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Eastern European Orthodox Christian Immigrant Women: A Pilot Study and Needs Assessment

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by

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Executive Summary

Problem Statement: Despite the longevity of Eastern European immigration to America and of Orthodox Christianity in America, there remains limited professional knowledge of Eastern European Orthodox Christian immigrant women's (EEOCIW) perceptions of women's healthcare.

Purpose: This project used Leininger's Theory of Culture Care Diversity and Universality with the Ethnonursing Research Process to identify perceptions of women's healthcare and possible barriers to care for EEOCIW and searched for similarities and differences compared to United States born Orthodox Christian women (USOCW). Trust was explored for the purposes of understanding the level of trust to willingly and openly communicate with healthcare providers.

Methods: Snowball recruitment methods through social media, church bulletins, and word-of-mouth, led to one-on-one interviews conducted to survey 14 EEOCIW and 25 USOCW. With a mixed method design, qualitative data were collected with content analyzed manually and via use of NVivo coding software. Data was coded and themed for similarities and differences between groups. Quantitative data of percentages of consensus were calculated in each group.

Significance: In order to advance the body of transcultural nursing knowledge, the performance of a health needs assessment for EEOCIW could improve nurse-patient conversations and education for women's healthcare.

Outcomes: Ten themes emerged which should be considered when developing culturally congruent care for the health and wellbeing of EEOCIW, or to help them face disability, dying or death.

Introduction

The pilot study was located in a midwestern urban area crisis pregnancy center. The crisis pregnancy center serves any woman who may be currently experiencing an unplanned pregnancy. Supported by various congregations within the Orthodox Church in North America and staffed with volunteer nurses, a medical director, and peer mentors, the center experiences a higher than average site visit by Orthodox Christian women. Using resources available, staff are trained regarding nurse counseling of women in crisis pregnancy, however the training resources are centered towards "mainstream" American women.

An unintended pregnancy may lead to an abortion. A woman chooses to abort a pregnancy or maintain a pregnancy for various reasons. Research demonstrates a relationship between induced abortion and depression, anxiety, adjustment disorder, and somatoform disorder that can manifest years after the event (Jacob, et. al., 2019).

Data from the United Nations shows that abortion rates were 37.4 per 1000 women aged 15-44 in the central and eastern European countries, which contains the area of origin for this project's population (United Nations, 2013). By comparison, the 2018 general population of the United States (U.S.) was 11.3 per 1000 (CDC, 2020).

Data shows at a global perspective, an estimated 44% of pregnancies overall were unintended in 2010 – 2014 (Bearak, et. al., 2018). Within the same time period, the percentage of unintended pregnancies that end in abortion in developed regions of the world was 59%, in developing regions of the world was 55%, in Eastern Europe was 77%, and in the U.S. was 36% (Bearak, et. al., 2018). There may be specific cultural or social reasons that drive this difference,

and those reasons may affect the nurse-patient conversation. Additionally, cultural and social experiences may affect the overall perspectives of women's healthcare. Research is scarce for EEOCIW population, but this information will be required to properly care for these women, as 40% percent of Orthodox Christians in America are immigrants and 23% are children of immigrants (Pew Research Center, 2017).

Problem Statement

How do EEOCIW between the ages of 18 and 55 years old who experienced women's healthcare in the U.S. perceive their experience of women's healthcare compared to USOCW within the first 25 years post immigration? Additionally, what are the elements that enhance trust between providers and this patient population?

Significance to Nursing

EEOCIW may be unique in their beliefs, values, and practices that create diversity from mainstream America. Because they are European and a majority Caucasian, cultural imposition can occur. The nurses at the center and elsewhere across America can benefit from this study by recognizing that cultural blindness may exist, and then tailor their services to consider cultural differences, and connect through cultural similarities. Understanding the healthcare beliefs and experiences of the EEOCIW can help build trust, enhance nurse-patient conversations, and ultimately improve the health and wellbeing of these women.

Background

Immigration

The Romanian Revolution in December 1989 preceded decades of Eastern European ethnic conflicts and revolutions that would follow in the 1990's and 2000's: the Georgian Civil War, the Croatian War of Independence, the First Georgian War, the Bosnian War, the First Chechen War, the Kosovo War, the Second Georgian War, and the Second Chechen War. (Mojzes, 2011; The Polynational War Memorial, 2018). These wars account for approximately 70,000 war-related deaths, however, this list is not in totality of the military actions in Eastern Europe to the present date (The Polynational War Memorial, 2018). These conflicts and others not listed, some of which continue today, led to the most recent wave of immigration beginning in the mid-1990's of Eastern Europeans to the U.S. The primary reasons for immigration from Eastern Europe to America in the 21st century are humanitarian protection and to reunite with family members (Zong & Batalova, 2016).

In 2016, of the approximately 44 million immigrants in the U.S., 2.1 million were from Eastern Europe (Migration Policy Institute, 2018). English is not the first native language of the Eastern European immigrants. Within Russia and south-eastern Europe, Orthodox Christianity is the dominant religion (Leustean, 2009). Upon arrival to the U.S., many immigrants find a support system of their native countrymen within the various ethnic Orthodox Churches (Zentos & Marley, 2021).

Post Immigration Health Disparities

In 2018, of the 27.9 million nonelderly, uninsured people in the U.S., 24% are noncitizens (Kaiser Family Foundation, 2020). These noncitizens include lawfully present and

undocumented immigrants. Of the 27.9 million nonelderly uninsured, 76% are U.S. citizens (Kaiser Family Foundation, 2020). Based on the total U.S. population, nonelderly noncitizens are significantly more likely to be uninsured: 23% of lawfully present and 45% of undocumented immigrants are uninsured, compared to one in ten or 9% of citizens (Kaiser Family Foundation, 2020).

Barriers to securing access to healthcare for lawful immigrants include:

- enrollment barriers of fear, confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges, and
- finances (Kaiser Family Foundation, 2020).

Literature Review

Literature regarding Orthodox Christian immigrants from Eastern European countries and their shared health beliefs and perceptions is scarce. Of greater scarcity is the literature specific to the female immigrant of said group. Available literature dated within the past five years focuses primarily on the Muslim immigrant experience and perceptions of health in the U.S. Asian and Hispanic immigrant health perception literature is available focusing on specific disease states and pregnancy. Information focusing on faith, religion, or spirituality in immigrant groups overall is lacking. This literature search yielded 27 relevant or close-to-relevant books and articles by searching various terms and phrases in combination such as Orthodox Christian immigrant women, Eastern European immigrant health, immigrant health beliefs, immigrant perception of health, immigrant trust and healthcare, Orthodox Christians and health, Latina perception of health, Catholic, Christian, spirituality, and religion. Three relevant articles follow.

The first article, from the European Union, is a level 5 systematic review of qualitative studies. Although not focused on the Orthodox Christian immigrant woman, the researchers provide insight into the female immigrants' perception of a specific women's health issue, which is pregnancy. The researchers examined the perceptions of the immigrant woman's needs and experiences in relation to their children and their pregnancies (Balaam, et. al., 2013). Evaluated were 16 articles where the researchers extracted data to develop overall themes. The common themes among the immigrant women included the need to preserve one's integrity in the new country, struggling to find meaning and caring relationships, communication and connection, striving to cope and manage, struggling to achieve a safe pregnancy and birth, and maintaining bodily integrity (Balaam, et. al., 2013). One of the limitations is this study was done in Europe. Another limitation is the specificity of the condition being pregnancy. The researchers identify implications for practice which are healthcare providers must focus on continuity of care for the migrant woman's health, the migrant woman's health must be monitored and improved for the provision of necessary healthcare services, and most important is preserving the integrity of the migrant woman. (Balaam, et. al., 2013).

The second article is a level 6 qualitative study examining the effects of cultural acculturation on the somatic health of 915 immigrant women, utilizing a reference group of 449 native-born American women (Consedine, et. al., 2014). The study includes Eastern European immigrant women. Two phases of the study were utilized. The first stage included data on census blocks for demographics; the second stage was trained female interviewers met with the participants for face-to-face 90-minute interviews (Consedine, et. al., 2014). The researchers'

findings that show that Eastern European immigrant women may moderate their emotions more than native-born American women (Consedine, et. al., 2014). A limitation of this study is that it does not include a religious or spiritual perspective and the reliance on the interpreters for translational accuracy. The researchers found the immigrant women who most closely assimilated to the mainstream culture had the fewest trait negative affectivity symptoms (Consedine, et. al., 2014). This information is relevant because Orthodox Christian immigrant women could rely on the ethnic community for support, and by tradition the Orthodox Church is not part of mainstream culture.

The final qualitative content article is level 6 evidence and focuses more specifically to the female immigrant experience and religion. The researcher studied 50 Latina immigrants attempting to discover how religiosity influences their perceptions of health and health-promotion behaviors (De Jesus, 2016). The researcher's findings indicated women felt they had a personal responsibility to God to maintain their own health; and the immigrant women felt health included mental and physical health (De Jesus, 2016). The researcher uncovered the participants' view of religiosity, which is religion is part of their health; they will put their family's health before their own, but this is the reason to always try to stay healthy (De Jesus, 2016). The researcher's findings also included the participants felt prayer is beneficial but is not a substitute for personal action (De Jesus, 2016). A limitation is the small sample size of 50. The researcher points out that the findings are consistent with other research regarding the positive effects of religiosity and Latinas (De Jesus, 2016).

Project Implementation and Measures

Theoretical Framework

Culture influences affect how patients perceive health. Leininger's Theory of Culture Care Diversity and Universality was utilized as a theoretical framework for understanding the attitudes, beliefs and perceptions regarding women's healthcare for the EEOCIW. Conceived in the mid-1950's the goal of the theory is "to discover comparative culture care knowledge to meet the needs of diverse and similar cultures" (Leininger, 1997, p. 34). This knowledge assists nurses in providing culturally congruent care that supports the wellbeing of people or assists people through the processes of disabilities, dying, or death (McFarland & Wehbe-Alamah, 2019, p. 40). According to McFarland & Wehbe-Alamah, "Prior to her passing in 2012, Dr. Leininger personally entrusted Drs. McFarland and Wehbe-Alamah with the honor and responsibility of writing future editions of her internationally acclaimed books" (McFarland & Wehbe-Alamah, 2019, p. ix).

