. On average, adults arriving in the United States from the former Soviet Union have completed an average of 13.5 years of formal education, one more year than the United States average. While the scope of former occupations is broad among newcomers, large numbers have worked in technical fields including engineering, computer science, and other professional areas (Gold and Tuan, 1993). However, because the former Soviet Union is behind the United States in terms of technological advancements, re-training in technical areas is often necessary. Due to high education levels and the fact that Russian-speaking Jewish women as well as men generally worked outside the home in their countries of origin, the average family

income is higher than that of many recently arrived refugee groups.

In general, this community does not have well-established, formalized self-help organizations, instead the rely on existing organizations that work with the Jewish community in the United States, as well as informal assistance networks among families and friends, which demonstrates the importance of family connections in resettlement (Galperin, no date). Unfortunately, in some cases community members do not access established, formal organizations because they feel misunderstood and that their issues are not addressed. One study showed that newcomers who were interviewed wanted service providers to understand and be more respectful of their culture. On the other hand, service providers sometimes express frustration because they view Russian-speaking newcomers as demanding, lacking trust, hostile and manipulative (Birman, no date).

There are challenges facing this community as newcomers resettle here. One of the common difficulties of resettlement is adjusting to an automatic loss of status by migrating. Problems may include reversals in provider/recipient roles within families, dependency of older family members, generational differences in religious identity, defining their community in American society and adjusting to life in the United States (Gold and Tuan, 1993).

Like all immigrants, there are many health and related socio-cultural practices and beliefs that are important to keep in mind when working with this community. Newcomers from the former Soviet Union can be perceived as non-compliant by health care providers. For example, they may change or initiate medications or prescriptions as they feel is appropriate and may not follow instructions given by providers. Preventative health screening is not typically done in the former Soviet Union so people often don't understand its importance, and thus newcomers will not go for screening procedures unless they suspect something is wrong. These practices are based, at least in part, on their experiences with health care in the former Soviet Union (Schulhoff, no date). In terms of physical health issues, positive reactions to tuberculosis skin tests are very common, which indicates exposure and latent infection (Moyer, no date). Russian-speaking newcomers have great respect for elders and a strong family focus and thus families like to discuss medical decisions together and take care of ill family members. Some believe that causes of illness include poor nutrition, not dressing warmly, family history, or too many medications. The traditional Russian diet is high in starch, fat and salt. (Lipson, 2000; Weinstein, 1999).

Mental health is a major problem with this newcomer community. Many newcomers express

depression, stress, feelings of isolation and misplacement. A study conducted with Russian-speaking refugees in 2001 at a San Francisco mental health clinic found that 68% of clients developed severe depression, anxiety and other mental health issues within one year of arrival in the United States. According to the study the primary causes for this were related to feelings of a loss of home (due to both the collapse of the former Soviet Union as well as immigration), aging and emotional issues. (Zinchenko, 2001).

Two studies were done in Santa Clara County, California that examined issues impacting Russian-speaking newcomers in this Bay Area County (Hobbs, 2000; Weinstein, 1999). Due to the geographic proximity as well as similarities among the communities, many of the findings and issues outlined below can be assumed to be comparable for community members living in San Francisco.

The majority of Russian-speaking newcomers cited major barriers to obtaining health and social services: lack of English language skills, unavailable information, unaffordable health care, a fear and mistrust of the government, and difficulty accessing transportation.

According to participants, major issues of stress are health, finances, employment and housing. Participants tend to like many aspects of America: freedom/democracy, the American people, opportunity and choice, economic security, safety, natural beauty and strong laws, American literature, theatre, television, medicine and science.

In general, resettlement issues are more difficult for older newcomers due to language, isolation, and loss of careers. The older newcomers dislike the public transportation system, having to make appointments, less depth in doctor-patient relationships, a less rigorous public education system, and television programs that portray nudity, violence, and cruelty. The health problems of the older community members are typical of the elderly. Even prior to emigration the most common problems were hypertension, arthritis, glaucoma, cardiac and prostate problems and cataracts. Since coming to the U.S. some elderly interviewees report an improvement in their health as a result of surgery (ear, eye, cardiac or orthopedic) or improved medical management of cardiac, hypertension or bacterial problems. Some new problems that developed since resettlement are related to mental health: depression, psychological pain, headaches and fibromyalgia.

Many Russian-speaking newcomer participants realize that community education lies at the heart of improving the lives of immigrants and their families. Without knowledge of how to understand the new society or how to improve themselves, many immigrants run into dead ends

or have problems that can be avoided. Therefore, there is great unanimity of agreement that it is important to develop multi-topic immigrant community education programs addressing cultural proficiency and social services, immigration and health access issues.

A literature review done in 2000 by the SUNSET Russian Tobacco Education Project related to tobacco use and Russian-speaking newcomers highlights some important issues on this pressing health issue (Escobar, 2000). Although very little data on tobacco and Russian-speaking newcomers was found, there is some information from the former Soviet Union that may provide clues for tracking current tobacco use. Russian cigarette consumption has increased 40% since 1986. Approximately 67% of Russian men smoke and 25-35% of Russian women smoke. Smoking initiation by young people is currently on the rise. In 1995, 41% of all deaths among men 35-69 in the former Soviet Union countries were caused by tobacco. This fact is a great contributor to the Russian males' average life expectancy of 57 years of age.

With the fall of communism, these countries have been the targets of increased marketing by Western tobacco companies looking for new markets to replace the ones lost by programs and policies in developed countries. Many Russian-speaking newcomers have had high exposure to cigarette smoke, have been assailed by tobacco advertising, and perceive that tobacco use is normal. It has also been noted that Russian-speaking newcomers are fiercely protective of their personal choice coming from a history of oppression. They also hold a fatalistic outlook that although smoking is dangerous it is ultimately up to fate if one will be harmed by it. Data from patient intake logs at the Refugee Medical Clinic and Ocean Park Health Center show many patients suffering from tobacco-related illnesses. Interventions need to be designed to appeal to the different ethnic groups in the United States and be sensitive to the mindset of people who have lived through the unique circumstances of the former Soviet Union.

V. Methodology

A. Analysis of Department of Public Health Patient Utilization Data, 1998-2000

A dataset was constructed from the administrative billing data available from outpatient public health primary care clinics of the San Francisco Department of Public Health. The clinics are: Family Health Center's Refugee Medical Clinic, Family Health Center's Gold Team, and Ocean Park Health Center. The selection of the data included the patients from these sites who had clinical services anytime during the time period of 1998 to 2000 who met the following criteria:

1. language was listed as Russian, English, unknown, unable to determine, Turkish or Polish;
2. race was documented as White, other or unknown;
3. ethnicity was noted as Russian, Russian Jew, other European, White, other or unknown.

The purpose was to attempt to obtain a comprehensive list of all possible patients from the former Soviet Union. Newcomers Health Program staff then went through this list and selected the group of patients for the dataset by Russian surname. The final data sample consisted of 711 Russian-speaking newcomer visits, which does not include those Russian-speaking newcomers who use primary care providers or another public health clinic.

The dataset was broken into two subsets by time periods: 1998 and 1999 - 2000. It includes information on age, gender, insurance, zip code of residence, and clinics visited. Also included in the findings section are diagnostic groupings for the first patient visit only and diagnostic groupings for all patient visits. These diagnoses are based on billing data and only include one diagnosis per patient visit, and only the primary diagnosis and not secondary ones are incorporated.

B. Analysis of California Refugee Health Section Data, 2000-2002

The California Refugee Health Section funds the Newcomers Health Program to provide comprehensive health assessments to newly arriving refugees and recently documented asylees. An on-line case management database system, referred to as RHEIS (Refugee Health Electronic Information System), was developed by the Refugee Health Section to allow all funded counties to enter, track and report information such as demographics, health history, diagnoses, and immunizations gathered during the health assessment. The Refugee Health Section has the capability of producing aggregate reports related to the data input into the system by the

counties.

The Newcomers Health Program requested the following aggregate reports from the Refugee Health Electronic Information System:

1. top ten diagnoses for refugees and asylees from the former Soviet Union for the twelve months of the fiscal year October, 2000 through September, 2001
2. top ten diagnoses for refugees and asylees from the former Soviet Union for the first eight months (October through May) of the fiscal year October, 2001 through September, 2002. This is the extent of the data for the 2001-02 fiscal year that was available at the time of the request.

