Authors
Dr. Lela Sturua, Nino Shushania

Dr. Poonam Dhavan, Migration Health Division, IOM, provided public health expertise during conceptualisation of this project, technical inputs and review of the Survey report

Editorial Team
Nino Sanikidze, Joanna Grace Fernandez

Research Team
Research design: Dr. Lela Sturua, Nino Shushania
Statistical programme development, data entry and data analysis: Maya Butsashvili, Marina Shakh-Nazarova
Database operators: Lia Kindzadze, Susana Shakhbudagiani, Liana Khuchua, Ludmila Ediberidze, Tamar Pilauri, Guliko Lomidze, Nino Grdzelidze, Lela Tsertsvadze, Maya Chokheli, Tsimi Chanadiri and Nari Gognadze
Field coordinators and supervisors: Dali Trapaidze, Tamar Chachava, Eliso Iobashvili, Zaal Merabishvili
Researchers: Lia Mgaloblishvili, Nino Mamukashvili, Sophio Chirakadze, Lia Skhirtladze, Maya Beruchashvili, Pikria Nemsadze and Ketevan Maminaishvili
Drivers: Otar Tsagareishvili, Anzor Zubashvili, Sergo Narimanidze, Mamuka Kaladze, Malkhaz Goderdzishvili, Giorgi Zubashvili, David Tskhovrebashvili, Akaki Ketiladze, Zaza Lezhava and Zurab Sultanishvili

Gratitude goes to:
All migrants who took part in the Survey as respondents, the Ministry of Labour, Health and Social Affairs of Georgia, the Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia, the Ministry of Corrections and Legal Assistance of Georgia, the personnel of the Reception and Temporary Accommodation Centre for Asylum Seekers, the personnel of the State Fund for Protection and Assistance of Victims of Human Trafficking, Tbilisi State Medical University, WHO Country Office in Georgia.

Special gratitude goes to:
Mrs. Ilyana Derilova, IOM Georgia Chief of Mission; Mr. Guglielmo Schinina, Head of IOM Psychosocial and Cultural Integration Unit; colleagues of IOM Georgia Tbilisi and Kutaisi offices and colleagues at IOM Migration Health Division; Mrs. Nata Avaliani, Director General of the National Centre for Disease Control and Public Health[1]; Mr. Zurab Utiashvili, Head of the Department of Emergency Situations Coordination and Regime of the Ministry of Labour, Health and Social Affairs of Georgia; Mr. Valeri Kopaleishvili, Head of the Administrative Department of the Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia; Mr. Giorgi Khojevanishvili, Head of the Department of International Relations of the Ministry of Corrections and Legal Assistance of Georgia, and Mr. Zurab Vadachkoria, Rector of Tbilisi State Medical University.

[1] Upon completion of the project due to organizational changes and movements of personnel, Ms. Ekaterine Kavtaradze was appointed on the position of NCDC&PH Director General

Cover photo: by Cole Garside, IOM's mobile team providing psychosocial assistance to internal forcefully displaced migrants' residing in Berbuki settlement, aftermath August war 2008

TABLE OF CONTENTS

LIST OF ACRONYMS 4
EXECUTIVE SUMMARY 5
INTRODUCTION 12
GENERAL SITUATION ON NCDs 12
NCDs IN GEORGIA 13
MIGRATION AND ITS IMPACT ON HEALTH OUTCOMES 14
ISSUES RELATED TO MENTAL HEALTH OF MIGRANTS IN GEORGIA 17
METHODOLOGY 23
SURVEY RESULTS 33
INTERNAL FORCEFULLY DISPLACED MIGRANTS 33
RETURNED MIGRANTS 73
FOREIGN MIGRANT STUDENTS 88
ASYLUM SEEKERS 104
TRAFFICKED MIGRANTS 113
FOREIGN MIGRANT DETAINEES 118
CONCLUSIONS AND RECOMMENDATIONS 127
RECOMMENDATIONS 140
BIBLIOGRAPHY 142

LIST OF ACRONYMS

NCDs - Non-Communicable Diseases
WHO - World Health Organization
IOM - International Organization for Migration
NCDC - National Centre for Disease Control and Public Health
STEPS - Stepwise approach towards non-communicable disease risk factor surveillance
EU - European Union
TSMU - Tbilisi State Medical University
IOM MHD - International Organization for Migration, Migration Health Division
MoLHSA - Ministry of Labour, Health and Social Affairs of Georgia
IFDM - Internal Forcefully Displaced Migrants
CVDs - Cardio Vascular Diseases
NRC - Norwegian Refugee Council
PASW - Predictive Analytics SoftWare Statistics
SPSS - Statistical Package for the Social Sciences
BMI - Body Mass Index
IOM PCI - International Organization for Migration, Psychosocial and Cultural Integration Unit
ATIPFUND - State Fund for Protection and Assistance of Victims of Human Trafficking
IOM AVRR - Assisted Voluntary Return and Reintegration Programmes
PPS - Probability Proportional to Size
PHC - Primary Health Care
WHA - World Health Assembly
VoT - Victim of Trafficking

EXECUTIVE SUMMARY

Migration and Health is an emerging issue globally and in particular for the South Caucasus, being a volatile region. Considering that the health information systems in Georgia do not contain the routine data on health conditions and healthcare access for migrant populations, while simultaneously lacking the data on specific disease prevalence among these vulnerable groups, the present Survey was initiated with the overall objective to strengthen the respective national surveillance systems of the country. Data obtained through the Survey will facilitate planning and implementing measures against primary NCDs risk factors, and will provide the basis for mainstreaming adequate programmatic response to ensure that psychosocial needs of diverse migrant populations are addressed and primary health care services are strengthened in view of migrant friendly healthcare delivery.

NCDs such as heart disease, stroke, cancer, diabetes, and chronic lung disease share the same risk factors: tobacco use, including exposure to second-hand smoke, unhealthy diets high in fats, salt, and sugar, physical inactivity, and harmful use of alcohol. Four key risk factors, coupled with those considered as intermediate ones such as obesity, increased blood pressure and concentrations of glucose and cholesterol coupled with socioeconomic determinants, e.g. poverty, inequality, unemployment, social instability, unfair trade, and global inequity, are considered to be major and acute health issues.

In Georgia, the crucial factors for NCDs are high morbidity and death rate, and poor access and affordability of medical treatment. According to the WHO 2011 report, NCDs are estimated to account for 91 per cent of all deaths in Georgia. According to the *First Nationwide NCDs Risk Factors Survey* (STEPS 2010, NCDC&PH, WHO, EU) only 4.5 per cent of surveyed were not exposed to risk factors of NCDs, and about 40 per cent are exposed to three or more risk factors.

Although there is a considerable knowledge about the causes of NCD and the interventions that are effective against them, much still needs to be done to ensure that this knowledge is applied in practice, that all segments of society benefit and that these benefits are spread across the whole country as well as worldwide.

Global estimates of migrant populations demonstrate that migrants make a considerable impact worldwide. Monitoring variables related to migrant health is an essential aspect of improving both health status and utilization of health services by migrants; it is desirable to integrate variables into existing data collection systems in a way that allows for disaggregation of the data by specific population groups, age and gender.

The Survey intended to determine the prevalence of major NCDs' behavioural and biological risk factors among diverse migrant populations residing in Georgia, study psychosocial and cultural anthropological needs of migrants, define the prevalence of psychosomatic conditions subsequent to migration per se, explore the issues pertaining to access and affordability of health and psychosocial services and ascertain the migrants' knowledge, attitude and practices on NCDs.

Considering importance of multi-sectoral approach towards migration health domain and recognizing that health outcomes can be influenced by the multiple dimensions of migration (since the migration itself is conceptualized as a social determinant of health), IOM and its implementing partner NCDC have adapted and applied existing standard tools and adhered to the comprehensive methodological approach towards the present Survey.

The Survey instrument builds upon the following key elements: STEPS approach to chronic disease risk factor surveillance and assessment of mental health and psychosocial well-being of migrants as well as their knowledge, attitude and practices on NCDs. The statistical population of this Survey comprised: internal forcefully displaced migrants[2] (1200) subsequent to the August 2008 Georgia-Russia war, foreign migrant students (150) enrolled in TSMU, asylum seekers (43), trafficked persons (24), returned migrants (Georgian nationals) (75), and foreign migrant detainees (30).

The fieldwork commenced on 5 December 2011 and accomplished on 31 January 2012. The overall response rate was quite high and amounted to 89 per cent. Ethical clearance was obtained at the Institutional Review Board of NCDC, informed consent obtained from each data subject prior to commencing an interview. None of the trafficked migrants was willing to participate in the Survey.

Project was designed by IOM Georgia and IOM MHD, in collaboration with Government of Georgia, namely with the Department of Emergency Situations Coordination and Regime of the MoLHSA. The project received funding from the IOM Development Fund in amount of USD50.000 for the duration of six months. Sustainability of the given project consists in strengthening of Health Information Systems of Georgia and providing to the government officials and diverse stakeholders an opportunity to plan coordinated action for addressing existing need on the ground.

Data was collected by IOM and NCDC Survey Teams. IOM and NCDC worked together at each stage of the project implementation. Data was collected and managed in accordance with IOM data protection principles. Analysis of quantitative data was done by using PASW Statistics 18 (formerly SPSS Statistics), which is known as a comprehensive system for analyzing data. Qualitative data was managed and analyzed manually and red both in a qualitative and quantitative manner.

The limitations of the given Survey consisted in resource shortages, which impeded geographical expansion while compiling the sampling frame, relatively small sample size of certain migrant groups, unwillingness of certain vulnerable groups to participate in the Survey and a language barrier with following withdrawal from the Survey of the part of non-English speaking migrants.

[2] Those individuals that according to the definition of the UNHCR and in compliance with the Georgian legislation are identified as Internally Displaced Persons (IDPs), within the given Survey Report these are referred to as Internal Forcefully Displaced Migrants.

THE SURVEY RESULTS

INTERNAL FORCEFULLY DISPLACED MIGRANTS

The Survey was conducted among 8 clusters of IFDM; 1125 visits were carried out. The response rate was 94 per cent. Yearly income of 79.2 per cent of interviewed was less than GEL2,600[3] or GEL217 per month. 20.9 per cent of respondents (47.7% male and 1.2% female) were current smokers. 87.8 per cent of current smokers were daily smokers. Mean age of smoking initiation among daily smokers was 19 years. Prevalence of alcohol consumption was very high and comprised 86.6 per cent; all respondents (100%) were under diet-related risk.

Only 2.3 per cent were engaged in vigorous-intensity sports, fitness or recreational activities; only 4 per cent were engaged in moderate-intensity sports. Overwhelming majority of the interviewed holds the state health insurance policy. The main reason for visiting doctor consisted in a concrete health problem.

Hypertension during the last 12 months was detected among 80.3 per cent; 66.8 per cent are currently receiving medicines. The hyperglycaemia during the last 12 months was reported by 83.6 per cent; 20.9 per cent are currently receiving insulin and 37.9 per cent are taking oral medicines. Mean systolic blood pressure among the surveyed population was 140mmHg and mean diastolic blood pressure - 85mmHg; among those who have been treated for hypertension during the past two weeks, 76.5 per cent still has hypertension. 53.3 per cent of respondents being on antihypertensive treatment during the past two weeks have second stage of hypertension. Pulse among both sexes comprised 79 beats per minute. BMI was 27.2; 35.6 per cent were overweight and 25.4 per cent were obese.

Respondents consider that since the August 2008 Georgia-Russia war, and subsequent displacement, their health and psychological conditions deteriorated. Aiming to relieve these problems of psychological and psychosomatic nature, the surveyed most commonly refer to their neighbour, a friend or a relative. Knowledge on major NCDs and their risk factors is quite low among both sexes.

The following prevailing needs were identified among the IFDM communities: improving socio-economic settlements and ensuring better access to healthcare services; providing employment opportunities and job placement; facilitating reconciliation with the national, communal and individual losses and assisting coping with traumatic experiences. Bonds among the displaced communities are quite strong, while ties with the local communities are weaker. Lack of initiative and passiveness of the community members concerning participatory approaches is particularly disturbing, which points to the condition of learned helplessness. Constant and recurring connection with principal sources of stress has damaging influence on psychological state of the displaced and impedes the process of coping with traumatic experience.

Awareness regarding preventive measures and ways of managing NCDs is poor and limited to broad perceptions. Less than half of surveyed hardly have any experience in this regard. Importance of proper treatment of hypertension is not recognized accordingly, which is why the

[3] National currency exchange rate: USD1=GEL1.6219

treatment practice is narrowed to the episodic interventions intended to decrease elevated blood pressure at the given moment only.

RETURNED MIGRANTS

41 returned migrants participated in the Survey; the response rate was 55 per cent. Yearly income of 70.7 per cent of interviewed was less than GEL2,600. Healthcare services are financially affordable for only 13.8 per cent of male respondents. Only one person holds the health insurance policy. The main reason for visiting doctors or medical staff is related to specific health problem.

65.9 per cent are current smokers; average age of smoking initiation among daily male smokers was 21 years; Prevalence of the lifetime alcohol consumption amounts up to 100 per cent. All respondents were under diet-related risk. Only 10.8 per cent of male were engaged in vigorous-intensity sports, only 13.5 per cent were engaged in moderate-intensity sports.

Majority have ever measured the blood pressure. Hypertension during the last 12 months was reported by 68.4 per cent; 36.8 per cent are currently receiving medication. Majority of respondents have never checked glucose concentration in blood. Hyperglycaemia was detected during the last 12 months in one female only.

Mean systolic blood pressure was 152mmHg and mean diastolic blood pressure - 95mmHg. Hypertension was detected among 80.5 per cent of respondents; 10 per cent of respondents were treated for raised blood pressure with medication. Pulse among both sexes amounts up to 81 beats per minute. BMI was 28.5; 37.8 per cent were obese; 29.7 per cent were overweight.

Respondents consider that since migration, their health and psychological conditions deteriorated. Aiming to relieve these problems of psychological and psychosomatic nature, returned migrants mostly approach their neighbour, a friend or a relative. Knowledge on major NCDs and their risk factors is quite low among both sexes.

Priority psychosocial needs of returned migrants are as follows: providing employment opportunities and facilitating reintegration of returned migrants subsequent to their comeback to homeland, ensuring social and humanitarian assistance and improving healthcare services.

Awareness regarding preventive measures and ways of managing NCDs is low and virtually none of the surveyed held respective experience.

FOREIGN MIGRANT STUDENTS

142 foreign migrant students of TSMU participated in the Survey. The response rate was 97 per cent. 7.1 per cent were current smokers; 55.6 per cent of current smokers were daily smokers. Average age of smoking initiation among daily smokers was 15 years. Prevalence of alcohol consumption amounts up to 29.6 per cent; all respondents were under diet-related risk. 31.0 per cent were engaged in vigorous-intensity sports, fitness or recreational activities; 43.3 per cent were engaged in moderate-intensity sports. For 33.8 per cent of respondents healthcare services are financially affordable.

Throughout last 12 months, hypertension was reported by 40.0 per cent; 26.7 per cent were currently receiving medication. Hyperglycaemia during the last 12 months was not reported by any of the foreign migrant students. The main reason for visiting doctors or medical personnel was associated with a specific health problem.

Mean systolic blood pressure was 117mmHg and mean diastolic blood pressure - 73mmHg. Blood pressure ≥140/90mmHg or hypertension was detected among 4.9 per cent; 2.1 per cent of respondents were detected as having the blood pressure ≥160/100mmHg or being on treatment. Pulse comprised 83 beats for both sexes per minute. BMI was 22.9; 18.4 per cent were overweight; 7.1 per cent were obese.

Respondents consider that since migration, their health and psychological conditions deteriorated. Aiming to relieve these problems of psychological and psychosomatic nature, respondents usually refer to their neighbour, a friend or a relative. Knowledge on major NCDs and their risk factors is quite low among both sexes.

The following prevailing needs of psychosocial nature were identified among the group of foreign migrant students: facilitating interaction among the communities of local and migrant populations, providing language courses, strengthening primary health care services and mainstreaming migrant-friendly healthcare delivery.

Foreign migrant students were well aware concerning four major risk factors of NCDs but hardly have had any experience in this regard. Referral to medical facilities and practice of preventive screening was low due to financial restrictions and communication-related problems.

ASYLUM SEEKERS

12 asylum seekers participated in the Survey. The response rate was 30 per cent. Yearly income of 50 per cent of interviewed was less than GEL2,600. None of surveyed held health insurance policy. Healthcare services are financially affordable for only 8.3 per cent. 33.3 per cent were current smokers; 75 per cent of current smokers were daily smokers. Mean age of smoking initiation among daily smokers was 18 years. Prevalence of alcohol consumption comprised 50 per cent; all respondents were under diet-related risk. 33.3 per cent were engaged in vigorous-intensity sports, 16.7 per cent were engaged in moderate-intensity sports.

Only one asylum seeker reported about occurrence of hypertension during the last 12 months; 66.7 per cent are currently receiving medication. Only two asylum seekers have ever checked glucose concentration in blood; one respondent reported on the occurrence of hyperglycaemia during the last 12 months. 60 per cent of interviewed visit doctors aiming at alleviating concrete health problem.

Mean systolic blood pressure among surveyed population was 137mmHg and mean diastolic blood pressure – 83mmHg. Blood pressure ≥140/90mmHg or hypertension was detected among 41.7 per cent; second stage hypertension (≥160/100mmHg) was detected among one respondent who does not take any medication. Pulse slightly exceeds a norm and comprises 81 beats per minute. BMI was 23.8. Three male were overweight; two male were obese.

Respondents consider that since migration, their health and psychological conditions deteriorated. Aiming to relieve these problems of psychological and psychosomatic nature, asylum seekers habitually approach the hospital, a clergyman, a local pharmacy, a neighbour, a friend or a relative. Knowledge on major NCDs and their risk factors is quite low.

The asylum seekers identified following needs of psychosocial nature: expediting decision-making pertaining departure to the third destination countries, supporting family reunification, and addressing mental and physical health conditions.

Asylum seekers are well aware regarding four major risk factors of NCDs but hardly refer to respective practices. Interviewees did not consider hypertension as a disease and only a few of them tend to believe that the given condition is likely to be cured by avoiding anxiety and maintaining respective diet.

TRAFFICKED MIGRANTS

Exposure to the risk factors of NCDs among the group of trafficked migrants is high against the low degree of willingness to resist these harmful influences. Even though the trafficked migrants are able to maintain healthy diet and balanced nutrition, the low physical activity remains an issue to be addressed. Oral cavity health is of a particular concern, since almost all of trafficked migrants suffer from acute dental problems.

Concerns of psychosocial nature relate to the difficulties in adapting to social and economic realities after experiences of trafficking, resistance to offered assistance developed due to traumatic experience and tendency towards self-humiliation, as well as health-related problems.

FOREIGN MIGRANT DETAINEES

Nine foreign migrant detainees participated in the Survey. The response rate was 30 per cent. None of the foreign migrant detainees held the health insurance policy. The reason of visiting doctors consists in the concrete health problem. 44.4 per cent were current daily smokers; mean age of smoking initiation among daily smokers was 22 years. Prevalence of alcohol consumption comprised 88.9 per cent. 100 per cent were under diet-related risk. Three respondents were engaged in vigorous-intensity sports.

The majority of respondents reported having measured the blood pressure by medical personnel. In one case, hypertension was detected and this person is currently receiving medication. None of the respondents has ever checked glucose concentration in blood.

Mean systolic blood pressure was 124mmHg and mean diastolic blood pressure - 78mmHg. Hypertension was detected among 22.2 per cent of respondents. Pulse comprised 78 beats per minute. BMI was 23.1; 33.3 per cent were overweight.

Respondents consider that since migration and imprisonment, their health and psychological conditions deteriorated. Knowledge on major NCDs and their risk factors was quite low.

The following needs of psychosocial nature were identified among foreign migrant detainees: betterment of communication systems, mainstreaming of social activities and providing language courses.

Partial knowledge revealed among certain number of foreign migrant detainees concerning preventive measures and ways to manage NCDs is hardly enough for comprehensive understanding of the subject. However, the efforts to resort to the respective practices made by those few of surveyed confirming the above-mentioned are insignificant.

INTRODUCTION

GENERAL SITUATION ON NCDs

NCDs present a considerable challenge to health globally, both now and for the foreseeable future. These diseases place an increasingly heavy burden on people's health and on health systems, and are detrimental to the economic and social development globally, and particularly for Georgia.

NCDs such as heart disease, stroke, cancer, diabetes, and chronic lung disease share the same risk factors: tobacco use, including exposure to second-hand smoke,[4] unhealthy diets high in fats, salt, and sugar, physical inactivity, and harmful use of alcohol. Four key risk factors, coupled with those considered to be the intermediate ones such as obesity, increased blood pressure and concentrations of glucose and cholesterol, were considered as major and acute health issues for developed countries in the past, but for the present are common in the poorest countries and are rising rapidly.[5,6,7]

Poverty increases the risk of developing chronic diseases globally, and increases the chances of developing complications and dying prematurely. NCDs can cause individuals and families to fall into poverty and create a downward spiral of worsening social conditions and negative health outcomes. But the impact is not only on individuals and their families; chronic diseases also hinder the macroeconomic development of many countries worldwide.

States should assess and monitor the public health burden imposed by non-communicable diseases and their determinants, with special reference to the poor and marginalized populations like migrants. Similarly, prevention and control of non-communicable diseases should be incorporated explicitly into the poverty-reduction strategies and relevant social and economic policies, mainstreaming multi-sectoral and multidimensional approaches to the policy development that involve all governmental departments and relevant stakeholders. The aforementioned efforts should ensure that public health issues are addressed in the complex way, and that the basis are being built for elaboration of comprehensive and targeted

[4] M. Oberg, MS. Jaakkola, A. Woodward, A. Peruga, A. Prüss-Ustün, Worldwide Burden of Disease from Exposure to Second-hand Smoke: a Retrospective Analysis of Data from 192 Countries (Lancet, 2011, 377: 139–46).

[5] MM. Finucane, GA. Stevens, MJ. Cowan et al, *National, Regional, and Global trends in Body Mass Index since 1980: Systematic Analysis of Health Examination Surveys and Epidemiological Studies with 960 Country-years and 9·1 Million Participants,* On Behalf of the Global Burden of Metabolic Risk Factors of Chronic Diseases Collaborating Group (Body Mass Index). (Lancet 2011, 377: 557–67).

[6] G. Danael, MM. Finucane, JK. Lin et al, *National, Regional, and Global Trends in Systolic Blood Pressure Since 1980: Systematic Analysis of Health Examination Surveys and Epidemiological Studies with 786 Country-years and 5·4 Million Participants*, On Behalf of the Global Burden of Metabolic Risk Factors of Chronic Diseases Collaborating Group (Blood Pressure). (Lancet 2011, 377: 568–77).

[7] F. Farzadfar, MM. Finucane, G. Danael et al, *National, Regional, and Global Trends in Serum Total Cholesterol Since 1980: Systematic Analysis of Health Examination Surveys and Epidemiological Studies with 321 Country-years and 3·0 Million Participants,* On Behalf of the Global Burden of Metabolic Risk Factors of Chronic Diseases Collaborating Group (Cholesterol). (Lancet 2011, 367**:** 578–86).

interventions to tackle the social determinants of non-communicable diseases in a circular manner.

In recognition of the global threat of NCDs, mainly heart disease, stroke, cancer, diabetes, and chronic respiratory diseases, the United Nations High Level Meeting on NCDs was held in September, 2011.[8] The heads of states and governments attended the meeting, creating a unique opportunity to advance globally the prevention and treatment of NCDs that are considered as "silent killers" worldwide. An urgent and concerted response is required because no country alone can address the threat of this magnitude.

NCDs IN GEORGIA

Despite an observable progress in public health interventions and improvement of access to the healthcare services, NCDs continue to pose significant challenge to healthcare system of Georgia. According to the WHO 2011 report, NCDs are estimated to account for 91 per cent of all deaths in Georgia, with CVDs accounting for 71 per cent, cancer – 12 per cent, diabetes – two per cent, chronic respiratory diseases – one per cent and other NCDs for five per cent of total death toll.[9] The disease trends for the period of 2000-2010 show rapidly increasing incidence of CVDs in Georgia that can be explained not only by the real incidence growth, but also by the improvement in reporting, compared to previous years. Among CVDs the most prevalent are hypertension, ischemic heart disease and cerebrovascular diseases.

According to the official statistics of NCDC[10], incidence of arterial hypertension has increased by 1.24 and the prevalence by 1.79 from 2005 to 2010. According to the WHO estimates (2002), Georgia was listed among five countries with the highest numbers of high arterial blood pressure among the world population; arterial hypertension was the leading cause of death with 48.8 per cent of all death cases related to 10 major risk factors (2002).[11] The 2009-2011 study of the European Network for Prevention and Health Promotion in Family Medicine and General Practice (EUROPREV) shows that the highest proportion of patients visiting primary health care in Georgia is those with high blood pressure.

The first nationwide *Non-communicable Disease Risk Factors Survey* (STEPS Survey) was conducted in Georgia in 2010 by the NCDC under the WHO and EU collaboration. According to the Survey, 33.4 per cent of respondents are considered as actual and potential hypertensives; 61.1 per cent of hypertensives do not take antihypertensive treatment. Mean systolic blood pressure was estimated 129.3 mmHg and mean diastolic blood pressure – 81.3mmHg.

The tobacco-related death toll in Georgia is estimated to be around 11,000 deaths per year. The share of smokers is higher in the capital Tbilisi and big cities than in small towns and rural area.

[8] United Nations, Prevention and Control of Non-communicable Disease (New York, 2011). Available from: http://www.un.org/ga/search/view_doc.asp?symbol=A%2F64%2FL.52&Submit=Search&Lang=E
[9] www.euro.who.int
[10] www.ncdc.ge
[11] European Health Report, Public Health Action for Healthier Children and Populations (WHO, 2005).

The tobacco market in Georgia is on the level of 10 billion sticks (0.5 billion packs) worth GEL0.58 billion.[12]

According to the STEPS Survey, the prevalence of current smoking is 30.3 per cent (27.7% daily smokers); the proportion of smoking among men is nearly eleven times higher than among women. 23.3 per cent (32.9% men and 13.7% women) of respondents are exposed to passive smoking at workplaces. Georgian Reproductive Health Survey 2010[13] determined that six per cent of women aged 15-44 are current smokers. 52 per cent of all women and 50 per cent of non-smoker women are exposed to tobacco smoke at home, 44 per cent of all women and 40 per cent of non-smoker women are exposed to tobacco smoke at work.

The STEPS Survey showed that 41 per cent of respondents (59.4% male and 23.4% female) are current drinkers. Recorded adult per capita consumption is around 6.4 litres of pure alcohol. According to the above mentioned Reproductive Health Survey, 17 per cent of women are current drinkers. The STEPS Survey showed that 70 per cent consume less than five servings of fruit and/or vegetables per day average. The Survey showed alarming data that more than 56 per cent of Georgian population is overweight (58.6% male and 54.2% female) and 25.1 per cent is obese (21.8% male and 28.5% female); mean BMI was 26.7. Blood glucose concentration was elevated among 21 per cent of respondents (more among male, 23% vs. 18.6%); blood cholesterol was raised among 18 per cent (more among female, 21% vs. 15%). 78.6 per cent of respondents are not engaged in intensive physical activity, whereas 60 per cent of the polled is engaged in vigorous intensity physical activity. 3.3 hours are spent in sedentary activities daily.

In general, according to the results of STEPS Survey 2010, only 4.5 per cent of surveyed were not exposed to any of risk factors of NCD, and about 40 per cent are exposed to three or more risk factors.

MIGRATION AND ITS IMPACT ON HEALTH OUTCOMES

Global estimates of migrant populations demonstrate that migrants make a considerable impact globally. The vast majority of migrants (740 million) move internally within the country, without crossing its borders. About 40 per cent of estimated 214 million international migrants move to a neighbouring country. Only an estimated 37 per cent of migration is from developing to developed countries, about 60 per cent of migrants move between developing or between developed countries and only three per cent - from developed to developing countries.

Migration as a phenomenon and of itself, is not a risk to health, however, coupled with poverty, poor access to education and employment, as well as additional micro and macro environmental factors represents one of its social determinants.

Migrants travel with their health profiles, values and beliefs, reflecting the socio-economic and cultural background and the disease prevalence of their community of origin. Such profiles and

[12] Population Survey on Tobacco Economy and Policy in Georgia (FCTC Implementation and Monitoring Center in Georgia, 2008).
[13] F. Serbanescu, V. Egnatashvili, A. Ruiz, D. Suchdev, M. Goodwin, Georgia Reproductive Health Survey, Summary Report (2010); Available from: www.ncdc.ge

beliefs can be different from those of the host community, and may have an impact on the health and related services of the host community as well as on the health and usage of health services by migrants. Migrants may introduce conditions into the host communities and/or can acquire conditions while migrating or residing therein. Migrants can also introduce acquired conditions when returning home. This refers not only infectious problems, but as evidence proves non-communicable conditions as well.

Most migrants are healthy, young people, and some may even benefit from a so-called "healthy migrant effect" when they first arrive in their host community. However, conditions inherent to the migration process can increase vulnerability to ill health. This is particularly true for people who migrate involuntarily, flee natural or manmade disasters and human rights violations; and for those who find themselves in an irregular situation, such as those who migrate through clandestine means or have no documents. Other risk factors may include poverty, stigma, discrimination, social exclusion, language and cultural differences, separation from family and socio-cultural norms, administrative hurdles and legal status – the latter often being the determining factor for access to health and social services. Lack of social security and protection can lead to the excessive costs for migrants who may pay out-of-pocket, and to the exacerbation of their health conditions that could have been prevented, had the lower-cost services been available. Hence, developing and implementing national health policies that incorporate a public health approach to the health of migrants and promote equal access to health services of migrants regardless of their status is thought to be humane and mutually beneficial for both, countries of origin and countries of destination. In addition, it proves to be cost-effective since providing care to people before they become seriously ill reduces the overall burden on health systems.

Governments increasingly recognize the need for a paradigm shift in how to think about health and migration and how health systems and related policies should address migrants' health. The health of migrants and health matters associated with migration are crucial public health challenges faced by governments and societies globally. This notion formed the basis for the Resolution on the health of migrants, endorsed by the sixty-first WHA resolution in May 2008.[14] It is worth mentioning hereby, that the report prepared by the WHO Secretariat in support of the WHA Resolution on the health of migrants identifies four basic principles for desirable public health approach, considering relevant response to the health of migrants and hosting communities:

- To avoid disparities in health status and access to health services between migrants and the host population;
- To ensure migrants' health rights. This entails limiting discrimination or stigmatization, and removing impediments to migrants' access to health preventive and curative interventions, which are the basic health entitlements of the host population;
- To put in place lifesaving interventions so as to reduce excess mortality and morbidity among migrant populations. This is of particular relevance in situations of forced migration resulting from disasters or conflict;
- To minimize the negative impact of the migration process on migrants' health outcomes. Migration generally renders migrants more vulnerable to health risks and

[14] WHA Resolution 61.17 on Health of Migrants (2008), Available from: http://www.who.int/gb/ebwha/pdf_files/A61_R17-en.pdf.

exposes them to potential hazards and greater stress arising from displacement, and adaptation to new environments.

In light of the above mentioned, establishment of migration health units within the ministries of health is critical in order to create a venue for effective programming and evolving a multi-sectoral dialogue. While pursuing a comprehensive migrant health agenda, a progress on the way of defining globally accepted minimum standards of migrant health is desirable, which are rights-based and rooted in the public health concepts of equity and safety. Moving towards the set goals will help migrants benefit from an improved standard of physical, mental and social well-being, enabling them to contribute substantially to the social and economic development of their home and host communities.

Monitoring variables related to migrant health is an essential aspect of improving both health status and utilization of health services by migrants. Health stakeholders including all levels from the civil society organizations, the national governments, would benefit from a policy statement and recommendations on what data to collect, how to collect it, and how to use this information to increase the comparability and application of data to specific health goals. Migrant health variables should be integrated into existing data collection systems in a way that allows for disaggregation of the data by specific population groups, age and gender. Other data collection instruments to consider include census data, data collected by other sectors such as housing, education and employment, and data collected by the targeted surveys aimed at harder-to-reach or smaller populations. In their turn, the qualitative investigations can be conducive for designing tailored interventions to address socio-cultural factors, which affect health behaviour. Figures on mortality rates and life expectancy for migrant populations are often unreliable, because the denominator (the size of the underlying population) is not always accurately known. Evidence of self-reported health state is often used to estimate the general level of health among migrants, in result of which researchers tend to underreport mortality rate and life expectancy for these groups.

The illnesses from which migrants and ethnic minorities suffer are to a large extent the same as those found in the majority of the population. Migrant and ethnicity groups show deviations from average prevalence rates of CVDs, their rates are usually higher – yet they are lower among some groups for certain disorders. The findings on prevalence of cancer among migrants and ethnic minorities are complex, varying between groups and between types of cancer. Even though the incidence of cancer may not be raised, the disease tends to be detected at a later stage among these groups, so that timely treatment is less often possible. Studies in the Great Britain, the Netherlands and Norway have shown that people of migrant origin – with the exception of some groups – may be especially vulnerable to type 2 diabetes.[15][16][17] Serious methodological issues complicate research on mental illnesses among migrants. These relate to the fact that concepts, beliefs and practices in this area vary greatly between countries. Such variations are found across the whole spectrum of health problems, but they appear to be particularly wide in the case of mental disorders.

[15] S.D. Garduño-Diaz Prevalence, Risk Factors and Complications Associated with Type 2 Diabetes in Migrant South Asians (Diabetes Metabolism Research and Review, 2012, 28:6-24).

[16] Davies et al. Social determinants and Risk Factors for Non-communicable Diseases in South Asian Migrant Populations in Europe (Asian Eur J, 2011).

[17] S.B. Rafnsson, Large-scale Epidemiological Data on Cardiovascular Diseases and Diabetes in Migrant and Ethnic Minority Groups in Europe (Eur J Public Health (2009, 19(5):484-491).

Depression and anxiety disorders are quite common among migrants, particularly among older people[18]. Regarding causal mechanisms, it is known that poverty and lower socioeconomic status are associated with depression. At present it is not known to what extent these factors explain the differences found among migrants and ethnic minorities. Certain studies[19] have also suggested that perceived discrimination or racism can increase rates of common mental disorders. Social support and adequate social networks are also regarded as important protective factors for mental health[20], and strengthening such networks can help combating isolation, loneliness and vulnerability.[21]

Overall, migration and displacement both require major adaptations, since migrants need to redefine their personal, interpersonal, socio-economic, urban and geographic boundaries. Simultaneously, this also implies redefining individual, familiar, group, and collective identities, roles and respective systems, and may represent an upheaval and a source of stress not only for individual, but for the family as well as the communities involved. Natural and manmade disaster-related displacement is accompanied by multiple stressors that include economic constrains, security issues, breakdown of social and primary economic structures and consequent devaluation or modification of individual roles, loss of loved ones, motherland and cultural belongings. Often these elements bring about variety of unpleasant feelings and symptoms that are considered as being "normal reactions to abnormal events" or circumstances, and by all means, are generally not of a psychopathological nature. Evidence shows that only in a very limited number of cases such conditions evolve in post-traumatic occurrences, making people unable to function[22].

ISSUES RELATED TO MENTAL HEALTH OF MIGRANTS IN GEORGIA

Nevertheless, considering the above mentioned, it is worth noting the specificities inherent to the internal forcefully displaced migrants, in Georgian context, those confirmed by the psychosocial service providers, as well as respective surveys undertaken recently. As far as other migrant groups residing in Georgia are concerned, there was no evidence available so far concerning mental health and psychosocial conditions as well as respective vulnerabilities inherent to these groups, which imparts particular importance to the given Survey.

[18] MG. Carta, M. Bernal, MC. Hardoy, JM. Haro-Abad, Migration and Mental Health in Europe: Clinical Practice and Epidemiology in Mental Health (2005, 1:13).

[19] S. Karlsen, J. Nazroo, K. McKenzie et al. Racism, Psychosis and Common Mental Disorder among Ethnic Minority Groups in England (Psychol Med. 2005, Sep 29; 1-9).

[20] M.J. Levitt, J.D. Lane & J.L. Levitt, Immigration Stress, Social Support, and Adjustment in the First Post-migration Year: An intergenerational Analysis, (Research in Human Development, 2005, 2, 159-177).

[21] S. Hernandez-Plaza, C. Pozo & E. Alonso-Morillejo, The Role of Informal Social Support in Needs Assessment: Proposal and Application of a Model to Assess Immigrants' Needs in the South of Spain. Journal of Community & Applied Social Psychology, 2004, 14(4), 284–298; S. Hernandez-Plaza, M. Garcı´a-Ramırez, C. Camacho & V. Paloma, Mobility and Wellbeing. In C. Stuart (Ed.), The Psychology of Global Mobility. International Psychology (New York, 2010) Springer.

[22] International Organization for Migration, Inter Agency Standing Committee 2007; Assessment of the Psychosocial Needs of Haitians Affected by the January 2010 Earthquake (Port Au Prince, Haiti, September 2010).

The NRC Survey pertaining to the level of stress among internal forcefully displaced migrants and general population confirms that overall, Georgian population experiences stress, the intensity of which clearly exceeds the average level and that the level of stress experienced by the displaced and local populations is approximately the same with the difference in underlying causes of it. While local population suffers mainly due to high mortality and morbidity rates in the country, problems related to drug addiction, family violence, unemployment and corresponding concerns of social nature, internal forcefully displaced migrants are mainly oppressed for the reason of the absence of shelter, factual changes either fear of foreseeable changes in their living conditions, as well as social isolation and societal trauma related to social stigmatization[23]. In addition, a Survey conducted in 2009 by the Mental Health and Psychosocial Support sub-cluster group of WHO Georgia inclusive of IOM, confirmed the occurrence of deteriorations in physical ailments, also known as psychosomatic conditions among the new wave of internal forcefully displaced populations subsequent to the 2008 August war. Namely, the prevalence of raised blood pressure, sleeping problems, headaches, loss of energy, aggravation of non-communicable chronic conditions, as well as chronic fatigue and respiratory problems were observed.

Stemming from the above mentioned, notwithstanding the existence of certain evidence on internal forcefully displaced migrants' health conditions obtained by the health stakeholders so far, little is known about health vulnerabilities of other migrant groups due to the lack of relevant data. **Therefore, health information systems of Georgia do not provide for disaggregated data on health of diverse migrant populations residing in Georgia**, which is considered to be a dire need and primary obstacle to migrant health policy development and to the planning and delivery of the migrant-sensitive healthcare. In light of this, it is desirable to advance awareness on which health conditions affect migrants in Georgia, what are the key risk factors conducive for negative health outcomes for these groups, how migrants utilize available health services and how affordable these services are. Coupled with the qualitative perspective on migrants' health seeking behaviours, their mental health conditions and vulnerabilities, the aforementioned approach is essential for augmenting respective programmatic response within the healthcare system of Georgia and forging migrant sensitive health systems.

[23] Norwegian Refugee Council, *Stress and Displacement: Psychological Problems and Ways to Overcome Them,* Course of Lectures for Future Teachers, Psychologists and Social Workers (Tbilisi, 2011).

