

Pregnancy and Infant Care Experiences of Meshketian Turkish Refugees

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ABSTRACT

Many of the Meshketian Turkish refugees are receiving pregnancy and infant care at the University of Virginia Health System's International Family Medicine Clinic. As new refugees from a different culture and with previous experiences in a different health care system, they are challenged to care for their infants and themselves, and physicians are challenged to care for them in a culturally sensitive manner. This study utilized two focus groups to investigate the experiences and views of these women on pregnancy and childcare in order to improve the care that they receive at UVA. The focus group on pregnancy had two women, and the focus group on infant care had four women. A Russian interpreter was used. Common themes in both discussions were: 1) the importance of family, 2) familiarity with Western medicine, 3) approval of how medicine is practiced in the United States versus Russia, and 4) inadequate communication between UVA and refugee patients.

INTRODUCTION

Meshketian (also spelled Meskhetian) Turks are a growing refugee population in Charlottesville, Virginia. An ethnic group created under Stalin during WWII, the Meshketian Turks primarily originated from the Georgian/Turkish border as a collection of small Muslim ethnic groups. Stalin deported all of the groups to Central Asia, primarily Uzbekistan, where the groups coalesced into the Meshketian Turks. Ethnic violence broke out in Uzbekistan against the Meshketian Turks in the late 1980s; most fled to Russia where they faced discrimination by being denied Russian citizenship and the rights that go along with it, such as the right to health care, the right to work, and the right to advanced education.¹ The United States granted the Turks refugee status in 2004.² The International Refugee Committee (IRC) and other nonprofit organizations sponsor them for resettlement. The IRC's Charlottesville Chapter has resettled a large number of families locally.

Very little has been published about the Meshketian Turks. However, while there were no hits on Meshketian Turks in PubMed, there were multiple articles on Uzbekistan, Russian and Islam, and we also spoke with a nurse at UVA who had been a Peace Corps volunteer in Uzbekistan from 2003-5. As members of the Former Soviet Union, we expected some commonalities between the Meshketian Turks, Uzbekistanis, and Russians, but it was unknown just how far those similarities stretched,

especially since many of the participants were preteens or younger when the Soviet Union fell. Meshketian Turks are also of Muslim heritage but many do not practice, so we could not make assumptions about their health care beliefs based on their religious tradition. Add many years of persecution into the mix, and it was difficult to presume anything about this population. The solution was to ask them directly, and focus groups were the best interview method given our time and budget constraints.

The focus group method is a widely accepted qualitative method for uncovering the views and opinions of the participants using a discussion format. It has been commonly used as a market research technique for over 50 years and has since become popular in the health sciences and many other research venues.² The concept of focus groups is that most human opinions and beliefs are formed by group interaction, and therefore a permissive, non-threatening environment will help identify and clarify the thoughts and opinions of like individuals concerning a particular subject of interest.³ If done correctly, those beliefs uncovered by the focus group can then be assumed to be the beliefs held by the demographic represented by the focus group. A moderator, typically one of the researchers, poses questions to a group of 4-12 participants, and then allows the discussion to flow freely while he/she listens unobtrusively.² The moderator may also prompt the participants to elaborate or clarify their responses, or to encourage quiet participants to speak or dominant ones to let others talk. Other researchers may also be present to assist the moderator, keep track of time, take notes on particular comments or participant interactions, and troubleshoot during the group. Discussions are typically tape recorded to allow for better recall after the session.⁴

Many of the Meshketian Turks are receiving pregnancy and infant care in the UVA Department of Family Medicine's International Family Medicine Clinic. Unfamiliar with the culture and health care system of the United States, these new refugees have difficulties in caring for their infants as well as in getting care for themselves. Likewise, the health care providers face challenges in providing them with culturally appropriate care and in introducing them to unfamiliar tests, procedures, and recommendations. This study used the focus group technique to investigate the experiences and beliefs of these women on pregnancy and child care in order to improve the care that they receive at UVA. A Russian interpreter was utilized during the focus groups. The discussions were tape recorded, from which

abridged transcripts were created and analyzed for thematic content.

METHODS

The study was approved by the Institutional Review Board for Health Sciences Research at the University of Virginia Health System. Participants were selected if they were Meshketian Turkish women who were either pregnant or had children less than 18 months old with previous knowledge or experience of being pregnant or raising a child in Russia. We decided to contact four women in each group. They were telephoned by staff members at the International Rescue Committee (IRC) and the participants received a reminder call the day of the session. The focus group sessions were held at the IRC office as it was a well-known and comfortable location for the participants.

