Aging in Displacement:

Assessing Health Status of Displaced Older Adults in the Republic of Georgia

A study conducted by

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The study team comprised faculty and students from Johns Hopkins Bloomberg School of Public Health (JHSPH) collaborating with staff and interviewers hired and trained by the Institute for Policy Studies (IPS).

For Johns Hopkins, the Principal Investigator was Courtland Robinson, from the Department of International Health and the Center for Refugee and Disaster Response. Co-investigators included George Rebok and Judy Bass from the Department of Mental Health. Student researchers and investigators included Paul Perrin and Namrita Singh. Additional data analysis was provided by Nino Paichadze and Holly Schuh.

For the Institute for Policy Studies, the study Co-investigator was Nana Sumbadze. Other staff included Tamar Abashidze, Irina Zhvania, Tamar Makharadze, Maia Maisuradze and Ekaterine Pirtskhalava. Interviewers for the IDP survey included Maka Eristavi, Ana Eristavi, Tamta Chelidze, Irina Makharadze, Nutsa Sagaradze, Tamta Narimanishvili, Sophio Mchedlishvili, Natia Ubilava, and Tata Zenaishvili.

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Executive Summary

A. Overview

Following Georgia's declaration of independence in 1991, secessionist movements in the provinces of Abkhazia and South Ossetia led to civil war within the borders of the new republic. In 1992-93, 252,000 people fled Abkhazia, primarily moving to the region bordering Abkhazia and to the Georgian capital of Tbilisi. Of the nearly 270,000 initially displaced, around 40,000 have returned to their regions of origin, leaving around 230,000 in "protracted" displacement for more than 17 years. Of these, nearly 30% are 60 or older (and nearly 60% are female). Renewed conflict between Georgia and the Russian Federation in 2008 displaced approximately 30,000 South Ossetians within their territory, nearly 135,000 ethnic Georgians to areas outside of South Ossetia, and another 38,000 South Ossetians to North Ossetia in Russia. Around three-quarters of the displaced returned to their areas of origin but, as of March 2009, the Government of Georgia still recognized about 26,000 of the recently displaced population as IDPs. In addition to the IDPs, Georgia has hosted refugee populations from neighboring countries, some of whom are now also counted among those in protracted displacement conditions. In 1999, an estimated 8,000 refugees from the second Chechen war fled into Georgia, settling mostly in rural areas in Pankisi Valley. Of these, fewer than 900 remained as of 2010, including around 46 older adults.

The presence of both "protracted" and shorter-term IDPs living in both urban and non-urban environments in the Republic of Georgia, nearly one-third of whom are older adults—along with a smaller population of Chechen refugees—provided a significant need and opportunity, first to develop an appropriate and valid measure of physical and mental health status among displaced older adults, second to measure prevalence of physical and mental health outcomes across different displaced populations, and third to provide policy makers and program practitioners with measurement tools and evidence to inform improved response to older adults, especially in protracted situations of displacement in urban areas. This is a timely moment in the Republic of Georgia as it seeks to fully integrate all IDPs, a goal recognized and supported by UNHCR's Global Needs Assessment. Displaced older adults— more than 60% of whom are women, and many of whom are physically and psychologically disabled—are among the most vulnerable population and most in need of targeted integration assistance.

This study of displaced older adults—including Georgians internally displaced in their own country and Chechen refugees fleeing civil war in Chechnya—was led by researchers working at the Johns Hopkins Center for Refugee and Disaster Response at the Johns Hopkins Bloomberg School of Public Health (JHSPH), in collaboration with the Georgian non-profit organization, the Institute for Policy Studies (IPS). The study was funded by the US State Department's Bureau of Population, Refugees, and Migration. Ethical approval was obtained from Institutional Review Boards at JHSPH and the National Center for Disease Control of Georgia.

B. Study Design

The 12-month study adopted a mixed-methods approach, incorporating both qualitative and quantitative methods in a sequential manner to gather contextual data on the populations of interest, develop and validate survey instruments, and implement the population surveys among displaced older adults. This report presents the four distinct but inter-related elements of the study.

- *Qualitative Study of Older Adult IDPs:* The first phase or element of the study included formative, qualitative research in three regions—Tbilisi, Shida Kartli, and Samegrelo—utilizing free-listing and key informant interview methodologies. The total sample size included 75 free-list interviews (25 from each region) and 45 key informant interviews (15 in each region) for a total of 120 interviews, of whom 74 were female and 45 were male respondents.

- *Instrument Development and Validation*: Using the data from the qualitative interviews and mapping this to existing or adapted scales, the study team developed, then pilot-tested and validated an assessment tool to measure physical and mental health status of displaced older adults. The validation process involved sampling 100 older adult IDPs in Shida Kartli and Tbilisi (including 66 females and 34 males), specifically to assess the psychometric properties of the Geriatric Depression Scale (GSD), which was adapted and normed to the Georgian context.

- *Prevalence Study of Older Adult IDPs*: The third phase of the study involved implementing a 30-cluster, 900-household sample survey of displaced older adults, stratifying by "protracted" displaced and shorter-term displaced populations. In the study, approximately half of the sample comprised older adults displaced during the 1992/93 civil conflict (referred to in this study as "Wave One" IDPs) and half were older adults displaced during the 2008 conflict with Russia ("Wave Two" IDPs). In all, 899 interviews were conducted, of whom 672 respondents were female and 227 were male.

- *Chechen Refugee Case Study*: In order to be able to make some comparisons between the IDP population and refugees from other countries, the study supplemented the IDP survey with a case study that included interviews with 15 Chechen refugee older adults and 11 key informant interviews with service providers and community leaders.

C. Results

1. Qualitative Results-IDPs

Analyses of the qualitative data demonstrate the presence of common salient problems across IDP communities in Georgia. In particular, analyses of free list interviews showed that older IDPs consider economic and health problems to be most prominent in their lives. Economic problems came down to a lack of financial resources and money to pay for medical visits and medication, housing repairs, or to support children and grandchildren. Unemployment was a significant concern for respondents, both for themselves and for their adult children and grandchildren. Unemployment was a problem not only because of money shortages but because it contributed to a collective feeling of, and frustration with, inactivity.

The health problems respondents listed included both the experience of various illnesses and conditions, as well as difficulties in accessing health care. The most frequently mentioned illnesses and conditions were chronic in nature and included mobility problems, blood pressure problems, diabetes and blood sugar problems, digestive problems, arthritis, and heart disease. Experiences of ill-health and financial hardship intersected in the health access problems that respondents named. These problems namely included prohibitively high costs of prescription medications, high costs of specialist care and surgeries, and inadequate health insurance coverage.

Free list respondents named a number of problems that were particularly tied to their status as IDPs. These included a strong desire to return to their homelands, recalling and longing for the past, grieving what was lost during the war and displacement, concerns over documentation, inadequate assistance or attention from the government, cramped living conditions in collective centers, a lack of plots, inability to own living spaces, and a fear of eviction.

In terms of functioning, respondents said that they took care of themselves by performing household chores and taking care of their own health needs, when possible. However, a number of respondents said that they could not do anything to take care of themselves. Respondents supported their families by looking after young children in their households and by helping out financially. Participation in the larger community was characterized by helping out in various ways at community gatherings such as weddings and other celebrations, as well as funerals. Community participation also included socialization and conversing with neighbors and friends.

Free list respondents did not frequently list mental health or psychosocial problems. However there were commonalities in the types of psychological problems that were described across sites. These problems included feelings of nervousness, anxiety, and stress; depression, unhappiness, grief and loss; isolation, hopelessness, and helplessness; irritation, quarreling, and conflict; being a burden to the family; and abandonment or neglect by the government. Key informant interviews provided more insight into these psychological issues from the perspectives of IDP community members, service providers, and other community representatives. Interviews demonstrated the importance of older IDPs' perceived roles in their communities for their overall functioning and psychological well-being. What was also highlighted through key informant interviews, as in the free list interviews, was the salience of displacement-related experiences for older IDPs. Difficulties in adapting to new environments, grieving the past and worrying about the future, a sense of inactivity, apathy, and hopelessness, and experiences of trauma were described as permeating older IDPs' daily lives and contributing to IDPs' lowered quality of life and well-being. Informants also stressed the fact that there are not enough programs specifically directed towards helping older adults and older adult IDPs.

b. Quantitative Results-IDPs

The overall picture that emerges from the survey of 900 Georgian older adults in displacement is one of people living in poor economic conditions, overwhelmingly unemployed, with serious concerns about the cost of medicines, small pensions and lack of concern from their government. More than half reported experiencing combat or war in their displacement, lacking food and water, being close to death, destruction or loss of property, serious illness, and dangerous escape. Their self-reported health status is less than 50 on a scale of 0-to-100, and majorities express moderate or serious problems with pain and discomfort, walking about, and carrying out usual activities like housework, family and leisure activities. Nearly three-quarters score as likely depressed on a Geriatric Depression Scale normed to the Georgian context, and more than two-thirds score above cut-offs for Generalized Anxiety Disorder, characterized by excessive, exaggerated anxiety and worry about everyday life events.

While this is the overall picture, there are three perspectives on this population that bring different experiences and burdens to light: wave of displacement, settlement type and gender. For many key measures (see Table 6.15), it appears that the Wave Two sample—those displaced in 2008—had higher depression and anxiety scores and lower health scores than their first wave counterparts—those displaced in 1992/93, despite the fact that Wave One respondents reported experiencing higher numbers and proportions of traumatic events during displacement. It

might be tempting to conclude from this that time heals some wounds, though, absent any baseline measures at time of displacement, such judgments should be made cautiously.

Another pattern we observed is that of poorer health and mental health status found among populations living in the state-owned collective centers and better status among populations living in private accommodations. Although Wave Two populations in the aggregate fare worse than Wave One populations on depression, anxiety and health-related quality of life scores, disaggregating the Wave One population by settlement type shows that individuals living in state-owned collective centers had higher levels of depression, more problems on three of five health-related quality of life domains (self-care, pain/discomfort, and anxious or depressed). The overall health score was also lower for populations living in the state-owned collective centers, compared to those in private accommodations. While these differences were not statistically significant (though marginally so in some cases), the data suggest that state-owned collective centers are likely the least healthy of all possible settlement alternatives for displaced older adults.