This data includes only refugees and asylees who resettled in San Francisco and received health assessments at the Refugee Medical Clinic during this time period. In some cases more than one diagnosis was given for a single patient. Three hundred-twenty four refugees and asylees from October, 2000 through September, 2001 and 171 refugee and asylees from October 2001 through May, 2002 are included in the dataset.

C. Refugee Medical Clinic Health Education Assessment Survey, 2002

In order to assess the health education issues, interests and preferred ways of learning of refugee patients and design health education programs that are more tailored to meet these needs, the Newcomers Health Program staff developed a patient health education assessment survey. The survey was developed in English and translated into Russian for patients from the former Soviet Union (see Appendices A and B). Between April and June 2002 it was distributed to a convenience sample of adult refugees utilizing health care services at the Refugee Medical Clinic. Sixty Russian-speaking patients self-completed the survey.

D. Key Informant Interviews, 1999-2000

D.1. Key Informant Interviews: General Health and Social Service Issues, 1999-2000

Due to Newcomers Health Program's primary role in providing medical screenings, health education and health referrals to incoming refugees in San Francisco, the type of information Newcomers Health Program staff can obtain on refugee communities is often limited to physical health needs or issues. Through a series of in-depth interviews with San Francisco service providers working with Russian-speaking refugee and immigrant populations, Newcomers Health Program hoped to obtain valuable information about the community beyond their

immediate health needs.

Eleven in-depth semi-structured interviews were conducted with service providers working in a variety of health and human services agencies in San Francisco. A search was made to identify appropriate service providers, the capacity in which they served the clients, and whether they could provide information for the assessment. Contacts were made within the community by recommendation of other service providers and by prior association with the Newcomers Health Program.

These agencies offer a variety of services to refugees, immigrants, and low-income populations. Interviewees were recruited through word-of-mouth, staff and providers at public health clinics, previously established collaborative networks between and among San Francisco Department of Public Health agencies and other public service agencies.

Interviews were conducted either by telephone or face-to-face. All interviews were done in English since the service providers and interviewers had that language in common. Interviews were conducted by San Francisco State University graduate students as well as two staff members from Newcomers Health Program. The interview tools were semi-structured and included questions concerning issues, aspects, obstacles, barriers, strengths and weaknesses of the Russian-speaking community. The focus of the design was to highlight topics for investigation so that interviews could be guided but not restricted to question-answer format. Topics and issues which reflect the overall health of the population and contributing factors, information about the agencies, and the interaction between clients and service providers were the focus of all assessment tools. Four separate interview tools were developed for use (Appendices C-F). One was a general tool for community organizations, two tools focused on service providers: primary health and mental health, and social services. A third tool, across agency questions, was used for all interviewees to obtain general information about their agency.

D.2. Key Informant Interviews: Tobacco Related Issues, 2000

In order to provide a culturally appropriate intervention related to tobacco education the SUNSET Russian Tobacco Education Project, a collaborative project of Bay Area Community Resources and the Newcomers Health Program, identified key informants who are members of or work with this community. The goal was to give insights on how to most effectively implement a tobacco awareness program for the Russian-speaking community.

In the Fall and Winter 2000, SUNSET project staff conducted the interviews. The interview

tool was semi-structured and included questions about how the interviewee worked with Russian-speakers, perceptions on numbers of smokers, special characteristics of smokers, attitudes and behaviors related to tobacco use (and if these were affected by gender and/or acculturation), secondhand smoke issues, tolerance to smoking in public places, tobacco sales to minors, challenges to the success of the SUNSET project and community strengths that would facilitate the success of this project (Appendix G).

Nine people were interviewed during seven sessions. Most interviews were conducted in person, with one over the telephone. Key informants were chosen by convenience sample through recommendations by the Newcomers Health Program and other service agencies as well as staff outreach. The key informants represented a wide sector of the community including Russian medical interpreters, staff and board members of social service agencies, the faith community, media and health providers.

E. Focus Groups

E.1. Focus Groups: General Health and Social Service Issues, 2000

Although the Russian-speaking community is not homogenous, Russian-speaking newcomers have many similar experiences and needs. Focus groups were conducted to gather information regarding perceived needs and gaps in services directly from Russian-speaking newcomers. Newcomers Health Program staff and San Francisco State University graduate students designed focus group questions to elicit in-depth discussion, which highlighted health issues. The findings from these focus groups provide information from the perspective of Russian-speaking newcomers about health issues.

Questions were designed to obtain data on demographics, perceptions of life in San Francisco, and perceptions of health and social issues impacting the community. The draft questions were field tested by three Russian-speaking service providers and reviewed by staff from the Tobacco Free Project. The final instrument included a standardized introduction that was read at each focus group and was composed of eight questions (Appendix H).

A total of twenty-two Russian-speaking newcomers participated in the focus groups. Of that number eighteen were female and four were male. All participants were recent immigrants to the United States, with residency in San Francisco ranging from ten months to six years.

Focus group audiotapes and notes were reviewed and a descriptive summary of each question

completed. Observations made during the debrief sessions were included in the data analysis. General themes were identified and categorized and are the basis for the findings and recommendations. Factors such as frequency (how often a response was given), extensiveness (how many people said it) and intensity (how strong the opinion was) were taken into consideration.

E.2. Focus Groups: Tobacco-related Issues, 2000

In the Fall of 2000, the SUNSET Russian Tobacco Education Project conducted four focus groups with a total of 27 participants. The groups were chosen by convenience sample and to include a cross-section of the community. They included a group of youth at a Russian language school, their parents, a group of health workers serving Russian-speaking patients and a group of visiting Russian ad executives, several of whom had worked on tobacco advertising campaigns in the former Soviet Union and gave unique perspectives on Russian advertising and how to counter pro-tobacco influences.

The goal of these groups was to help identify successful outreach strategies, education materials and program direction. Semi-structured interviews were conducted in both Russian and English using set questions that were slightly modified as needed and appropriate to maximize information gathering. The tool included questions on effective messages for smokers and best communication messages for this issue with this community (Appendix I).

VI. Findings

A. Analysis of San Francisco Department of Public Health Patient Utilization Data, 1998-2000

The information in this section pertains to Russian-speaking patients primarily at three outpatient public health clinics in San Francisco: Family Health Center's Refugee Medical Clinic, Family Health Center's Gold Team, and Ocean Park Health Center. The majority of visits from Russian-speaking newcomers fell within these zip code areas: 94102, 94122, 94118, 94121, which represent the following neighborhoods: Tenderloin/Hayes Valley, Sunset, Inner Richmond/Presidio, and Outer Richmond (see Appendix K).

Demographics of Patients at Public Health Centers

A total of 237 Russian-speaking newcomers are represented in Table I, which has a breakdown by age, gender and frequency of visits in 1998.

Table I. Age and Gender for 1st visit – Public Health Clinic Patient Data, 1998

Age	**# of Respondents (%)**
Under 18	49 (20.68%)
19-34	31 (13.08%)
35-59	114 (48.1%)
60 and over	43 (18.14%)
Gender	**# of Respondents (%)**
Female	127 (53.59%)
Male	110 (46.41%)
Total	**237 (100%)**

When we examine the age and gender for 1998, Russian-speaking newcomers between the ages of 35-59 years of age have a greater proportion of visits than other age groups. The gender ratio is about the same. The majority of Russian-speaking newcomers who made 1st time visits reside in either the Richmond or the Sunset areas of San Francisco. Over 64% of Russian newcomers made their 1st time visit to the Ocean Park Health Center, while nearly 20% visited other facilities not mentioned.

Table II. Age and Gender for 1st visit – Public Health Clinic Patient Data, 1999-2000

Age	**# of Respondents (%)**
Under 18	97 (20.4%)
19-34	86 (18.1%)
35-59	217 (45.7%)
60 and over	74 (15.6%)
Gender	**# of Respondents (%)**
Female	294 (61.9%)
Male	181 (38.1%)
Total	**474 (100%)**

There are of 474 Russian-speaking newcomers presented in Table II. When we examine the age and gender for 1999-2000, Russian newcomers between the ages of 35-59 years of age have a greater proportion of visits than other age groups. The gender ratio is substantially higher for females than males. The majority of Russian-speaking newcomers in this group reside primarily in the Richmond or Sunset districts of San Francisco

Table III. Age and Gender for all visits – Public Health Clinic Patient Data, 1998

Age	**# of Respondents (%)**
Under 18	273 (2.9%)
19-34	371 (3.9%)
35-59	4,102 (43.4%)
60 and over	4,714 (49.8%)
Gender	**# of Respondents (%)**
Female	6,286 (66.5%)
Male	3,174 (33.6%)
Total	**9,460 (100%)**

There is information on 9,460 Russian-speaking newcomers presented in Table III. When the age and gender is examined for all visits, Russian-speaking newcomers over the age of sixty have a greater proportion of visits than other age groups. The gender ratio is almost twice

as high for females. The largest percentage of Russian-speaking newcomers resides in the Richmond area, followed by the Sunset and the Presidio. Over 60% of all visits by Russian newcomers to a health care clinic were made to the Ocean Park Health Center.