The theory acknowledges the experiences, cultures, and worldviews of patients are linked to health outcomes (McFarland & Wehbe-Alamah, 2019). Leininger described an open, qualitative approach is necessary to discover generic views, also known as the people's natural or insider views, which she termed "emic" (Leininger, 1997, p. 43). This approach requires researchers and clinicians listen to participants, record everything heard or seen, code, and develop themes to explain the interdependence of care and cultural phenomena, particularly noting the similarities and differences between groups (McFarland & Wehbe-Alamah, 2018).

Leininger developed the Sunrise Enabler (Figure 1) as an assistive guide to uncover influencers and informers of attitudes and beliefs towards healthcare (McFarland & Wehbe-Alamah, 2019).

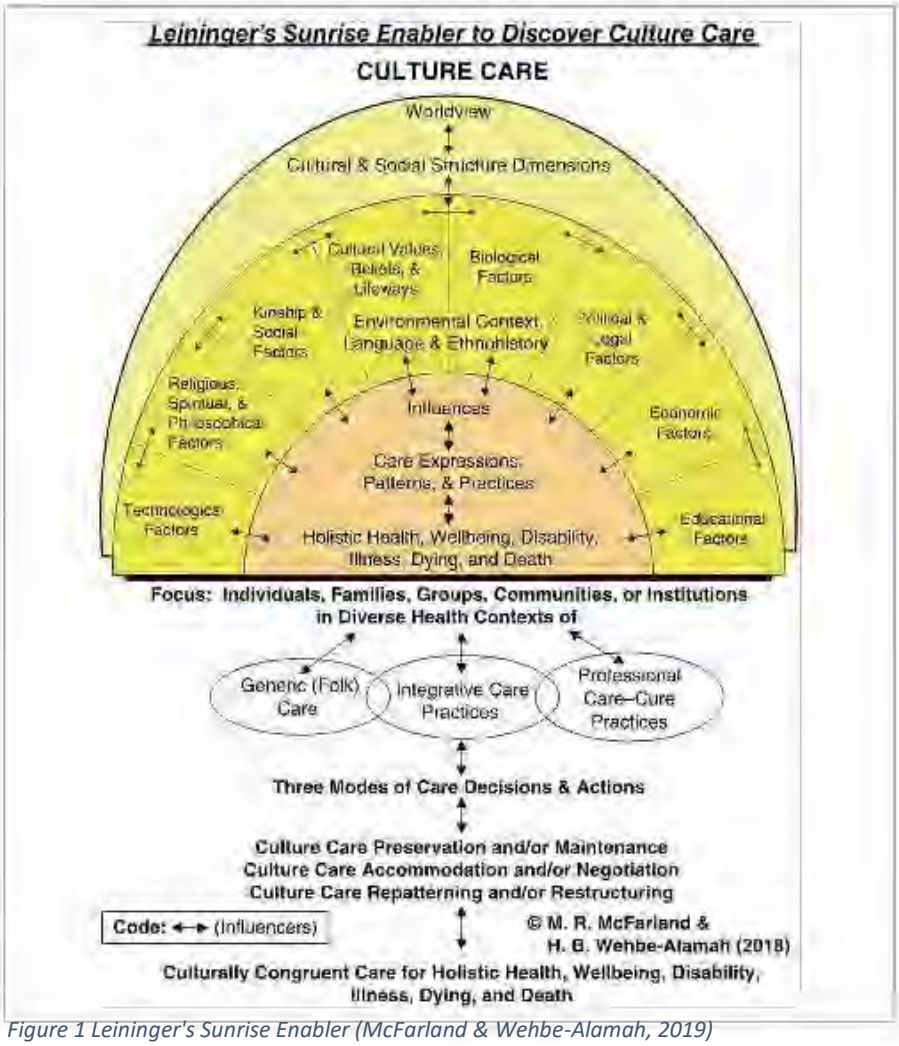

Figure 1 Leininger's Sunrise Enabler (McFarland & Wehbe-Alamah, 2019)

There are four tenets for use with the Culture Care Theory:

- The first tenet is culture care expressions, meanings, patterns and practices are diverse and yet parts are shared.

- The second tenet is worldview, social factors, ethnohistory, environmental context, language, and generic and professional care are critical influencers to predict health.
- The third tenet is emic and etic (professional nursing care) care influence health and illness outcomes, and a fourth tenet based on the prior three.
- The fourth tenet is the development and commencement of culturally congruent care for the general health and wellbeing of patients, or to help them face dying or disability. The fourth tenet is developed through the utilization of the knowledge gained through the first three tenets (McFarland & Wehbe-Alamah, 2018).

From the analysis of the first three tenets, three major decision and action modes blossom to provide culturally congruent care. This is the fourth tenet. These three decision and action modes include:

1. Culture Care Preservation/Maintenance,
2. Culture Care Accommodation/Negotiation, and
3. Culture Care Repatterning/Restructuring (McFarland & Wehbe-Alamah, 2018).

The nurse can utilize findings regarding the influencing factors to help create a culturally supportive plan of care for the patient.

The initial mode of action is Culture Care Preservation/Maintenance, which suggests the nurse should first consider what the culture is doing right and incorporate that into the care. Next, the Culture Care Accommodation/Negotiation is a mode of action where the nurse helps the culture adapt or negotiate to incorporate care. Finally, the Culture Care Repatterning/Restructuring deals with professional actions and mutual decisions that bring

change or restructuring to lifeways for better outcomes (McFarland & Wehbe-Alamah, 2018). These three modes of action are intended to produce nursing care that is individualized to the patient's cultural needs which can build trust, reduce stress, improve the nurse-patient relationship, and positively impact patient outcomes (McFarland & Wehbe-Alamah, 2018).

The scope of this project focused on the first and second tenets of culture care. For the first tenet which is acknowledging that care diversities and universalities exist, interviews with USOCW allowed for comparing for diversities and universalities between EEOCIW and USOCW (McFarland & Wehbe-Alamah, 2019). The second tenet acknowledges that worldview and social constructs influence meanings and patterns in different cultures (McFarland & Wehbe-Alamah, 2019). This project utilized the religious and philosophical factors, kinship and social factors, and cultural values, beliefs and lifeways of the Sunrise Enabler to assist in learnings of the second tenet. Additionally, this project explored trust, which is integral to all tenets, and lastly recommends actions to integrate into caring for patients.

Project Objectives

The objective of this project was to gather insights into the perspectives of EEOCIW regarding their women's healthcare. These perspectives could improve engagement between clinician and patient by helping the clinician add awareness, knowledge and intention, clarify expectations, recognize concerns, build trust, and improve communication with the patient. In order to achieve this objective, the author interviewed and sought the perspectives of both EEOCIW and USOCW for purposes of seeking similarities and differences. Insightful information was obtained from both groups.

Methodological Approach

This mixed method designed project utilized Leininger's Ethnonursing Research Process. The five guiding principles are:

1. Using open discovery, active listening, and a learning attitude.
2. Actively participate with the informants in reflection about what is heard, being sensitive to the local (emic) view and this view will affect the professional (etic) view.
3. Record everything.
4. If an experienced ethnonursing research mentor is not available to assist, then utilize appropriate ethnonursing publications.
5. Clarify the purpose of using ethnonursing with another method if another method is needed (McFarland & Wehbe-Alamah, 2018).

Leininger maintained that qualitative research methods and findings can stand on their own merit, without needing to be justified by quantitative methods (McFarland & Wehbe-Alamah, 2018). Although primarily qualitative in design, because this project compared between groups, quantitatively, percentages of consensus were calculated.

Protection of Human Subjects

Institutional Review Board (IRB) approval (Appendix A) was solicited and received (HS 2021-07) and amended to include Slovakia (Appendix B). All interview questions (Appendix E) were approved.

Budget

This project was awarded $400 through the University Student Research Fund (Appendix G). Participant stipends of $20 each were given for a cost of $780. NVivo coding software student license was a cost of $85. NVivo Transcription package was a cost of $499. Textbook purchase of Transcultural Nursing for additional learnings of applicable theory was $67.39. Incidental costs went towards refreshments for project related meetings and recruitment flyer copying expenses, which together totaled $28. Less the student grant award, out-of-pocket expenses were $1059.39.

Recruitment and Sample Population

Snowball recruitment methods through social media, church bulletins, and word-of-mouth led to 39 one-on-one interviews. Recruitment and interviews occurred from September 2020 through November 2020. The goal for sample size was 10 EEOCIW and 10 USOCW. Recruitment screen failures (n = 11) included: significant language barriers (n = 5), immigrants born outside of Europe (n = 2), older than 55 years (n = 2), USOCW resided outside of the U.S. for greater than one year (n = 1), and USOCW convert (n = 1). Consents to participate were obtained from EEOCIW n = 16 and USOCW n = 28. Three EEOCIW and three USOCW who signed consent to participate were lost to follow up for scheduling study interview. Participants who completed the interview included EEOCIW n = 14 and USOCW n = 25. The achieved sample size aligned with Leininger's recommendations to have 12-15 key informants and 20-25 general informants (McFarland & Wehbe-Alamah, 2018).

Inclusion criteria for EEOCIW (n = 14) were the following: females aged 18 through 55 years old; native of Bosnia-Herzegovina, Croatia, Belarus, Bulgaria, Estonia, Georgia, Greece, Hungary, Kosovo, Latvia, Lithuania, Moldova, Montenegro, North Macedonia, Romania, Russia, Serbia, Slovakia, Slovenia, or Ukraine; lawful immigration to the U.S. after January 1, 1995; ability to understand the spoken English language; and currently practicing the Orthodox Christian faith. Inclusion criteria for USOCW (n = 25) were the following: females aged 18 through 55 years old; native of the U.S. having not taken permanent residence outside of the U.S. for greater than one year; and currently practicing the Orthodox Christian faith as a U.S. born cradle Orthodox Christian.