Table 1. Summary Table of Health Measures, by Wave of Displacement

Domain	Measure	Total	Wave One	Wave Two	p-value
Anxiety	Prevalence of GAD	73.6%	70.3%	76.6%	p=0.03
Depression	Prevalence of likely depression	70.1%	69.4%	71.9%	p=0.42
Health	Walking about	0.71	0.72	0.71	p=0.71
	Self-care (washing or dressing)	0.43	0.44	0.42	p=0.53
	Usual activities	0.75	0.74	0.76	p=0.53
	Pain/discomfort	0.90	0.88	0.91	p=0.17
	Anxious or depressed	0.71	0.66	0.75	p=0.001
	EQ-VAS	42.6	42.9	42.3	p=0.70

Table 2. Summary Table of Health Measures, by Settlement Type (Wave One)

Domain	Measure	Total	State-Owned Collective Center	Private Accom-modation	p-value
Anxiety	Prevalence of GAD	70.9%	70.6%	71.2%	p=0.89
Depression	Prevalence of likely depression	70.0%	73.2%	68.3%	p=0.28
Health	Walking about	0.72	0.72	0.72	p=1.0
	Self-care (washing or dressing)	0.45	0.48	0.43	p=0.35
	Usual activities	0.75	0.73	0.76	p=0.44
	Pain/discomfort	0.89	0.92	0.87	p=0.09
	Anxious or depressed	0.66	0.71	0.64	p=0.13
	EQ-VAS "Health Thermometer"	42.8	41.1	43.7	p=0.10

Table 3. Summary Table of Health Measures, by Gender

Domain	Measure	Total	Male	Female	p-value
Anxiety	Prevalence of GAD	73.6%	59.5%	78.4%	p<0.001
Depression	Prevalence of likely depression	70.8%	57.7%	75.2%	p<0.001
Health	Walking about	0.71	0.52	0.78	p<0.001
	Self-care (washing or dressing)	0.43	0.33	0.46	p<0.001
	Usual activities	0.75	0.62	0.80	p<0.001
	Pain/discomfort	0.90	0.81	0.93	p<0.001
	Anxious or depressed	0.71	0.59	0.75	p<0.001
	EQ-VAS "Health Thermometer"	42.6	47.5	40.9	p<0.001

c. Results-Chechen Refugee Case Study

The findings of the qualitative interviews revealed that there are economic, social and health-related problems among Chechen refugees. Social-economic hardships are expressed in terms of lack of money, need for proper living conditions, and concerns about unemployment and poverty. Some of the key informants noted that Chechen refugees mostly have high levels of education, they are used to living in town and in Pankisi Gorge it is very difficult for them to find proper employment, especially for men. Health problems are mainly expressed as general poor health of refugees, age-related chronic health conditions and mental health problems (stress, neurosis). Analysis of qualitative data revealed also that elderly Chechen refugees do not feel they are a burden to family, and do not feel they are abandoned or isolated. It is important to take into consideration the influence of strong cultural traditions and norms of Chechen society while analyzing these responses, as there may be some hidden issues that are not coming out because of cultural habits. As one of the key informants noted, "old Chechens can feel abandoned or isolated though they never show this."

Although the health and mental health scores are notably more adverse than the general Georgian population, the anxiety, depression scores among the Chechen refugees were all better than their IDP counterparts (due to small numbers in the Chechen study, only mean scores are presented rather than prevalence and no tests for significance are included). Similarly, the EuroQol health-related quality of life scores were higher than among IDPs in either Wave One or Wave Two. While the results of the Chechen case study are based on a small number of interviews and cannot be compared statistically with the IDP sample, it is interesting to note that the gender differentials paralleled the IDP study (albeit at lower levels). For all three key health measures, Chechen refugee women scored worse than their male counterparts.

Table 4. Health Measures: Chechen Refugees and IDP Wave of Displacement

Domain	Measure	Chechen Refugees	IDP Wave One	IDP Wave Two
Anxiety	Generalized Anxiety Index (GAI) Mean Score	10.9	12.5	13.3
Depression	Geriatric Depression Scale (GDS) Mean Score	8.3	9.3	9.6
Health	EQ-VAS Overall Health Score	48.7	42.9	42.3

D. Recommendations

It has been twenty years since conflict within and on the borders of Georgia produced the first large wave of displaced persons. Many of those people are still living where they "temporarily" settled, though older now and burdened by poverty and poor health. They have since been joined by refugees and by a new wave of internally displaced, many of whom are also older adults. The year 2012, according to a recent UNHCR report, "should herald a crucial transition in Georgia from humanitarian interventions for refugees and IDPs to sustainable longer term development" (UNHCR, 2012). UNHCR has phased out its direct assistance to IDPs and to Chechen refugees. The government of Georgia, international donors, international organizations, and non-governmental organizations and civil society are seeking to shift priorities from ad hoc, short-term relief (however prolonged it has been) to more integrated, development-oriented approaches. The challenge, and one of the key measures of success, will be to do so while maintaining, even strengthening, vital health and social supports for the most vulnerable populations, including older adults. One of the ways to strengthen services for older adults is to support the kinds of programs and policies that promote healthy aging and restore a sense of place to those aging in displacement.

The recommendations below from the Institute for Policy Studies and the Johns Hopkins Bloomberg School of Public Health are based on the results of the research on IDP older adults and Chechen refugee older adults in Georgia, and on discussions about study findings at a July 2011 workshop in Tbilisi, Georgia, which included participants from the Georgian government, PRM, USAID, UNHCR, and a number of local and international non-governmental organizations. The recommendations are directed toward the Georgian government, UNHCR, PRM and other humanitarian donors, and the NGO community and civil society in Georgia.

1. *Recommendations to the Georgian government.*
    - For the IDP populations living in protracted displacement, the Georgian government needs to complete its targeted objective to close all the state-owned collective centers and either help residents to move to private accommodations elsewhere or to remain in the newly privatized (and improved) facilities. There is little question that the placement of IDPs in collective centers on the assumption that these would be only temporary facilities pending their rapid return to their homes proved both to be misguided and, in the long-term, harmful to the physical and mental health of the populations who remained for years in these centers. The government of Georgia should also expand home ownership and privatization efforts to encompass the more recently displaced, whether they are living in state-owned collective centers or IDP settlements.

    - The government of Georgia should provide transitional income and pension support to IDPs and refugees as they shift from a status-based support system to one that is integrated into national pension and health insurance schemes. These schemes, moreover, in the context of ongoing health care reform need to incorporate a greater sensitivity to the needs of older adults in general and displaced persons in particular.

    - The government of Georgia should develop and promote programs to involve older adults as volunteers and counselors in health, education and social welfare programs. One idea is that of an Experience Corps®-like program that trains older adults to work as volunteer mentors in local schools. Another approach is the development of multi-purpose community centers in areas where there are larger numbers of IDP and non-IDP older adults living. These community centers should include "elder-friendly" spaces for meaningful social interaction, informal support groups, and mobile health clinics.

- When preparing for, and responding to, the needs of future displaced populations—whether IDPs or refugees, the government of Georgia should formulate plans, policies and programs that (1) incorporate input from the current IDP and refugee populations and their host communities, (2) address the needs of older adult and disabled populations (including accessibility, social support, etc), and (3) provide for settlement and support services that focus on integration into local communities, even while promoting alternative durable solutions, including return home.

- For Chechen refugees who remain in Georgia, the government should support full and rapid legal integration of Chechen refugees in local communities through registration, documentation, and provision of secure status concluding with naturalization. Steps should include improving refugee registration procedures, helping refugees with limited or no documentation to apply for citizenship or dual citizenship, and making naturalization procedures easier and shorter.

- The government of Georgia should support and promote the integration of geriatric health and social welfare issues into the university education system with a focus on research, policy development and evaluation, and programs for training researchers, policy makers, and health and mental health professionals.

2. *Recommendations for UNHCR (and partners)*
   - While the focus of the UNDP-UNHCR joint program for Pankisi Valley on economic development, particularly micro-level entrepreneurship, is appropriate for working-age refugees, UNHCR should supplement that with support for community-based programs that enable older adults to contribute productively as teachers, mentors, and counselors, whether that be in the context of local business development, education, or community health and mental health initiatives.

   - UNHCR should work with international partners and with the government of Georgia to develop needs-based, transitional health and mental health support for vulnerable sub-populations among refugees, IDPs and people in IDP-like situations, including older adults, people living with disabilities, and female-headed households. This could include, among other things, short-term assistance to medically needy individuals and access to psycho-social rehabilitation programs.

   - UNHCR should continue to provide training and capacity building for national, regional and local authorities to implement more comprehensive and efficient procedures for refugee registration, documentation and, where appropriate, naturalization and local integration.

   - UNHCR should continue to support and build capacity for needs assessments among refugees and displaced persons, and for monitoring and evaluation of the programs that serve them, that gathers accurate and detailed information on all vulnerable groups, including older adults, people living with disabilities, and female-headed households, so that program and population data can be disaggregated by age and gender.

   - UNHCR should continue to promote the effective implementation of the government of Georgia's state strategy for internally displaced persons, with its two goals of (1) creating conditions for the safe, voluntary and dignified return of IDPs to their homes and/or

places of origin and (2) supporting full integration of IDPs into their communities, with decent living conditions and an adequate standard of living.

3. *Recommendations for PRM (and other bilateral and multilateral donors)*
   - PRM should coordinate with USAID and other development actors to support the 2011-2015 UN Development Assistance Framework (UNDAF) plan for Georgia, supplementing support for UNHCR and UNDP with funds for independent monitoring and impact evaluation of the two-year UNDP-UNHCR program, "Independent Socio-Economic Development of Pankisi Valley." As noted in the joint program document, "the experiences and results gained through its implementation will be used to develop similar initiatives in Shida Kartli and West Georgia for IDPs" (UNDP-UNHCR, 2011).

   - While PRM should support Transitional Solutions Initiatives like the above UNDP-UNHCR joint program in Pankisi Valley, the Bureau should also support needs-based, transitional health and mental health support for vulnerable sub-populations among refugees, IDPs and people in IDP-like situations, including older adults, people living with disabilities, and female-headed households in Georgia. This could include, among other things, short-term assistance to medically needy individuals and access to psycho-social rehabilitation programs.

   - PRM should continue to support operations research in Georgia and elsewhere that documents and shares examples of good practice on inclusion of vulnerable groups in population needs assessment, program design and implementation.

   - PRM should take concrete steps to first acknowledge then correct the disparity that exists in humanitarian financing between the proportion of the global population who are aged 60 and above (over 11 percent) and/or living with disabilities (over 15 percent) and the proportion of humanitarian aid that targets these vulnerable populations (around 1 percent) (HelpAge International and Handicap International, 2012). U.S. leadership in support of humanitarian aid and transition initiatives would provide a salutary example for other countries and international donors to follow.

