PROMOTING CARDIOVASCULAR HEALTH AMONG NEWCOMERS FROM THE FORMER SOVIET UNION

by

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ABSTRACT

Cardiovascular disease (CVD) is the leading cause of death in the United States and globally. Risk factors for CVD include obesity, dyslipidemia, hypertension, diabetes mellitus, sedentary lifestyle, smoking, and excessive alcohol use. These risk factors are modifiable but require the vigilant adherence to specific behaviors to reduce risk. Health promotion interventions for CVD in the United States encourage people to adopt healthy lifestyles, presuming that participants will use knowledge of risk to initiate and maintain healthy behaviors. Such assumptions are underpinned by mainstream American cultural values of individual autonomy and responsibility, which may not be universal to vulnerable immigrant populations. Newcomers from the Former Soviet Union (FSU) are a vulnerable group who suffer disproportionately high rates of CVD in their home country and in the United States and who have culturally-specific expectations of health care. The growth of the FSU newcomer population in the United States has resulted in a clash of cultures, and health care providers are challenged to find effective ways of promoting cardiovascular health among this population.

This project uses a conceptual framework of social cognitive theory (SCT) embedded into a social ecological approach to identify facilitators and impediments to health promotion among FSU newcomers, and to suggest health promotion strategies that are most appropriate for this population.
CHAPTER ONE: THE PROBLEM

Chronic diseases such as cardiovascular disease (CVD) long ago surpassed infectious diseases as the leading cause of mortality and morbidity in the United States. Vulnerable populations, which are growing steadily with increasing rates of immigration to the United States, suffer disproportionately from chronic diseases due to social and cultural factors. Chronic diseases and the risk behaviors that contribute to them are typically addressed by the promotion of healthy lifestyles. Health promotion as practiced in the United States focuses primarily on behavioral modification interventions, of which education is the one most widely practiced in Nursing. American dominant cultural values underpin health promotion practices in the United States, but these values may not be valid for vulnerable populations. Thus the challenge facing health care practitioners and policy-makers is how to effectively promote health among vulnerable populations to reduce chronic disease. This project is designed to address this challenge.

Purpose and Aims

The primary purpose of this project is to identify effective health promotion approaches for vulnerable populations. Using newcomers from the Former Soviet Union (FSU) as a proxy for vulnerable populations, this project examines questions about health promotion by elucidating the links between health behaviors and CVD among older newcomers from the FSU, situated within the social context of recent migration from the FSU to the United States. More specifically, this project uses a conceptual framework of social cognitive theory (SCT)
embedded into a social ecological approach to identify facilitators and impediments to health promotion among FSU newcomers, and to suggest health promotion strategies that are most appropriate for this population.

The secondary purpose of this paper is to lay the foundation for a Practice Inquiry project to evaluate a community health promotion program currently underway with FSU newcomers in San Francisco. The evaluation will analyze the Chronic Care Model (CCM) used to guide the design of the program, and identify strengths and weaknesses of the model for health promotion.

The specific aims of this Master’s Report are to:

1. Provide a brief overview of concepts relevant to health promotion with vulnerable populations to provide an analytical framework for the project
2. Complete a structured literature review of health determinants of FSU newcomers following a social ecological framework and SCT principles
3. Identify facilitators and impediments to health promotion among FSU newcomers and link them to health promotion approaches
4. Propose a practice inquiry project which will evaluate a health promotion program currently being implemented with FSU newcomers

Overall, the practice inquiry project will help bridge gap between health promotion theory and practice, leading to improved interventions for health promotion among FSU newcomers, and possibly serving as a model for other vulnerable populations.
Background and Significance

According to the Centers for Disease Control and Prevention (CDC), chronic diseases such as CVD, diabetes, and chronic pulmonary obstructive disease, are the leading causes of death and disability in the United States (CDC, 2010). Chronic disease accounts for more than 50% of all deaths in the United States each year and 60% of all deaths worldwide (CDC, 2010). Not only are chronic diseases deadly, but they are largely preventable. Four health-related behaviors (unhealthy diet, physical inactivity, tobacco consumption, and excessive use of alcohol) are key risk factors for many chronic diseases that constitute a rapidly growing health burden globally (World Health Organization [WHO], 2009). These risk behaviors are influenced by social determinants of health such as stress and poverty (WHO, 2009).

The recognition of the role of individual behavior in chronic disease combined with an appreciation of underlying social factors has led to the growth of the field of health promotion. The WHO defines health promotion as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health" (WHO, 2010, p. 8). The United States Department of Health and Human Services (HHS) provides guidelines, goals, and health indicators for U.S. public health promotion through its program Healthy People 2010, currently being updated for 2020. (HHS, 2005). The vision of Healthy People 2010 is “healthy people living in healthy communities,” with the overarching goals of increasing quality and years of life and eliminating health disparities (HHS, 2005, p.1).

The HHS defines health disparities as “differences in the occurrence, frequency, death, and burden of diseases and other unfavorable health conditions that exist among specific
population groups, including racial and minority groups” (Agency for Healthcare Research and Quality [AHRQ], 2007, p. 12). The authors of an Institute of Medicine (IOM) report from 2002 found that, in the United States, health disparities “do exist, even when controlling for insurance status, income, age, and severity of condition” and that the challenge confronting United States health care now is not debating the existence of disparities, but designing effective interventions to reduce and eliminate them (IOM, 2002, p. 21). The disparities among immigrant populations identified in the literature have commonly been attributed in part to high levels of acculturation stress, lower socioeconomic status, discrimination, and limited access to health care services due to language and literacy barriers and/or lack of understanding of how to navigate the terrain of the United States health care system (Ivanov & Buck, 2002; Miller, Wang, Szalacha, & Sorokin 2009; Mehler et al., 2001).

Immigrants meet the ‘vulnerable population’ criteria according to the Agency for Health Care Research and Quality (AHRQ) definition. Vulnerable populations are those who are disadvantaged by their economic status, age (young or old), functional or developmental status, language ability, the presence of chronic illness or disability, or place of residence (AHRQ, 2007). Vulnerable populations have fewer resources to improve their conditions, and are therefore at greater risk for suffering poorer health outcomes related to disparities in health care and social services (Pender, Murdaugh, & Parsons, 2005).

Immigration to the United States has increased considerably over the last twenty years and presents challenges for health care providers and public health policy-makers (Capps, 2003). For the year 2005, the United States Census Bureau recorded 35.2 million foreign-born people in the United States, accounting for more than 12% of the total population (Miller et al., 2009).
Approximately 24.9 million of them (more than 70%) arrived relatively recently, between the years 1990 and 2005 (Capps, 2003; Camarota, 2005; Miller et al., 2009). If current immigration trends continue, the foreign-born population of the United States will double by the year 2050, representing 15% of the total population (calculated from figures in Capps, 2003; Camarota, 2005; Miller et al., 2009). These newcomers have generated an unprecedented degree of cultural diversity in this country, bringing a wide array of health care beliefs and practices with them.

This increasing diversity and vulnerability challenge health care providers to address issues of culture, values, and social factors that influence health and healthy behaviors. Professionals engaged in health promotion must make themselves aware of the differences that exist in how diverse cultures view health promotion goals and activities. Leininger and McFarland define culture as “the learned, shared, and transmitted values, beliefs, norms and lifeways of a particular group that guides their thinking, decisions, and actions in a patterned way and often intergenerationally” (Leininger & McFarland, 2006, p. 13).

Health care providers must be sensitive to the culture of those with whom they work, including the biomedical culture in which the newcomer was socialized in his or her country of origin. Cultural sensitivity is “employing one’s knowledge, consideration, understanding, respect, and tailoring after realizing awareness of self and others and encountering a diverse group or individual” (Foronda, 2008, p. 210). Cultural sensitivity is a prerequisite for developing cultural competence. Cultural competence is an accumulation of specific “cognitive, affective, and psychomotor skills that are necessary for the facilitation of cultural congruence between provider and patient” (Alexander, 2008, p. 416). Cultural competence is not an end point, but a continuum of growth and learning that develops throughout one’s interaction with other people.
(Montgomery & Jones Schubart, 2010). Cultural competence results in more satisfying communication for both sides and more effective health interventions.

**Definitions**

**Former Soviet Union**

People from the Former Soviet Union (FSU) are often lumped together as “Russians,” but in reality, the Soviet Union was comprised of 15 separate republics, mostly established on the basis of ethnicity. The newly independent countries of the FSU, therefore, have unique ethnic identities and indigenous languages. For this reason, it may be a mistake to refer to someone from the FSU as "Russian." A person may be Ukrainian, Latvian, Belorussian, Georgian, Kazakh, or other ethnicity.

**Russian-speaking**

In spite of the diversity of peoples from the FSU, most immigrants from the FSU speak Russian as a *lingua franca*, as a second or even third language. The Russian language was and still is the dominant language across the FSU and was the “main axis of identity” for an otherwise diverse group of immigrants (Remennick, 1999, p. 1673). There was a great emphasis on assimilation during the Soviet period, and even those who are not ethnically Russian have a knowledge and understanding of Russian culture, which was considered hegemonic throughout the FSU (Birman, 2006). Perhaps more important is an acknowledgement of the Soviet culture, a relatively recent development, officially lasting less than a century (during the existence of the
Soviet Union from 1917 to 1991), but which has left a huge legacy frequently referred to throughout this paper. Russian language and Soviet culture, therefore, provide a common denominator when speaking about people from the FSU.

**Older person**

This project aims to shed light on the impact of having been socialized in the Soviet system before emigrating to the United States and being called upon to navigate in a substantially different system. Given that the Soviet Union ceased to exist in 1991, people who experienced it as adults will, by definition be of a certain age. Because this project is also looking at CVD, the population in question is more likely to be middle-aged or older. Older immigrants tend to be more vulnerable due to language barriers and poorer health upon arrival, which is another reason to focus on older adults in this study. No specific age range is defined as “older” for this project. The literature delineates many different age ranges (for example, 55-64; 50-60; 55-65) which will be noted in the literature review when necessary.