Chart 1: Proportional mortality (% of total deaths in all ages, Georgia, 2008)

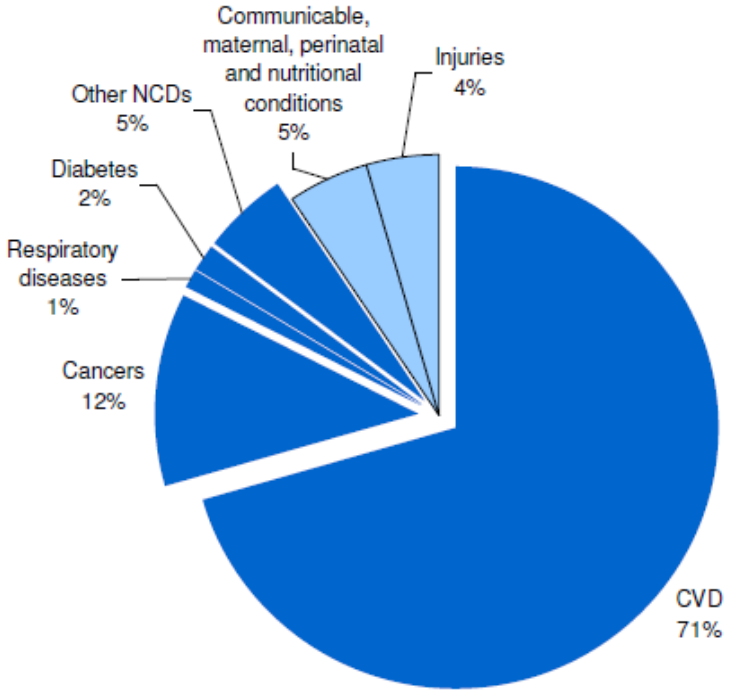


Chart 2: Shares of total deaths attributable to 10 leading diseases in Georgia, 2002

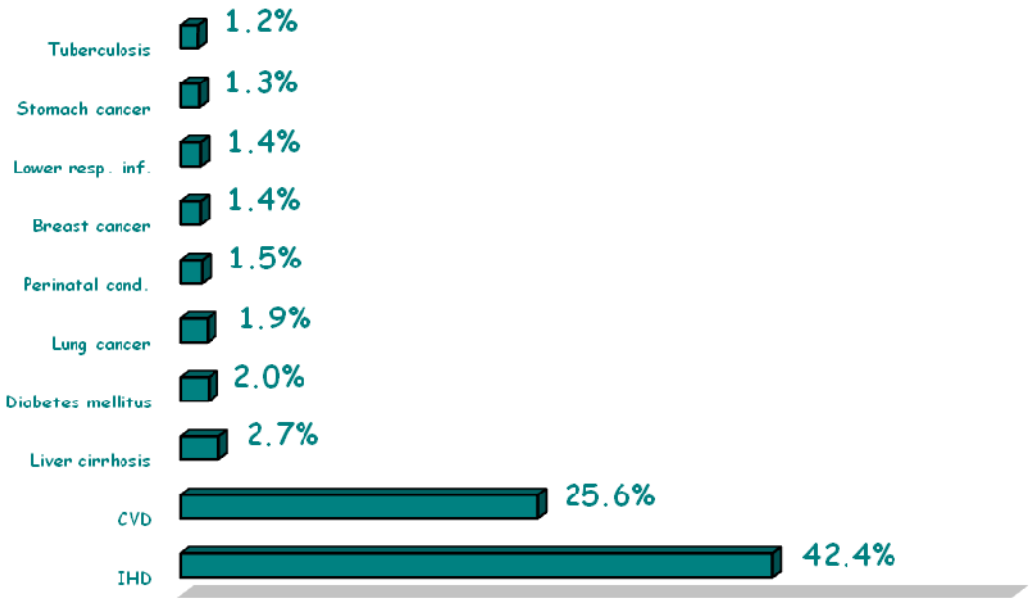
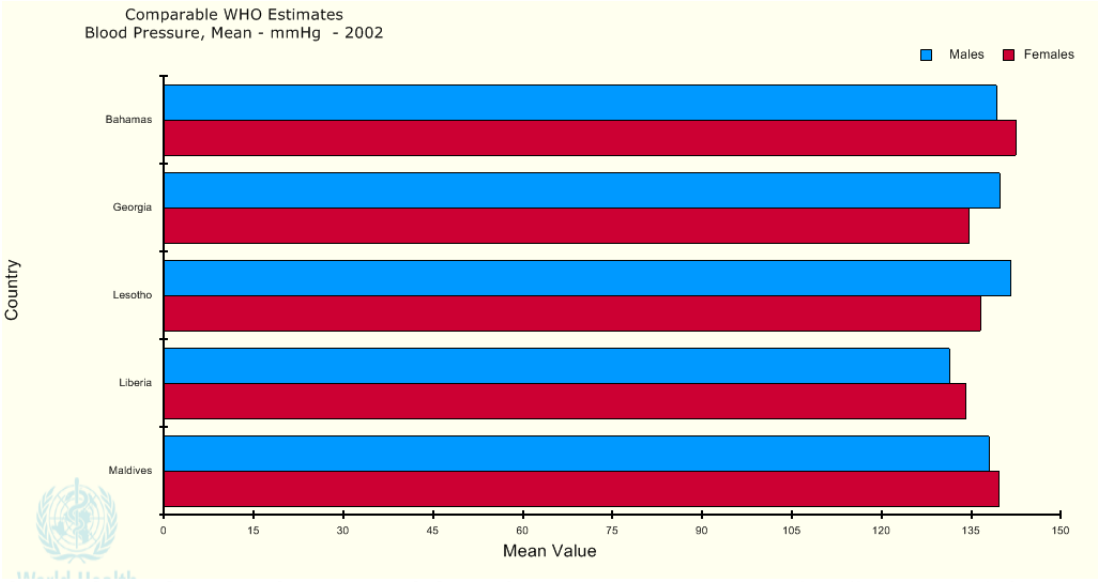


Chart 3: Countries with the highest figures of arterial blood pressure among population, 2005



Source: Ono T, Guthold R, Strong K. WHO Global Comparable Estimates, 2005 (http://www.who.int/infobase IBRef: 199999)

Chart 4: Shares of total deaths attributable to 10 leading risk factors in Georgia, 2002

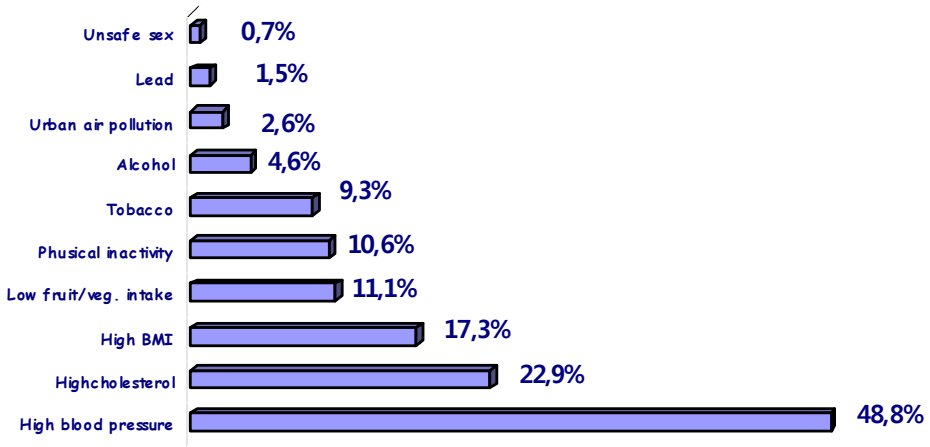


Chart 5: High blood pressure by country, 2009-2011

- Participation in EUROPREV study EUROPREVIEW in 2009-2011
  (the article is submitted for publishing)

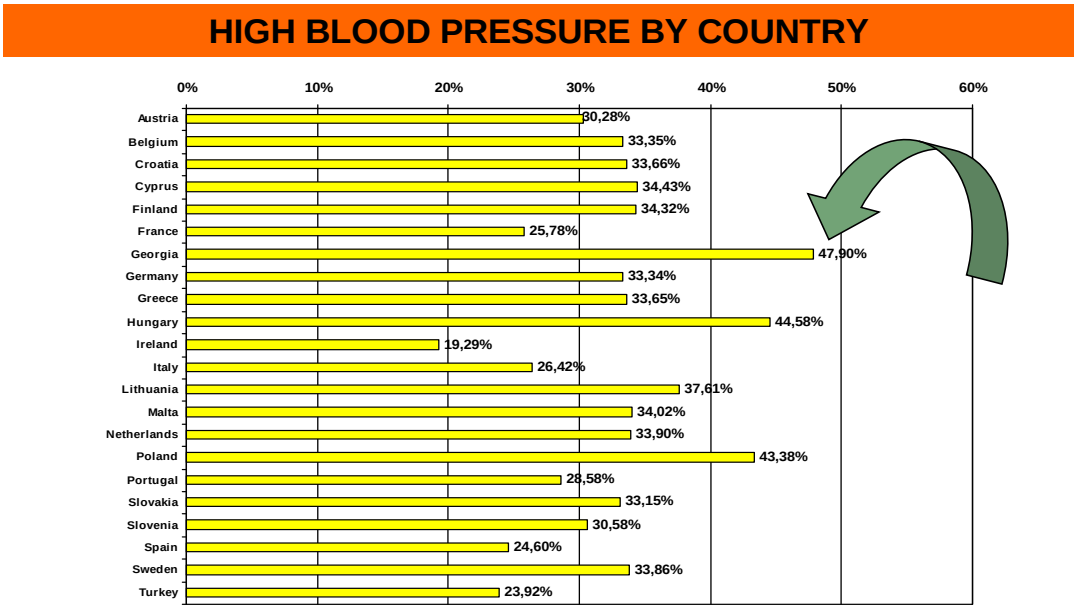
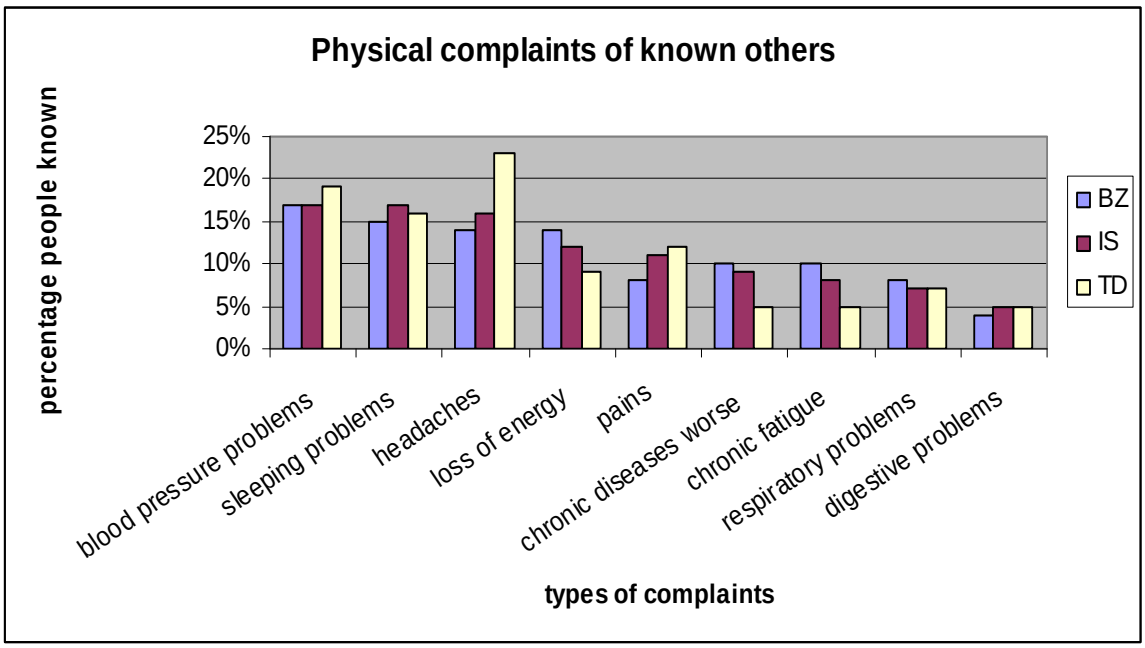


Chart 6: Physical ailments of people known to internal forcefully displaced migrants' community members, Georgia, 2009



Source: An Assessment of the Mental Health & Psychosocial Needs of the Conflict-Affected Populations; October 2009. The World Health Organization/EURO

METHODOLOGY

GOAL OF THE SURVEY

The goal of this Survey consisted in determining the prevalence of major NCDs' behavioural and biological risk factors among diverse migrant populations residing in Georgia, studying psychosocial and cultural anthropological needs of migrants, defining the prevalence of psychosomatic conditions subsequent to migration per se, exploring the issues pertaining to access and affordability of health and psychosocial services and ascertaining the migrants' knowledge, attitude and practices on NCDs. Exploration of the interrelations among thematic areas of the research gains particular significance in the framework of the given Migrant Health Survey.

SURVEY OBJECTIVES

The Survey objectives were defined as follows:

- Application of international standard methods and instruments for surveying the distribution of risk factors of NCDs among diverse migrant populations residing in Georgia, designing tools for studying psychosocial and cultural anthropological needs of migrants as well as knowledge, attitude and practices among these groups, which would allow for obtaining the relevant and reliable data at minimal expenditure and in a timely manner;
- Contribute to the mainstreaming of health related data on diverse groups of migrant populations in the Health Information Systems of Georgia;
- Obtaining the evidence for needs-tailored and comprehensive follow up action on migrant sensitive healthcare programming;
- Preparation of the bilingual research report and organizing the dissemination workshop involving the frontline health stakeholders of Georgia.

METHODS

Considering importance of the multi-sectoral approach towards migration health domain and recognizing that health outcomes can be influenced by the multiple dimensions of migration[24] since the migration itself is conceptualized as a social determinant of health, IOM and its implementing partner NCDC have jointly elaborated and adhered to the comprehensive methodological approach towards the present Survey. The given approach comprises social, migration, demographic, environmental, psychological, behavioural and economic aspects in view of acknowledged complementarities of those and justifies its conformity to the WHO definition of health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[25].

[24] Sixty-First World Health Assembly, WHA61.17, Agenda item 11.9, Health of migrants (24 May 2008).

[25] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, (New York, 19 June – 22 July 1946); signed on 22 July 1946 by the representative of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

Pursuant to the above mentioned, the methodology of the present Survey incorporated the approaches and tools for revealing the prevalence of major behavioural risk factors for NCDs and conditions prevalent to those risk factors, psychosocial and psychosomatic outcomes, especially those induced, caused or being deteriorated due to migration per se, as well as the issues related to the differences among existing psychosocial needs, healthcare access and affordability of the respective health services for distinct groups of migrant populations residing in Georgia.

An opportunity of gaining information and evidence on the knowledge, attitude and practices regarding NCDs among migrants provides an added value to this particular Survey by laying a solid foundation for the follow-up action on the evidence-based health programming and mainstreaming the migrant-sensitive approaches with the emphasis on existing knowledge, attitude and practices.

STUDY INSTRUMENT

The Survey instrument builds upon the following key elements:

STEPwise approach to chronic disease risk factor surveillance (STEPS)

The WHO STEPS is the WHO's recommended tool for surveillance of NCDs and their risk factors. The STEPS approach focuses on obtaining a core data on the established risk factors that determine major disease burden. It is rather flexible to allow the country to expand on the core variables and risk factors, and incorporate the optional modules related to the local or regional interests.

The STEPS Instrument covers three different levels of "steps" of the risk factor assessment. These steps are: questionnaire, physical measurements, and biochemical measurements.

The STEPS[26] tool used to collect data and measure chronic disease risk factors is called **STEPS Instrument**.

All countries/sites are recommended to undertake the core items of Step 1; most countries/sites are recommended to undertake Step 2; and Step 3 are only recommended for well-resourced settings.

Due to financial limitations, IOM in collaboration with NCDC conducted Step 1 and Step 2.

The questionnaire covers the core, expanded and country specific modules. The core module is used for calculating main baseline indicators, while the expanded one is applied for obtaining detailed information. By comparing baseline indicators it becomes possible to conduct a country-specific comparative analysis.

In addition, aiming at studying geographical and financial accessibility of health and psychosocial services as well as the levels of satisfaction and enjoyment of the state health insurance policy

[26] www.who.int/chp/steps/instrument/en/index.html

(among IFDMs), respective questions were borrowed[27], readapted and included into the questionnaire.

The questionnaire was translated into Georgian and adapted to the local situation. Questions on educational background, working status, ethnicity and revenue were adjusted according to the Georgian reality. Both the core and expanded questions were used. In the process of research, the STEPS manual developed by the WHO was applied as well, which was also translated into Georgian in the framework of the 2010 Georgian Nationwide STEPS Survey implemented in close collaboration with WHO.

Assessment of mental health and psychosocial well-being of migrants as well as their knowledge, attitude and practices on NCDs

In line with the IOM PCI's approach, the Survey incorporated the methods for assessing the needs concerning the mental health and psychosocial well-being, prevalence of certain psychosomatic conditions influenced by and through migration processes as well as the tools aiming at exploring knowledge, attitude and practices of diverse migrant groups residing in Georgia. Hence, the mentioned integrated approach would provide for the opportunity to analyze the interconnection of emotional, psychological, social, environmental and cultural anthropological needs of distinct migrant groups residing in Georgia and identify existing knowledge-, attitude- and practice-related aspects on NCDs. The findings produced within the framework of the Survey will make possible to build upon, empower, support and facilitate better management and surveillance of non-communicable conditions among migrants.

Consistency with the previous IOM assessments has been preserved; the relevant questions from the already elaborated IOM tools[28] were borrowed and readapted considering the need and specificity of the current Survey.

More precisely, the Survey offered migrants to self-identify their psychosocial and cultural anthropological needs, with the purpose of preparing the ground for further possibility to augment the needs-tailored community-based interventions. In addition, the Survey explored psychosocial conditions of migrants and provided the opportunity for an in-depth perspective on relevant definitions and estimations of pain level related to traumatic experiences, frequency of its occurrence and underlying causes of the given phenomenon.

The quantitative part of the Survey aimed at revealing possible dynamics of changes in migrants' health outcomes (with particular emphasis on psychosomatic conditions) by considering the migration as the reference point for these alterations. Moreover, the facts on migration history, duration of exposure (period of living in Georgia), ethnicity of migrants, geographical distribution and certain social indicators constituted the basis for respective correlations.

[27] The mental health assessment tool elaborated by WHO, IOM and Health Thematic Group (HTG) and Mental Health and Psychosocial Support Sub-group (MHPSS) members for the WHO Survey on Mental Health and Psychosocial Support Needs of the Conflict-Affected Populations (Georgia, 2009).

[28] Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return. IOM Middle East Assessment Tools (Beirut, April 2008).

The rationale for including the knowledge, attitude and practices feature consisted in determinative importance of health stakeholders' awareness concerning existing knowledge, attitude and practices on NCDs among diverse migrant groups: namely, what migrants know about NCDs, how they perceive non-communicable conditions and what is the essence of their personal behaviour in view of self-monitoring and examination of NCDs.

The questions incorporated into the Survey instrument were closed and open-ended, and have been reviewed and analyzed both in a quantitative as well as qualitative manner. The certain quotations from the responses were used for giving figures more substance and to animate certain parts of the reports not fully reflected at the quantitative part.

ETHICS AND CONSENT

The Survey protocol, questionnaire and consent form were reviewed by NCDC's Institutional Review Board.

The Survey coordinator was responsible for overall ethical considerations and ensuring confidentiality of data in accordance and compliance with the IOM Data Protection Principles[29].

SAMPLE

Study Area

IFDM Settlements:
Shida Kartli region: Karaleti, Verkhvebi, Sakasheti, Metekhi
Mskheta-Mtianeti region: Tserovani, Bazaleti, Tsilkani
Imereti region: Kutaisi

Returned migrants:
Shida Kartli region**:** Borjomi, Kareli district: Akhalsopeli village and Kvemo Khvedureti village, Kaspi, Kaspi district: Teliani village, Gori, Khashuri, Gori district: Tirdznisi village

Mtskheta-Mtianeti region**:** Dusheti, Dusheti district: Mchadijvari village, Gremiskhevi village, Mlashe village, Tianeti, Mtskheta, Mtskheta district: Tserovani village, Nichbisi village and Dzalisi village, Kareli district: Dirbi village

Imereti region: Kutaisi, Zestaponi district: Kvaleti village, Sachkhere district: Gorisa village, Skhvitori village, Tskaltubo district: Partskanakanevi village and Maghlaki village, Sachkhere village, Chiatura, Khoni, Terjola district: Rupoti village.

Foreign migrant students:
Tbilisi

Asylum seekers:
Kvemo Kartli region: Gardabani district, village Martkopi

[29] International Organization for Migration, IOM Data Protection Principles, 1 May 2009

Trafficked migrants:
Tbilisi

Foreign migrant detainees:
Mtskheta-Mtianeti region, village Ksani

Study population

The statistical population of the present Survey comprised:

(a) IFDM subsequent to the Georgia-Russia war in August 2008
(b) all foreign migrant students enrolled in TSMU
(c) asylum seekers
(d) trafficked migrants
(e) returned migrants (Georgian citizens)
(f) foreign migrant detainees

Sampling Frame

(a) The full list of IFDM settlements throughout the country with numbers of people living at each settlement by age and gender. The total number of settlements is 79. The recently updated list of settlements was obtained from the database of the Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees in June 2011.

(b) The full list of foreign migrant students enrolled in TSMU. The list of foreign migrant students was obtained from the database of the TSMU in October 2011.

(c) The full list of asylum seekers (beneficiaries of the Reception and Temporary Accommodation Centre for Asylum Seekers). The list of asylum seekers was obtained from the database of the Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia in December 2011.

(d) Trafficked migrants were communicated through the personnel of the ATIPFUND, Georgia, in December 2011.

(e) The full list of all registered returned migrants (Georgian citizens) residing in Shida Kartli, Mtskheta-Mtianeti and Imereti regions of Georgia, beneficiaries of the IOM AVRR Programmes. The list of returned migrants residing in Shida Kartli, Mtskheta-Mtianeti and Imereti regions of Georgia was obtained from the IOM AVRR projects database in July 2011.

(f) Foreign migrant detainees were communicated through the personnel of the Ministry of Corrections and Legal Assistance of Georgia.

Four groups of Survey participants from IFDM subpopulation were formed and dichotomized by gender and age (18-60 and 60+ age groups).

Sample size

The sample size calculation was done by the methodology for descriptive studies for the expected proportion of major risky behaviours (current alcohol and tobacco use identified by STEPS Survey), total width of the confidence interval 0.10 (+/- 0.05), and a confidence level of 95%. According to the STEPS 2010 nationwide Survey, current daily tobacco consumption rate comprised 27.7 per cent; prevalence of alcohol consumption amounted up to 78.5 per cent.

By this methodology, minimum of 714 IFDMs were selected from each gender and age groups of 18-60, and 612 from each gender and age groups of 60 and older, ensuring a representative samples of the corresponding age and gender populations are available as well as considering roughly 20 per cent potential for non-response rate. Based on the experience of similar studies previously conducted in Georgia by NCDC, the required sample size was calculated as follows:

IFMDs – 1200;

Foreign migrant students - 150; TSMU personnel and the respondents were contacted in December 2011. Similarly to IFDMs, calculation for the sample group of foreign migrant students was done in view of comprising the representative sample of 730 students and considering possibility of 20% non-response rate. By this methodology, 150 respondents were selected to participate in the Survey.

Asylum seekers – 43; the number of persons residing at the shelter when the Survey was conducted. Convenience sampling was done. The Shelter personnel and the respondents were contacted in January 2012. Due to the language barrier (majority of asylum seekers were of Turkish, African or Iranian origin who did not speak English) it was possible to interview 12 persons only.

Trafficked migrants – 24; the number of persons residing at the two state-run shelters at the time of Survey implementation. Convenience sampling was done. The personnel of the shelters and the respondents were contacted in December 2011. Obtaining the list of trafficked migrants turned out impossible due to particular vulnerability of the given target group. Therefore, contact with the respondents was possible through the state shelters' personnel.

Returned migrants – 75; the list of returned migrants was obtained from the IOM AVRR projects' database. Random sampling was performed considering possibility of 20 per cent non-response rate, and ensuring the representative sample of the overall number of the surveyed located in the three regions of Georgia. Each selected individual was contacted via phone. Subsequent to obtaining verbal consent the date of interview was agreed and study subjects were visited in their places of residence.

Foreign migrant detainees – 30; the representatives of the Ministry of Corrections and Legal Assistance of Georgia were communicated in January 2012. Obtaining of the list of foreign migrant detainees turned out impossible due to particular vulnerability of the given target group. Contact with the respondents was established through the personnel of detention centres. The personnel of detention centre performed random sampling per se, considering 20

per cent non-response rate as well as necessity for comprising the representative number of the entire target group.

Sampling procedure

PPS sampling technique was used for the selection of the number of study subjects from the list of IFDM settlements. It has to be noted that PPS was used only for selection of sites where IFDM reside. The site was conceptualized as the Survey site whereas the settlement was considered as part of the site. The list of settlements included 79 settlements from different regions of Georgia. The number of residents in the settlements ranged from 101 (Kutaisi) to 5924 (Tserovani) and their average number amounted up to 1628.

Considering the planned numbers of IFDM study subjects (total number = 1200), a total of 8 sites or primary sampling units were selected to be included in the study. The number of study subjects at each primary sampling unit was calculated proportional to the number of residents. The coefficient used was 6.5. The sampling interval equalled to 1575 (12599:8). The random starting point selected by random number was 1115. As a result of PPS sampling, 8 settlements were selected.

At the next stage, meetings with the health authorities were jointly organized and held by the IOM and NCDC, and eventually, the focal points[30] from each selected settlement were identified, contacted and invited to participate in the Survey. These persons were tasked to provide the data on IFDMs' places of residence at the particular settlement as well as facilitate organizing the interviews. As mentioned above, a simple random sampling was used to generate the potential list of study subjects with predefined number.

Likewise, the random sampling technique was used for selection of the number of study subjects from the list of foreign migrant students enrolled in TSMU and the list of returned migrants. Random sampling was used to comprise a representative sample of the foreign migrant detainees as well. As for asylum seekers and trafficked migrants, convenience sampling was done.

It should be noted that the lists of foreign migrant students, asylum seekers, returned migrants and IFDMs were shared by the respective entities considering conditionality for adherence to the IOM data protection principles and strict observance of the confidentiality of personal data.

QUESTIONNAIRE PRE-TESTING

The questionnaire was pre-tested with a randomly selected small group of IFDMs at Tserovani settlement, not enrolled in the Survey before, with the purpose of defining workload of interviewers and adapting the questionnaire content before shifting to the main phase of the Survey.

[30] Each IDP settlement or community centre has a community representative and leader, a person who is responsible for circulating information among the community and serves as a reference point for the local governmental structures as well as IGOs, INGOs and NGOs.

In view of piloting the English version of the instrument, the second pre-test was conducted at the TSMU with randomly selected group of four foreign migrant students. Consequently, the instrument was adapted to the Georgian reality, considering the cross-cultural specificities of non-Georgian population likewise. Specifically, minor edits were introduced within the group of questions relating to social and demographic data.

FIELD WORK

Training and selection of interviewers

The NCDC representatives conducted a three-day training course on 29-30 November and 3 December, 2011. 12 interviewers (10 staff members from NCDC plus the IOM project coordinator and the project assistant) participated in the training. During the three-day course the participants obtained information on the following subjects: WHO STEPS methodology, selection of respondents, interviewer's skills, STEPS instrument consisting of Step 1 - questionnaire on behavioural aspects of NCDs risk factors and Step 2 - physical measuring procedures; the IOM methodology for assessing the psychosocial and cultural anthropological needs of migrants; and the tools for exploring the knowledge, attitude and practices on NCDs. Four groups were formed with two interviewers and one supervisor for each team. Subsequent to piloting of the instruments, on a third day of the training course, the Survey team was additionally instructed on the practical details regarding the Survey implementation.

Survey Inventory

Each group of the researchers was equipped with electronic scales, a device for measuring arterial blood and heartbeat (Microlife 100 Plus) and an instrument for measuring height and circumference. All the devices were standardized before the field work.

Data collection

Fieldwork started on 9 December 2011 and was completed on 31 January 2012. Each Survey Team was composed of one supervisor, two interviewers and one driver; the group was given its identification code, equipped with a complete set for Survey implementation, and was assigned to the pre-defined cluster. The Survey teams carried out a step by step selection of the households in accordance with the estimated start-up time and location.

Prior to commencement of the interview, an official consent was obtained from the data subject. Only after that was the questionnaire filled up and physical measurements conducted. Arterial blood pressure was measured according to the WHO recommendations, using different size cuffs. The data were recorded on a printed form. Data relating to the psychosocial, cultural anthropological needs of migrants as well as knowledge, attitude and practices on NCDs was obtained considering "do no harm" principle and in compliance with internationally recognized professional ethics of interview behaviour.

Methodology of Filling up the Questionnaire

The questionnaire was filled up according to the following rules:

- An interviewer puts a question, writes down the respondent's answer in the questionnaire;
- If a respondent is unable to answer, the question is repeated;
- If the respondent still cannot answer, the question can be put the third time in other words;
- Answers are recorded without interpretation or changes;
- Data on psychosocial, cultural anthropological needs as well as knowledge, attitude and practices on NCDs was obtained in a conversational manner, without interpretation or changes in answers other than provision of explanatory notes in quotation marks (if needed) pertaining to connotation or context of the given report.

DATA MANAGEMENT & ANALYSIS

The database variable names were included into the special field in the questionnaire to create a data key indicating the origin of the data in each field of the database. The Survey database was created and analyzed in the PASW Statistics 18 known as a comprehensive system for analyzing data. After calculating frequencies, outliers of all variables were checked against the paper-based questionnaires, to control a quality of data entry.

Age, sex, type of migration, stratum and cluster specific prevalence rates were calculated. Means and confidence intervals were calculated for all physical measurements.

Qualitative data was managed and analyzed manually and red both in a qualitative and quantitative manner.

QUALITY CONTROL

With the aim of carrying out a quality control of the Survey, a number of measures were taken by means of ongoing and final monitoring. The ongoing quality control implied supervising the Survey process in the field by team supervisors and coordinators, and providing regular reports on the progress of Survey field works to IOM Georgia. The main task was an identification of the problem in a timely manner and taking measures for addressing thereto, while the final monitoring, due to its evaluative nature, did not affect the process of the Survey whatsoever.

The supervisors conducted monitoring by double-checking and controlling numbers of visits to families, numbers of individuals in the family, identification numbers of the researched individuals, sex and age of the participants, number of participants, numbers of consents and refusals at each stage separately, individual comments, etc. Apart from supervisors, internal quality control was carried out by the Survey coordinator with technical support and overall guidance rendered by IOM Georgia and IOM Migration Health Division teams.

The examination criteria implied evaluating the different components of the Survey according to the technical, professional and ethical aspects such as: completeness and serviceability of interviewer's technical set; professional behavioural and technical skills for obtaining an official consent on participation, conducting an interview and carrying out physical measurements;

compliance with the internationally recognized ethical norms while interacting with data subjects, considering the cross-cultural differences when liaising with non-Georgian population, and adherence to the general "do no harm" principle.

In addition to the above mentioned, the Survey coordinator was checking and tidying up the obtained data in accordance to the protocol, which means that questionnaires were reviewed and instruments were checked and re-calibrated when needed. On the whole, the system of current quality control ensured the implementation of the Survey without any substantial drawbacks.

Overall, the Survey was accomplished efficiently due to the well-preparedness of the interviewers equipped with the comprehensive, consistent and easy-to-operate methodology as well as the proper organization of the working process supported by the profound interest of the population.

Table 1: Response rates by strata

Clusters	Estimated Sample Size	Real number of interviews	Response rate
IFDM (1-8)	1200	1125	94%
Foreign migrant students (9)	150	142	97%
Returned migrants (10)	75	41	55%
Asylum seekers (11)	43	12	28%
Trafficked migrants (12)	24	0	0
Foreign migrant detainees (13)	30	9	30%
Total	**1490**	**1329**	**89%**

The overall response rate was quite high - 89 per cent; response rates were especially high among internal forcefully displaced migrants (1-8), foreign migrant students and returned migrants, but quite low among asylum seekers and foreign migrant detainees. None of the trafficked migrants was willing to participate in the Survey.

SURVEY RESULTS

INTERNAL FORCEFULLY DISPLACED MIGRANTS

SOCIAL-DEMOGRAPHIC CHARACTERISTICS

Response Rate

The Survey was conducted among eight clusters of IFDMs, 1125 visits were carried out. Intended sample size was 1326. The response rate was 94 per cent.

Sex and age

The participants were divided into five age groups. Most of respondents (24.2%) were individuals of the age of 65 and older.

Ethnicity

According to ethnicity, the largest Survey group was Georgians (94.6%). Among ethnic minorities, the relatively bigger groups were Ossetians (4.4%).

Marital status

According to marital status, six groups were distinguished. The largest group (68.7%) was made up of presently married.

Education

Mean number of years of education (overall number of years spent at school or full-time schooling, except for pre-school education) was 10.4 years. This index slightly varies according to age groups. Men and women spend the same time on education, which equals 10.1 years for both.

Level of completed education (the highest education level completed by a participant) was divided into seven levels. The majority of the surveyed have complete secondary (58.8%) and university (25.7%) education.

Table 2: Social-demographic characteristics, IFDMs, Georgia, 2011-12

	18 - 24	25 - 34	35 - 44	45 - 54	55 – 64	65+	Total
Male	49,4%	38,7%	35,6%	48,1%	43,3%	43,4%	42,6%
Female	50,6%	61,3%	64,4%	51,9%	56,7%	56,6%	57,4%
Education							
No formal schooling	1.1%	.0%	.0%	.0%	1.2%	1.8%	.7%
Less than primary school	.0%	.0%	.0%	.0%	.0%	4.8%	1.2%
Primary school completed	2.3%	.0%	.0%	.0%	.6%	2.9%	1.0%
Secondary school completed	18.4%	12.7%	4.4%	.5%	7.6%	28.7%	12.4%
High school completed	63.2%	47.0%	65.0%	70.7%	67.4%	45.6%	58.8%
University completed	14.9%	39.8%	30.5%	28.4%	23.3%	15.8%	25.7%

Post graduate degree	.0%	.6%	.0%	.5%	.0%	.4%	.3%
Ethnicity							
Georgian	94.3%	96.7%	91.1%	96.6%	95.3%	93.8%	94.6%
Abkhaz	.0%	.0%	.5%	.0%	.0%	.4%	.2%
Ossetian	5.7%	3.3%	6.4%	2.9%	3.5%	4.8%	4.4%
Azerbaijani	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Armenian	.0%	.0%	.5%	.0%	.6%	.4%	.3%
Russian	.0%	.0%	1.5%	.5%	.0%	.7%	.5%
Other	.0%	.0%	.0%	.0%	.6%	.0%	.1%
Marital status							
Single	56.3%	13.3%	6.9%	5.3%	6.4%	2.9%	10.4%
Currently married	41.4%	81.1%	82.3%	84.6%	66.3%	48.2%	68.7%
Separated	.0%	1.1%	.0%	1.0%	.6%	.4%	.5%
Divorced	1.1%	3.3%	4.4%	2.9%	.6%	1.8%	2.5%
Widowed	1.1%	1.1%	4.9%	6.3%	26.2%	46.7%	17.6%
Cohabitating	.0%	.0%	1.0%	.0%	.0%	.0%	.2%

Occupation

According to work status, four groups were distinguished. The biggest group (77.2%) was made up by individuals with unpaid work status. Women with this status took up 81.8 per cent, while men – 70.9 per cent. Individuals of unpaid work status prevail among 64 and older (96.3%) and 18-24 years (92.5%) age groups.

13.6 per cent of interviewed work in state structures. Among those working for non-governmental sector there are more male (9.2%) than female (2.3%). The percentage of self-employed was higher among men (6.9%) than among women (1.9%).

Among the individuals with unpaid status prevails the number of retired (28.1%). In this group, the second biggest sub-group is comprised by the able-bodied unemployed (28%). The index of able-bodied unemployed is much higher among men (38.4%) than among women (20.5%).

The index of pensioners among female is higher (29.8%) than among male (26%). Percentage of the unemployed unable to work is higher among male (3.8%) than among female (1.2%). Group of students is more representative among women than among men (2% and 1.3% respectively).

On the question what was their scope of work before migration, the most prevalent scope of work was a government employee (30.7%, male – 31%, female – 30.4%). The second biggest group was retired (21.5%, male – 20.3%, female – 22.5%) followed by self-employed (13.1%, male – 21.8%, female – 6.7%). Able-bodied unemployed were 8.2 per cent (male – 8.8%, female – 7.8%). 5.4% (male – 9.4%, female – 2.5%) were working in NGO sector. Group of students is more representative among women than among men (3.4% and 1.7% respectively).

Placement in the conflict zone during military activities

92.7 per cent of IFDMs were placed in the conflict zone during military activities. 65.7 per cent of respondents feel absolutely safe at their place of residence, 33.8 per cent mentioned they feel relatively safe and only 1.1 per cent feel absolutely unsafe.

Household revenue

According to average yearly revenue, the households were clustered in five groups. Yearly income of 79.2 per cent of interviewed was less than GEL2,600. Revenues of few households vary between GEL2,600 - 5,000 (16.4%) and even fewer have yearly income of between GEL5,000 - 10,000 (2.9%) and that of more than GEL10,000 - 20,000 (0.6%). Figures are alarming as about 80 per cent of IFDM's households have income of GEL217 per month.

BEHAVIOURAL RISK FACTORS (STEP 1)

Tobacco consumption

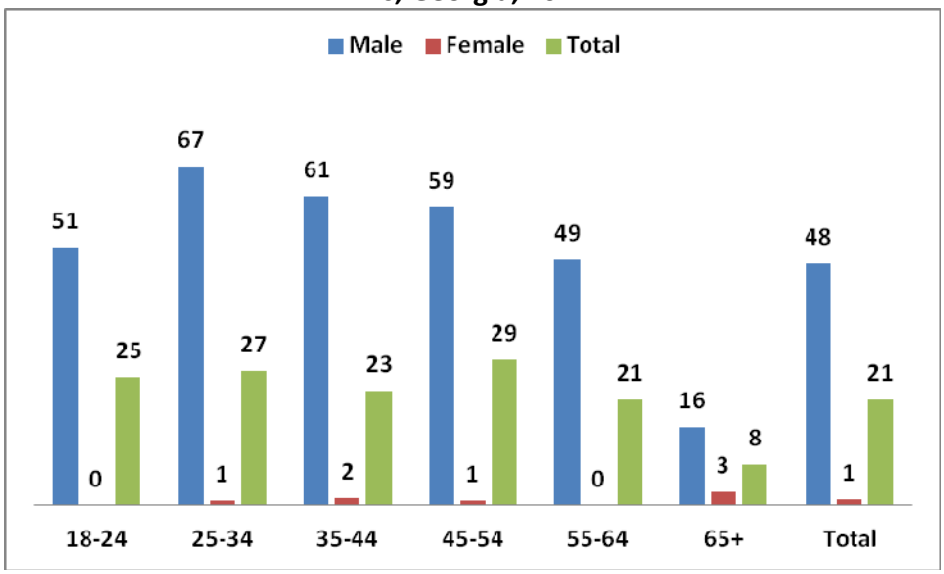
For studying the use of tobacco, the research comprised eight questions. The Survey participants were asked questions about current smoking, previous smoking, the age of smoking initiation, duration of smoking, and the quantity of tobacco smoked daily. Current smoking is defined as current daily or occasional smoking, while daily smoking means using at least one cigarette a day.

Current smokers

Currently any kind of tobacco product (smoked and smokeless) was consumed by 20.9 per cent of respondents (47.7% male and 1.2% female). The difference between the distribution of smoking among men and women is evident. Apparently, the tendencies of prevalence of smoking among sexes have not changed in Georgia so far, due to which higher prevalence is reported among men compared to women. It also has to be taken into consideration that women's smoking is still a tabooed subject and it is presumable that some women keep this habit as a secret. As a result, the received data may not reflect the real situation accurately.

According to age groups, smoking was most prevalent among those aged 45-54 years (28.8%). The lowest prevalence was among individuals of 65 and older age groups (8.1%). It is interesting that 51.2 per cent of male in the age group of 18-24 were smokers. If we consider the results of the Survey carried out among 13-15 year old children (current smoking 8.7%) in 2008 (*Global Youth Tobacco Survey 2008*) as well as the results of the pilot research *Tobacco, Alcohol and Other Drug Consumption Among Georgian Students of 16 Years of Age,* carried out by the European School Project on Alcohol and Other Drug – ESPAD the same year (current smoking 16%), it can be presumed that forming of a smoker status in the large majority of men and women occurs at the age between 15 to 24.

Chart 7: Percentage of respondents according to current smoking status, sex and age, IFDMs, Georgia, 2011-12



87.8 per cent of current smokers were daily smokers. Percentage of current daily smoking among male (90%) was much higher than among female (25%).

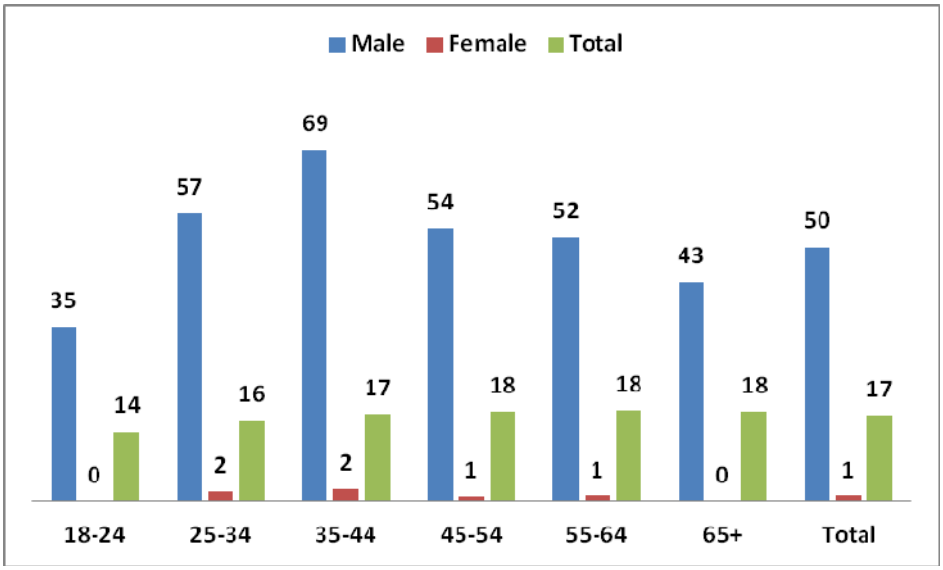
Mean age of smoking initiation among daily smokers was 19 years (male-19, female-18). In addition, daily smokers aged 18-24 started smoking earlier (17 years) than those in age groups of 25 and over. It was revealed that among female, smoking initiation occurs at an earlier age than among male.

98.8 per cent of daily smokers use manufactured cigarettes. 0.9 per cent of male daily smokers use hand rolled cigarettes.

Former smokers

Prevalence and characteristics of former daily smoking were studied. The status of a former daily smoker was defined as a daily smoker in the past that does not smoke currently, or smokes occasionally (not daily). Former daily smokers comprised 17 per cent of the population. 50.3 per cent male and 1.1 per cent female were daily smokers in the past. The share of male former smokers in every age group was much more than that of females; it was especially high among 35-44 age groups (69.4%).

Chart 8: Percentage of former smokers according to sex and age, IFDMs, Georgia, 2011-12



Attempts to quit smoking

Over the past 12 months, attempts to quit smoking were made by 30.5 per cent of ever smokers (30.8% for men and 20% for women). The highest figure (47.8%) of attempts to quit smoking among current smokers was recorded in the age group of 18-24.

At least one supporting measure to quit smoking was used by 44 per cent of current smokers (98 men and two women). Nicotine-replacement therapy was used by only four men, medicaments by two men, telephone consultation by just one man, no one used counselling in clinics, maybe due to mere absence of this type of service. 17 per cent used other methods, which may include so called "light" cigarettes containing less nicotine and tar but in fact inflicting the same damage to health.

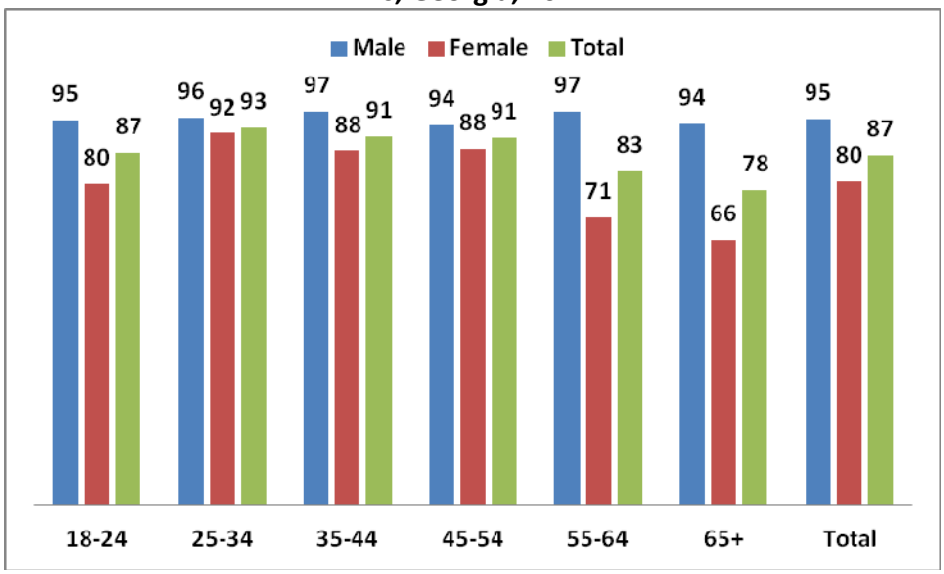
The respondents refrained from smoking for 323 days the longest (app. 0.9 year). It should be emphasized that for male this period totalled 330 days, for female - four days, which means that men make more attempts to quit smoking than women do and therefore their willingness to stop this practice is far stronger.

Alcohol consumption

Lifetime alcohol consumption

Prevalence of alcohol consumption is very high among IFDMs and amounts up to 86.6 per cent. This figure is very high for men - 95.4 per cent. In every age prevalence of drinking among male is approximately the same (94%-97.3%), among female the highest figure was revealed in 25-34 age groups, which is 91.9% per cent and it decreases with age.

Chart 9: Percentage of the lifetime alcohol consumers according to sex and age, IFDMs, Georgia, 2011-12

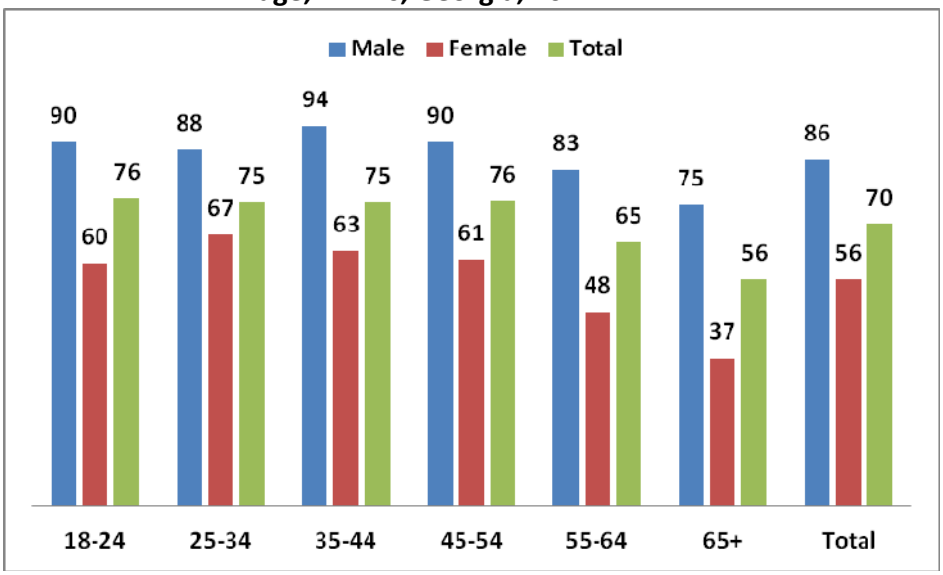


On average, every seventh respondent does not consume alcohol at all.

Alcohol consumption status throughout 30 days and 12 months prior to the Survey
During the interview the focus was made, on one hand, on alcohol consumption status based on time (30 days, 12 months) and, on the other, on frequency and amount of consumed alcohol, considering the norms recognized by the WHO.