Methods

Informed consents were obtained from all participants. Both groups were asked to answer research questions via semi-formal, one-on-one interviews conducted through Microsoft (MS) Teams or phone call. Participants were informed that responses would be recorded by the interviewer and the transcripts would be analyzed with the results reported in this project. Participants were reminded of confidentiality at the start of the interviews. Twelve research questions were open-ended and divided into four groups with three questions in each group (Appendix E). The groups included:

1. General perceptions of women's healthcare.
2. Factors influencing women's healthcare.
3. Women's healthcare and contraception.
4. Personal trust influencing women's healthcare.

All participant conversations were recorded. The recordings were transcribed using NVivo Transcription Software (QSR International, 2020). NVivo software was utilized to create individually numbered cases which were labeled with country of origin or "immigrant" to distinguish immigrant from U.S. born. The cases were analyzed with NVivo software utilized to code qualitative data. Through textual content analysis the codes were developed into themes via DNP student interpretation. EEOCIW themes were developed. USOCW themes were developed. The themes between the two groups were searched for similarities and differences. The DNP student advisor validated the themes as being sourced from the data.

Analysis and Outcome Evaluation

Ten themes emerged from the data analysis.

1. Wellbeing and Mental Health

EEOCIW included overall wellbeing and mental healthcare in their perceptions of women's healthcare. This is congruent with DeJesus's findings (DeJesus, 2016). Data from the group of questions examining general perceptions of women's healthcare found consensus between the groups regarding what they think of when they hear "women's healthcare"; overall the groups consider gynecologic visits with mammograms, contraception, and reproductive health: EEOCIW n = 11; 79%, and USOCW n = 21; 84%.

Differences between the groups included 50% of EEOCIW (n = 7) thought of a healthy lifestyle and overall wellbeing including mental healthcare compared to 16% of USOCW (n = 4). Interestingly, three EEOCIW (21%) stated they thought of "dental care" when they considered women's healthcare, whereas zero USOCW mentioned dental care. One EEOCIW stated

"…many problems can come from the teeth." As a follow up question, one EEOCIW stated she would consider her dentist someone she could go to for healthcare information.

2. Healthcare Information and Decisions

EEOCIW tended to obtain healthcare information from their healthcare providers, family and friends, but were more private with their final decisions. A higher rate of 36% of EEOCIW stated they would seek healthcare information from family and friends (n = 5) versus USOCW at 20% (n = 5). Conversely, 72% of USOCW (n = 18) would seek healthcare information from internet sources including WebMD, hospital and insurance sites, and Google searches. EEOCIW (n = 8, 57%) stated they would turn to the internet for healthcare information with five women with the 57% preferring validated internet research. Overall, 64% of EEOCIW and 68% of USOCW would seek healthcare information from their healthcare provider.

Results indicated 40% of USOCW (n = 10) stated opinions of friends and family are factors in their healthcare decisions, and 21% of EEOCIW (n = 3) asked friends and family for advice in decisions. An interesting observation was more EEOCIW would seek health care information from family and friends, but less EEOCIW would ask the opinions of family and friends when it was time to make the actual decision. The results were opposite for USOCW. This was also reflected by 21% of EEOCIW (n = 3) stated it is their personal responsibility to make their own healthcare decisions. One quote is "Think about caring about yourself. Nobody can help you. That's a personal thing….You have to be the person who is really responsible for this." None of the USOCW provided personal responsibility as a factor in their healthcare decisions.

3. Technology and Time

EEOCIW believed their healthcare in the U.S. had better technology and secured more timely appointments, but often felt the providers seemed to rush through the visit. When discussing providers and the care they receive, 64% of EEOCIW (n = 9) stated they have had a good experience of healthcare in the U.S. Within that group, five women stated they receive faster care in the U.S. Four of the five stated, when in Eastern Europe a person knows someone on the inside of the hospital to have an issue treating quickly. When discussing her native country, one woman described that her ill father was able to receive care more quickly than expected because a relative knew people at the hospital and was able to have him seen, adding "Usually, wait for certain things is like a year or year and a half but always have a private option that you can pay cash and go in and do it." This same woman explained while she was in the U.S. she was very afraid when she learned she had to have a surgical biopsy, but the speed of response and personalized attention she received from her physician meant so much to her, as she stated, "I cannot explain how good [it was]!" Another woman stated, "In Serbia, sometimes you'll have to wait months....That's just how it was, all socialized and they really didn't care what kind of condition you were and what you need, that you just have to wait." Overall findings from EEOCIW were favorable to US medical care, but voiced concern for hurried practitioners.

Four of the nine women who had a good experience in the U.S. stated the technology is better in the U.S. Two women mentioned that overseas there are so few workers trained to be able to properly use the equipment. One of these women stated, "We were donated mammogram machines…we had to return these machines…we had no trained staff to run these tests and no

radiologists to read these tests yet left and right we have women dying of breast cancers and metastases." This comment was shared in the context of lack of adequate care in the native country.

While the U.S. healthcare providers are fast to help people obtain appointments, 36% of EEOCIW (n = 5) felt that they were rushed through their appointments, given pills too quickly without getting to the root cause of their illnesses, and were not being asked about their mental health status. The women stated they felt the providers were preoccupied with their computer work, lacked empathy, had trouble linguistically understanding the women's speech, or were judgmental of them. Of the USOCW, 28% felt similarly rushed through their appointments.

Data shows location is another similar factor between the groups EEOCIW 29% and USOCW 28%. One EEOCIW described the stressful, fast pace of life in America and compared it to life in Serbia. She stated in Serbia there is time to visit with friends and family during the week, not only weekends as in America. Reserving time for family and friends was more valuable to her than spending the time driving to a farther location to see a particular doctor.

4. Cost

Health insurance, cost and financial ability to pay was cited as a barrier to care for EEOCIW, driving some to seek care overseas even though they believe the technology is better in the U.S. Three EEOCIW stated they go back to their native countries to receive healthcare because of either the high cost in America or are not insured in America. One woman stated "Serbian people go to the doctor to Serbia. They don't go to the doctor here." She explained she

could pay for her plane ticket and dental procedure for what her dental procedure would cost here in the U.S.

Both groups cited health insurance and money as primary factors to consider when making decisions about healthcare: EEOCIW (n = 8, 57%) and USOCW (n = 12, 48%). Two of the USOCW shared an experience of being uninsured. The uninsured time span was a few months that occurred during a transition, either between college and career, or an interstate geographic move. Ten of the twelve USOCW shared they currently considered co-pays or high deductibles. The EEOCIW (n = 8) experienced difficulty understanding the payments an employee makes for insurance coverage. One EEOCIW described the process as an employee "pays" for insurance and then must "pay" for a deductible, then "pay" for a co-pay, and finally "pay" for medications, and compared it to her native country where all citizens receive "free" healthcare. Another EEOCIW stated "I mean, it's so confusing because it's totally different here and I'm still in shock about the people here affording some doctor services, it's very expensive for normal salaries." Four of the eight EEOCIW shared they had periods of time uninsured, and for them the duration was many years.

One EEOCIW stated, "It's a big issue, health insurance…most of those guys [Serbian] drive trucks. There's no health insurance, no regular income, no money. You cannot go to the doctor spend thousands of dollars….Going to doctors...that's my last resort." Another woman stated, "I sprained my ankle…we went to church and asked if somebody can help….Eight to nine years we would ask for help from people in the [Bulgarian Orthodox] Church like a doctor

or nurse or somebody in the Bulgarian community." She shared this ended nine years ago when she married and received her husband's insurance.

5. Education

The emic and etic education received by EEOCIW effects perceptions of health and healthcare. When asked about factors that influence women's healthcare, education began to emerge as a theme with EEOCIW. For this question, zero USOCW mentioned education and four EEOCIW (29%) cited education as a factor influencing women's healthcare. Education was explained that in parts of the southern Balkan area some are considered "peasants" and "don't know too much about health" and when faced with a health challenge are "not going to be open, they are going to say it's nothing. Do not worry, that's happening to everybody, or will wait, not want to talk about it. God is going to heal everything." Other EEOCIW explained that they are healthcare professionals themselves and (etic) education is a big factor.

When discussing past cultural or personal events, perceived facts or experiences that affected the subject's current health or access to healthcare, 36% of USOCW mentioned a lack of sex education growing up, both classic (school-based) and religious, whereas zero EEOCIW identified this. For classic education one example was, "I don't think I got enough education….Most of what I learned is through friends or the Internet. We had basic sex ed.…the expectation was 'you're not having sex, so you don't need to even learn that stuff.'" Regarding a lack of religious education an example given was, "I was very much bought into the women's rights stuff. I made some bad decisions around contraception and abortion because of what I learned outside of the (Orthodox) Church and what the Church lacked in teaching growing up."

Lack of sex education, from the viewpoint of the classic education and religious education, was cited as a past experience that affected current health of the whole woman.

6. Shame

Women's health issues and/or sickness could be viewed as shameful and something to be kept private, even to the detriment of the women's health. A theme of privacy and shame emerged when discussing factors affecting health and healthcare. A USOCW shared, "Women's health is [also]…are you mentally OK? Is your anxiety level so intense you can't handle simple tasks? Are you emotionally healthy; are you not treated as an equal in your own home? Is anybody checking on the moms?". Another USOCW example shared was, "It was very taboo to talk about the seizure disorder….If I had to spend the night with somebody besides my parents, I wasn't supposed to tell what my pills were for." There was a similar number of women in each group, 21% EEOCIW (n = 3) and 20% USOCW (n = 5) who believed health concerns should be kept private. Interestingly, the USOCW believed this was culturally passed through their grandparents or parents who were from Eastern Europe.