4. *Recommendations for local and international NGOs*
   - Local and international NGOs should develop community-level programs that target older IDP mental health needs. Community-based interventions should seek to improve functioning by addressing the roles of displaced older adults in their communities and by providing opportunities where they can actively utilize their skills and knowledge. This could include increasing access to income-generating activities for older IDPs, increasing access to plots and gardens, making better use of older adults' skills and professional training in community projects, connecting displaced older adults with young adults or children for mentorship and teaching activities, and/or establish multi-purpose community centers for older adults to use, along with others to promote inter-generational exchange.

   - Local and international NGOs should engage in policy advocacy and program development to promote improved health care access for displaced older adults including extending insurance coverage of medications and developing innovative measures to reach older IDPs, many of whom have mobility problems. For example, mobile health clinics at community centers might help target older adults.

- Local and community-based organizations should establish a network for groups working with older adults, which would include older adult representation, and could promote such things as (1) developing health communication media and efforts directed towards older adults and their specific needs, (2) connecting or building networks across IDP communities, (3) organizing roundtable discussions with government agencies, NGOs, and local communities to discuss social issues, and (3) improving understanding of the social, economic, and health conditions that affect older adults in general and displaced populations particularly.

- When they carry out needs assessments, NGO and community-based programs should use valid and reliable instruments to capture health, mental health, and other key characteristics. These assessments should also collect data on older adults, people living with disabilities, and female-headed households and be able to disaggregate the data by age and gender.

E. Conclusion

It is critical that the humanitarian community—including host governments, donors, international organizations, non-governmental organizations, and civil society—in the Republic of Georgia and around the world, take clear and concrete steps to recognize that an aging global population means that, all else equal, the proportion of older adults among displaced populations is also rising. Humanitarian guidelines have begun to focus more closely on older people as a priority vulnerable population, more so because a majority are likely to be female (and possibly single heads of household) and many may also be physically and psychologically disabled (Sphere Project, 2004). It is time now to recognize—and to build this recognition into humanitarian policies and programs—that older adults may have special vulnerabilities but they have special skills and experience that makes them resources, including, even especially, in times of crisis. Re-establishing a sense of "place"—whether that be through return to one's place of origin or integration into a new place—not only helps to restore competence and control to displaced older adults but employs their talents to improve their own lives, those of their family and neighbors, and the welfare of society as a whole.

References

HelpAge International and Handicap International, 2012. *A study of humanitarian financing for older people and people with disabilities, 2010-2011*. London, UK and Lyon, France.

UN Development Program – UN High Commissioner for Refugees, 2011. *Joint Program Document - Integrated Social-Economic Development of Pankisi Valley*. Retrieved April 2012, from http://www.undp.org.ge/files/project_files/prodoc-joint-Pankisi.pdf.

UN High Commissioner for Refugees, 2012. *Georgia: 2012 Regional Operations Profile-Eastern Europe*. Retrieved April 2012, from http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48d2e6.html.

Chapter One: Introduction

A. Background

At the start of the 20th century, cities were plagued by infectious disease associated with overcrowding and poor sanitation. By the 1950s, economic development and technological innovation provided urban populations an increased health advantage over their rural counterparts. In the latter half of the century, however, the urban health advantage was compromised, as large-scale rural-to-urban migration (and international migration), coupled with emerging infectious diseases and a rise in chronic diseases, brought new health risks to cities (Vlahov & Galea, 2002). As of 2007, more than half the world's population live in urban areas and the most rapidly growing cities are in developing countries. Mirroring this trend, it is estimated that perhaps as many as half of the world's refugees live in non-camp settings, including urban areas (UNHCR, 2007). Globally, around four million internally displaced persons (IDPs) are in urban areas (Fielden, 2008).

Of the world's 580 million older adults (aged 60 years and more), nearly two-thirds live in developing countries, where they are more vulnerable to poverty, isolation, poor health, and to the adverse effects of disaster and conflict (WHO, 2006). Indeed, aid organizations have noted, "Poverty and exclusion remain the greatest threat to older people. Disasters make a bad situation worse" (HelpAge International/UNHCR/ECHO, 1999). Older adults displaced by natural disaster or human conflict have been largely overlooked in humanitarian emergencies, and their physical and mental health conditions are too infrequently and too poorly measured (Wells, 2005; Burton & Breen, 2002; Fernandez et al, 2002; Ngo, 2001). An aging global population means that, all else equal, the proportion of older adults among displaced populations is also rising. The Sphere Project's Minimum Standards in Disaster Response focus on older people as a priority vulnerable population, more so because a majority are likely to be female (and possibly single heads of household) and many may also be physically and psychologically disabled (Sphere Project, 2004).

Displacement has also become an increasingly protracted experience. There are more than 30 situations of extended displacement in the world today and both the number and duration are growing: In 1993, persons in these situations had been displaced an average of 7 years; by 2004, the average had risen to 17 years (Loescher et al, 2007). It stands to reason that, as the global population ages, displaced populations are also aging. The classic image of the refugee camp—on an African plain or in an Asian rainforest, and teeming with young children—has been replaced by a more complex picture of displacement, where multi-generational families may be as likely to live in tenements as in tents, and the burden of illness is likely to be weighted more toward chronic conditions.

1. Displacement and Aging

From a policy perspective, the term "aging-in-place" means the ability to remain in the current setting as one ages, coupled with the notion that successful aging-in-place involves maintaining a certain degree of competence and control over one's environment (Cutchin, 2003). One of the most salient features of disasters for all affected populations, but perhaps especially older adults, is the displacement from home and community, often for extended periods of time. In this sense, what might be called "aging-in-displacement" represents aging-in-place turned upside-down: one cannot remain in a familiar setting as one ages, one has limited to no control over one's environment, and changes in place and circumstance are so abrupt and unsettling as to be fundamentally disintegrating.

2. Displacement and Mental Health
Adverse conditions including economic impoverishment, disability, isolation, relocation, and bereavement have all been linked with depression and other forms of psychological distress in older people (Alexopoulos, 2005). Depression among older people is associated with chronic illness, cognitive impairment, and disability, and may also exacerbate these conditions (Blazer, 2003). Poor physical health, in particular, has an important influence on older people's psychological well-being (Gallo et al, 2003; Gureje et al, 2006; Prakash et al, 2007). Low socio-economic status and especially cases of extreme deprivation often trigger and exacerbate depressive symptoms (Wilson et al, 1999). Forced relocation, loss of a spouse, family members and friends, social isolation, and unmet needs for physical aid and psychosocial support have been linked with depression among older adults (Gureje et al, 2002; Watanabe et al, 2004; HelpAge International 2004; Chaaya et al, 2007).

3. Displacement and Physical Health
The kinds of adverse events associated with displacement may have both short and long-term effects on physical health. In the short term, displaced persons may be at risk of physical injury, malnutrition, and infectious disease (Toole & Waldman, 1997). Longer-term displacement may lead to a lack of preventive medical care, to impoverishment and to social isolation, all of which are linked to poorer health outcomes. In addition, a growing body of evidence supports the idea that social adversity itself, especially family and economic adversity, has long term, and perhaps cumulative, effects on physical health (e.g. Gallo et al. 2000; Hughes & Waite, 2009; McDonough et al, 1997; McDonough & Berglund, 2003; Williams & Umberson 2004). These effects may be especially strong for chronic diseases (Hertzman 1999; Lynch & Davey Smith 2005; McEwen & Stellar 1993; Singer & Ryff 1999).

4. Displacement and Urban Health
Based on a review of published literature, Vlahov & Galea (2002) suggest that most of the factors that affect health—particularly in urban areas—can be considered within three broad themes: the social environment, the physical environment, and access to health and social services. Principal features of the urban social environment include socioeconomic status, presence of marginalized populations (including in-migrants), and the higher prevalence of psychological stressors that accompany increased urban diversity and density. Relevant features of the urban physical environment include the built environment, access to safe water and sanitation, transportation and access to resources. Issues of health and social services in urban areas focus on inequities in access to and availability of health services. For displaced older adults in urban areas, these three themes are particularly salient, as older IDPs may face life in poorer living conditions, greater social isolation, and with greater barriers to health and social services.

B. Displacement in the Republic of Georgia

Following Georgia's declaration of independence in 1991, secessionist movements in the provinces of Abkhazia and South Ossetia led to civil war within the borders of the new republic. The first to flee were roughly 12,000 Georgians from the Tskhinvali region. In 1992-93, 252,000 more people fled Abkhazia, primarily moving to the region bordering Abkhazia and to the Georgian capital of Tbilisi (Sumbadze & Tarkhan-Mouravi, 2003). Of the nearly 270,000 initially displaced, around 40,000 have returned to their regions of origin, leaving around 230,000 in "protracted" displacement for more than 17 years. Of these, nearly 30% are 60 or older (and, of these displaced older adults, nearly 60% are female). By comparison, the

proportion of older adults (60+) in the Georgian population is estimated at 18-20%, with a life expectancy of 69 years for men and 77 for women (HelpAge International, 2004).

Table 1.1. Age Groups of "Protracted" IDPs in Georgia (as of June 2009)

	Age	0-4	5-11	12-17	18-59	60 +	Total
Gender							
Male		6,977	11,669	7,932	50,189	26,706	103,473
Female		6,491	10,637	7,589	60,434	39,520	124,673
Total		13,468	22,306	15,521	110,623	66,228	228,142
Source: Ministry of Refugees and Accommodation [http://adjara.mra.gov.ge/index]							

*R*enewed conflict between Georgia and the Russian Federation in 2008 displaced approximately 30,000 South Ossetians within their territory, nearly 135,000 ethnic Georgians to areas outside of South Ossetia, and another 38,000 South Ossetians to North Ossetia in Russia. Around three-quarters of the displaced returned to their areas of origin but, as of March 2009, the Government of Georgia still recognized about 26,000 of the recently displaced population as IDPs (MRA, 2010).

In addition to the IDPs, Georgia has hosted refugee populations from neighboring countries, some of whom are now also counted among those in protracted displacement conditions. In 1999, an estimated 8,000 refugees from the second Chechen war fled into Georgia, settling mostly in rural areas in Pankisi Valley. As noted in Table 1.2 below (from a May 2010 UNHCR report, "Report on the Integration Prospects of the Chechen Refugees in Georgia: Pankisi Valley"), the older refugees (60+) in Pankisi number only 46 (6% of the population). UNHCR also reported roughly 47 urban refugee households living in Akhmeta and Tbilisi (no age breakdown provided on these households).