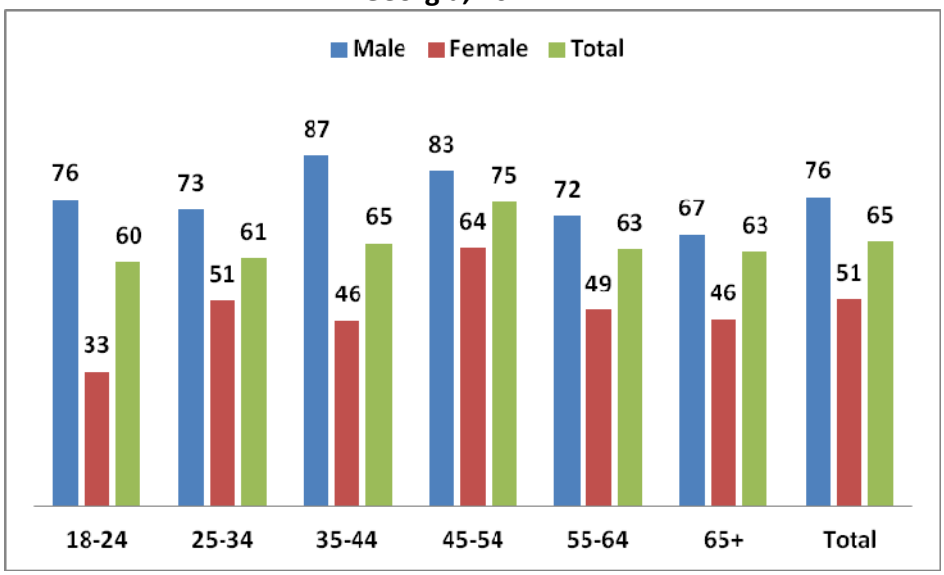
For the last 12 months, prevalence of alcohol consumption totalled 69.7 per cent. This figure is higher for men (85.6%) than for women (56%). Situation is the same in all age groups.

Chart 10: Percentage of the last 12 months alcohol consumers according to sex and age, IFDMs, Georgia, 2011-12



Prevalence of alcohol consumption for the last month prior to the interview totalled 65.4 per cent (76.3% for male and 51% for female).

Chart 11: Alcohol consumption for the last 30 days according to age and sex, IFDMs, Georgia, 2011-12



Frequency and amount of alcohol consumption

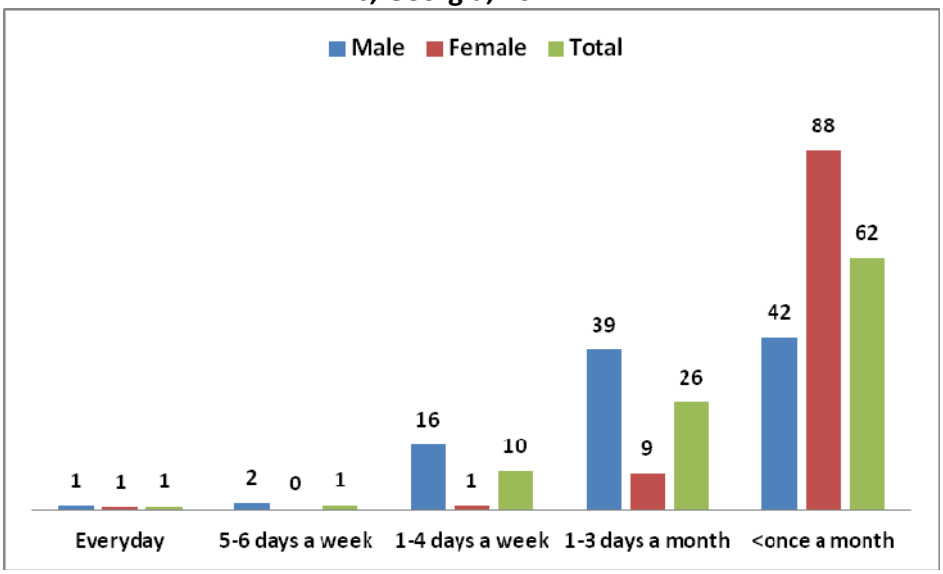
Most alcohol consumers drink less than once in a month (61.5%), the second frequent answer was 1-3 times in a month (26.4%), followed by 1-4 days per week (9.6%).

Despite the fact that the prevalence of daily alcohol consumption is low for both sexes and on average does not exceed 0.9 per cent, it was revealed that alcohol is consumed daily by 2.4 per cent male and 0.9 per cent female.

Vast majority of the male respondents (42.6%) use alcohol 1-3 days per week, while 22.4 per cent does so for 1-4 days.

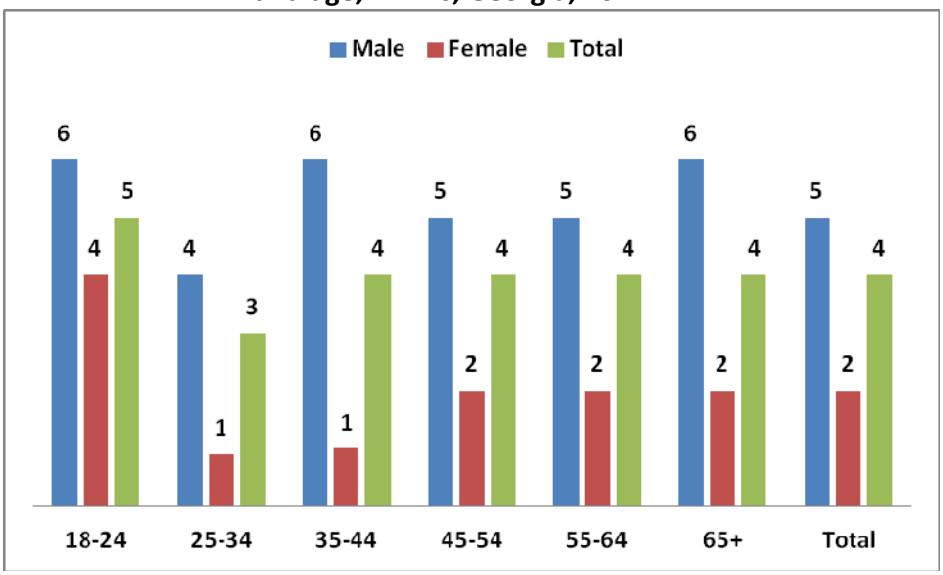
These indicators, respectively, exceed the analogue figure for female twice and 7-times. Generally, it should be noted that overwhelming majority of women (75.3%) consume alcohol once per month, especially from the age of 45.

Chart 12: Frequency of alcohol consumption for the past 12 months according to sex, IFDMs, Georgia, 2011-12



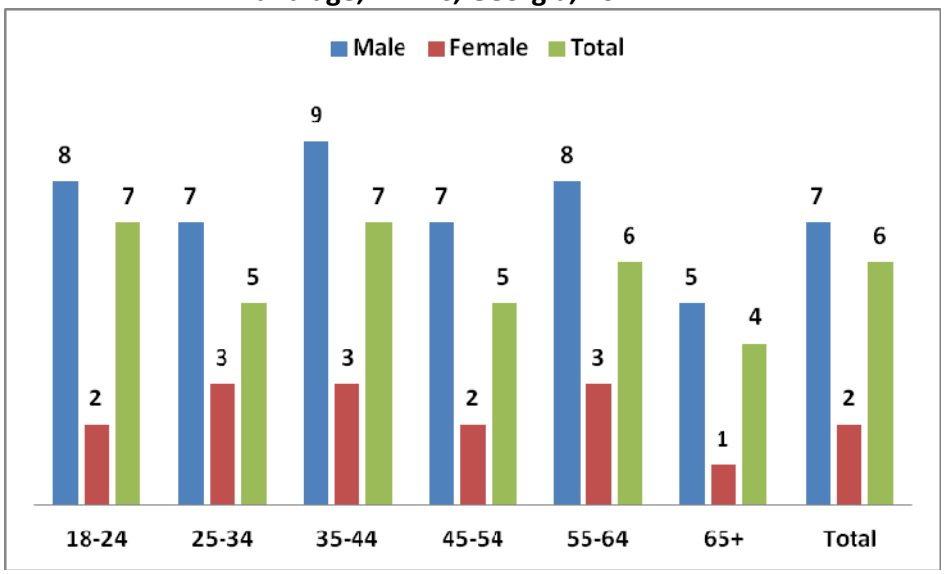
65.4 per cent respondents have consumed alcohol during the last 30 days. Few respondents (five men and two women) confirmed on four occasions of alcohol consumption during the last month.

Chart 13: Frequency of alcohol consumption during the last month according to sex and age, IFDMs, Georgia, 2011-12



As for the dose of alcohol, six standard alcohol drinks were consumed throughout the last 30 days during one drinking occasion on average; men consume seven, while women consume two standard alcohol drinks at a time.

Chart 14: Amount of standard alcohol drink consumed at one time according to sex and age, IFDMs, Georgia, 2011-12

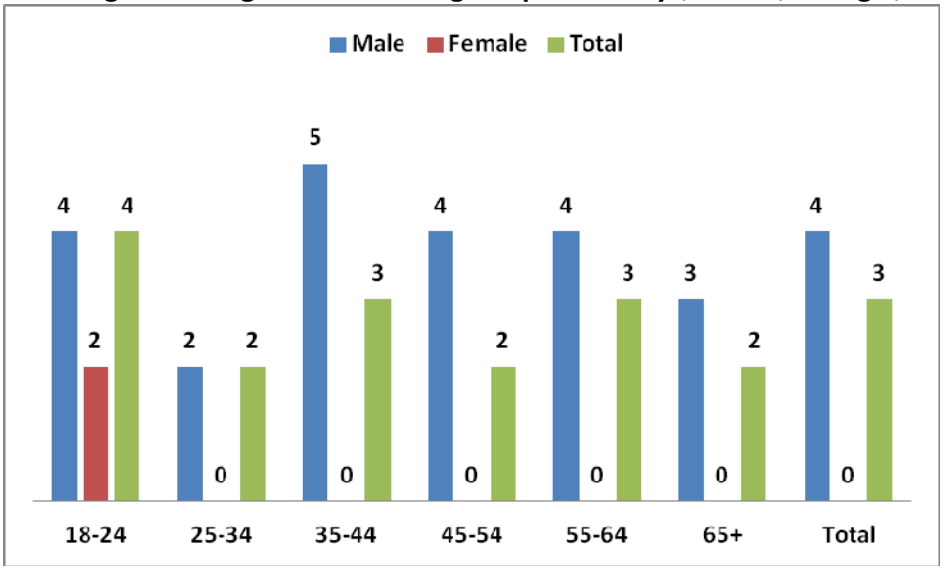


It is remarkable that the maximal amount of drink portions received at a time during the last month prior to the interview turned out to be very high among men, while women do not take more than three standard dozes.

Five or more standard alcoholic drinks were consumed by male throughout single drinking occasion at four times during the past 30 days; female consumed four or more standard alcoholic drinks in a single drinking occasion four times during the past 30 days.

67 per cent men consumed five and more drinks at a time, while only two women (both from 18-24 age group) consumed four and more drinks during the past 30 days.

Chart 15: Amount of occasions when male consumed ≥5 and female consumed ≥4 drinks in a single drinking occasion during the past 30 days, IFDMs, Georgia, 2011-12



Diet

Daily food consumption

The majority of respondents (52.2%; male–58.6%, female–48.1%) take food three times a day. The second big group of respondents (37.2%; male–31.6% and female-41.1%) has two meals a day. 5.5 per cent (male–3.8% and female-6.8%) eat once per day; 4.3 per cent (male–4.8% and female-3.9%) have four meals per day. Two male 35-44 year old respondents do not eat every day.

General structure of food consumption

According to the results of the Survey, all respondents take fewer than five servings of fruit and vegetables per day, on average. All respondents (100%) take two servings of fruit and vegetables. Average frequency of fruit consumption was three days a week and average frequency of vegetable consumption was five days a week. These figures don't differ by sex or age.

Meat products are consumed on average once per week and average amount of servings is two. The difference among age groups was insignificant. Meat consumption as well as number of servings was higher among men than among women.

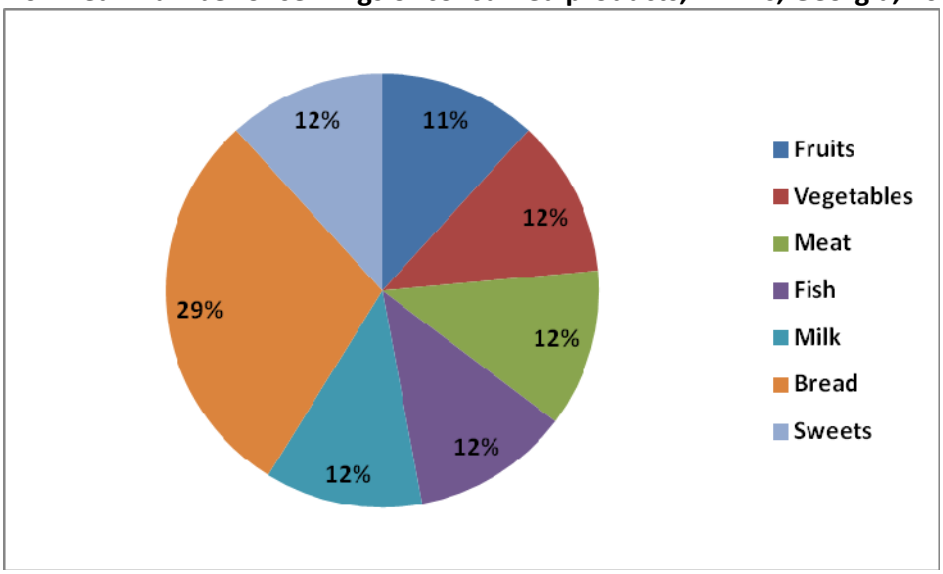
Fish is consumed once per week on average and mean number of servings is two. Fish consumption as well as number of servings was higher among men than among women.

Dairy products are consumed two days per week on average, and average number of servings is three. These figures slightly vary according to age and sex.

Consumption of bread and cereals occupied the first place in food types consumed among interviewed; seven days a week and five servings a day. According to number of servings males consume more products (6 servings) than females (4 servings).

Level of intake of sweets and products with sugar content is remarkably high. According to number of consumption days, it takes the second place and follows bread and cereal products. The tendency is the same in terms of consumed servings. The interviewed take sweets for six days per week. Female consume more sweets (6 days) than male do (5 days). Three servings of sweets are taken by male and two – by female.

Chart 16: Mean number of servings of consumed products, IFDMs, Georgia, 2011-12



Consumption of less than five servings of fruit and/or vegetables per day and diet-related risk

Diet-related risk was evaluated on the basis of consuming less than five servings of fruit and vegetables. The results of the Survey showed that all respondents (100%) are under diet-related risk.

Fat consumption

The most common fat for cooking at home is vegetable oil (97.2% of the interviewed). It is followed by butter, which takes up 1.9 per cent. Use of margarine (0.3%) and pork fat (0.2%) was rather rare.

Eating outside

Consumption of food prepared outside is rather low (once a week). The most frequent food intake outside home occurs among male aged 45-64 and female aged 35-44.

Physical Activity

16.7 per cent (male-22.2% and female-10%) of respondents stated that their work involves a vigorous-intensity activity that causes large increases in breathing or heart rate for at least ten

minutes continuously. Vigorous-intensity activities as part of the work are performed throughout four days (male-four days and female-three days) in a typical week; and amount up to 260 minutes (male-255 and female-274).

58.4 per cent (male-55% and female-61.1%) of respondents stated that their work involves moderate-intensity activity. Moderate-intensity activities as part of the work are performed throughout six days (male-five days and female-six days) in a typical week; and amount up to 191 minutes (male-225 and female-168).

74.7 per cent (male-73.1% and female-75.9%) walk or use a bicycle (pedal cycle) for at least 10 minutes continuously to get to and from places. This activity is performed throughout six days in a typical week; and amounts up to 64 minutes (male-85 and female-48).

Only 2.3 per cent (male-4.2% and female-0.9%) stated they are engaged in vigorous-intensity sports, fitness or recreational activities (running or playing football, for instance) that cause large increases in breathing or heart rate for at least 10 minutes continuously. This is done five days in a typical week; and amounts up to 88 minutes (male-98 and female-46).

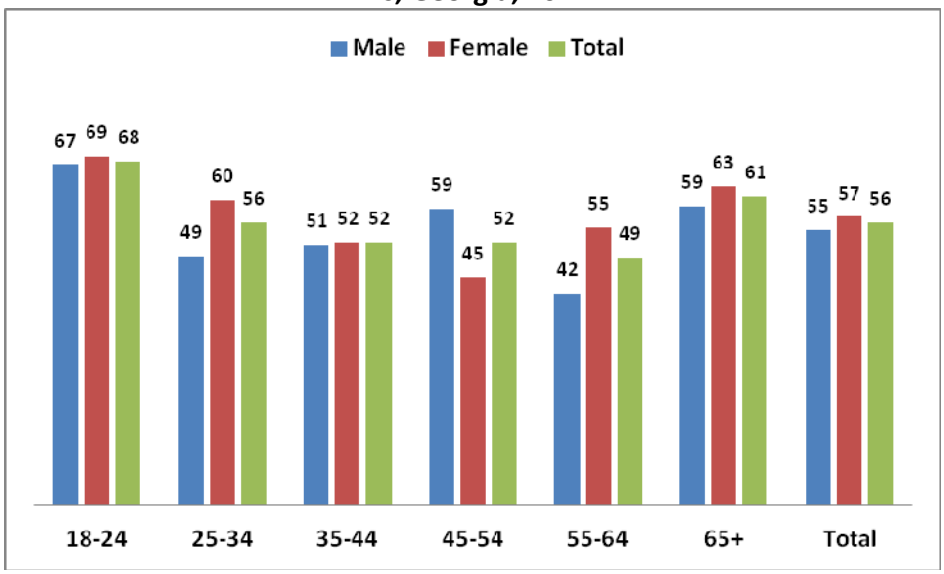
Only four per cent (male-5.7% and female-2.8%) stated that they are engaged in moderate-intensity sports, fitness or recreational activities (running, playing football) that cause large increases in breathing or heart rate for at least 10 minutes continuously. These activities are performed for four days in a typical week; and last for 62 minutes (male-73 and female-42).

HEALTHCARE ACCESS

On the question what health services are available for their community, majority of IFDMs (78.5%) named polyclinics, 58.6 per cent - emergency health service, 29.8 per cent - hospitals, 25.2 per cent - nurse post, 1.7 per cent - NGO service (mobile clinic) and only 0.5 per cent - psychosocial services.

Healthcare services are financially affordable for 55.8 per cent of respondents.

Chart 17: Self-reported financial affordability of healthcare services by sex and age, IFDMs, Georgia, 2011-12



For 76 per cent it takes less than 30 minutes to get to the medical facility, 11.8 per cent of respondents have to spend 1-2 hours to get there and for 5.5 per cent - it takes 30 min-1 hour. The main type of transport is walking (53.3%), followed by a bus (28.6%) and a car (7.9%).

Awareness on health insurance policy and its enjoyment

Overwhelming majority of interviewed have been issued a state health insurance policy. However, the given benefit is not affordable for the lesser minority of those surveyed due to expiration of the validity period of the policy, absence of personal identification documents, or as respondents say, the relevant social authorities abstain from issuing a health insurance policy to those who have been paid a compensation fee[31].

Over the half of respondents, 53.9 per cent (n=717) are informed about components of the health insurance policy, nevertheless, their awareness is fairly vague. The respondents confirmed their satisfaction concerning coverage of medical services such as surgical operations and urgent interventions. However, allegedly due to the insufficient awareness, interviewees were interchangeably pointing to the amounts of GEL50.000, GEL32.000 or GEL15.000 available for the coverage of the given interventions, highlighting that all that the policy provides for is the coverage of certain medical investigations likewise. In their argumentation, respondents were referring to the explanatory notes included into the policy and specifying its components, but in fact were interpreting the contents of the notes inaccurately. Moreover, reportedly, the policy provides for the coverage of diverse operations, amongst those, urgent surgeries, such as removal of inflamed appendix, as well as planned surgical operations, such as lumbar intervertebral osteochondrosis, removal of uterus, and fibroma surgery. “Medical investigations, heart angioplasty (stent placement) and 20-50 per cent discounts for medicines are also affordable”, meaning that “whenever needed, the policy proved to be functional”. In addition,

[31] Lump sum compensation was paid to certain part of IFDMs in amount of GEL10.000 aftermath 2008 August war.

the policy covers the costs for insulin and medicines for TB treatment. It is worth noting that the policy was applied especially widely and successfully in case of child delivery and appreciations were made in this regard repeatedly. "The policy covered the costs for child delivery and partially, caesarean section". The fewest reports referred to satisfaction regarding the policy covering the number of urgent interventions including surgeries (tonsillectomy and appendectomy) in children. Nevertheless, despite their satisfaction, every now and again interviewees still kept complaining for the reason that payments were not rendered for medicaments, which imposed heavy financial burden on their households' budget.

39 per cent (n=519) of surveyed are either extremely unsatisfied by the package of benefits available within the services covered by the policy, or are unaware about its components or have not utilized available benefits so far due to the lack of need or the lack of capacity to do so. "We don't go to the doctor because the medical facility is too far". Complaints were mentioned concerning the lack of affordability of the essential medicines and "poor quality of services", highlighting that sometimes the entire income of households is spent on medicines and that "those investigations that are pricey are not affordable". Some respondents expressed discontent due to the lack of coverage for dental treatment, obligations to cover the fee for visiting the doctor and incapacity of the policy to cover the treatment of chronic non-communicable conditions. Dissatisfaction of IFDMs was mainly related to the fact that the policy "is useless" and provides for the "coverage of only surgical operations, without any concessions conducive for the affordability of essential medicine". Lack of the coverage for gynaecological check-ups was mentioned as well. The recurring objections underlying the respective statements were as follows: "The fee for doctor's services is covered, while the essential medicine is pricey" "What is the use of visiting doctor if one can not afford prescribed medication"?

Fewer reports 2.1 per cent (n=28) referred to the inability of using the policy or not having the policy at all, for the reason of having paid a compensation fee (mentioned above).

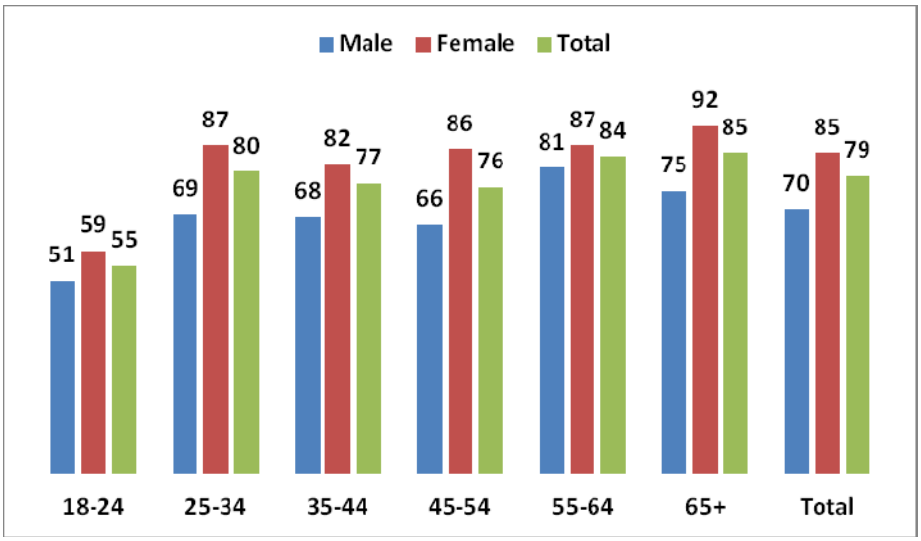
Data on (n=65) of surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

CLINICAL HISTORY

History of raised blood pressure

The majority of respondents (78.6%) reported as having ever measured the blood pressure by medical personnel. The percentage of those who has never checked blood pressure is higher among male (29.9%) than among female (14.9%).

Chart 18: Hypertension lifetime measurement by sex and age, IFDMs, Georgia, 2011-12



Hypertension was reported by 56.6 per cent of respondents. Hypertension prevalence increases with age. In younger age hypertension prevalence is higher among male, after 45 years the tendency turns out to be the opposite.

Chart 19: Hypertension lifetime diagnosis by sex and age, IFDMs, Georgia, 2011-12

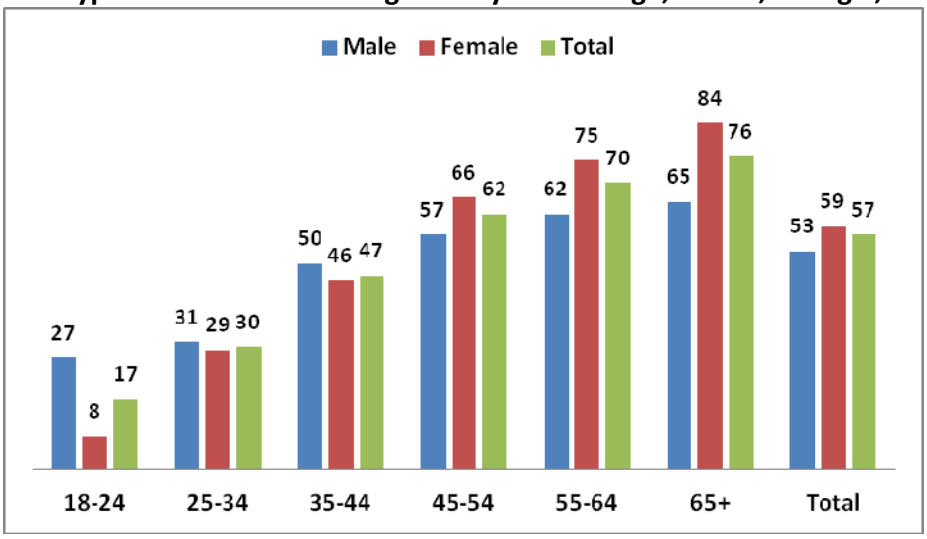
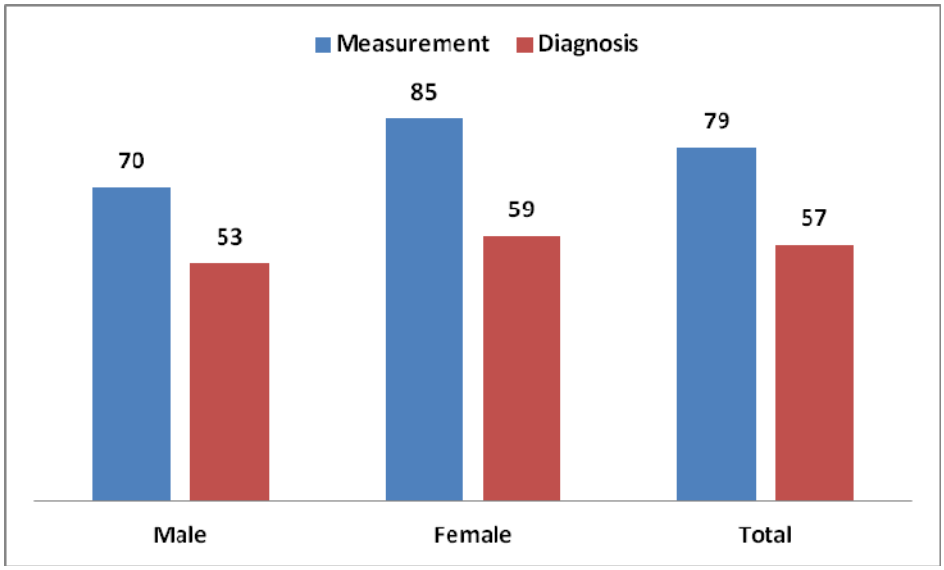


Chart 20: Hypertension lifetime measurement and diagnosis by sex, IFDMs, Georgia, 2011-12



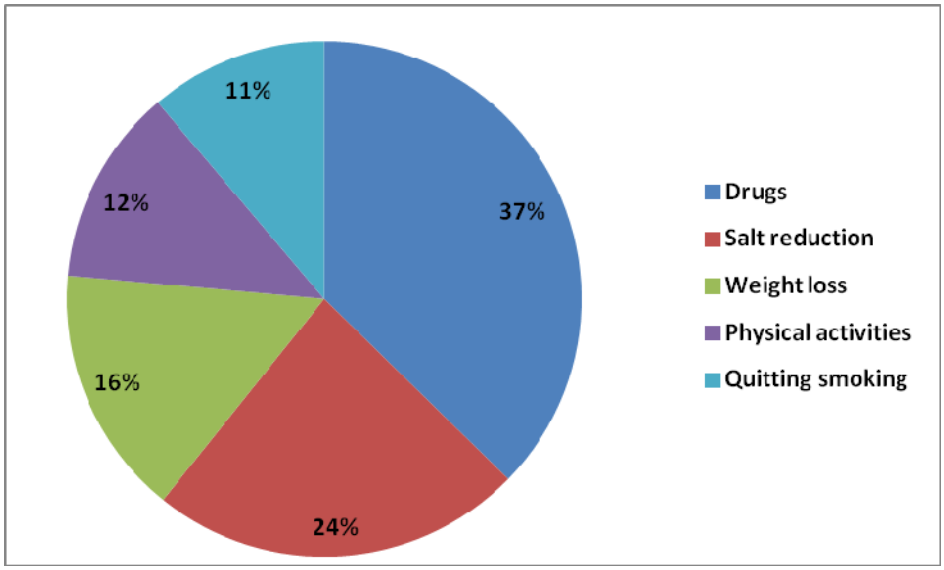
Hypertension during the last 12 months was reported by 80.3 per cent of IFDMs.

44.8 per cent (male-48.8% and female-40.9%) of 18-24 years respondents have never checked blood pressure.

The most significant is the prevalence of not checking the blood pressure among men of 45-54 age groups. While estimating the cardiovascular risks, the age of 45 years and higher among men was considered as one of the risk factors. Hence, the deficit of screening activities is associated with the high risks of blood vessel catastrophes development especially in this age group.

66.8 per cent (male-61.2% and female-69.9%) are currently receiving medication for high blood pressure prescribed by a doctor or other health worker. 42.1 per cent (male-38.8% and female-44%) received recommendation to decrease salt intake, 28.1 per cent (male-25.5% and female-29.6%) received recommendation to lose weight; 22.2 per cent (male-26.6% and female-19.8%) were encouraged to be engaged in physical activities, and 20.1 per cent (male-25.5% and female-17.1%) – to quit smoking.

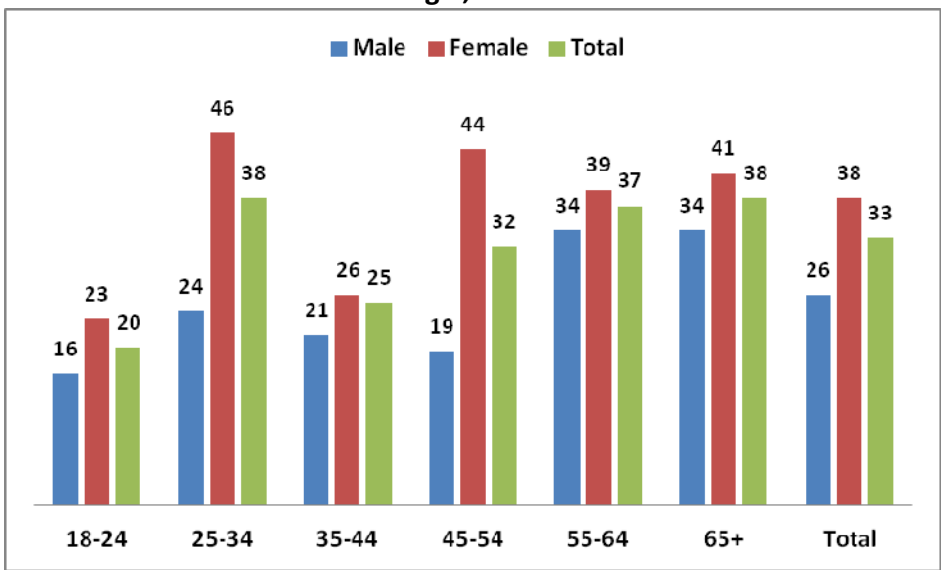
Chart 21: Proportion of respondents currently receiving any treatments/advice for high blood pressure prescribed by a doctor or other health worker, IFDMs, Georgia, 2011-12



Diabetes history

The majority of respondents 67 per cent (male-73.8% and female-62%) have never checked glucose concentration in blood; 15 per cent of the interviewed reported concerning high glucose level.

Chart 22: Glucose lifetime blood glucose measurement by sex and age, IFDMs, Georgia, 2011-12



15 per cent (male-18.4% and female-13.4%) confirmed cases of hyperglycaemia.

Chart 23: Hyperglycaemia lifetime diagnosis by sex and age, IFDMs, Georgia, 2011-12

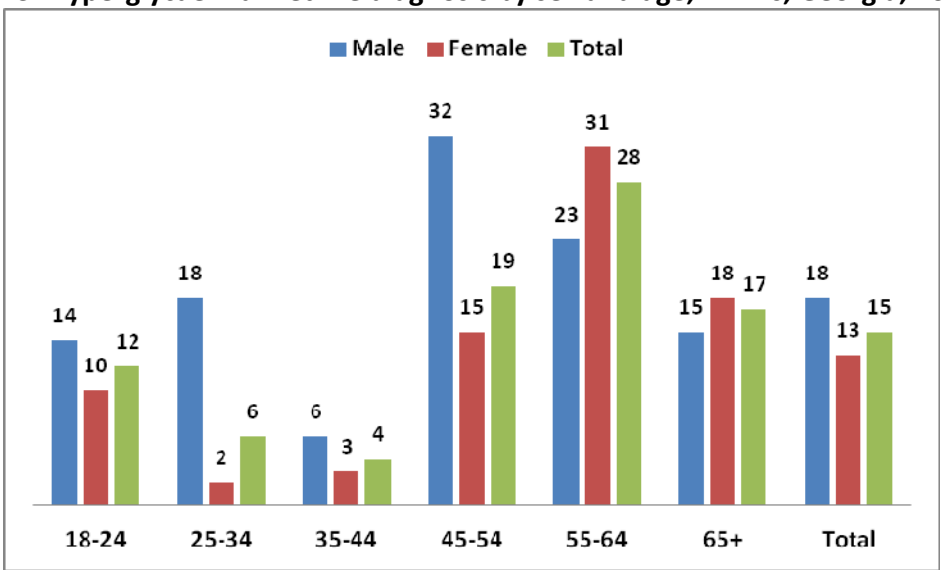
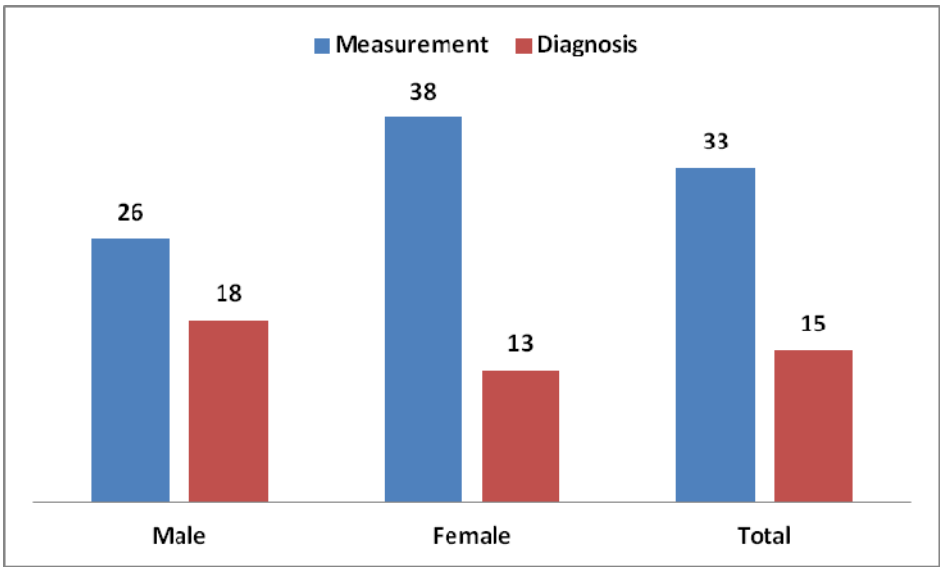


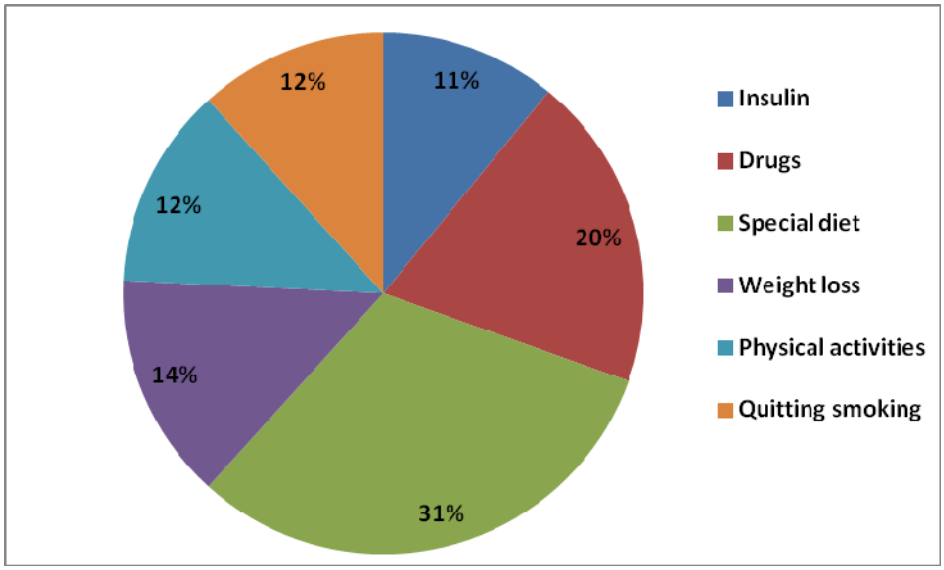
Chart 24: Hyperglycaemia lifetime measurement and diagnosis by sex, IFDMs, Georgia, 2011-12



Cases of hyperglycaemia during the last 12 months were reported by 83.6 per cent (male-84% and female-83.3%) of IFDMs.

20.9 per cent (male-34.6% and female-12.2%) are currently receiving insulin for hyperglycaemia prescribed by a doctor or other health worker. 37.9 per cent (male-40% and female-36.6%) are taking oral drugs. 60.6 per cent (male-63% and female-56.1%) were prescribed a special diet; 27.3 per cent (male-28% and female-26.8%) received recommendation to lose weight; 24.2 per cent (male-24% and female-24.4%) were encouraged to be engaged in physical activities, and 22.7 per cent (male-32% and female-17.1%) to quit smoking.

Chart 25: Percentage of respondents currently receiving any treatments/advice for high blood pressure prescribed by a doctor or other health worker, IFDMs, Georgia, 2011-12



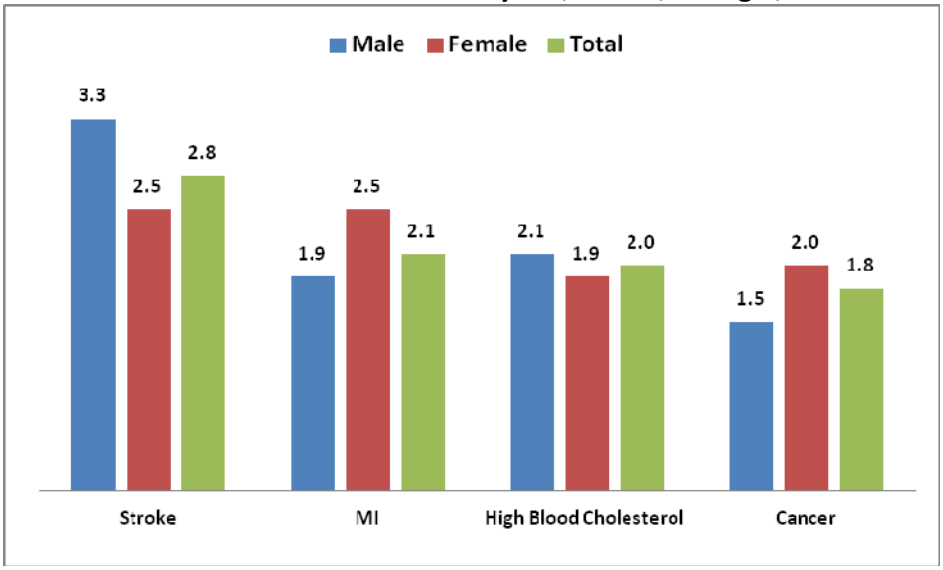
History of other diseases

This part of questionnaire was intended to obtain information on the history of other diseases and conditions; particularly, on myocardial infarction, stroke, cancer and raised cholesterol.

Stroke occupies the first place in the history of diseases 2.8 per cent (male-3.3% and female-2.5%); followed by myocardial infarction 2.2 per cent (male-1.9% and female-2.5%), raised blood cholesterol 2 per cent (male-2.1% and female-1.9%), and cancer 1.8 per cent (male-1.5% and female-2%).

Frequency of the above-mentioned diseases proportionally increases with age.

Chart 26: Distribution of diseases by sex, IFDMs, Georgia, 2011-12



Visiting doctors

The motives and frequency of visits to doctors or other medical personnel have been inquired for the period of past 12 months. The total percentage of both sexes, visiting doctor throughout past 12 months was 55.3 per cent (male-48.9% and female-60%). This figure increases with age.

The main reason for visiting doctors or medical personnel consisted in specific health problems (88.6%). The second reason was preventive screening (6.9%), followed by the combination of the both above-mentioned reasons (1.6%).

Self-treatment

Only 1.7 per cent (male-1.3% and female-2%) of respondents resort to self-treatment, which should be considered as a positive trend.

With regard to diseases mentioned in the questionnaire (diabetes or raised blood glucose, high blood pressure, stroke, cancer, raised blood cholesterol and early myocardial infarction) respondents most frequently resort to self-treatment of high blood pressure (14.9%, male-9.5% and female-18.7%). This tendency indicates that Georgian population quite often makes independent decisions on self-treatment in case of hypertension (compared to cancer, diabetes and stroke). The given assumption means that the patients also take decision to change treatment schemes or dose titration by themselves, which is confirmed by critical shortage of titration visits to physicians. Information on the necessity of lifelong treatment of hypertension is very low in patients and regrettably among the medical personnel as well.

Self-treatment was extremely rarely detected among patients suffering from other diseases (0.2%).

Family history of diseases

When inquired whether their relative (mother, father, sister, brother and spouse and his/her relative) have ever been diagnosed on hyperglycaemia / diabetes, high blood pressure, stroke, cancer, hypercholesterolemia, or early myocardial infarction, the majority of respondents (50.5%) confirmed on the occurrences of high blood pressure, then, in an order of descending sequence, on cancer (16.3%), diabetes (14.2%), stroke (13.2%) and myocardial infarction (6.2%). The minimal number of respondents (2%) mentioned the occurrence of hypercholesterolemia in the family history of diseases.

The figures of lipid profile examinations among the respondents are low; the same is manifested by the history of diseases of their relatives. This fact is explained by ignoring the mentioned lab tests by the primary health care personnel while estimating cardiovascular risk, which indicates a poor awareness of the PHC personnel on the importance of examining the lipid spectrum for estimating cardiovascular risk, managing the manifested disease and its prevention.