**Newcomer**

There is a dearth of theoretical literature defining the term “newcomer.” It has been conceptualized in rural health in terms of insider/outsider in the context of a newcomer’s acceptance or anonymity in sparsely populated rural Montana communities (Long & Weinert, 1989. The term “newcomer” has also been conceptualized in the discourse on psychological identity formation in the context of incomer/old-timer on a remote island in Scotland (McKinlay & McVittie, 2007).
For purposes of this paper, the term “newcomer” refers to immigrants, refugees, and asylum seekers (Ogilvie, Burgess-Pinto, & Caufield, 2008). This project focuses on people who have migrated to the United States from the FSU since 1991 (approximately the last 20 years as of this writing). They arrived here after the 1991 collapse of the Soviet Union. People from the FSU fall under many different official labels:

1. legal permanent residents, who have permanent resident visas (“green cards”);
2. refugees (who fit the official definition of fleeing persecution) and other humanitarian admissions;
3. temporary residents (mostly with visas for employment or education);
4. undocumented immigrants, who do not have authorization to be living or working in the United States; and
5. immigrants who have attained citizenship of the United States (Capps, 2003).

Movement between these categories occurs regularly (Capps, 2003). Much of the literature on FSU newcomers refers to them as immigrants regardless of legal status. This researcher will use “newcomers” when speaking generally, and “immigrants” or “refugees” when citing specific literature, maintaining the terminology of the source.

**Health Disparity**

Health disparity can be defined as “a decline in a dynamic state or condition of physical or psychological well-being for one individual or group compared with another that is not a result of individual physiologic variance” (Fink, 2009).
Vulnerable Populations

Flaskerud defines vulnerable populations as social groups who have an increased relative risk or susceptibility to adverse health outcomes as compared to the general population (1998). Nyamathi, Koniak-Griffin, and Greengold add to Flaskerud’s definition by stating that vulnerable populations are “individual groups of people who are susceptible to harm or neglect by acts of commission or omission on the part of others” (2007, p. 3). The vulnerability to risk is demonstrated by increased relative morbidity and mortality, as well as diminished quality of life (Aday, 1994). Vulnerable groups typically include women and children, ethnic people of color, immigrants, gay men and lesbians, the homeless, and the elderly.

Cardiovascular Disease (CVD)

CVD is an abnormal function of the heart or blood vessels (arteries and veins), which can lead to: 1) coronary heart disease, 2) hypertension, 3) stroke, and 4) heart failure. CVD results in decreased quality of life and decreased life expectancy (Cardiovascular Disease Foundation, 2009). Risk factors include obesity and overweight, dyslipidemia, hypertension, diabetes mellitus, sedentary lifestyle, smoking, and excessive alcohol consumption.

Cardiovascular Disease in the United States and FSU

The challenges of health promotion with vulnerable populations suffering from chronic disease will be addressed through the example of FSU newcomers. The story begins with the
context of CVD in the United States, which will then be compared with CVD in the FSU. Next will be a discussion of the context of migration from the FSU to the United States.

**CVD and Health Promotion in the United States**

**Incidence and Prevalence**

CVD is the leading cause of death in the United States, accounting for 26.0% of all United States deaths in 2006 (Heron et al., 2009) and 29% worldwide (WHO, 2009). Rates of CVD in the United States, however, have been declining over the last 40 years due to downward trends in cholesterol, blood pressure, and smoking among the general population, as well as wider use of effective CVD treatments among people with existing CVD (Lloyd-Jones et al., 2010). Nonetheless, these encouraging trends are offset by the prevalence of diabetes, obesity, and the aging of the United States population, all risk factors for CVD (National Heart, Lung, and Blood Institute, 2007).

**Risk Factors**

In most cases CVD is caused by narrowing of the arteries supplying blood to the heart, brain, and other essential organs (Raza, Babb, & Movahed, 2004). Although a small number of CVD cases are linked with genetic predisposition (Assmann & Gotto, 2004), the majority of individuals develop the disease as a result of a constellation of unhealthy behaviors. Modifiable CVD risk factors include high blood pressure, obesity, hyperlipidemia, diabetes, sedentary lifestyles, smoking, and excessive alcohol consumption (National Heart, Lung, and Blood
Institute, 2007). Each of these modifiable risks is targeted in the *Healthy People 2010* program (HHS, 2010).

Modifiable risk factors are responsible for about 80% of cardiovascular disease (WHO, 2009). Some risk factors can be addressed directly through behavior change, such as improving one’s diet, quitting smoking, or exercising more. Other risk factors, known as intermediate risk factors, are only indirectly affected by diet, smoking, and exercise. These are blood pressure, blood glucose, blood lipid levels, and being overweight. There are also underlying social determinants of CVD, such as poverty and stress, that influence one’s ability to adopt and maintain healthy lifestyles that can lead to improved cardiovascular health (WHO, 2009).

Many CVD risk factors reinforce each other. For example, regular exercise provides cardiovascular health benefits that positively affect other risk factors such as hyperlipidemia, obesity, and hypertension. Similarly, weight loss can lower blood pressure and improve lipid profiles in obese adults (National Heart, Lung, and Blood Institute, 2007). Alternatively, negative risk factors accumulate, compounding the detrimental effects. This is demonstrated by the fact that clinical practice guidelines for managing chronic conditions such as hypertension vary depending on the presence of other risk factors (Chobanian, Bakris, & Black, 2003).

How are Americans coping with the behavioral risk factors? According to the CDC (2010), more than 43 million American adults smoke (approximately 20%). Approximately 30% of adults who drink alcohol report binge drinking (consuming 4 or more drinks on one occasion for women, 5 or more drinks on one occasion for men) in the past month. As recently as 2007, only 24% of adults reported eating five or more servings of fruits and vegetables per day. Lastly, fewer than one-third of all adults in the United States meet the recommendations for aerobic
physical activity, and 23% report not having engaged in any leisure-time physical activity in the previous 30 days (CDC, 2010).

**Health Promotion**

Given the large scope of the problem of CVD and the potentially significant health impact of improved health behaviors, it comes as no surprise that the prevention of CVD has been a top priority of the American Heart Association (AHA) since the 1940s (AHA, n. d.).

The AHA’s Impact Goal for 2010 focuses on reducing the prevalence of CVD risk factors and death rates. The AHA attributes the declining rates of CVD seen over the last 40 years to successful primary preventive programs targeting the population as a whole, and secondary prevention practiced on an individual basis (Lloyd-Jones et al., 2010). The population shifts are thought to be a result of changes in health-related behaviors such as screenings for elevated blood pressure and cholesterol (Rose, 1991), smoking cessation, increased physical activity, and improved blood pressure and cholesterol levels through diet and exercise (accounting for approximately 45% of the reduction) as well as environmental factors. Medical treatments such as the use of revascularization procedures and medication regimens explain another 45% of the reduction. The remaining 10% was unexplained by the statistical model (Lloyd-Jones et al., 2010). These examples demonstrate the value of population-level prevention approaches in combination with individual clinical interventions in making an impact on CVD.

In setting goals for the year 2020, the AHA has reframed its Impact Goal as one of health promotion rather than disease prevention. The new Impact Goal is stated: “By 2020, to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular
diseases and stroke by 20%.” (Lloyd-Jones et al., 2010, p. 587). Cardiovascular health is defined in terms of health factors and health behaviors rather than risk factors. Ideal cardiovascular health, as defined by the AHA, can be measured as “the presence of both ideal health behaviors (nonsmoking, body mass index 25 kg/m2, physical activity at goal levels, and pursuit of a diet consistent with current guideline recommendations) and ideal health factors (untreated total cholesterol 200 mg/dL, untreated blood pressure 120/80 mm Hg, and fasting blood glucose 100 mg/dL)” (Lloyd-Jones et al., 2010, p. 591).

Whether framed as disease prevention or health promotion, the AHA goals require vigilant self-management to engage in correct behavior to proactively modify one’s risk factors for disease. The concept of individual responsibility is strikingly evident in the term modifiable risk factors. American health promotion/disease prevention activities presume a high level of self-regulation and a willingness to control one’s behavior to avert risk of death or disability (Nelkin, 2003). These presumptions have implications for health promotion activities that will be addressed later in this paper.

CVD and Health Promotion in the FSU

Incidence and Prevalence

According to the 2009 Update to the Heart and Stroke Statistical Report from the American Heart Association, Russians have the highest death rates from CVD in the world (2,214 per 100,000) (Lloyd-Jones, Adams, Brown, & Carnethon, 2009). Unfortunately, data are available for Russia only, not for the other former Soviet Republics. The United States ranks 16th
on this list, with 428 deaths per 100,000. Contrary to the declines in CVD seen in the United States over the last 40 years, deaths due to CVD increased in the Soviet Union by 50% from 1960 to 1989 (Miller, Wilbur, Chandler, & Sorokin, 2003). How can such a large increase be explained?

**Risk Factors**

The WHO’s MONICA study (Monitoring of Trends and Determinants in Cardiovascular Disease) showed a high level of risk factors for CVD (smoking, high blood pressure, and obesity) in Russia in the 1980s and 1990s (Perlman, Bobak, Steptoe, Rose, & Marmot, 2003). However, a 2003 study conducted in the Archangelsk area of Russia found that even though CVD mortality is high, the population scored at approximately the same level on Framingham risk scores as comparable populations in the United States and Western Europe (Averina et al., 2003), suggesting other factors may be involved. Framingham criteria include age, sex, total cholesterol, HDL cholesterol, systolic blood pressure, and smoking.

The typical Russian diet is very high in saturated fat, a known risk factor for CVD. Since the 1960s, the diet has shifted from cereals and potatoes to more sugar and red meat, and by 1990 over 36% of calories came from fat, with men consuming about 50% more fat than women (Cockerham, Snead, & DeWaal, 2002). The diet is also high in sodium, partly due to high consumption of preserved (salted) meats and fish, contributing to high blood pressure. A random sample of 162 individuals in Novosibirsk, Siberia, identified 54 persons with diagnosed hypertension, a rate of 33% (Kuznetsova et al., 2000).
The diet of all population groups in the FSU suffers from a dearth of fresh fruits and vegetables, especially in winter due to lack of availability (Shpilko, 2006). Smoking is still culturally acceptable in the FSU, more so among men than women, and is widely promoted by tobacco companies. Russia is the largest importer of tobacco products in the world (Cockerham, 2000). Leisure-time exercise, especially aerobic exercise, is not culturally acceptable except for elite athletes in training. Rest is generally promoted more than activity in recovering from even minor illnesses.

Alcohol consumption has long been a major health concern in the FSU, and when consumed in excess, it is a risk factor for CVD. According to the Russian Federation’s Healthcare and Social Development Ministry, per capita alcohol consumption in Russia has reached 18 liters of alcohol per year; more than double the 8-liter level that the WHO defines as dangerous for health (Novosti, 2009; Golikova, 2009). Excessive rates of alcohol consumption, combined with a propensity toward binge drinking, results in death from cardiac arrhythmias and/or cardiomyopathy, which may be classified in Russia as cardiovascular disease (Mehler et al., 2001). However, it should be noted that FSU immigrants generally have not been seen to suffer from alcoholism to such an extent (Shpilko, 2006).

