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

ERZİNCAN'A YERLEŞTİRİLMİŞ AHISKA TÜRKÜ GÖÇMENLERİN SAĞLIK İHTİYAÇLARININ BELİRLENMESİ; KESİTSEL BİR ÇALIŞMA

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Öz

Amaç: Bu çalışmanın amacı, Erzincan'ın Üzümlü ilçesine yerleştirilen Ahıska Türkü göçmenlerin sağlık durumlarını ve sağlık ihtiyaçlarını belirlemek, elde edilen veriler ışığında sağlık politikalarını iyileştirmektir.
Materyal ve Metot: Kesitsel tipte bir çalışmadır. Çalışmanın evrenini Üzümlü'de yaşayan 1231 Ahıska Türkü oluşturmaktaydı. Örneklem büyüklüğü en az 233 olarak hesaplanmış, örneklemi belirlemek için sistematik örneklem metodu kullanılmıştır. Araştırma 1 Nisan ile 30 Eylül 2017 tarihleri arasında demografik bilgilerin yer aldığı, sağlık durumuna ve sağlık ihtiyaçlarına yönelik 41 soru içeren bir anket aracılığıyla uygulanmıştır. Tanımlayıcı istatistiksel analizler için SPSS 23 istatistik programı kullanılmıştır.
Bulgular: 237 katılımcı çalışmaya dahil edilmiştir. Kronik hastalık oranı %47.00 olup, bu hastaların %54.00'ı kronik hastalıklarının kontrol altında olmadığını belirtmişlerdir. Ortalama hekim ziyareti sayısı 3,56 olarak saptanmıştır. Katılımcılar en çok ziyaret ettikleri sağlık profesyonelini 'aile hekimi' olarak belirtmişlerdir. Katılımcıların %17.50'si kısa depresyon tarama ölçeğinin iki sorusuna da olumlu cevap vermiştir. Katılımcıların %60,10'u sağlık hizmeti alırken sorun yaşadıklarını belirtmişlerdir. 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 profesyoneli olarak akıllarına ilk gelen aile hekimleriydi. 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 questionairre, 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.[1] 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.[2] 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, cardiovasculer diseases (CVDs), chronic diseases (CDs), pregnancy and birth complications.[3-5] Additionally, the main problem about non-communicable diseases (NCDs) is the limits to access the healthcare services.[4] 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.[6]

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.[7] It was recommended that most appropriate time for checking health status of refugees is as soon as their arrival.[8]

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.[9] 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.[10] As of 25 December 2015, Ahiska Turks were placed in Uzumlu district of Erzincan due to the conflicts between Russia and Ukraine.[11]

The aim of this study was to determine health status and health needs of Ahıska 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% confidental interval, with the 0.050 mistake) at least 233 within 1231 target population of study.[12] Systematic sample method was used for determining sample. The researchers visited the Ahıska Turks immigrants at their houses. The houses for Ahıska 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 questionnairre, 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 (Appoval 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
Musculocutaneus 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

stated their needs for pyshicological support. 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
Pychological guidance	18.10
Exercise guidance	17.30

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

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%), discriminition (8.40%). And, 83.10% of participants suggested some solutions for these problems (Table 3).

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.[13] The mostly seen NCDs among refugees in developing countries were; musculoskeletal disease and pain problems, CVDs, diabetes and chronic respiratory disease.[6] 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%.[14] 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%.[15] 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).[16] It was stated that the utilization of primary care services is affected by the organization of the health system organisation and the consept of social security.[17] 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.[18] 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 healtcare 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.[19] Another issue is that immigrants need counselling for how to use the health care service in their resettled country till accomplished the adaptation.[20] 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.[21] In recent years, migration waves have increased to Europe, and discussion turn into the how healthcares 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.[22] 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 health care service to different minorities together with host population.[23] 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.[24] 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.[23] 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.[25] In Turkey, Syrian health professions were employed within 'SIHHAT project'.[26] So, the employement of health professions within Ahiska Turks immigrants might support efficient healthcare delivery. Turkish healthcare policy makers should also administer the process of taking 'cetificate 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 pyshicological support. PHQ-2 has 2 questions and positive answer for both questions means that person should be referred to further evaluation for depression.[27] 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.[28] Health professions should also have the skills to support psyhicologically for immigrants.[29] Some therapeutic techniques were suggested to reveal the psychosocial reasons underlying the patient's complaints within the insufficient time in primary care.[30] 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 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 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 CDs prevalences should be studied in the future. For the next step, researchers recommend determining the physicians' opinions, beliefs, and suggestions on immigrants' healthcare services.

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