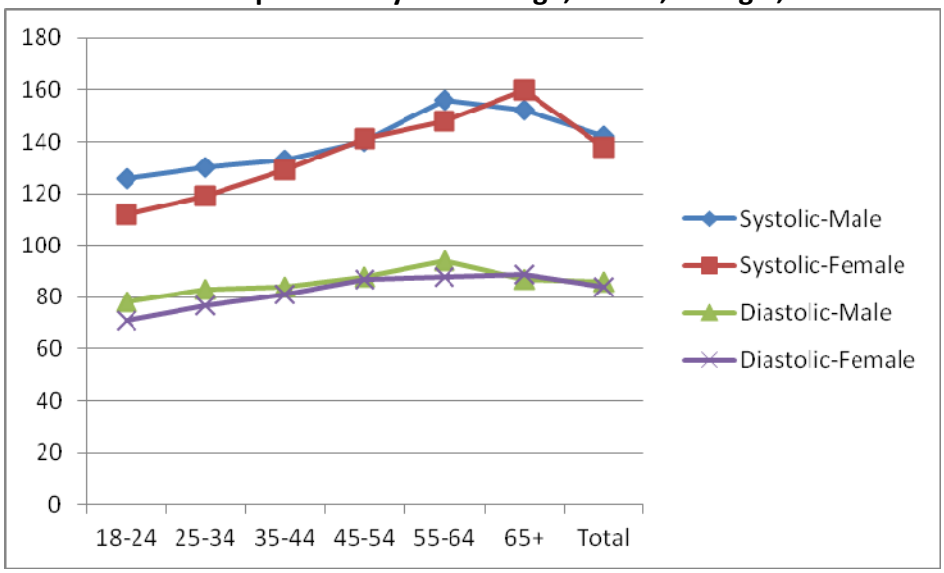
PHYSICAL MEASUREMENTS (STEP 2)

Arterial hypertension, heartbeat rate, weight, height, body mass index, and waist circumference were assessed and measured.

Arterial Blood Pressure and Heartbeat

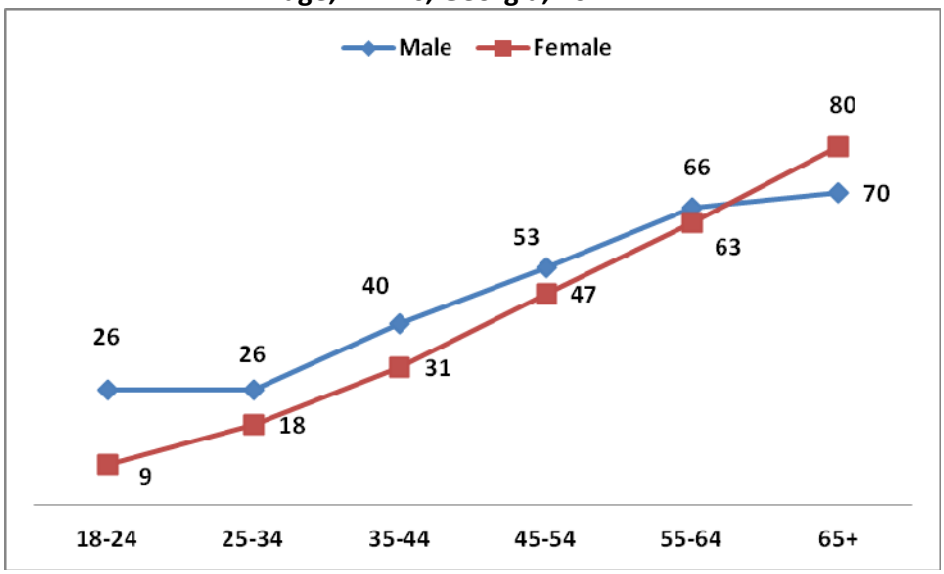
Mean systolic blood pressure among surveyed population was 140mmHg (male-142 and female-138) and mean diastolic blood pressure - 85mmHg (male-86 and female-84). Both figures steadily increase with age; systolic pressure from 119 (18-24 age group) to 157mmHg (64 and older age group) and diastolic pressure from 74 (18-24 age group) to 91mmHg (55-64 age group).

Chart 27: Blood pressure by sex and age, IFDMs, Georgia, 2011-12



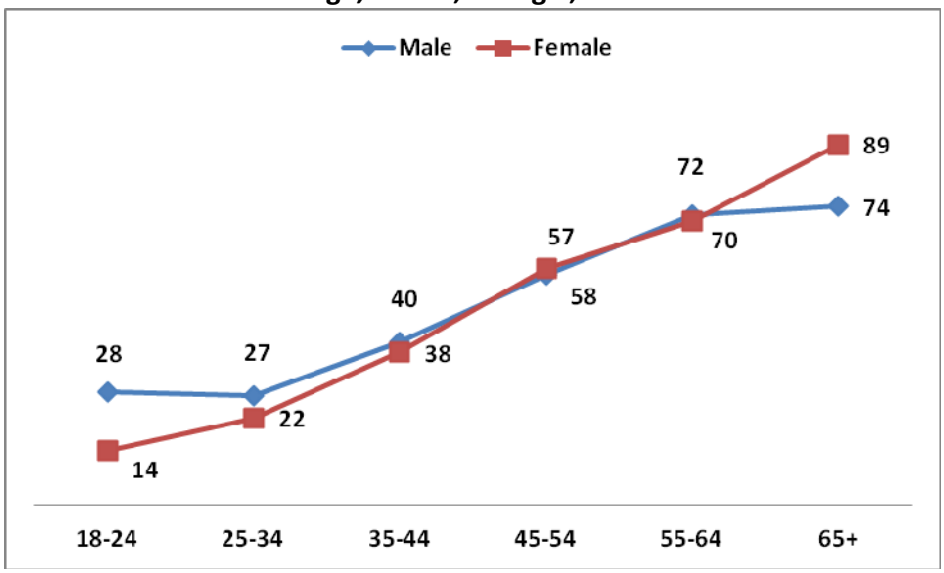
Blood pressure 140/90mmHg or hypertension was detected among 48.2 per cent of respondents (male-50.6% and female-46.4%) who do not take any medication. Hypertension prevalence is increasing with age. 51.8 per cent of respondents do not have high blood pressure, neither have they taken any medication. Hypertension prevalence was lower among young female; among 55-64 age group the prevalence was the same as among male and among those older than 65 years, prevalence was higher among female than among male.

Chart 28: Hypertension (≥140/90 mmHg, without medication) prevalence by sex and age, IFDMs, Georgia, 2011-12



Having a blood pressure ≥140/90mmHg or being on treatment was confirmed by 53.9 per cent of respondents (male-53.9% and female-53.8%)[32]. Hypertension prevalence is rising with age; despite the fact that the compliance with treatment process increases with age, still prevalence of hypertension among the elder age is higher. Prevalence was lower among female of younger ages; among the age group of 45-64 the prevalence was the same as among male and among those older than 65 years prevalence was higher among female than among male.

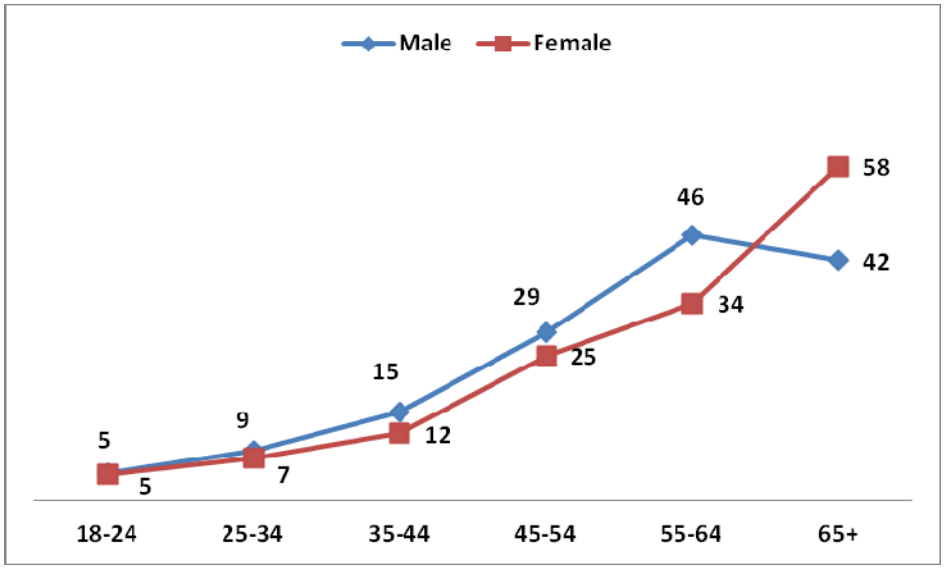
Chart 29: Prevalence of hypertension (≥140/90 mmHg) or being on medication by sex and age, IFDMs, Georgia, 2011-12



[32] These and following charts of a similar nature combine physical findings with self-reported treatment history.

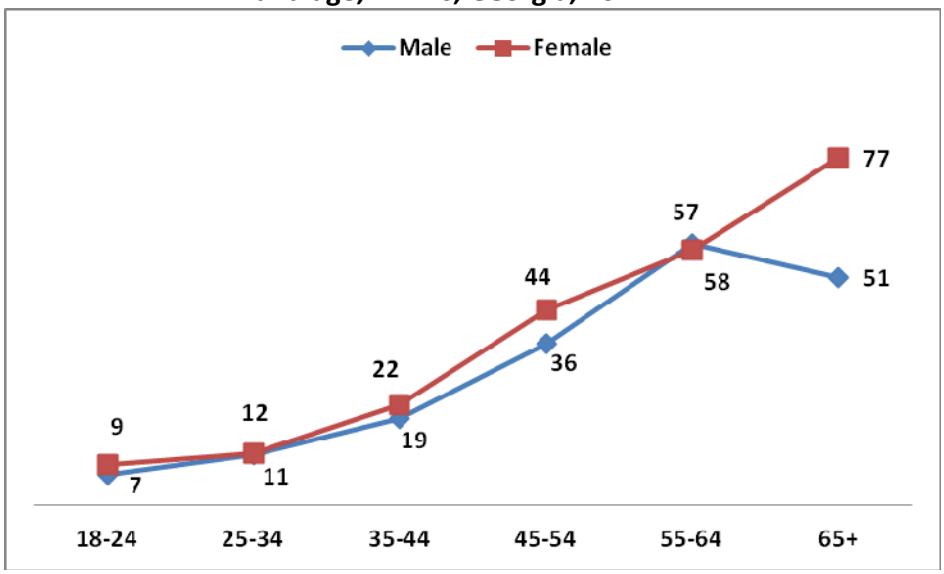
Second stage hypertension (160/100mmHg) according to the national hypertension guideline was detected among 27.1 per cent (male-27.4% and female-27%) who do not take any medication. The prevalence was approximately the same among both sexes in the age group of 18-34; in the age group of 35-64 the prevalence was higher among male and among those older than 65 years, prevalence was higher among female.

Chart 30: Hypertension (≥160/100 mmHg, without medication) prevalence by sex and age, IFDMs, Georgia, 2011-12



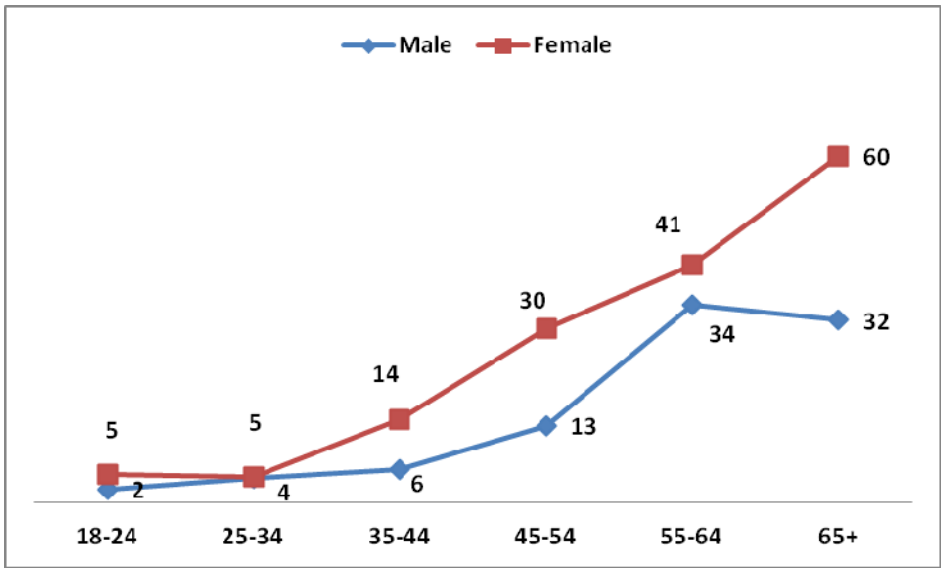
Having a blood pressure 160/100mmHg or being on treatment was confirmed by 38.4 per cent of respondents (male-34.3% and female-41.4%). Hypertension prevalence is rising with age, which also indicates that even though compliance with treatment process increases with age, still the prevalence of hypertension is higher among the elder age. Prevalence is almost the same among both sexes in the age group of 18-34; it is the highest among female of the age group of 35-54 and 65; among the age group of 55-64 the prevalence is a bit higher among male.

Chart 31: Prevalence of hypertension (≥160/100mmHg) or being on medication by sex and age, IFDMs, Georgia, 2011-12



24.7 per cent of respondents (male-17.7% and female-29.7%) have been treated for raised blood pressure with medication prescribed by a doctor or other health worker during the past two weeks. This figure grows with age. There is almost no difference among male and female in their younger ages (18-34); from the age of 35, prevalence of respondents taking antihypertensive treatment is much higher among female than it is in total.

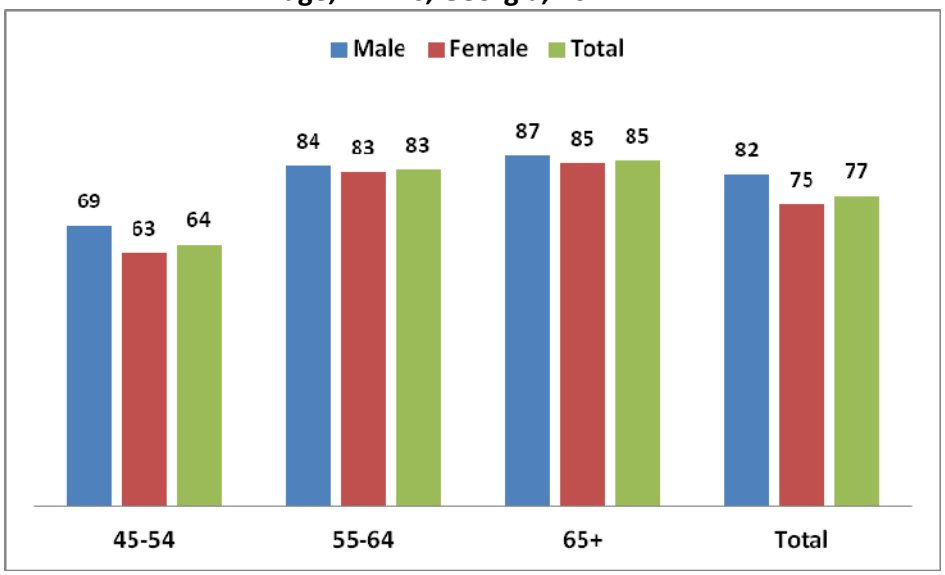
Chart 32: Prevalence of antihypertensive treatment by sex and age, IFDMs, Georgia, 2011-12



Among those being on antihypertensive treatment prescribed by a doctor or other health worker during the past two weeks, 76.5 per cent (male-81.9% and female-74.5%) of

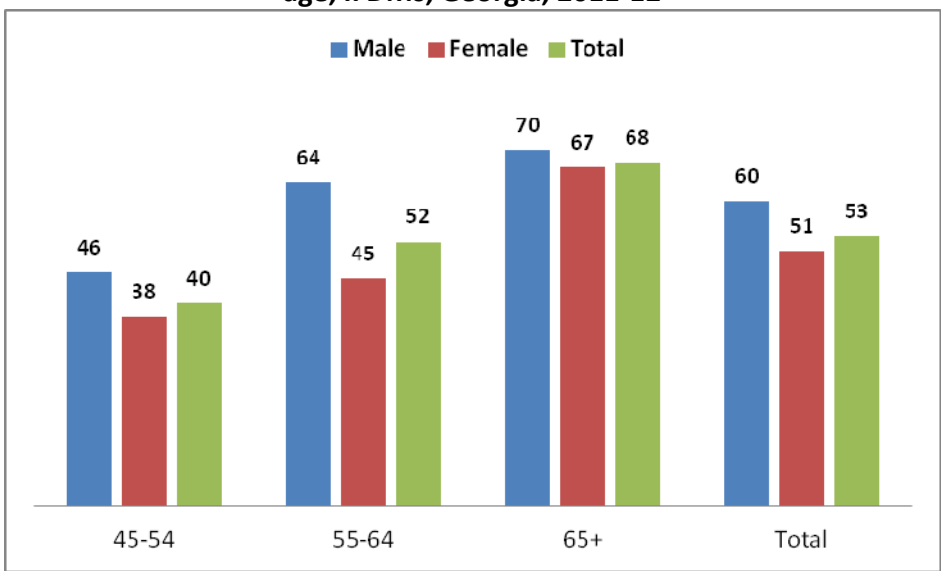
respondents still have hypertension (≥140/90mmHg). The situation is identical among both sexes.

Chart 33: Prevalence (%) of uncontrolled hypertension (≥140/90 mm Hg) by sex and age, IFDMs, Georgia, 2011-12



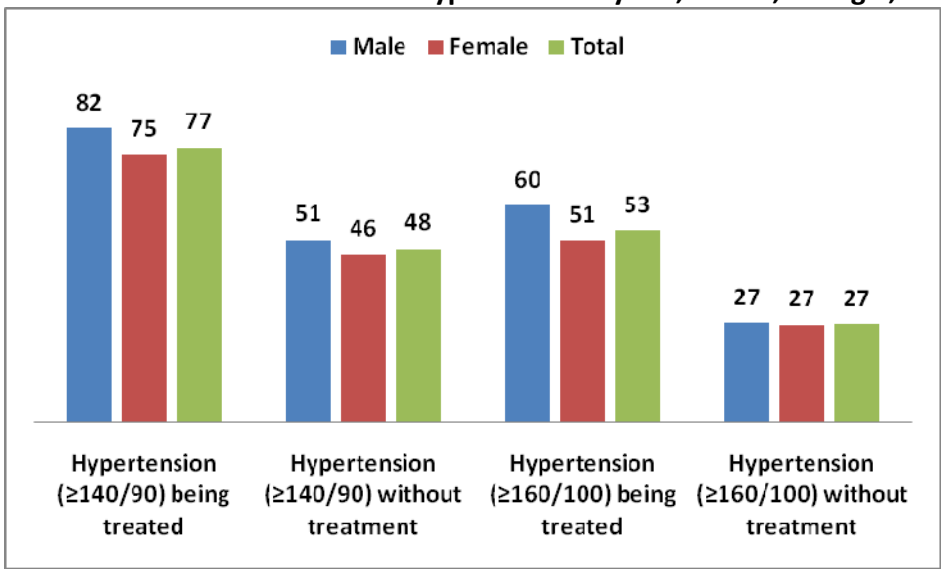
53.3 per cent (male-60.2% and female-50.5%) of respondents being on antihypertensive treatment prescribed by a doctor or other health worker during the past two weeks have second stage of hypertension (≥160/100mmHg). The number of male in all age groups carrying uncontrolled hypertension is higher. Female are more compliant to treatment than male are.

Chart 34: Prevalence (%) of uncontrolled hypertension (≥160/100 mm Hg) by sex and age, IFDMs, Georgia, 2011-12



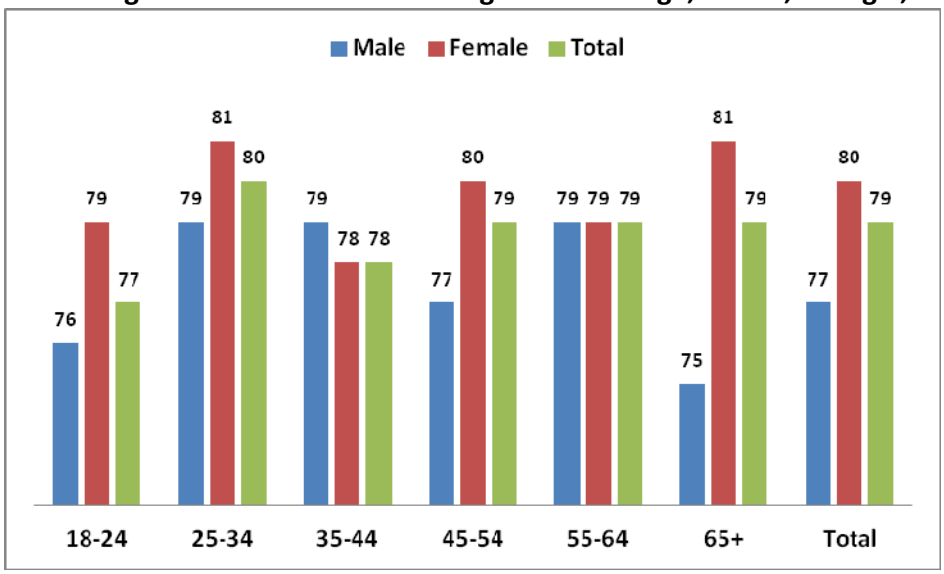
If we compare hypertension prevalence among the respondents being on antihypertensive treatment prescribed by a doctor or other health worker during the past two weeks to the analogue figures among those who do not take any medication, we could see that hypertension prevalence is higher among those respondents that are on treatment. The figures of uncontrolled hypertension, even when treated are alarming and highlight absence of proper hypertension management among IFDMs.

Chart 35: Prevalence of uncontrolled hypertension by sex, IFDMs, Georgia, 2011-12



Pulse among both sexes amounts up to 79 beats (male-77 and female-80) per minute.

Chart 36: Average heartbeat rates according to sex and age, IFDMs, Georgia, 2011-12



Physical measurements

The average height among male (174.3cm) was higher than among female (162.1cm). These numbers are the highest among the age group of 18-24 and decrease with age.

The average weight among male (80.8kg) is higher than among female (72.6kg).

BMI is 27.2 (male-26.6 and female-27.6); it rises with age. The highest figures are detected among the age group of 45-54.

Table 3: Mean BMI by sex and age, IFDMs, Georgia, 2011-12

	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65+	Total
Male	23	26	27	28	28	26	27
Female	21	25	28	31	30	29	28
Total	22	25	28	29	29	28	27

According to BMI, four groups were distinguished. For both sexes, the biggest group 36.9 per cent (male-37.7% and female-36.3%) consisted of people having normal weight (BMI=18.5-24.9). Prevalence of underweight (BMI<18.5) among both sexes was 2.1 per cent (male-0.6% and female-3.1%). 35.6 per cent (male-43% and female-30%) are overweight (BMI=25.0-29.9). 25.4 per cent (male-18.7% and female-30.4%) are obese (BMI>30.0).

Chart 37: Distribution of normal, overweight and obesity among male by age, IFDM, Georgia, 2011-12

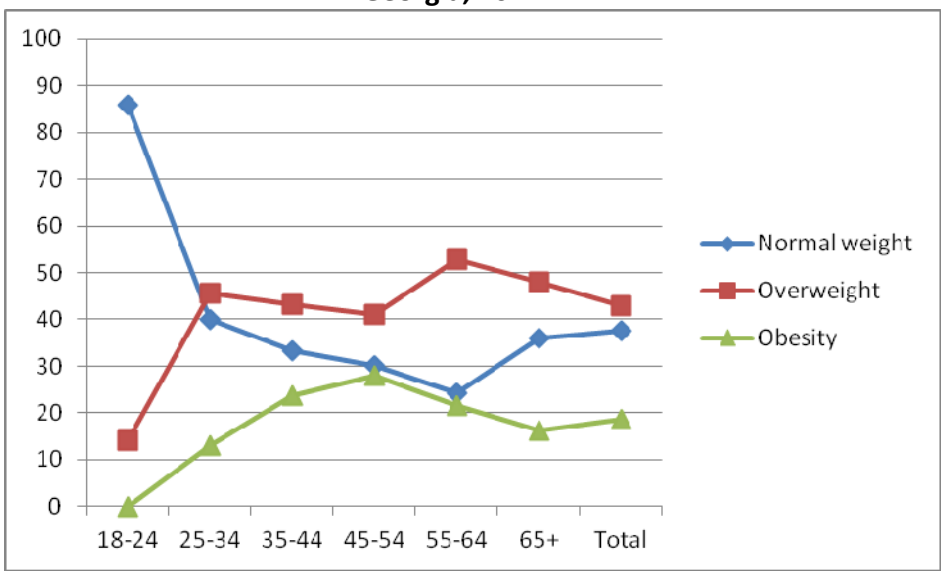


Chart 38: Distribution of normal, overweight and obesity among female by age, IFDMs, Georgia, 2011-12

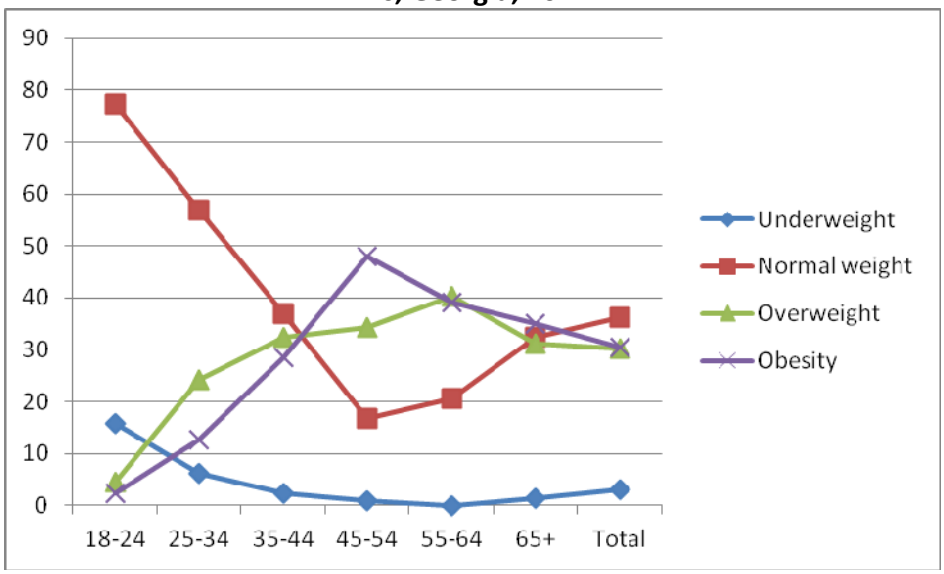
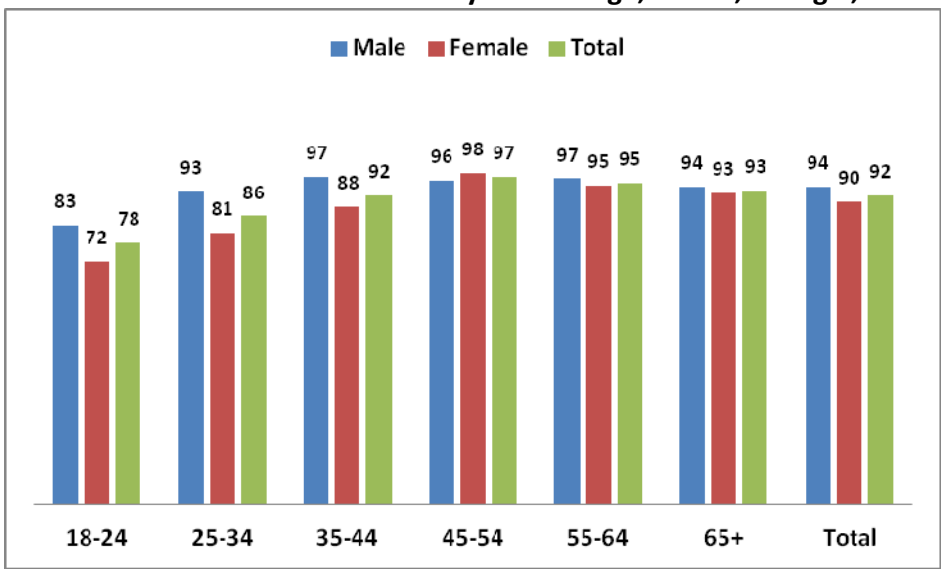


Table 4: BMI among both sexes by age, IFDMs, Georgia, 2011-12

	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65+	Total
Underweight	8%	4%	2%	1%	1%	1%	2%
Normal weight	82%	50%	36%	23%	23%	34%	37%
Overweight	9%	33%	36%	38%	45%	38%	36%
Obesity	1%	13%	27%	39%	31%	27%	25%

Mean waist circumference was 91.6cm (male-94.1cm and female-89.7cm).

Chart 39: Mean waist circumference by sex and age, IFDMs, Georgia, 2011-12



MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

Three types of prevailing needs became apparent mainly. 41.1 per cent (n=547) of interviewees outlined that **betterment of infrastructural environs** of their settlements, would it be a collective centre and or an individual dwelling, is a prerequisite for improvement of general psychosocial well-being of the community. “We live in a swamp, our dwellings are damp, walls are literally “crying”, rain comes into our houses and this dampness destroys our health, causing moral and psychological damage”. Moreover, reports of surveyed comprise and refer to the needs such as building schools, kindergartens, children playgrounds, public squares, recreational centres and clubs as well as provision of respective equipment and accessories such as books for the library, for instance. “Fixing water supply system and building / repairing plumbing system and bathroom fitments is needed”; “fixing windows, roof and balcony is vital”. In addition, respondents outline the requirement for building the hospital either a medical facility and ask for the presence of a doctor in the community. “There is no ambulatory; the kindergarten is far away”. Some respondents were pointing to the necessity of “solving the problem relating to the lack of transportation means, increasing pensions, provision of benefits for transport and communal services (implying monthly pecuniary allowances or beneficial tariffs for transport, gas and electricity) as well as increasing healthcare access via improvement of the policy services”.

Another major issue of concern relates to the need of constructing roads (fixing roads within the settlements and those leading to the land plots). In this regard, the need for constructing communication and illumination systems, building a fence and storage facilities as well as distributing land plots was highlighted, in light of the humane aspiration for healthier future. Subsequent to witnessing the violence and direct effects of war, IFDMs are all the more “longing for peace”.

38.1 per cent (n=507) of surveyed prioritized issues regarding **unemployment**, the lack of descent remuneration for their labour as well as lack of humanitarian aid. “We are short of firewood and humanitarian packages containing groceries”; “First of all, for me the priority need is employment. I am a widow and am responsible for raising my children”.

Simultaneously, **the problem of reconciliation with national, communal, human and property losses** seems to be generally unsettled. The IFDMs believe that a sole option for really improving their community well-being is the return to homeland. “I wish I could see my courtyard once again, before I die”; ”First of all, the return to homeland! Further on ensuring the respect for human rights of migrants. We are forgotten and abandoned by everyone!”

Data on (n=231) of surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

The majority of surveyed, 60.4 per cent (n=803) confirmed that the community of IFDMs “cohesive fairly enough”, however, only a few pointed to relations with local populations. In order to facilitate and intensify internal as well as external interactions of the community, 4.6 per cent (n=62) of respondents suggested improvement of social infrastructure with particular reference to the need of constructing and opening factories and production facilities. On the other hand, “creating community-based organizations (CBO) aiming at empowering women and appointing a community representative would be conducive for improving external and internal

communication; this would be quite helpful for overcoming isolation". Other statements were calling upon "peace, unity, mutual trust and governmental support".

Close to 5 per cent (n=66) of surveyed were either not cognizant on the given subject or were pointing to their discontent since "habitually, interaction among community members is low and it would be much better if inhabitants of one village were settled densely"; in addition, it was stated likewise that "tensions rise among neighbours due to unfair allocation of grants by humanitarian organizations" and that "relations even between family members can easily be damaged when families find themselves in hardship".

Data on (n=398) of surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

Notwithstanding a more or less clearly identified suggestions for psychosocial responses, the majority of respondents, 63 per cent (n=839) demonstrated the lack of initiative, passiveness and inability to come up with specific ideas regarding potential initiatives based on community-based participatory approaches. Nevertheless, the minority, 8 per cent (n=107) have incidentally proved about their readiness "to do whatever needed / anything possible" for improving social infrastructure and directing their own efforts towards this goal. The special reference was made to the importance of "dealing with feelings of envy" and proposals related to organizing joint events, such as "baptizing among communities" to facilitate interaction and cohesion between the IFDMs and local residents. In addition, indications were made to the abilities for tutoring services, which could be utilized as a self-empowerment by means of empowering others and for facilitating development in case the relevant incentives are put forward.

Data on (n=380) of surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

Psychosocial conditions

Slightly over the half of surveyed, 51.4 per cent (n=684) report general irritability, depressive mood and abusive language while experiencing temporary feelings of uneasiness. In addition, respondents referred to definitions such as "feeling bad or sick, being hard up, crying, shouting and fighting, to be in pain, to be placed in unbearable conditions and calling on for God's, mother's or someone else's help". Expressions relating to existential crisis were sounded likewise, such as "why I was born at all?", "The prospect of being buried here is scaring". The fewest have mentioned about writing poems when feeling nostalgic for homeland. Certain quantity of respondents defines these sensations as psychosomatic experiences, such as "sleeplessness, anxiousness, nervousness, moodiness, aggression towards oneself and surrounding people – for instance, shouting at family members, hopelessness, neurosis, depression, sadness, worries, withdrawal and oppression, headaches, waist pain, heaviness in the chest and heart area (especially while observing their houses on the Occupied Territories through binoculars or via Internet), heart and health related problems, tiredness and general fatigue". Considerable number of surveyed defines feelings of sadness as "nostalgia for homeland". "I am always at home in my dreams"; "Our lives here are pointless. How long should it last? We became ill due to nervousness"; "Each morning I have the feeling that I am going back home; I miss everything, graveyard of my ancestors and our sanctuaries". One respondent described this condition even more picturesquely: "We don't have a Fatherland neither a

Motherland; all we have is the Orphan Land". In their words, IFDMs are "dreaming about birthplace and native land" are "longing to return and languish for the taste of fruits" that they used to enjoy in their own gardens.

However, not everyone tends to refer to any wording, mentioning that "while feeling sad", they usually "appear to be gloomy". The fewest mentioned about their tendency to falling into sleep, which could be interpreted as a sign of escapism that gravely influences abilities either willingness of an individual to connect with the world meaningfully. Conversely, only the minority 1.8 per cent (n=25) state the opposite, affirming on "being optimistic". It has to be noted hereby, that simultaneously the fewest of those are not cognizant on the given matter.

The majority of interviewed confirm that these gloomy feelings are spread widely in their community and that they personally experience occurrences of uneasiness, which is rather of a permanent than a temporary nature. "Each gathering begins with a toast for homeland". The fewest reject these obviously acknowledged and loudly voiced sentiments - they are not certain on the given issue or mention that they witness appearance of these feelings in themselves somewhat rarely.

Table 5: Levels of pain associated with memories relating to traumatic experiences, IFDMs, Georgia, 2011-12

Pain level	Abs. number	%
1	12	0.9%
2	40	3%
3	57	4.2%
4	43	3.2%
5	125	9.4%
6	101	7.5%
7	122	9.1%
8	229	17.2%
9	83	6.2%
10	208	15.6%

Six per cent (n=80) of surveyed didn't have an answer.

Data on (n=229) of surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

Touching upon the causes that foment these gloomy feelings, more than a half of interviewed 56 per cent (n=745) specify the three types of interrelated causes that underlie the given discomfort. These basic motives are related to **the human and material losses, migration and war, unemployment and current economic constrains**. IFDMs lament concerning "deprivation of private property and belongings, absence of financial means at the new places and inability of self-realization, which causes depression eventually"; "We had everything there, gardens full of fruit, vegetables, and the cattle, but now, we have to worry about everything"; "We left behind the history and resting places of our deceased ancestors".

It needs to be noted that some of respondents experienced displacement for the second time throughout their lives. In this context as well as in general, references were made to personal

tragedies of families due to losses of loved ones, mostly related to the issue of grief, loss, unfinished mourning as well as changes in the mentality of people caused by migration itself. Personal tragedies of interviewed are also related to such miserable events of war as captivity and inhumane violence. In addition, feelings related to nostalgia and longing to return supplement the above mentioned negative experiences. The special reference was made to untroubled existence when residing in native villages and to the constant dreams about home as well as reminiscences on migrants' abilities to lead descent and high-quality life by self-employment. All in all, causes pertaining to social change and respective chain of its consequences are of a complex nature.

The above mentioned is followed by references to somatic complaints and worsening of health outcomes 12.1 per cent (n=161) due to migration per se as well as inability to afford timely and appropriate responses mainly due to the incompleteness of services available through the policy. The respondents have pointed to aggravation of such health conditions as "stroke, brain sclerosis and heart problems, elevated blood pressure, digestive problems, pain in the stomach and limbs, neurosis and headache". In addition, worries related to health conditions of family members constitute the basis for permanent anxiety and distress. In view of this, anxiousness, aggressiveness and inability to manage oneself fuel the given discomfort further.

2.1 per cent (n=29) are either unaware or didn't have an answer.

Data on (n=394) of surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

Psychosomatic conditions

Since the 2008 August crisis and subsequent displacement, reportedly, health conditions were aggravated among IFDMs: the majority of respondents, 49.6 per cent (male-43.5% and female-54.1%) complain concerning headaches; 44.9 per cent (male-34.2% and female-52.9%) refer to chronic fatigue and loss of energy; 41.8 per cent (male-34.8% and female-46.9%) mention about somatic complaints (such as headaches, stomach, heart or breathing problems); 40.7 per cent (male-32.4% and female-46.8%) point to the problems with elevated blood pressure and 39.1 per cent (male-34.7% and female-42.4%) had difficulties with aggravation of chronic/non-communicable diseases. Health problems increase with age and are considerably prevalent among female.

Psychological problems

Psychological problems following the 2008 August crisis and subsequent to displacement were confirmed to an even larger extent: 71.4 per cent (male-66.3% and female-75.2%) are overwhelmed by worrying thoughts about the conflict, displacement and migration for 24 hours; 71.3 per cent (male-71.6% and female-71%) are getting angry more often and losing control; 63.5 per cent (male-56.9% and female-68.2%) often experience bad mood; 60.4 per cent (male-39.5% and female-75.8%) often feel sad or want to cry; 57.7 per cent (male-51.7% and female-62.2%) are disturbed due to waking up at night and finding it hard to get back to sleep because of thoughts and worries; and 51.2 per cent (male-43.7% and female-56.9%) are having trouble with going to sleep.

Similarly to the aggravation of health conditions, psychological problems are considerably prevalent among female. It is worth noting that mostly the above-mentioned problems are significantly widespread among the age group of 25-34, which is of a particular concern.

Individuals, paraprofessionals, professionals and facilities that IFDMs refer to for relieving their problems of psychosomatic and psychological nature

Aiming to relieve the enumerated problems, IFDMs usually approach their neighbour, a friend or a relative (63.1%, male-63.1% and female-63.1%). In order of descending sequence, policlinic is the most common place of reference for 7.2 per cent (male-7.2% and female-7.2%), followed by the emergency health service (6.8%, male-5.5% and female-7.7%) and by a nurse post (5.2%, male-4.7% and female-5.7%); with fewest reports confirming about references to the hospital (5%, male-6.6% and female-3.9%); clergyman (4.1%, male-2.7% and female-5.2%); the local pharmacy (2.9%, male-2.3% and female-3.3%); a psychologist (1.5%, male-1.1% and female-1.9%); a psychiatrist (0.7%, male-0.4% and female-0.9%); local community worker (0.4%, male-0 and female-0.6%); and finally, the NGO worker or a mobile clinic (0.3%, male-0.2% and female-0.3%).

Cultural practices and bonds with the native country

Almost all of interviewed confirmed that they keep following their cultural practices, such as traditional beliefs, customs, rituals and lifestyle without hindrances individually as well as on the community level. It was stressed that observing traditions and family customs facilitates empowerment and strengthening of the community on the whole. “Our customs are not forgotten. Villages are competing with each other in preserving traditions.” The fewest mentioned however that they are not willing to be involved in practicing cultural traditions due to “the lack of genuine and sincere joy, which flows directly from heart and which is of vital importance in such case”. “Each ritual had the special meaning when being practiced in the village of its origin, so they lose meaning outside our homeland”. It has to be noted that the virtual connection by means of Google Earth, Internet and simple binoculars allow the displaced population to observe their native land and houses of worship on a daily basis. Notwithstanding the heart-warming connotation of this occurrence, its continuity is detrimental to the process of recovery from possibly traumatizing experience due to repetitive connection with the principal source of stress.

Unlike many other settlements covered by the Survey, residents of Tsilkani settlement confirmed that they continue keeping ties with their place of origin, with the majority of the interviewed 79.8 per cent (n=83) providing respective confirmation. The reason for this possibility consists in the fact that most residents of Tsilkani arrived from Akhalgori district (the part of the Occupied Territories which is accessible by its former residents)[33].

The frequency of sharing memories among family members, children and neighbours is quite high with the overwhelming majority of respondents defending this notion. “We are thinking of it even at night. We are reflecting on what we were and what we are currently”. “I would prefer to live in a box there rather than having a castle here, but what can I do?” “There is not a day that passes without remembering our gorge”. Memory-sharing episodes particularly with children mostly contain compulsory implications due to such argumentation as “they have to

[33] These figures depict majority of respondents that were interviewed in Tsilkani settlement in particular.

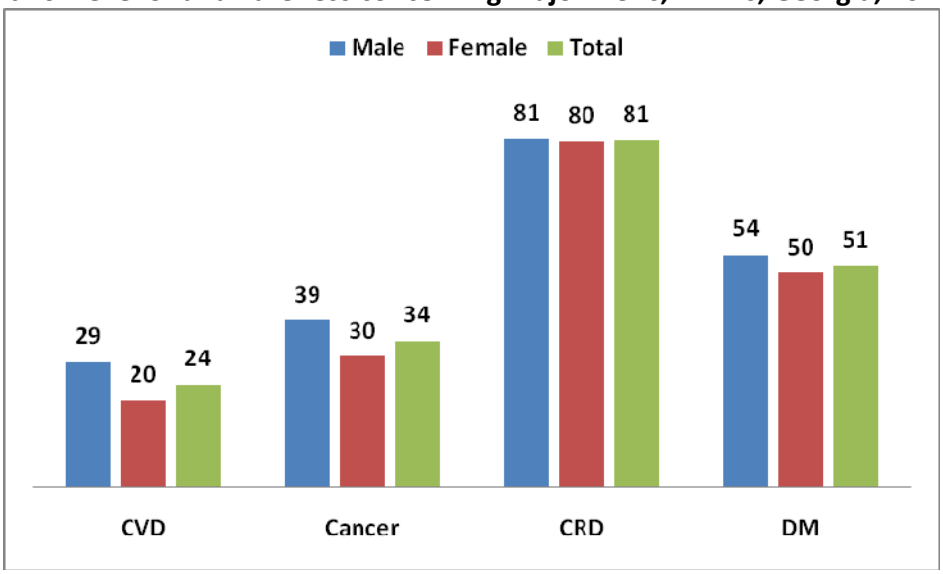
remember where they come from". The given nature of memory-sharing as well as the recurring returns to the places of origin (both physically and mentally) create the foundation conducive for hindering the recovery and trauma coping processes, developing condition of complicated grief and transcending of traumatic experience through generations[34]. Only a few of interviewees declared that they avoid bringing up issues pertaining to their homeland with children on purpose, to avert the reawakening of unpleasant thoughts. It has to be noted likewise that some of the displaced are "writing poems about native places", which points to the origin of the poetry and creative works relating to "displacement and migration" per se.

KNOWLEDGE, ATTITUDE AND PRACTICES TOWARDS NCDs

Knowledge on NCDs

76.4 per cent of respondents (male-71.1% and female-80.2%) have mentioned CVDs as the prevalent NCDs in Georgia. 66.2 per cent of respondents (male-61.4% and female-69.8%) have mentioned cancer; only 19.2 per cent of respondents (male-18.9% and female-19.6%) have mentioned chronic respiratory diseases (CRD) and 48.6 per cent of respondents (male-46% and female-50.3%) have mentioned diabetes mellitus (DM) as the prevalent NCD in Georgia.

Chart 40: Level of unawareness concerning major NCDs, IFDMs, Georgia, 2011-12



23.4 per cent of respondents (male-24.2% and female-22.8%) were wrong while mentioning HIV/AIDS as the prevalent NCD in Georgia, whereas 17.2 per cent of respondents (male-18.1% and female-16.6%) were wrong while mentioning hepatitis and 45.1 per cent of respondents (male-42.6% and female-46.9%) while mentioning flu as the prevalent NCD in Georgia.