Here it is worth noting that one of the Soviet Union’s earliest experiences with health promotion was President Gorbachev’s Alcohol Prohibition Campaign which began in May 1985 and is frequently cited as the reason for a temporary decline in overall mortality rates in the FSU from 1985 to 1987 (Bobak, Pikhart, Hertzman, Rose, & Marmot, 1998; McKee, 1999; Koek, Bots, & Grobbe, 2003). Within a year, however, the prohibition policy led to sharp increases in the illicit production of samogon (moonshine) as well as a rise in sales of medicinal and
industrial alcohol. Numerous deaths from alcohol poisoning were reported. Consequently, the program was allowed to fade away without enforcement by 1987 (Novosti, 2009).

**CVD Prevention Strategies**

Efforts to reduce CVD began during the period of *glasnost* (openness) in the Soviet Union in the 1980s with international assistance from the European Union and World Health Organization (Levintova, 2006). The assistance programs focused on national level policies and strategies, epidemiological surveillance, and technical assistance (Levintova, 2006). These programs did not emphasize health promotion activity, which is still considered the weakest area of health programmatic activity in Russia (Levintova & Novotny, 2004). It should also be noted that the mass media in Russia lacks a tradition of involvement in health promotion or reporting, though international assistance to professional journalism associations in Russia is addressing this gap (The World Bank Group [2002] as cited in Levintova, 2006).

According to Levintova (2006), health promotion activities have been a low priority of the three major international assistance programs to the Russian government: MONICA (Monitoring of Trends and Determinants in Cardiovascular Disease), TACIS (a grant-financed technical assistance program launched by the EU in 1991 for the countries of the former Soviet Union) and CINDI (Countrywide Integrated Non-communicable Disease Intervention).

Thwarting health promotion efforts even more than the lack of focus by international assistance programs is the attitude of health care policy-makers and providers in Russia, who still adhere to the biomedical model of the Soviet period. One professional interviewed for a study summed-up the prevailing attitude this way, “We need to save the lives of the individuals who are sick. We
can’t take care of everyone and everything, so we need to take care of the sickest” (Levintova, 2006).

The underemphasis on health promotion in the Soviet Union did not empower people to exercise control over their own health. This was a paternalistic system where preventive care was rare, and physicians were expected to cure people (Cockerham et al., 2002; Lipson, Weinstein, Gladstone, & Sarnoff, 2003). "There was little emphasis in the FSU on health promotion and prevention of disease, though treatment for illness was readily accessible and available (Miller et al., 2003). Historically, there has been a lack of public education utilizing mass media campaigns (Levintova, 2006). The lack of public policy for health promotion to address chronic disease undoubtedly contributed to the rise in chronic disease such as CVD since the 1960s (Cockerham et al., 2002).

Transition from the FSU to the United States

Historically, the major ethnic, religious, or cultural group represented among Soviet newcomers to the United States was Jewish people fleeing anti-semitism and discrimination. Since the 1980s era of glasnost (openness) and the 1991 dissolution of the Soviet Union, however, the newcomer population to the United States included many more Russians and other nationalities as restrictions on leaving the country were loosened. From 1992 to 2005, approximately 2.6 million people emigrated from the FSU, mostly to Israel (56%), Germany (22%), and the United States (11%) (Tishkov, Zayinchkovskaya, & Vitkovskaya, 2005). Between the years 1990-1993, FSU newcomers comprised 6% of the total number of immigrants
Contrary to expectations, the overall rate of emigration from the FSU to the United States actually decreased after the dissolution of the Soviet Union, after its high point in the 1980s era of glasnost (Tishkov, Zayinchkovskaya, & Vitkovskaya, 2005). However, the diversity of emigrants increased as more people from the fourteen non-Russian republics of the FSU, as well as ethnic minorities living inside Russia, began to leave in increasing numbers (Kropf et al., 1999; Tishkov, Zayinchkovskaya, & Vitkovskaya, 2005). Ethnically Russian people living in the non-Russian republics also began to leave as the titular national groups gained ascendancy in their newly independent states.

For example by the end of 1995, the five FSU Republics of Azerbaijan, Armenia, Tajikistan, Georgia, and Russia were listed by the U.S. Committee for Refugees as being in the top 25 principal source countries of the world’s refugees (as cited in Kropf et al., 1999). Other groups include Ukrainians, Byelorussians, Moldavians, Georgians, Estonians, Armenians, Uzbekistanis, and others. In 2001, 14,888 refugees from FSU countries were admitted to the United States (Polyakova & Pacquiao, 2006).

Migration is not an easy process, and it has mainly been parents with growing children who had the greatest motivation to overcome the bureaucratic headaches with the Soviet government to gain permission to emigrate (Ucko, 1986). In the FSU, however, the care of the elderly is considered to be the responsibility of the family, and few government resources are available. Therefore, a large number of elders reluctantly emigrated with their children. There was a Russian policy in place that required the entire family to emigrate as a unit so as not to
leave behind a large population of elderly without extended families in the FSU (Ucko, 1986; Kropf et al., 1999; Fitzpatrick & Freed, 2000). Consequently, FSU residents in their 70s and 80s with chronic illnesses agreed for their children's sakes to leave the country (Wheat, Brownstein, & Kvitash, 1983). As one interpreter explained, "You can't leave your old mother or father behind. They must come if they want to or not." FSU elderly suffer high rates of depression once they arrive in the United States (Miller & Gross, 2004). About 20% of the newcomers have been 65 years and older, making this group one of the oldest immigrant populations. (Brod & Heurtin-Roberts, 1992).

Where do FSU newcomers go once they arrive in the United States? The majority settle in California, New York, Washington DC, Pennsylvania, Massachusetts, and Illinois (Miller et al., 2003). For the most part they go to major urban areas, including New York City, Chicago, Los Angeles, and San Francisco, although most United States cities have received at least a few FSU newcomers from all of the republics. “Secondary immigration patterns make it difficult to estimate accurately the number of emigres in any given location” (Brod & Heurtin-Roberts, 1992).

Many of these older FSU newcomers were professionals in their homeland, and most are highly educated. The literacy rate in the Soviet Union was greater than 98%, and 65% of newcomers have a college education (Mehler et al., 2001). The elderly have been identified as the most vulnerable sub-group of FSU newcomers, in part due to the reluctance with which they came, and the difficulties of emigrating to a new country without knowing the language, so late in life (Brod & Heurtin-Roberts, 1992; Polyakova & Pacquiao, 2006).
FSU newcomers shared a common experience under the Soviet system and the deterioration of health care since the collapse of the Soviet Union. Another shared experience these diverse newcomers have in common, unfortunately, is poor health when they arrive and vulnerability to health care disparities once they settle here. The rest of this paper examines the process and challenges of health promotion with FSU newcomers. Health promotion is of great significance to nursing, as is described in the next section.

**Significance to Nursing**

All nurses, particularly Advanced Practice Nurses (APNs) have long understood the concept and practical implications of vulnerability. “Beginning with Florence Nightingale, nurses have demonstrated dedication and aptitude for identifying persons, groups, and environments in need of intervention and new approaches to assessing and reducing vulnerability” (Nyamathi & Koniak-Griffin, 2007, p. iv). Nurses are uniquely poised to provide culturally competent care to vulnerable populations. The provision of culturally competent care entails skills that nurses are adept at practicing, such as “understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations” (Betancourt, Green, Carillo, & Ananeh-Firempong, 2003, p. 297). Older FSU newcomers are a vulnerable population, and this Master’s Report and subsequent Practice Inquiry will provide insights for APNs into how to most effectively work with them.
Health promotion is a central function of nursing as is frequently pointed out in the literature. This project will also help to bridge the gap between theory and practice on health promotion. By using Social Cognitive Theory to help explain the dynamics of individual behavioral change, this project will help APNs design effective interventions to facilitate positive lifestyle changes and improved health outcomes among our patient populations.

Advance practice nurses are ideally situated to provide health care for the more than 600,000 Americans suffering from CVD. Due to their graduate-level education in pathophysiology, culturally competent care, and health promotion, combined with a clinical focus on primary and preventive care, APNs will be in the forefront in caring for those with chronic disease. The insights gained from the evaluation of the cardiovascular health promotion project will provide APNs with additional strategies for treating patients with CVD.

**Overview of this Paper**

This chapter has outlined and defined the challenge of conducting health promotion with a vulnerable population from a different culture and with different values. This chapter has also provided the background and rationale for this project, defined key terms, and outlined the significance to nursing.

Chapter two provides a brief overview of concepts relevant to health promotion with vulnerable populations and will describe an analytical framework for the project. A literature review of health determinants of FSU newcomers will follow, structured according to the conceptual framework of the social ecological perspective and SCT principles. Information
gleaned from the literature review will be used to identify facilitators and impediments to health promotion among FSU newcomers which will then be linked to health promotion approaches.

Chapter three lays the foundation for a Practice Inquiry project to evaluate a community health promotion program entitled “Let’s Be Healthy” currently ongoing with FSU newcomers in San Francisco. The evaluation will analyze the Chronic Care Model (CCM) used to guide the design of the program, and identify strengths and weaknesses of the model for health promotion.
CHAPTER TWO: CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Health promotion is interpreted differently by various stakeholders. Differences in interpretation create challenges for operationalizing and applying the concepts, and in evaluating progress. This section of the paper provides a brief overview of the field of health promotion, and explains how the concepts have been interpreted by various stakeholders, including the integral role of nursing in health promotion. It attempts to answer questions that are pertinent to this project, namely, who practices health promotion and how? What is the goal of health promotion, and how do we know whether we are succeeding? How do promoters of health address the needs of vulnerable populations?

A conceptual framework for this project is described, and the literature on health determinants of FSU immigrants is reviewed according to the framework. This is followed by an analysis of the facilitators and impediments to health promotion among FSU immigrants.

**Health Promotion**

The Ottowa Charter for Health Promotion, adopted by the WHO in 1986, is considered by many in public health to be the defining document providing the philosophical guidance for the practice of health promotion. According to Maurice Mittelmark, former president of the International Union for Health Promotion and Education (IUHPE), “the Ottowa Charter is inarguably the ethical cornerstone for health promoters around the world” (Mittelmark, 2007, p. 79). In the Ottowa Charter, health promotion is defined succinctly as “the process of enabling
people to increase control over, and to improve their health” (WHO, 2010). The definition was fine-tuned by the WHO with the Bangkok Charter in 2005 as “the process of enabling people to increase control over their health and its determinants, and thereby improve their health” (WHO, 2010, emphasis by this author). This definition is informed by a social-ecological approach with a clear emphasis on empowerment (Mittelmark, 2007).