Table IV. Age and Gender for all visits– Public Health Clinic Patient Data, 1999-2000

Age	**# of Respondents (%)**
Under 18	622 (4.7%)
19-34	865 (6.6%)
35-59	5,775 (44.2%)
60 and over	5,811 (44.4%)
Gender	**# of Respondents (%)**
Female	8,466 (64.8%)
Male	4,607 (35.2%)
Total	**13,073 (100%)**

There are 13,073 Russian-speaking newcomers presented in Table IV, which outlines age and gender for all visits from 1999-2000. When we examine the age and gender for all visits, Russian-speaking newcomers between the ages of 35-59 years of age, and 60 and over have a substantially greater proportion of visits than other age groups. The gender ratio is almost doubled for females.

The largest percentage of Russian-speaking newcomer patients in this cohort live in the Richmond or Sunset areas of San Francisco. There also appears to be a growing number of community members living in the Western Addition area of San Francisco. Over 45% of all visits to a health facility were at Ocean Park Health Center, while 10% of Russian-speaking newcomers visited the Refugee Medical Clinic.

Diagnosis at Public Health Center Visits

There were a total of 191 first patient visits with diagnosis in 1998. Many of these are new arrivals from overseas. The first visit to a medical center is often for prophylactic vaccines which are administered to newcomers in the United States to prevent communicable diseases.

Table I. Diagnostic Groupings – First Visit at Public Health Clinics, 1998

Diagnostic Groupings	Frequency (%)
Prophylactic vaccine	29 (15.2%)
Screening viral or bacterial disease	16 (8.4%)
Hypertensive disease	15 (7.9%)
Diseases of musculoskeletol system and connective tissue	11 (5.8%)
Ill defined conditions and symptoms	11 (5.8%)
Well child visit	11 (5.8%)
Note: The total number of first patient visits with a diagnosis was 191 in 1998, percentages are based on this total	

There were a total of 429 first patient visits during 1999-2000, which are illustrated in Table II. The frequency of ill-defined symptoms, which is related to a general feeling of unwellness with no specific diagnosis, almost doubled from 1998 to 1999-2000.

Table II. Diagnostic Groupings – First Visit at Public Health Clinics, 1999-2000

Diagnostic Groupings	Frequency (%)
Prophylactic vaccine	60 (14.0%)
Ill defined conditions and symptoms	44 (10.3%)
Screening viral or bacterial disease	39 (9.1%)
General exam	32 (7.5%)
Hypertensive disease	25 (5.8%)
Family planning	22 (5.1%)
Note: The total number of first patient visits with diagnosis was 429 1999-2000, percentages are based on this total	

There were 7,595 total patient visits with diagnosis at public health clinics in 1998. Table III outlines the frequency and percentage of the five most common diagnoses in this time period. It is interesting to note that the second most common diagnosis is ill-defined conditions which encompass vague symptoms and lack of feeling well, which can be connected to general depression.

Table III. Diagnostic Groupings - All Visits at Public Health Clinics, 1998

Diagnosis	Frequency (%)
Hypertensive disease	793 (10.4%)
Ill defined conditions and symptoms	766 (10.1%)
Metabolic Disorders	754 (9.9%)
Diseases of musculoskeleton sys/connective tissue	730 (9.6%)
Diseases of the nervous system/sense organs	540 (7.1%)
Note: The total number of patient visits with diagnosis was 7,595 in 1998, percentages are based on this total	

There were a total of 11,287 patient visits with diagnosis during this time period of 1999-2000, as shown in Table IV. The top diagnosis are similar to those in 1998, however hypertension has a much higher rate in 1999-2000 than in 1998.

Table IV. Diagnostic Groupings - All Visits at Public Health Clinics, 1999-2000

Diagnosis	Frequency (%)
Hypertensive disease	1,221 (19.8%)
Ill defined conditions and symptoms	1,111 (8.8%)
Diseases of musculoskeletol systems/connective tissue	995 (8.8%)
Diseases of nervous system/sense organs	814 (7.2%)
Metabolic disorders	741 (6.6%)
Diseases of the circulatory system	641 (5.7%)
Note: The total number of patient visits with diagnosis was 11,287 in 1999-2000, percentages are based on this total	

B. Analysis of California Department of Health Services Data, 2000-2002

There were a total of 324 patients in the twelve months from October 2000 through September 2001. Table I illustrates the frequency and percent of the most common diagnosis in the California Department of Health Services Data from the Refugee Health Electronic

Information System on-line database system. This data only includes diagnosis on the first visit for newly arriving refugees and recently documented asylees who receive comprehensive health

assessments at Refugee Medical Clinic. In some cases patients had more than one diagnosis. The top three diagnoses are the same for males and females: essential (primary) hypertension, blindness and low vision, and arthritis.

Table I. Diagnosis for Males and Females, 12 months of 2000-2001

Diagnostic Groupings	Female Frequency & (%)	Male Frequency & (%)
Essential (Primary) hypertension	17 (11.6%)	23 (13.7%)
Blindness and low vision	17 (11.6%)	22 (13.1%)
Other abnormal immunological findings in serum (rheumatoid arthritis)	15 (10.3%)	15 (8.9%)
Pain in throat and chest	5 (3.4%)	5 (3.0%)
Unspecified parasitic disease	4 (2.7%)	0
Menopausal & other perimenopausal disorders	4 (2.7%)	0
Other functional intestinal disorders (chronic diarrhea)	3 (2.1%)	0
Depressive episode	3 (2.1%)	0
Malignant neoplasm of the breast (cancer)	3 (2.1%)	0
Mental & behavioral disorders due to the use of tobacco	1 (.07%)	9 (5.4%)
Chronic ischemic heart disease	0	4 (2.4%)
Note: The percentages are based on total number of diagnoses in dataset, which is 146 diagnoses for females and 168 for males.		

There were a total of 171 patients in the first eight months quarter (October – May) of the 2001-2002. Similar to Table I above, Table II illustrates the frequency and percent of the most common diagnosis in the California Department of Health Services Data from the Refugee Health Electronic Information System on-line database system. This data only includes diagnosis on the first visit for newly arriving refugees and recently documented asylees who receive services at Refugee Medical Clinic. In some cases patients had more than one diagnosis. The top three diagnoses for females and for males were the same in both years.

Table II. Diagnosis for Males and Females, first 8 months of 2001 – 2002

Diagnostic Groupings	Female Frequency & (%)	Male Frequency & (%)
Essential (primary) hypertension	14 (14.4%)	14 (14.7%)
Other abnormal immunological findings in serum (Rheumatoid arthritis, SLE)	13 (13.4%)	12 (12.6%)
Blindness and low vision	8 (8.2%)	8 (8.4%)
Mental & behavioral disorders due to the use of tobacco		8 (8.4%)
Other hearing loss	3 (3.1%)	6 (6.3%)
Pain in throat and chest	0	3 (3.2%)
Insulin-dependent diabetes mellitus	0	3 (3.2%)
Other nontoxic goiter	4 (4.1%)	0
Chronic ischemic heart disease	4 (4.1%)	0
Other joint disorders not elsewhere classified	4 (4.1%)	0
Iron deficiency anemia	3 (3.1%)	0

Note: The percentages are based on total number of diagnoses in dataset, which is 97 diagnoses for females and 95 for males.

C. Refugee Medical Clinic Health Education Assessment Survey, 2002

The country of birth for the majority of respondents 57 (95%) was the former Soviet Union, and three (5%) self-identified as being from other countries. Of the sixty Russian-speaking respondents, thirty-seven (64%) were female and twenty-one (36%) were male.