Other NCDs as prevalent in Georgia were mentioned by 15 per cent of respondents (male-14.8% and female-15.1%); 44.9 per cent (male-40.7% and female-48.1%) supposed there are no more

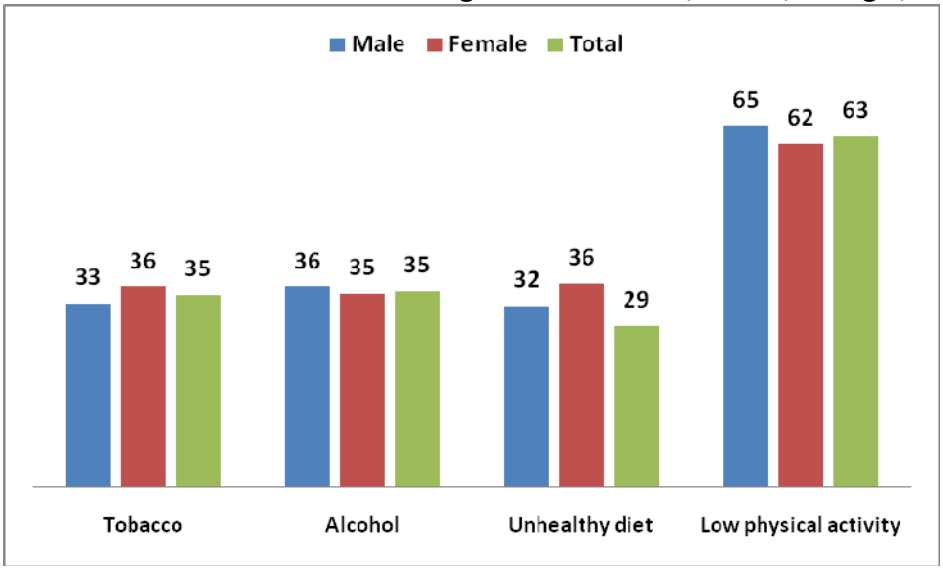
[34] The Harvard Medical Health School, Family Health Guide; Complicated Grief (December 2006). Available from: http://www.health.harvard.edu/fhg/updates/Complicated-grief.shtml

such diseases and 40.1 per cent (male-44.5% and female-36.9%) did not have an answer to this question.

Knowledge on NCDs risk factors

Tobacco as one of the risk factors of NCDs was named by 65.5 per cent of respondents (male-67.2 per cent and female-64.1%); excessive use of alcohol as one of the risk factors of NCDs was named by 64.8 per cent of respondents (male-64.1% and female-65.3%); unhealthy diet as one of the risk factors of NCDs was confirmed by 71.1 per cent of respondents (male-67.6% and female-73.6%); physical inactivity as one of the risk factors of NCDs was named by 37.2 per cent of respondents (male-35.2% and female-38.5%).

Chart 41: Level of unawareness concerning NCD risk factors, IFDMs, Georgia, 2011-12



Negligence of hygiene norms as one of the risk factors of NCDs was wrongly deemed by 41 per cent of respondents (male-38.7% and female-42.9%); unsafe sex practice as one of the risk factors of NCDs was wrongly mentioned by 30.1 per cent of respondents (male-28.5% and female-31.4%).

Knowledge on major risk factors is low especially regarding low physical activity among both sexes.

Attitude on NCDs

In view of preventive measures and ways to avoid contracting NCDs, considering priority sequencing, 58.6 per cent (n=780) identify such broad categories as peace in the country, healthy lifestyle, proper diet, improvement of social and economic conditions, getting rid of anxiety and resisting to the influence of four major risk factors of NCDs. References were made likewise to the necessity of avoiding public gatherings and places, adherence to hygiene norms and cautiousness. Importance of caring for environment, ability for positive thinking, decreasing salt intake, adhering to the relevant dietary habits for managing diabetes and avoiding carrying

heavy load was mentioned as well. “As long as there is a job I can be busy with, problems could be solved easily”.

Only the tiny minority 3.2 per cent (n=43) of interviewed prioritize the requirement of preventive screenings and consultations with doctor on a regular basis, at least twice per year. Accordingly, it is reckoned that one should follow the prescription given by a doctor strictly and should be persistent enough to be able to withstand the influence of a disease. However, respondents mentioned likewise that all necessary precautions should be taken to avoid visiting non-professional physicians. In spite of demonstrating awareness it is uncertain whether the respondents really implement their words in practice though. 2.1 per cent (n=28) of respondents offered such conditional and predictive statements as “if circumstances were conducive, I would not worry at all; “if I would have enough financial means, I would be able to protect my children from this threat”; “I am not able to afford essential medicine to control my blood pressure”. In addition, those interviewed tend to believe that “the illness resembles the fate. Consequently, one cannot escape what is already written up there”. 10.4 per cent (n=139) were not aware either not able to avoid contracting NCDs and pointed to regrets concerning aggravation of their health outcomes due to inability to practice preventive measures. “We are not able to clean the air and the environment”; “Any action is belated since I am already sick”.

Data on (n=339) of surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

As it was assumed, overall majority of interviewed do not have experience of practicing preventive measures; moreover, some respondents point to such misleading notions as “awareness on prevention of influenza”. On the other hand, implying possession of the respective experience, those interviewees confirmed on the subject of worsening in their health outcomes due to nervousness and unwanted changes caused by consequences of forceful displacement. “Yes, I have contracted diabetes subsequent to war”; “Yes, following war problems with elevated blood pressure emerged”; Yes, I got neurosis since the war happened.” However, the minority confirms on the subject of practicing preventive measures, by giving such examples as “regular health check-ups, selectiveness when it comes to the issue of groceries’ purchase”; “trying to be physically active as much as possible”; “I gave up smoking tobacco for already 18 years and am encouraging surrounding people to follow my example”.

About 27 per cent (n=381) of surveyed considers hypertension being a temporary occurrence, “which necessitates constant treatment and attention, since it can easily cause a lethal outcome if drugs are not taken in a timely manner.” Whereas nearly 48 per cent (n=638) believe that a raised blood pressure is a disease, “which is a permanent condition and necessitates medication constantly, even though it is subject to control, yet it is still not easy to fight this phenomenon”. Small number of interviewed, six per cent (n=83) were unaware of any of the options proposed above or were uncertain on the given issue and made dubious comments: “It depends” “Could be both”.

Data on (n=227) of surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

For treatment of high arterial blood pressure the overwhelming majority of respondents, refer to taking the relevant medication or resorting to the traditional remedies such as hot foot bath

and cold vinegar applications on the back of the head. It is worth noting here that the referral to emergency services, primary health care personnel or a family doctor for alleviation of the given severe health condition was mentioned somewhat rarely. In addition, notwithstanding whether the surveyed considered the hypertension being a temporary occurrence or disease, the irreversible necessity of medicine intake has been equally confirmed. It is noteworthy that the given finding emerged in the last pharmaco-epidemiological Survey carried out among general population of Georgia, stating likewise, that taking medication is crucial for treatment of hypertension[35][36]. However, by the "treatment process", IOM NCDC Survey respondents implied the episodic decrease in arterial blood pressure (which is thought to be a major deficiency), opposed to the desirable knowledge about the planned and continuous treatment process, aiming at prevention of disease exacerbation and its potential risk factors.

Interestingly, while talking about the attitude towards the care for a person suffering from NCDs, again the overall majority of respondents emphasized the necessity of rendering psychological and family support to the victim, "taking care of him, ensuring proper and timely medicine intake as well as diet regime, being attentive and providing all-inclusive nursing". Very few mentioned about the necessity of wearing surgical disposable face mask. Habitually, out of ignorance, respondents were associating the given state of health with the lethal condition of the victim and were pointing to the necessity for palliative care respectively. The given finding justifies critically poor awareness and wrong perception on the ability to manage NCDs efficiently, while simultaneously ensuring continuity and quality of the life lived. In addition, this particular finding proves once again the lack of motivation among patients towards the prolonged treatment process, which is thought to be the typical feature inherent to the general population and is being caused, among other contributing factors, by inertness of the medical personnel in view of health promotion. Therefore, not surprisingly, only a very few responses implied requirement of involving a doctor in the process of treatment per se.

The trust-related aspects towards healthcare workers were positively assessed by 69.4 per cent (n=923) of interviewed, whereas at about 54.4 per cent (n=723) confirmed their confidence towards the state healthcare system. "Our doctors are well educated, are always trying to alleviate patients' condition and are attentive enough". "Gori hospital is very good; there are well-qualified healthcare workers in Tbilisi likewise". "I like the healthcare system but it applies to Tbilisi only". "Hospitals are of a high-quality". "When I needed medical assistance, the policy has covered everything my family needed". "If one has enough money, treatment is available". However, some of these contented reports also outline the importance of expanding the coverage of costs for medicines by introducing respective amendments into the policy. It was mentioned as well that "the healthcare system should pay more attention to education of doctors" and that "it's good to see opening of so many new hospitals, which hopefully would be conducive for making free treatment services more affordable".

Conversely, about 8.2 per cent (n=109) of respondents confirm on the opposite. Mainly complaints relate to the lack of affordability of healthcare services and essential medicine as well as either dissatisfaction relating to the policy due to its incapacity to cover essential services or the entire absence of this benefit. "Nobody speaks about the Hippocratic Oath anymore. Unfortunately, the medicine and doctor's services turned into the mere trading business and

[35] Assessment of NCD Prevention and Control Mechanisms in Primary Health Care (WHO / NCDC&PH, Georgia, 2009).
[36] Non-communicable Diseases Risk Factors (STEPS) Survey (Georgia, 2010).

profit-making". "Medicines are pricey and sometimes outdated". "Health access and affordability is an issue nowadays" and "those holding the policy are not treated attentively". Disillusioning stems from the lack of competence among healthcare professionals, as stated by some of interviewed while addressing different specialists for one and the same health problem and receiving controversial diagnoses from them. They added as well that "Medicines are extremely expensive and the system is by no means is far from being tailored to the needs of those suffering from chronic non-communicable conditions".

13.6 per cent (n=182) were either not cognizant on the given subject or did not have an answer.

Practices on NCDs

Over the half of surveyed, 58 per cent (n=784) are either unaware or find it difficult to specify concrete ways to avoid contracting NCDs, or encounter difficulties in adherence to these preventive measures in spite of their willingness to do so. About 20 per cent (n=269) of interviewees specified on such broad categories as requirement for increasing the responsibility of the government and enhancing respective support coupled with the special appeal to enhance quality control on food products; ensuring employment opportunities; striving for the betterment of economic conditions and increasing the benefits for social services; guaranteeing peaceful co-existence and healthy environment for all; increasing taxes on alcohol and tobacco products.

Only a tiny minority of interviewees 2 per cent (n=32) consider that timely practice of preventive screening (at least twice per year) as well as referral to doctor for advice and regular check-up are the best ways for managing and preventing NCDs. Fewest of those have mentioned that they already practice these measures by controlling arterial blood pressure, as well as consuming relevant medicine and undergoing diabetes treatment by insulin.

Data on (n=244) of surveyed is missing, either due to the fact that they skipped the question or due to their unawareness on this subject.

As for the referral to healthcare facilities, more than a half of interviewed, 52 per cent (n=703) point to dissatisfaction and confirm that they rarely refer to the primary healthcare services. Some of them added that the referral takes place only in case of emergency. Financial constrains and inability to afford the prescribed medicine was considered as the main impediments to the referral, which is why medical facilities are approached rather rarely. Interviewees were dissatisfied due to the "lack of attention and negligence", especially when referral concerned the issue of NCDs. Considerable minority 22.1 per cent (n=294) pointed to their satisfaction and confirmed that no major impediments were encountered while approaching the medical facility for respective assistance. However, even among those being satisfied, complains were sounded pertaining to the costs for medical investigations, treatment and medicaments as well as discontent due to the inability of a doctor to provide accurate diagnosis.

Fewer 7.7 per cent (n=103) are either unaware on the given subject or have not resorted to the referral services due to the lack of need.

Data on (n=229) of the surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

When inquired whether the respondents are prone to yield to the risk factors of NCDs, the majority confirmed that they lack willpower to resist these negative influences and or ability to manage oneself. However, respondents declared on their intention to intensify their abilities to avoid the major four risk factors; references were made to their efforts directed to reducing salt intake and eating sweets. Conversely, the minority corroborated regarding their incapacity to refuse negative but appealing influences of these risk factors. More precisely, the interviewed confirmed on consumption of tobacco and alcohol, inability to get rid of permanent anxiousness, and engagement in heavy physical work (carrying heavy loads, for instance).

Pertaining to the subject of changing behavioural habits, fortunately, most of the surveyed confirmed their ability to change them. Considerable amount of reports referred to such conditional statements as “if I am back to homeland, I change immediately”. “If need be, I quit tobacco”. It was noted that “combating poverty, displacement and threat of war in the country” is of a primary importance for this purpose. Approximately 20 per cent of interviewed defend thoroughly opposite opinion though. It was mentioned that due to economic constrains and permanent nature of oppressive circumstances, there is no option other than yielding to risk factors. Hereby, it should be noted that particular reference was made to “inability to refuse tobacco and alcohol consumption, decreasing salt intake and controlling one’s weight”. “It is impossible to change a person” and actually “there is no need to change, since the worst has already happened” (referring to the presence of incurable disease). The fewest have mentioned about the uselessness of this proposition due to their elder age.

And finally, while being asked about the likelihood of adherence to the treatment process, most of the surveyed confirmed about their readiness to comply. The respondents declared they would do anything possible even “borrow money for completing what was prescribed by the healthcare worker”. “Patient should give a hand of support to himself by staying obedient to doctor”. “One should follow the path defined by the doctor, if not then self-prescription and self-treatment takes place, which is useless”. In addition, some of those have brought up conditional arguments such as inability to afford the given “obedience” due to financial constrains, lack of trust towards healthcare worker as well as issues relating to the affordability of essential medicine. “I am obedient to doctor but the prescribed medicine is extremely pricey and I am not able to afford it”. Lesser minority is unaware or has pointed to the lack of need for the treatment. On the other hand, some were simply not willing to follow doctor’s prescription due to their “stubbornness” either “lack of willpower”, especially while facing the challenge of completing long-standing prescriptions.

RETURNED MIGRANTS

SOCIAL-DEMOGRAPHIC CHARACTERISTICS

Response Rate

41 returned migrants participated in the Survey. The response rate was 55 per cent.

Sex and age

Among 41 returned migrants, 37 (90.2%) were men and four (9.8%) women. The participants were distributed among five age groups. Most of respondents (34.1%) were individuals of the age of 35-44.

Ethnicity

All returned migrants participating in the Survey were Georgians (94.6%).

Marital status

According to the marital status, six groups were distinguished. The largest group (65.9%) comprised presently married.

Education

Average length of education was 10 years. This index slightly varied according to age groups. Female spent slightly more time on education (11 vs. 10 years).

Level of completed education (the highest education level completed by a participant) was divided into seven levels. Majority of surveyed had the university (48.8%) and complete secondary (43.9%) education.

Occupation

According to the work status, four groups were distinguished. The biggest group (53.7%) was made up of able-bodied unemployed individuals. Self-employed were 24.4 per cent.

One man (2.4%) reported about working in governmental structures; two (women) stated about working for non-governmental sector; and two women reported they are housewives. Among the individuals with unpaid status, one woman was retired and two men were unable-bodied unemployed.

When being asked about their professional activity before migration, the prevailing type of occupation among returned migrants turned out to be the government employee (male – 27%). The second biggest group was comprised of self-employed (male – 18.9%), followed by students (male – 8.1%). Able-bodied unemployed comprised 32.4 per cent of interviewed.

Table 6: Socio-demographic characteristics, returned migrants, Georgia, 2011-12

	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65+	Total
Male	2.7%	32.4%	32.4%	18.9%	13.5%	.0%	90.2%
Female	.0%	.0%	50.0%	25.0%	25.0%	.0%	9.8%
Education							

No formal schooling	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Less than primary school	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Primary school completed	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Secondary school completed	.0%	.0%	.0%	.0%	.0%	.0%	.0%
High school completed	.0%	25.0%	64.3%	50.0%	33.3%	.0%	43.9%
University completed	100.0%	75.0%	28.6%	37.5%	50.0%	.0%	48.8%
Post graduate degree	.0%	.0%	.0%	.0%	16.7%	.0%	2.4%
Marital status							
Single	100.0%	25.0%	14.3%	12.5%	.0%	.0%	17.1%
Currently married	.0%	75.0%	64.3%	62.5%	66.7%	.0%	65.9%
Separated	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Divorced	.0%	.0%	21.4%	25.0%	33.3%	.0%	17.1%
Widowed	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Cohabitating	.0%	.0%	.0%	.0%	.0%	.0%	.0%

Placement in the conflict zone during military activities

Only two returned migrants (men) were placed in the conflict zone during military activities. 59.3 per cent of respondents confirmed that they feel absolutely safe at their place of residence, 29.6 per cent have mentioned they feel relatively safe and 3.7 per cent (one man) felt absolutely unsafe.

Household revenue

According to the average yearly revenue, the households were clustered in five groups. Yearly income of 70.7 per cent of interviewed was less than GEL2,600. Revenues of the few households varied between GEL2,600-5,000 (14.6%) and even fewer reported on yearly income ranging between GEL5,000-10,000 (9.8%); and none of respondents ever mentioned about sums in amount of GEL10,000-20,000. Figures were alarming as about 71 per cent of returned migrants' households reported about the income of GEL217 per month.

BEHAVIOURAL RISK FACTORS (STEP 1)

Tobacco consumption

Current smokers

Currently any kind of tobacco products (smoked and smokeless) was consumed by 65.9 per cent of respondents (70.3% male); one female was a smoker. The difference between the distribution of smoking among men and women was evident.

According to age groups, smoking was most prevalent among 35-44 and 45-54 years of age (78.6% and 75% respectively).

Average age of smoking initiation among daily male smokers was 21 years; the only smoker female started smoking at 37 years of age.

All daily smokers use manufactured cigarettes.

Former smokers

Prevalence and characteristics of former daily smoking was studied. It must be mentioned that the status of a former daily smoker was defined as a daily smoker in the past that does not smoke currently, or smokes occasionally (not daily).
Former daily smokers totalled 63.2 per cent of male population. Three female have never smoked.

Attempt to quit smoking

Over the past 12 months attempts to quit smoking were made by 50 per cent (15 individuals) of ever smoker males. The highest figure (83.3%) of attempts to quit smoking among current smokers was recorded in the age group of 45-54. Among these 15 migrants, two tried medicines (buproprion or tabex), one referred to the smokeless tobacco product.

Alcohol consumption

Lifetime alcohol consumption

Prevalence of lifetime alcohol consumption was very high among male returned migrants and totalled 100 per cent of the entire group of surveyed. Two female among those four who participated in the Survey, have ever consumed alcohol.

Alcohol consumption status throughout 30 days and 12 months prior to the Survey

During the interview the focus was made, on one hand, on the alcohol consumption status based on the timeframe of 30 days, 12 months and, on the other, on the frequency and amount of consumed alcohol, considering the norms recognized by the WHO.

For the last 12 months, prevalence of alcohol consumption totalled 97.3 per cent among male (36 among 37); two females have consumed alcohol 12 months prior to the Survey.

Prevalence of alcohol consumption for the last month prior to the interview amounted up to 83.3 per cent among male (30 among 37 individuals); two female have consumed one month prior to the Survey.

Frequency and amount of alcohol consumption

Most alcohol consumers drink 1-3 times per month (50%), the second frequent answer was – 1-4 days per week (28.9%), then less than once per month – 18.4 per cent.

Male respondents consumed alcohol on six occasions during the last month.

As for the dose of alcohol, male consumed eight standard alcoholic drinks throughout last 30 days during one drinking occasion on average, and female – two standard alcoholic drinks at a time.

Male consumed five or more standard alcoholic drinks in a single drinking occasion, seven times during the past 30 days; no female consumed four or more standard alcoholic drinks in a single drinking occasion during the past 30 days.

Diet

Daily food consumption

Majority of respondents (51.2%; male–51.4%, female–50%) take food three times per day. The second large group of respondents (39%; male–40.5% and female 25%) have two meals per day. 4.9 per cent have four meals per day; 2.4 per cent of surveyed eat once per day.

General structure of food consumption

According to the Survey results, all respondents on average take fewer than five servings of fruit and vegetables per day. All respondents take two servings of fruit and vegetables. Mean frequency of fruit and vegetable consumption was four days per week.

Meat products are consumed on average two times per week, with average two servings. According to the age groups, the difference was insignificant. Meat consumption, as well as number of servings was higher among 25-44 age group.

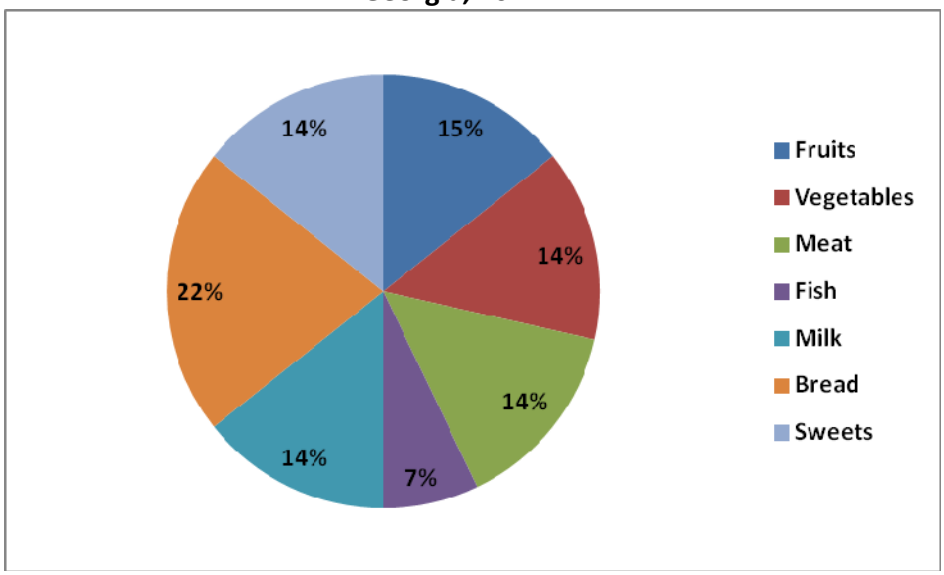
Fish was consumed on average once per week, with one average serving. Fish consumption, as well as number of servings was higher among men than among women.

Dairy products are consumed, on average, three days per week; with average two servings.

Consumption of bread and cereals occupied first place for the food types among the interviewed population – seven days per week and three servings per day.

Level of intake of sweets and products with sugar content was remarkably high. According to the number of consumption days, the given indicator occupied second place following bread and cereal products. The tendency appeared to be the same in terms of consumed servings. The interviewed confirmed that they consume sweets for five days per week. Intake of two servings of sweets was confirmed by male and intake of three servings – by female respectively.

Chart 42: Mean number of servings of consumed products, returned migrants, Georgia, 2011-12



Consumption of less than five servings of fruit and/or vegetables per day and diet-related risks

Diet-related risk was evaluated on the basis of consuming less than five servings of fruit and vegetables. The results of the Survey showed that the whole group of surveyed is facing diet-related risks.

Fat consumption

The most common fat for cooking at home was vegetable oil (95.1% of interviewed). This was followed by the butter, amounting up to 4.9 per cent.

Eating outside

Consumption of food prepared outside is rather low (once per week).

Physical Activity

29.7 per cent of male respondents mentioned that their work involves vigorous-intensity activity, which causes large increases in breathing or heart rate for at least 10 minutes continuously. Vigorous-intensity activities as part of the work are done five days in a typical week; and last up to 387 minutes. None of the women stated that their work involved vigorous-intensity activity.

64.9 per cent of male respondents affirmed that their work involves moderate-intensity activity. Reportedly, moderate-intensity activities as part of the work are done for five days in a typical week; and last up to 214 minutes. Two females confirmed about their involvement in moderate-intensity activity, which means that they work seven days in a typical week for the duration of 135 minutes.

70.3 per cent of male walk or use a bicycle (pedal cycle) for at least 10 minutes continuously to get to and from places. This is done throughout seven days in a typical week; and amounts up to 103 minutes. Two females confirmed on the same; they walk or use a bicycle throughout seven days in a typical week; and the given activity lasts up to 55 minutes.

Only 10.8 per cent of male said they are engaged in vigorous-intensity sports, fitness or recreational activities (running or playing football) that cause large increases in breathing or heart rate for at least 10 minutes continuously. This is done four days in a typical week and lasts up to 112 minutes.

Only 13.5 per cent of male stated about their engagement into moderate-intensity sports, fitness or recreational activities (running or playing football) that cause large increases in breathing or heart rate for at least 10 minutes continuously. This is done throughout four days in a typical week; and lasts up to 84 minutes. One female mentioned about the same; confirming on her engagement into the moderate-intensity sports activity throughout three days in a typical week, which amounts up to 60 minutes.

HEALTHCARE ACCESS

When inquired on what health services are available for their community, majority of returned migrants mentioned about polyclinics and emergency healthcare service (68.3% each), 58.5 per cent - hospitals, 26.8 per cent - a nurse post, 4.9 per cent - NGO service (mobile clinic) and psychosocial services.

Healthcare services are financially affordable for only 13.8 per cent of male respondents. However, none of the female agreed with this proposition.

For 78 per cent of interviewed it takes less than 30 minutes to get to the medical facility, 9.8 per cent confirmed that they have to travel 1-2 hours, 4.9 per cent mentioned about 30 min-1 hour and 2.4 per cent noted that it takes more than two hours to get there. The main type of transport is by foot, a bus and a car (32.5% each).

Awareness on Health Insurance Policy and its Enjoyment

Only one person among the group of returned migrants held the health insurance policy. Apart from extremely low appearance of this occurrence among the given group of respondents, conditions were impeded by the fact that the interviewee purchased the given policy and therefore it did not represent the social assistance mechanism available through the state programming.

CLINICAL HISTORY

History of raised blood pressure

Majority of respondents (75.6%; male-73% and all of four females) reported as having ever measured the blood pressure by medical personnel. The percentage of those who has never checked blood pressure was higher among 45-54 years old male (42.9%).

Hypertension was detected among 61.3 per cent of surveyed (male-63% and two female). Hypertension during the last 12 months was detected among 68.4 per cent (male-64.7% and two females) of returned migrants.

36.8 per cent (male-35.3% and one female) of interviewed are currently receiving medication for high blood pressure prescribed by a doctor or other health worker. 31.6 per cent (male-29.4% and one female) received recommendation to reduce salt intake, 15.8 per cent (male-17.6% and no female) received recommendation on weight loss; none of returned migrants were prescribed to quit smoking and engage into physical activity.

Diabetes history

Majority of respondents, 65.9 per cent (male-64.9% and three female) have never checked glucose concentration in blood. One female only, who is currently receiving insulin prescribed by a doctor or other health worker, reported occurrence of hyperglycaemia during the last 12 months. Intake of oral drugs was confirmed as well, coupled with the specially prescribed diet.

History of other diseases

The first place in the history of diseases was held by myocardial infarction (two male and one female); the second - by high blood cholesterol (one male and one female); followed by a stroke (one female).

Visiting doctors

Inquiry was made on motives and frequency of visiting doctors or other medical personnel throughout last 12 months. The total percentage of both sexes, visiting doctor for the past 12 months amounted up to 32.5 per cent (male-30.6% and two female).

The main reason for visiting doctors or medical staff consisted in a specific health problem (50%); preventive screening was mentioned by 6.3 per cent of surveyed; both above-mentioned reasons were reported by 18.8 per cent, and none of these reasons were specified by 25 per cent of interviewed.

Self-treatment

Reportedly, the interviewees resorted to self-treatment quite rarely, which should be considered as a positive outcome. Only 9.8 per cent of respondents (male-8.1% and one female) confirmed on resorting to self-treatment regarding an elevated blood pressure.

Family history of diseases

When inquired whether their relative (mother, father, sister, brother and spouse and his/her relative) ever been diagnosed on hyperglycaemia or diabetes, high blood pressure, stroke, cancer, hypercholesterolemia, or early myocardial infarction, the majority of respondents (70.7%) mentioned a high blood pressure. Diabetes was confirmed by (26.8%), followed by a

stroke (14.6%), cancer (12.2%), and myocardial infarction (9.8%). None of the interviewed reported about the occurrence of hypercholesterolemia in the family history of diseases.

The figures of lipid profile examinations among respondents were low; the same was shown by the history of diseases of their relatives. This could be explained by ignoring the mentioned lab tests by the primary health care personnel while estimating cardiovascular risk due to the lack of awareness of the latter on the importance of lipid spectrum tests, management of manifested cardiovascular disease and its prevention.

PHYSICAL MEASUREMENTS (STEP 2)

Arterial hypertension, heartbeat rate, weight, height, body mass index, waist circumference were assessed and measured.

Arterial blood pressure and heartbeat

Mean systolic blood pressure among returned migrants was 152mmHg (male-155 and female-131) and mean diastolic blood pressure - 95 mmHg (male-97 and female-82). The highest numbers of systolic blood pressure were detected among 45-54 age group of male – 172mmHg; the highest numbers of diastolic blood pressure were detected among the same age and group.

Blood pressure ≥140/90mmHg (hypertension) was detected among 80.5 per cent of returned migrants (male-83.8% and two female) who do not take any medication.

Blood pressure ≥140/90mmHg was detected among 82.9 per cent of those respondents (male-83.8% and one female) who receive treatment.

Second stage hypertension (160/100mmHg) (according to the national hypertension guidelines) was detected among 43.9 per cent of respondents (male-83.8% and one female), who do not take any medication.

Blood pressure ≥160/100 mmHg was detected among 48.8 per cent of respondents (male-51.4% and one female), who receive treatment.

10 per cent of respondents (male-8.3% and one female) were treated for raised blood pressure with medication prescribed by a doctor or other health worker during the last two weeks.

Pulse among both sexes was 81 beats per minute (male-82 and female-72).

Physical measurements

The average height among male (177.4cm) was higher than among female (160.3cm). These numbers were highest among the age group of 18-24 and decreased with age.

The average weight among male (88.8kg) was higher than among female (70.0kg).

BMI was 28.5 (male-28.3 and female-31.1). The highest figures were detected among the age groups of 45-54.

According to BMI, four groups were distinguished. Among male the largest group (37.8%) was obese (BMI>30.0); 29.7 per cent of people had a normal weight (BMI=18.5-24.9) and were overweight (BMI=25.0-29.9). Prevalence of the underweight (BMI<18.5) was 2.7 per cent. Among four females, two were overweight and the other two were obese.

Mean waist circumference was 102.5cm (male-102.8cm and female-100 cm).

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

Majority of surveyed, 63 per cent (n=26) outlined the needs relating to employment opportunities, as well as social and humanitarian assistance as a priority. “Humanitarian and social assistance is of a primary importance for us. If I would have at least a very small apartment of my own, containing only one room, I would be more than happy”; “IOM’s assistance programme is of vital importance”; “Programmes aiming at beneficial tariffs for costs for social services” would be conducive for improvement of the overall well-being of returned migrants. About 12 per cent (n=5) of respondents referred to health related needs. “I need prosthesis to be able to work”; “State health insurance system should be far flexible and much better. There are numerous barriers that result in reluctance and thus force one to refuse to address the health facilities at all”. In addition, it was stated that “healthcare should be far affordable than it is now”.

About 20 per cent (n=8) of interviewed did not have a clear idea to propose and thus were pointing to such general and abstract interpretations as “everything positive and useful could be helpful”. Simultaneously, returned migrants were expressing their acceptance and openness towards everything offered to alleviate their routine problems and concerns, mostly relating to the source of permanent financial income.

When inquired about concrete actions aiming at facilitating betterment of returned migrants’ community in Georgia, the majority of respondents, 68 per cent (n=28) did not specify anything in particular. However, close to 30 per cent (n=12) of surveyed referred to the issues related to the need of integration and pointed to the significance of improving the quality of life in Georgia. “If descent employment opportunities were available here, no one would think of migration at all”; “General public should be more tolerant and open towards returned migrants, it would be useful if positive attitude among general public is ensured”; “Integration is extremely difficult, all niches are occupied, and people are facing hardship. All the more, impeding factor is the elder age, in this case integration becomes almost impossible”; “Would be nice if mutual respect is promoted”.

When inquired about community-based participatory interventions, again the majority of surveyed, 68 per cent (n=28) turned out to be passive either unaware, whereas 34 per cent (n=14) of respondents were referring to their abilities for entrepreneurship and business start-up. It is worth noting that some of those interviewed pointed to their readiness for mutual empowerment by means of “collaborative measures”. Particular reference was made to the

importance of developing programmes relating to "the cultural origins of Georgia", as well as increasing affordability for health services and ensuring employment opportunities.

Psychosocial conditions

The majority of interviewed, 44 per cent (n=18) were unable to find a specific word to define temporary feeling of uneasiness. However, 36 per cent (n=15) of surveyed described these feelings as "feeling bad, either gloomy or moody"; "Having experiences of trial and suffering". The fewest reports, 12 per cent (n=5) referred to the use of "abusive language" and feelings of discomfort due to the "absence of job".

More than half of respondents, 56 per cent (n=23) considered that these gloomy and oppressive feelings are "extremely widespread" in the community of returned migrants, moreover, respondents also confirmed that these occurrences apply to the state of general public likewise. However, about 36.5 per cent (n=15) of the polled was unaware either have not agreed with this proposition at all or considered that such episodes were not frequent enough.

46.3 per cent (n=19) of interviewed reckoned that personally they do experience the above mentioned gloomy feelings of discomfort on a frequent basis. 36.5 per cent (n=15) of surveyed considered that respective experiences are rather rare, either are not witnessed at all or respondents did not have an answer to this question.

Data on (n=7) of the surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

Table 7: Levels of pain associated with memories relating to traumatic experiences, returned migrants, Georgia, 2011-12

Pain level	Absolute number	%
1	0	0
2	0	0
3	2	4.8%
4	3	7.3%
5	5	12.1%
6	1	2.4%
7	1	2.4%
8	6	14.6%
9	3	7.3%
10	12	29.2%

Data on (n=11) of the surveyed is missing, either due to the fact that they have skipped the question or due to their unawareness on this subject.

When being asked to specify the causes of the above mentioned experiences, more than a half of interviewed 53 per cent (n=22) pointed to such issues as "financial constrains, inability to afford treatment and respective medical services, absence of job and idleness, migration and failure of initiatives, routine problems and fatigue that stems from these worries, and finally, current situation in the country". Whereas, 12.1 per cent (n=5) of respondents referred to "emotionally stressful, oppressive circumstances, spiritual trauma and respective suffering,

anxiousness due to the idle mode of existence, neurosis as well as irritability due to the state of general anxiety". 36.5 per cent (n=15) were unable to specify any particular cause, either did not have an answer or did not think the above mentioned discomfort was associated with any concrete reason.

Psychosomatic conditions

The interviewees reported that their health conditions were aggravated subsequent to migration: 46.3 per cent (male-45.9% and two female) suffer from chronic fatigue and loss of energy; 39 per cent (male-35.1% and three female) point to the frequent occurrence of headaches; 36.6 per cent (male-35.1% and two female) mention about somatic complaints (such as headaches, stomach, heart or breathing problems); and 24.4 per cent (male-24.3% and one female) concerning difficulties with aggravation of chronic/non-communicable diseases, as well as problems pertaining to elevated blood pressure.

Psychological problems

As being reported, psychological problems subsequent migration are all the more obvious among returned migrants: 53.7 per cent (male-54.1% and two female) are getting angry more often and losing control; 52.5 per cent (male-50% and three female) point to the frequent occurrences of bad mood; 51.2 per cent (male-48.6% and three females) are having trouble with waking at night and finding it hard to get back to sleep because of thoughts and worries; 46.3 per cent (male-43.2% and three females) confirmed on frequent occasions of feeling sad or wanting to cry; and 36.6 per cent (male-35.1% and two female) are having trouble with going to sleep.

Individuals, paraprofessionals, professionals and facilities that returned migrants refer to for relieving their problems of psychosomatic and psychological nature

Due to the above-mentioned problems, 48.8 per cent (male-48.5% and two females) of returned migrants usually refer to a neighbour, a friend or a relative. In a descending order of sequence, the hospital was named as a place of reference by 22 per cent of interviewed (male-21.6%, three females), a clergyman - by 22 per cent (male-21.6%, one female); a nurse post – 19.5 per cent (male-21.6%, no female); local pharmacy - 19.5 per cent (male-18.9%, one female); polyclinic - 12.2 per cent (male-10.8%, one female); a psychologist - 9.8 per cent (male-8.1%, no female); a local community worker - 7.3 per cent (male-5.4%, one female); NGO worker/mobile clinic - 7.3 per cent (male-8.1%, no female); emergency healthcare service - 4.9 per cent (male-2.7%, one female); and a psychiatrist - 4.9 per cent (male-5.4%, no female).

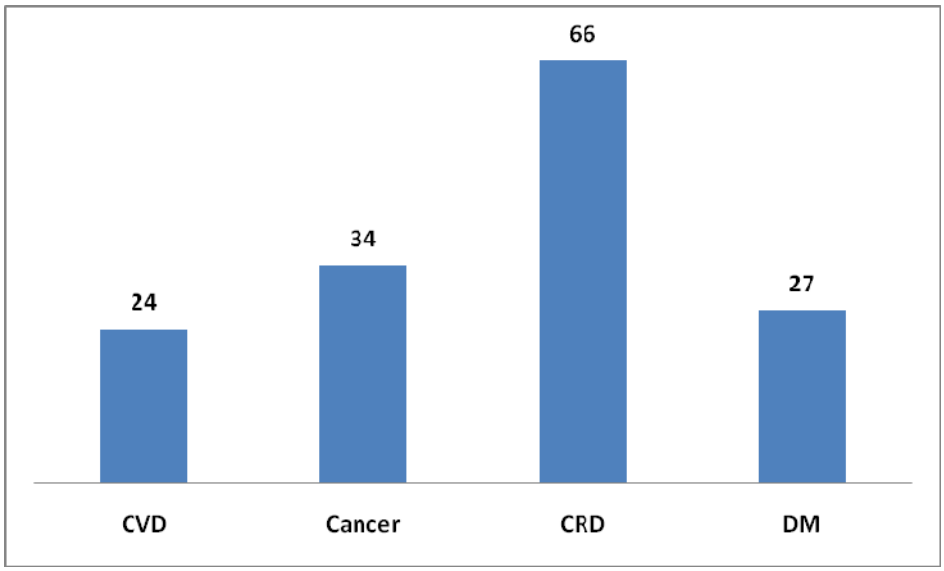
KNOWLEDGE, ATTITUDE AND PRACTICES TOWARDS NCDs

Knowledge on NCDs

75.6 per cent of respondents (male-73% and all four female) mentioned CVDs as prevalent NCD in Georgia; 65.9 per cent of respondents (male-64.9%, three female) mentioned cancer as prevalent NCD in Georgia; 34.1 per cent of respondents (male-32.4%, two female) mentioned chronic respiratory diseases (CRD) as prevalent NCD in Georgia; 73.2 per cent of respondents

(male-70.3% and all four females) mentioned diabetes mellitus (DM) as the prevalent NCD in Georgia.

Chart 43: Level of unawareness concerning major NCDs, returned migrants, Georgia, 2011-12

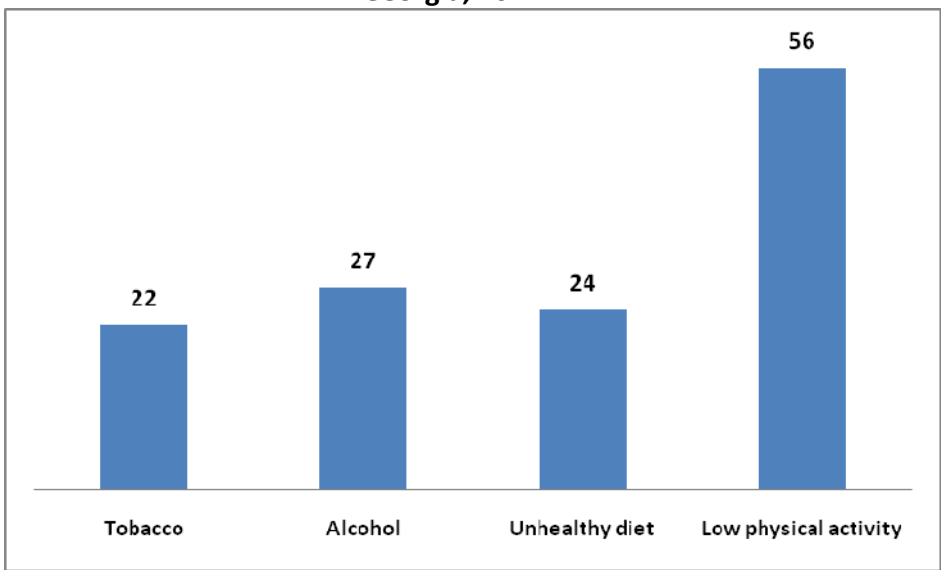


36.6 per cent of respondents (male-35.1%, two female) were wrong while mentioning HIV/AIDS as the prevalent NCD in Georgia; 65.9 per cent of respondents (male-64.9% and three female) were wrong while mentioning hepatitis as the prevalent NCD in Georgia; 65.9 per cent of respondents were wrong while mentioning flu as the prevalent NCD in Georgia.

Knowledge on NCDs risk factors

Tobacco as one of the risk factors of NCDs was confirmed by 78 per cent of respondents (male-75.7% and all four females); excessive use of alcohol as one of the risk factors of NCDs was mentioned by 73.2 per cent of respondents (male-70.3%; all four female); unhealthy diet was reckoned as one of the risk factors of NCDs by 75.6 per cent of respondents (male-73% and all four female); physical inactivity was deemed as one of the risk factors of NCDs by 43.9 per cent of respondents (male-45.9%, one female).

Chart 44: Level of unawareness concerning NCD risk factors, returned migrants, Georgia, 2011-12



Neglecting hygiene norms has been reckoned wrongly as one of the risk factors of NCDs by 58.5 per cent of respondents (male-54.1%, all four female); unsafe sex was wrongly mentioned as one of the risk factors of NCDs by 51.2 per cent of respondents (male-51.4%, two female).

Attitude on NCDs

When inquired concerning ways to avoid contracting NCDs, the majority of respondents, 75.6 per cent (n=31) referred to general propositions, such as "live a healthy and good quality life, pay attention to physical complains on time, protect oneself from anything and avoid everything that is excessive". Nevertheless, some pointed to relatively concrete solutions such as "To attend a church on a regular basis and live a well-thought and evenly planned day"; "Find a job for having less time for negative thoughts and do what one loves doing"; "Avoid risk factors listed above"; "Engage in treatment process"; "Reduce fat and get rid of anxiety". Only one respondent mentioned about significance of "safe sex practice", another one confirmed the incapacity to avoid kidney disease. Several reports, 19.5 per cent (n=8) were pointing to either unawareness or rare occurrence of preventive practices.

A little less than half of respondents, 49 per cent, confirmed having experience of practicing preventive measures. "Yes, I'd try to withdraw, if I knew something is harmful"; "I quitted drinking alcohol"; "I practice physical exercises". However, some mentioned that they are not able to be engaged in certain healthy practices due to physical constrains. Approximately, the same amount of interviewed, 51 per cent (n=21), confirmed the opposite, mentioning that practicing preventive measures is not affordable due to lack of resources.

41.1 per cent (n=17) of respondents consider elevated blood pressure as a temporary occurrence which would pass on its own. Whereas, nearly 49 per cent (n=20) of surveyed tend to believe that the given condition is a disease, since "for some it could be chronic". Moreover, "it is necessary to take medicine, since occurrences of elevated blood pressure could be related

to some kind of a disease" (implying possibility of co-morbidity). The fewest responses 9.7 per cent (n=4) pointed to unawareness of interviewed.

