THE DETERMINATION OF HEALTH NEEDS OF AHISKA TURK IMMIGRANTS RESETTLED IN ERZINCAN; A CROSS-SECTIONAL STUDY

ERZİNCAN’A YERLEŞTİRİLMİŞ AHISKA TÜRKÜ GÖÇMENLERİNİN SAĞLIK İHTİYAÇLARININ BELİRLENMESİ; KESİTSEL BİR ÇALIŞMA

Selçuk Akturan¹, Arif Caner Erdoğan², Aybeniz Şenay³, Hatice Gizem Çadırcı⁴, Göksu Açıbay⁵, Bilge Tuncel¹

¹Department of Medical Education, Karadeniz Technical University, Trabzon, Turkey
²Departments of Obstetrics and Gynecology, Necmettin Erbakan University, Meram Faculty of Medicine, Konya, Turkey
³Seyhan State Hospital, Adana, Turkey
⁴Erzurum Regional Educational And Research Hospital, Erzurum, Turkey
⁵Olur State Hospital, Erzurum, Turkey

Yazıışma Adresi / Correspondence:
Selçuk Akturan (e-mail: selcukakturan@gmail.com)

Geliş Tarihi (Submitted): 15.04.2020 // Kabul Tarihi (Accepted): 05.05.2020
Öz

Amaç: Bu çalışmanın amacı, Erzincan’ın Üzümlü ilçesine yerleştirilen Ahıska Türk göçmenlerin sağlık durumlarını ve sağlık ihtiyaçlarını belirlemek, elde edilen veriler işığında sağlık politikalarını iyileştirmektir.

Materisal ve Metot: Kesitsel tipe bir çalışmadır. Çalışmanın evrenini Üzümlü’de yaşayan 1231 Ahıska Türk oluşturuyordu. Örnekleme büyüklüğü en az 233 olarak hesaplanmıştı, örneklemi belirlemek için sistematik örneklem metodunu kullanmıştır. Araşturma 1 Nisan ile 30 Eylül 2017 tarihleri arasında demografik bilgilerin yer aldığı, sağlık durumuna ve sağlık ihtiyaçlarına yönelik 41 soru içeren bir anket aracılığıyla uygulanmıştı. Tanımlayıcı istatistiksel analizler için SPSS 23 istatistik programı kullanılmıştı.

Bulgular: 237 katılımcı çalışmaya dahil edilmişti. Kronik hastalık oranı %47.00 olup, bu hastaların %54.00’ün kronik hastalıklarının kontrol altında olmadığını belirtemişlerdir. Ortalama hekim ziyareti sayısı 3,56 olarak saptanmıştı. Katılmaların %17.50’i kısa depresyon tarama ölçeğinin iki sorusuna da olumlu cevap vermiştir. Katılmaların %60,10’u sağlık hizmeti alırken sorun yaşadıklarını belirtemişlerdir. En çok ifade edilen sorunlar: iletişim (% 34.00), özensiz bakım (% 18.50) ve ayrımcılık (% 8.40) idi.

Sonuç: Kronik hastalık prevalanslarının Türk popülasyonundan daha düşük olduğu söylenebilir. Göçmenlerin destek almak için sağlık profesyonelini ilk gelen aile hekimleri idi. Ayrımcılığın azaltılması amacıyla “çeşitlilik yönetimi” politikasının uygulanması, aile hekimlerinin göçmenlere yönelik etkili sağlık hizmeti sunmaları için bu doğrultuda eğitilmeleri önerilebilir.

Anahtar Kelimeler: Dış göçmenler, sağlık hizmetleri, sağlık politikası.

Abstract

Objectives: The aim of this study was to determine health status and health needs of Ahiska Turks immigrants settled in Uzumlu district of Erzincan, and to improve health policies in the light of data obtained.