Data showed a patriarchal system for some EEOCIW (n = 4, 29%). One woman stated, "You go to the doctor and let them talk to you, what they have to say. You don't ask questions because it's not your place to ask questions…you're there to see what the doctor will tell you and that's it." Another woman stated, "For years under the Turks…alot of Islam cultural influence….The women…not equal to men for a long time…. They have to respect their husbands….It has to do with educational level, emancipation….Women stay at home, never get to go to school." These comments indicate a patriarchal structure of individual relationships.

Related to privacy, 57% of EEOCIW (n = 8) and 24% of USOCW (n = 6) shared there exists within the culture a feeling that doctors are not able to help or that they should withstand as much as possible and only see a doctor if absolutely necessary. Several participants indicated this was due, in some cases, to shame. Describing shame, a USOCW stated, "I remember the fear that my Baba [Macedonian] had in seeking health care, the taboo of it, you don't talk about it, can't tell people….There's superstition surrounding health and shame in being unhealthy and not wanting people to talk about you." An EEOCIW comment was "I'm talking about everything is hush hush under the rug and nobody talks about anything, and stuff happens. So, people are so much left alone." One EEOCIW stated when referring to her family, "Even if they have a problem, they say, OK, the doctor cannot help me or anything. My brother had a heart problem….I asked him did you go to doctor and he would say 'Why would I go to the doctor?'". Another EEOCIW stated "Many times girls, their moms were abused and grandmothers, you know, but they are quiet and they're doing their jobs. We don't know about that because it's very closed. It's very, they are not talking about it." Privacy or shame was a frequent theme.

7. Spirituality and Religion

Spirituality and religion were important and could influence healthcare behaviors and/or decisions. Despite participants' opinions that communism made access to religion challenging, a theme that emerged was spirituality or religion, particularly the belief in God or the teachings of the Orthodox Church. Furthermore, subjects' statements indicated that their spiritual or religious beliefs influenced women's healthcare decisions. When asked specifically about the belief in God or the teaching of the Orthodox Church affecting healthcare decisions, 71% of EEOCIW (n

= 10) indicated one or more of the following: faith helps them make stable decisions, drives their decisions, is part of their overall spiritual wellbeing, tells them abortion is not good, or would actively ask their priest or spiritual father to help them make a health care decision. This number is similar to USOCW with 80% (n = 20) feeling likewise that religion affects their decisions.

An EEOCIW stated, “Religion is part of positive spiritual wellbeing….Communism fell, and we tried to go back to religion….Maybe that absence of…Church gave me the space to recognize the importance of spirituality, mindfulness and having calm, happy thoughts [for] a healthy body.” Quotes from USOCW women include “The church usually comes first, the church's stance on health, and then especially women's health care. With the support of your family, your spouse, your spiritual father, those things all help contribute to my decision making in my health care.”; “I would definitely seek resources from the church.”; “I follow the teachings of the church, but I've also had to make decisions in the course of my life, you know, that are for the benefit of my family.”; “Finding a doctor that is in line with kind of my general beliefs.” This aligned with thoughts of birth control in USOCW as religious beliefs could affect birth control usage. Data showed 32% of USOCW did not use birth control in marriage or abstained from sex until married due to their religious beliefs. Two USOCW stated their religious beliefs allow them to be more open with their husbands regarding sexuality in marriage. While zero EEOCIW stated religion affected birth control methods, religion did affect thoughts on abortion.

Although both groups felt religion can influence their decisions, 48% of USOCW included their religion as something they felt their providers should understand about them, and one EEOCIW (7%) felt the provider should understand this. The USOCW stated they would

want their provider to understand they are Orthodox Christians; as such, this can influence perspectives and guide decisions including family planning. Comments included: “I know Christian people that…make their decisions based off religion and faith…and seek out Christian healthcare providers…It's very hard to identify someone who is specifically Orthodox Christian. I know that I'm not the only one who would really appreciate that.” and “I think, whatever medical advice that they're giving, is this compliant with my faith….I think doctors, even if they have a faith that they own, they push that aside…without considering how much a patient’s faith might be affecting medical decisions.” The desire to include faith or spirituality in care was voiced by these participants.

8. Radiation Exposure

There was a concern for providers to be mindful of potential long-term effects from exposure to environmental radiation. A theme unique to EEOCIW is a physical health concern that is also an environmental concern, potentially affecting future generations in Serbia. This was the concern for depleted uranium left in the soil from the NATO bombings of the area in 1999 (European Western Balkans, 2019). Likewise, radiation fallout from the 1986 Chernobyl nuclear disaster was also a concern (World Nuclear Association, 2020). A comment from an EEOCIW was, “We were around…the Russian Chernobyl. It affected people in some ways….We may have to be more assertive and keep asking for things….Maybe now you are healthy, but in your 50s, 60s, 70s, you'll have pancreatic cancer or other things.” Five EEOCIW (36%) stated they had experienced cancer themselves, a family member developed cancer, or they had a fear of themselves or a family member developing cancer due to these incidents.

9. Contraception

Another theme emerged concerning the subjects expressing their discomfort with using hormonal birth control methods. Of the total participants, 100% agreed that birth control should be accessible to women. Within the EEOCIW, 50% offered that they experienced side effects to the birth control pill and would not take it again. One EEOCIW stated, “I personally don't like taking any pills that would be bad for my health.” Three USOCW (12%) stated the same. However, zero EEOCIW felt there was a stigma attached to asking for birth control, whereas three USOCW stated there was. One comment from a USOCW was, “I think it's something that's very taboo in society based on your age or religion or where you're at that makes it not as accessible as it should be.” This comment links to shame and privacy.

Natural family planning (NFP) was a form of birth control used, with five USOCW and one EEOCIW utilizing NFP. Abstinence was used by one EEOCIW and two USOCW. Five USOCW (20%) mentioned using an IUD. Three of those five women offered that it was a negative experience, with comments such as “I tried an IUD which went horribly wrong”, “I don’t like it. I’m getting it taken out.” and “It’s a copper one. I actually ended up getting pregnant on that, which caused it to be an ectopic pregnancy. I had to have surgery to have the fetus and part of my tube removed where it had implanted.” Some EEOCIW stated they knew about the availability of the intrauterine device (IUD), but did not say they had used one. Condoms were cited most often by EEOCIW (n = 9, 64%).

Data concluded similarity between the groups regarding being absolutely opposed to abortion, EEOCIW (n = 2, 14%) and USOCW (n = 4, 16%), and absolutely supportive of

abortion even as a birth control method, EEOCIW (n = 4, 29%) and USOCW (n = 5, 20%). Others varied between the extremes. One EEOCIW had accompanied a friend to an abortion while living in Eastern Europe and expressed regret later in life, stating, "I mean, this is heavy on me. I can't imagine for someone who actually went through this and had an abortion and didn't even think about it [at the time]…then the other issues and problems that come with it." Another woman who was in support of abortion in some cases explained, "After the Turkish invasion in Cyprus, the Church gave absolution to women who've had abortions, who were raped by Turkish soldiers….If you are raped or incest, I wouldn't wish a woman to keep a baby she was uncomfortable keeping." Firmly against abortion, this USOCW stated, "I had secular views of relationships and women's rights….I had one abortion….It was the most horrible thing, after, how I felt about myself….It was a beautiful thing when I was received back into the Orthodox Church…it's a healing process." One EEOCIW from Serbia who is firmly supportive of abortion stated, "I'm pro-abortion because shit happens. My friend's mom, she had eleven abortions….She had sex when he [her husband] was drunk. She said she didn't get contraception because she didn't want to use any kind of hormonal pills." Another EEOCIW stated, "I think it's…a husband and wife's right to decide on. And I'm not against abortion, if that's what she wants to do, because it's the right thing or the right moment to have a baby." At least in specific situations, overall consensus (85%, n = 33) was in support of abortion.

10. Respect

Responses from 100% of the women indicated that empathy, open communication, and to be respected by the provider were needed to build trust with a healthcare provider. One EEOCIW

commented, “They listen. That's kind of the big thing, if they listen. You hope that means they really kind of care. And if they listen then they would know what you actually want or you can or you cannot do.” Another EEOCIW stated, “If you are like, you're in pain and you need somebody to, you know, you feel like crying and you need somebody to say it’s okay to cry.” One USOCW stated, “A health care provider who listens to my questions and my experiences, my symptoms, my concerns, one who doesn't jump to prescribe medication right away or necessarily push one idea…” The responses from the women regarding developing trust with a provider shows a congruency between groups.

Data collected on “what a provider should understand about you?” varied. EEOCIW (n = 6, 43%) felt their provider should understand that they came from Eastern Europe. A comment was, “I may be too sensitive to find the right words when we talk and just be polite and get my trust. That's it. Be honest and polite to see me in a nice way, whatever it is, so that's it.” EEOCIW explained coming from Eastern Europe means to them that they did not have consistent medical care, preventative care, possibly could have been exposed to radiation, and because of these things, please look into complaints a little deeper, while being more patient with developing language skills.

When asked if there are topics that would be uncomfortable to share with a healthcare provider, most women stated they were comfortable sharing all information about their health with a healthcare provider: 57% EEOCIW (n = 8) and 60% USOCW (n = 15). However, one EEOCIW (7%) and three USOCW (12%) stated they are uncomfortable sharing their Christian faith. One EEOCIW living on the West Coast stated, “In America people are so open to

accepting different religions, but…people look at you when you say that you're Christian in particular, they're like, 'Oh, wow. You must not be that educated.' It's just there's the stigma nowadays." All three USOCW related this discomfort to NFP, with one summarizing, "I say we're Christian…we don't practice birth control, and that gets me a look like I'm a horrible person…She's like pushing, pushing birth control….I'm uncomfortable putting my trust in that they respect my faith and want to work with me." Overall, most women in the study were comfortable sharing everything with a provider (n = 23, 59%), with a small number hesitant on sharing faith (n = 4, 10%).