The majority of respondents, 43 per cent (n=18) take the condition of elevated blood pressure seriously and suggest referring to a doctor and resorting to treatment. The latter includes "medicine intake, proper diet, avoiding not recommended food and adhering to regular visits to doctor". However, about 19 per cent (n=8) of interviewed reckon that one should take medicine, make cold applications on the head and take hot foot bath. In addition, "good sleeping regime, relaxation as well as avoidance of alcohol and tobacco consumption" is thought to be useful. All in all, a person with elevated blood pressure "should be cautious, should control blood pressure and avoid anxiety". 36.5 per cent (n=15) were either unaware or did not have any complaints concerning blood pressure.

63 per cent (n=26) of surveyed outlined the variety of factors relating to the care for a person with NCDs. Attention, care and observance of a doctor's prescription were highlighted as major needs. The respondents referred to adherence to hygiene, proper regime, and dietary norms as well as avoidance of anxiety and the need for financial resources. 36.5 per cent (n=15) of interviewed did not have an answer on the given question.

When being inquired about the attitude pertaining to healthcare workers and healthcare system, most of respondents were positively disposed to the staff of available healthcare facilities, mentioning that "Not all doctors deserve trust, but if one approaches a physician the trust should be unconditional definitely". The returnee from the Ireland stated that the Georgian healthcare system is "far better in comparison with that of Ireland". Nevertheless, reasonable amount of surveyed were disappointed, since "prices have increased, they are almost triple"; "huge construction works are going on everywhere, but nothing is done for people". Whereas, in the destination countries "everyone holds health insurance and is protected therefore". Despite of the positive disposition revealed by certain amount of interviewed towards medical personnel, some of them believe that "healthcare system is not enough flexible and affordable". It was mentioned that "the illness of a family member should not automatically mean the heaviest burden for the whole family and household", which is the case for present-day Georgia.

Practices on NCDs

The majority of respondents, 58.5 per cent (n=24) were unaware regarding ways for preventing and managing NCDs. About 19.5 per cent (n=8) specified on more general options such as "improving health, ensuring that conditions are conducive and quality of life is relevant". At the same time, the ideas to hand over responsibilities to the government were voiced: "Government should ensure the preventive counselling is at least affordable". However, at times concrete suggestions were proposed as well such as "adhering to proper dietary habits, controlling blood pressure, quitting alcohol and reducing burden of high physical activity". One respondent noted about his ability to control diabetes by medication. 17 per cent (n=7) of respondents offered to refer to a doctor for advice and undertake self-examination and treatment. It was noted that preventive immunization is important and should be performed as well. The fewest reports, 4.8 per cent (n=2) were pointing to such wrong interpretations as "preventive medicine intake with the purpose of curing cold, practicing safe sex and refusing psychoactive substances".

A little less than 40 per cent (n=16) of surveyed were unaware pertaining to the implication of the referral services due to the lack of experience and rare occasions of visiting doctor. Lesser amount of interviewed, 36 per cent (n=15), were extremely disappointed and revealed negative disposition, stating that “it is all just a hidden corruption”, affirming in addition that “if one has no money the patient is completely lost”. The respondents reckon that the process of the referral services is very complicated, there are numerous barriers and the referral services lack sufficient flexibility, since “if a doctor is qualified enough, he/she should not redirect the patient to another healthcare worker”. Close to the quarter of respondents 24.3 per cent (n=10) considered that “no barriers either difficulty was met throughout the referral process” and that “the referral takes place properly”, implying correct redirection of a patient to another healthcare worker in case of the respective need. It was noted in addition, that “it would have been a far more handy if all services are placed at one facility and location”.

Nearly 40 per cent (n=16) of surveyed were unaware on the given subject and exactly the same distribution of responses points to the inability of respondents to withhold the risk factors of NCDs. “Yes, I do yield to those, have not enough willpower to refuse”; “I am trying, but have difficulties pertaining to quitting cigarette”; “It is quite complicated, since I am not trying to practice healthy lifestyle”. Only about 22 per cent (n=9) of interviewees confirmed regarding their ability to withstand and refuse risky behaviour, “if it is known that it could be harmful for one’s health”.

The majority of surveyed, 58 per cent (n=24), confirmed on the probability of change based on the existing experience. Argumentations mainly referred to the importance of being aware concerning harmful effects of certain behavioural aspects to ensure commitment for change. It is worth mentioning that self-suggestion was named as an option for the respective approach. 31 per cent (n=13) of respondents are either unaware or have not thought of the given possibility so far. Only the minority, 7 per cent (n=3) had given up repeating attempts due to unwillingness caused by past failures. And, finally, only one person (n=1) proposed conditional argumentation, noting that “if one had a good life to live, he/she would change definitely”.

When inquired whether respondents would comply with the treatment process, the majority confirmed on the given subject, highlighting the vital importance of the affordability of essential medicine and proficiency of health care workers. In addition, such contributing factors as motivation for cure, affordability of biological groceries and medicine, trust towards health care workers and psychological readiness to engage in treatment process were highlighted in view of being successful in this regard. Very few were either unaware on the given subject or reluctant to pursue doctor’s prescriptions stemming from unpleasant past experiences mostly relating to experimental nature of prescriptions provided by the doctor.

FOREIGN MIGRANT STUDENTS

SOCIAL-DEMOGRAPHIC CHARACTERISTICS

Response Rate

142 foreign migrant students of Tbilisi State Medical University were participating in the Survey. The response rate was 97 per cent.

Sex and age

Among 142 foreign migrant students, 80 (56.3%) were male and 62 (43.7%) were female. The participants were distributed among five age groups. 97.5 per cent of 142 foreign migrant students were of the age group of 18-24.

Ethnicity

95.8 per cent of foreign migrant students were predominantly of Indian, Sri-Lankan and Turkish ethnicities. Mean time of residing in Georgia was one year.

Marital status

According to marital status, six groups were distinguished in the proposed questionnaire. The largest group (97.2%) was comprised of unmarried.

Education

Average length of education was 13 years. Female spend a bit more time on education (14 vs. 13 years).

The majority of surveyed had complete secondary education (90.1%).

Occupation

All respondents were students.

Household revenue

According to average yearly revenue, households were clustered into five groups. Yearly income of 9.2 per cent of interviewed was less than GEL2,600. 24.8 per cent of students confirmed the yearly incomes between GEL2,600 - 5,000, yearly income between GEL5,001 - 10,000 was reported by 18.4 per cent of surveyed, 4.3 per cent indicated the figures of GEL10,001-20,000, and 2.1 per cent stated their yearly income exceeded GEL20,000. 41.1 per cent of surveyed students did not have an answer.

BEHAVIORAL RISK FACTORS (STEP 1)

Tobacco consumption

Current smokers

Currently any kind of tobacco product (smoked and smokeless) was consumed by 7.1 per cent of respondents (11.3% male and 1.6% female).

55.6 per cent of current smokers are smoking on a daily basis. None of the female and 50 per cent of male are currently smoking on a daily basis.

Average age of smoking initiation among daily smokers was 15 years (male-n=15, female-n=16). 63.6 per cent of daily smokers use manufactured cigarettes, 10 per cent of male (n=1 male) daily smokers use hand-rolled cigarettes.

Former smokers

Former daily smokers total three per cent (n=4 students, n=3 male and n=1 female) of the sample population. All of them were daily smokers in the past.

Attempt to quit smoking

Over the past 12 months attempts to quit smoking were made by 45.5 per cent (n=5 students, male-n=4, female-n=1) of ever smokers.

None of the therapeutic interventions or assistance measures to quit smoking had ever been used.

The longest period respondents abstained from smoking was 65 days (male-78 days, female-14 days).

Alcohol consumption

Lifetime alcohol consumption

Prevalence of alcohol consumption among foreign migrant students amounted up to 29.6 per cent. This figure was higher for male than for female (40% vs. 16.1%).

Alcohol consumption status throughout 30 days and 12 months prior to the Survey

Throughout last 12 months prevalence of alcohol consumption amounted up to 88.1 per cent. This figure was higher for male than for female (93.8% vs. 70.0%).

Prevalence of alcohol consumption for the last month prior to the interview amounted up to 59.5 per cent (66.7% for male and 28.6% for female).

Frequency and amount of alcohol consumption

Most alcohol consumers drink less than once per month (62.2%), in order of descending sequence second answer was 1-3 times per month (18.9%), and finally, 1-4 days per week (10.8%).

65.4 per cent of interviewed have consumed alcohol during the last 30 days. Respondents confirmed consumption of alcohol on two occasions (male three times and female one time) during the last month. As for the dose of alcohol, respondents consumed two standard alcohol drinks for the last 30 days during one drinking occasion. On average, male consumed two and female - one standard alcohol drink at a time.

Male consumed five or more standard alcoholic drinks in a single drinking occasion, three times during the last 30 days; female did not consume more than four standard alcoholic drinks in a single drinking occasion during the past 30 days.

Diet

Daily food consumption

Majority of respondents (50.0%; male–51.3%, female–48.4%) consume food two times per day. The second largest group of respondents (33.8%; male–33.8% and female-33.9%) consume three meals per day. 7.7 per cent (male–2.5% and female-14.5%) have four meals per day, 6.3 per cent (male–8.8% and female-3.2%) eat once per day; one male respondent does not eat daily.

General structure of food consumption

According to the Survey results, all respondents take less than five servings of fruit and vegetables per day on average. All respondents (100%) take two servings of fruit and vegetables. Fruit consumption takes place two days a week and vegetable consumption, five days a week, on average. These figures do not differ by sex.

Meat products intake occurs on average three days per week, with average two servings. Meat consumption is higher among men than among women.

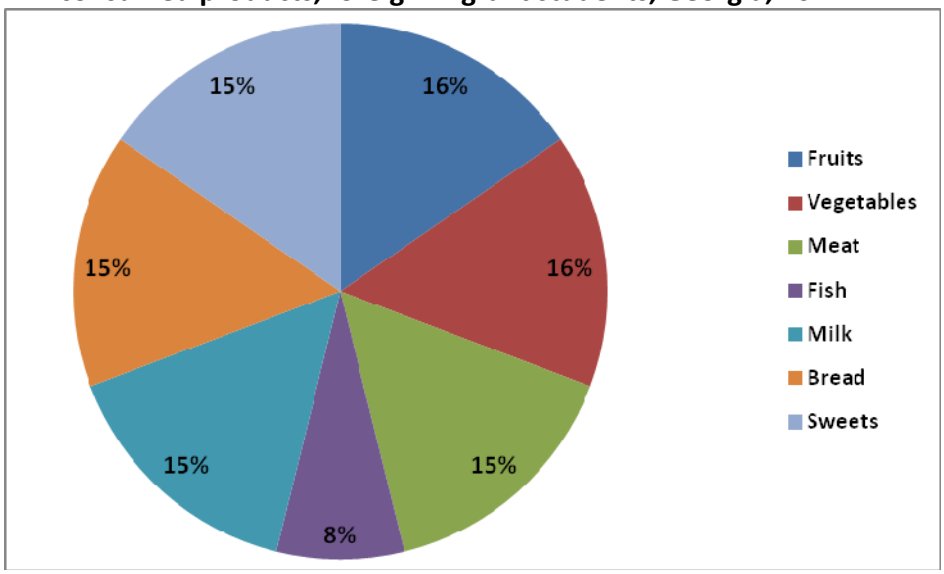
Fish or sea products intake occurs once per week on average, with one serving average. Fish or sea products consumption is higher among females.

Dairy products are consumed, on average, four days per week; with two servings average.

Bread and cereals are consumed, on average, four days per week; with two servings average.

Sweets and products with sugar content are consumed five days per week; with two servings average.

Chart 45: Mean content of conditioned daily menu according to number of servings of consumed products, foreign migrant students, Georgia, 2011-12



Consumption of less than five servings of fruit and/or vegetables per day and diet-related risk

Consuming less than five servings of fruit and vegetables was defined as the criteria for assessing diet-related risk. Results of the Survey showed that all respondents (100%) are under diet-related risk.

Fat consumption

The most common fat for cooking at home was vegetable oil (90.1% of interviewed), followed by the butter, which makes up 4.2 per cent. Use of margarine (0.7%) and pork fat (0.7%) are rather rare.

Eating outside

Reportedly, on average foreign migrant students consume four meals per week outside.

Physical Activity

11.3 per cent (male-10% and female-12.9%) of respondents confirmed that their work involves vigorous-intensity activity that causes large increases in breathing or heart rate for at least 10 minutes continuously. Vigorous-intensity activities as part of work are done three days (male-four days and female-three days) in a typical week; and last up to 106 minutes (male-119 and female-91).

46.8 per cent (male-39.2% and female-56.5%) of respondents reported that their work involves moderate-intensity activity. Moderate-intensity activities as part of work by both sexes are performed throughout four days in a typical week; and last up to 128 minutes (male-115 and female-138).

86.4 per cent (male-86.1% and female-86.9%) walk or use a bicycle (pedal cycle) for at least 10 minutes continuously to get to and from places. This is done throughout six days in a typical week; and lasts up to 57 minutes (male-62 and female-52).

31.0 per cent (male-37.5% and female-22.6%) of interviewed mentioned that they are engaged in vigorous-intensity sports, fitness or recreational activities (running or playing football) that cause large increases in breathing or heart rate for at least 10 minutes continuously. This is done for three days (male-three days and female-four days) in a typical week; and lasts up to 111 minutes (male-126 and female-78).

43.3 per cent (male-44.3% and female-41.9%) of surveyed are engaged in moderate-intensity sports, fitness or recreational (leisure) activities (running or playing football) that cause large increases in breathing or heart rate for at least 10 minutes continuously. This is done throughout four days (male-four days and female-three days) in a typical week; and last up to 73 minutes (male-90 and female-51)

HEALTHCARE ACCESS

On answering the question about available healthcare services for the community, majority of foreign migrant students (90.1%) indicated hospitals, 71.1 per cent - an emergency healthcare service, 50.7 per cent - polyclinics, 24.6 per cent - a nurse post, 17.6 per cent - NGO service (mobile clinic) and only 15.5 per cent mentioned about psychosocial services.

For 33.8 per cent (male-35.0% and female-32.3%) of respondents, healthcare services are financially affordable.

For 88 per cent it takes less than 30 minutes to get to the medical facility, 4.9 per cent have to travel 1-2 hours to get there. The main type of transport is by foot (47.5%), followed by a bus (36.3%) and a car (10%).

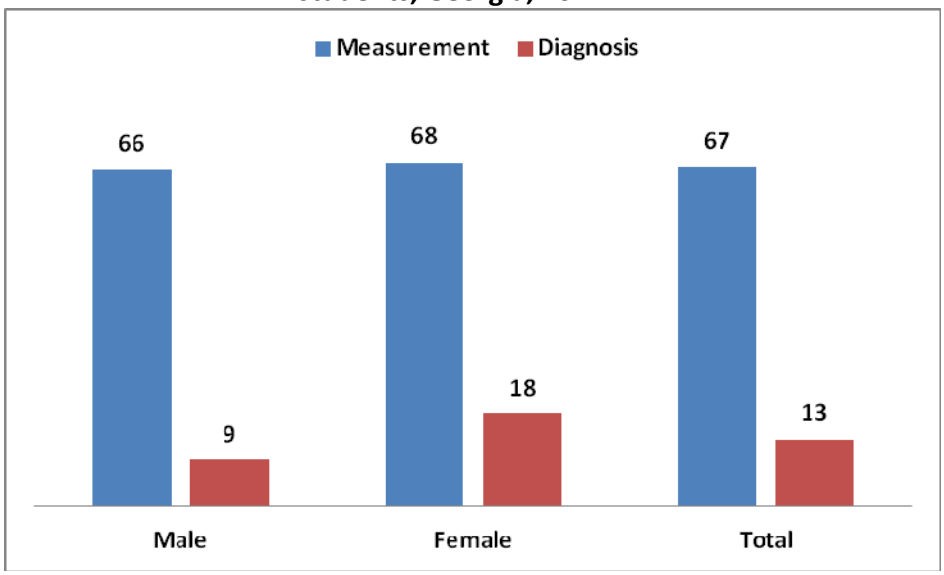
CLINICAL HISTORY

Hypertension history

Majority of respondents (66.9%; male-66.3% and female-67.7%) reported as having ever measured the blood pressure by medical personnel.

Among 13.1 per cent (male-9.1% and female-18.2%) hypertension was detected.

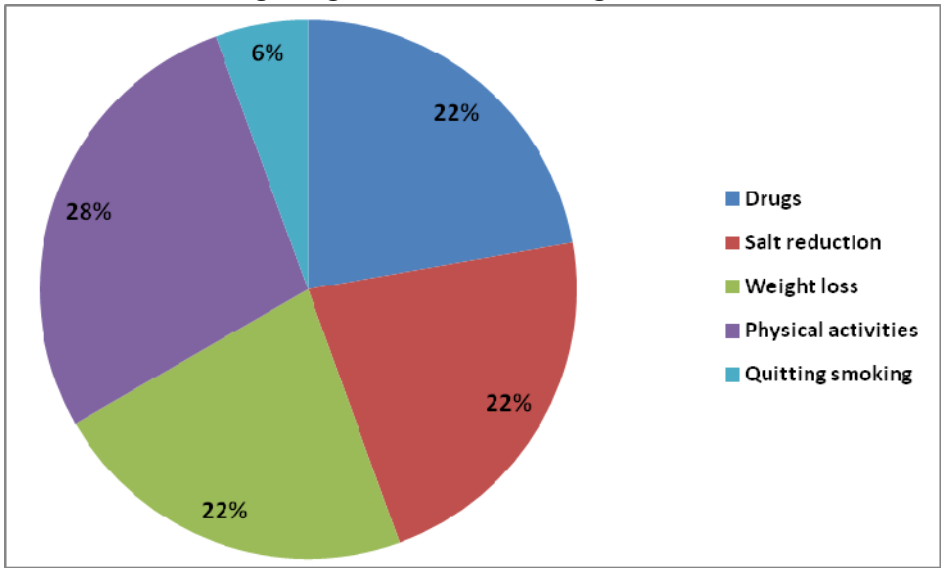
Chart 46: Hypertension lifetime measurement and diagnosis by sex, foreign migrant students, Georgia, 2011-12



Occurrences of hypertension throughout last 12 months were reported by 40.0 per cent of students who has ever measured the blood pressure.

26.7 per cent (male-33.3% and female-22.2%) are currently receiving medication for high blood pressure prescribed by a doctor or other health worker. 26.7 per cent (male-50.0% and female-1.1%) received recommendation to decrease salt intake, 26.7 per cent (male-50.0% and female-1.1%) received recommendation to lose weight, 33.3 per cent (male-50.0% and female-22.2%) were encouraged to be engaged in physical activities and 6.7 per cent (male-16.7% and no female) - to quit smoking.

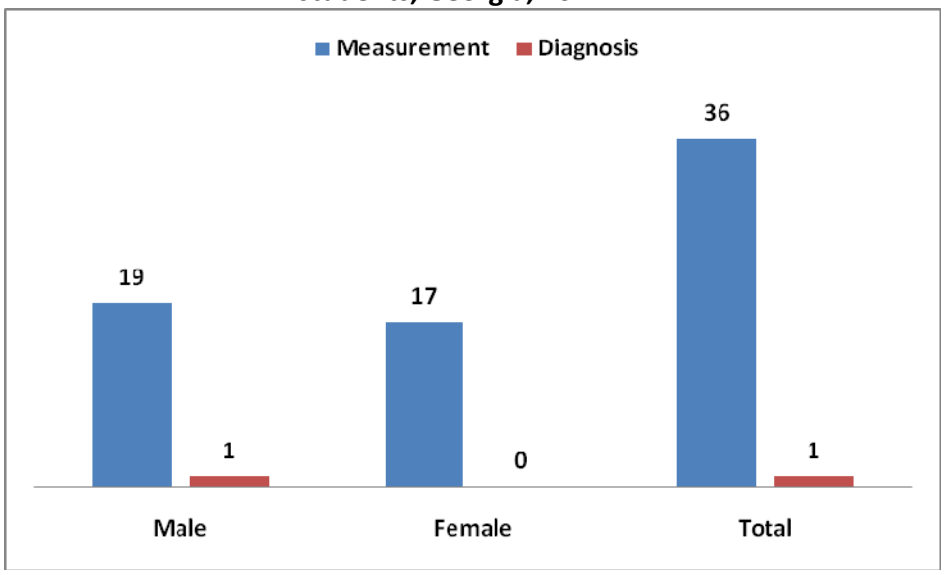
Chart 47: Percentage of respondents currently receiving any treatment or advice for high blood pressure management prescribed by a doctor or other health worker, foreign migrant students, Georgia, 2011-12



Diabetes history

The majority of respondents, 73.9 per cent (male-75% and female-72.6%) have never checked glucose concentration in blood; one male student mentioned about high glucose level.

Chart 48: Hyperglycaemia lifetime measurement and diagnosis by sex, foreign migrant students, Georgia, 2011-12



An occurrence of hyperglycaemia throughout last 12 months was not reported by any of the foreign migrant students.

None of the students is currently taking insulin for hyperglycaemia prescribed by a doctor or other health worker. Two male respondents are taking oral drugs. A special diet, weight loss and physical activities were prescribed to one male respondent; none of these respondents received advice on quitting smoking.

History of other disease

The first place in the history of diseases was held by raised blood cholesterol (n=2 male and n=2 female); the second was occupied by the myocardial infarction (n=2 male and n=1 female), followed by a stroke (n=1 male) and cancer (n=1 female).

Visiting doctors

Inquiry was made on motives and frequency of visiting doctors or other medical personnel throughout last 12 months. The total percentage of visits to a doctor for the past 12 months amounted up to 38.0 per cent (male-30.0% and female-48.4%).

The main reason for visiting doctors or medical personnel consisted in a specific health problem (36.9%), then in an order of decreasing sequence, preventive screening (27.7%), none of the above-mentioned reasons were confirmed by 15.4 per cent of interviewed, and both of the above-mentioned reasons were corroborated by 9.2 per cent of respondents.

Self-treatment

Only 2.8 per cent (male-5% and no female) of respondents resorted to self-treatment, which should be considered as a positive trend.

With regard to the diseases mentioned in the questionnaire (diabetes or raised blood glucose, high blood pressure, stroke, cancer, raised blood cholesterol and early myocardial infarction) majority of respondents - 4.9 per cent (male-6.3% and female-3.2%) resorted to self-treatment of high blood pressure followed by self-treatment of high blood cholesterol - 4.2 per cent (male-6.3% and female-1.6%). Self-treatment was quite rare among patients suffering from other diseases.

Family history of diseases

When inquired whether their relative (mother, father, sister, brother and spouse or his/her relative) ever been diagnosed on hyperglycaemia or diabetes, high blood pressure, stroke, cancer, hypercholesterolemia, or an early myocardial infarction, the majority of respondents - 55.6 per cent mentioned diabetes, followed by high blood pressure - 52.8 per cent, hypercholesterolemia - 31.0 per cent, stroke - 17.7 per cent, myocardial infarction - 8.5 per cent and cancer - 4.2 per cent.

PHYSICAL MEASUREMENTS (STEP 2)

Arterial hypertension, heartbeat rate, weight, height, body mass index, and waist circumference were assessed.

Arterial blood pressure and heartbeat

Mean systolic blood pressure among surveyed population was 117mmHg (male-120 and female-112) and mean diastolic blood pressure, 73mmHg (male-74 and female-72). Blood pressure ≥140/90mmHg or hypertension was detected among 4.9 per cent of respondents (male-7.5% and female-1.6%) who do not take any medication.

Blood pressure ≥140/90mmHg or being on treatment was detected among 5.6 per cent of respondents (male-8.8% and female-1.6%). Second stage hypertension (≥160/100mmHg) according to the national hypertension guideline was detected among 1.4 per cent (male-2.5% and no female) who do not take any medication.

Blood pressure ≥160/100mmHg or being on treatment was detected among 2.1 per cent of respondents (male-3.8% and no female).

One male respondent has been treated for raised blood pressure with medication prescribed by a doctor or other health worker during the past two weeks. Hypertension was not detected.

Hypertension (≥140/90mmHg) was not detected among respondents being on antihypertensive treatment prescribed by a doctor or other health worker during the past two weeks.

Pulse among both sexes was 83 beats for both sexes per minute.

Physical measurements

The average height among male (173.8cm) is higher than among female (160.7cm). The average weight among male (70.0kg) is higher than among female (62.0kg). BMI is 22.9 (male-23.1 and female-22.7).

According to BMI, four groups were distinguished. For both sexes, the biggest group - 64.5 per cent (male-57.5%, female-73.8%) consisted of people having normal weight (BMI=18.5-24.9). Prevalence of underweight (BMI<18.5) was 9.9 per cent (male-13.8% and female-4.9%). 18.4 per cent (male-20.0% and female-16.4%) were overweight (BMI=25.0-29.9). 7.1 per cent (male-8.8% and female-4.9%) were obese (BMI>30.0).

Mean waist circumference was 81.3 cm (male-84.6cm. and female-77.1 cm.).

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

Majority of respondents (27% n=39) among foreign migrant students' community consider that language training and facilitation of inter-communal interaction are those two factors, which would contribute to the betterment of foreign migrants students' social well-being the most. It is worth mentioning hereby that only few respondents requested to increase their access to Georgian language training, mostly suggestions were made for enhancing the level of English language knowledge among general public. The needs to "develop friendly attitude towards people" and facilitate "greater understanding between migrant and local communities" were mentioned in light of increasing interethnic and intercultural sensitivity, in order to "let people know (local population implied) that we (foreign migrants) are not that bad". Organizing "cultural fast interactive programmes" and supporting "medical awareness campaigns" involving foreign migrant students enrolled in TSMU was reckoned being conducive for enhancing the "value of volunteering for the needy" and simultaneously, being beneficial in view of cross-cultural interactive programming.

25 per cent (n=36) of interviewed consider that the improvement of primary healthcare services would significantly contribute to the betterment of their overall social well-being. Increased efficiency of healthcare systems, availability of supplementary primary healthcare facilities and their compliance with the international standards of hygiene norms were outlined as a priority need. Due to their status, foreign migrant students necessitate financial concessions, which would ensure the accessibility of healthcare services and affordability of essential medicine. "Better healthcare including medical packages for students, improved treatment methodologies", availability of "consultations with a family doctor on (migrants') native either English language" and "improved communication between the doctor and the patient" would significantly facilitate migrants' access to healthcare and ultimately, would contribute to their overall social well-being. Greater affordability of yearly health check-up services was deemed to be advantageous for surveillance of migrants' health conditions according to 6 per cent (n=9) of interviewed.

8 per cent (n=12) of respondents consider that their socio-economic conditions are not satisfactory, being impeded by frequent water cuts and inability of maintaining desired cleanliness of houses.

7.7 per cent (n=11) believe that awareness raising and promotion on psychosocial and health related issues, with particular emphasis on proper diet and desired physical activity would facilitate nurturing of adequate "health opinions" among general audience and would ensure "maintaining a healthy life through healthy habits". Hereby, a special reference was made pertaining to increasing access to regular medical check-ups for migrants, availability of discounts on essential medicines and facilitation of health promotion campaigns to prevent certain risky behaviours. Specific activities such as education campaign on "diseases, their causes, symptoms and ways of their treatment" as well as training on intercultural competencies in order to "prevent culture shock" were considered helpful for reduction of stress inherent to migration process itself. Initiatives encouraging "more interaction" and "more affinity" among migrant and local communities were encouraged and deemed useful.

Psychosocial conditions

Relating to the temporary feeling of sadness or uneasiness, a reference was made to prevailing conditions of anxiety as well as "being upset, moody, fed up, and bored, disturbed and irritated". In addition, respondents were referring to the condition of mental instability. 11.2 per cent (n=16) of interviewed define the given conditions as "depression and sadness" while 6.3 per cent (n=9) as a "stress". 5.6 per cent (n=8) attribute causes of the given condition to "detachment from family, homesickness, loneliness and isolation". However, the majority of interviewed either are not aware whether this feeling is widespread in their community or do not agree with this proposition.

36 per cent (n=51) confirmed temporary occurrence of the above mentioned gloomy feelings, but considering the scale from 1 to 10, being 1 the minimum and 10 the maximum of the given discomfort level, only 34.5 per cent (n=49) estimated this state from 1 to 10 with insignificant differences in their responses. The majority of those, 17 per cent overall, (n=9), (n=8) and (n=7), attributed the given condition to levels of 2, 4, and 5 respectively.

As for the causes of temporary uneasiness, a considerable number of interviewed 65.4 per cent (n=93) was unable to specify explicit underlying causes of the given temporary discomfort. However, 17.6 per cent (n=25) commonly refer to the "burden of studies and loneliness", followed by 14.7 per cent (n=21), attributing the given state to "personal problems, homesickness, detachment from family, parents, difficulties caused by differences among room mates and general public per se, as well as (issues pertaining to) security and safety". Only fewest responses 4.2 per cent (n=6) refer to "migration and language barrier", the latter being impediment of migrants' interaction with general public, and consider these as triggers of the above mentioned discomfort.

Psychosomatic conditions

As being reported by interviewees, their health problems are aggravated subsequent to migration: 41.1 per cent (male-40.0% and female-42.6%) complain concerning headaches; 30.5 per cent (male-27.5% and female-34.4%) refer to somatic complaints (such as headaches, stomach, heart or breathing problems); 24.8 per cent (male-21.3% and female-29.5%) mention about digestive problems; and 13.6 per cent (male-16.3% and female-11.5%) suffer from respiratory problems.

Again, health problems are considerably prevalent among female.

Psychological problems

Foreign migrant students reported concerning appearances of psychological problems subsequent to migration: 39.0 per cent (male-36.3% and female-42.6%) confirm on frequent occurrences of bad mood; 36.2 per cent (male-33.8% and female-39.3%) avoid situations that make them scared or anxious; 33.3 per cent (male-31.3% and female-36.1%) complain concerning problems with concentration; 31.2 per cent (male-25.0% and female-39.3%) mention that they have lost their interest in life or activities they used to enjoy; 28.4 per cent (male-27.5% and female-29.5%) often experience feeling as if they are a different person

sometimes; 24.8 per cent (male-18.8% and female-32.8%) are often feeling sad or want to cry; and 23.4 per cent (male-20.0% and female-27.9%) are getting angry more often or losing control.

Again, psychological problems are considerably prevalent among female.

Individuals, paraprofessionals, professionals and facilities that foreign migrant students refer to for relieving their problems of psychosomatic and psychological nature

While experiencing the above-mentioned discomfort, 65.2 per cent of foreign migrant students usually approach a neighbour, a friend or a relative (male-56.3% and female-77.0%). In order of descending sequence, 37.6 per cent mentioned about referring to the hospital (male-45.0% and female-27.9%); 21.3 per cent named a local pharmacy (male-21.3% and female-21.3%); 19.9 per cent mentioned about an emergency healthcare service (male-21.3% and female-18.0%); 18.4 per cent named a psychiatrist (male-17.5% and female-19.7%); 17 per cent - a psychologist (male-18.8% and female-14.8%); 14.9 per cent mentioned about a clergyman (male-12.5% and female-18.0%); 13.6 per cent named a polyclinic (male-12.7% and female-14.8%); 10.0 per cent mentioned about a nurse post – (male-11.4% and female-8.2%); 9.9 per cent named an NGO worker or the mobile clinic (male-10.0% and female-9.8%); and 8.5 per cent have mentioned about referring to a local community worker (male-10.0% and female-6.6%).

Cultural Practices and Bonds with the Native Country

Overall majority of respondents, 88.7 per cent (n=126) confirm that they keep practicing their cultural beliefs, customs and lifestyle. Only fewest reports, 7.7 per cent (n=11) refer to such obstacles to the above mentioned as “difference among religions, traditions and culture” as well as lack of “costs to travel to the native country” and “lack of faith” among the general public.

Again, according to the majority, 81.6 per cent (n=116) foreign migrant students are able to keep ties with their native country and extended family. Of that, 26 per cent (n=37) report that the most widespread sources of their interaction are internet (facebook, skype, e-mail, or other social networks) and telephone communication.

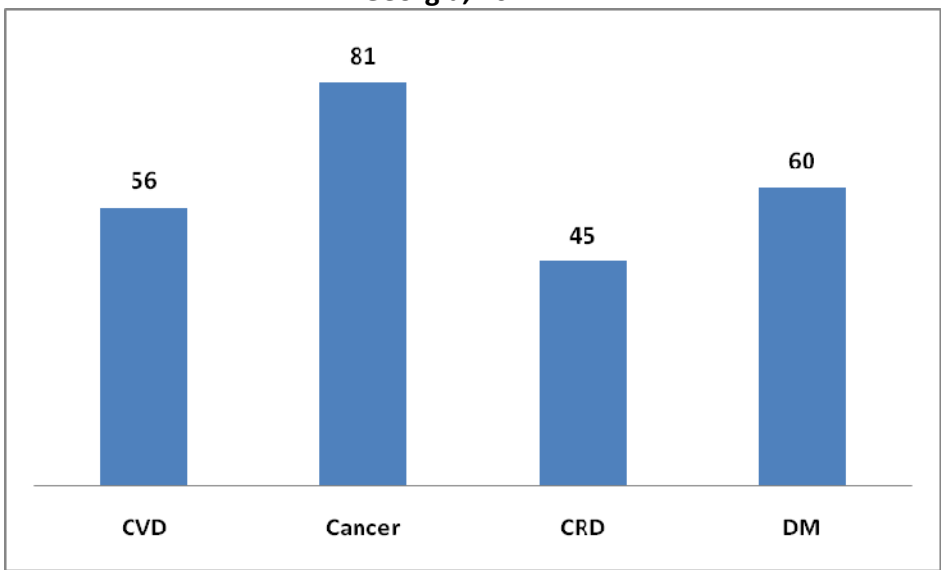
Naturally, similarly to the above mentioned, the majority 75.3 per cent (n=107) confirmed about frequent discussions and exchange of memories concerning place of origin with their roommates in particular.

KNOWLEDGE, ATTITUDE AND PRACTICES ON NCDS

Knowledge on NCDs

44.4 per cent (male-47.5% and female-40.3%) of respondents mentioned CVDs as prevalent NCD in Georgia; only 8.5 per cent (male-8.8% and female-8.2%) of respondents mentioned cancer and 54.9 per cent (male-52.5% and female-58.1%) of respondents mentioned chronic respiratory diseases (CRD) as prevalent NCD in Georgia. Only 40.1 per cent (male-41.3% and female-38.7%) of respondents mentioned diabetes mellitus (DM) as prevalent NCD in Georgia.

Chart 49: Level of unawareness concerning major NCDs, foreign migrant students, Georgia, 2011-12

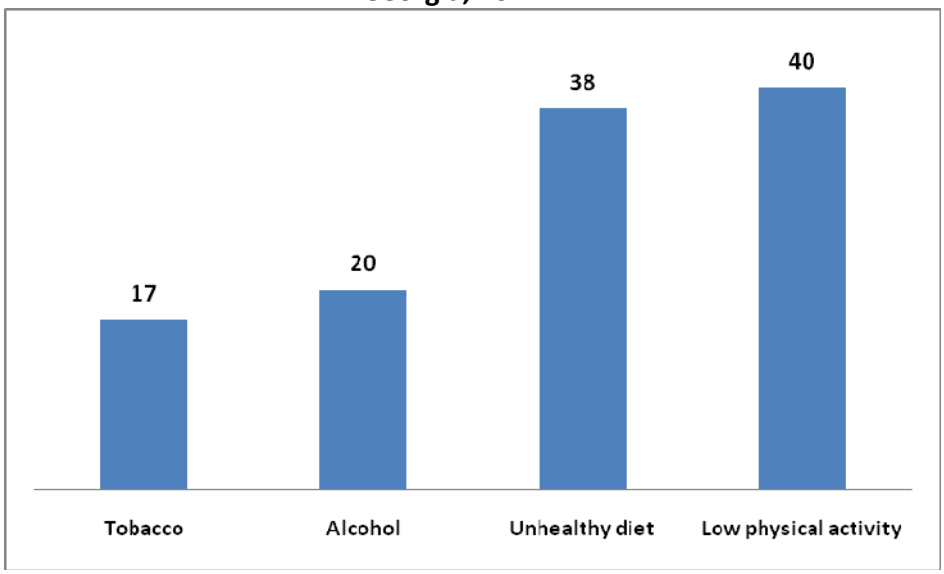


13.5 per cent (male-15.0% and female-11.5%) of respondents were wrong while mentioning HIV/AIDS as prevalent NCD in Georgia. 33.1 per cent (male-33.8% and female-32.3%) of respondents were wrong while mentioning hepatitis and 36.9 per cent (male-33.8% and female-41.0%) while mentioning flu as the prevalent NCD in Georgia.

Knowledge on NCDs risk factors

Tobacco as one of the risk factors of NCDs was confirmed by 83.1 per cent (male-83.8% and female-82.3%) of respondents; excessive use of alcohol as one of the risk factors of NCDs was named by 79.6 per cent (male-80.0% and female-79.0%) of respondents; unhealthy diet as one of the risk factors of NCDs was mentioned by 62.0 per cent (male-58.8% and female-66.1%) of respondents; physical inactivity as one of the risk factors of NCDs was reckoned by 59.9 per cent (male-60.0% and female-38.5%) of respondents.

Chart 50: Level of unawareness concerning NCD risk factors, foreign migrant students, Georgia, 2011-12



Neglecting hygiene norms as one of the risk factors of NCDs was mentioned by 45.8 per cent (male-47.5% and female-43.5%) of respondents; practice of unsafe sex as one of the risk factors of NCDs was mentioned by 52.8 per cent (male-56.3% and female-48.4%) of respondents.

Attitude on NCDs

Majority of respondents 48.5 per cent (n=69) demonstrated awareness and referred to the necessity to manage the four major risk factors for NCDs, such as tobacco consumption, physical inactivity, harmful use of alcohol and unhealthy diet, if the efficient ways to avoid contracting these diseases are to be sought. However, 17.3 per cent (n=12) out of this number, simultaneously refer to the requirement of observing hygiene norms, for instance, "maintenance of clean surroundings" as well as "practice of safe sex". Only 12.6 per cent (n=18) consider that sole observance of hygiene norms would have been helpful as a preventive measure. According to these reports, "personal hygiene" and avoidance of those who suffer from NCDs is a must, in order to prevent contracting NCDs. The attitude of 23.2 per cent (n=33) of interviewed differs from the above mentioned and emphasizes the importance of awareness and "knowledge about different aspects of diseases, their causes and reasons" as well as "preventive measures" to be practiced. Nevertheless, despite satisfactory level of awareness on prevention of NCDs, only 19.7 per cent of interviewed held experience of practicing preventive measures in the past or in their current routine daily activities.

A slightly over the half of respondents 52.1 per cent (n=74) were aware that increased blood pressure is not a temporary occurrence, whereas 7.7 per cent (n=11) said it "should be measured over the period of time" and "conclusions should be made respectively".

When being asked about proper behavioural aspects while dealing with high arterial blood pressure, 29.5 per cent (n=42) referred to the need to "behave calmly", "avoid mental stress" as well as the importance of managing anger and being kind. 23.3 per cent (n=33) believe that

persons with high blood pressure should take all adequate precautionary measures such as visiting a doctor, taking proper medication and keeping healthy habits like a well-balanced diet, avoidance of tobacco and alcohol consumption and practicing physical training. In addition, 6.3 per cent (n=9) refer to reduction of salt intake. 36.6 per cent (n=52) either did not have an answer or merely specified on the symptoms inherent to high arterial blood pressure.

While studying the attitude towards what care for a person with chronic disease implies, 48.5 per cent (n=69) highlighted about the necessity of "counselling with a doctor or a psychologist, timely and proper medication, adhering to diet and physical activity, conducting regular health check-ups and surrounding a patient with an atmosphere of love, care and attention". The fewest reports 4.2 per cent (n=6), referred to adherence to hygiene norms as a priority, whereas 46.4 per cent (n=66) among the interviewed were ignorant on the related aspects of care for the patients with NCDs.

When being asked about their attitude towards healthcare workers and healthcare system in Georgia, 45.7 per cent (n=65) mentioned that Georgian healthcare workers are to be trusted, respected and are proficient in their respective fields. Only the minority 11.9 per cent (n=17) described such obstacles as language barrier, laziness (of healthcare workers) and existence of occasional prejudices (towards migrants) among the primary healthcare personnel. In this regard one of the reports should be taken into account, highlighting that "(doctors) should consider that all community people are equal". As for the foreign migrant students' attitude towards healthcare system, 39.4 per cent (n=56) of interviewed assessed the latter as cooperative, worth being trusted and respected. Nevertheless, 14.7 per cent (n=21) again refer to the problem of language barrier, expensive costs and lack of efficiency of the emergency services in the country.

Practices on NCDs

While discussing the ways to prevent chronic non-communicable conditions, 21.8 per cent (n=31) referred to the control of four main risk factors for NCDs and the need to "adjust one's lifestyle" accordingly. Nearly 12 per cent of interviewed (n=17) believe that general audience should be well-educated concerning "different health conditions" and respective "preventive measures" to be able to apply this knowledge into practice.

The issue of communication and language barrier remains to be impeding when it comes to the referral to healthcare services. The majority of foreign migrant students, 76 per cent (n=108) did not have an answer to this topic, 17.6 per cent (n=25) referred to such obstacles as communication, language barrier, costly prices and lack of sanitation in healthcare facilities.

Throughout the discourse on behavioural habits and aspects of self-control, according to the reports obtained, 42 per cent (n=60) of interviewed do not easily yield to behavioural risk factors, while 15.4 per cent (n=22) are not resistant to the above mentioned exposures and 41.5 per cent (n=59) are not conscious on the given subject.

Around a half of interviewed, 47.8 per cent (n=68) confirmed about their commitment to change their lifestyle and willingness to "think about the best way to change it". However, fewest reports were not providing positive perspective and about 35 per cent (n=49) turned out to be ignorant in this regard.

While referring to the issue of adherence to treatment instructions, about 24 per cent (n=34) of the respondents confirmed on their obedience to doctor's prescription and necessity of active involvement of patient in a treatment process itself, having outlined such defining factors for the given activity as motivation and self-control. The rest of respondents did not have an answer to the given subject and only a few of them mentioned that they do not have any health related problems.

ASYLUM SEEKERS

SOCIAL-DEMOGRAPHIC CHARACTERISTICS

Response Rate

12 asylum seekers participated in the Survey. The response rate was 28 per cent. Convenience sampling was performed. Due to the language barrier, only 12 persons from the list provided by the shelter personnel were able to participate in the Survey.

Sex and age

All of the interviewed asylum seekers were male. The interviewees were grouped according to five age group categories. Most of respondents (50%) were individuals of the age group of 25-34, followed by the age group of 18-24 (25%); two respondents comprised the age group of 35-44 and one fitted into the age category of 45-54.

Ethnicity

All of 12 asylum seekers were predominantly of Iranian, Sri Lankan and Uzbek nationalities.

Marital status

According to marital status, six groups were distinguished. The largest group (eight people-66.7%) was made up of unmarried. Three were presently married and one separated. The rate of married was highest among the contingent of 25-34 years of age (six people).

Education

Average length of education (overall number of years spent at school or full-time schooling, except for pre-school education) was 11 years.

The majority of surveyed have incomplete secondary education (58.3%). 25 per cent have university education and 16.7 per cent completed primary school only.

Table 8: Socio-demographic characteristics, asylum seekers, Georgia, 2011-12

	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65+	Total
Male	25.0%	50.0%	16.7%	8.3%	.0%	.0%	100.0%
Education							
No formal schooling	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Less than primary school	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Primary school completed	.0%	16.7%	50.0%	.0%	.0%	.0%	16.7%
Secondary school completed	100.0%	50.0%	50.0%	.0%	.0%	.0%	58.3%
High school completed	.0%	.0%	.0%	.0%	.0%	.0%	.0%
University completed	.0%	33.3%	.0%	100.0%	.0%	.0%	25.0%
Post graduate degree	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Marital status							
Single	66.7%	100.0%	.0%	.0%	.0%	.0%	66.7%
Currently married	33.3%	.0%	100.0%	.0%	.0%	.0%	25.0%
Separated	.0%	.0%	.0%	100.0%	.0%	.0%	8.3%

Divorced	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Widowed	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Cohabitating	.0%	.0%	.0%	.0%	.0%	.0%	.0%

Occupation

According to the work status, four groups were distinguished. The largest group (75%) was comprised of able-bodied unemployed individuals. One person mentioned about the unpaid work status and another one did not have an answer to this question.