**Social Ecological Perspective**

Health promotion demands a multi-level, comprehensive approach such as that provided by the social ecological perspective. The social ecological perspective emphasizes the interaction among all factors related to health on multiple levels ranging from the individual, to families, to communities, and onwards up to macro level social and economic policies (Rimer & Glanz, 2005). See Figure 1 below.

The social ecological approach also provides guidance for developing successful programs by identifying social factors in the environment that must not be overlooked. Individual health-related behavior is understood as both influencing and being influenced by the social environment (Rimer & Glanz, 2005). The model also incorporates the concept of time, as the interactions between the multi-levels are not fixed, but shift and evolve over time.
Due to the comprehensive nature of the social ecological approach, it can be difficult to operationalize the concepts (Stokols, 1996). There is a risk of the analysis being so watered-down as to lose its analytical weight. And even when looking at broad social determinants of health, the goal of health promotion still involves individual behavioral change to some degree. Whether the interventions are targeted at individuals or communities, or even a large-scale public health educational campaign, the goal is still to have people adopt and maintain healthy behaviors. Health promotion interventions aim to impact objective health indicators, either directly through motivation for behavioral change, or indirectly by improving social indicators of health to facilitate the adoption of healthier lifestyles.
Because of the importance of behavior in chronic disease and in health promotion, a behavioral theory is a good complement to the social ecological perspective. The principles of the social ecological perspective are consistent with the concepts of Social Cognitive Theory (SCT), which is described below. The complementary nature of SCT with the social ecological perspective suggests that it is important to create an environment that facilitates change in order to be conducive to the adoption of individual positive health-related behaviors. Effective health promotion programs, therefore, may combine macro-level public health policies with community-level interventions and individualized health care services in an effort to promote individual behavioral change within the broader social context in which it occurs.

**Social Cognitive Theory**

SCT looks at the relationships among individuals and their environment that contribute to health behavior (Rimer & Glanz, 2005). As Bandura explains it, a person's knowledge, environment, and behavior exert influence on each other in a three-way dynamic and reciprocal model, and they are constantly evolving in a mutually deterministic relationship (Bandura, 2001). A person's behavior may change as a result of that person’s thoughts as well as environmental influences, and this behavior may subsequently lead to new ways of thinking along with further behavioral and environmental adjustments (Pender et al., 2005). Each part of the triad influences the other. See Figure 2 below.

SCT posits that "individuals are neither driven by inner forces nor automatically controlled by external stimuli" (Pender et al., 2005, p. 40). A person can be both an agent of change as well as a responder to change (Rimer & Glanz, 2005). Internal and external factors
interact, and no single part of the triad (cognition, environment, and behavior) is more influential than the other (Pender et al., 2005).

![Triad of Reciprocal Determinism (Bandura, 1977)](image)

Figure 2: Triad of Reciprocal Determinism (Bandura, 1977).

A key premise of SCT is that in addition to learning by their own direct experiences, human beings also learn by observing the actions of others and the consequences of those actions, referred to as observational learning (Bandura, 2001).

Another key concept, self-efficacy, is defined by Bandura as a person’s confidence in his or her ability to take action and to persist in that action despite obstacles or challenges (Bandura, 2002). In other words, self efficacy may be thought of as "a judgement of personal capability to successfully execute a specific behavior" (Pender et al., 2005, p. 41). With SCT, a person's perception of self efficacy evolves as knowledge and experience are gained, and this perception influences the likelihood of a given behavior being adopted. This is a critical concept in SCT, and one that is shared among other behavioral change theories, such as the Health Belief Model.
(HBM), the Theory of Planned Behavior, and Pender’s Theory of Health Promotion (Pender et al., 2005).

SCT synthesizes concepts from other cognitive, behavioral, and emotional models of behavior change, and can be readily applied to counseling interventions for disease prevention and management. Health providers can design interventions to increase patients’ self-efficacy to adopt healthy behaviors or break unhealthy habits using three types of strategies: (a) setting short-term and incremental goals so that progress is achieved early and can be reinforced; (b) entering into behavioral contracts with patients to establish expected behaviors, goals, and rewards; and (c) monitoring and reinforcement of expected behaviors, including patient self-monitoring (Rimer & Glanz, 2005).

Bandura’s SCT has been applied to the challenge of health promotion in public health (Bandura, 2004). SCT considers a person’s self-efficacy for achieving certain expected outcomes, in light of social or structural obstacles or facilitators that may be encountered along the way. By directly addressing the impediments and by building on the facilitators, effective strategies for health promotion may be developed. See Figure 3 below.
Figure 3: Paths of Influence in the SCT causal model (Bandura, 2004).

For this project, health determinants of FSU newcomers will be grouped into personal, environmental, and behavioral determinants according to Figure 2. Next, facilitators and impediments to the achievement of health behavior goals will be identified.
FSU Newcomers’ Health Determinants

The next section uses this analytical framework to structure a review of literature about FSU newcomers. Literature specific to FSU newcomers’ health knowledge and health status is not abundant. Studies from Israel are used to supplement the studies done in the United States where appropriate. Contradictions abound in this literature, most likely due to extremely small sample sizes in many cases, the frequent use of convenience samples and/or self-selected participants. Studies about FSU newcomers’ experiences with United States health care and social services were more numerous, though not without contradiction. Conflicting reports are presented here. The results from individual studies are not generalizable to FSU newcomers as a whole, yet for purposes of inclusiveness and thoroughness in this analysis, insights from those studies are included here.

Placement of information in one category is not necessarily exclusive, but is meant to provide a rough guideline on how to interpret the content. For example, access to health care services is considered a component of the environment, external to the individual. However, utilization of health care services is a behavior, internal to the individual. There is a fine line distinguishing these factors, yet the rationale for placing them in one category over another is based on the locus of control, whether internal or external to the FSU immigrant.
**Personal**

Personal determinants of health include those factors which are internal to the individual. This includes biological factors such as self-reported measures of health and objective measures of health conditions. It also includes cognitive factors such as knowledge of CVD and risk factors, how to mitigate risk, as well as knowledge of how to access health care services and information. Lastly, this category includes emotional factors such as the meaning and value of health, the value of self, folk medicine beliefs, beliefs about the causes of illness, trust in oneself, and health control beliefs.

**Biological: Health Status and Health Functioning**

Immigrants from the former Soviet Union have a higher prevalence of several chronic diseases (hypertension, coronary disease, gastrointestinal problems, diabetes, and cancer) than United States-born caucasians (Fitzpatrick & Freed, 2000). Higher rates of CVD risk factors have also been documented. A study of FSU immigrants in Denver (Mehler et al., 2001) found a higher prevalence of hyperlipidemia and hypertension among immigrants aged 55–64 years than among the general United States population; and a high prevalence of hypertension among those aged 65-74 (Mehler et al., 2001). In the United States, approximately 25% of the adult population has hypertension (defined as a systolic blood pressure > 140 mm Hg and/or a diastolic blood pressure > 90 mm Hg and/or the use of antihypertensive medication) (AHA, 1997, as cited in Mehler et al., 2001). The Denver study of FSU immigrants found the rate of hypertension to be 56% (Mehler et al., 2001). The same study found a higher percentage of FSU immigrants with cholesterol levels above 200 mg/dl in the 55-64 age category than in their
United States counterparts. FSU immigrants also have more peripheral vascular disease and higher rates of prior myocardial infarction (more than double) compared with United States-born caucasians (Fridman, Vandalovsky, & Bergmann, 2006).

Self-rated health has been more likely to be rated “fair” or “poor” among FSU immigrants than among their American counterparts in the United States or their Israeli counterparts in Israel (Duncan & Simmons, 1996; Baron-Epel & Kaplan, 2001; Remennick, 2003; Aroian & Vander Wal, 2007). An early, small study in Virginia (of 30 FSU immigrants in 1995) found that the majority rated their health as fair or poor. Self-reported chronic diseases included heart disease (13%), hypertension (6%), and diabetes mellitus (3%). Family health history included coronary vascular accident (7%), hypertension (25%), diabetes mellitus (7%), and cancer (3%). Seventy-three percent of the newcomers identified themselves as having a chronic health problem (Duncan & Simmons, 1996).

**Cognitive: Health Knowledge**

FSU immigrants are highly literate and typically well-educated. Overall, they appear to be knowledgeable about chronic illness and the influence of unhealthy behavior on health. Says an FSU immigrant woman, “We are all educated people and know what is good and bad for our health; it is just that few of us can keep up with the rules of healthy lifestyle” (Resick, 2008). However, even though there is a general understanding among the FSU newcomer population about how behavior affects health, the knowledge is incomplete and/or scientifically unfounded (Benisovich & King, 2003). Older FSU women in particular lack knowledge of what constitutes a healthy diet, and even well-educated people are not well-informed about nutrients, vitamins,
and fats contained in common foods (Miller et al., 2003). Another study found, however, that FSU immigrants are aware that fruits and vegetables are beneficial for health, and that smoking and excessive alcohol consumption are bad for health (Benisovich & King, 2003). There was a growing awareness among older women about reducing cholesterol in the diet (Miller et al., 2003). Exercise is understood to be beneficial, though how often, for how long, and what type of exercise were not well-understood (Benisovich & King, 2003).

There is a general lack of knowledge among FSU newcomers about how to receive objective, reliable health care information. Life experience and intuition have been cited as a way to get information about health. Says one FSU immigrant, “Each person trusts his own body. He knows what is good for him and what harms him and each person adjusts accordingly” (Benisovich & King, 2003, p. 140). Many attribute their lack of knowledge about preventive services to the fact that a physician had not told them they needed these services (Ivanov & Buck, 2002). On the other hand, FSU immigrants are generally reputed to be aggressive seekers of health information from physicians, often seeking out Russian-speaking physicians or asking fellow immigrants for assistance with obtaining information (Resick, 2008). Mid-life Russian immigrants tend to seek out health-related information if they are unsure of a diagnosis (Resick, 2008).

Newcomers are more likely to get their health information from within the immigrant group and may be unfamiliar with other sources (Benisovich & King, 2003). Language barriers, of course, may impede the flow of health information to newcomers. According to the Department of Health and Human Services, people with limited language skills often cannot understand the basics of how to apply for programs for which they may be eligible, including
Medicaid and other social services and welfare programs (as cited in Shpilko, 2006). Russian newspapers and Russian radio are widely available in large urban Russian-speaking communities and have been cited by FSU newcomers as important sources of health information (Benisovich & King, 2003).