Conclusion and Recommendations

Ten themes emerged as a result of this project that should be considered when developing culturally congruent care for the health and wellbeing of EEOCIW, or to help them face dying or disability. The themes include:

- EEOCIW included overall wellbeing and mental healthcare in their perceptions of women's healthcare.
- EEOCIW tended to obtain healthcare information from their healthcare providers and from family and friends but were more private with their final decisions.
- EEOCIW believed their healthcare in the U.S. is better technology and secured more timely appointments, but often felt the providers seemed to rush through the visit.
- Health insurance, cost and financial ability to pay was cited as a barrier to care for EEOCIW, driving some to seek care overseas.

- The education that a EEOCIW received, both emic and etic, effects perceptions of health and healthcare.
- Women's health issues and/or sickness could be viewed as shameful and something to be kept private, even to the detriment of the women's health.
- Faith and religion were important and could influence healthcare behaviors and/or decisions.
- There was a concern for providers to be mindful of potential long-term effects from exposure to environmental radiation.
- EEOCIW and USOCW may experience unique birth control needs.
- Open and honest communication with empathy and mutual respect to individualize the care and build trust is needed by both groups of women.

Recommendations for action to integrate into nursing care include becoming astute to cultural imposition when discussing methods of birth control with EEOCIW. Be aware that wellness of the whole woman, including mental, spiritual, and dental health is considered important and should be preserved, and the nurse should emphasize this care. Recognize that the self-defined wellness of the whole woman may not allow for the use of hormones in birth control. Additionally, NFP is a reality for some Orthodox Christian women and should be accommodated by adding NFP as an option and topic of inquiry with these patients. Within the women's center, the creation of a position for a Natural Family Planner to educate on how NFP is incorporated into the woman's lifestyle would fulfil a need for NFP education. Furthermore, NFP education developed for youth may provide for educational awareness of natural signs and symptoms of fertility, which could help sexually active youth understand when risk of pregnancy

is high. Action is needed to develop sexual educational resources for youth and women regarding non-hormonal contraception that is inclusive and nonjudgmental of NFP. Detailed education regarding the indications, mechanism of action, and adverse effects of hormonal contraception to help dispel misconceptions and eliminate the need for seeking this information from unreliable sources is necessary. Repatterning methods for learning about contraceptive information is desirable. Pregnancy center websites should include reliable, evidence-based sources of contraceptive information, including NFP and hormonal contraception, and available in Eastern European languages. Providers should ask patients if and how their faith plays a role in their healthcare decisions and be non-judgmental with responses.

Providers should inquire about potential exposure to environmental radiation with any patients from Eastern Europe and be cognizant of a potential lack of consistent medical care over the years. Providers are encouraged to be mindful of the anxiety and body language of those women who uses English as a second language. Another point for providers is to moderate tone and allow patients additional time to express their needs and responses to questions. Translators in the room could cause the patient to become more private and share less information. The assessment with the EEOCIW would require the provider to make eye-contact, allow the patient time to process thoughts, allow addition appointment time, and utilize re-statement to be sure of the patient's intentions.

Providers should open-endedly ask EEOCIW where they are obtaining their healthcare, being aware of the potential for medical tourism. In follow up to the response, providers should specifically ask if patients are receiving care overseas or from friends or family. Offering the

assistance of social services to EEOCIW who are in financial need of co-pay assistance would be beneficial.

Anecdotally, when discussing EEOCIW recruitment efforts with various people within the Eastern European immigrant community, a few times they used the phrase “mandatory volunteerism”. The phrase implies that in Eastern Europe during the time of communism, citizens were mandated by the government to volunteer for research or other needs. Therefore, the people became accustomed to volunteering when mandated, and if not mandated, are reluctant to volunteer. Also shared, as the countries of post-communist Eastern Europe acquire new forms of government and integrate with the European Union, willing volunteerism is increasing among the youth.

Limitations

The study was limited in the following ways. First, the literature reviewed is not of the ethnic demographic studied in the project. Next, demographic information regarding education and socioeconomic status was not solicited, although at times volunteered by participants. This information may provide further insights into a cause and effect on perceptions. Third, 55% of immigrant screen failures were due to language barriers. This group of immigrants recently arriving to the U.S. with language barrier is unrepresented in this project. Fourth, the Eastern European group inclusion criteria allows for multiple countries. Intra-country specific factors could produce inter-country variability, which could skew results. Fifth, the snow-balling sampling method allowed for a majority of the EEOCIW group to be from the from the Balkan area (n = 11), which shared similar experiences and ethnicity.

Summary

This pilot study and needs assessment, which explored the perceptions of women's healthcare and birth control of EEOCIW, aimed to add to the cultural care body of nursing knowledge for women in the target population. The framework of Leininger's Theory of Culture Care Diversity and Universality supported by Leininger's Ethnonursing Research Process and a quantitative percentage analysis, allowed for a more complete, robust and insightful understanding of the similarities and differences of the EEOCIW, while also gaining perspective on USOCW. Understanding the themes and incorporating the recommendations into nursing care will produce cultural care individualized to these women. Trust will be built, stress will be reduced, nurse-patient conversations will be enhanced, and outcomes will be positively affected. Continued research on the social structure dimensions and worldview of the EEOCIW will help ensure culturally congruent care that encourages holistic health and wellbeing, and will provide for needs and comforts during times of disability, illness, dying, and death.

References

Atriga, S. & Pham, O. (2019). Addressing health and social needs of immigrant families: Lessons from local communities. *Issues Brief, KFF, 2020.* *https://www.kff.org/disparities-policy/issue-brief/addressing-health-and-social-needs-of-immigrant-families-lessons-from-local-communities/*

Balaam, M., Akerjordet, K., Lyberg, A., Kaiser, B., Schoening, E., Fredriksen, A., Ensel, A., Gouni, O., & Severinsson, E. (2013). A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. Journal of Advanced Nursing (John Wiley & Sons, Inc.), 69(9), 1919. https://login.ezproxy.otterbein.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=89703739&site=eds-live&scope=site

Bearak, J., Popinchalk, A., Alkema, L., & Sedgh, G. (2018). Global, regional, and subregional trends in unintended pregnancy and its outcomes from 1990 to 2014: estimates from a Bayesian hierarchical model. The Lancet Global Health, 6(4), E380-E389. https://doi.org/10.1016/S2214-109X(18)30029-9

Centers for Disease Control and Prevention. (2020). Reproductive health data and statistics. https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm

Consedine, N. S., Chentsova-Dutton, Y., & Krivoshekova, Y. S. (2014). Emotional acculturation predicts better somatic health: Experiential and expressive acculturation among immigrant women from four ethnic groups. Journal of Social & Clinical Psychology, 33(10), 867-889. https://doi.org/10.1521/jscp.2014.33.10.867

Crisan, C. O. (2013). *Ethnicity, assimilation and transnationalism: a comparative study of Eastern European migration to the United States (1940-2012)*. [Doctoral dissertation, Loyola University, Chicago]. eCommons.

De Jesus, M. (2016). How religiosity shapes health perceptions and behaviors of Latina immigrants: Is it an enabling or prohibitive factor? Psychology, Health & Medicine, 21(1), 128-133. https://login.ezproxy.otterbein.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=s3h&AN=110694111&site=eds-live&scope=site

European Western Balkans. (2019). https://europeanwesternbalkans.com/2019/03/25/twenty-years-bombing-serbia-nato-stand-today/

Hartmann, B. (2016). Reproductive rights and wrongs: The global politics of population control. Haymarket Books.

Jacob, L., Kostev, K., Gerhard, C., Kalder, M. (2019). Relationship between induced abortion and the incidence of depression, anxiety disorder, adjustment disorder, and somatoform disorder in Germany. Journal of Psychiatric Research, 114(July 2019), 75-79.

Kaiser Family Foundation. (2020). Health coverage of immigrants. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/

Leininger, M. (1997). Overview of the theory of culture care with the ethnonursing research method. Journal of Transcultural Nursing, 8(2), 32-52.

Leustean, L. N. (2009). Orthodoxy and the Cold War (1st ed.). London, England: Palgrave MacMillan.

McFarland, M. R., Wehbe-Alamah, H. B. (2018). Leininger's Transcultural Nursing Concepts Theories, Research & Practice (4th ed.). New York, NY: McGraw-Hill Education.

McFarland, M. R., Wehbe-Alamah, H. B. (2019). Leininger's theory of culture care diversity and universality: An overview with a historical retrospective and a view toward the future. Journal of Transcultural Nursing 30(6), 540-557. https://doi.org/10.1177%2F1043659619867134

Migration Policy Institute. (2018). European immigrants in the United States. https://www.migrationpolicy.org/article/european-immigrants-united-states

Mojzes, P. (2011). Balkan Genocides: Holocaust and Ethnic Cleansing in the Twentieth Century (1st ed.). Lanham, MD: Littlefield Publishers.

Moran, K., Burson, R., Conrad, D. (2014). The Doctor of Nursing Practice Scholarly Project (2nd ed.). Burlington, MA: Jones and Barlett Learning.