Informed consent was obtained by the interpreter reading the consent form to the participants and then participants signed a short-form of the consent written in Russian. Participants were read instructions about the focus group process, and given the opportunity to ask questions before the session began. Each discussion lasted 90 minutes long, used a script of about 25 questions, and there was an optional 30 minute educational presentation on contraception methods in the United States afterward. Snacks were provided during the session and participants were given a gift basket of infant care products (value \$25) at the end of the session.

RESULTS

We interviewed two participants in the infant care group and four in the pregnancy group. Participants had been in the United States a mean of 10.5 months (range: 6 months-18 months), and had one or two children (66% had one child) about 4.5 years of age (range: 5 months-15 years), not including their current pregnancy. All were married, and all had given birth in Russia, except one participant in the infant care group who had only given birth in the United States.

The discussions revealed major topics of interest and of concern. Common themes in both discussions were: 1) the importance of family, 2) familiarity with Western medicine, 3) approval of how medicine is practiced in the U.S. versus Russia, and 4) inadequate communication between UVA and refugee patients.

Importance of family

In both focus groups, the importance of family was clearly demonstrated. All the women agreed that there is significant pressure to start a family—Meshketian Turkish marriages are typically arranged and the wife is

expected to get pregnant within one year, and most of the women we spoke to had become pregnant within a few weeks of getting married. The women explained:

D: “Turkish customs, if [a new couple] don’t have children for a long time, rumors go around. Maybe they have something wrong with them.”

Ga: “When they have a daughter-in-law...and she’s not pregnant immediately or shortly after, they start spreading rumors—maybe something is wrong with her or she’s sick or she can’t get pregnant.”

The family also can exert significant influence on the care of children and the running of the household. The husband is the head of his family, but his mother is the matriarch over the extended family, and she traditionally lives with the youngest married son. In terms of the daughter-in-law, her mother-in-law can be her best friend or her worst enemy. She may dote on her daughter-in-law, buying her things:

“Ga: They also have special pillows to feed the baby, and my mother-in-law says ‘let’s go buy you some, something like this, something special.’”

She may also argue constantly with her daughter-in-law over how to care for children:

“N: We have discussion and argument at home...the disputes are between grandma and grandpa and myself. They are so used to the Russian style of overdressing their children...and [I think] babies should not be overdressed.”

However, it is very typical for the daughter-in-law to get most of her child care advice from her mother-in-law, often more so than her own mother; most of the participants mentioned her mother-in-law when asked about whom they get advice from, but only two mentioned their own mother. All of the women we spoke to also assumed that it was the mother-in-law’s role to provide child care if needed. One woman in the pregnancy group explained:

“D: My mother-in-law is at home, she helps;...my mother-in-law watches my daughter, and I go to work come home.”

When asked if the mother-in-law usually helps, another woman in the infant care group agreed:

“U: When she is at home, she does help.”

The mother-in-law can also use her childcare role to get her own way; one of the women who was supposed

to come to the focus group had to cancel because her mother-in-law unexpectedly decided to go out of town, and it was assumed by everyone that it was the mother-in-law's way of preventing her daughter-in-law from attending the focus group.

Husbands are also expected to help their wives with child care and household chores as they are able, although they don't always do so. One woman in the infant care group lamented:

"U: Honestly, I can tell you, I have seen no help from my husband. I gave birth and took care of my child...I would leave my child with my mother-in-law when I needed to get something...no, it's not typical, better husbands help better."

The women in the pregnancy group agreed that their husbands help and are supposed to help:

"Gn: My husband helped me all 9 months, even after I gave birth."

"Ga: Before birth and after because [it was] the first baby...and now [that I'm pregnant again] my husband helps me of course."

All of the pregnant women also felt that the husband helps out even more now that they are in the United States:

"Ga: Yes, they try [to help out more]."

"Gn: They work more."

"D: Sometimes they cover two jobs."

"Ga: They come from work very tired but they try to help me too."

"Gn: Same from me."

It should be mentioned that it is possible that the more cooperative husbands would be more willing to give their wives permission to attend a focus group. However, we only had two women who did not attend, one of which we know was because of the mother-in-law, so it is very possible that the Turkish husbands are very helpful in general.

Knowledgeable of Western Medicine

The focus group discussion revealed that the Meshketian Turks were well-acquainted with Western medicine. In both groups, the women strongly agreed that doctors' medical opinions outweigh all other opinions, even among their close relatives:

"Ga: Doctor advises me something, my relatives would agree with the doctor."