Table 1.2. Chechen Refugees in Georgia as of May 2010, By Age and Sex

The results of MRA re-registration present that the Kist/Chechen *prima facie* refugee population in Pankisi counts a total of 848 Individuals, with a gender balance of 50.3 % Females (F).

	Age Group 0/4	Age group 5/12	Age Group 13/17	Age Group 18/59	Age Group 60+	Total
Males	81	65	57	186	32	421
Females	60	63	51	239	14	427

As indicated in the above table roughly 425 i.e. more then the half of the refugee population is of working age (18-59), whereas elderly make less than 6 % of the refugee population.

(Source: UNHCR, 2010)

The presence of both "protracted" and shorter-term IDPs living in both urban and non-urban environments in the Republic of Georgia, nearly one-third of whom are older adults—along with a smaller population of Chechen refugees—provided a significant need and opportunity, first to develop an appropriate and valid measure of physical and mental health status among displaced older adults, second to measure prevalence of physical and mental health outcomes across different displaced populations, and third to provide policy makers and program practitioners

with measurement tools and evidence to inform improved response to older adults, especially in protracted situations of displacement in urban areas. This is a timely moment in the Republic of Georgia as it seeks to fully integrate all IDPs, a goal recognized and supported by UNHCR's Global Needs Assessment. Displaced older adults— more than 60% of whom are women, and many of whom are physically and psychologically disabled—are among the most vulnerable population and most in need of targeted integration assistance.

This study of displaced older adults—including Georgians internally displaced in their own country and Chechen refugees fleeing civil war in Chechnya—was led by researchers working at the Johns Hopkins Center for Refugee and Disaster Response at the Johns Hopkins Bloomberg School of Public Health (JHSPH), in collaboration with the Georgian non-profit organization, the Institute for Policy Studies (IPS). The study was funded by the US State Department's Bureau of Population, Refugees, and Migration. Ethical approval for the study was obtained from Institutional Review Boards at both JHSPH and the National Center for Disease Control of Georgia.

References

Alexopoulos, G. S. (2005). Depression in the elderly. *Lancet,* 365(9475), 1961-7.

Blazer, D. G. (2003). Depression in late life: review and commentary. *Journal of Gerontology,* 58A(3),249-65.

Burton, A., & Breen, C. (2002). Older refugees in humanitarian emergencies. *Lancet*, Supplement 360, s47-s48.

Chaaya, M., Sibai, A., Fayad, R., & El-Roeiheb Z. (2007). Religiosity and depression in older people: Evidence from underprivileged refugee and non-refugee communities in Lebanon. *Aging Ment Health,* 11(1), 37-44.

Cutchin, M. P. (2003). The process of mediating aging-in-place: a theoretically and empirically based model. *Social Science & Medicine*, 57, 1077-1090.

Fernandez, L. S., Byard, D., Lin, C. C., Benson, S., & Barbera, J. A. (2002). Frail elderly as disaster victims: Emergency management strategies. *Prehospital and Disaster Medicine*, 17(2), 67-74.

Gallo, J. J., Rebok, G. W., Tennsteds, S., Wadley, V. G., Horgas, A., & the ACTIVE study investigators. (2003). Linking depressive symptoms and functional disability in late life. *Aging & Mental Health*, 7(6), 469-380.

Gureje, O., Ogunniyi, A., Kola, L., & Afolabi, E. (2006). Functional disability in elderly Nigerians: Results from the Ibadan Study of Aging. *JAGS,* 54, 1784-1789.

HelpAge International. (2004a). *Ageways 65: Ageing and Mental Health.* London: HelpAge International.

HelpAge International. (2004b). *Georgia Community Mobilization Initiative (GCMI): Technical Training and Advice for NGO Grantees on Working with Older People*. Tbilisi.

HelpAge International, UNHCR, & ECHO. (1999). *Older People in Disasters and Humanitarian Crises: Guidelines for Best Practice*. London.

Hughes, M. E., Waite, L. J., Hawkley, L. C., & Cacioppo, J. T. (2004). A Short Scale for Measuring Loneliness In Large Surveys: Results From Two Population Based Studies. *Research on Aging, 26*(6), 655-672.

Loescher, G., Milner, J., Newman, E., & Troeller, G. (2007). Protracted Refugee Situations and Peacebuilding. United Nations University, Policy Brief, Number 1, 2007.

Ministry of Refugees and Accommodation (MRA), Republic of Georgia, http://adjara.mra.gov.ge/index.php?lang_id=ENG&sec_id=175. Accessed May 20, 2010.

Ngo, E. (2001). When disasters and age collide: Reviewing vulnerability of the elderly. *Natural Hazards Review*, 2(2), 80-89.

Prakash, O., Gupta, L. N., Singh, V. B., Singhal, A. K., & Verma, K. K. (2007). Profile of psychiatric disorders and life events in medically ill elderly: experiences from geriatric clinic in Northern India. *Int J Geriatr Psychiatry*.

Sphere Project. (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*. Oxford: Oxfam Publishing.

Sumbadze, N., & Tarkhan-Mouravi, G. (2003). *Working Paper on IDP Vulnerability and Economic Self-Reliance* (in English and Georgian). Tbilisi: UNDP.

Toole, M. J., Waldman, R. J. (1997). The Public Health Aspects of Complex Emergencies and Refugee Situations. *Annu Rev Public Health*. 18, 283-312.

UN High Commissioner for Refugees. (2010). *Report on the Integration Prospects of the Chechen Refugees in Georgia: Pankisi Valley*. UNHCR Country Office, Tbilisi, Georgia.

Vlahov D., Galea S. (2002). Urbanization, urbanicity, and health. *J Urban Health*. Dec, 79(4Suppl 1):S1-S12.

Watanabe, C., Okumura, J., Chiu, Y. Y., & Wakai, S. (2004). Social support and depressive symptoms among displaced older adults following the 1999 Taiwan earthquake. *Journal of Traumatic* Stress, 17(1), 63-67.

Wells J (2005). *Protecting and assisting older people in emergencies*. Humanitarian Practice Network Paper, number 53. Retrieved April 2012, from http://www.odihpn.org/documents/networkpaper053.pdf

Wilson, K. C., Chen, R., Taylor, S., McCracken, C. F., & Copeland, J. R. (1999). Socioeconomic deprivation and the prevalence and prediction of depression in older community residents. *Br J Psychiatry*, 175, 549-53.

World Health Organization. (2006). *What are the public health implications of global ageing?* Geneva: WHO.

Chapter Two: Study Design and Methods

A. Target Populations

Conflicts in 1992/93 and in 2008 created two distinct waves of internal displacement in the Republic of Georgia. There has also been an influx of refugees in 1999 fleeing the second Chechen war:

1. IDPs from 1992/93 conflict ("Wave One"): Following Georgia's declaration of independence in 1991, secessionist movements in the provinces of Abkhazia and South Ossetia led to civil war within the borders of the new republic. The first to flee were roughly 12,000 Georgians from the Tskhinvali region. In 1992-93, 252,000 more people fled Abkhazia, primarily moving to the region bordering Abkhazia and to the Georgian capital of Tbilisi (Sumbadze & Tarkhan-Mouravi, 2003). Of the nearly 270,000 initially displaced, around 40,000 have returned to their regions of origin, leaving around 230,000 in "protracted" displacement for more than 17 years. Of these, nearly 30% are 60 or older (and, of these displaced older adults, nearly 60% are female). By comparison, the proportion of older adults (60+) in the Georgian population is estimated at 18-20%, with a life expectancy of 69 years for men and 77 for women (HelpAge International, 2004).

2. IDPs from 2008 conflict ("Wave Two"): The United Nations estimated that renewed conflict between Georgia and the Russian Federation in 2008 displaced approximately 30,000 South Ossetians within their territory, nearly 135,000 ethnic Georgians to areas outside of South Ossetia, and another 38,000 South Ossetians to North Ossetia in Russia. Around three-quarters of the displaced have returned to their areas of origin but, as of March 2009, the Government of Georgia still recognized about 26,000 of the recently displaced population as IDPs (MRA, 2010).

3. Refugees from Chechnya: In 1999, an estimated 8,000 refugees from the second Chechen war fled into Georgia, settling mostly in rural areas in Pankisi Valley. According to a May 2010 UNHCR report, "Report on the Integration Prospects of the Chechen Refugees in Georgia: Pankisi Valley"), the older refugees (60+) in Pankisi numbered only 46 (6% of the population). UNHCR also reported roughly 47 urban refugee households living in Akhmeta and Tbilisi (though no age breakdown was provided on these households).

B. Research Project Description

1. Study Aims and Objectives: The three specific aims of the research were:

Aim 1: To develop, pilot and validate an assessment instrument to measure physical and mental health status of older adults (aged 60 and over) in displacement in the Republic of Georgia.

Aim 2: To conduct a prevalence study of physical and mental health problems among older adults, comparing "protracted" IDP populations with "shorter-term" displaced populations, comparing urban with non-urban displaced, and comparing IDP and refugee experiences.

Aim 3: To disseminate guidelines for measuring physical and mental health status of older adults displaced by natural and human-made disasters and to utilize study findings to improve program and policy interventions for healthier aging in displacement.