Pew Research Center. (2017). Orthodox Christianity in the 21st century. https://www.pewforum.org/2017/11/08/orthodox-christianitys-geographic-center-remains-in-central-and-eastern-europe/

The Polynational War Memorial. (2018). Wars since 1990. http://www.war-memorial.net/wars_all.asp?q=3

QSR International. (2020). NVivo. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

United Nations. (2013). World abortion policies 2013. https://www.un.org/en/development/desa/population/publications/pdf/policy/WorldAbortionPolicies2013/WorldAbortionPolicies2013_WallChart.pdf

US Centers for Medicare and Medicaid Services Coverage. (2021) for lawfully present immigrants. https://www.healthcare.gov/immigrants/lawfully-present-immigrants/

US Citizenship and Immigration Services. (2019). Laws and policies: Immigration and Nationality Act. https://www.uscis.gov/laws-and-policy/legislation/immigration-and-nationality-act

World Nuclear Association, (2020). https://www.world-nuclear.org/information-library/safety-and-security/safety-of-plants/chernobyl-accident.aspx

Zentos, N. J. & Marley, W. (2021). Eastern Orthodox churches. https://case.edu/ech/articles/e/eastern-orthodox-churches

Zong, J. & Batalova, J. (2016) European immigrants in the United States in 2014. Migration Policy Institute. https://www.migrationpolicy.org/article/european-immigrants-united-states-2014

Appendix A

IRB Approval Letter

OTTERBEIN UNIVERSITY

INSTITUTIONAL REVIEW BOARD

__X__ Original Review
_____ Continuing Review
_____ Amendment

Dear Dr. Shoemaker,

With regard to the employment of human subjects in the proposed research:

HS # 20/21-07
Shoemaker & Babich-Speck: Eastern Orthodox Christian Women Immigrants ...

THE INSTITUTIONAL REVIEW BOARD HAS TAKEN THE FOLLOWING ACTION:

✓ Approved	_____ Disapproved
_____ Approved with Stipulations*	_____ Waiver of Written Consent Granted
✓ Limited/Exempt/Expedited Review	_____ Deferred

* Once Stipulations stated by the IRB have been met by the investigator, then protocol is APPROVED.

1. As Principal Investigator, you are responsible for ensuring that all individuals assisting in the conduct of the study are informed of their obligations for following the IRB-approved protocol.
2. It is the responsibility of the Principal Investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject's participation in the proposed activity. Should the Principal Investigator leave the university, signed consent forms are to be transferred to the IRB for the required retention period.
3. If this was a limited, exempt, or expedited review, there is no need for continuing review unless the investigator makes changes to the proposed research.
4. If this application was approved via full IRB committee review, the approval period is one year, after which time continuing review will be required.
5. You are reminded that you must promptly report any problems to the IRB, and that *no procedural changes may be made without prior review and approval.* You are also reminded that the identity of the research participants must be kept confidential.

Date: 24 Sept. 2020 Signed: Meredith C. Jones
Chairperson

(Revised January 2019)

Appendix B

Institutional Review Board Amended to Include Slovakia

OTTERBEIN UNIVERSITY

INSTITUTIONAL REVIEW BOARD

__X__ Original Review
____ Continuing Review
11/13/2020 Amendment *

Dear Dr. Shoemaker,

*Amended to Include Slovakia (as attached)

With regard to the employment of human subjects in the proposed research:

HS # 20/21-07
Shoemaker & Babich-Speck: Eastern Orthodox Christian Women Immigrants ...

THE INSTITUTIONAL REVIEW BOARD HAS TAKEN THE FOLLOWING ACTION:

✓ Approved	_____ Disapproved
_____ Approved with Stipulations*	_____ Waiver of Written Consent Granted
✓ Limited/Exempt/Expedited Review	_____ Deferred

* Once Stipulations stated by the IRB have been met by the investigator, then protocol is APPROVED.

1. As Principal Investigator, you are responsible for ensuring that all individuals assisting in the conduct of the study are informed of their obligations for following the IRB-approved protocol.
2. It is the responsibility of the Principal Investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject's participation in the proposed activity. Should the Principal Investigator leave the university, signed consent forms are to be transferred to the IRB for the required retention period.
3. If this was a limited, exempt, or expedited review, there is no need for continuing review unless the investigator makes changes to the proposed research.
4. If this application was approved via full IRB committee review, the approval period is one year, after which time continuing review will be required.
5. You are reminded that you must promptly report any problems to the IRB, and that *no procedural changes may be made without prior review and approval.* You are also reminded that the identity of the research participants must be kept confidential.

Date: 24 Sept. 2020 Signed: Meredith C. [illegible]
Chairperson

(Revised January 2019)

Appendix C

Timeline

May 2020
• Spoke with advisor topic selection • Draft of project problem identification
June 2020
• Project literature search • Project scaffolding • Data collection plan and analysis plan
July 2020
• Budget developed • Timeline developed • Project proposal PowerPoint created • Project proposal presented to students and Project Team Leaders
August 2020
• Draft of Institutional Review Board application submitted • Draft grant proposal submitted
September 2020
• Submission to the Otterbein University IRB (Attachment A) • Submission to the Otterbein Student Research Fund • After Otterbein University IRB approval, recruitment and interviews begin
October 2020
• Interviews continue • Recruitment continues • Otterbein Student Research Fund Approval

November 2020
• Recruitment ends • Submitted to IRB for amendment to include Slovakia (Attachment B) • Interviews continue • Meeting with Community Member
December 2020
• Interviews end • Purchase NVivo Software • Transcription of interviews
January 2021
• Transcription of interviews
February 2021
• Analysis of findings
March 2021
• Flow of report preparation delayed by health crisis • Report Analysis and Outcome Completed • Report edited • Shared results with participants • Finalized DNP Final Project Report, Presentation, and Poster
April 2021
• Final DNP Scholarly Project Presented 4/22/2021 • Submitted DNP Final Scholarly Project Report to EDT Center and The Digital Commons at Otterbein Institutional Repository 4/23/2021 • Submitting DNP Final Scholarly Project Poster to Digital Commons at Otterbein • Received Doctor of Nursing Practice Degree on Friday, April 23, 2021

Appendix D

Recruitment Letter for Flyers

Attention Orthodox Christian Women!

Greetings! My name is Kimberly Babich-Speck. I am a nurse practitioner, and I am a doctor of nursing practice student from the Nursing Department at Otterbein University in Westerville, Ohio. With the support of pregnancy center (name redacted), I am a writing to invite you to participate in my research study about the perceptions of women's healthcare amongst Eastern European Orthodox Christian immigrant women. I am recruiting Orthodox Christian women between 18 and 55 years old who were either born in the United States and cradle-raised in the Orthodox faith, or those who have immigrated to the United States from one of the following Eastern European countries where they were born: Albania, Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, Estonia, Georgia, Greece, Hungary, Kosovo, Latvia, Lithuania, Moldova, Montenegro, North Macedonia, Romania, Russia, Serbia, Slovakia, Slovenia, or Ukraine.

If you decide to participate in this study, you will be asked twelve interview questions concerning your general perceptions of women's healthcare, factors influencing women's healthcare, women's healthcare and contraception, and trust in healthcare. Consent will be through Survey Monkey. Interviews will take place over the computer using MS Teams. You will be compensated $20 for participating in this study. The report will be shared with pregnancy center (name redacted) to aid in the improved understanding of the Eastern European Orthodox Christian immigrant woman's perceptions of women's healthcare.

Remember, this is completely voluntary. You can choose to be in the study or not. If you would like to participate or have any questions about the study, please contact me at (phone number redacted) or Kimberly.babichspeck@otterbein.edu.

Thank you very much for your consideration.

Kimberly Babich-Speck

Recruitment statement for church newsletters

Are you an Orthodox woman age 18 to 55 years willing to share your opinions about women's healthcare needs in America? This research is being completed by Kimberly Babich-Speck, doctorate of nursing practice student at Otterbein University with the support of pregnancy center (name redacted). Participants who interview will be paid $20. Call Kimberly at (phone number redacted) or email Kimberly.babichspeck@otterbein.edu for details.

Appendix E

Interview Questions

Interview Guide

The following three questions are about general perceptions of women's healthcare:

1. What do you think of when I say women's healthcare?
2. Where do you seek women's health care and healthcare information?
3. Depending on if US-born or non-US-born participant
    a. How does the women's healthcare you receive in the United States compare to the healthcare you received in your native country? (only non-US-born participants)
    b. What is your general opinion of the women's healthcare you receive? (only US-born participants)

The following three questions are about factors influencing women's healthcare:

4. Tell me about the factors that most affect your women's healthcare decisions.
5. Tell me about any past personal or cultural events, facts, or experiences, that you feel may affect your current health or access to healthcare.
6. How does your belief in God or the teachings of the Orthodox Church affect your women's healthcare decisions?

The following three questions are related to women's healthcare and contraception:

7. Tell me your opinion about women's healthcare related to access to birth control.
8. What methods of birth control have you experienced?
9. What is your opinion of and experience with abortion?

The following three questions are about personal trust influencing women's healthcare:

10. What issues would you not be comfortable sharing with a doctor or a nurse, and why?
11. What helps you develop trust with a healthcare provider?
12. Is there anything else you would like to share?

Appendix F

Informed Consent

Consent for
Participation
in Interview
Research

Otterbein University Department of Nursing

Purpose of Research: The purpose of this study is to identify the perceptions of women's healthcare and the possible barriers to care for Eastern European Orthodox Christian immigrant women.

Procedure: This study will recruit Orthodox Christian women from the ages of 18 to 55 years old who after 1/1/1995 immigrated to the United States from one of the following countries of which they are native-born: Albania, Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, Estonia, Georgia, Greece, Hungary, Kosovo, Latvia, Lithuania, Moldova, Montenegro, North Macedonia, Romania, Russia, Serbia, Slovakia, Slovenia, or Ukraine; and those Orthodox Christian women who are 18 to 55 years old who are native-born in the United States and have not lived abroad for greater than one year. If you participate in this research, you will be interviewed during a casual discussion about your experiences and perceptions of women's healthcare. The interview will consist of 12 questions and will take approximately 60 minutes and be completed online via Microsoft Teams. The 12 questions will fall into one of four categories covering general perceptions of healthcare, factors influencing women's healthcare, women's healthcare and contraception, and trust in healthcare. The interview will be audio recorded and a written record of the interview will be completed by the researcher. The researcher will ask questions and lead the discussion. Your participation is completely voluntary. You may choose not to answer a question and you may choose to withdraw from this study at any time without penalty. Participants will be paid $20 for completion of the interview.