"D: Yes, doctors know what to do."

The women agreed that both Russian and U.S. doctors tell their pregnant patients to restrict coffee, to exercise, and that breastfeeding is taught and encouraged. Additionally, women in the pregnant group all agreed that they preferred female doctors, specifically female obstetricians, in part because in Russia all obstetricians are women and because:

"D: I prefer women. When a man is present, I'm too shy."

The women in both groups were comfortable using prescriptions and over-the-counter medications to treat disease, and did not commonly use any home remedies. They were also used to regular prenatal and well-child visits on a schedule similar to the United States. In fact, the infant care group wanted even more frequent well-child visits in Russia, and agreed:

"U: I wish [the children] would be checked out monthly and regularly [in the U.S.]...when there is something changing within the month from appointment to appointment then you can have that question resolved with the interpreter and ask the doctor."

The pregnant women's group was familiar with taking prenatal vitamins, and with common procedures of pregnancy, such as ultrasounds, blood tests, and IV lines, although their use may be different than in the United States. Not all women took prenatal vitamins nor saw the need for them, blood tests may have been more frequent in Russia (although this was seen as negative—they prefer less testing), and epidurals are not commonly used in Russia—even those women who had given birth less than two years ago had barely heard of epidurals, much less had one during delivery. Additionally, all the women we interviewed had given birth in the hospital under the supervision of an obstetrician, although they reported that in Russia the husband or family members are not allowed in the hospital building to witness the birth or visit the newborn.

There are some differences in standards of care for pregnancy and childcare between Russian and the United States. Doctors in Russia discourage women from always putting infants on their backs to sleep—a practice that is encouraged in the U.S. to prevent Sudden Infant Death Syndrome. Women in both groups also agreed that in Russia they are also told to avoid certain fruits or vegetables while nursing because these foods were supposed to cause gastrointestinal problems in the infant:

“D: They say don’t eat anything red, strawberries or pickles, because they say if you eat that, the baby will have diarrhea.”

“Ga: I ate a tomato and the very same day [my daughter] had constipation and everything else--the stomach problems.”

“N: Sometimes people say you can’t eat fruit. They say babies will have stomach problem if you eat fresh fruit.”

However, the participants did recognize that in the United States they are encouraged to eat all foods and are happy doing that:

“Gn: My brother-in-law had a baby [in the U.S.] and the doctor told them they can eat everything after birth, a little bit of everything and nothing has happened. But in Russia, the baby was sick immediately after you eat something wrong.”

The consumption of water by pregnant women or infants also differs between the US and Russia. In Russia, if a woman has edema she is restricted from water, but in the U.S. pregnant women are encouraged to drink water. Also, in the United States women are told to restrict giving water to infants until six months, but in Russia water was not restricted and mothers were especially encouraged to have the infant drink water if the child had a fever.

Approval of Medicine in the United States

The women in both focus groups were generally pleased with the medical care they were receiving at UVA and preferred it to the care they had received in Russia. Health care providers were seen as much more friendly in the United States and women preferred to be pregnant in the United States rather than in Russia. Multiple women revealed experiences where they had been yelled at by their Russian health care providers because the women didn’t give enough “tips” (bribes), didn’t provide enough supplies for a procedure (in Russia, a patient is expected to provide all the gauze, gloves and other medical supplies), or they were upset because a procedure was uncomfortable. The participants also explained that they were assigned a doctor for their prenatal care and they could not switch providers:

“Ga: We had no choice. There was only one doctor we had. But if I say, ‘I don’t want you,’ she would say, ‘go anywhere you want.’ ...whoever they assigned you, all women had no choice.”

The women in the infant group also explained that because Meshketian Turks were not legal Russian citizens, most Russian doctors would not see them and they were treated differently by doctors because of their Turkish background.

Some of the women in the pregnancy focus group revealed very difficult or terrifying experiences and unsanitary conditions within the Russian health care system. One particular conversation about why one of the participants delayed prenatal care until 16 weeks gestation was particularly emotional:

“Ga: I had different advice from other people. They advised not to go there because they said they wouldn’t treat you well. The women were sharing different things, scary things. They say when they do the testing, they can harm the pregnancy and it’s scary.”

“Gn: Same happen to me. They used cold, metal instruments. They were so uncomfortable. It was very scary. And they were screaming at us, ‘How does your husband take you, that you don’t like this?’”