When inquired about their scope of work prior to migration, the most prevalent response referred to the option of able-bodied unemployed (25%). Two persons (16.7%) worked in the NGO sector, another two were self-employed, one asylum seeker used to be a government employee. 33.3 per cent (four asylum seekers) refused to answer.

Placement in the conflict zone during military activities

57.1 per cent of asylum seekers were in the conflict zone during military activities. 50 per cent mentioned they felt relatively safe, 41.7 per cent felt absolutely unsafe, and 8.3 per cent refused to answer.

Household revenue

According to the average yearly revenue, the households were clustered in five groups. Yearly income of 50 per cent of interviewed was less than GEL2,600. Another 50 per cent refused to answer.

BEHAVIORAL RISK FACTORS (STEP 1)

Tobacco consumption

Current smokers

Currently any kind of tobacco product (smoked and smokeless) is consumed by 33.3 per cent of respondents. 75 per cent of current smokers consume tobacco on a daily basis. Mean age of smoking initiation among daily smokers was 18 years. All daily smokers use manufactured cigarettes.

Former smokers

Former daily smokers comprised 18.2 per cent of surveyed.

Attempt to quit smoking

Over the past 12 months attempts of stopping smoking were made by 66.6 per cent (two asylum seekers) of ever smokers; none of them used any means of assistance to quit smoking. The longest period respondents abstained from smoking lasted throughout 56 days (app. 2 months).

Alcohol consumption

Lifetime alcohol consumption

Prevalence of alcohol consumption among asylum seekers comprised 50 per cent (six respondents).

Alcohol consumption status throughout 30 days and 12 months prior to the Survey

For the last 12 months prevalence of alcohol consumption comprised 66.7 per cent (four respondents). Prevalence of alcohol consumption among those who resorted to alcohol for the last month prior to the interview comprised 75 per cent (three respondents).

Frequency and amount of alcohol consumption

Mostly alcohol is consumed by (50%, two respondents) for 5-6 days per week. One person consumes alcoholic drinks 1-4 days per week and another one reported that these occasions occur less than once per month.

As for the dose of alcohol, on average five standard alcoholic drinks were consumed throughout last 30 days during one drinking occasion.

Diet

Daily food consumption

50 per cent of respondents take food twice per day. The second large group of respondents (41.7%) consumes three meals per day. One male of 45-54 age category reported that he did not eat every day.

General structure of food consumption

According to the Survey results, all respondents take fewer than five servings of fruit and vegetables per day on average. All respondents take two servings of fruit. Mean days of fruit consumption comprise three days per week. Mean days of vegetable consumption comprise four days per week, considering the portion of two servings per meal.

Meat products are consumed on average three times per week, with average number of two servings.

Fish or sea products are consumed on average once per week, with average number of two servings.

Dairy products are consumed on average two days per week; with average number of two servings.

Consumption of bread and cereals occupied first place among food types reported by the interviewed population – six days per week and two servings per day.

Level of sweets intake and products with sugar content was remarkably high. According to the number of consumption days, these occupied the second place following bread and cereal

products. The tendency was the same in terms of consumed servings. The interviewed take sweets for six days per week, two servings per day.

Consumption of less than five servings of fruit and or vegetables per day and diet-related risk

Consumption of less than five servings of fruit and vegetables was defined as criteria for evaluating the diet-related risk. The results of the Survey showed that all respondents are under diet-related risk.

Fat consumption

The most common fat for cooking at home was vegetable oil (58.3%). Followed by a butter, comprising 8.3%.

Eating outside

None of the respondents stated about food intake outside of the Asylum Seekers' Shelter.

Physical activity

8.3 per cent (n=1) of respondents stated that their work involves vigorous-intensity activity that causes large increases in breathing or heart rate for at least 10 minutes continuously. Vigorous-intensity activities as part of work are performed throughout five days in a typical week.

25 per cent of respondents mentioned that their work involves moderate-intensity activity. Moderate-intensity activities as part of work are performed throughout six days in a typical week; and last up to 120 minutes.

66.7 per cent walk or use a bicycle (pedal cycle) for at least 10 minutes continuously to get to and from places. These activities are done throughout five days in a typical week and last up to 34 minutes.

33.3 per cent mentioned that they perform vigorous-intensity sports, fitness or recreational activities (running, playing football) causing large increases in breathing or heart rate for at least 10 minutes continuously. This is done throughout four days in a typical week; and lasts up to 107.5 minutes.

16.7 per cent said they do any moderate-intensity sports, fitness or recreational activities (running, playing football) causing large increases in breathing or heart rate for at least 10 minutes continuously. This is performed throughout four days in a typical week; and lasts up to 37.5 minutes.

HEALTHCARE ACCESS

When inquired about the type of health services that are available for their community, 50 per cent of asylum seekers mentioned hospitals, emergency healthcare service and a nurse post; 41.7 per cent mentioned about polyclinics, 16.7 per cent - NGO service and mobile clinic, and only 8.3 per cent referred to the psychosocial service providers.

Healthcare services are financially affordable for only 8.3 per cent of respondents.

For 33.3 per cent it takes less than 30 minutes / 1-2 hours to reach the medical facility. The main type of transport is a bus (83.3%).

Awareness on Health Insurance Policy and its Enjoyment

None of the surveyed owned a health insurance policy and accordingly, the respondents did not have an answer pertaining to assistance that might have been available if the respective benefit was in place.

CLINICAL HISTORY

History of Raised Blood Pressure

Only 33.3 per cent of interviewed reported as having ever measured the blood pressure by medical personnel. Among 16.7 of surveyed, hypertension was detected. One (33.3%) asylum seeker reported occurrences of hypertension throughout last 12 months.

66.7 per cent (n=2) are currently receiving medication for high blood pressure treatment prescribed by a doctor or other health worker. This is followed by the recommendation to decrease salt intake (33.3%, n=1), weight loss (33.3%, n=1), and quitting smoking (33.3%, n=1). Physical activities were not prescribed by a doctor or other health worker to any of the surveyed.

Diabetes history

The majority of respondents (75%, n=9) have never checked glucose concentration in blood; only two asylum seekers have ever checked glucose and only one has mentioned about hyperglycaemia. One asylum seeker only reported occurrences of hyperglycaemia throughout last 12 months.

No medication or healthy life style choices were prescribed by a doctor or other health worker to any of asylum seekers.

History of other diseases

None of the asylum seekers has ever been diagnosed by myocardial infarction, stroke, cancer or raised blood cholesterol.

Visiting doctors

Inquiry was made on motives and frequency of visiting doctors or other medical personnel throughout last 12 months. Total percentage of both sexes, visiting doctor for the past 12 months comprised 33.3 per cent (n=4). Amongst those, 60 per cent of interviewed have visited a doctor or other medical personnel aiming to alleviate concrete health problem. None stated about preventive screening as an underlying reason of visiting a doctor.

Self-treatment

None of asylum seekers resorted to self-treatment. This should be considered positively.

Family history of diseases

When inquired whether their relatives (mother, father, sister, brother and spouse and his/her relative) have ever been diagnosed hyperglycaemia or diabetes, high blood pressure, stroke, cancer, hypercholesterolemia, an early myocardial infarction. Two respondents have mentioned about high blood pressure and diabetes (16.7%), one respondent mentioned about cancer, stroke, myocardial infarction and hypercholesterolemia (8.3%) in the family history of diseases.

PHYSICAL MEASUREMENTS (STEP 2)

Arterial hypertension, heartbeat rate, weight, height, body mass index, and waist circumference were assessed and measured.

Arterial blood pressure and heartbeat

Mean systolic blood pressure among the surveyed population was 137mmHg and mean diastolic blood pressure - 83mmHg. Both figures steadily increase with age, systolic from 132 (age group of 18-24) to 186mmHg (age group of 45-54) and diastolic from 76 (age group of 25-34) to 114mmHg (age group of 45-54).

Blood pressure ≥140/90mmHg or hypertension was detected among 41.7 per cent of respondents (n=5) who do not take any medication.

Second stage hypertension (≥160/100mmHg) according to the national hypertension guideline was detected among 8.3 per cent (n=1) who do not take any medication. 8.3 per cent (n=1) of respondents were detected as having the blood pressure ≥160/100mmHg or being on treatment.

None of the respondents have been treated for raised blood pressure with medication prescribed by a doctor or other health worker during the past two weeks.

Pulse comprised 81 beats per minute.

Physical measurements

The average height was 173.8cm; the average weight - 72kg.

BMI was 23.8, which rises with age. The highest figures were detected among the age group of 45-54.

According to the BMI, four groups were distinguished. For both sexes, the biggest group (50%, six males) consisted of people having normal weight (BMI=18.5-24.9). Prevalence of

underweight (BMI<18.5) was 8.3 per cent (one male). 25 per cent (three males) were overweight (BMI=25.0-29.9). 16.7 per cent (two males) were obese (BMI>30.0).

Mean waist circumference was 87.7cm.

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

According to surveyed, the most efficient ways to address the psychosocial needs of asylum seekers consist in **facilitation of decision-making relating to their migration to the third destination countries, supporting family reunification and provision of essential assistance to ensure the respective response to their health and mental well-being needs**. More specifically, the respondents were calling for the state to offer assistance programmes that would contribute to increasing interaction among asylum seekers and local communities. The need for opening a health centre was particularly underlined.

Psychosocial conditions

There were no particular definitions offered by the surveyed to specify feelings of distress or uneasiness, however, fewest have described the given state as “inadequacy of funds and accommodation, injustice and feeling of being upset”. One of the interviewed offered a culturally specific idiom: “when my heart is sad, my mind is busy” The surveyed were unaware whether the feelings of temporary discomfort are widespread in their community, although some confirmed that personally they experience the given discomfort with minor intensity. As for the underlying causes of the experienced discomfort, respondents referred to the worries relating to responsibility over the family, inhumane treatment, confusion pertaining to the status of asylum seekers and uncertainty of the future.

No major hindrances were outlined with regards to the ability to practice one’s own cultural beliefs, the only barrier being the far location of the Mosk. The respondents are able to keep ties with their places of origin, mainly by phone communication; they follow updates and news pertaining to countries of their origin by radio broadcasting. Only the fewest confirmed on the opposite; some did not have an answer to the given subject. Family members and roommates share memories quite often, again with the negligible minority stating the opposite.

Psychosomatic conditions

As it was reported by the interviewees, their health conditions are aggravated subsequent to migration: five respondents (41.7%) outlined somatic complaints (headaches, stomach, heart or breathing problems); four of them (33.3%) confirmed on the occurrences of headaches; three (25%) reported on problems with digesting; two respondents (16.7%) experienced aggravation of chronic/non-communicable diseases; two (16.7%) have mentioned about chronic fatigue and loss of energy; one had problems with blood pressure; and one respondent referred to the respiratory problems.

Psychological problems

The respondents consider that psychological problems subsequent to migration are even more obvious: seven respondents (58.3%) avoid situations that make them scared or anxious; seven respondents (58.3%) reported on many worrying thoughts about migration for 24 hours; seven of them (58.3%) are having trouble with going to sleep; five respondents (41.7%) are feeling sad or want to cry; five (41.7%) have lost their interest in life or activities they used to enjoy; four (33.3%) are feeling scared; four (33.3%) are having problems with concentration; four (33.3%) are having trouble with waking at night and finding it hard to get back to sleep because of thoughts and worries; four (33.3%) sometimes have a feeling as if they are a different person; four (33.3%) have confirmed on the occurrences of bad mood; two (16.7%) are getting angry more often and lose control; and two (16.7%) of the interviewed mentioned about their willingness to drink more alcohol than usual. None of respondents admitted about their willingness to take narcotic drugs.

Individuals, paraprofessionals, professionals and facilities that asylum seekers refer to for relieving their problems of psychosomatic and psychological nature

Due to the above-mentioned complaints, asylum seekers refer to the hospital (66.7%, n=8), a clergyman (58.3%, n=7), local pharmacy (41.7%, n=5); a neighbour, a friend or a relative (33.3%, n=4); polyclinic (33.3%, n=4); a nurse post (33.3%, n=4); a psychologist (33.3%, n=4); a local community worker (33.3%, n=4); NGO worker and mobile clinic (33.3%, n=4); emergency healthcare service (25%, n=3) and a psychiatrist (8.3%, n=1).

KNOWLEDGE, ATTITUDE AND PRACTICES ON NCDS

Knowledge on NCDs

16.7 per cent (n=2) have mentioned CVDs and cancer as prevalent NCDs in Georgia; only 8.3 per cent (n=1) of respondents have mentioned chronic respiratory diseases (CRD) and diabetes mellitus (DM) as prevalent NCDs in Georgia.

8.3 per cent (n=1) of respondents were wrong while mentioning HIV/AIDS and hepatitis as prevalent NCDs in Georgia. 25 per cent (n=3) of respondents were wrong while mentioning flu as a prevalent NCD in Georgia.

Knowledge on major diseases was extremely low.

Knowledge on NCDs risk factors

Tobacco as one of the risk factors of NCDs was mentioned by 58.3 per cent (n=7) of respondents; excessive use of alcohol was reckoned as one of the risk factors of NCDs by 66.7 per cent (n=8) of respondents; unhealthy diet was considered as one of the risk factors of NCDs by 75 per cent (n=9) of respondents; physical inactivity was considered as one of the risk factors of NCDs by 83.3 per cent (n=10) of respondents; neglecting hygiene norms was wrongly regarded as one of the risk factors of NCDs by 75 per cent (n=9) of respondents; and practice of unsafe sex was wrongly deemed as one of the risk factors of NCDs by 50 per cent (n=6) of respondents.

Knowledge on major risk factors was low especially regarding hygienic factors and practice of unsafe sex.

Attitude on NCDs

When thinking over the ways to avoid contracting NCDs, respondents proposed such options as being engaged in sporting activities, reducing alcohol and tobacco consumption, avoiding application of psychoactive substances, as well as unsafe sex practices and unhealthy diet. Some referred to the importance of respective standard of life, maintenance of clean environment and affordability of medical check-ups. Very few confirmed although on having above-mentioned practices of preventive measures.

The level of awareness on NCDs among asylum seekers was fairly poor. Only fewest of surveyed considered elevated blood pressure as a disease, reckoned that a person with high blood pressure should avoid anxiety, and should adhere to the proper diet. When inquired on what does care for a person with NCDs implies, the interviewees referred to such propositions as "controlling blood pressure on a daily basis, ensuring that a patient has nothing to worry about, provide adequate nutrition, create stabile, safe environment and support a patient".

According to some of surveyed, the attitude towards health care workers and health care system is positive; however the majority was unaware on the given matter.

Practices on NCDs

The respondents did not specify anything clearly concerning practices on NCDs, partially due to their unawareness and partially stemming from the language barrier. Not a single person was able to propose anything when inquired on ways to prevent and manage NCDs. Some have confirmed that they easily yield to risk factors, but simultaneously have mentioned that they would change their behavioural habits "for the better" and would comply to treatment process if need be.

TRAFFICKED MIGRANTS

None of trafficked migrants was willing to participate in the Survey. Aiming at compensating the absence of the data on this group, the in-depth interviews were held with ATIPFUND personnel working directly with trafficked migrants, with the particular emphasis on the health conditions and needs of this vulnerable group. Therefore, the data given below represents the secondary data obtained from the Staff of the ATIPFUND Georgia, concerning trafficked migrants residing at the ATIPFUND shelter.

SOCIAL-DEMOGRAPHIC CHARACTERISTICS

In the beginning of conversation respondents mentioned about the problem of the language barrier while interacting with foreign trafficked migrants.

Reportedly, information on places of living of trafficked migrants is partially available; however, some beneficiaries prefer to keep this data secretly. The ATIPFUND staff is aware of this information although it should be considered that for the most of cases the majority of trafficked migrants do not have a permanent residence. The staff is also aware of the dates of birth and level of education of trafficked migrants, being mostly an incomplete primary or secondary education. Only one case was mentioned when a trafficked person had higher education. It has to be noted hereby that no individual data was shared with an IOM interviewer to ensure observance of confidentiality.

There were following ethnicities mentioned among trafficked migrants: Georgian, Uzbek, Russian and Turkish.

Problems relating to the registration of trafficked migrants appeared in case of Uzbek nationals solely. They were deported to Georgia from Turkey and did not hold transit documents. Nevertheless, the majority of state shelter's beneficiaries have personal documentation. Upon returning to or entering Georgia, some identified themselves as victims of trafficking, while others are granted the status of the VoT on the border. Accordingly, the latter already have the status of VoT when entering the shelter.

The majority of trafficked migrants were married or cohabiting, others are divorced with children.

Mostly, trafficked migrants are able-bodied unemployed both prior to becoming a VoT as well as subsequent to this fact.

The information concerning annual revenue of households was not available. However, as mentioned by respondents, usually, the absence of income is the primary reason for becoming a VoT. At the same time, the ATIPFUND's personnel mentioned that in case of sexually exploited persons it is possible to define the household revenue approximately, which totals GEL200-300 per month (<GEL2,600 per year).

Reportedly, sexually exploited trafficked migrants are facing acute problem relating to the observance of hygiene norms. It is likely that due to their grave experiences, sexually abused persons have developed mental resistance that points to their psychological state rather then lack of necessities at the shelter needed for keeping personal hygiene.

BEHAVIORAL RISK FACTORS (STEP 1)

Tobacco consumption

Trafficked migrants consume cheap, manufactured filtered cigarettes on a daily basis, amounting up to approximately 10 pieces. There were fewest attempts made to quit tobacco consumption and beneficiaries of the State Fund were offered such supportive measures as the manual of Allen Carr's "Easy Way to Give up Smoking" and pills of Tabex. However this approach did not work. Hereby it should be mentioned that generally, trafficked migrants are not really willing to stop smoking, but there are single cases when, for instance, a minor quitted smoking.

Alcohol consumption

The majority of trafficked migrants consume alcohol but not regularly. Again, the given tendency is rather frequent among sexually exploited persons. The experience of one trafficked person was brought as an example who, while working at the night bar in Turkey, had to drink considerable amounts of high-alcohol beer regularly, and this tendency have gradually developed into addiction. Accordingly, upon finding herself in the shelter, this person suffered from absence of alcohol.

It was stated that on average, the experience of trafficking lasted for 2-3 months, but in some cases it extended for the year or two. This information was useful for identifying the period of alcoholization, which according to the ATIPFUND staff, could last for one year minimum. As about the amount of consumed alcohol, usually, it constitutes the quantity enough for evoking good spirits; stemming from this the dose of drinks is not high. It has to be noted that considering the specificities on a case by case basis, the process of curing the alcohol addiction differs in its complexity.

Overall, it was mentioned that the level of alcohol consumption is moderate presently.

Diet

The feeding regime at the shelter consists of four meals per day. The ratio of diet is compiled according to the advice of medical personnel, therefore, the beneficiaries consume fruits on a daily basis, and meals are prepared using vegetable oil or butter. There are no cases of eating outside.

Physical activity

The physical activities of trafficked migrants are extremely low. However, as mentioned by interviewees, one of the beneficiaries was engaged in physical exercises on a daily basis. The

beneficiaries practically do not walk long distances, but they have a short walk in the shelter's courtyard, which they are usually reluctant to do, preferring watching TV.

HEALTHCARE ACCESS (GEOGRAPHICAL AND FINANCIAL)

All types of medical services mentioned in the questionnaire are geographically within the reach for trafficked migrants. As for financial affordability, according to respondents, the entire costs for medical services are covered by the state.

Health insurance

Trafficked migrants do not hold the insurance policy, but their health related costs are covered from the Fund's budgetary allocation, which, in its turn, receives funding from the state budget.

Awareness of available health benefits

Upon entering the shelter, trafficked migrants are presented internal regulations of the shelter, which includes the information and explanatory note on health services available for them; they are also provided with the information on their rights.

History of raised blood pressure

As it was mentioned by respondents, trafficked migrants are aware of the numbers of their blood pressure and basically, carry a normal blood pressure, 120/70mmHg.

Antihypertensive medication is administered quite rarely. It has to be noted that health services available for trafficked migrants do not include preventive measures. Hence the referral to doctor takes place only when in case of concrete health problem. The majority have never ever needed measuring glucose concentration level in blood.

History of other diseases

None of the diseases included in the questionnaire were indicated by trafficked migrants, the only one exception being a woman, diagnosed with uterine cancer. Another case was related to a person who had been diagnosed with TB before being trafficked and underwent respective treatment. However during the period of forceful exploitation due to trafficking, his health condition worsened severely. Upon entering the shelter, patient was examined and treated respectively.

The respondents mentioned that oral cavity health of trafficked migrants is of a particular concern since almost all of them suffer from dental problems. State fund provides certain coverage for dental treatment, but dental problems among this group had supposedly been serious enough before being trafficked, so upon entering the shelter, they necessitate surgical and orthopaedic interventions.

The information concerning history of family members' diseases was not available.

PHYSICAL MEASUREMENTS (STEP 2)

Body Mass Index
Relating to BMI respondents mentioned that trafficked migrants are neither underweight nor obese. Weight is often balanced following placement at the shelter and improved eating regime.

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

Mostly, trafficked migrants have low level of education and thus have difficulties in specifying their needs and wishes. As regards to the employment opportunities, it was mentioned that when employed, beneficiaries experience problems with adapting to the work place due to the lack of necessary vocational skills, however, despite that, they are not always eager to take certain job. Problems relating to the incapacity to overcome traumatic experience were mentioned as well. Namely, the case of former beneficiary and victim of sexual exploitation was mentioned who completed a waitress' course at the Vocational Education Centre (VET), however could not manage to adapt herself to the new occupation at the prestigious restaurant due to the fear of possible encountering with former aggressor. Stemming from the above mentioned, it is desirable to introduce programmes which provide opportunities for vocational education and subsequent support in adapting to the working environment.

Psychosocial conditions

Trafficked migrants usually do not define their gloomy feelings verbally. Shelter beneficiaries express their moodiness by their appearance, preferring to keep alone at some peaceful corner.

As for the reasons of the above-mentioned moodiness, assumptions concerning reawakening the recollections associated with the period of trafficking as well as fear of the future independent life were named. Reportedly, almost all trafficked migrants are disillusioned: "I have tried and that is what happened. What else shall I do on my own?" The ATIPFUND staff attributes the incapacity and lack of enthusiasm to be employed which is inherent to trafficked migrants to these very reasons.

Another psychological aspect peculiar to trafficked migrants consists in the tendency of bullying towards each other, instead of expected unity due to the common heavy experience in the past. It was mentioned by respondents that "they (trafficked migrants) are striving for leadership, gaining power and having influence on others" and within this context, argument can easily arise over the small routine things. Such discontent and following disputes often emerge concerning violation of private space.

Abilities to practice cultural beliefs

Trafficked migrants can freely practice their local cultural and religious customs and traditions. As for foreign migrant beneficiaries of the shelter, they always had an opportunity to keep ties with their countries of origin as well as family.

Psychosomatic conditions

Reportedly, trafficked migrants experience almost all of psychosomatic discomforts mentioned in the questionnaire with only few exceptions. Problems pertaining to disturbed sleep, fear and problems with concentration were highlighted particularly. In this respect, the ATIPFUND staff supposes that stress-related difficulties affected the intellectual abilities of trafficked migrants, which had already been rather poor. To alleviate the burden of psychosomatic conditions, trafficked migrants can refer to a nurse or a psychologist based at the shelter. It was mentioned that organizing a visit of a clergyman is also possible if need be.

KNOWLEDGE, ATTITUDE AND PRACTICES ON NCDS

Knowledge on NCDs

The level of knowledge concerning cardiovascular diseases is poor. According to the ATIPFUND's staff, the knowledge of trafficked migrants concerning the above mentioned is very general against the rather advanced awareness of communicable diseases such as flu and HIV/AIDS.

The knowledge of preventive ways and measures is also extremely poor. Moreover, trafficked migrants are not aware that frequent and unsafe sexual contacts impose risk for health and that this threat necessitates practicing respective safety measures.

Attitude on NCDs

As it was reported by the ATIPFUND's staff, in case of elevated blood pressure trafficked migrants consider necessary to administer relevant medication. As about their attitude towards healthcare workers and healthcare system, altogether it is positive and trust-based.

Practices on NCDs

According to the ATIPFUND's staff, trafficked migrants do not have any problems with referral services, since they can address the ATIPFUND's medical staff any time during 24 hours.

As for the ability to resist risk factors of NCDs, it was reckoned that factors of a willpower and counselling only are not enough to ensure the given resilience. Providing a very strong argumentation concerning acuteness of the given state and necessity of refusing the risk factors due to their grave effects on overall health conditions is crucial. However it was mentioned hereby, that despite such efforts, the majority of trafficked migrants are not willing to change their harmful habits.

According to the ATIPFUND's staff, the situation regarding compliance to treatment is grave likewise and in most cases, beneficiaries hardly agree to engage in lengthy process of treatment of NCDs.

FOREIGN MIGRANT DETAINEES

SOCIAL-DEMOGRAPHIC CHARACTERISTICS

Response Rate

Nine foreign migrant detainees participated in the Survey. The response rate was 30 per cent.

Sex and age

All nine respondents were male. Most of them (n=6; 66.7%) were individuals of 25-34 years old, the rest of the three were 35-44 (15.3%) years old.

Ethnicity

One respondent was Armenian, two Azerbaijani and the rest of them were Pakistani, Turkish and Iranian.

Marital status

According to marital status, five respondents were unmarried, two were currently married, one was cohabitating, and one refused to answer.

Education

Average length of education (overall number of years spent at school or full-time schooling, except for pre-school education) was 11 years.

The majority of surveyed completed secondary (44.4%) and university (33.3%) education. One respondent had a complete primary and another one incomplete secondary education (11.1%).

Table 9: Social-demographic characteristics, foreign migrant detainees, Georgia, 2011-12

	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65+	Total
Male	.0%	66.7%	33.3%	.0%	.0%	.0%	100.0%
Education							
No formal schooling	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Less than primary school	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Primary school completed	.0%	16.7%	.0%	.0%	.0%	.0%	11.1%
Secondary school completed	.0%	.0%	33.3%	.0%	.0%	.0%	11.1%
High school completed	.0%	66.7%	.0%	.0%	.0%	.0%	44.4%
University completed	.0%	16.7%	66.7%	.0%	.0%	.0%	33.3%
Post graduate degree	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Marital status							
Single	.0%	66.7%	33.3%	.0%	.0%	.0%	55.6%
Currently married	.0%	16.7%	33.3%	.0%	.0%	.0%	22.2%
Separated	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Divorced	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Widowed	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Cohabitating	.0%	.0%	.0%	33.3%	.0%	.0%	11.1%

Placement in the conflict zone during military activities

None of foreign migrant detainees were in the conflict zone during military activities. 55.6 per cent of respondents feel absolutely safe at the detention facilities, 44.4% mentioned that they feel relatively safe.

BEHAVIORAL RISK FACTORS (STEP 1)

Tobacco consumption

Current smokers

Currently any kind of tobacco product (smoked and smokeless) is consumed by 44.4 per cent (n=4) of surveyed, all of them were current daily smokers and use manufactured cigarettes. Mean age of smoking initiation among daily smokers was 22 years.

Former smokers

Two respondents were former daily smokers, both in the age group of 25-34.

Attempt to quit smoking

Over the past 12 months attempts to quit smoking were made by two respondents. One of them stated about using so called "light" cigarettes containing less nicotine and tar (but inflicting the same damage to health).

The longest period respondents abstained from smoking was 56 days (app. 2 months).

Alcohol consumption

Lifetime alcohol consumption

Prevalence of alcohol consumption was very high among foreign migrant detainees and comprised 88.9 per cent (n=8).

Alcohol consumption status throughout 30 days and 12 months prior to the Survey

None of foreign migrant detainees has consumed alcohol for the last 12 months.

Diet

Daily food consumption

The majority of respondents (66.7%) take food three times per day, 33.3 per cent has two meals per day.

General structure of food consumption

According to the Survey results, all respondents take fewer than five servings of fruit and vegetables per day on average. Respondents take two servings of fruit and one serving of vegetables. Average days of fruit consumption comprised three days per week and average days of vegetable consumption comprised six days per week.

Meat products are consumed three times per week on average, with average two servings.

Fish and sea products are consumed on average once per week, with average two servings.

Dairy products are consumed, on average, two days per week; with average one serving.

Consumption of bread and cereals occupied the first place among food types mentioned by the interviewed – everyday with average three servings per day.

Level of intake of sweets and products with sugar content was remarkably high. According to number of consumption days, it occupied the second place following bread and cereal products. The tendency was the same in terms of consumed servings. The interviewed reported on consuming sweets for four days per week; with average number of three servings.

Consumption of less than five servings of fruit and/or vegetables per day and diet-related risk

Diet-related risk was evaluated on the basis of consuming less than five servings of fruit and vegetables. The Survey results showed that all of respondents are under diet-related risk.

Physical Activity

One respondent mentioned that his work involves vigorous-intensity activity that causes large increases in breathing or heart rate for at least 10 minutes continuously. Vigorous-intensity activities as part of work are performed every day; and last up to 300 minutes.

None of respondents mentioned about moderate-intensity activity during their work.

Two respondents confirmed that they walk or use a bicycle (pedal cycle) for at least 10 minutes continuously to get to and from places. This is an everyday practice and lasts up to 120 minutes.

Three respondents reported that they are engaged in vigorous-intensity sports, fitness or recreational activities (running, playing football) that cause large increases in breathing or heart rate for at least 10 minutes continuously. This is done throughout four days per week and lasts up to 150 minutes.

Three respondents mentioned that they are engaged in moderate-intensity sports, fitness or recreational activities (running, playing football) that cause large increases in breathing or heart rate for at least 10 minutes continuously. This is done throughout six days in a typical week; and lasts up to 95 minutes.

HEALTHCARE ACCESS

When inquired on what health services are available for their community, five respondents (55.6%) named a polyclinic, two respondents (22.2%) – emergency healthcare service, two interviewees (22.2%) named a hospital, five (55.6%) – a nurse post, and two (22.2%) – have mentioned about psychosocial services. None of the interviewed has mentioned about referral to the NGO service either mobile clinic.

Awareness on Health Insurance Policy and its Enjoyment

None of foreign migrant detainees held health insurance policy and consequently, none of them had any information concerning the given benefit.

CLINICAL HISTORY

History of raised blood pressure

The majority (n=5; 55.6%) reported as having measured blood pressure by medical personnel. In one case hypertension was detected; the occurrence being the same for this respondent for the last 12 months. The hypertensive patient received prescribed medication for high blood pressure. However, there were no other recommendations granted.

Diabetes history

None of respondents have ever checked glucose concentration in blood.

History of other diseases

None of respondents mentioned as ever having myocardial infarction, stroke, cancer or raised cholesterol.

Visiting doctors

Inquiry was made on motives and frequency of visiting doctors or other medical personnel throughout last 12 months. Three respondents have visited doctor throughout last 12 months. The reasons of visiting doctors or medical staff consisted in the concrete health problems (n=2; 66.7%), and for preventive screening (n=1; 6.9%).

Self-treatment

One hypertensive respondent reported on practice of high blood pressure self-treatment.

Family history of diseases

When inquired whether their relative (mother, father, sister, brother and spouse and his/her relative) ever been diagnosed on hyperglycaemia or diabetes, high blood pressure, stroke, cancer, hypercholesterolemia, an early myocardial infarction, the majority of respondents (n=4 - 44.4%) mentioned about high blood pressure, followed by a cancer (n=2 - 22.2%), diabetes (n=2 - 22.2%) and stroke (n=1 - 11.1%). None of respondents have stated about hypercholesterolemia and myocardial infarction in the family history of diseases.

PHYSICAL MEASUREMENTS (STEP 2)

Arterial hypertension, heartbeat rate, weight, height, body mass index, waist circumference were assessed and measured.

Arterial blood pressure and heartbeat

Mean systolic blood pressure among surveyed population constituted 124mmHg and mean diastolic blood pressure - 78mmHg.

Blood pressure ≥140/90mmHg or hypertension was detected among 22.2 per cent of respondents (n=2) who do not take any medication. 22.2 per cent of respondents (n=2) were detected as having the blood pressure ≥140/90mmHg or being on treatment.

Second stage hypertension (≥160/100mmHg) was not detected at all.

None of respondents have been treated for raised blood pressure with medication prescribed by a doctor or other health worker during the past two weeks.

Pulse comprised 78 beats per minute.

Physical measurements

The average height was (173.3cm), the average weight - 69.6kg.

BMI was 23.1.

According to the BMI groups, 55.6 per cent (n=5) had normal weight (BMI=18.5-24.9). Prevalence of underweight (BMI<18.5) was 11.1 per cent (n=1). 33.3 per cent (n=3) were overweight (BMI=25.0-29.9).

Mean waist circumference was 89.6cm.

MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

When contemplating on betterment of the overall conditions, mainly respondents were pointing to the need for “improvement of communication systems and mainstreaming social activities”. In addition, respondents were asking for amnesty and granting permission to go home.

Stemming from evidence concerning the issue of community coherence, the language barrier was considered as the most acute impediment. Out of this very reason, respondents were proposing to introduce “language courses” and reckoned that joint sporting activities would be conducive for more interaction. When offered to think over the community-based participatory approaches, propositions relating to “appointments with family members” were made.

Psychosocial conditions

Occurrences of temporary feelings of uneasiness were confirmed by almost all interviewed; at the same time respondents were pointing to the likelihood of the prevalence of these conditions in a whole community of foreign migrant detainees. The experiences of gloomy feelings were described as “feeling bad” and “homesick”. Simultaneously, respondents have spoken about respective coping mechanisms and pointed to “taking a walk” or “falling asleep”, which, similarly to the above mentioned tendency among IFDM community, could be interpreted as a tendency towards escapism. In a scale of 10, one being the lowest and 10 being a highest rate, the estimation of five was given to the intensity of unpleasant experiences, with only one interviewee assigning to these experiences an estimation of eight. Homesickness and confinement were outlined as underlying causes of distress and discomfort, experienced by surveyed.

The ability of practicing cultural beliefs and traditions was confirmed by the majority of interviewed, and it was mentioned that the given notion applies to the whole community. The interviewees are able to keep ties with their families and places of origin by means of phone communication and following updates and news concerning their motherland. Memory sharing was confirmed again by the majority of surveyed.

Psychosomatic conditions

Respondents consider that subsequent migration, their health conditions deteriorated: 22.2 per cent (n=2) had difficulties with aggravation of chronic NCDs; 11.1 per cent (n=1) experienced problems with blood pressure; 11.1 per cent (n=1) – problems with digestion; 22.2 per cent (n=2) – respiratory problems; 22.2 per cent (n=2) – headaches; 11.1 per cent (n=1) – somatic complaints (such as headaches, stomach, heart or breathing problems); 11.1 per cent (n=1) – mentioned about chronic fatigue and loss of energy.

Psychological problems

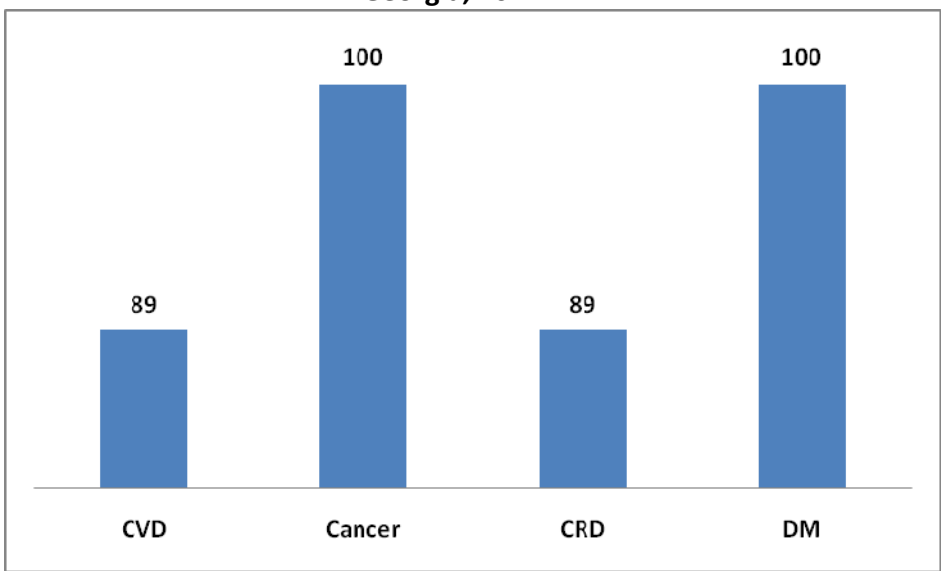
Respondents consider that subsequent migration, their psychological conditions deteriorated: 66.7 per cent (n=6) are getting angry more often and losing control easily; 62.5 per cent (n=5) – confirmed on avoidance of situations that make them scared or anxious; 42.9 per cent (n=3) – experience many worrying thoughts about migration for 24 hours; 42.9 per cent (n=3) – have trouble with going to sleep; 42.9 per cent (n=3) – have trouble with waking at night and finding it hard to get back to sleep because of thoughts and worries; 42.9 per cent (n=3) – of surveyed sometimes have a feeling as if they are a different person.

KNOWLEDGE, ATTITUDE AND PRACTICES ON NCDS

Knowledge on NCDs

One respondent (11.1%) has mentioned CVDs as the prevalent NCD in Georgia; none of respondents have mentioned cancer as the prevalent NCD in Georgia; one respondent (11.1%) has mentioned chronic respiratory diseases (CRD) as the prevalent NCD in Georgia; none of respondents have mentioned diabetes mellitus (DM) as prevalent NCD in Georgia.

Chart 51: Level of unawareness concerning major NCDs, foreign migrant detainees, Georgia, 2011-12

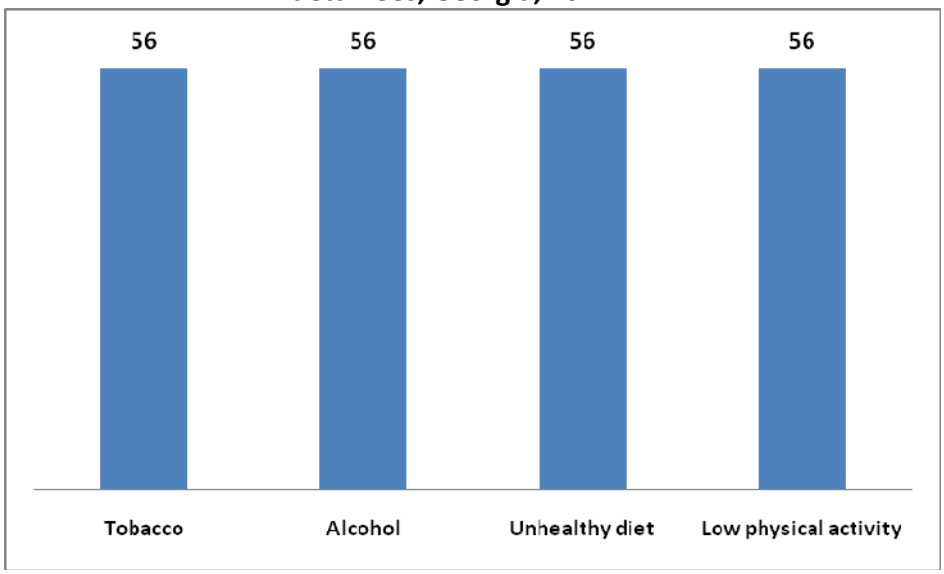


Four respondents (44.5%) have mentioned HIV/AIDS as the prevalent NCD in Georgia; two respondents (22.2%) were wrong while mentioning hepatitis as the prevalent NCD in Georgia; one respondent (11.1%) has wrongly mentioned flu as the prevalent NCD in Georgia.

Knowledge on NCDs risk factors

Tobacco was mentioned as one of the risk factors of NCDs by four respondents (44.5%); excessive use of alcohol was reckoned as one of the risk factors of NCDs by four respondents (44.5%); unhealthy diet was deemed as one of the risk factors of NCDs by four respondents (44.5%); physical inactivity was mentioned as one of the risk factors of NCDs by four respondents (44.5%)

Chart 52: Level of unawareness concerning NCD risk factors, foreign migrant detainees, Georgia, 2011-12



Neglecting hygiene norms was wrongly considered as one of the risk factors of NCDs by four respondents (44.5%); practice of unsafe sex was wrongly deemed as one of the risk factors of NCDs again by four respondents (44.5%).

Attitude on NCDs

The majority of surveyed were unaware of the ways to avoid contracting NCDs. Some mentioned about quitting tobacco consumption and referred to such needs as “awareness raising, sports and proper diet”.

Exactly the half of interviewed held respective experience of practicing preventive measures, whereas another half of surveyed did not have an answer to the given question.

Again, half of respondents correctly considered elevated blood pressure as a disease; however, another half of surveyed was not aware on the given topic. The interviewees were confident that when experiencing elevated blood pressure, a person should refer a doctor and control the condition by medication. Same applied to the attitude towards care for a person with chronic / non-communicable diseases – the respondents believed that it is important to approach a doctor and receive medication according to the prescription assigned.

The surveyed were particularly positively disposed towards health care workers and toward the entire healthcare system. The health care workers were associated with “feeling of happiness”, which means that foreign migrant detainees experience relief while interacting with medical personnel. It was stressed in this regard that respondents “need” health care providers. Supposedly, medical personnel are perceived not only as a provider of assistance for improvement of respondents’ physical condition, but as a possibility for emotional relief as well. As for the health care system, it was thought to be “well-functioning”.

Practices on NCDs

Mostly, respondents were unaware regarding practices on NCDs. When thinking over the ways to prevent and manage NCDs, interviewees offered to refer to a doctor for advice.

Some mentioned that they do not yield easily to risk factors of NCDs. Only one respondent confirmed on the given occurrence, whereas half of interviewed were unaware on the given subject.

Half of respondents were not confident whether they would comply with treatment process or not, however some have confirmed on the likelihood of this occasion, since they reckoned that "it is necessary to be complaisant".

CONCLUSIONS AND RECOMMENDATIONS

DISCUSSION

Comparative analysis of STEPs behavioural risk factors among the general population and internal forcefully displaced migrants

In 2010, the National Centre for Disease Control and Public Health, in collaboration with the Georgian Health and Social Project Implementation Centre (EU) and WHO conducted a nationwide survey on non-communicable diseases and their risk factors using the WHO STEPS (STEPwise approach to NCD Surveillance – STEPS) methodology.

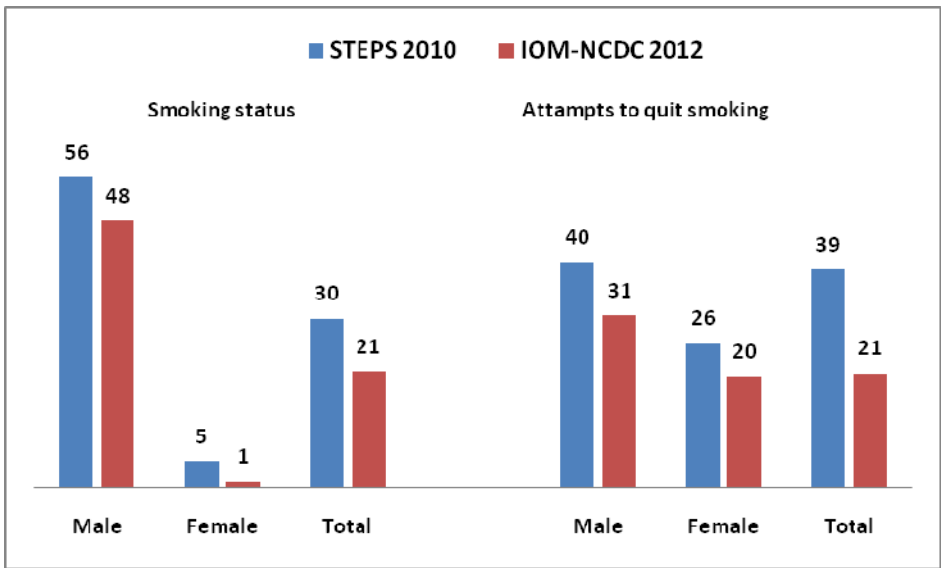
Since the same standardized STEPS instruments were adapted and utilized in the IOM-NCDC Survey, it provides for an opportunity to draw comparisons, in particular to build up discussion on similarities and differences between the general population and Internal Forcefully Displaced Migrants (IFDMs) subsequent to the 2008 Georgia-Russia war.