2. Study Locations: The study was conducted in five regions of the country (see maps below):

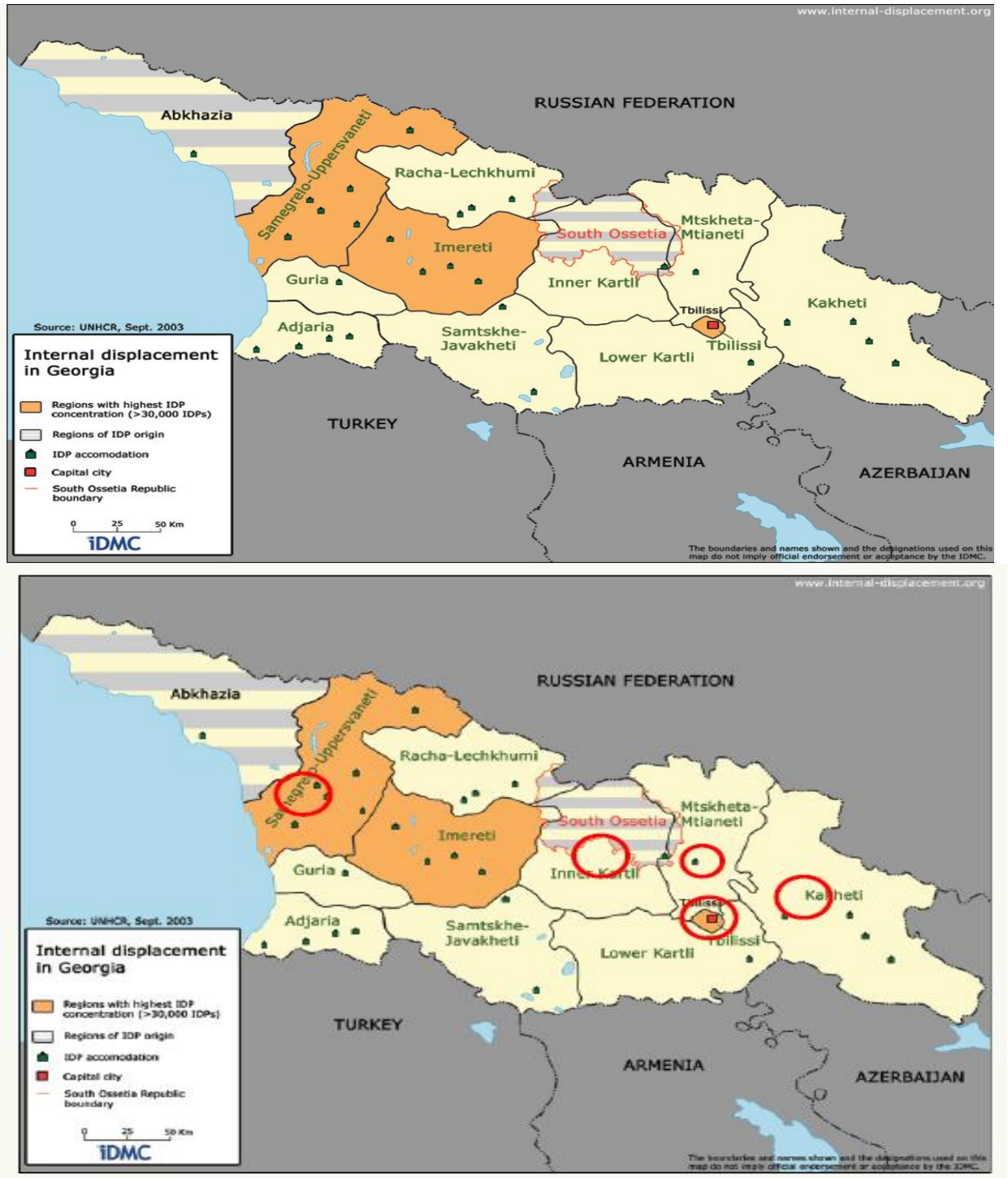


Figure 2.1: Map of Georgia with Study Sites (adapted from maps made by the Internal Displacement Monitoring Centre (IDMC)

Tbilisi is Georgia's capital city and has hosted more than 87,000 IDPs from the 1992/93 conflict; in 2008, hosted nearly the same number of more recently displaced Georgians. While the numbers of shorter-term displaced have declined since 2008, Tbilisi still has more than 100,000 IDPs and is the focus of many of the government's (and the international community's) efforts to integrate "protracted" IDPs.

Shida Kartli is the region incorporating South Ossetia and has been the locus of the most dynamic displacement and resettlement patterns since 2008. Total "protracted" and shorter-term IDPs number below 20,000, but the area is important to include for an understanding of these displacement dynamics and for the attention being given by the government to new settlements and villages to house the displaced.

Mtskheta region located between Tbilisi and Shida Kartli is an area of substantial new settlements of 2nd Wave IDPs (this region was added, following review of updated IDP data provided by the Ministry of Refugees and Accommodation).

Samegrelo region in western Georgia borders Abkhazia and has hosted a population of more than 83,000 "protracted" IDPs, second only to Tbilisi. The number of IDPs from 2008 is relatively small, though there has been some movement back and forth between Samegrelo and Abkhazia. The region includes the city of Zugdidi and a number of non-urban areas where IDPs are living.

Kakheti region in northeastern Georgia, as of 2010, was home to around 872 Chechen refugees, the remaining population of an estimated 8,000 who fled into Georgia in 1999. The region includes the city of Akhmeta and a number of non-urban areas where Chechen refugees were living, mainly in the Pankisi Valley.

3. Study Design: The 12-month study adopted a mixed-methods approach, incorporating both qualitative and quantitative methods in a sequential manner to gather contextual data on the populations of interest, develop and validate survey instruments, and implement the population surveys among displaced older adults. This report presents four distinct, but inter-related, elements of the study.

Qualitative Study of Older Adult IDPs: The first phase or element of the study included formative, qualitative research in three regions—Tbilisi, Shida Kartli, and Samegrelo—utilizing free-listing and key informant interview methodologies. The total sample size included 75 free-list interviews (25 from each region) and 45 key informant interviews (15 in each region) for a total of 120 interviews, of whom 74 were female and 45 were male respondents.

Instrument Development and Validation: Using the data from the qualitative interviews and mapping this to existing or adapted scales, the study team developed, then pilot-tested and validated an assessment tool to measure physical and mental health status of displaced older adults. The validation process involved sampling 100 older adult IDPs in Shida Kartli and Tbilisi (including 66 females and 34 males), specifically to assess the psychometric properties of the Geriatric Depression Scale (GSD), which had been adapted and normed to the Georgian context.

Prevalence Study of Older Adult IDPs: The third phase of the study involved implementing a 30-cluster, 900-household sample survey of displaced older adults, stratifying by "protracted" displaced and shorter-term displaced populations. In the study, approximately half of the

sample comprised older adults displaced during the 1992/93 civil conflict (referred to in this study as "Wave One" IDPs) and half were older adults displaced during the 2008 conflict with Russia ("Wave Two" IDPs). In all, 899 interviews were conducted, of whom 672 respondents were female and 227 were male.

Chechen Refugee Case Study: In order to be able to make some comparisons between the IDP population and refugees from other countries, the study supplemented the IDP survey with a case study of Chechen refugees and service providers. Initially, we had hoped to find all 46 of the older Chechen adults identified in the 2010 UNHCR census (though even with these numbers, statistical comparisons with the larger sample of IDPs would have been inappropriate). As of May-June 2011, when we were carrying out the study, despite help from UNHCR and several local NGOs, we were able to find only 15 Chechen refugee older adults (and this required relaxing the age cut-off to include anyone 55 and older). We also interviewed a total of 15 key informants, including community members and service providers.

4. Study Outcomes: Following the field work, which concluded in July 2011, the research team has focused on data entry, cleaning, and analysis, as well as write-up and dissemination of study results, focusing not only on key findings for health and humanitarian programs in Georgia but with broader recommendations for humanitarian policies and programs for displaced older adults. In addition to this research report, the study has presented preliminary findings and recommendations in two venues:

a. *Workshop in Tbilisi, Georgia, July 18, 2011:* The July 2011 workshop was organized by the Institute for Policy Studies and held at the Courtyard Marriott in Tbilisi. Presenters included (in addition to JHSPH and IPS study team members) Greg Gardner, PRM; Sophie Yucer, UNHCR; Tamara Sirbalidze, USAID; Tamar Amzashvili, Georgian Samaritans Association; and Lela Tsiskarishvili, Georgian Centre for Psychosocial and Medical Rehabilitation of Torture Victims (CGRT). Invitees (all of whom received copies of the workshop report) included the Government of Georgia's Ministry of Refugees and Accommodation (MRA); the National Security Council; the State Ministry of Reintegration; Charity Humanitarian Centre Abkhazeti (CHCA); Transparency International; and the Gender Information Network of South Caucasus.

b. *Presentation at the American Public Health Association (APHA) Annual Meeting, Washington, DC, October 31, 2011.* We also presented our study findings at the APHA's Program on Aging & Public Health, Session on Chronic Disease Management in Various Settings. The target audience included public health professionals and researchers working in humanitarian emergency and natural disaster settings, and public health professionals working with older adult refugee, internally displaced persons, and migrant populations in developing country settings.

We are also nearing completion of three manuscripts to be submitted to peer-reviewed public health and migration journals. The initial sequence will focus on key findings from the qualitative research among older adult IDPs, the instrument validation study, and the prevalence study of physical and mental health status among IDPs.

References

HelpAge International. (2004). *Georgia Community Mobilization Initiative (GCMI): Technical Training and Advice for NGO Grantees on Working with Older People*. Tbilisi.

Ministry of Refugees and Accommodation (MRA), Republic of Georgia, http://adjara.mra.gov.ge/index.php?lang_id=ENG&sec_id=175. Accessed May 20, 2010.

Sumbadze, N., & Tarkhan-Mouravi, G. (2003). *Working Paper on IDP Vulnerability and Economic Self-Reliance* (in English and Georgian). Tbilisi: UNDP.

UN High Commissioner for Refugees. (2010). *Report on the Integration Prospects of the Chechen Refugees in Georgia: Pankisi Valley*. UNHCR Country Office, Tbilisi, Georgia.

Chapter Three: Qualitative Study

"I would go back to Tskhinvali at this very minute and I was the last one to leave. I miss my youth days, I was a cyclist and now I dream about a bicycle that will hold me. I want to feel that old feeling again." -- 64 year old widow, IDP from South Ossetia

A. Study Purpose and Objectives

The goal of the qualitative inquiry was to describe current problems for internally displaced older adults in Georgia, as well as to elicit local terminology and constructs used to describe psychological problems among internally displaced older adults. The study aimed to describe problems at the individual, household, and community level across all domains, but with a particular emphasis on daily activities and modes of functioning. The perspectives and experiences of both older adult IDPs and knowledgeable community informants were of concern. Through this exploration of local problems, daily activities, and local terms, we aimed to 1) present an in-depth picture of the context and living conditions of our study population and 2) facilitate the adaptation process of a household survey instrument. We intended that the development and adaptation of the survey instrument would draw heavily on the findings and terminology collected through the qualitative study.

The qualitative inquiry sought to answer the following questions through conversations with both older adult IDPs and knowledgeable community informants:

1. What are the major problems that older adult IDPs have?
2. What are the major problems older adult IDPs have that affect their families?
3. What routine tasks do older adult IDPs do to take care of themselves, their families, and to participate in their communities?
4. What are thoughts, feelings, and behaviors associated with common psychological problems for older adult IDPs?