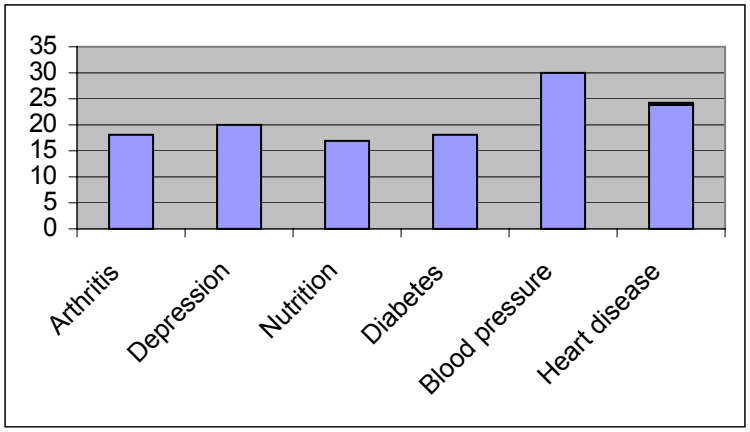
A wide variety of age groups participated in the survey. One person (2%) was under 18 years of age. Nine individuals (15%) were in the 18-35 age bracket. Twenty-five respondents (42%) were in the 36-65 age bracket and another 25 respondents (42%) in the 65+ age bracket. The largest percentage 35 (58%) of the respondents were married, while 42% were single, divorced/separated or other.

All respondents read very well in their native language. Six (10%) of Russian-speakers said they read English very well. Thirty-one (53%) respondents said they could read English somewhat, and 22 (37%) said they could not read English at all. The respondents' understanding of English was split (50-50) between understanding it somewhat and not understanding it at all.

When Russian-speakers were asked about health, 48 (80%) said they wanted to learn more about health care, and twelve (20%) said they were not interested in learning about health.

Respondents were given a wide variety of health-related topics (13) from which to choose. Table I illustrates the responses. The most important topics of interest to Russian-speakers (half were over 36 years of age) were blood pressure 30 (18%), heart disease 24 (15%), depression 20 (11%), diabetes 18 (11%), nutrition 17 (10%) and arthritis 18 (11%).

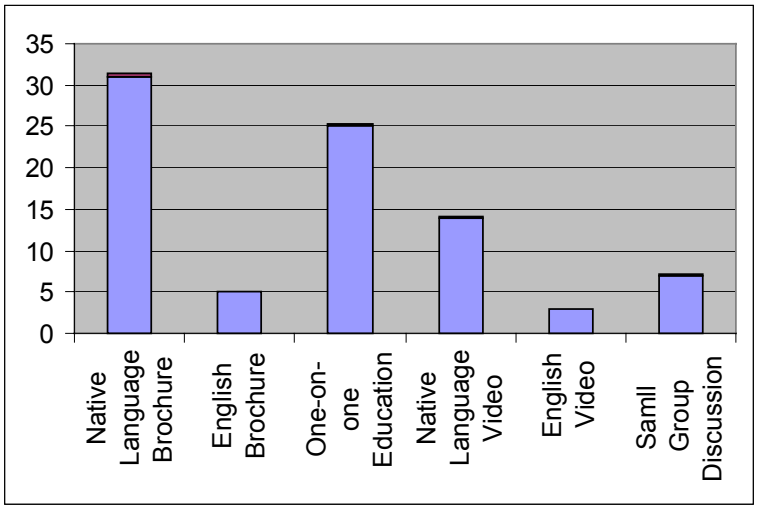
Table I. Health Education Topics of Interest to Russian-speaking Respondents



Note: Arthritis18, Depression 20, Nutrition 17, Diabetes 18, Blood pressure 30, Heart disease 24

Table II shows the preferred ways of learning for the respondents. Sixty respondents were given six choices of preferred learning methods: native language brochures 31 (36%), one-on-one education 25 (29%), native language video 14 (16%), small group discussion 7 (8%), English brochure 5 (6%), and English video 3 (4%).

Table II. Preferred Way of Learning for Russian-speaking Respondents



Note: native language brochures 31, English brochure 5, one-on-one education 25, native language video 14, English video 3, small group discussion 7.

D. Key Informant Interviews, 1999-2000

D.1. Key Informant Interviews: General Health and Social Service Issues, 1999-2000

The key informant interviewees revealed much information about methods of coping with health and social problems, communication and cultural practices having to do with health, and the services available.

A number of social service agencies serve the Russian-speaking population to provide job referral, housing assistance, ESL classes, food security, and legal assistance. Members of the Russian community reported that there are good methods of reaching people about health services: community bulletin boards, Russian newspapers (K Stati, Vestnikm and Russian Life), religious organizations and community-based agencies. While word-of-mouth is a major source of communication among Russian-speaking people, there can also be a great deal of misinformation and miscommunication via this method.

Two major problems were determined: access to health care services, and the aspect of communication between providers and clients in the clinic setting. It appears that many Russian-speakers are unaware of services available and therefore do not seek assistance for health problems. There are ample opportunities for communication that are underutilized, but more organized and consistent attempts to reach individuals in the community would greatly benefit those who need help.

Several individuals felt they would be more comfortable with the health care community if there were more Russian-speaking nurses and dentists available. Refugee Medical Clinic was the only agency interviewed that reported no problems with interpretation services. The problem ranged from moderate to severe in other agencies. The problem appears to be lack of available translators and lack of funds to pay translators.

There is often a lack of trust in western medicines and health care. In the former Soviet Union, physicians provided home visits and care. Many newcomers complain about American health care system, for example, having to schedule and wait for appointments, having little contact with primary physicians, being referred to specialists, the lack of long term relationships with providers and the lack of culturally and linguistically competent health care providers.

Nearly every service provider discussed communication problems with the Russian-speaking community. These problems are related to language, culture and attitudinal differences between Soviet and American approaches to authority and medicine. The Soviet medical model is based largely on drug therapy regimes mixed with alternative therapies, so newcomers may rely heavily on medications in order to believe they are being helped, and may believe care is incomplete if it does not include alternative treatments. If they do not understand the

medications prescribed to them or if the medications result in side effects that frighten them and cause further mistrust, they quickly become non-compliant. This is a frustration to health care providers and patients alike. It makes perfect sense for the patient who is only acting in his or her own best interests.

All service providers reported common wide-spread health problems in the Russian-speaking community, such as: hypertension, heart disease, arthritis, high cholesterol, depression, and anxiety.

Many Russian-speakers are uninformed or in denial about risky health behaviors such as alcoholism, smoking or poor eating habits. Many are obese or overweight and continue to choose the foods which were readily available in their country of origin rather than include more healthy selections referred by nutritionists.

During the field interviews there were at least two subjects, domestic violence and violence against women, that were absent from discussion and conspicuous by their absence. For the most part, Russian-speaking providers were particularly silent about this subject even when questioned directly.

The following are common comments (paraphrased) made by service providers about these culture differences and their implications:

1. Clients need a lot of reassurance and explanations about their health problems.
2. Russian-speaking patients are not familiar with preventative or prophylactic therapies. They may not be compliant with medication taken for this purpose, or with screening exams.
3. Patients are used to being told what to do and what to take for their health problems. They are not used to being active participants in the interaction between doctor and patient.
4. In the former Soviet Union alternative therapies are commonly prescribed along with more "accepted" therapies. When these are lacking in treatment regime, patients believe care is not complete.
5. Psychiatric and emotional problems carry a heavy negative stigma.

Russian-speakers are one of the fastest growing group of consumers of mental health services in San Francisco. Prior to 1993, Richmond Area Multi Services, Inc. had no Russian-speaking patients. At the time of the interview 300 Russian-speaking patients were receiving mental health services at the clinic. The majority (two-thirds) of Russian-speakers were women in their

late fifties through early sixties. Two thirds had no previous psychiatric history, but within a few years of arrival in the United States, they developed severe psychopathology; major depression, anxiety disorder, post traumatic stress disorder and other somatic complaints.

Many newcomers suffer from depression and stress due to the tremendous losses they suffered and/or shifts in their lives. However, because psychological problems are stigmatized in the culture, it is not acceptable to discuss one's problems outside the family. Thus, mental health issues may be underreported and services underutilized. Newcomers may prefer to seek treatment at primary health care facilities and receive medications to help deal with their depression or stress without addressing the cause or considering stressors as possible causes of illness.