The IOM-NCDC Survey among IFDMs found that the yearly income of 79.2 per cent of those interviewed was less than GEL 2,600. Nevertheless, this condition is relatively satisfactory in comparison with the Nationwide STEPS Survey 2010 results, which identified the annual income of 95.5 per cent of general population being less than GEL 2,600 or GEL 217 per month.

All (100% of the respondents) IFDMs were found to be exposed to one or more risk factors; while according to the results of the Nationwide STEPS Survey 2010, about 4.5 per cent of general population was not exposed to any of the NCD risk factors.

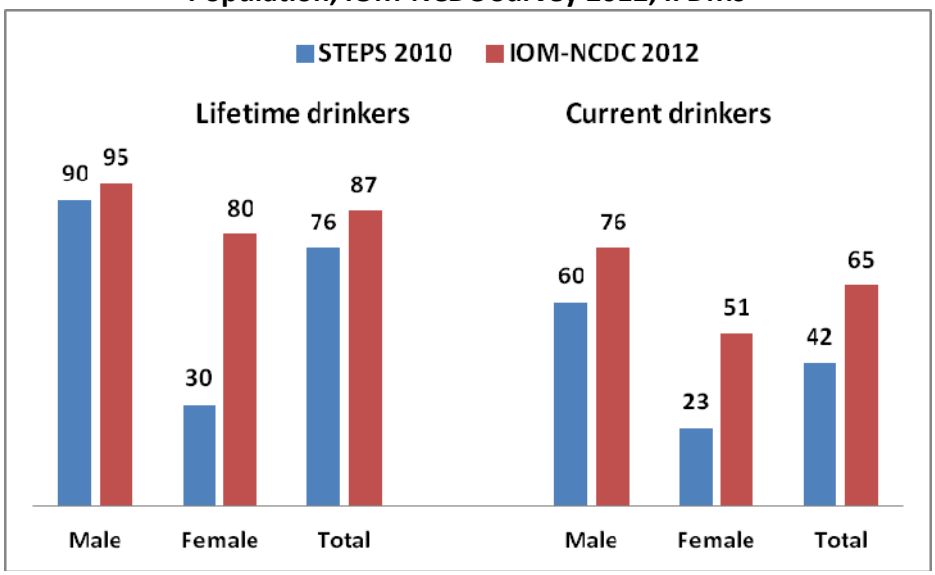
Smoking prevalence was higher among general population compared to IDPs. The age of smoking initiation as well as the type of cigarettes used was similar in both populations. 17 per cent of IFDMs are former smokers, which again corresponds to 12 per cent of general population with insignificant difference; relatively more ever smokers among general population than among IFDMs reported they have attempted to quit smoking over the past 12 months.

Chart 53: Smoking status & attempts to quit smoking (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



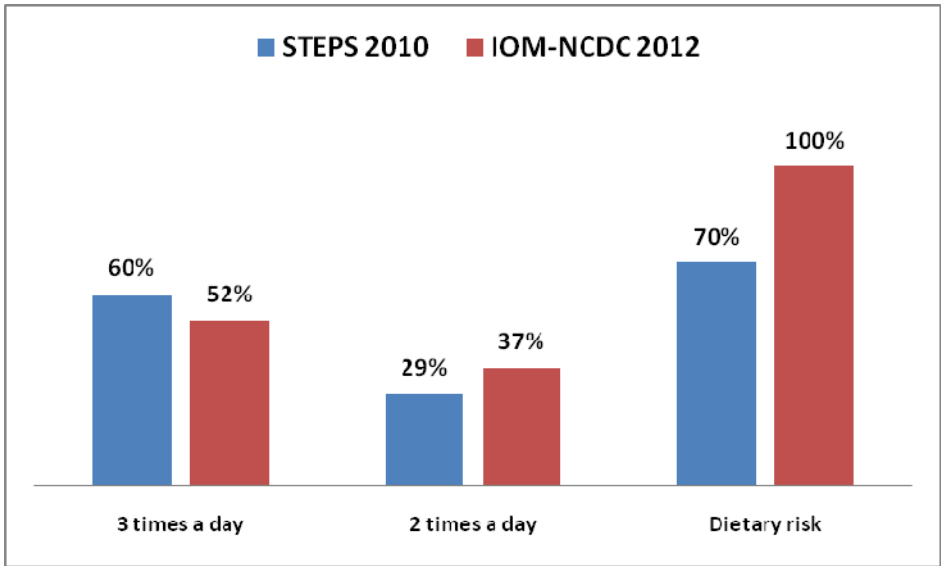
Prevalence of alcohol consumption was higher among IFDMs in comparison with general population. Figures on male groups are extremely high.

Chart 54: Alcohol consumption (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



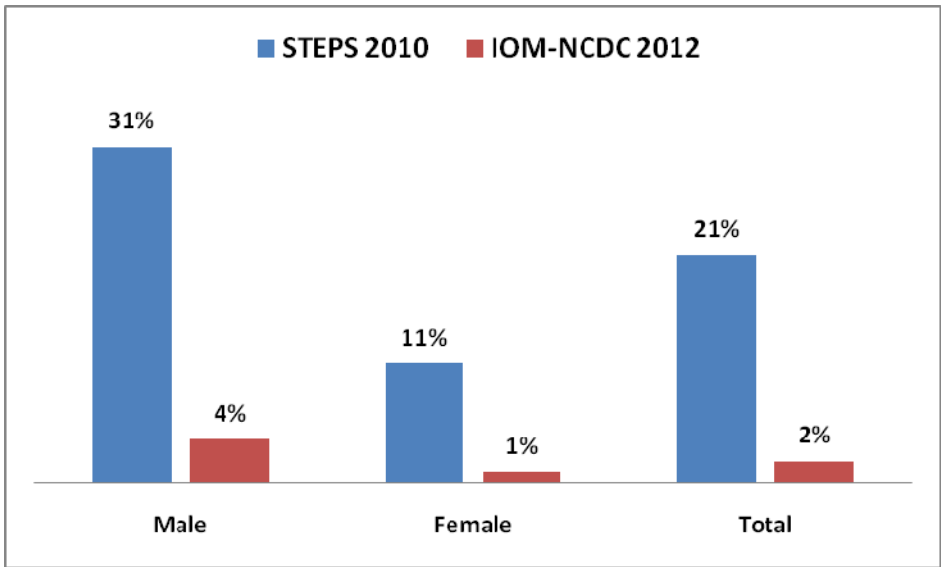
Substantial number of both populations consumes food three times per day. All IFDMs and majority of general population consume less than five servings of fruits and vegetables per day either are exposed to dietary risk. Consumption of food prepared outside is rather low among both populations (once per week).

Chart 55: Food daily consumption (%) and Dietary risk (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



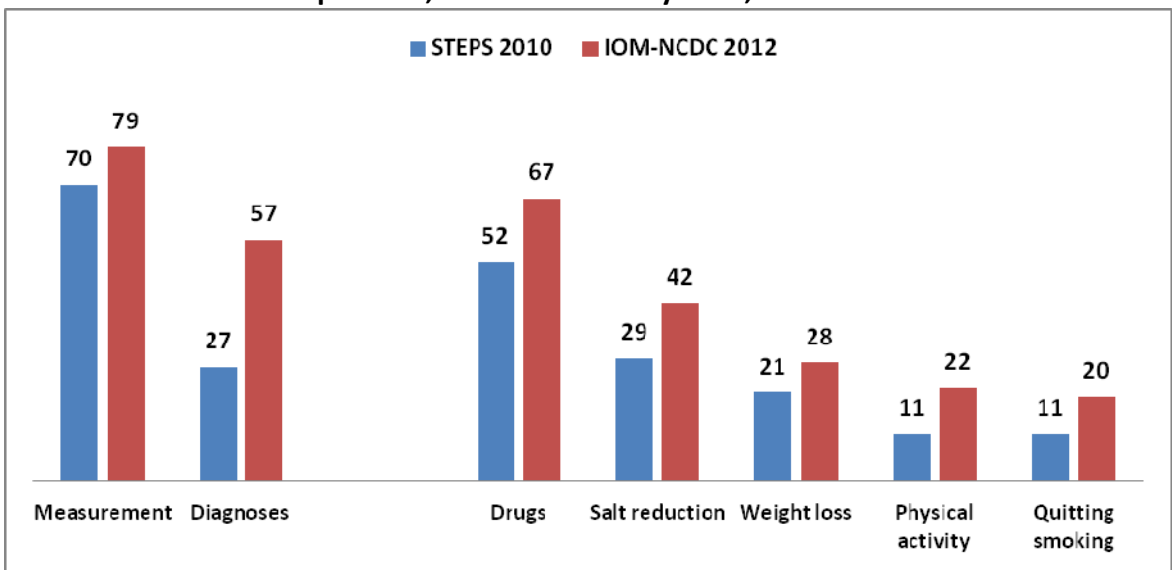
Regarding physical activity we only were able to compare vigorous-intensity sports, fitness or recreational activity as other variables in the national survey were calculated in a different way. Disparity relating to the engagement in vigorous-intensity sports, fitness or recreational activities is considerable, pointing to the low levels of physical activity among IFDMs.

Chart 56: Vigorous-intensity sports (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



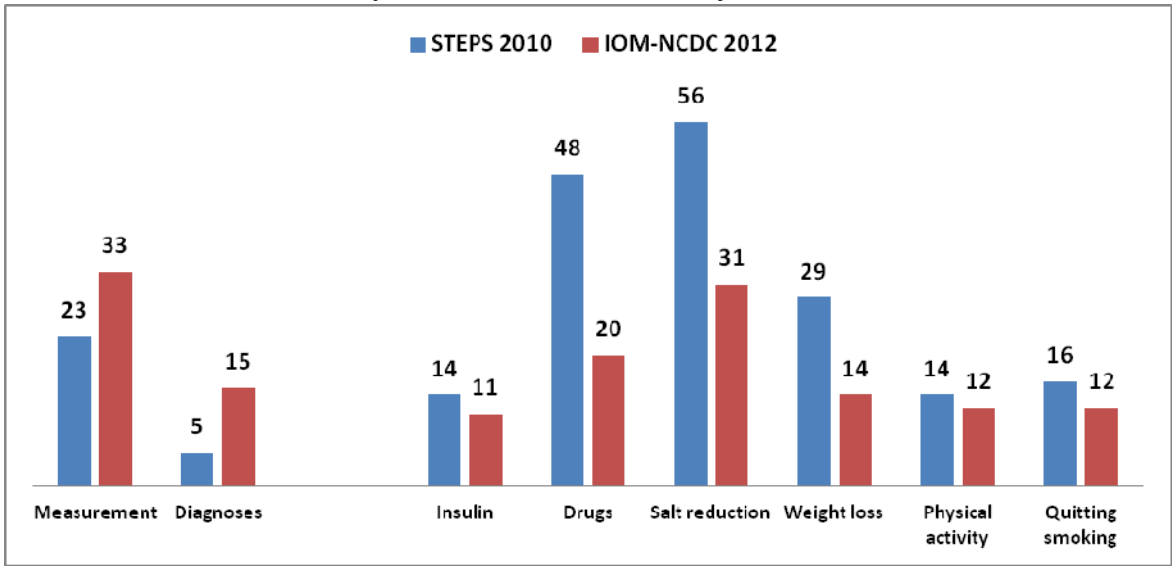
The majority of both populations reported as having ever measured the blood pressure by medical personnel. During the IOM-NCDC Survey, a higher prevalence of hypertension was detected among IFDMs as compared to the prevalence of hypertension found in the STEPS survey among general population in 2010. The most frequent recommendation for treating high blood pressure prescribed by a doctor or other health worker was medication for both of the surveyed populations; recommendations received on healthy lifestyle choices were rather low.

Chart 57: Hypertension measurement and diagnoses & recommendations prescribed by a doctor or other health worker (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



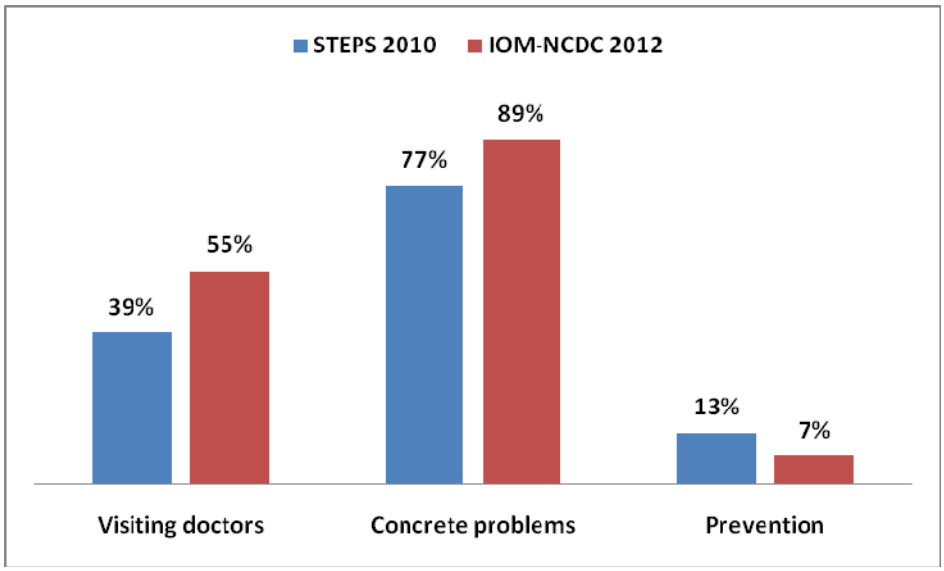
Glucose concentration measurement in blood as well as hyperglycaemia reports were higher among IFDMs. Most of the recommendations for hyperglycaemia prescribed by a doctor or other health worker included insulin, oral drugs and special diet; recommendations on healthy lifestyle choices were rather low.

Chart 58: Hyperglycaemia measurement and diagnoses & recommendations prescribed by a doctor or other health worker (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



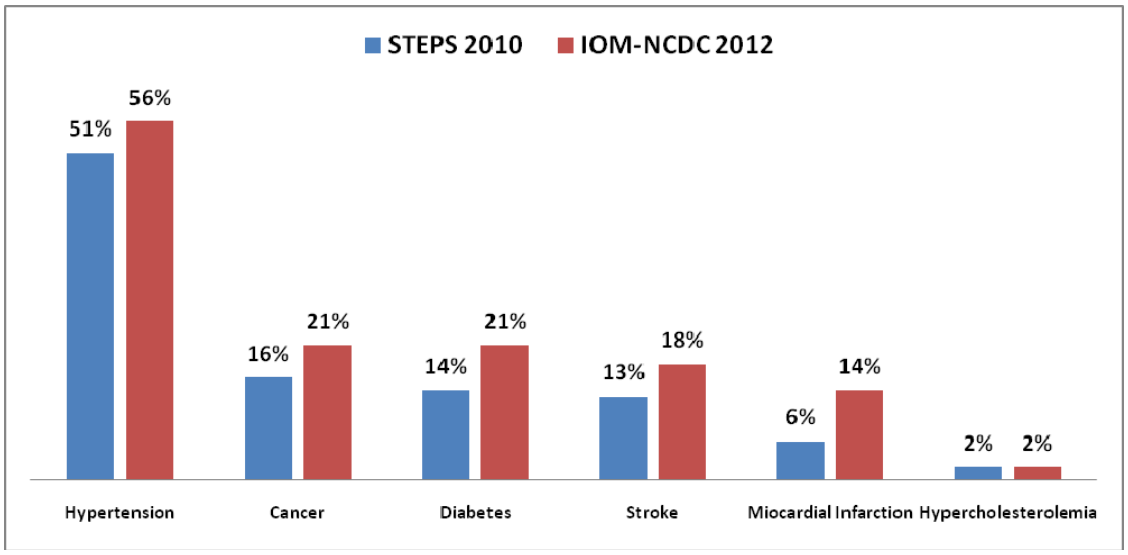
The occurences of visiting doctor throughout past 12 months were higher among IFDMs comparing to the general population. However, it is noteworthy, that number of cases of preventive screening is still quite rare among both populations and even slightly lesser among IFDMs.

Chart 59: Visiting doctors (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



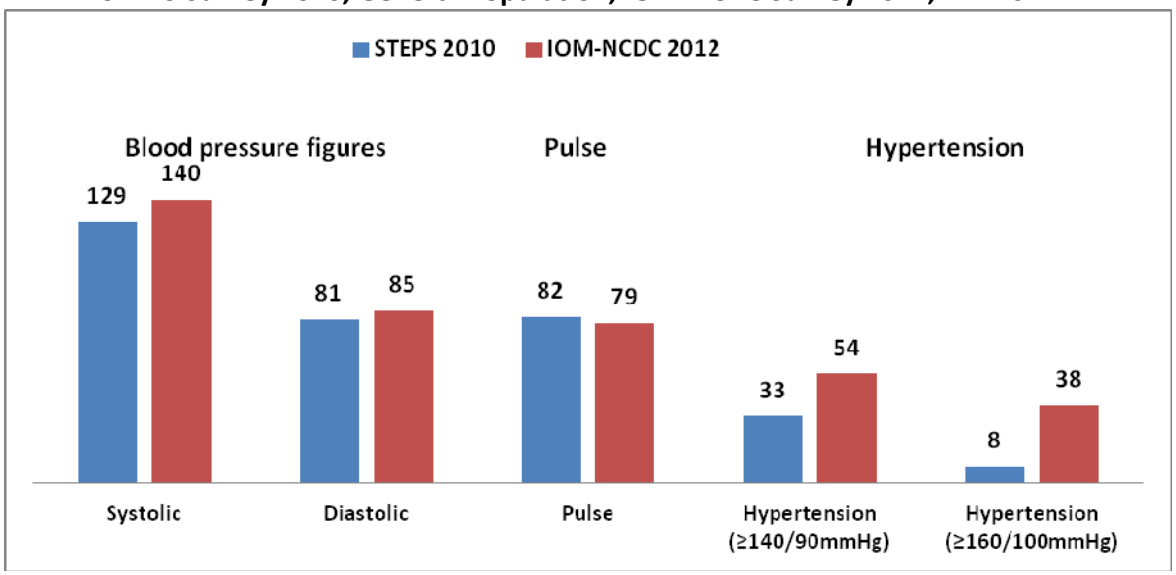
Family history of common non-communicable diseases is characterized by similar trends among both population groups, albeit figures are higher among IFDMs.

Chart 60: Family history of diseases (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



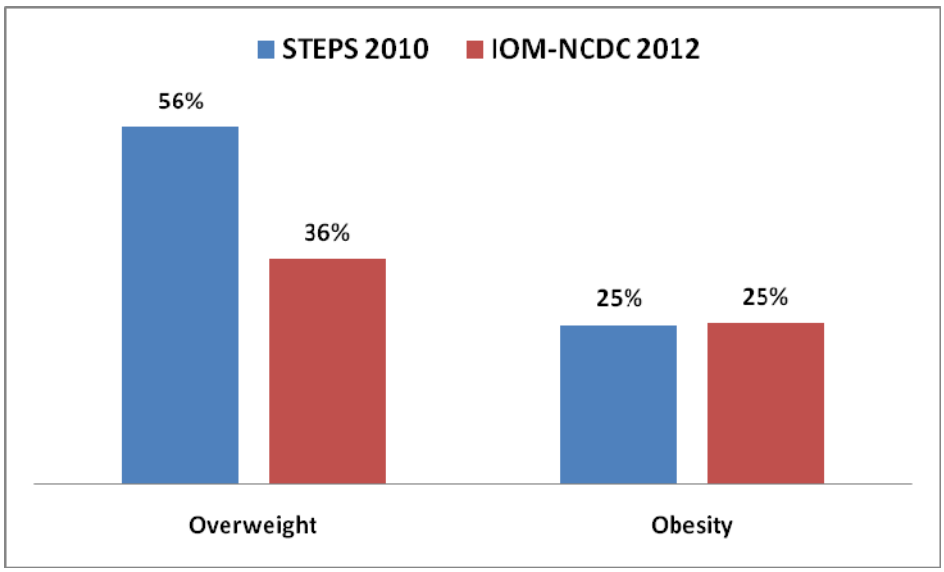
Blood pressure figures (both systolic and diastolic) are higher among IFDMs; correspondingly, the rates of hypertension prevalence are much higher among migrant population; nevertheless the pulse repetition frequency is almost the same among both surveyed populations.

Chart 61: Mean blood pressure and pulse, hypertension prevalence (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



Mean BMI in both populations is high (27.2 in IFDMs and 26.7 in general population); prevalence of obesity was found to be almost similar in the two surveys, but the Nationwide STEPS Survey 2010 detected a higher prevalence of overweight, i.e. in the general population as compared to the IOM-NCDC Survey 2012.

Chart 62: Overweight and obesity (%), Nationwide STEPS Survey 2010, General Population, IOM-NCDC Survey 2012, IFDMs



On the whole surveyed groups of general population and internal forcefully displaced migrants subsequent to the 2008 Georgia-Russia war are characterized by similar tendencies regarding non-communicable diseases and influence of their risk factors. Nevertheless, certain differences were revealed as well; e.g. higher prevalence levels of moderate to severe hypertension among IFDMs, which may indicate poor treatment access or compliance rates through routine healthcare; fewer self-reported attempts to quit smoking which indicates to the higher need for health education and promotion among IFDMs compared to findings on general population. It is worth mentioning that in both surveys, reportedly activities relating to the health education with particular emphasis on lifestyle choices for NCD prevention and control were rather low, which clearly points to the need for health education and promotion interventions concerning tobacco use cessation, alcohol prevention, etc.

Comparative analyses of STEPS behavioural risk factors among the groups of returned migrants, foreign migrant students, asylum seekers and foreign migrant detainees

Smoking

Current smoking prevalence was highest among returned migrants (65.9%) and turned out to be the lowest among foreign migrant students (7.1%); 33.3 per cent of asylum seekers and 44.4 per cent of foreign migrant detainees were current smokers.

Alcohol consumption

Lifetime alcohol consumption prevalence was very high among returned migrants (100%) and foreign migrant detainees (88.9%); whereas among asylum seekers it amounted up to 50 per cent; and among the group of foreign migrant students the respective figure was rather low (29.6%).

Nutrition

All migrants take fewer than five servings of fruit and vegetables per day, which means that they are under the dietary risk.

Physical activity

Majority of all migrants of foreign origin are engaged in vigorous-intensity sports, fitness or recreational activities. The respective figure among the group of foreign migrant students amounts up to 31 per cent with a minor difference comparing to asylum seekers - 33 per cent. As far as the returned migrants (Georgian nationals) are concerned, only 10.8 per cent of them confirm on the above-mentioned activities. The given wide margin might be explained by distinct behaviour practices that are inherent to the countries of origin of foreign migrants and those attributable to the Georgian population.

Blood pressure measurement and diagnoses

Blood pressure measurement by medical personnel turned out to be quite common among returned migrants (75.6%), foreign migrant students (66.9%) and foreign migrant detainees (5 out of 9); and only 33.3 per cent of asylum seekers resort to respective practices, which might be explained that the latter have less access to healthcare and their knowledge on health related issues is poor.

Blood pressure figures

The highest numbers of blood pressure were detected among returned migrants (systolic-152mmHg and diastolic-95mmHg). The respective numbers were lower among asylum seekers though. Pulse comprised 78 to 81 beats per minute.

Hypertension

The highest figures of hypertension prevalence during the last 12 months were reported by returned migrants (61.3%; blood pressure ≥140/90mmHg was detected among 82.9%; and the blood pressure ≥160/100mmHg was detected among 48.8%); as about the other migrant groups, the prevalence was relatively lower, being the lowest among foreign migrant students (13.1%) which seems to be relevant, since most of the foreign migrant students are 20-24 years old.

Blood glucose measurement

The majority of all migrants have never checked glucose concentration in blood.

Visiting doctors

The main reason for visiting doctors or medical personnel consists in specific health problems (50%) for all migrant groups. Practice of screening activities turned out to be the highest (27.7%) among foreign migrant students, which possibly could be explained by their educational background (medical) as well as accepted practices in the countries of their origin. Financial

affordability of healthcare services turned out to be the highest among foreign migrant students (33.8%) and lowest among returned migrants and asylum seekers (13.8% and 8.3% respectively).

Physical measurement
Mean body mass index (BMI) was especially high among returned migrants (28.5); prevalence of the overweight and obesity was also very obvious and high among returned migrants comparing to the other migrant groups.

All migrant groups are exposed to one or more NCD risk factors. Particular attention should be drawn to the group of returned migrants, who seem to be exposed to the several NCD risk factors. As migrant populations differ by their health profiles, lifestyle, exposure to risk factors and history of diseases it is tremendously important to look at various migrant types separately.

CONCLUSIONS BASED ON THE QUALITATIVE COMPARATIVE ANALYSIS:

Awareness on State Health Insurance Policy and its enjoyment

- Apart from the fewest exceptional cases, all of the internal forcefully displaced migrants hold state health insurance policy. Nevertheless, notwithstanding the explanatory notes included into the policy specifying the components of the given benefit, awareness of the beneficiaries regarding affordable services is low. Satisfaction with the policy was expressed regarding urgent surgical interventions, particularly regarding childbirth services as well as 20-50 per cent discounts for essential medicines. However, complaints were still voiced about the lack of financial affordability of these essential medicines and quality treatment of NCDs.
- None of the remainder migrant groups hold state health insurance policy.

Mental Health and Psychosocial Needs

(Comparative Analysis)

The following issues were highlighted as a priority for addressing the psychosocial conditions and the welfare of internal forcefully displaced persons:

(a) Improving socio-economic infrastructure of the settlements, which implies repairing dwellings, providing transport means;
(b) Providing employment opportunities and ensuring job placement, introducing beneficial tariffs for social services (such as electricity, gas and water supply), increasing pecuniary allocations and ensuring access to healthcare services;
(c) Facilitating re-elaboration of individual and collective losses;
(d) Since bonds among the IFDM communities are rather strong while their ties with local (hosting) communities are weaker, it is desirable to mainstream community bonding activities into the further psychosocial programming;
(e) Considering that the rate of passiveness of IFDMs with regards to participatory approaches was alarming and represents a particular concern, it is preferable to resort to community-based participatory approaches to avoid nurturing of the learned helplessness among IFDM communities.

Priority psychosocial needs of returned migrants are:

(a) Providing employment opportunities;
(b) Ensuring social and humanitarian assistance;
(c) Improving healthcare services in terms of increasing access and affordability of essential medicines;
(d) Reintegration of returned migrants subsequent to their comeback to homeland is a paramount concern. The problem is crucial from the social perspective - in terms of difficulties with finding a decent job; as well as from the societal perspective – in terms of stereotyped attitude that prevails among the general population in relation to returned migrants.

Priority psychosocial needs of foreign migrant students are:

(a) Providing language courses (Georgian language courses for foreign migrants, English language courses for local Georgian population);
(b) Facilitating interaction among the communities of local and migrant populations. In this context, the importance of interethnic and intercultural understanding was highlighted in particular, which points to the need of implementation of intercultural interactive programmes.
(c) Foreign migrant students predominantly underlined the need for strengthening primary health care services. Mainstreaming of migrant-friendly healthcare delivery is of primary importance for the enhancement of social well-being of the respondents. It needs however to be highlighted that respondents were all students of Tbilisi State Medical University, and therefore particularly sensitized to the issue.

Asylum seekers identified the following priority areas of their psychosocial needs:

(a) Expediting decision-making pertaining departure to the third destination countries;
(b) Supporting the family reunification;
(c) Addressing the mental and physical health conditions.

Foreign migrant detainees consider following priority needs for the improvement of their psychosocial well-being:

(a) Enhancement of communication systems;
(b) Planning and implementation of social activities;
(c) Language barrier is considered detrimental to interaction with local population and service-providers.

Foreigner victims of trafficking in Georgia and Georgian survivors of trafficking who returned reveal the following concerns of psychosocial nature:

(a) Difficulty in adapting to social and economic realities after the given experience;
(b) Resistance to offered assistance developed due to the violations suffered in their recent past and the resulting lack of trust and tendency towards self-humiliation;
(c) Health-related problems, namely dental problems.

Psychosocial conditions

Overall irritability and moodiness are quite frequent among all migrant groups, with the variable degree and intensity. Some symptoms of depression can be also found in this population but not

in pathological above threshold forms. The different underlying causes to this discomfort distinguish one migrant group from another:

- Internal forcefully displaced persons experience uncertainty and disorientation, anxiety and grief due to the various losses faced in the past and predicaments of the present. The tendency towards so called escapism is evident. The major motives can be defined as the causes to the depressive mood: i) humane and material losses; ii) direct experience of violence and displacement; iii) unemployment and poverty;
- Returned migrants are frustrated due to failed attempt to restart their lives abroad and experience discomfort stemming from reintegration difficulties, unemployment, and lack of affordability of healthcare services;
- Foreign migrant students complain about being isolated from local communities, loneliness, longing for family members and burden of studies;
- Asylum seekers are disturbed due to prolonged decision-making about their status determination and isolation from local communities;
- Foreign migrant detainees reveal the underlying causes of psychological discomfort being in communication problems (due to language barrier), lack of social activities, and homesickness.

In addition, regarding internal forcefully displaced persons it can be concluded that constant and recurring connection with principal sources of stress (observing their former places of residence by Internet and binoculars) has damaging influence on the psychological state of IFDMs and impedes the process of coping with their past experiences. The natural tendency of memory sharing is also apparent among all migrant groups; however, a compulsory nature of this practice among the IFDM families, particularly with the emphasis on children, contributes to "chosen traumas".

Psychosomatic conditions

All migrant groups confirm the presence of psychosomatic conditions; however, certain symptoms prevail among specific groups of migrants. Internal forcefully displaced persons and returned migrants complain concerning hypertension, aggravation of chronic diseases, headaches, sleeplessness and chronic fatigue; whereas foreign migrant students mention about headaches, chronic fatigue and problems with concentration mostly and consistently with results of studies with non-migrant student populations worldwide. Asylum seekers point to anxiety, appearance of worrying thoughts and sleeplessness; foreign migrant detainees experience general irritability, sleep problems and alienation; and in contrast with the above-mentioned groups, reportedly, trafficked migrants experience almost all of the psychosomatic symptoms specified in the questionnaire.

Knowledge, Attitude and Practices towards NCDs

Knowledge on NCDs

Knowledge on NCDs is low among all migrant groups participating in the Survey.

Attitude on NCDs

- Awareness of internal forcefully displaced and returned migrants regarding preventive measures and ways of managing NCDs is poor and limited to broad perceptions; less than a half of the polled (and the fewest in case of returned migrants) hardly have any experience in this regard. Contrary to this, foreign migrant students and asylum seekers are well aware of four major risk factors of NCDs, but again hardly refer to respective practices. Awareness of foreign migrant detainees and trafficked migrants on preventive measures and ways to manage NCDs is extremely low. Certain number of foreign migrant detainees demonstrated partial understanding of the harmful effects of tobacco consumption and low physical activity, however, only the fewest confirm on the respective practices.
- Awareness of internal forcefully displaced migrants on the occurrence of hypertension is satisfactory; however, the importance of proper treatment is not recognized accordingly. Therefore, treatment practice is being limited to episodic interventions intended to decrease elevated blood pressure at the given moment only. In contrast to those, returned migrants, foreign migrant students and foreign migrant detainees have proper understanding of the hypertension phenomenon, which is proved by the prevalent suggestions on the necessity to refer to a doctor, observe special diet and administer prescribed medicines. Necessity of taking medication was also confirmed by trafficked migrants as well. As far as the asylum seekers are concerned they do not reckon hypertension as a disease and only a few believe that it should be addressed by avoiding anxiety and maintaining respective diet.
- All migrant groups associate care for a person with chronic diseases with care for a terminally ill patient. The given finding points to the lack of knowledge on managing NCDs and poor understanding that the person suffering from chronic conditions can at the same time live a quality life with appropriate compliance with preventive and treatment/control measures.
- Trust towards healthcare personnel and healthcare system is high among all migrant groups equally: however, internal forcefully displaced and returned migrants complained about the lack of the access to treatment and affordability of essential medicine as well as insufficient flexibility of healthcare system since the illness imposes grave impact on the economic conditions of the family. Foreign migrant students point to the problems of the language barrier and existence of prejudices towards migrants among the general public. Foreign migrant detainees underlined the positive aspect of interaction with the healthcare personnel, which not only brings a substantial relief but is conducive for both their physical health as well as psychosocial well-being.

Practices on NCDs

- Awareness on prevention measures of NCDs is extremely poor among all of the migrant groups except for foreign migrant students. Basically, the argumentation is rather broad, such as importance to observe healthy lifestyle and refer to the healthcare workers for professional advice, while the foreign migrant students point to the necessity of managing four major risk factors and highlight the significance of raising awareness among general population.
- Referral to medical facilities and healthcare professionals is extremely low among the groups of internal forcefully displaced and returned migrants and the attitude towards referral practice is negative in general. This is why the referral is being limited to the

cases of emergency only. Another reason consists in financial constrains and inability to afford essential medicines. The same tendency applies to the groups of foreign migrant students and asylum seekers, but the reason basically lies in the problem of language barrier and discontent with hygiene standards at the medical facilities. Unlike to these groups, trafficked migrants refer to healthcare professionals on a regular basis.

- Internal forcefully displaced and returned migrants, as well as asylum seekers and foreign migrant detainees experience influence of NCDs risk factors. In particular, difficulties were revealed with abstaining from consumption of alcohol and tobacco, reducing salt intake and controlling weight. Nevertheless, willingness to overcome harmful habits and change lifestyle was expressed that should be strengthened by raising awareness and implementing health promotion programmes. The situation is different regarding the groups of foreign migrant students and trafficked migrants. Foreign migrant students successfully resist the risk factors and confirm on their willingness to progress further. To the contrast, trafficked migrants yield to the risk factors of NCDs and confirm on their inability to change behavioural habits.
- Both internal forcefully displaced and returned migrants confirm on the vital necessity of compliance to treatment process, at the same time mentioning about problems relating to the lack of affordability of essential medicines and insufficient qualification of healthcare professionals. In addition, they voice conditional suggestions stating that the degree of their compliance to treatment is substantiated by respective motivation, availability of organic food as well as overall social, political and economic situation in the country. Contrary to these groups, awareness of foreign migrant students, asylum seekers and foreign migrant detainees on the significance of compliance to treatment is poor.

RECOMMENDATIONS

Monitoring Migrant Health

1. It is advisable to ensure the regularity of the given Migrant Health Survey every 3-5 years in order to establish a sustainable surveillance system to estimate existing tendencies and provide sustainable networking for information exchange and evaluation.
2. It is reasonable to develop and strengthen the mechanism for monitoring and surveillance of health conditions of not only internal forcefully displaced but also other diverse migrant groups, in order to develop an understanding of the health of these emerging groups, and identify any health challenges in an appropriate and timely manner.
3. It is desirable to disseminate the Survey results among the Insurance Companies as well as other governmental and non-governmental, national and international health stakeholders in the country (such as health policy makers and other regulating authorities; non-governmental stakeholders in migrant health – e.g. UN agencies, NGOs working with migrant groups, universities hosting foreign migrant students, post-trafficking services and other relevant actors) to undertake an in-depth analysis, oriented at win-win solutions, in view of increasing capacities/coverage offered by the State Health Insurance Policy with regards to NCDs treatment.
4. It is advisable to present the Survey results to the concerned migrant populations, to ensure their awareness as well as availability of health related information.
5. Any further research would be valuable – e.g. intervention research with implementation of NCD prevention measures and evaluation of health insurance/allowance impact for NCD drugs on NCD treatment compliance, etc. such information can inform policy makers and other partners/donors on the needs.
6. It is reasonable to disseminate Migrant Health Survey results to communicate the needs of diverse migrant groups to frontline stakeholders such as policy/decision makers, INGO and NGO sector, community leaders, etc. through different types of media sources.

Migrant Sensitive Health Systems

7. Capacity building of primary health care personnel with a special emphasis on NCDs and health promotion among PHC is crucially important. In light of this, it is advisable to provide respective training to PHC personnel to ensure that proper recommendations are issued to migrants using migrant-friendly methods in view of preventing influence of behavioural risk factors of NCDs and proper treatment of non-communicable conditions.
8. It is advisable to use the evidence obtained in result of the given Survey to ensure raising awareness, facilitating health promotion and reducing NCD-related risks. For example, as reported by foreign migrant student groups, communications and language are key barriers to obtain health education and healthcare, this should be addressed by health services that cater to migrants. On the other hand, it is desirable to strengthen capacities of PHC personnel and to enable them to facilitate awareness raising on NCD-related risks among hard-to-reach migrant populations such as some IFDM settlements, since the level of migrants' health knowledge is extremely scarce, coupled with poor practices in view of prevention and treatment of NCDs.

9. It is rational to elaborate simplified Information, Education and Communication (IEC) materials to ensure accessibility and explicitness of health-related information intended for diverse migrant groups as well as general population. Highlighting the importance of regular preventive screening activities is of vital significance, to ensure respective behaviour change in view of enhancing monitoring of NCDs.
10. It is advisable to raise awareness of internal forcefully displaced migrants on benefits and health entitlements available through the State Health Insurance Policy. Applying interactive approaches and ensuring respective capacity building of mediation services' staff is important.
11. It is rational to build upon the comparative analysis provided in the part of conclusions of the given Survey and implement needs-tailored mental health and psychosocial support (MHPSS) programmes for each of the migrant groups involved in the sample, based on multi-sectoral, multi-faceted and coordinated action.
12. Planning and implementing participatory migrant health programmes is a key aiming at raising awareness on preventive measures and ways of managing NCDs among all migrant groups involved in the Survey, considering cultural peculiarities and diversities of all.

Policy-Legal Frameworks

13. It is advisable to include migrant populations in any NCD prevention and control strategy and respective action plan, based on the Survey results.
14. It is rational to develop a plan and implement effective interventions directed to reducing the prevalence and incidence of NCDs among diverse migrant groups, considering the specific context of various migrant types and seeking "best buy" approaches and solutions proved to be successful in other low-income countries worldwide.

Partnerships, Networks and Multi-Country Frameworks

Networking of relevant stakeholders at the MoLHSA, NCDC, WHO, IOM as well as other frontline stakeholders is a key for devising plans to expand coordinated action on treatment coverage and prevention of NCDs. This will be important to expand the benefits available through the policy, especially in view of increasing access to preventive screening of NCDs and ensuring affordability of essential medicines.

BIBLIOGRAPHY

M. Oberg, MS. Jaakkola, A. Woodward, A. Peruga, A. Prüss-Ustün

2011 *Worldwide Burden of Disease from Exposure to Second-hand Smoke: a Retrospective Analysis of Data from 192 Countries.* The Lancet, 377: 139–46.

MM. Finucane, GA. Stevens, MJ. Cowan et al.

2011 *National, Regional, and Global trends in Body Mass Index since 1980: Systematic Analysis of Health Examination Surveys and Epidemiological Studies with 960 Country-years and 9·1 Million Participants, On Behalf of the Global Burden of Metabolic Risk Factors of Chronic Diseases Collaborating Group (Body Mass Index).* The Lancet, 377: 557–67.

G. Danael, MM. Finucane, JK. Lin et al.

2011 *National, Regional, and Global Trends in Systolic Blood Pressure Since 1980: Systematic Analysis of Health Examination Surveys and Epidemiological Studies with 786 Country-years and 5·4 Million Participants, On Behalf of the Global Burden of Metabolic Risk Factors of Chronic Diseases Collaborating Group (Blood Pressure).* The Lancet, 377: 568–77.

F. Farzadfar, MM. Finucane, G. Danael et al.

2011 *National, Regional, and Global Trends in Serum Total Cholesterol Since 1980: Systematic Analysis of Health Examination Surveys and Epidemiological Studies with 321 Country-years and 3·0 Million Participants, On Behalf of the Global Burden of Metabolic Risk Factors of Chronic Diseases Collaborating Group (Cholesterol).* The Lancet, 367**:** 578–86.

United Nations

2011 *Prevention and Control of Non-communicable Disease.* New York. http://www.un.org/ga/search/view_doc.asp?symbol=A%2F64%2FL.52&Submit=Search&Lang=E

World Health Organization

2005 *European Health Report, Public Health Action for Healthier Children and Populations.*

Framework Convention on Tobacco Control Implementation and Monitoring Center in Georgia

2008 *Population Survey on Tobacco Economy and Policy in Georgia.*

F. Serbanescu, V. Egnatashvili, A. Ruiz, D. Suchdev, M. Goodwin

2010 *Georgia Reproductive Health Survey, Summary Report* www.ncdc.ge

World Health Assembly

2008 *Resolution 61.17 on Health of Migrants* http://www.who.int/gb/ebwha/pdf_files/A61_R17-en.pdf.

S.D. Garduño-Diaz Prevalence
2012 *Risk Factors and Complications Associated with Type 2 Diabetes in Migrant South Asians.* Diabetes Metabolism Research and Review. 28:6-24.

Davies et al.
2011 *Social determinants and Risk Factors for Non-communicable Diseases in South Asian Migrant Populations in Europe.* Asian Eur J.

S.B. Rafnsson
2009 *Large-scale Epidemiological Data on Cardiovascular Diseases and Diabetes in Migrant and Ethnic Minority Groups in Europe.* European Journal of Public Health. 19(5):484-491.

MG. Carta, M. Bernal, MC. Hardoy, JM. Haro-Abad
2005 *Migration and Mental Health in Europe: Clinical Practice and Epidemiology in Mental Health.* 1:13.

S. Karlsen, J. Nazroo, K. McKenzie et al.
2005 *Racism, Psychosis and Common Mental Disorder among Ethnic Minority Groups in England.* Psychological Medicine. Sep 29:1-9.

M.J. Levitt, J.D. Lane & J.L. Levitt
2005 *Immigration Stress, Social Support, and Adjustment in the First Post-migration Year: An intergenerational Analysis.* Research in Human Development. 2:159-177.

S. Hernandez-Plaza, C. Pozo & E. Alonso-Morillejo
2004 *The Role of Informal Social Support in Needs Assessment: Proposal and Application of a Model to Assess Immigrants' Needs in the South of Spain.* Journal of Community & Applied Social Psychology. 14(4):284–298.

S. Hernandez-Plaza, M. Garcı´a-Ramırez, C. Camacho & V. Paloma, C. Stuart (Ed.)
2010 *Mobility and Wellbeing. The Psychology of Global Mobility.* International Psychology. New York, Springer.

International Organization for Migration
2010 Assessment of the Psychosocial Needs of Haitians Affected by the January 2010 Earthquake. Port Au Prince, Haiti.

Norwegian Refugee Council
2011 *Stress and Displacement: Psychological Problems and Ways to Overcome Them,* Course of Lectures for Future Teachers, Psychologists and Social Workers. Tbilisi

World Health Organization
2009 Assessment of the Mental Health and Psychosocial Support Needs of the Conflict-Affected Populations.

Sixty-First World Health Assembly
2008 WHA61.17, Agenda item 11.9, Health of migrants.

World Health Organization
1948 *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, (New York, 19 June – 22 July 1946); signed on 22 July 1946 by the representative of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.*

International Organization for Migration
2008 *Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return. IOM Middle East Assessment Tools.* Beirut.

International Organization for Migration
2009 *IOM Data Protection Principles*

The Harvard Medical Health School
2006 *Family Health Guide; Complicated Grief. Available from:* http://www.health.harvard.edu/fhg/updates/Complicated-grief.shtml

World Health Organization, National Centre for Disease Control and Public Health
2009 Assessment of NCD Prevention and Control Mechanisms in Primary Health Care. Tbilisi, Georgia

National Centre for Disease Control and Public Health
2010 Non-communicable Diseases Risk Factors (STEPS) Survey. Tbilisi, Georgia.