These questions were answered using a linked qualitative methodology of free list and key informant interviews. Data collection for the qualitative inquiry took place between November 2010 and March 2011. Qualitative data were collected in three study regions: Tbilisi, Shida Kartli, and Samegrelo. Respondents were drawn from three urban centers in each region (Tbilisi city, Gori, and Zugdidi), as well as from surrounding towns and villages.

B. Study Methodology

The study utilized the linked methods of free list and key informant interviews. This methodology was adapted from an approach that has been employed and validated in numerous international study sites for mental health research. This approach has been particularly useful for instrument adaptation, validation, and prevalence studies (Bolton and Tang, 2004; Bass, Ryder, Lammers, Mukaba, and Bolton, 2008). This approach advocates for the use of qualitative and textual forms of data collection in the survey development and administration process in order to 1) adapt standard psychiatric (and other) measures using local terminology and 2) interpret survey data more fully by integrating analyses of narrative interview data. The often ill-defined parameters of mental illness constructs across settings and the extent to which these constructs are influenced by context requires that they be measured using indicators and terms that are consistent with the study setting. This, in part, means moving beyond the simple translation of measures to adapting wording and adding indicators in order to integrate local interpretations and experiences of mental health, illness, and functioning. Such an approach is

also useful for redressing potential conflict between clinical, psychiatric and local definitions of health and mental health. In the present research context, a qualitative study was also seen as a way to gather more nuanced and in-depth information on older adult IDPs and their living conditions.

Although the methods of free list and key informant interviews are broadly characterized as forms of qualitative data, free listing is more accurately described as a form of systematic data collection (Weller & Romney, 1988) Free listing bridges qualitative and quantitative forms of data collection and analysis. Free list interviews aim to identify all items, or included terms, that belong to a given category, or cognitive domain. This is accomplished by asking respondents a 'primary question,' which is typically to list all the types of the category of interest that respondents can think of. Secondary questions may follow to collect a wider range of information. Free list data can be analyzed both qualitatively, through the identification of key themes, the relationships between them, and the words used to describe them, as well as quantitatively, through frequency calculations of listed items. Frequency calculations highlight those items and terms that were most frequently mentioned and thus, most cognitively available to respondents. Frequency of mention should not be necessarily equated with perceived importance. Items may be infrequently mentioned, for example due to a sensitive topic or to difficulties in listing a concept as distinct items, but may retain high significance and warrant further investigation. Still, frequency of mention does indicate the extent to which certain problems or topics are readily accessible and thought about in a community.

In this study, free listing was essential for instrument adaptation purposes, as it allowed for the efficient and clear identification of important problems for the community, including local constructs, which could be mapped onto existing scales or appended to the instrument. Key informant interviews were used to gather more in-depth information on themes from the free list interviews that referred or were related to mental health or psychological problems. These themes were not typically the most frequently mentioned, given the sensitive nature of mental health topics. Key informant interviews provided the opportunity to learn more about mental health problems and how they were talked about, from the perspectives of knowledgeable community members.

1. Sample Design

The total number of respondents interviewed in the qualitative inquiry was 120, which included both free list and key informant interview respondents. Respondents were sampled from rural/peri-urban and urban sites in the three study sites of Tbilisi, Shida Kartli, and Samegrelo. Free list interviews were carried out solely with IDPs. The following inclusion criteria were used for free list respondents: 1) IDPs from either the new or the old case-load; 2) Residing in one of the three study regions; 2) Ages 60 and older. Respondents from Tbilisi and Zugdidi were all from the old case-load, whereas respondents from Shida Kartli were from both case-loads, but primarily the new caseload. IDPs living in all settlement types were sampled, including private accommodation, compact settlements, new settlements, and collective centers (both public and privately owned). With the assistance of local service organizations that worked with IDP communities, respondents were purposively sampled in order to represent different sexes, ages within the target age bracket, locations, and settlement type. In total, 75 free list respondents were interviewed, with 25 respondents per study region.

Key informant interviews were carried out with a range of community members who were identified as being knowledgeable about issues concerning older adult IDPs. Key informants were not restricted to any social or age group. The inclusion criteria used for selecting them were: 1) Community members residing and/or working in one of the three study regions; 2)

Knowledgeable about issues concerning older adult IDPs. Key informants were selected from all three study regions, from both urban and non-urban sites, and were of all (adult) ages. Key informants were both IDPs and non-IDPs, and were made up of, in part, local community leaders, government representatives, lawyers, NGO workers, doctors, psychiatrists, and social workers. Key informants were purposively selected based on recommendations made by free list respondents during interviews or by IPS senior research staff familiar with service organizations in the study sites. In total, 45 key informants were interviewed, with 15 informants per study region. Please see Appendix A, Tables 1 and 2 for tables of respondent characteristics for the free list and key informant interviews.

2. Field Interviewers

A team of IPS staff (all female) were trained in the study protocol and qualitative interviewing strategies and techniques over the course of several days. Six field interviewers and one field supervisor were trained. Field interviewers all had prior experience with qualitative methods and interviews. During initial meetings between Hopkins and IPS staff, feedback was gathered on the study protocol, methods of recruitment, and the wording of free list interview questions. Feedback from IPS staff was regularly solicited and gathered during the data collection process. This was particularly necessary for the development of key informant interview questions, which emerged out of analyses of free list interview data. Reflections with field interviewers were regularly carried out after data collection trips, in order to gather interviewers' feedback on the data collection process, insight into the study population and context, and initial analyses of interview data.

3. Data Collection

Free list interviews took the form of five open-ended questions and lasted approximately 45 minutes. The interviewer posed each question and asked the respondent to list his/her responses. When the respondent had completed listing responses for a given question, the interviewer moved on to the second question. Data collection and analysis took parallel forms for both the free list and the key informant interviews. All interviews were conducted by several pairs of field interviewers, with the first interviewer posing the questions and the second taking detailed hand-written notes of responses. The following questions were asked (See Appendix A for the free list interview instrument):

1. What are the major problems that displaced older adults (ages 60 years and older) have?
2. What are the major problems displaced older adults have that affect their families?
3. What routine tasks do displaced older adults do to take care of themselves?
4. What routine tasks do displaced older adults do to take care of their families?
5. What routine tasks do displaced older adults do to participate in the community?

Question 1 was intentionally framed as a broad, open-ended question to elicit a wide range of responses and to find out what community members themselves considered important problems. Questions 2-5 were follow-up questions that were intended to gather data on how respondents related to others, particularly their families, as well as on how well they were able to function and to carry out daily activities. Finally, participants were asked to recommend community members who were knowledgeable about the problems facing older adult IDPs. Key informant interviews were used to gather more in-depth information on themes that emerged from the free list interviews that were related to mental health or psychological problems. These themes were typically not the most frequently mentioned free list responses, perhaps in part due to the sensitive nature of mental health topics. Key informant interviews therefore provided the opportunity to learn more about mental health problems and how they were talked about, from the perspectives of a range of community members. Free list analysis

forms and frequency tabulations were reviewed by the study team to identify themes and responses that had to do with mental health or psychological problems and which seemed to hold significance within the study population. Selected themes for key informant interviews differed slightly across study sites, depending on what free list responses were given in each. Key informant interviews were typically carried out three to four weeks after free list interviews were conducted.

The key informant interview involved inquiring about associated *thoughts, feelings, and behaviors* for each selected theme. Examining this phenomenological triad is essential for diagnosing mental illness in clinical settings and as such, is also useful in research settings for uncovering and describing mental health problems from multiple angles. Key informant interviews lasted approximately one hour. The interviewer posed each question and allowed the respondent to answer; the interviewer then asked additional probing questions to gather more in-depth information. The following themes, or categories, were selected for inclusion in the key informant interviews (Please see Appendix B for the key informant interview guides):

Table 3.1. Selected Categories for Key Informant Interviews

Site	Selected Categories
Tbilisi	Nervousness
	Nothing makes me happy
	Feeling abandoned
	Feeling isolated
Shida Kartli	Nervousness
	Nothing makes me happy
	Impassivity/ Having nothing to do
	Lack of concern
Samegrelo	Nervousness
	Nothing makes me happy
	Quarrel frequently
	Burden to family/ Cannot help family

4. Data Analysis

After each day of data collection, interviewer pairs reviewed their written notes amongst themselves and with the rest of the team. Interviewers also shared their initial interpretations of responses during group reflection meetings that occurred after each site visit. Interview data were initially rapidly analyzed in the field by the local team. Analyses were then reviewed by other members of the study team. Textual responses for both free list and key informant interviews were simultaneously entered and coded using standardized Excel analysis forms. All interviews were conducted in Georgian. English translations were subsequently added into the forms (see Appendix A for the analysis form templates). Entering text from key informant interviews involved systematically isolating segments of text that corresponded with categories of perceived cause, symptoms/signs, associated problems, and coping mechanisms. For both free list and key informant interviews, frequency analyses were run on the codes to identify the most commonly mentioned codes, or themes. Note that frequencies were run on listings of problems, not on respondents naming those problems; that is, one respondent might have mentioned several variants of a given problem and all those variants would be counted in the frequency calculation. Later analyses took place on-site at JHSPH. These more in-depth

analyses involved reading through all responses to focus on the context surrounding specific themes, as well as on the connections respondents made between various themes.

C. Free List Interview Results

1. Overview of Problems

A comprehensive list of all problem categories (i.e. the codes that were assigned to clusters of related listings) is presented in Appendix A, Table 5. From this list, it is evident that across all three study regions, the most salient problems for respondents had to do with health problems, health care access, and economic conditions. A key problem across sites that linked these top problem categories was not having enough money to purchase medicines. In all three sites, "health problems" was the most frequently mentioned problem category. This category mostly included the listing of specific illnesses or conditions, but also included general statements about pain or health concerns. In Tbilisi, the next two problem categories were "no money for medicine" and "no health insurance." In Shida Kartli, "no health insurance" was the second most frequently mentioned problem and "no money for medicine" was the third. In Samegrelo, "poor living conditions" was the second most frequently mentioned problem and having a "lack of money" was the third. Both of these problem categories were also found in the other two sites. Not having health insurance was also a concern for respondents from Samegrelo, but was less frequently mentioned. Other top problems across sites tended to be economic in nature, such as having a "small pension," "unemployment," a "lack of money," "high taxes" and "affording firewood or electricity for heat." Notably, amongst these pragmatic top categories were two categories that were more emotional: the "indifference of others towards IDPs" and having a "desire to return to Abkhazia/Ossetia." It appears that these experiences were nearly quite salient for respondents. In fact, in Tbilisi, the "indifference of others towards IDPs" was more frequently mentioned than any non-health related economic problems. This category is outlined in greater depth below, but included many statements about the extent to which the government cared about IDPs and their situation. It is likely that in Tbilisi, this problem is more salient for respondents than in other cities because they are in the capital, because they may be less integrated with the non-IDP local population, and because of the recent evictions in collective centers. As one respondent said: "No one remembers us. We do not exist. No one asks about us. Nobody comes, nobody wants us. They only remember us before the elections" (Respondent 1).