Benefits and Risks: Your participation in this research may benefit you, your family, friends, community, and society by helping the researcher and the pregnancy center (name redacted) to understand the women's healthcare perceptions of Eastern European immigrant Orthodox Christian women and US cradle-born Orthodox Christian women in America. There are no anticipated risks associated with this study.

Confidentiality: Your confidentiality will remain secure. In all cases, no study participant identity will be disclosed in any discussions, reports, or documents that are developed as a result of this research.

If you need further information or have questions about this research, please contact the researcher, Kimberly Babich-Speck, at (phone number redacted).

*1. Consent: **By clicking the** I AGREE **box below, you affirm that you are at least 18 years of age but no more than 55 years of age; that you are a US-born cradle Orthodox Christian woman OR that you are an Orthodox Christian woman who emigrated from one of the above named countries to the US after 1/1/1995; and you are indicating that you fully understand the above information and that you agree to voluntarily participate in this interview.**

I AGREE
I DISAGREE

*2. **Please type your name as your signature and then click the SUBMIT RESPONSE button.**

SUBMIT RESPONSE

Appendix G

Research Grant

OTTERBEIN UNIVERSITY
OFFICE OF ACADEMIC AFFAIRS

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Westerville, OH 43081
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www.otterbein.edu

October 29, 2020

Kimberly Babich-Speck
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Dear Kimberly,

On behalf of the Student Research Fund Committee, I am pleased to inform you that your proposal, "Eastern European Orthodox Christian Women Immigrants: A Pilot Study and Needs Assessment." been officially approved for a $400.00 SRF Research Grant.

Student Research Fund recipients are competitively selected based upon the quality of their proposed research and/or creative endeavor. Congratulations on this achievement!

Your advisor, Dr. Joy Shoemaker, will be informed about your award, and will be able to help you request reimbursement for your expenses for costs incurred after the award approval. Please visit the SRF webpage for help with Claiming Expenses or contact Academic Affairs (614-823-1556 or academicaffairs@otterbein.edu).

Finally, we would like to let others know of your good work. When you submit your final invoice for payment on the award, please also submit an abstract that is suitable for publication and addresses the significance of the research, the methodology, and the conclusion you reached. This 200 word abstract should include your name, your advisor's name, the title of your research or presentation, and the signature of your advisor.

Should you have questions, please feel free to contact the SRF Team at academicaffairs@otterbein.edu.

Best wishes with your project.

Sincerely,

Dr. Kathryn M. Plank
Associate Provost for Curriculum, Teaching & Learning, and Mission
kplank@otterbein.edu | 614.823.1556

Appendix H

Summary of Raw Data

Questions	Coding	EE(n)	%	US(n)	%	EE#s	US#s
Question 1	prevention, contraception, mammograms, paps, reproductive health	11	79%	21	84%	1.21.31. 35.38.39 .19.23.2 6.33.44	14.15.17 .18.20.2 4.25.27. 3.4.43.4 5.6.7.16. 22.5.11. 30.32.25
	Healthy lifestyle and overall wellbeing, mention of mental healthcare	7	50%	4	16%	19.21.34 .37.44.2 3.26	20.30.9. 29
	physical health to include cancer and cardiac	4	29%	8	32%	34.42.37 .35	22.29.30 .11.3.45. 7.9
	dental	3	21%	0	0%	1.37.39	0
Question 2	internet	8	57%	18	72%	21.38.39 .44.31.3 7.42.33	27.28.3. 30.5.20. 29.12.14 .18.6.15. 17.11.24 .45.25.4 3
	dentist	2	14%	0	0%	1.39	
	doctors	9	64%	17	68%	19.21.23 .26.31.3 4.35.39. 44	11.15.16 .18.20.2 4.25.28. 3.32.4.4 3.45.5.6. 7.9
	church/faith	1	7%	2	8%	19	12.9
	family and friends	5	36%	5	20%	1.19.31. 37.42	18.27.45 .5.9

Question 3	USA high Cost	3	21%	2	8%	33.39.44	3.5
	no health insurance or difficulty understanding	4	29%	3	12%	31.35.39 .44	24.3.5.
	no preventive care overseas or better in USA	2	14%	2	8%	19.37	20.28
	USA better technology	4	29%		0%	21.33.44 .37	
	Good Experience USA,	9	64%	12	48%	19. 21.44.26 .33.34.3 5.28.37	11.14.16 .22.25.2 7.28.32. 4.43.45. 7
	faster care in USA	5	36%		0%	21.35.37 .42.44	
	USA rush you through or pushing pills	5	36%	7	28%	23.26.31 .38.44	15.30.5. 24.6.9.1 1
	USA doesn't ask about mental healthcare	1	7%	2	8%	23	5.9
	it is personal responsibility wherever you go	2	14%	3	12%	1.37	10.15.32
	awkward as an Orthodox Christian		0%	2	8%		12.22
Question 4	Personal Responsibility and Lifestyle	3	21%	0	0%	1.37.34	0
	Family and friends	3	21%	10	40%	19.31.33	10.12.17 .20.22.2

							8.29.3.4 5.9
	Insurance/money	8	57%	12	48%	19.26.35 .37.38.3 9.42.44	11.15.16 .18.20.2 2.24.25. 28.43.3. 5
	how long do I have to wait	2	14%	7	28%	23.35	16.18.27 .30.32.4. 7
	Location	4	29%	7	28%	23.26.37 .42	16.27.30 .4.43.5.7
	faith religion morals	2	14%	8	32%	31,26	10.20.22 .28.29.4. 6.9
	doctor's manner and capability	3	21%	9	36%		
	understanding access to system	3	21%	0	0%	31.35.39	0
	communism, stoicism, embarrassment, language,	4	29%	1	4%	19.33.34 .37	15
	Education	4	29%		0%	21.33.34 .39	
Question 5	Unable to adjust easily to the foods (too much sugar everywhere). Unhealthy eating	2	14%	1	4%	1.33	
	Lack of US access to dentistry	3	21%		0%	1. 34.37	
	Stress, US fast-paced, lack of time for life	2	14%		0%	1.38	

	Lack of trust in doctors (particularly people from rural areas), doctors can't help them. Lack of understanding of US h/c system or Stoic- withstand as much as possible and only see doc if absolutely necessary or shame	4	29%	0	0%	21,33,35, 44	0
	Man is number one, woman behind the man. Not woman's place to ask questions or seek help. Lack of female advocate to teach in youth sex education	8	57%	6	24%	1.21.34.2 6.31 33.35.44	15.29.43. 31.9.32
	Not woman's place to ask questions or seek help	4	29%	1	4%	21.34.35. 44	32
	Miscarriage and long delay to be seen	1	7%		0%	23	
	Born overseas can't give blood	1	7%		0%	26	
	Family history of Chernobyl radiation cancer	1	7%		0%	26	

	Language barrier when coming to US or parents didn't speak English	3	21%	2	8%	31.34.35	25.12
	Church parishioners medical gave free healthcare or support	2	14%		0%	31.39	
	Friends overseas would mail needed medication	1	7%		0%	-31	
	Accustomed to no cost healthcare overseas	3	21%		0%	33.37.39	
	Old wives tales	2	14%		0%	1.35	
	Lack of education of female health due to cultural patriarchy	4	29%	9	36%	21.33.35.44	12.15.16 20.25.28. 29.32.9
	Depending on the area of eastern Europe, some areas lower education	1	7%	1	4%	1.44	32
	Closed community: do not share troubles: keep private or shame	3	21%	5	20%	33.35.1	20.29.32. 6.9
	Belief that you have to help yourself and God will help you	1	7%		0%	35	

	NATO bombing depleted uranium and cancer or Family history of Chernobyl radiation cancer	5	36%		0%	37.38.1.39.26	
	No health insurance/medical bills	2	14%	3	12%	42.39	14.24.28
	Keeping the FAST	1	7%	2	8%	1.	27.7
	Shame to discuss female health - being judged- including mental health	1	7%	13	52%	1.	20.22.24.25.29.32.43.6.9.16.18.43.10
	Education passed mother to daughter through culture	1	7%	1	4%	44	20
	Smoking marijuana		0%	1	4%		10
	Domestic violence		0%	1	4%		10
	Child custody battle		0%	2	8%		10.14
	Cancer diagnosis		0%	1	4%		11
	Reliance on secular perspectives of women's rights influenced bad decisions. Secular filled in where church was absent.	0	0%	2	8%		12.15
	Parents didn't speak English	0	0%	1	4%		12

	Stoic- withstand as much as possible and only see doc if absolutely necessary	0	0%	6	24%		15.32.43.6.9.20
	Lack of sex education as a child. Lack of female advocate to theach in youth	0	0%	6	24%		15.29.32.9.43.31
	Dismissive doctors (including mental and emotional health)	0	0%	4	16%		16.18.43.9
	Women are equal	0	0%	1	4%		3
	Lack of a female advocate to teach things in youth	0	0%	3	12%		43.9.31
	Strong help from mother raising children	0	0%	1	4%		7
Question 6	Faith helps you make stable decisions. Seek advice from priest or bible or abortion is bad. Part of spiritual wellbeing	10	71%	20	80%	1.19.23.34.31.39.37.26.35.38	12.18.20.27.28.29.3.4.6.45.5.9.30.32.14.17.7.25.10.11
	In old country priests did not say anything	1	7%	0	0%	1.	
	Faith tells me abortion is bad	4	29%	8	32%	19.23.34.39	14.12.15.17.24.29.4.7
	Communism took the place of faith (left with searching for	4	29%	0	0%	19.21.37.1	

	"roots" belonging after fall of communism)						
	Doesn't directly affect me for healthcare decisions	4	29%	5	20%	21.33.42.44	15.24.16.43.22
	Stay home from church if you have your cycle, father was a priest, consult him or mother for religious opinions for life/health. But religion doesn't affect my need to take birth control.	1	7%	0	0%	26	
	I consider first what the church teaches/talk to priest first	1	7%	3	12%	31	25.5.28
	Need more resources for healthcare for middle school orthodox girls	2	14%	1	4%	26.31	32
	Religion is part of spiritual well being	2	14%	1	4%	37.39	32
	Take care of yourself and God will take care of you	2	14%	0	0%	35.38	
	Keeping the FAST in all ways (meals, sex, piety, etc)	1	7%	1	4%	39	32
	Alcohol is okay	0	0%	1	4%		10

	Health circumstance is part of faith and something for my salvation	0	0%	1	4%		11
	Very clear what the church teaches about contraception but not widely available for lay people's knowledge	0	0%	1	4%		12
	Do not use contraception due to my faith and be more open with my spouse regarding sexuality	0	0%	8	32%		12.4.22.6.7.20.25.9
	Christ is forgiving and treat each other with love	0	0%	1	4%		17
	Holistic non pharmaceutical approach	0	0%	1	4%		20
	Abstinence	0	0%	2	8%		20.25
	Keep body healthy because it is the image and likeness of Christ	0	0%	1	4%		27
	Religion teaches me to be more open about my sexuality in marriage	0	0%	2	8%		9.6
Question 7	Pills are bad for my health	2	14%	2	8%	1. 34	32.4
	Leave this decision to my husband	1	7%	0	0%	1.	