The overwhelming majority of health care providers and those involved with refugee and immigrant services indicated that stress was a very serious health problem in the Russian-speaking population. It has been identified as a leading cause of somatic illness either directly or indirectly and the outcome of a complex set of circumstances ranging from pre-arrival psychological problems to economic struggles to culture shock.

Refugee and immigrant populations experience levels of stress because of the added burdens of acculturation, communication problems, and circumstances of their flight. The following are conclusions reached by health care providers about causes of stress in the Russian-speaking population and their ability to cope with stress: experiences prior to arrival, economic struggle in America, separation from family in homeland, inability to gain legal status, discomfort with American culture and "ways of doing things" (culture shock), failed expectations about life in America, frustration in dealing with administrative and bureaucratic procedures, fear and distrust of authority in America, and anxiety over the future of their children

In general, the most important issues for the target population are language acquisition, employment and affordable housing. On the strength of these needs it is apparent that the Russian-speaking refugees and immigrants have a keen desire to quickly become functioning members of the communities and to follow previously established cultural practices of work and self-sufficiency. Those newcomers that obtain refugee status or a green card can receive benefits at least for the first few months in order to begin to get established. After that it becomes more critical for them to quickly obtain language skills.

Some of the common behaviors that providers find challenging to deal with are the community members' mistrust and passive-aggressive behavior towards authority, enmeshment

or dependence on the service community, intolerance of differences, and unrealistic expectations of life in the United States. Many people from the former Soviet Union had an image of life in the United Sates which did not include homelessness, unemployment, racial problems, high crime and other unfortunate realities. This causes many Russian-speaking newcomers to become highly disappointed, and sometimes overly demanding.

Resettlement problems affect all ages of Russian-speaking newcomers. Many children and youth experience resettlement problems. There is an adjustment due to the difference in education system, language and culture. Tensions arise when teenagers no longer desire to speak Russian in many newcomers' households, especially when grandparents speak only Russian. There is reportedly no Russian speaking staff member at the Youth Guidance Center; a detention center for arrested youth. Teenagers and their families report problems when providers lack cultural sensitivity training. There is also a lack of linguistically appropriate materials on date rape, domestic violence, health issues etc. for youth

The 25-49 years old age group could benefit from English classes, vocational training, and employment opportunities. Health is not a priority for this age group. In general they are very concerned with issues such as housing, jobs, language, children's education and acculturation. They specifically need mental health/community/social services for Russian-speaking parents. There may be gaps in services such as parenting classes, substance abuse and domestic violence prevention programs.

The most significant resettlement issues are with the 50-65 year old population. It is found that many are welfare qualified, but not qualified for Social Security benefits, so their income is insufficient for the high cost of living in San Francisco. This group, more than others, needs Russian-speaking service providers, affordable housing, culturally appropriate health care, mental health care and supportive services programs.

D.2. Key Informant Interviews: Tobacco-Related Issues, 2000

Smoking is widespread among all socioeconomic classes. Key informants estimated that from 30% to 80% of Russian-speaking newcomers smoke, and men smoke much more than women. A practicing Russian doctor admitted that the majority of Russian doctors smoke. Many Russian-speakers say they know that smoking is bad for them, but don't believe it will hurt them. Their preference is to eat and smoke as much as they want in spite of losing extra years of life. They don't want to be told what to do and wouldn't respond to a heavy-handed

campaign.

Both male and female teens are smoking more frequently than in the past. This information is consistent with prevalence rates in the former Soviet Union and tobacco industry targeting in Eastern Europe with the fall of Communism. There is awareness that secondhand smoke is bad for one's health.

The respondents mentioned that Russian-speakers need a gentle approach with hard facts, and made these recommendations: approach people through strong love of family, to take care of themselves in order to provide for family and acculturation; emphasize issues improving quality of life in this new country; and, tie-in education with fun trips or cultural events.

On the positive side, these people are immigrating into California where tobacco use is not the norm, and where there are many healthy alternatives. It was mentioned that as Russian-speaking newcomers become more acculturated, particularly high tech workers, they began to quit smoking due to its social unacceptance.

E. Focus Groups

E.1. Focus Groups: General Health and Social Service Issues, 2000

Some focus group participants have a lack of trust in western medicines and the health care system. They expressed dissatisfaction with the difficulties of scheduling appointments by phone because of the language barrier. There is a lack of front office interpreters. Some participants are unhappy with the fact that it takes too long to obtain an appointment with a doctor and the emergency room wait is very long. Some participants complained about the short duration for hospitalization. They perceive this as a sign of not receiving adequate medical treatment. Focus group participants at the Refugee Medical clinic expressed appreciation for the clinic. Participants noted great satisfaction with the services and health/medical information provided by the doctors and nurses from San Francisco General Hospital and Mt. Zion Hospital.

Most participants mentioned they get their health care information from television first (Russian, and American shows such as ER and Chicago Hope). Russian newspapers are also another source of health information. All participants answered that they do not read brochures.

While none of the respondents were smokers, they all were aware of the health hazards of smoking and secondhand smoke. They were also happy with the non-smoking laws in California.

Respondents were asked to name the top three illnesses among Russian-speaking

newcomers. Depression was the first illness mentioned by all respondents. The second most frequently mentioned illness was high blood pressure/heart disease/high cholesterol. Arthritis and diabetes were also named as top illnesses. Respondents also spoke of dental problems and needing dentures that are very expensive and the costs are not covered by Medi-Cal insurance. The high cost of private insurance is prohibitive.

Participants requested more mental health programs, support and services. Some specifically requested special stress reduction programs. The language barrier was reported to cause significant stress on a daily basis.

Respondents cited problems with adjustment to life in the United States. Participants cited a lack of affordable housing in San Francisco, which caused stress and dissatisfaction. Some expressed fear of homelessness. Several respondents stated that they are pressured to move by landlords who want to charge new tenants higher rents.

Respondents cited loss of country, work and status as their biggest problems. After being respected and needed professionally for thirty or forty years, having no chance of employment is very difficult. Many respondents were frustrated at not having jobs since leaving their country of origin. Some commented about having a profession before coming here and now they have no work. There is a lack of vocational rehabilitation.

Many reported being grateful to be in America and acknowledged that their lives are better here overall. Participants felt that San Francisco is a beautiful place to live, people are very nice and very helpful; people try to understand when Russian-speaking newcomers talk or when they place a call. Public transportation is convenient and they like the accommodations for people with physical disabilities.

E.2. Focus Groups: Tobacco-Related Issues, 2000

All the focus group participants who are health workers knew the dangers of secondhand smoke. They believe that Russians are well-informed but choose to ignore the information. The youth understood its dangers, but perceived that the community regarded it as unpleasant rather than harmful. Two of the parents were uniformed about secondhand smoke. Respondents estimated that 20% to 80% of Russian-speakers use tobacco products. One participant, who works in health care services, estimates that about 80% of Russian-speaking patients at the site are smokers. It was reported that there is still some smoking in restaurants, restrooms and parks where Russians congregate.

All groups want to see tobacco awareness information packaged in beautiful images or humor rather than a hard sell. They felt that incentives were needed to get participants involved in the program. It was also suggested that tying in educational programs to cultural, recreational or socializing opportunities would be attractive.

In terms of outreach, respondents suggested direct mail, pamphlets and videos in both languages. Outreach from social service agencies, the faith community, Russian language media and Russian community concerts were also mentioned. Respondents also emphasized free help and personal contact. Russian-speakers strongly value their cultural history and would like to see entertainment figures in the campaign. They felt it would counteract the perception that all Russian cultural heroes, such as literary figures, are heavy smokers.

Youth and parents cited their perception that merchants care only about profits and break the law in regards to selling cigarettes to minors. Respondents suggested a poster summarizing tobacco laws be displayed in merchant's establishments. Respondents suggested the barriers to a successful anti-tobacco program are ignorance, a loosely organized Russian community and an unwillingness to change. Respondents felt that word-of-mouth and healthy parental direction would be good ways to encourage non-smoking behaviors. Health professionals were seen as important allies.

In another focus group, advertising executives from Russia stated that the tobacco industry influence in the former Soviet Union is intense and the advertising is very aggressive. There is an incredible amount of advertising, no counter ads and very little regulation. Tobacco billboards are everywhere and scantily clad women distribute free samples. At minimum, we can assume from the data on the tobacco environment in the former Soviet Union that newcomers arrive with a cultural norm that finds tobacco use normal.