Table 3.2.Top Problem Categories Across Study Sites, with Number of Listings

Tbilisi	#	Shida Kartli	#	Samegrelo	#
Health problems	27	Health problems	42	Health problems	27
No money for medicine	16	No health insurance	12	Poor living conditions	11
No health insurance	15	No money for medicine	11	Lack of money	9
Indifference of others towards IDPs	13	Small pension	11	Unemployment	9
Small pension	12	Unemployment	8	No money for medicine	8
Lack of money	10	Lack of money	8	Small pension	8
Unemployment	9	Poor living conditions	7	Desire to return to Abkhazia	6
High taxes	6	Indifference of others towards IDPs	5	Affording firewood or electricity for heat	6
Desire to return to Abkhazia	5	Desire to return to Ossetia	5	Indifference of others towards IDPs	5
Not owning living space	5	Family members' illnesses	5	Not enough food	5
				Expensive medical treatment	5
				Not owning living space	5

2. Health Access Problems

The main health access problem categories that were listed across sites were: not having enough money for medications, having no or insufficient health insurance, expensive medical treatments and ineffective medical treatments. Respondents talked about not being able to pay for the medicines that they knew they needed to treat and take care of their health problems which were often chronic. For example, one respondent in Zugdidi explained that "I visit the doctor, but I cannot buy the medicine" (8). Another respondent in Gori said that he had taken some medicines in the past but now he avoids visiting the doctor again since he knows his pension will not cover related costs: "I bought and drank medications then, and after that I haven't gone to a doctor. My pension is not enough for medications anyway" (2). In Tbilisi, listings within the category of "no health insurance" included problems such as not having insurance coverage for specialist care or screening and diagnostic tests. In their descriptions about inadequate insurance coverage, a couple respondents also mentioned additional problems with accessing health related to availability of, and geographic access to, services: "Every doctor denies taking me as a patient" (Respondent 1) and "I have heart ischemic disease, growing pains, and stones in kidneys and I have insurance, but the clinic is very far and I cannot go there" (Respondent 2). In Samegrelo, respondents described not being able to pay for "expensive medical treatments" such as eye surgery and heart surgery. Experiencing "ineffective medical treatments" was not as frequently mentioned as other health access categories, but included problems such as medicines not helping or causing further problems because of side effects, dirty hospitals, patients who die because of malpractice, and doctors who don't understand patients' problems. For example, one respondent in Shida Kartli explained: "There are no good doctors. I have one problem and they give medications for another. I went to a doctor and he just told me I was old. He nearly said "what else were you expecting? What else do you want?" I got very nervous" (19).

3. Economic Problems

In addition to high costs of medications and treatments, respondents also described a number of other economic problems, including having a "small pension," "unemployment," a "lack of money," "high taxes" and "affording firewood or electricity for heat." Having a "small pension," was a top problem across all study sites. Respondents repeatedly explained that the pension amount was simply not enough to pay for their various expenses and to help support their families. In Tbilisi, one respondent explained this situation: "Our pension is a laughingstock. I get 100 Laris [a month] and 50 are spent on medications" (8). In Shida Kartli, another said: "Pension is not enough. What can I buy on it? I need food and medicine--I don't know whether I should buy one or the other?" (25). Another respondent in Tbilisi commented on the insult of having a small pension after many years of service to the government: "I get 92 Laris. I had to go to the court to get more 7 Laris. They say I had to have 25 years length of service. I have 21. I am 4 years short. I have no nerves to go to the court. This government insulted me" (6).

"Unemployment" was a top problem across all three sites as well. Respondents explained how much of a problem unemployment was, for both older IDPs and for their adult children and grandchildren. Some described the irony of working for years and not being able to find a job now, others talked about how having a higher education no longer guarantees a job, and still others talked about wanting to work if they had the chance: "If there was some kind of job I would go out and work a little, to forget my problems" (Respondent 12 in Shida Kartli). One respondent in Tbilisi explained what effect unemployment has on her and her family: "The unemployment of our children and the fact that we also are jobless has a very bad effect on our moral. It is highly unpleasant" (9).

4. Living Conditions

No running water, no electricity or firewood, cramped living quarters, and leaking roofs were some of the problems respondents listed when describing their living conditions. Most of these responses were given by IDPs living in settlement types other than private accommodation, including collective centers that were privately owned. "Poor living conditions" was a fairly salient problem category across Tbilisi and Shida Kartli; in Samegrelo, it was the second most frequently mentioned category. Respondents in Samegrelo talked about having cold and damp rooms, leaking roofs, and having to carry water up flights of stairs from outside because there is no running water. Leaking roofs were problems in the other two sites as well. In Shida Kartli, respondents also talked about having heating problems such as no gas or not being able to afford an electric heater. Heating problems was a salient enough problem in Samegrelo that it became a separate problem category. A couple of respondents noted that they could not afford to buy firewood; others said they could not afford electricity. Respondents also talked about how hard it was to live in such small living spaces, particularly when many family members lived together in one room. Across all sites, respondents talked about waiting for the government to make repairs in collective centers or about broken promises from the government to fix problems: "We have no gas and it's very hard. We want them to build a gas pipeline, but no one cares. They promise us, but those are only words" (Shida Kartli, 6); "They promise to fix, but nobody cares. The time passes and nothing is done, the situation with IDPs is like a tale" (Samegrelo, 11).

5. Health Problems

A comprehensive list of all physical health problems named by respondents across sites is provided in Appendix A, Table 6.1. In addition, Table 6.2 displays categories of these health problems to provide a clearer picture of the types of illnesses respondents had. In Tbilisi and Shida Kartli, mobility problems were the number one category of problems; in Samegrelo, it was the second most frequently mentioned problem. Mobility problems included problems such as being unable to, or having difficulties with, moving, getting up, standing, walking, and running. Respondents also described other functionality problems with their legs, arms, and hands, such as having "sore feet," "sore legs," "swollen legs," paralysis, as well as "sore joints," "pain in fingers," and "arthritis." One respondent in Samegrelo described a fall she had: "I could not move for 8 months, I fell down on my way to the bathroom and broke a bone. It's the third year since I feel pain in my back, and my feet are insensitive, like a wooden stick" (20). In Samegrelo, the most frequently listed category of health problems was blood pressure problems. Several respondents mentioned this problem in Tbilisi and Shida Kartli as well. Problems with blood sugar levels or diabetes was a salient problem in Tbilisi and Shida Kartli, as the second most frequently mentioned problem in both. Two respondents listed this problem in Samegrelo. Other top problems were problems of the digestive system, such as gallbladder problems and hernias, vision problems such as cataracts, and heart problems, such as heart attacks and arrhythmia.

Table 3.3.Top Physical Health Problem Categories Across Study Sites

Tbilisi	#	Shida Kartli	#	Samegrelo	#
Mobility problems	7	Mobility problems	6	Blood pressure problems	6
Diabetes or blood sugar problems	6	Diabetes or blood sugar problems	4	Mobility problems	6
Digestive, including gallbladder, bowel, and hernia problems	6	Vision problems	4	Digestive, including gallbladder and hernia, problems	5
Heart disease or problems	5	Blood pressure problems	3	Other limb problems	5
Arthritis, sore joints, or osteochondrosis	4	Other limb problems	3	Pain	4

6. Mental Health Problems

In addition to physical health problems, respondents also listed problems that were related to mental health and psychosocial issues, though these were less commonly listed. These problems, including the actual responses given for each problem category, are listed in Appendix A, Table 7. An examination of the words used by respondents and the types of experiences described suggests that responses across sites can be grouped into two constellations of feelings: sad or depressed mood, and worried or anxious mood. It is possible that these constellations parallel psychiatric syndromes of depression and anxious, but this conclusion cannot be made from these exploratory data.

a. Sad or depressed mood Respondents in both Tbilisi and Shida Kartli used the words "depressed" and "depression" to describe their own or family members' emotional states. No prompts were given during the free-list interview. These respondents, therefore, were aware of and chose to use the term depression to describe their feelings. However, it is not clear whether or not they were aware of or identified with the psychiatric construct of depression. Still, it is noteworthy that the symptoms respondents described when talking about feeling depressed map onto psychiatric definitions of depression. This included feeling bad, no longer being able to find enjoyment in activities, crying all the time, not having the energy to get dressed, difficulty with carrying out activities/planning out activities. One respondent in Tbilisi also talked about feeling hopeless about the future; this again could perhaps map onto a depression construct or be a sign of a depression episode. In Samegrelo, respondents did not use the terms "depressed" or "depression" explicitly; however, one individual described feeling "strained" and said that "nothing makes me happy." Others talked about feeling "tormented" and lonely.

b. Worried or anxious mood Respondents in Tbilisi described worrying about their adult children, thereby clearly demonstrating a strong sense of interconnectedness with their family members. In Shida Kartli, respondents talked about feeling nervous, fearful, and having nightmares. One respondent talked about "going back to Tskhinvali in [his] thoughts and analyz[ing] what happened there, why it happened." This suggests that this respondent had repeated thoughts about his former life and how that life ended, and as he said: "These thoughts and fear is the worst thing for me" (23).

7. Displacement Related Problems

Respondents named a number of problems that had to do with their status as IDPs or life in displacement. Appendix A, Table 8.1 lists the categories of displacement related problems that respondents named, and Table 8.2 provides the actual responses that correspond with these categories to elucidate these problems and how respondents described them. For the most part, there was an even distribution of displacement related problems across the three study sites. What stands out is the top listing in Tbilisi of "indifference of others towards IDPs"; with 13 listings, this was by far the most frequently mentioned displacement related problem across all of the sites. As previously mentioned, it is likely that living in the capital city and near government agencies, as well as hearing of the regular evictions that had been taking place in the city, contributed to this sense of abandonment from the government. It is also possible that IDPs in Tbilisi experience more segregation because of greater economic disparities in the capital city. Finally, older IDPs in Tbilisi grew up in Abkhazia and therefore are from a different cultural sub-group than many other Tbilisi residents; one respondent described feeling like an "outcast" (25).