Materials and Methods: This is a cross-sectional study. Targeted population of study was 1231 Ahiska Turks who lived in Uzumlu. Sample size was calculated as at least 233. Systematic sample method was used for determining sample. Researches applied a questionnaire, which was including 41 questions for demographic information, health status and health needs between April 1 to September 30, 2017. SPSS 23 statistical program was used for descriptive statistical analyses.

Results: 237 participants were included in the study. The rate of chronic diseases (CDs) was 47.00%, and 54.00% of chronic disease patients indicated that their chronic disease had not been under control. The mean number of physician visits was 3.56, and the most visited physician was primary care physician (PCP). The 17.50% of participants answered positively to the two questions of short depression screening scale. The 60.10% of participants stated that they have problems during getting health care. The mostly stated problems were communication (34.00%), inattentive care (18.50%), and discrimination (8.40%).

Conclusion: It can be emphasized that our CDs prevalences are lower than Turkish population. The first healthcare profession came to immigrants’ mind for getting support was PCPs. For the purpose of decreasing discrimination, ‘diversity management’ policy should be implemented, and PCPs should be trained for efficient healthcare service.

Keywords: Immigrants, healthcare, health policy.
Introduction

People migrate to different places due to rapidly changing environmental, economic, political and social structures in many regions of the world. Depending on their immigration intentions, these people are given various names as refugees, asylum seekers or immigrants. Generally, the concept of immigrants is used for groups who had to leave their homeland due to pressures such as: war, poverty, hunger, torture, terrorism, human rights violation. The main issues for the immigrants during and after their resettlement process are the limitations and difficulties of getting health services. Although, the health problems of the immigrants are similar with the host populations, some are significant in immigrants such as: traumas, hypotermia, burns, cardiovascular diseases (CVDs), chronic diseases (CDs), pregnancy and birth complications. Additionally, the main problem about non-communicable diseases (NCDs) is the limits to access the healthcare services. The most reported NCDs among immigrants in developing countries were listed as: musculoskeletal disease and problems, CVDs, diabetes and chronic respiratory disease. Besides, CDs management was mostly needed healthcare service for immigrants.

WHO doesn't recommend screening programs for immigrants due to insufficient evidence of cost-effectiveness. In addition, WHO supports the idea of providing routine health services to immigrants as a host population. It was recommended that most appropriate time for checking health status of refugees is as soon as their arrival.

Turkey's immigration policy has been administered in a nation-state approach, and several regulations have been done in order to improve immigration and asylum policy based on changing conditions around the world. Unlike other definitions in the world, Turkish Settlement Law accepts as ‘immigrant’, if settled people are Turkish origin and have been living in Turkish culture. As of 25 December 2015, Ahiska Turks were placed in Uzumlu district of Erzincan due to the conflicts between Russia and Ukraine.

The aim of this study was to determine health status and health needs of Ahiska Turks immigrants settled in Uzumlu district of Erzincan, and to improve health policies in the light of data obtained.

Materials and Methods

This is a cross-sectional study. Ahiska Turks who lived in Uzumlu, Erzincan, Turkey answered the questionnaire between April 1 to September 30, 2017. Ahiska Turks immigrants came to Turkey because of the war in Ukraine. According to Doocy et al. study results, for 80.00% statistical power, the sample size was calculated (within 95.00% confidential interval, with the 0.050 mistake) at least 233 within 1231 target population of study. Systematic sample method was used for determining sample. The researchers visited the Ahiska Turks immigrants at their houses. The houses for Ahiska Turks immigrants were constructed in order,
so, researchers selected houses as: 1., 4., 8., ..., 20. houses within 250 houses in Uzumlu. Then, researchers visited selected houses and applied the questionnaire, which was including 41 questions for demographic information, health status and health needs, face to face to the households. Immigrants, who were: >18 age, <80 age, able to communicate in Turkish, at least 1 year had lived in Turkey, accepting to participate the study and signing the inform consent, included in study.