The executives suggested that people implementing small anti-tobacco campaigns take any successful pre-existing health promotion ads, research how they work and project them on the Russian community. The following suggestions were made:

1. Analyze the message and rework it to appeal culturally to the Russian-speaking community.
2. Research competitors for clues on how to counteract them.
3. Show consequences such as bad teeth, bad breath, or individuals with cancer.
4. Show a happy life without tobacco.
5. Show a house made out of cigarette packages to show how much money is spent on their habit.

6. Use the Russians' cultural attraction to comics as a way of appealing to their humorous side.
7. Suggest a play on words which makes fun of the Russian fatalist mentality.
8. Emphasize that part of the American experience is not smoking.
9. Focus on youth uptake.

VII. Discussion

Some Suggestions For Service Providers

As discussed throughout this report, there are many issues impacting the Russian-speaking newcomer community in San Francisco, a community that has many strengths it can draw on. As with any immigrant community there are similarities as well as differences among community members, and these impact their resettlement and adjustment experience.

The overall most common issues identified throughout this assessment are stress and depression among the newcomers. While long term psychosocial problems such as previous traumatic experiences, acculturation, intergenerational communication problems, family conflict and economic struggle cannot be solved easily, stress reduction and improvement of coping skills would ease the burden of these problems which can be overwhelming and cause much distress and suffering.

In general, one of the most critical issues for service providers is that we learn about and attempt to understand the culture, background and trauma that this community has faced in the past and is currently facing as newcomers resettle in the United States. Language is a major barrier for newcomers, however cultural misunderstandings can sometimes create a larger barrier than language, and one that is not as easily overcome. It is critical that service providers bridge that gap by educating themselves about the community and developing approaches, programs and services that bear in mind socio-cultural issues. Likewise, we need to provide newcomers with clear information about health and social services and how to access them, and educate them about our service delivery culture. Our hope is that this assessment report can help build a two way street of cultural understanding and cooperation.

In conclusion we have outlined below a list of findings and recommendations from our experiences while conducting the various steps of this assessment.

Some General Findings from the Assessment

1. *Diversity:* There are many differences in the waves of Russian speakers who live in the San Francisco Bay Area. There are subgroups based on the country of origin, religious practice, immigration status, age and socio-economic status.
2. *Physical health issues:* Chronic diseases such as hypertension, diabetes and heart disease are

very common. Diseases of the musculoskeletol system and connective tissues, diseases of the nervous system and sense organs, and rheumatoid arthritis are also common. Some of these are most likely related to lifestyle, diet and tobacco use.

3. *Mental health issues:* Loss of country, work and status cause many Russian-speaking newcomers to feel depression and stress. Many of the elderly have feelings of depression and become isolated due to a lack of English language skills. Some do not seek assistance in health care because they are uninformed about services available or due to the stigma associated with mental health.
4. *Employment opportunities:* Most Russian-speakers are well-educated and well-trained. However, due to language limitations or lack of current technology skills many are unable to get work or earn a substantial wage for the high cost of living in San Francisco.
5. *Supportive services:* One of the most frustrating areas for these newcomers is the lack of qualified Russians-speaking interpreters and service providers at many health centers and social service agencies. Many Russian-speaking newcomers expressed their appreciation for the health care providers at the Refugee Medical Clinic, Mt. Zion Hospital and San Francisco General Hospital.
6. *Housing:* The high cost of housing in San Francisco is a major concern for many Russian-speakers. Many fear homelessness. We are seeing a larger population settling in unsafe neighborhoods such as the Tenderloin and the Western Addition. Others move out of the city to suburban areas such as Daly City, Richmond, Walnut Creek and even to Sacramento where there is a large Russian population.
7. *Youth issues:* Youth tend to acculturate faster into the community than the older generations. Many don't want to speak Russian and this causes a communication problem with elderly family members who may only speak Russian. In addition, some Russian service providers perceive that Russian-speaking youth have a much higher smoking prevalence rate than American teenagers. If this is true, tobacco-related diseases will continue to affect this community at higher rates than the general population.
8. *Great strengths:* Russian-speakers know how to "find their way" in the culture and have a desire to work and become successful in the new environment. They are resourceful, resilient and developed skills in their homeland for getting around obstacles. They have a strong sense of family and a very good work ethic.

Recommendations

We based these suggested recommendations on the information gathered in this assessment. We believe that these could significantly and positively impact the health, well-being and resettlement experiences of Russian-speaking newcomers in San Francisco.

1. Increase access to health care services by providing the newcomers with an extensive orientation to the health care system in the U.S. (and more specifically in San Francisco) so they will better understand the process and be able to utilize services.
2. Develop health education prevention programs such as hypertension management, diabetes management and healthy eating programs that are culturally and linguistically appropriate. Use bilingual, bicultural staff to conduct outreach and implement activities.
3. Implement cultural competency training at all levels of service provision. Provide funding for more native language brochures, one-on-one education and native language videos.
4. Increase the availability of interpreter services and Russian-speaking providers throughout the health and social services arena.
5. Conduct social support groups for Russian-speaking newcomers citywide and develop mental health services that specifically meet the needs of older Russian-speaking community members. Identify and outreach to groups that are not seen as well as those that are more visible by their presence in the various assistance programs offered by service agencies. Very often those that are the least visible are, by definition, the ones that need the most attention from social service agencies and others in the community.
6. Develop youth and intergenerational programs to enhance family connections and build on cultural strengths.
7. Incorporate alternative medicine, stress reduction and coping strategies into more traditional health and social services models that are common in the United States. This idea is based in part on models practiced in the former Soviet Union, thus it is not only culturally appropriate but would also build trust in the community.
8. Increase the number of vocational training and job placement programs that serve Russian-speakers with limited English skills.

Lessons Learned from this Assessment by the Newcomers Health Program

As noted in earlier discussions (e.g. methodology and findings), there were a number of challenges we encountered implementing this community assessment. In this section, we would like to outline some of our thoughts for other agencies or programs thinking of conducting their own community assessment activities with Russian-speaking newcomers or other new refugee communities.

First of all, with any newcomer community, even after several years of resettlement, finding/compiling data and statistics, such as basic demographics, socioeconomic or health status, can be a major challenge. Limited information may be available from primary or secondary sources, provided their ethnicity or country of origin is recorded by public or private agencies.

Funding and staff resources were very limited to conduct this assessment. We did not have direct funding to support the majority of this project and thus had limited dedicated staff time. Through collaborations with the Masters in Public Health program at San Francisco State University, the Newcomers Health Program conducted many of the assessment activities in stages through the efforts of graduate student interns.

Furthermore, we found invaluable advice and feedback from staff at community-based agencies serving Russian-speaking newcomers. Key to implementing the activities was the involvement of our Russian-speaking staff, since they have had prior personal contacts as well as working relationships with the Russian community through resettlement and health services

VIII. References

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Appendix A
Refugee Medical Clinic Patient Health Education Assessment Survey
English Version

Thank you for taking the time to fill out the survey. The purpose of this survey is to gather information about health education needs of the patients at the Refugee Medical Clinic (RMC). The information you provided here will help us design health education programs for the RMC patients.

Today's date: _____

Please tell us about yourself

1. What is your gender?

   __ Female __ Male

2. How old are you?

   __ Under 18 __ 18-35 __ 36-65 __ Over 65

3. What is your marital status?

   __ Single __ Married __ Divorced or Separated __Other: _____

4. What is your country of birth?

__ Former USSR __ Bosnia __ Vietnam
__ Iraq __ Other: _____

5. How well do you read in your native language?

   __ Very well __ Somewhat __ Not at all

6. How well do you read in English?

   __ Very well __ Somewhat __ Not at all

7. How well do you understand English?

   __ Very well __ Somewhat __ Not at all

Please tell us about your interest in health education

8. Are you interested in learning more about taking care of your health?

   __ Yes (Please go to #10) __ No (Please go to #9)

9. If no, please briefly explain why below: (Then please go to #12)

_____

10. If yes, which of the following common health issues are you interested in learning more about? (Please check all that apply)

__ Arthritis
__ Asthma/breathing problem
__ Blood pressure
__ Depression
__ Diabetes
__ Heart disease
__ Hepatitis
__ HIV/AIDS
__ Immunization
__ Nutrition
__ Pregnancy care
__ Tuberculosis
__ Managed care
__ Smoking Cessation
__ Family planning/birth control
__ Women's health (Pap smear, breast exams)
__ Other: _____

11. Which of the following ways of learning do you prefer?
(Please check all that apply)

__ Brochure/pamphlet in your native language
__ Brochure/pamphlet in English
__ One-on-one education from your health care provider or interpreter
__ Watching a video in your native language
__ Watching a video in English
__ A small group discussion or class on specific topics in your native language
__ A small group discussion or class on specific topics in English
__ Other: _____

12. Is there anything you would like to tell us about your experience at Refugee Medical Clinic?

_____

Thank You!