Here it is worth highlighting a legacy from the Soviet system. Older FSU newcomers tend to be distrustful of the media, Russian-speaking or otherwise. They assume the health messages in the media have an ulterior motive of trying to sell something (Benisovich & King, 2003). In the Soviet Union, dietary recommendations were known to be changed depending on which crops had a surplus in any given year. There is still a belief that the system of economic and advertising is being manipulated by a central authority, and so messages are not objective (Benisovich & King, 2003).

**Emotional: Health Values and Beliefs**

FSU immigrants typically define health as the absence of disease. “Health was consistently defined as the lack of a negative rather than the presence of a positive state” (Benisovich & King, 2003, p. 124). This definition is consistent with the medical model of health currently practiced in the FSU, which was also practiced in the United States for much of the 20th century. The biopsychosocial model of health, which defines health as the presence of a positive quality of life, is beginning to be widely accepted in the United States but is still unknown in the FSU and to FSU newcomers (Benisovich & King, 2003).

Health is highly valued in Russian culture as demonstrated in many studies of Russian-speaking participants (Lipson, Weinstein, Gladstone, & Sarnoff, 2002; Resick, 2008). In a
hermeneutic phenomenological study with post-collapse immigrants, Resick (2008) found that the women placed a high value on health, though it was less of a priority during migration. Many FSU newcomers, particularly older women, value their own health needs less than the needs of family members. Immigration increases feelings of helplessness and stoicism about protecting one’s own health as they focus on being caregivers to others. Older women also believe they no longer have a need for routine health care once their reproductive years are over (Remennick, 2003).

In one study, many older women had fatalistic views about chronic diseases such as cancer, and were reluctant to have routine cancer screenings out of a belief that they would just be “looking for trouble” (Resick, 2008, p. 250). In another study, although they were aware of the benefits of early detection for saving lives, their reluctance was not decreased (Remennick, 2003). On the other hand, a different study found that older FSU immigrants perceived good health as an asset deserving of protection so as not to become a burden to younger family members (Aroian, Khatutsky, Tran, & Balsam, 2001). An elder from that study was quoted, “We go to see doctors all the time. We have to take care of our health so to not burden our children” (p. 269).

FSU immigrants hold fast to folk medicine beliefs about the causes of disease, such as cold drinks causing sore throats, sitting on concrete causes infertility in women, and swaddling babies even in summer to prevent colds (Grabbe, 2000). A recurring theme across many studies is that immigration itself causes illness (Lipson et al., 2003; Benisovich & King, 2003; Shpilko, 2006; Resick, 2008). Home remedies remain popular, such as garlic in the nostrils for upper respiratory infections and placing the feet in warm water. For coughs, flu, or bronchitis, cupping
is practiced, as is placing a plastic bag of boiled mashed potatoes on the chest. Vodka is commonly used in compresses for lung ailments, or consumed as prophylaxis against diarrhea, especially when traveling (Lipson et al., 2003). Interest in alternative and complementary medicine has always been high in the FSU, estimated to be at 60% in Russia (Shpilko, 2006). In the FSU standard medical practice combines folk remedies, complementary therapies, and allopathic medicine (Grabbe, 2000). Many FSU newcomers continue their use of alternative therapies such as massage therapy, herbal remedies, and spiritual healing, together with prescribed medications in the United States (Shpilko, 2006).

In general in the FSU, people have positive health control beliefs – they believe that one’s actions and behaviors impact one’s health. This is more true among younger people and people of higher socioeconomic status. However, despite this belief, people do not often change their behavior (Perlman et al., 2003). The collapse of institutions and even informal networks after the demise of the Soviet Union led to pessimism and low levels of perceived control over health (Bobak et al., 1998). FSU immigrants, particularly women, believe in trusting themselves over professionals to make decisions to manage health. They tend not to trust physicians and healthcare professionals. A woman in a small qualitative study is quoted “We did not trust anybody in Russia” (Resick, 2008). Trust in self-care indicates that FSU immigrant women believe that they can control some aspects of their own health by their own actions (Lipson et al., 2002).
Environmental

Environmental determinants are factors that are external to the individual. This section includes instrumental support from family and friends who help with specific needs to achieve positive health outcomes, multigenerational households, and social isolation due to language barriers and/or socioeconomic constraints. Environmental determinants also refer to access to health care and social services, and expectations of health care in the United States.

Family/Social Networks and/or Isolation

In the FSU, several generations of families tended to live together communally in a single household. As described in Chapter One of this paper, multi-generational families emigrated together, or younger adults went first, and elders joined them later. The result is the same – multi-generational immigrant families in the United States. Relocation of multi-generational families to the United States results in a role-reversal whereby the older parents who do not speak English become dependent on the younger family members who do (Fitzpatrick & Freed, 2000). This is quite a dramatic shift in familial power, as Russian culture has a strong tradition of parental authority.

In addition, United States immigration policy favors the establishment of separate households for each generation, so elders experience separation anxiety and increased social isolation (Althausen, 1993). This isolation comes at a time when many elderly newcomers suffer from chronic disease and disability, and their lack of English inhibits their ability to access social
services. Their adult children are preoccupied with finding employment and caring for their own children (Tran, Sung, & Huynh-Hohnbaum, 2008).

Marriage is also somewhat less important in Russian culture than in the United States. Friendships, however, especially among women in the FSU, are very strong, providing a source of moral and material support in a society where informal networks were critical for survival. Emigration of the family unit increases the reliance on the marital partner, though it breaks up the informal network requiring the establishment of a new one in the United States (Fitzpatrick & Freed, 2000).

The traditional importance of informal networks in the FSU, along with the comfort and familiarity of a community of people who share one’s culture and language, may account for the strength of Russian-speaking communities in the United States. Social networks mediate the transition of FSU newcomers to the United States and provide a source of social capital (Litwin, 1997). Information is readily shared about health resources and social services. One study quotes an elderly Russian, “Residents in the building ... the majority are Russian speaking. They all know each other. They all share information extensively. They all discuss their doctors and the programs they receive” (Aroian et al., 2001). This informal networking can make outreach by social service agencies easier, however, misinformation also “spreads like wildfire” and can cause confusion (Sloane, 1991, p. 195).

**Socioeconomic Circumstances**

As has been discussed, FSU immigrants tend to be well-educated and highly skilled. However, language barriers and the need to re-qualify or re-certify in their chosen professions to
meet United States standards or legal requirements leaves many FSU newcomers unable to find work in their specialties. FSU newcomers face many economic hardships, having to survive on low wages and social benefits (Ivanov & Buck, 2002).

In the case of the older immigrant, retirement age in the FSU is 55, yet in the United States it is 65. FSU newcomers between 55 and 65 years of age, therefore, need to find employment. With low English language fluency, even skilled workers will find this challenging. The most detailed studies of this phenomenon have been conducted in Israel, though the constraints are similar in the United States (Remennick, 2003). Women in their 50s often work multiple part-time jobs, mostly as caregivers of children or elderly. Older women frequently work as house-cleaners to wealthy households. In addition to working, these women also tend to their own families (elderly parents, husbands, adult children, and grand-children) leading to “double caregiver stress” (Remennick, 2001, p. 691).

The views expressed by the women of the “sandwich generation” are that they have neither time nor money to take care of their own health. Says one study participant, “I didn’t see doctors even when I had high blood pressure, colitis and other problems—since they are all chronic, I know all about the drugs, diet, etc . . . I have some prescription drugs at home; friends buy them for me in Russia. So you can figure out yourself that I have no time and no right mindset for preventive check-ups. I just take it easy—what will be, will be.” Preventive health care is seen as a luxury item that only well-off women can afford. A 53 year-old immigrant put it this way, ”A healthy lifestyle is expensive, and for someone like me it sounds like a joke” (Remennick, 2003, p. 159).
Access to Health Care

Health care is considered cost prohibitive, even when covered by insurance (because of co-pays), which limits access to care for FSU newcomers. Cost is especially challenging for those under 65 years of age who are not employed and cannot qualify for Medicare. Therefore, care is sought only after home remedies have not solved the problem. The limited income is tied up in groceries and household expenses, leaving little for seeing physicians for preventive health care. FSU immigrants also rely on less expensive medications brought by visitors from Russia (Ivanov & Buck, 2002).

Once they qualify for Medicare, however, they have almost no financial barriers to health care. Unlike many other low-income elderly groups, FSU immigrants do not express feeling ashamed of using governmental assistance such as Medicaid. This is likely due to having been socialized in the Soviet Union (Wheat et al., 1983). An adult child of elderly FSU immigrants put it this way, “This is Soviet mentality. If it is free, why don’t we use it? If it is free, we have to have it” (Aroian et al., 2001).

Lack of English language also presents a barrier to health care services for FSU newcomers because of their dependence on school-aged grandchildren to translate for them at medical appointments. Adult children may not know enough English to take them to the physicians. However, the grandchildren often do not know the medical terms even in Russian (Tran et al., 2008).

FSU newcomers, especially those who do not speak English well, feel alienated from the health care system. This alienation inhibits people from visiting a physician for routine care, but
instead waiting for an acute illness. They then are concerned that they may be receiving sub-
standard care (Benisovich & King, 2003). They also have an expectation of physicians being
accessible, even making house calls as was common practice in the Soviet Union. They are not
used to having to make appointments to see the physician. A participant in one study stated, “If
you get sick, you can’t go to a doctor right away. This is a huge inconvenience” (Benisovich &
King, 2003, p. 140).

Behavioral

Behavioral determinants of health include eating a high-fat diet, having a sedentary lifestyle, smoking, consuming excessive alcohol, and being non-compliance with medications. Health-related behaviors also include assertiveness/manipulation in obtaining desired services, participation in preventive health care services, and participation in health screenings.

CVD Risk Behaviors

FSU newcomers tend to have diets high in fat, cholesterol, and carbohydrates (Cockerham et al., 2002; Miller et al., 2003). They also have a higher prevalence of alcoholism, smoking, obesity, and other risk factors for cardiac disease than United States-born Caucasians (Fridman et al., 2006). They engage in less leisure-time exercise (Cockerham et al., 2002; Miller et al., 2003). FSU men engage in more negative health behaviors, consuming more alcohol, smoking more cigarettes, and eating a less-healthy diet than do women (Cockerham et al., 2002).
On the other hand, a study of 35 FSU newcomers in Northern California found that many exercised regularly and ate a diet rich in fruits and vegetables. Few indulged in fast food, smoking, or excessive alcohol consumption. A few had decreased salt and fat in their diets, though they also ate more red meat due to better availability of it in the United States than in the FSU (Lipson et al., 2003).