SPSS 23 statistical program was used for descriptive statistical analyses. Our study was approved by Erzincan University Non-Interventional Clinical Research Ethics Committee (Approval Number: 33216249-604.01.02-E.2725).

**Results**

The 237 participants were included in the study. The 56.10% of participants were female and 43.90% were male. The mean age of the participants was 43.08 ± 14.50. The rate of CD was 47.00%, and 54.00% of CD patients indicated that their chronic disease had not been under control (Table 1).

**Table 1. Chronic diseases of the participants**

| Chronic disease                  | %  |
|----------------------------------|----|
| Hypertension                     | 19.40|
| Cardiovascular diseases          | 11.40|
| Diabetes                         | 7.60 |
| Musculocutaneous disfunction     | 7.20 |
| High cholesterol                 | 5.10 |
| Anemia                           | 5.10 |

In last year, 16.5% of the participants used drugs without prescription, and 77.5% of those drugs were analgezics. The mean number of physician visits was 3.56, and the most visited physician was ‘primary care physician (PCP)’ with 86.90% in last year. Besides, the first healthcare provider came to their mind was PCPs (68.80%). After settling in Üzümlü, 87.30% of the participants registered with their PCPs, and 68.80% of them visited their physicians at least once.

The 17.50% of participants answered positively to the two questions of short depression screening scale. And, the rate of participants who have the depression history was 0.50%. Additionally, 18.10% of the participants
The 84.40% of the participants were stated that they need to get support for their health. The main topics of refugees’ needs are cancer screening, prevention of the CDs and emergency situations (Table 2).

**Table 2.** The headings of needs indicated by participants

| Type of support                        | %    |
|----------------------------------------|------|
| Cancer screening                       | 56.50|
| Prevention from chronic diseases       | 53.20|
| Emergency situations                   | 51.50|
| Family members healthcare              | 38.80|
| Prevention of communicable diseases    | 37.10|
| Chronic disease management             | 33.30|
| Nutrition                              | 31.20|
| Psychological guidance                 | 18.10|
| Exercise guidance                      | 17.30|

The 60.10% of participants stated that they have problems during getting health care. The mostly stated problems were: communication (34.00%), inattentive care (18.50%), discrimination (8.40%). And, 83.10% of participants suggested some solutions for these problems (Table 3).

**Table 3.** The solution suggestions to the problems during getting health care services

| The solutions to the problems                           | %    |
|---------------------------------------------------------|------|
| Employment of immigrants who are health profession     | 62.00|
| Specific primary care units for immigrants              | 38.40|
| Consultancy units in health care services of immigrants | 28.70|

In last year, 81.00% of the participants stated that they had a health screening, and these were include; blood pressure measurement (75.50%), blood glucose test (59.90%), PAP-smear test (27.00%) and mammography (23.70%).
Discussion

In our study, the rate of CD was 47.00%, and 54.00% of chronic disease patients indicated that their chronic disease had not been under control. The most common CDs were hypertension (19.40%), CVDs (11.40%) and diabetes (7.60%). NCDs have become a growing challenge of NCDs management in refugees. UNHCR reported that mostly seen NCDs have been reported in refugees were CVD, diabetes and chronic respiratory disease. The mostly seen NCDs among refugees in developing countries were; musculoskeletal disease and pain problems, CVDs, diabetes and chronic respiratory disease. Cancer has not been reported for most refugees, that might because of insufficient examinations and not be available for many refugees. The prevalence of NCDs was ranging between 9.00% to 51.50% among refugees in the Middle East. Besides, the prevalence among refugees in Asia and Africa was between 1.00% to 30.00%. In Turkey, ‘The Prevalence and Risk Factors of Chronic Diseases Study in Turkey’ determined that the prevalence of most common CDs were hypertension as 24.00%, diabetes mellitus 11.00%, and hyperlipidemia 11.20%. In the same study, prevalence of self reported coronary artery disease (CADs) is 4% in males and 2% in females over 20 years. According to TURDEP-2 study, two most common CDs’ were hypertension (25.60%) and diabetes (13.70%), in Turkey. So, it can be emphasized that our hypertension and diabetes prevalences are lower than Turkish population. Also, the reason of low CDs prevalences should be studied in the future.