Appendix B
Refugee Medical Clinic Patient Health Education Assessment Survey
Russian Version

Appendix C
Russian-Speaking Community Assessment
Key Informant Interview – Community Organizations
General Health and Social Issues Questions

Interviewee Name: _____

Title: _____

Ethnicity: _____

Country of Origin_____ Religion_____

Sex: □ Male □ Female

Name of organization or agency: _____

Address:_____

Phone/Fax: _____

Date: _____Time started interview: _____ Time ended: _____

Interviewer Name: _____ □ Via Phone □ In-person

1. What programs or services does your agency provide?

□ monetary □ food □ housing □ job-related
□ orientation to U.S. □ recreation □ mental health/counseling/support groups
□ citizenship classes □ ESL □ religious
□ other:
_____

2. What geographic areas/neighborhoods do you serve?

□ SF County: _____ □ Bay Area: _____

3. What other refugee groups does your agency serve?

□ Middle East: □ Africa: □ Europe: □ East Asia:
□ The Americas & the Caribbean: □ South & Central Asia:

4. What do you think are the top 3 health/psychosocial/resettlement issues for Russian speaking refugees?

□ affordable housing □ employment □ learning English □ mental health
□ health care □ day care □ crime/safety □ transportation
□ education/school □ culture shock □ intergenerational gap □ adaptation
□ other: _____

5. What are the obstacles and/or barriers to addressing these issues?

6. What do you think are the strengths and assets of the Russian-speaking refugee community in the SF Bay Area?

(e.g. What are some of the ways they are coping with their new lives here? Any mutual support groups or assistance groups? Tight neighborhoods, extended families, a helping network to find jobs, child care, shopping needs, language needs?)

7. In which neighborhoods do many of them first settle? To where do they later move?

8. What are the expectations of newly arriving refugees concerning the assistance your agency provides?

9. Have you experienced any particular challenges working with Russian-speaking refugees? (e.g. health-related beliefs or practices, including health care seeking practices)

10. What are some cultural, social or political considerations in working with them?

11. What programs or resources in the community have been effective, or ineffective, in helping them resettle, or hindered them, and why?

12. Are they successful in becoming part of the community? Why or why not?

13. What other groups do you think we cold work with to develop programs for Russian-speaking refugee (i.e. existing Russian community)?

14. Any suggested needed services, collaborations or interventions? (What specifics would make them successful to reach Russians in particular?)

15. What are your perceptions of the RMC or Newcomers Program (Do you know of the RMC/N.P.? Any realistic/new ideas for N.P.'s role in the community and other services that could be provided? Other agencies that could work in coalition w/N.P.?):

16. Referrals/Other contacts you can recommend to us (what other agencies work w/Russians or individuals/ key informants should we contact), can help in distributing surveys to Russians, and follow-up issues:

17. Other observations/notes:

Appendix D
Russian-Speaking Community Assessment
Key Informant Interviews - Health Provider Questions

Interviewee Name:_____ Title: _____

Agency/Address:_____

Length of time working w/Russian-speaking community in current job: _____

Ethnicity: _____Country of Origin_____

Sex: □ Male □ Female

Date: _____ Time started interview: _____ Time ended: _____

Interviewer Name: _____

□ Via Phone □ In-person

GENERAL HEALTH

1. What do you perceive to be the major health needs of Russian-speaking refugees initially arriving in the U.S. during their 1st few months, and later in their resettlement (after one year or more)? (e.g. TB treatment, orientation to the health care system, preventive health, dental care, family planning, maternal/child health, nutrition, mental health care or chronic conditions, communicable diseases, etc.)

2. To the best of your knowledge, what are some of the barriers to Russians receiving medical care and health education?

3. What do you suggest as a way to address these barriers?

4. What major health concerns are they self-reporting?

MENTAL HEALTH/SOCIAL SUPPORT

1. Do RMC providers typically screen for mental health needs?

2. What, in your opinion, are the major mental health problems among Russian-speaking refugees in the U.S.?

3. Which mental health services offering support to Russian-speaking refugees are you familiar with?

4. Do you, or anyone else you work with (e.g. interpreters), refer Russian-speaking refugees to any of these services?

5. If Russian-speaking refugees with mental health needs are not seeking help, why do you think this is? (cultural/religious barriers, lack of information, fear, stigma, poor access, other)

6. Can you suggest ways of overcoming these barriers and dealing with mental health problems of Russian-speaking refugees?

7. Do you think they want mental health providers from their country of origin or U.S.?

8. Based on your knowledge of Russian-speaking refugees, what could you identify as their primary means of social/psychological support? (e.g. What are some of the ways they are coping with their new lives here? Any mutual support groups or assistance groups? Tight neighborhoods, extended families, a helping network to find jobs, child care, shopping needs, language needs?)

FAMILY PLANNING

1. What methods of prescription and OTC contraception do Russians commonly use (back in home country vs. U.S.)?

2. Are Russian-speaking refugees informed about how these methods prevent a pregnancy? (how they work, how they are used, do they think they work well, do they think they are safe?)

3. Which person(s) do you think would influence their decisions to use contraceptives and a particular method? (e.g. spouse, partner, parent, sibling, friend, health professional, etc.)

4. If Russian-speaking refugee women in the U.S. do not use reliable family planning methods, why do you think this is?

5. What kind of help do you they would like with family planning in the U.S.?

6. What do they feel is the ideal family size? I their country? In the U.S.?

PREVENTIVE CARE

1. Do they appear to be knowledgeable about preventive health strategies available in the U.S.? (e.g. BSEs, CBE's, mammograms, pap smears, childhood immunizations, prenatal care, dental check-ups, avoiding substance abuse, including tobacco, alcohol, caffeine, domestic violence?)

2. Do they seem aware of how these work to maintain good health, what is involved and the importance of these services?

3. Do many Russian-speaking refugees utilize preventive services here in the U.S.? Who uses which services?

4. What are their attitudes/beliefs about smoking?

5. What are some helpful strategies to address smoking (e.g. cultural, family issues)?

HEALTH EDUCATION ISSUES

1. What do you think Russian-speaking refugees would like information on (or have expressed interest in)?

- ❑ prenatal care □ tests offered during pregnancy □ nutrition
- ❑ infant and child care □ family planning and women's reproductive health
- ❑ care for the elderly □ care for specific chronic complaints
- ❑ mental health/social support □psychosomatic health issues
- ❑ substance abuse □smoking cessation □infectious diseases
- ❑ other (specify): _____

2. How do you think Russians would most like to receive health education information?

□ Phone consultation or phone information line
□ Through the media (please specify): _____
□ One-to-one consultation
□ Have written materials in Russian in the clinic/doctor's office or other agencies
□ Provide a class or support group (please specify topics): _____
□ Hold community meetings
□ Other (please explain): _____

OTHER ISSUES

1. Have you experienced any particular challenges working with Russian-speaking refugees? (e.g. Cultural, social, political or health-related beliefs or practices, including health care seeking practices)

2. What other groups do you think we could work with to develop programs for Russian-speaking refugees e.g. existing Russian community, community agencies, health programs)?

3. Referrals/Other health providers in the community you can recommend to talk with us, other follow-up issues?

Appendix E
Russian-Speaking Community Assessment
Key Informant Interview - Social Service Provider Questions

Overall Objectives:

1. To inquire about specific environmental and social conditions which indirectly or directly affect the health of people in the RSR community.

2. To understand the comparative vulnerability of certain age groups in that population.

3. Clarify the role and (self) perceived services which that agency provides.

4. Describe the constraints and/or frustrations which the service agency experiences in trying the meet the needs of the RSR community.