Taking medications to control high blood pressure is an important behavior for reducing the risk of cardiovascular disease. Studies indicate that FSU newcomers tend to prefer taking medications brought from the FSU by friends, and they often neglect to tell their health care providers (Fridman et al., 2006). A study with a group of elderly Russian immigrants in the 55–64 age range showed that the high cost of medications in the United States combined with insufficient information about their efficacy and use were newcomers’ justification for sticking with familiar medications from the FSU (Shpilko, 2006).

Older FSU newcomers also seem unaware of the importance of taking certain medications every day, and instead take them for symptomatic treatment. Common prescriptions include medications for hypertension, cholesterol, cardiac conditions, and diabetes. FSU newcomers reportedly often take blood pressure medicine only when worried about something, or when their blood pressure measured on the sphygmomanometer at the supermarket indicates a high reading (Lipson et al., 2003). In one study, at least half the participants claimed to take medications as prescribed, but others cut the pills, stating that “U.S. medications are too strong” (Lipson et al., 2003, p. 861). Compliance with medication for high blood pressure is made more challenging due to the different ways of administering medications in the FSU. In Russia,
according to one patient, anti-hypertensives are given as monthly injections. Taking a daily pill indefinitely is seen as inconvenient (Benisovich & King, 2003).

**Utilization/Negotiation of Health Care and Social Services**

The literature diverges with regard to utilization of health care and social services, with some studies indicating a definite underutilization of services (Duncan & Simmons, 1996; Gutkovich et al., 1999; Mehler et al., 2001; Ivanov & Buck, 2002), and some over-utilization (Wheat et al., 1983; Aroian et al., 2001). The differences in health service utilization have been attributed to two key predictors: age (older people use more services, in part due to being covered by Medicare, in part because older people have more chronic illness); and health status (people with more illness utilize more services) (Aroian & Vander Wal, 2007).

Another distinction between over- and underutilization of health care services is whether the services are preventive or curative. It has been well documented that FSU newcomers seek care only as a last resort, when home remedies have failed to achieve the desired effect. Therefore preventive services are clearly underutilized (Duncan & Simmons, 1996; Ivanov & Buck, 2002; Remennick, 2003). It is also well-documented that FSU newcomers have definite expectations for medical care to be curative; therefore they aggressively seek care when ill, perhaps leading to over-utilization of services (Benisovich & King, 2003). Older age and free services for elder immigrants may also be a driver of over-utilization (Aroian et al., 2001).

The impressions of United States health care providers support the point of view of over-utilization of services. Said one provider, “There is no question about over-utilization of health care by Russians. Health care is being tremendously over-utilized” (Aroian et al., 2001). Most
frequently used services in one survey included primary health care, specialty health care, Meals on Wheels, medical translators, medical supplies and equipment, and transportation services to medical appointments (Aroian et al., 2001). In their over-utilization of services, FSU elders differ from their peers from other countries (Aroian & Vander Wal, 2007).

As noted in the previous section, one legacy of the Soviet system that has been carried over by FSU newcomers to the United States is a tendency to take advantage of any service viewed as “free.” A similar legacy of this system is the perceived need to approach the acquisition of goods and services quite assertively. The literature abounds with stories from the point of view of health care providers and social workers about their experiences with FSU newcomers described as “aggressive,” “manipulative,” “abrasive,” “adversarial,” “pushy,” “over-bearing,” “demanding,” “complaining,” and perhaps more generously as “adept at working the system” (Wheat et al., 1983; Gelfand, 1986; Sloane, 1991; Brod & Heurtin-Roberts, 1992; Duncan & Simmons, 1996; Ivanov & Buck, 2002). Health care providers and social workers in all of this literature express frustration with working with FSU newcomers. One study in particular mentions the difficulty in establishing relationships of trust with FSU newcomers, which providers in the United States see as a critical component in providing care (Gelfand, 1986).

Aggressive behavior with regard to obtaining critical social services can be seen as a survival mechanism acquired through generations of living under the Soviet system. In order to obtain a response from the bureaucratic system, one needed to be very proactive (Duncan & Simmons, 1996). “Cultural training [in the FSU] has made the Soviet immigrant highly astute at finding out what is available and how to get it” (Sloane, 1991, p. 195). A Russian language
interpreter in one study explained, “They come from a different system full of corruption. You are supposed to have a right to [health] care [in the FSU], but there is much corruption. You have to pay and bribe. They think it is the same here [in the United States]. We come from a rotten system, always standing in line” (Brod & Heurtin-Roberts, 1992, p. 334). Standing in line in the Soviet Union was so ubiquitous that it is now ingrained in the culture. Goods were scarce. Family members planned their activities around who would stand in which lines, and when. Older FSU newcomers have been socialized into that system of scarcity (Sloane, 1991). They are accustomed to having to behave this way and bring that behavior to their encounters with the United States health care system.

This mindset is vividly described by a social worker in Los Angeles, “For example, when a program which distributed surplus food commodities to low-income persons was first implemented, the rush for goods almost led to a riot at a local park. The Soviet immigrants, startled by the availability of free food and having very negative associations with waiting in lines, rushed to get as many of the goods as possible. Non-immigrants were shocked at this behavior. In more recent distributions, immigrants have conformed to the appropriate American behavior, but early experiences left a lasting impression on non-immigrants who still have the perception of the ‘pushy Russians’” (Sloane, 1991, p. 197). Another way the old Soviet-style behavior manifests itself in the United States is by newcomers claiming to have chest pain as a way of manipulating the triage nurses in the emergency department (Brod & Heurtin-Roberts, 1992). “Our Russian patients are well aware that a complaint of chest pain, particularly in an elderly patient, will insure their being seen promptly! Each time such an event occurs, we see clearly how they have been able to survive . . . and how that survival behavior continues here”
FSU newcomers believe that physicians are “gatekeepers” to further medical care and other social services, so they often make demands in the medical office to meet all of their other needs, whether housing, money, or transportation (Brod & Heurtin-Roberts, 1992).

**Acculturation**

As mentioned earlier in this chapter, the social ecological perspective posits that the multi-faceted determinants of health are not fixed in time. Unfortunately, however, the behavioral change models do not lend themselves to express determinants of health as they change through time. Acculturation may help conceptualize the dynamic, evolving interactions of personal, environmental, and behavioral determinants of health among immigrant populations.

A recent concept analysis defined acculturation this way, “Acculturation is a dynamic, multifactorial process of cultural learning that results in the changes in behavior, language, attitudes, lifeways, and values that occur from sustained interaction with different cultural groups. Acculturation occurs on a continuum with degrees or strategies that include assimilation, integration, and separation with individual and cultural differences in acculturative responses and strategies in personal and public lives” (McDermott-Levy, 2009, p. 285).

In operational terms, acculturation broadly refers to the process of selectively adopting and retaining language, identity, behavior, and values as one comes into contact with another culture. It is a complex process of “conflict and negotiation between two cultures” (Miller et al., 2009, 405). Acculturation models often seem to imply that acculturation is a uni-directional,
linear process (Hunt, Schneider, & Comer, 2004), but the definition used in this project understands it as described above – a process of negotiation over time.

Acculturation of FSU newcomers to the United States has been studied mostly with regard to acculturation stress and depression (Ucko, 1986; Althausen, 1993; Gutkovich et al., 1999; Miller & Chandler, 2002; Miller & Gross, 2004; Polyakova & Pacquiao, 2006; Birman, 2006; Miller et al., 2009). Mental illness is stigmatized in the FSU. Health care practitioners in the United States note a high degree of somatization of mental health complaints, such as pain, fatigue, and nausea (Miller & Chandler, 2002; Polyakova & Pacquiao, 2006). Older FSU newcomers may suffer from grief and mourning from the loss of their native country. Depression may occur during the first six months after the FSU newcomer has arrived in the United States. Symptoms of fear, anger, confusion, and a preoccupation with memories of their previous lives in the FSU are common (Fitzpatrick & Freed, 2000). Depression occurs from difficulties in forming meaningful relationships in the United States as well as a decline in social status (Fitzpatrick & Freed, 2000). FSU newcomers who witnessed the collapse of the Soviet Union may feel even more depressed or simply ambivalent about their situation (Fitzpatrick & Freed, 2000).

This researcher found only one study of acculturation among FSU newcomers that did not explicitly focus on mental health (Miller, Chandler, Wilbur, & Sorokin, 2004). A one-year longitudinal study of midlife FSU immigrant women in the United States, that looked at depression and CVD risk factors found that length of stay in the United States correlated with lower Framingham Risk Scores, indicating that CVD risk may decrease as women adopt a more American lifestyle (Miller et al., 2004).
Analysis

Now that the personal, environmental, and behavioral determinants of health among FSU newcomers have been identified and grouped, this section will categorize them in terms of whether they help or hinder the adoption of healthy behaviors. This information will be used to help evaluate health promotion interventions with this population.

Facilitators

Seven facilitators of health promotion were identified in the literature. These are described below and summarized in Table 1.

First, there are strong informal community networks among FSU immigrants which newcomers can tap into. These networks may facilitate health promotion communication. Peer support may also be strong, creating opportunities for observational learning through modeling. A Russian version of a promotora model could also be effective in this community.

Secondly, FSU newcomers are highly literate and well-educated. This facilitates the acquisition of new knowledge and suggests capability to apply the knowledge to daily life. Health promotion interventions should take the opportunity to provide detailed information about the links between CVD risk factors, behavior, and health consequences.

Third and fourth, health is highly valued among FSU newcomers, and FSU elders are motivated to maintain their health so as not to be a burden to their adult children. These two facilitators go together, as they indicate a receptiveness to health promotion activities. Interventions must be designed to capitalize on these values.
Fifth, FSU newcomers have a rich history of folk remedies and self care practices. Once again, this speaks to the high value placed on health and the motivation to stay healthy. Health care providers (HCPs) can build trust and credibility with FSU newcomers by demonstrating knowledge and understanding of these practices, and supporting them if not contraindicated.

Sixth, FSU newcomers have relatively high health control beliefs, meaning that they have an awareness that individual human behavior influences personal health. Unfortunately, the literature shows that the beliefs are not accompanied by healthy-behaviors. Nonetheless, beliefs are a starting point from which health promotion interventions can build.

Lastly, FSU newcomers are savvy about procuring necessary health care and social services when they think they need them. FSU newcomers are willing to put time and effort into obtaining services that they believe will benefit them. The implication for health promotion is that clear messages need to be sent to this community about the benefit of preventive care.