In our study, the mean of physician visits was 3.56, and the most visited physician was PCP with 86.90% in last year. After settling in Üzümlü, 87.30% of the participants registered to their PCPs, and 68.80% of them visited their physicians at least once. In Turkey, according to the data of the Ministry of Health, patients are admitted to a health care units on average 8.2 times in a year (2.9 times for primary care units, 5.3 for hospitals). It was stated that the utilization of primary care services is affected by the organization of the health system organisation and the concept of social security. Immigrants registered under the Temporary Protection Regime have the right to Social Security subsidized by AFAD. So, immigrants have free access to primary and secondary healthcare services. Although, the mean number of doctor visits was lower than Turkish population, it can be said that there is no any barrier to access health care services for Ahiska Turks immigrants in Turkey. Ahiska Turks immigrants also can register any of PCPs as host population in Uzumlu-Erzincan.

In our study, the first healthcare professional that comes to mind to support immigrants were PCPs (68.80%). This is also an advantage for PCPs to service effective healthcare to immigrants in primary care. Another issue is that immigrants need counselling for how to use the health care service in their resettled country till accomplished the adaptation. If they do not get sufficient counselling in adaptation period, they can struggle with to some problems during seeking healthcare. In our study, the 60.10% of the participants stated that they have problems during getting healthcare, and mostly stated problems were: difficulties in communication, inattentive care and discriminition. It was stated that immigrants experienced discriminations due to
difficulties in speaking language of the host country, because of their race or accent. In recent years, migration waves have increased to Europe, and discussion turn into the how healthcare for immigrants should be organized. Instead of giving ‘immigrant-specific’ healthcare, we should accept the diversity in 'normality' of health care system. Instead of keeping the migrants seperated from host population, we should accept the immigrants as a part of host population. One approach to deal with heterogeneity is ‘diversity management’. Diversity management helps how to accept and cope with different needs and expectations of immigrants in healthcare system. Additionally, ‘diversity management’ approach describes the management of giving healthcare service to different minorities together with host population. Although, participants of our study suggested ‘specific primary care units for immigrants’ (38.40%), studies do not support these suggestions in the frame of ‘diversity management’ healthcare approach. On the other hands, PCPs stated that they had difficulties in communication and felt incompetent for managing immigrants. For the purpose of decreasing discrimination and implementing ‘diversity management’ policy, PCPs should be trained for effective healthcare service. These trainings may also solve the complains of participants about taking lack of interest by physicians.

Additionally, our participants suggested ‘employment of immigrants who are health profession’ (62.00%). Health professions within immigrants might help to improve the diversity management in healthcare system. In time, immigrants should play role in healthcare to adapt them easier. For a better discussion about how healthcare management should be managed, working and thinking together with immigrants/refugees should be useful for the best solution. In Turkey, Syrian health professions were employed within ‘SIHHAT project’. So, the employment of health professions within Ahiska Turks immigrants might support efficient healthcare delivery. Turkish healthcare policy makers should also administer the process of taking ‘certificate of equivalence’ for these professions before starting their jobs.

The 17.50% of participants answered positively to the two questions of short depression screening scale (PHQ-2). And, the rate of participants who have the depression history was 0.50%. Additionally, 18.10% of the participants stated their needs for pyschological support. PHQ-2 has 2 questions and positive answer for both questions means that person should be referred to further evaluation for depression. In these results, although the positive response of the family members to the short depression screening scale is not sufficient for the diagnosis of depression, it can be said that the rate of depression patients may be higher than known. In a study, most of immigrant women indicated that they could not share and discuss their feelings related with depression with their doctors. Also, these women stated that their doctors didn’t ask about psychological disturbances during their visits. Health professions should also have the skills to support psychically for immigrants. Some therapeutic techniques were suggested to reveal the psychosocial reasons underlying the patient’s complaints within the insufficient time in primary care. In our study, the participants have high
frequency for using primary care services. So, the competencies of PCPs for their psychosocial approach should be evaluated, and if it is needed, the training for therapeutic interview techniques can be organized.