“Ga: During my delivery, doctor was under the influence of alcohol, a man. Of course, he was just supervising.”

In contrast to their difficult experiences in Russia, the participants were very pleased with their experience in the United States. All the women felt it was easy to be pregnant or raise a child in the U.S. They expressed delight over the maternity products that are available in the United States, such as maternity clothes and special pillows, none of which exist in Russia. The women in the infant care group also liked having Medicare and using WIC (Women Infants and Children), a special supplemental nutrition program in Virginia:

“U: I think it is all better here because I belong to the WIC program that helps me... Convenience is here in the United States. It is much better here.”

“N: In Russia, I was so busy with everything to take care of chickens, yards and orchard and here I have enough time to take care of the baby. And I have enough time and all the conveniences are there.”

Women in the pregnancy group echoed similar sentiments:

“Gu: I don’t have any difficulties [being pregnant in the U.S.]. Everything comes easy, normal. It’s a little boring.”

“Ga: Compared to Russia, over there we had cows and orchards to take care of, and gardens, and had

to go milk the cow, and canning. A lot of home work. It's easy here.

"Gn: Too much time. Everything is easy, all the conveniences are there."

When asked about their doctors in the United States, the women said:

"Ga: Here we are treated very well, very carefully tender."

*"Gn: And everybody is so happy that we have a baby--we feel so well!!"
[all laugh and nod]*

The women also approved of how they were constantly being asked their opinions or preferences in the United States:

"D: Here [in the U.S.], you are asking, 'who would you prefer, a woman or a man; or do you prefer one doctor over the other,' ...over there [in Russia] whoever would be matched, that all your choice."

Inadequate Communication at UVA

An unintended benefit of doing these focus groups was that we discovered that half of the women we interviewed were either no longer receiving prenatal or infant care and/or were not receiving follow-up appointments. These women were not aware that U.S. schedules for prenatal or well-child visits were similar to Russia so they didn't know that they were missing appointments. A pregnant woman said:

"Gn: How is it here? I haven't been called for a long time...Once I was called for ultrasound and I haven't been there for two months now. Do I have to make an appointment on my own?"

A similar situation was uncovered when it was mentioned that the five-month-old child of a woman in the infant group had only received one shot at two months of age. She explained:

"N: In Russia, we used to go to do the immunization shots; they would call after and check to see if the baby was doing well, maybe there was a swelling or something. At two months, we did a shot [in the United States] and after that, nobody called us and we didn't go to show the baby anymore."

The other woman in the infant care group had to take responsibility for making sure her children got their shots:

"U: I don't wait for [UVA] to call me, I already go by myself...I ask for the time of the appointment—when is my next immunization due—and they tell me the date and then I make the appointment."

The language barrier also makes it difficult for these women to make appointments:

"When I visit a doctor and it's a follow-up, then I get an appointment before I leave. If it's an emergency and I need to make a phone call, it's very hard for me. I'd rather go in person and it's easy for me to communicate in person, using the body language, using my hands, but over the phone it's very difficult."

However, the women in both of the groups agreed that they were able to communicate effectively using interpreters or the interpreter phone at the doctor visits—the difficulties they have are in situations when interpreters aren't involved. All the participants also agreed that they needed to learn English:

"U: It's not so great not to know English and I thank you for having interpreters available."

"Ga: If there is no live interpreter, we use the phone. We wouldn't understand each other if we didn't have them. But we have to learn the language."

DISCUSSION AND CONCLUSION

Based on the literature review and focus groups, we concluded that the Meshketian Turks are most similar to Russians in terms of their health care beliefs and to the Uzbekistani for their family arrangements. Additionally, aside from a male head of household, the Meshketian Turks have little in common with Muslim traditions. The literature review also supports many of the statements made by the women during the focus groups.

The family arrangement of the Meshketian Turks is parallel to the Uzbekistani. Like the Turks, arranged marriages are common in Uzbekistan.^{5,6} An Uzbek husband is the dominant partner in a marriage and the wife is supposed to defer to him;⁶ the Meshketian Turks have a similar family arrangement but it may be a more cooperative structure than the Uzbekistani have. Also, the role of the mother-in-law is still as the matriarch of the extended family in Uzbekistan, and she exerts considerable control over her daughter-in-law and her family, just as she does in the Meshketian Turkish community.⁶

The health care experiences discussed by the women in our focus groups are also substantiated by the literature review as being most similar to Russia,

although there is also overlap with Uzbekistan and other countries in the Former Soviet Union. Russians are used to taking western medications,⁶ multivitamins and prenatal vitamins, and to intravenous lines during procedures.⁷ Russians living in the United States are also likely use Russian medications brought over by family and friends.^{8,9} Bribes are commonly distributed after a major procedure in both Russia and Uzbekistan,⁶ which is further complicated since refugees and immigrants are not usually eligible for free care.⁷ Intimidation by doctors is also very common in both Russian and Uzbekistan^{6,8} and was likely worse for our participants because of their refugee status. Female physicians are also preferred by Russians,⁸ an opinion that was expressed during the focus group.