5. Express how the RSR community prioritizes its own social service needs, as they relate to health.

6. Introduce and inform the agency about Newcomers Health Program.

TOPIC CHECKLIST

1. Housing: Availability; Expectations; Security

2. Environment of the Home

3. Heat: Crowding; Water; Sanitation

4. Acculturation: Community cohesion; Integration (self imposed isolation or attempts at integration); Self help to aid acculturation; Outside aid to acculturation and how accessed

5. Faith support: Role of the faith community; Support by the faith community; Services;

6. Sources of Information: How accessed, by what medium; Information seeking practices

7. Outreach: How; What groups are left out; What attempts have been made to reach marginalized groups

8. Gang activity: Prevalence; Alternative outlets for youth; Actual versus perceived threat

Appendix F
Russian-Speaking Community Assessment
Key Informant Interview - Across Agency Questions

Agency Name/Department: _____

Address: _____

Contact: _____

Phone: _____

Services Available: _____

Russian Language Services Available? Yes/No _____

Questions

1. What are the 5 most common reasons refugees seek assistance in this agency?

2. What is the process for processing refugee requests for assistance?

3. Do you have a designated person in the agency that works with the Russian speaking population?

4. Can you estimate what percentage of your clients are from the Russian speaking refugee or immigrant population in San Francisco?

6. Have your Russian speaking clients indicated whether they found the services helpful?

7. How do the RSR find out about your agency?

8. Are there particular constraints on your agency's ability to deliver services to the RSR population?

9. How do the RSR community expectations of your agency's services match actual services?

10. Does your agency have a referral system?

11. How would you rate your services to the RSR population. Equal to other community groups, better, would like improvement, don't know.

12. What do you believe is your agency's most effective service the RSR community? To other populations?

13. Did you know about Newcomers Health before this interview?

Appendix G
SUNSET Russian Tobacco Education Project
Key Informant Questions

Questions

1. How do you work with Russian speaking newcomers? How many do you work with?

2. Estimate the number/percent of Russian newcomers who smoke through your contacts. Describe this population of smokers:
□ age □ income (low, middle, high) □ other unique characteristics

3. What are the attitudes and behaviors related to tobacco use? Follow up questions: How about when gender and/or acculturation levels differ? (acculturation is how well someone has assimilated into American society)

4. Is it common to smoke in the home? (where, when, by whom etc.) Even if there are children present?

5. Are there areas in the community where Russian speaking Newcomers smoke in public places? Please identify and describe them:

6. What is your opinion of the Russian speaking community's tolerance toward smoking in public places or selling tobacco to minors?

7. What are some of the challenges/barriers to the success of this proposed program?

□ Historical? □ Political? □ Economic? □ Cultural? □ Other?
□ How do we overcome these?

8. What strengths does your community have which would facilitate the success of this program?

□ Historical? □ Political? □ Economic? □ Cultural? □ Other?
□ How can we build on these?

9. Is there anything else you can tell us that will help us understand the tobacco-related issues facing this community? Please describe:

Appendix H
Russian-Speaking Community Assessment
Focus Group Questions

Introduction

I would like to welcome all of you to our discussion today. We thank you for taking the time to talk with us. My name is _____ and (introduce all team members). We are all graduate students at San Francisco State University in Public Health and are working with Newcomers Health Program. We are conducting activities with the Russian-speaking community and want to listen to what health concerns you may have. It is our intent to use the information that you share with us today to provide your community with relevant health information and services. You were selected because you represent the newcomer Russian-speaking community. For data collection purposes, this session will be recorded. However, no information will be linked to you or your names specifically. Do you have any questions or concerns before we begin?

1. **Let's go around the room and find out everyone's name and how long you have lived in San Francisco.**

2. **Our program would like to provide health information and improve the overall well-being of the Russian newcomer community. What suggestions do you have for us?**

3. **Moving to San Francisco has been a special experience for each of you and your families. What are some of the things you like most about your life here? What are some of the things you like least about life here?**
   Probing: What are some of the ways you are adjusting to life here?

4. **What are the top three illnesses among Russian-speaking newcomers who you know?**

5. **If someone you know is feeling sick, what would you tell them to do?**
   If someone you know feels "blue" or sad, what would you tell them to do?
   Probing: Where would you tell them to go?

6. **How or where do you get health information?**
   Probing: if they come up with answers, then can suggest. TV, radio, newspapers, friends, adult children/grandchildren, doctors, nurses - - If media, which newspapers, tv shows, radio stations, etc.

7. **What do you know about the health problems of people who smoke cigarettes? What do you know about the health problems or people who live or work with smokers?**
   Probing: Do you know anyone now who is ill because of smoking? Who quit smoking? If so, how did they quit?

8. **Does anybody have anything else they would like to talk about that we have not already discussed?**

Appendix I
SUNSET Russian Tobacco Education Project
Focus Group Questions

Questions:

1. How many smokers are in your family?

2. What have you heard about secondhand smoke?

3. Finish this sentence: Your Russian friends think that smoking is....

4. What are the most effective messages for attracting people's attention to tobacco-related issues?
(A follow up question can be tailored to the specific issue you have in mind.)

5. What are the most important things that we should keep in mind when developing tobacco education materials and programs for your community?

6. What are the best places for sharing information in your community?

7. What is the most effective format for communicating with your community: videos, posters, pamphlets, radio announcements, music, community events, spokespersons such as sports and/or entertainment figures?

7. Which radio and television stations do you and your friends listen to/view?

Appendix J
Russian-Speaking Community Assessment
List of Key Informants

Arinkoff, Elena (1999). Case worker at Diocese Outreach.

Baylin, Marina (2002). Health at Home Agency, San Francisco Department of Public Health

Boyko, Nina (1999) Refugee Medical Clinic, Newcomers Health Program

Buick, Nick (2002). Director of Russian American Community Services.

Dubon, Lisa (1999). San Francisco Department of Human Services.

Flom, Zinovy (2000). Former Program Assistant, San Francisco Senior Center.

Goldenshteyn, Irina (1999). Catholic Charities of San Francisco.

Greenberg M.D., Lisa (1999). Jewish Family and Children's Services, Émigré Department.

Grzhonko, Leonid (2000). Board Member, Jewish Community Center of San Francisco; Board Member, Jewish Family and Children's Services.

Hoover, Diana (1999). Richmond Area Multidisciplinary Services (RAMS).

Johnson, M.D., Lisa (1999). Medical Director. Ocean Park Health Center.

Lipson, Juliene G. (2000). Culture and Nursing Care: A Pocket Guide. UCSF School of Nursing, UCSF Nursing Press, 2000. (Chapter by Luba J. Evanikoff.)

Litt, Barbara (1999). Jewish Community Center, Russian Émigré Department.

Margolin, Rabbi (2000). Director, Techia Corporation (non-profit religious organization); Founder, Institute of Leaders of Immigration; Editor, "Jewish World" (Russian language paper).

McGirr, RN, MPH, Kevin (1999). Department of Public Health, San Francisco.

Mednikova, Marsha (1999). Richmond Area Multidisciplinary Services (RAMS).

Mogilev, Bella (2000). Health Interpreter, Newcomers Health Program, Refugee Medical Clinic

Nisenzon, M.D. Boris (2000). Board Member, Colleague (Organization of retired doctors from FSU); Board Member of Active Longevity (a Russian Jewish seniors organization); Foreign Medicine Correspondent, "Doctor's Gazette" (Moscow paper), and many other Russian newspapers.

Obosky, Diana (1999) Case manager. Mt. Zion Outpatient Services.

Obukhova, Yelena (1999). Richmond Area Multidisciplinary Services (RAMS).

Orthodox Church Worker (2002). Anonymous source.

Ostergren, Maisha, (1999). Refugee Transitions.

Pavlova, Inna (1999). Jewish Vocational Services.

Pearl, Lauren (2000). Youth Program Coordinator, Jewish Family and Children's Services.

Pulshik, Eleanor (1999). San Francisco Department of Human Services.

Radom, Olga (2000). Refugee Medical Clinic, Newcomers Health Program

Rozman, Ella (1999). International Institute of San Francisco.

Rudoy, Irina (1999). Tuberculosis Clinic, Newcomers Health Program, and University of California, San Francisco.

Simon, M.D., Ann (1999). Ocean Park Health Center.

Yusupova, Natalya (2000). Club Noon Program Coordinator, Jewish Family and Children's Services.