The limitations of our study can be indicated as; exclusion of the pediatric population, not being questioned about family planning adequately, and the data were based on only the statements of the participants.

It can be emphasized that our CD's prevalences are lower than Turkish population. The first healthcare profession came to immigrants' mind for getting support was PCPs. For the purpose of decreasing discrimination and implementing 'diversity management' policy, PCPs should be trained for efficient healthcare service. And, the employment of health professions within Ahiska Turks immigrants might support efficient healthcare service. The participants have high frequency for using primary care services. So, the competencies of PCPs for psychosocial approach should be evaluated to support immigrants psychologically. The reason of low CD's prevalences should be studied in the future. For the next step, researchers recommend determining the physicians' opinions, beliefs, and suggestions on immigrants' healthcare services.

References

1. Assi R, Özger Si, İlhan MN. Health needs and access to health care: the case of Syrian refugees in Turkey. Public Health 2019;172:146-52 (doi: 10.1016/j.puhe.2019.05.004).
2. UN Refugee Agency. (Internet). Mid Year Trends-2018. Available from: https://www.unhcr.org/5c52ea084.pdf. (Date accessed: July 22, 2019)
3. İlhan MN, Gözli M, Atasever M, Dündar MA, Büyüköök D, Barkan OB. Göç ve Halk Sağlığı. Analiz 2016;2(7):1-15.
4. Hossain SMM, Leidman E, Kingori J, Harun AA, Bilukha OO. Nutritional situation among Syrian refugees hosted in Iraq, Jordan, and Lebanon: cross sectional surveys. Conflict and Health 2016;10:26: (doi: 10.1186/s13031-016-0093-6).
5. Alkahtani S, Cherrill J, Millward C, et al. Access to medicines by child refugees in the East Midlands region of England: a cross-sectional study. BMJ Open 2014;4:e006421 (doi: 10.1136/bmjopen-2014-006421).
6. Amara AH, Aljunid SM. Noncommunicable diseases among urban refugees and asylum-seekers in developing countries: a neglected health care need. Globalization and Health 2014;10:24 (doi: 10.1186/1744-8603-10-24).
7. Razum O, Spallek J. Addressing health-related interventions to immigrants: migrant-specific or diversity-sensitive?. Int J Public Health 2014;59:893–95 (doi: 10.1007/s00038-014-0584-4).
8. Tatah L, Delbiso TD, Rodriguez-Llanes JM, Gil Cuesta J, Guha-Sapir D. Impact of Refugees on Local Health Systems: A Difference-in-Differences Analysis in Cameroon. PLoS ONE 2016;11(12):e0168820 (doi:10.1371/journal.pone.0168820).
9. İnan CE. Türkiye’de göç politikaları: İskan kanunları üzerinden bir inceleme. Göç Araştırmaları Dergisi 2016;2(3):10-33.
10. T.C Resmi Gazete. (Internet). İskan Kanunu-2006. Available from: http://www.mevzuat.gov.tr/MevzuatMetin/1.5.5543.pdf. (Date accessed: December 20, 2019)
11. R.T. Ministry of Foreign Affairs. (Internet). Where is Ahıska and who are the Ahıska Turks?. Available from: http://www.mfa.gov.tr/sorular.tr.mfa. (Date accessed: December 20, 2019).
12. Doocy S, Lyles E, Roberton T, Akhu-Zaheya L, Oweis A, Burnham G. Prevalence and care-seeking for chronic diseases among Syrian refugees in Jordan. BMC Public Health 2015;15:1097.
13. UNHCR. (Internet). Responding to the challenge of non-communicable disease-2019. Available from: https://www.unhcr.org/en-us/protection/health/5e1352b67/responding-challenge-non-communicable-diseases.html?query=non-communicable%20disease (Date accessed: February 20, 2020).