<table>
<thead>
<tr>
<th>Factor (Facilitator)</th>
<th>Implications for health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong informal community networks</td>
<td>Communication may be easier, peer support may be stronger, with opportunities for observational learning.</td>
</tr>
<tr>
<td>Highly literate and well-educated population</td>
<td>FSU newcomers are able to assimilate and apply health-related information to daily life.</td>
</tr>
<tr>
<td>Health highly valued in the culture</td>
<td>FSU newcomers may be highly motivated to adopt healthy behaviors.</td>
</tr>
<tr>
<td>Elders motivated not to be a burden on adult children</td>
<td>FSU newcomers may be highly motivated to adopt healthy behaviors.</td>
</tr>
<tr>
<td>Robust culture of folk remedies to build on</td>
<td>By demonstrating knowledge and understanding of these folk beliefs, HCPs can build trust and credibility with the community.</td>
</tr>
<tr>
<td>Positive health control beliefs</td>
<td>FSU newcomers are aware that individual behavior impacts health.</td>
</tr>
</tbody>
</table>
Factor (Facilitator) | Implications for health promotion
--- | ---
Savvy about obtaining necessary health care and social services when needed | FSU newcomers are willing to put effort into obtaining services that will benefit them.

Table 1: Facilitators of health promotion among FSU newcomers

**Impediments**

Nine impediments to health promotion were identified in the literature. These are described below and summarized in Table 2.

First, there is a distrust of messages from the media, which stems from the legacy of the Soviet Union propaganda system. Awareness of this perception is critical for health promotion practitioners. Interventions such as public health campaigns that utilize radio, newspapers, billboards, and television are unlikely to be taken seriously, and messages from credible sources are likely to be disregarded. Public health professionals may need to invest in educating FSU newcomers about the difference between commercial advertising and non-profit public service announcements.

Second, FSU newcomers lack English language abilities, which impedes their communication with health care providers, curtails their access to pertinent health information, makes it less comfortable and convenient for them to get preventive health screenings, and results in social isolation and in some cases alienation from the system that aims to provide care. The implications of the lack of language ability on health promotion has been well-documented elsewhere.
Third, among FSU newcomers there is a low level of knowledge of CVD risk factors and of how to mitigate risk through healthy lifestyles. Without knowledge of the links between behavior and health outcomes, the status quo of high-fat diets and sedentary lifestyles is unlikely to change.

Fourth and fifth, lack of experience with regular preventive health care and screenings, and expectations of curative rather than preventive care. Preventive care was not emphasized in the FSU. Consequently, FSU newcomers seek care only as a last resort, when home remedies have failed to achieve the desired effect. FSU newcomers have definite expectations for medical care to be curative; therefore they aggressively seek acute care services when ill. The implication for health promotion are that the status quo is unlikely to change without a culturally tailored educational campaign about the value of preventive care.

Sixth, among FSU newcomers there is a low level of compliance with medications for CVD prevention (such as anti-hypertensives). This is manifested by not taking the medication at all, taking it only when they think it is needed, or taking it in combination with medications about which the prescriber is not aware. The implications for health promotion are the lower efficacy of the medication if not taken as directed, which then may not have the intended health result of reducing CVD risk. There is also a risk of interactions of prescribed medications with home remedies.

Seventh and eighth, FSU newcomers undergo the stress of multiple caregiver roles as well as of coping with lower socioeconomic status. This leads to a preoccupation with finding time to care for multiple family members, accompanying them on visits to health care providers,
trying to earn extra income, and providing for extended family. Transportation becomes inaccessible, and routine health care becomes cost prohibitive depending on insurance.

Lastly, the literature abounds with reports of inappropriate aggressive and manipulative behavior on the part of some FSU newcomers in order to obtain health care and social services. The implication for health promotion is the risk that HCPs will feel alienated resulting in lower quality of care.

<table>
<thead>
<tr>
<th>Factor (Impediment)</th>
<th>Implications for health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distrust of media messages</td>
<td>FSU newcomers disregard even the credible messages believing there is a hidden motive.</td>
</tr>
<tr>
<td>Lack of English language</td>
<td>There are frequent miscommunication with HCPs, a reluctance to get preventive health screenings, and a sense of isolation among the newcomer.</td>
</tr>
<tr>
<td>Low level of knowledge of CVD risk factors and how to mitigate risk through healthy lifestyles</td>
<td>There is a continuation of the status quo with regard to CVD risk behavior.</td>
</tr>
<tr>
<td>Lack of experience with regular preventive health care and screenings. Fatalistic view of preventive care</td>
<td>There is a continuation of the status quo, which is to avoid preventive care and screenings.</td>
</tr>
<tr>
<td>Expectations of curative rather than preventive care</td>
<td>There is a continuation of status quo, which is to overutilize acute care services and underutilize preventive care.</td>
</tr>
<tr>
<td>Low level of compliance with medications for CVD risk (anti-hypertensives, etc.)</td>
<td>There is a risk of lower efficacy of the medication if not taken as directed. There is a risk of interactions of medications with home remedies.</td>
</tr>
<tr>
<td>Stress of multiple caregiver roles</td>
<td>There is a preoccupation with finding time to care for multiple family members, and with accompanying them on visits to health care providers.</td>
</tr>
<tr>
<td>Stress of low socioeconomic status</td>
<td>There is a preoccupation with earning extra income and providing for extended family. There is a lack of accessible transportation. There is an inability to pay copays and fill prescriptions.</td>
</tr>
<tr>
<td>Inappropriate aggressive and manipulative behavior to obtain health care and social services</td>
<td>There is a risk of alienation of HCPs resulting in lower quality of care for the newcomer.</td>
</tr>
</tbody>
</table>

Table 2: Impediments to health promotion among FSU newcomers
Summary: Implications for Health Promotion

Many FSU newcomers spent their formative years under a completely different biomedical culture that emphasized curative care over preventive care. Health promotion was not practiced, though health control beliefs indicate awareness of the links between behavior and health. FSU newcomers’ minimal feelings of personal responsibility for health care and lack of appreciation of preventive health care have adverse implications for their ability to attain good cardiovascular health. Because older FSU newcomers often do not understand a need to practice self-management of their chronic illnesses, they are at risk for complications and sequelae.

Mutual education is required between FSU newcomers and United States health care providers. The FSU newcomers must be taught how the U.S. system works and its underlying values. Health care providers should be educated about the cultural influences (broadly defined to include biomedical culture and Soviet culture, not only “Russian” culture) that have shaped the behavior and attitudes of the newcomers. Health promotion interventions and public health campaigns must be tailored to the health beliefs and values of FSU newcomers.

The values of self-control and individual agency are paramount in American culture, and pervade our society. In the United States biomedical culture, practitioners do not often reflect on the cost of perfect self regulation on quality of life, especially for immigrant populations socialized in other cultural values. Immigrant patients may quickly be labeled non-compliant for simply making tradeoffs between control and acceptable risk, based on their cultural values.

Limitations of the Literature
Little research has been done on successful health promotion strategies with FSU newcomers. Much of the research on health beliefs and practices of FSU newcomers concludes with policy recommendations or advice to health care providers. These recommendations, however, remain untested and/or undocumented. Therefore, evidence is lacking to demonstrate the effectiveness of the recommendations.

Many of the studies reviewed in this paper used small sample sizes \((N = 30)\), used self-selected participants who were eager to express either a negative or positive point of view, or took place in unique geographic areas not generalizable to other parts of the country (e.g. Boston, where there is a high concentration of FSU immigrants as well as Russian-speaking health care providers; or semi-urban Virginia, with 30 people self-selected from a Pentacostal church). Many studies were done with a subset of the population (e.g. mid-life women). Nonetheless, by synthesizing those studies here, the goal has been to provide a thorough picture of the heterogeneity of voices, as well as pull out some recurring themes that unite these diverse experiences.
CHAPTER THREE: PRACTICE INQUIRY

This chapter describes an ongoing health promotion activity implemented with this population and describes the incremental evaluations that have been performed to date. The following description of the “Let’s Be Healthy!” project comes from two sources, the program description provided to the public by the San Francisco (SF) Department of Public Health at the program’s inception in 2005 (Diamondstone, 2006) and the latest evaluation report produced in 2008 (Meucci, 2008).

“Let’s Be Healthy!”

The “Let’s Be Healthy!” Project is a project of the SF Department of Public Health, started in 2005. The project’s purpose is to “change norms around health.” The project aims to “equip Russian immigrants in San Francisco with the resources they need to maintain healthy lives” (Meucci, 2008, p. 1). Behavioral change around CVD risk factors is the project’s main aim. The project addresses “behaviors and risk factors prevalent among newcomers from the Former Soviet Union such as high blood pressure and cholesterol, obesity and overweight, tobacco use, and alcohol consumption” (Diamondstone, 2006, p. 1).

The specific objectives are: 1) recruitment and training of eight pomoshniks (the Russian word for “helper”) from the Russian-speaking community; 2) outreach to 7,000 Russian-speaking newcomers through the community education campaign; 3) newcomer participation in Healthy Living activities (cooking classes, walking group, and perhaps others not listed in the
available documents); and 4) addressing chronic health conditions (50 individuals attend Group Medical Visits) (Meucci, 2008).

The target population is FSU newcomer middle-age and older adults who already suffer from chronic disease or who are at risk. The project is not limited to people with chronic disease, but is open to the Russian-speaking community at large (Meucci, 2008). There are approximately 25,000 Russian-speaking newcomers in San Francisco (Diamondstone, 2006).

The implementation of the project is based on the Chronic Care Model (CCM), which is a clinically-oriented implementation model which posits that improved clinical and functional health outcomes are the result of “productive interactions between informed, activated patients and the prepared, proactive practice team of clinicians and healthcare professionals” (Barr et al., 2003, p. 75). The CCM will be analyzed as part of the practice inquiry project.

The “Let’s Be Healthy!” project combines “community-based prevention and education efforts with innovative patient-centered care.” The project builds on the strengths of the FSU newcomer community, and the comfort derived from group activities, including medical visits which are structured as group visits, “tapping into their existing cultural norms” (Meucci, 2008, p. 2). Project activities include community outreach, role modeling, education, and support for adopting healthier behaviors. In addition, community members work on a mass media campaign about adopting healthy lifestyles. They develop messages for a community health campaign that “defines health broadly as being physically active, eating nutritiously, having self-esteem and self-empowerment, and enjoying one’s quality of life” (Diamondstone, 2006, p. 2).
The press release describes the philosophy as follows (Diamondstone, 2006):

Let’s Be Healthy!, situated in San Francisco’s Sunset neighborhood, sponsors a growing menu of free or low-cost activities for Russian-speakers of all ages. Activities are based on expert recommendations and were developed with input from the Russian community. Each activity is facilitated by trained, Russian-speaking, community health workers who are themselves immigrants from the former Soviet Union (FSU). Activities include healthy cooking classes that modify traditional recipes and a variety of walking groups for people with common interests. The Pioneers are a walking group made up of Russian-speakers who came during the first wave of immigration in the 1970’s. More activities are being planned such as a swimming and sauna group and the highly anticipated healthy borsch-tasting contest.