Pregnancy and infant care of the Meshketian Turks has commonalities with the Uzbekistani and Russians. Breastfeeding is common practice in Russia⁷ just as the participants in this study all breastfed, and knew that is was better for the mother and child. In Uzbekistan, vegetables are supposed to be avoided during breastfeeding because the baby will supposedly have gas,⁶ and half of our participants spoke about avoiding fruits or vegetables. Children are typically dressed warmly in Russia,¹⁰ a practice that was described by the women in the infant care group, and Russian husbands are expected to help with raising the children and with the household chores as they are able.¹¹

The focus group format was modified for this research. Typically a minimum of three sets of focus groups per condition are necessary for the results to be applied to a population whereas we only had one group per condition. However, there were only five or six women in Charlottesville who fit our selection criteria for each group so in effect we tried to sample the entire population of interest. We also choose not to invite one participant who fit our criteria for the pregnancy group because she had a very dominating personality and a history of emotional instability, which might have destroyed the focus group dynamics.

The infant care group had two participants fail to show up to the focus group, which left only two participants, below the minimum standard of four participants to have scientific validity.² However, given the small population size and that the two participants were in agreement during much of the session, we feel that the discussion may still offer valuable insights into infant care of Meshketian Turks in Charlottesville. Additionally, there were findings in the infant group that were confirmed by the pregnancy discussion and by the literature review, which makes us more comfortable in accepting the data, albeit with reservations. We hope health care providers at UVA will use the transcript to recognize issues that they should discuss with their patients, but providers should not assume that patients

hold certain beliefs or do certain practices based solely on the transcript.

Our focus groups also included an interpreter out of necessity, which made the moderator more obtrusive than is optimal,¹² and impeded the flow of discussion among participants. However, all of the women have become accustomed to using an interpreter and we believe the effect on the participants' responses were minimal. It did create challenges for the interpreter because sometimes participants would begin having side conversations, and instead of using the participants direct words, the interpreter would have to say, "D--- said..." Also, even though the participants had been instructed to speak one at a time, this did not always occur because participants would chime in with their own interpretation of another participant's response, comments which would be lost because the interpreter could only interpret for one at a time. That said, the interpreter was very good at following the flow of discussion and we believe that all the important comments were heard.

Lastly, while we uncovered communication problems between UVA and the Meshketian Turks, the high prevalence makes us suspect that it is not unique to this refugee population, and it might be beneficial for UVA to hold a similar large group with each refugee population on a semi-regular basis to catch those individuals who might be missing important prenatal or infant care visits. We also uncovered areas during the focus group where there was inadequate communication about pacifier and thermometer use, SIDs prevention, and prenatal nutrition despite UVA's best efforts to convey that information. This is also probably indicative of a larger problem among all refugees, which may be traced to too much information being given only orally at each patient visit for the patient to remember it all. Most information about childcare and infant care at UVA is commonly distributed orally, written, and visually, but materials are usually only in English or Spanish, which is not helpful to most of the refugee groups so they are missing two of the three ways information is conveyed and remembered. Also, most of the participants we interviewed did not have any books or videos about childcare in their native language so they had no reference sources to use if they had questions later.

On a personal note, I was fortunate to be involved in all aspects of this research. I did all of the literature review, drafted the protocol for the IRB-HSR and the focus group scripts, co-moderated the focus groups, wrote and co-lead the educational presentation on contraception, shopped for and assembled the gift baskets, created the abridged transcripts and wrote up this final report. I also prepared and gave a short presentation to the nurses in Primary Care at UVA about

our research and the health care system in Russia and other countries of the Former Soviet Union. The only thing missing from my total involvement in this project would have been to submit this paper for publication, which we have decided not to do. Given that I have never worked with the IRB and I knew nothing about focus groups before all this started, I feel that I have gained a useful skill set as a result of this experience. I am grateful to Dr. Hauck for this opportunity and to the Medical Student Summer Research Program.

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