14. Rehr M, Shoabi M, Ellithy S, et al. Prevalence of non-communicable diseases and access to care among non-camp Syrian refugees in northern Jordan. Conflict and Health 2018;12:33 (doi: 10.1186/s13031-018-0168-7).

15. Public Health Agency of Turkey. (Internet). The prevalence study of chronic diseases and risk factors in Turkey. Presidency of Refik Saydam Health Center-2013. Directorate of Hıfzıssıha Institution. Available from: https://sbu.saglik.gov.tr/Ekutuphane/kitaplar/khrfai.pdf. (Date accessed: February 20, 2020).

16. Republic of Turkey Ministry of Health. (Internet). News Bulletin of 2013 for Annual Health Statistics. Available from: https://dosyasb.saglik.gov.tr/Eklenti/2774,siy2013haberbultenipdf.pdf. (Date accessed: February 20, 2020).

17. WHO/Europe. (Internet). Report on the health of refugees and migrants in the WHO European Region. No PUBLIC HEALTH without REFUGEE and MIGRANT HEALTH. Available from: http://www.euro.who.int/en/publications/abstracts/report-on-the-health-of-refugees-and-migrants-in-the-who-european-region-no-public-health-without-refugee-and-migrant-health-2018. (Date accessed: February 20, 2020).

18. Akik C, Ghattas H, Mesmar S, et al. Host country responses to noncommunicable diseases amongst Syrian refugees: a review. Conflict and Health 2019;13:8 (doi: 10.1186/s13031-019-0192-2).

19. Eckstein B. Primary Care for Refugees. American Family Physician 2011;83(4): 429-36.

20. Joshi C, Russel G, Cheng IH, et al. A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries on access, quality and coordination. International Journal for Equity in Health 2013;12:88.

21. Mangrio E, Forss KS. Refugees’ experiences of healthcare in the host country: a scoping review. BMC Health Services Research 2017;17:814 (doi:10.1186/s12913-017-2731-0).

22. Cattacin S, Chimienti M. From control policies to health policies as a tool for inclusion. Int J Public Health 2007;52:73–4.

23. Salisbury J, Byrd S. Why Diversity Matters in Health Care. CSA Bulletin Spring 2006: 90-3.

24. Jensen NK, Norredam M, Priebe S, Krasnik A. How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark. BMC Family Practice 2013;14(17): (doi:10.1186/1471-2296-14-17).

25. Xin H, Morrison S, Dharod J, Young A, Nsonwu M. Cross-Cultural Allies in Immigrant Community Practice: Roles of foreign-trained former Montagnard health professionals. Health, Culture and Society 2014;6(1):62-72.

26. SIHHAT Project. (Internet). Available from: https://www.sihatproject.org/proje-faaliyetleri_0-657. (Date accessed: March 27, 2020).

27. O’Connor EA, Whitlock EP, Beil TL, Gaynes BN. Screening for depression in adult patients in primary care settings: a systematic evidence review. Ann Intern Med. 2009;151(11):793-803 (doi: 10.7326/0003-4819-151-11-200912010-00007).

28. Ahmed A, Stewart DE, Teng L, Wahoush O, Gagnon AJ. Experiences of immigrant new mothers with symptoms of depression. Arch Womens Ment Health 2008;11(4):295–303.

29. Walden J. Refugee Mental Health: A Primary Care Approach. American Family Physicians 2017;96(2): 82-4.

30. Akturan S, Kaya ÇA, Ünalın PC, Akman M. The effect of the BATHE interview technique on the empowerment of diabetic patients in primary care: A cluster randomised controlled study. Prim. Care Diab. 2017;11(2):154-61 (doi: 10.1016/j.pcd.2016.12.003).