Another aim of the “Let’s Be Healthy!” project is to assist with language barriers between Russian-speaking patients and health care providers. Bilingual staff will be integrated into clinic services at the Ocean Park Health Center, which sees a large number of Russian-speaking patients. The language facilitation is not only to “help with translation but also empower patients with the knowledge needed to self-manage chronic diseases” (Diamondstone, 2006, p. 2).

The Program Manager of San Francisco’s Department of Public Health says this about the program, “We are aiming not only to provide Russian-speakers with resources and information to manage their chronic illnesses, but more importantly to promote overall well-being and change community norms about healthy living through raising awareness and leadership development” (Diamondstone, 2006, p. 2).
Though the words “health promotion,” “vulnerable population,” and “cardiovascular disease” do not appear in the “Let’s Be Healthy!” project documents, the project description, goals, and activities make this an appropriate program to evaluate for this practice inquiry.

**Monitoring Progress**

An evaluation of “Let’s Be Healthy!” was conducted in 2008 by an outside consultant in concert with the project staff. The process included: 1) evaluation of the pomoshnik training, which was measured by three focus groups with the pomoshniks; 2) evaluation of the Healthy Living Series group, which was done with a post-test participant evaluation; and 3) evaluation of the Chronic Disease Self-Management group using a pre-test and post-test of participants, as well as participant evaluation of the group medical visits and clinical indicators for each series of group medical visits (Meucci, 2008).

The data used in the evaluation were primarily quantitative (number of pomoshniks trained, number of participants in the activities, and other numerical measurements). Qualitative data were gathered in the form of anecdotes extracted from focus group discussions to support the successful accomplishment of the objectives. The indicators of success were generally more process-oriented than outcome-oriented with the exception of the clinical indicators from the medical visits, which were not analyzed for statistical significance, rather were summed up in an appendix at the back of the report.
Potential Outcome Indicators

The “Let’s Be Healthy!” Project meets the criteria as a suitable health promotion project to evaluate for use of effective strategies for health promotion with vulnerable populations. However, the objectives as outlined in the available project documents, and the indicators that were measured in the evaluation in 2008, allow for only a superficial analysis of the health promotion outcomes. The program is ongoing at this time. I propose to take a different approach to the program evaluation, selecting a new set of indicators based on the analysis of impediments and facilitators described in Chapter Two. A preliminary set of indicators is proposed in the table below. These indicators, however, will be adjusted as I gain access to the core project documents and can clarify the parameters of the project.

<table>
<thead>
<tr>
<th>Factor (Facilitator)</th>
<th>Implications for health promotion</th>
<th>Strategy/Intervention</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong informal community networks</td>
<td>Communication may be easier, peer support may be stronger, opportunities for observational learning</td>
<td>Community-level interventions may be more effective</td>
<td>Capable, effective community network and communication mechanism</td>
</tr>
<tr>
<td>Highly literate and well-educated population</td>
<td>Able to assimilate and apply health-related information to daily life</td>
<td>Find innovative ways to educate FSU newcomers about CVD pathophysiology and the links between behaviors and health outcomes</td>
<td>Increased knowledge and understanding of consequences of CVD risk behaviors</td>
</tr>
<tr>
<td>Health is highly valued in the culture</td>
<td>FSU newcomers may be highly motivated to adopt healthy behaviors</td>
<td>Support health-related activities that FSU newcomers enjoy</td>
<td>Maintain or improve health-related quality of life and well-being</td>
</tr>
<tr>
<td>Elders are motivated not to be a burden on adult children</td>
<td>FSU newcomers may be highly motivated to adopt healthy behaviors</td>
<td>Support health-related activities that FSU newcomers enjoy</td>
<td>Maintain or improve functional health status</td>
</tr>
<tr>
<td>Robust culture of</td>
<td>By demonstrating</td>
<td>HCPs should learn all</td>
<td>Improved relationships</td>
</tr>
<tr>
<td>Factor (Facilitator)</td>
<td>Implications for health promotion</td>
<td>Strategy/Intervention</td>
<td>Expected Outcome</td>
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<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>folk remedies to build on</td>
<td>knowledge and understanding of these folk beliefs, HCPs can build trust and credibility with the community</td>
<td>they can about these remedies and support them if not contraindicated</td>
<td>of trust, respect, and credibility between HCPs and FSU newcomers</td>
</tr>
<tr>
<td>Positive health control beliefs</td>
<td>FSU newcomers are aware that individual behavior impacts health</td>
<td>Positive reinforcement to strengthen self-efficacy</td>
<td>Higher perceived self-efficacy among FSU newcomers</td>
</tr>
<tr>
<td>Savvy about obtaining necessary health care and social services when needed</td>
<td>FSU newcomers are willing to put effort into obtaining services that will benefit them</td>
<td>Send a clear message about the benefits of preventive care and make it accessible to the community</td>
<td>More FSU newcomers participate in preventive care services</td>
</tr>
</tbody>
</table>

Table 3: Facilitators to health promotion, suggested interventions, and expected outcomes

<table>
<thead>
<tr>
<th>Factor (Impediment)</th>
<th>Implications for health promotion</th>
<th>Strategy/Intervention</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distrust of media messages</td>
<td>FSU newcomers disregard even the credible messages believing there is a hidden motive</td>
<td>Distinguish between for-profit advertising and non-profit Public Service Announcements</td>
<td>Increased awareness of credible public media sources</td>
</tr>
<tr>
<td>Lack of English language</td>
<td>Miscommunication with HCPs, reluctance to get preventive health screenings, isolation</td>
<td>More Russian-speaking HCPs, more trained interpreters to accompany on health visits, more written materials in Russian</td>
<td>Increased attendance at health screenings</td>
</tr>
<tr>
<td>Low level of knowledge of CVD risk factors and how to mitigate risk through healthy lifestyles</td>
<td>Continuation of the status quo with regard to CVD risk behavior</td>
<td>Find innovative ways to educate FSU newcomers about CVD pathophysiology and the links between behaviors and health outcomes</td>
<td>Increased knowledge and understanding of consequences of CVD risk behaviors</td>
</tr>
<tr>
<td>Lack of experience with regular preventive health care and screenings</td>
<td>Continuation of status quo - avoid preventive care and screenings</td>
<td>Send a clear message about the benefits of preventive care and make it accessible to the community</td>
<td>More FSU newcomers participate in preventive care services</td>
</tr>
<tr>
<td><strong>Factor (Impediment)</strong></td>
<td><strong>Implications for health promotion</strong></td>
<td><strong>Strategy/Intervention</strong></td>
<td><strong>Expected Outcome</strong></td>
</tr>
<tr>
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</tr>
<tr>
<td>Fatalistic view of preventive care</td>
<td>Continuation of status quo - overutilization of acute care services and underutilization of preventive care</td>
<td>Send a clear message about the benefits of preventive care and make it accessible to the community</td>
<td>More FSU newcomers participate in preventive care services</td>
</tr>
<tr>
<td>Expectations of curative rather than preventive care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low level of compliance with medications for CVD risk (anti-hypertensives, etc.)</td>
<td>Lower efficacy of medication if not taken as directed. Risk of interactions with home remedies.</td>
<td>HCPs should be sure to educate FSU newcomers about medications and instruct them about the importance of declaring all other medications from the FSU that they may be taking</td>
<td>Increased understanding among FSU newcomers about medications, decreased risk of inefficacy, decreased incidence of drug-to-drug interactions</td>
</tr>
<tr>
<td>Stress of multiple caregiver roles</td>
<td>Preoccupation with finding time to care for multiple family members, accompanying them on visits to health care providers</td>
<td>Expand services such as Meals on Wheels, senior day care programs for Russian-speakers, and home health nurses. Develop a community support network where long-time FSU immigrants can support newcomers</td>
<td>Lower levels of stress, higher rated quality of life</td>
</tr>
<tr>
<td>Stress of low socioeconomic status</td>
<td>Preoccupation with earning extra income and providing for extended family. Lack of accessible transportation. Inability to pay copays and fill prescriptions</td>
<td>Expand transportation services for the elderly. Develop a community support network where long-time FSU immigrants can support newcomers</td>
<td>Lower levels of stress, higher rated quality of life</td>
</tr>
<tr>
<td>Inappropriate aggressive and manipulative behavior to obtain health care and social services</td>
<td>Risk of alienation of HCPs resulting in lower quality of care</td>
<td>HCPs and Social Workers should provide reassurance about service availability and entitlements to care. More case managers to coordinate care</td>
<td>More FSU newcomers participate in preventive care services and other social services</td>
</tr>
</tbody>
</table>

Table 4: Impediments to health promotion, suggested interventions, and expected outcomes
Conclusion

Chapter One outlined and defined the challenge of conducting health promotion with a vulnerable population from a different culture and with different values. It also provided the background and rationale for this project, defined key terms, and outlined the significance to nursing. Newcomers from the FSU were selected as the target population to illustrate the challenges.

Chapter Two provided a brief overview of concepts relevant to health promotion with vulnerable populations and described an analytical framework for the project integrating SCT into a socioecological perspective. A literature review of health determinants of FSU newcomers followed, structured according to the conceptual framework of personal determinants, environmental determinants, and behavioral determinants. Information gleaned from the literature review was analyzed to identify facilitators and impediments to health promotion among FSU newcomers which was then linked to health promotion approaches.

Chapter Three laid the foundation for a subsequent practice inquiry project to evaluate a community health promotion program entitled “Let’s Be Healthy” currently ongoing with FSU newcomers in San Francisco. The evaluation will analyze the Chronic Care Model (CCM) used to guide the design of the program, and will identify strengths and weaknesses of the model for health promotion. Overall, this Master’s Project combined with the Doctoral practice inquiry will help bridge the gap between health promotion theory and practice.

An improved understanding of the challenges of health promotion with FSU newcomers, combined with an evaluation of an existing program, will lead to improved interventions for
health promotion among FSU newcomers, and will possibly serve as a model for health promotion programs with other vulnerable populations.
REFERENCES