	Better to use a condom	1	7%	0	0%	1.	
	I don't use contraception	2	14%	1	4%	1. 38	10
	Pills for medical problems of hormone balance	1	7%	7	28%	19	14.20.22. 25.32.43. 7
	Woman's decision what she wants to do	5	36%	8	32%	21.23.37. 38.42	11.15.16. 17.22.30. 5.6
	I had bad reaction to the pill or afraid of it	7	50%	4	16%	1. 19.23. 26.31.34. 38	24.28.5.1 7
	We need more education for tweens/teens for birth control	4	29%	9	36%	26.33.39. 42	11.17.18. 20.28.29. 45.5.9
	It needs to be accessible	6	43%	19	76%	23.26.35. 37.38.42	11.15.16. 17.18.20. 24.27.28. 29.3.30.3 2.43.45.5 .6.7.9
	It is free at planned parenthood	1	7%	1	4%	31	29
	It is easy to access	4	29%	5	20%	31.35.37. 42	22.25.27. 28.29
	I had no education on bc growing up	1	7%	1	4%	33	9
	Control it by medical worker	2	14%	0	0%	34.26	
	The unfortunate alternative is abortion	2	14%	1	4%	35.26	17
	I am pro choice	1	7%	0	0%	37	

	It's hard to get if you don't see a doctor yearly	0	0%	1	4%		10
	I want more education on natural family planning	0	0%	4	16%		12.4.5.28
	It's taboo to even ask for it	0	0%	3	12%		18.32.9
	No idea what the church thinks about it	0	0%	2	8%		25.45
	Makes it easy to sleep around safely. 18 year old girls should not be on contraception, but if she needs it then yes	0	0%	2	8%		32.9
Question 8	Pills	3	21%	14	56%	26.31.42	10.11.12. 16.14.18. 20.22.25. 27.3.30.4 .9
	Pills but stopped due to side effects	3	21%	3	12%	1.19.23	24.28.5
	Condom	9	64%	12	48%	1. 26.31.33. 44.42.34. 37.19	42.15.11. 17.16.22. 18.28.29. 4.6.7
	Ligation		0%		0%		
	I know about the IUD but didn't use it	5	36%		0%	21.31.34. 35.37	
	Chose no children by choice due to economics	1	7%		0%	1.	
	Abstinence	1	7%	2	8%	37	16.45
	Foam		0%	1	4%		11

	IUD that went horribly wrong		0%	5	20%		12,14,24,29,6
	Natural family planning	1	7%	5	20%	38	12.20.4.6.9
	Patch		0%	1	4%		14
	IUD		0%	2	8%		14.24
	Afraid of the pill or IUD		0%	2	8%		17.5
	LARC but didn't like it		0%	1	4%		29
	Vasectomy		0%	2	8%		3.6
Question 9	Against	2	14%	5	20%	1.42	32.10.12.15.17
	Communism accepted it	7	50%	0	0%	1. 21.31.33. 35.37.44	
	Not a big deal. Just something you could do	3	1%	1	4%	1.35.44	17
	Weighs heavily on me that I assisted a friend through abortion without talking about options with her	1	7%	0	0%	19	
	I wouldn't do it but still pro-choice	4	29%	8	32%	21.23.26. 35	2427.28. 29.3.30.4 3.6
	Life begins at conception but I'm not 100% against it	2	14%	0	0%	26.31	
	Using it for birth control is wrong	1	7%	0	0%	31	

	I/Mother/Friend had abortions and struggles emotionally with the decision years later assisted a friend and weighs heavily on me	2	14%	5	20%	31. 19	20.4.6.9. 12
	Pro choice even for birth control	4	29%	5	20%	33.37.39. 44	11.16.18. 22.5
	Taboo to discuss in USA and guilt on the girls for rest of lives	2	14%	2	8%	33.37	17.6
	May be okay for a medical reason, otherwise against it	2	14%	4	16%	34.38	20.25.45. 7
	I had an abortion. It's a long healing process afterwards	0	0%	1	4%		12
	If the mother feels it is her only choice, but I don't want to know about it or have tax dollars paying for it	0	0%	1	4%		14
	Pro-life and that means for the mother too	0	0%	1	4%		32
Question 10	Don't give them more than they need to make decisions	1	7%	0	0%	1.	
	Don't need to talk to my kids without me present	1	7%	0	0%	1	

	Sexual relations	3	21%	4	16%	19.26.33	11.16.17.28
	None	8	57%	15	60%	21.23.34.35.37.39.42.44	14.15.18.20.22.24.25.27.29.3.30.32.43.5.7
	I don't like sharing on west coast that I am Christian. Feeling I get judged as uneducated, and NFP	1	7%	3	12%	31	12, 4, 9
	Language barrier that causes another person in the room will make people not share	1	7%	0	0%	35	
	Smoking status	1	7%	0	0%	38	
	More apt to share w doctor over nurse (repeating myself)	1	7%	0	0%	42	
	Anything that would jeopardize access to my kids	0	0%	1	4%		10
	Prefer a female doctor	0	0%	3	12%		22.5.6
	Weight control	0	0%	1	4%		45
	Relationship with my spouse	0	0%	1	4%		6
Question 11	Longevity	3	21%	4	16%	1.23.37	24.28.27.6
	Knowledgeable	5	36%	1	4%	1.35.39.42.44	16

	Listen to me	4	29%	5	20%	1.23.35. .26.31.42	11.20.22. 25.9
	Interested in me to tease out information	2	14%	13	52%	1.35	16.18.20. 22.25.3.3 0.32.43.4 5.5.6.7
	Good communication	5	36%	5	20%	23.31.34. 38.44	14.29.25. 32.4
	Take time with me	5	36%	11	44%	23.26.35. 38.44	11.14.16. 18.28.24. 25.29.45. 5.9
	Non judgmental	2	14%	0	0%	33.35	
	Female doctors	2	14%	0	0%	37.38	
	From my native area	1	7%	0	0%	38	
	Not fake, honest with me	0	0%	1	4%		10
	If they respect my opinions	0	0%	4	16%		12.17.7.9
	Empathy	0	0%	9	36%		14.22.25. 27.29.30. 45.6.7
	Explain things to me	0	0%	2	8%		15.25
	longevity and knowledge	8	57%	5	20%	1.23.37. 35.39.42 .44	24.28.27 .6.16.10
	Empathy and communication	14	100%	25	100%	1.23.35. 33.19.26 .31.42.2 1.34.38. 44.37.39	11.20.15 .22.25.1 4.29.4.1 4.28.24. 29.9.16. 18.3.30. 32.43.45

							.5.6.7.10 .12
	Remembers me	0	0%	1	4%		30
Question 12	Don't be more involved than necessary	1	7%	0	0%	1. 19.	
	Coming from Eastern Europe exposed to much radiation or I'm from a communist country and had no consistent care. Look into problems a little deeper. Be patient while I find the right words.	6	43%	0	0%	19.33.37. 21.38.34	
	I need to see the whole picture and time to process information that they give me	1	7%	0	0%	21	
	I'm very active and exercise even though my BMI is higher, and still take my health seriously	1	7%	0	0%	26	
	I am Orthodox, and this can influence my perspectives; faith guides what I do (NFP)	1	7%	12	48%	31	32.11.22. 12.16.17. 25.4.45.5 .6.9
	I'm a smoker and it's not so easy to quit	1	7%	0	0%	33	

	Be honest and polite, open, honest information, but will make my own decision	1	7%	6	24%	34	14.15.20. 3.32.5
	I work too much	2	14%	1	4%	35.42	32
	I am from eastern Europe and may go back. I'm a newcomer and adopted a new lifestyle	1	7%	0	0%	37	
	I'm always scared to go to doctor and language makes it harder	1	7%	0	0%	38	
	I don't like going to doctor and I might have concerns about vaccines or certain medications	1	7%	2	8%	39	22.45
	Understand me holistically, even my job stress	1	7%	3	12%	42	30.32.7
	I will try to do the right thing	0	0%	1	4%		10
	Burden is on us to assimilate, rather than to seek to be understood	1	7%	1	4%	44	29
	I really only go when something is wrong, so please listen to me.	0	0%	3	12%		15.18.24
	I'm pretty open	0	0%	1	4%		-27

	I worry a lot, bedside manner is important, I'm sensitive	0	0%	2	8%		28.9
	I want the doctor to take time to read my history and my chart	0	0%	2	8%		15.43
	Presenting options is important	0	0%	1	4%		6
	I need you to listen to me and try to understand me.	6	43%			21.42.39 .38.34.1	
	Sometimes I need to hear it's okay to cry	1	7%		0%	21	