Tbilisi was the only site where one respondent described dissatisfaction with the integration process. Cultural differences may therefore also heighten IDPs' feelings of dissatisfaction with

their situation, status, and the government. Although it was not mentioned as often in Shida Kartli and Samegrelo, feeling abandoned, ignored, or indifference was a salient problem in these sites as well. A "desire to return to Abkhazia/Ossetia" was also a top problem across sites. In Tbilisi, a couple of respondents talked about the fact that they could no longer visit family graves in Abkhazia. In Shida Kartli and Samegrelo, several respondents explained that not having access to land, either in the form of plots or gardens, was a real problem as they wanted to be able to work, make a living, and grow their own food.

Table 3.4.Top Displacement Related Problem Categories Across Study Sites, with Number of Listings

Tbilisi	**#**
Indifference of others towards IDPs	13
Desire to return to Abkhazia	5
Not owning living space	5
Shida Kartli	**#**
Indifference of others towards IDPs	5
Desire to return to Ossetia	5
Having nothing	4
Samegrelo	**#**
Desire to return to Abkhazia	6
Indifference of others towards IDPs	5
Not owning living space	5

8. Functioning

Questions three through five in the free list interview were intended to elicit information about functioning in the study population, that is, what respondents expect healthy functioning to look like and how respondents describe their own levels of functioning.

a. Self-care In response to the third free list interview question, "*What routine tasks do displaced older adults do to take care of themselves?"* the most common responses were related to performing household chores and managing health needs, primarily through medications.

- In Tbilisi, respondents gave equal attention to the tasks of cooking or preparing food for themselves and their families and of routinely taking medications. Almost a third of respondents also stated that work or income-generating activities were routine tasks in which they engaged. A number of different work occupations were listed, including: housekeepers/maids; baby-sitters; street cleaners; yard-keepers; doctors; shop-keepers; street-sellers and traders.
- In Samegrelo, the most frequent answer, given by roughly half of respondents, was not a particular task but rather the observation that older adults "cannot do anything" and cannot care for themselves, mostly because of a lack of regular income. Conversely, only a few respondents in Tbilisi stated that older IDPs "cannot do anything." Respondents in Samegrelo also frequently mentioned the tasks of preparing food, washing up and tidying up, and taking care of their health.
- In Shida Kartli, the most common routine task that respondents listed was taking medications; cooking/preparing food and washing/bathing and getting dressed were also mentioned. In Shida Kartli, as in Samegrelo, a number of respondents noted that older adults simply cannot do anything anymore.

A variety of other routine tasks were listed by respondents at a lower frequency, and these responses were given by IDPs across sites. These self-care activities included showing care and affection to their spouses, taking care of one's physical appearance, and socializing with

neighbors and spouses. In both Samegrelo and Shida Kartli, several respondents listed farming activities, such as looking after livestock or tending plots. In Tbilisi, a few respondents listed religious activities, including going to church, reading religious texts, and fasting. A few other respondents described taking care of their health independent of the formal health care system, including boiling and consuming herbs, doing physical exercises, doing independent research on health problems, and listening to advice on the television.

b. Care of Families In response to the fourth free list question, "*What routine tasks do displaced older adults do to take care of their families?"* the most common responses were related to looking after children and contributing support through financial means. Respondents in all three sites also commented that they, or other older people like them, cannot do anything anymore.

- In Tbilisi, most respondents listed child care as the primary activity they engaged in to support their families. Child care included activities such as accompanying children to school, sports games, and swimming lessons, cooking for and feeding children, and spending time with and looking after children. Respondents often referred to children in a general sense, suggesting that they took care of whichever children were in their household, but at times respondents specified that they were referring to their grandchildren. Respondents in Tbilisi also said that they supported their family through financial means, usually with their pensions.
- In Shida Kartli, most respondents explained that they supported their families primarily through sharing their pensions or other forms of financial support, such as working small jobs. Many respondents also said that they cooked for their families.
- In Samegrelo, the most frequently mentioned mode of support for older IDPs was financial support, either through sharing their pension or through trading. Respondents also said that they helped by doing repairs at home and tidying up the home.

c. Participation in the Community Respondents were also asked a fifth free list question: *"What routine tasks do displaced older adults do to participate in the community?*" Across all three sites, the most salient response was that older adults help community members, in good times and bad times, for better or for worse. This included solving communal problems, such as collecting money for new water pipes or for electricity in the collective centers. Supporting each other also meant helping families pay for funerals and weddings, as well as cooking, preparing rooms, and cleaning up after funerals and weddings. In Tbilisi and Shida Kartli, respondents also frequently mentioned talking to each other as a form of communal support. Respondents described older women who gathered in the hallways of collective centers to talk to each other, going outside themselves to socialize in the yard when the weather was nice, visiting with neighbors, and sharing problems at the bus stop. One respondent described "Bukha's Bar," a small, curtained off area on one of the floors in the collective center, where neighbors would gather in the evenings to talk. As one 61 year old widow, displaced from South Ossetia and living in Gori, said: "We talk, because there is nothing else to do."

D. Key Informant Interview Results

1. Overview

Key Informants were engaged in semi-structured interviews to gather more in-depth information on target categories of mental health or psychosocial problems that had been culled from the free list data. Separate analyses were carried out for each target category. (These categories are listed in Table 3.1). Analysis of these interviews considered both the content and the form of responses, that is, descriptions of the target categories and the particular words used

to describe these categories. Analysis of form involved reviewing responses to assess which words and phrases were used to describe the target categories. Common terms, phrases, and themes across both free list and key informant interviews were considered as candidate domains and items during the instrument development and adaptation phase. They were also used as guides for the translation of existing measures. To analyze the content of responses, frequencies were run on segments of text that corresponded with four topical areas, or sub-categories, covered in the interviews. These sub-categories are reflected in the interview guide probes and include: perceived causes of the target category, signs and symptoms of the target category, effects and associated problems of the target category, and coping behaviors. Categories of responses and frequencies for each target category are presented in Appendix A, Tables 9-16.

2. Summaries of responses for target mental health and psychosocial categories

a. Nervousness (All sites) Key informants across all three sites primarily attributed "nervousness" among older IDPs to problems with money and health care access. For example, in Tbilisi, the most frequent response category was "Limited access to health services," whereas in Shida Kartli it was "Having nothing to do including unemployment and inactivity," and in Samegrelo it was "Cannot afford medical treatment." However, top responses in all sites about perceived causes also had to do with displacement-related experiences, such as difficulty adapting to new environments, worrying, war trauma, inactivity, remembering the past, grieving what was lost, stress, being evicted from homes, and a desire to return. Coping behaviors for nervousness primarily involved older IDPs providing support to each other and receiving support from neighbors and family members. Working on plots, trading/income-generating activities, and inter-personal communication (through talking) were other behaviors that helped with nervousness.

b. Nothing makes me happy (All sites) In Tbilisi and Shida Kartli, key informants primarily attributed the feeling that "nothing makes me happy" to living in difficult circumstances and poor conditions. Other perceived causes included not having money, problems with local integration, the losses experienced because of displacement, being isolated, and not being able to work. In Samegrelo, informants described having nothing to do, feeling hopeless about return, not being respected, and having health problems as causes. The most commonly mentioned coping behavior across all sites was talking and sharing problems. Informants across sites also noted that older IDPs feel a sense of helplessness about attending to their happiness or that they cannot, in fact, help themselves. Relationships with family, particularly children and grandchildren, were also said to help older IDPs.

c. Feeling abandoned (Tbilisi) In Tbilisi, key informants discussed the problem of older IDPs "feeling abandoned" and attributed this feeling to both a general lack of attention and a lack of support from the government. Coping behaviors for this problems included receiving help from relatives and older IDPs encouraging themselves.

d. Feeling isolated (Tbilisi) In Tbilisi, key informants discussed the problem of older IDPs "feeling isolated." This problem was attributed to an inability to locally integrate and experiences with negative attitudes from the local population towards IDPs. Key coping behaviors included receiving help from family members, communicating with others, and being active. Key informants also noted that there is not enough help or attention to older IDPs.

e. Having nothing to do (Shida Kartli) In Shida Kartli, key informants discussed the problem of older IDPs having "nothing to do." This problem was attributed to a lack of jobs, being alone, problems with local integration, as well as living in cramped spaces where there is not enough

room to engage in activity. Key informants described the effects of having nothing to do as including missing the past, worrying, insomnia, having negative thoughts, and having health problems. Coping behaviors included talking to each other and sharing problems, getting involved with programs and initiatives, working on plots, and receiving help from neighbors and family members. Key informants also said that they, and others, cannot always help older IDPs.

f. Lack of concern (Shida Kartli) In Shida Kartli, key informants discussed the problem of older IDPs feeling a "lack of concern" from others. This feeling was attributed to thinking about the past, feeling that nobody needs them, as well as to living apart from their children, having health problems, and experiencing tensions with the younger generation. Coping behaviors for this feeling included talking with others and being listened to, working on a plot, and taking care of children. Some informants said that older IDPs cannot do anything to help with this feeling.

g. Quarreling frequently (Samegrelo) In Samegrelo, key informants discussed the problem of older IDPs "quarreling frequently." This problem was primarily attributed to living in poverty and without adequate material or financial resources, including not being able to provide financial support to families. Another perceived cause of quarreling was a lack of understanding or frustration between generations. Key informants said that older IDPs dealt with quarrels by separating themselves from their families temporarily and being on their own or by having others calm them down.

h. Burden to family (Samegrelo) In Samegrelo, key informants discussed the problem of older IDPs feeling like they are a "burden to their family." This problem was primarily attributed to older IDPs being ill and feeling that they cannot help their families or provide financial support to them. Coping mechanisms included encouraging each other, socializing and talking, working, and being listened to by others.

E. Discussion

Analyses of the qualitative data demonstrate the presence of common salient problems across IDP communities in Georgia.

→*In particular, analyses of free list interviews showed that older IDPs consider economic and health problems to be most prominent issues in their lives.*

- Economic problems came down to a lack of financial resources and money to pay for: medical visits and medication, housing repairs, and support for children and grandchildren. Unemployment was a significant concern for respondents, both their own unemployment, and that of their adult children and grandchildren. Unemployment was a problem not only because of money shortages but because it contributed to a collective feeling of, and frustration with, inactivity. Respondents described a desire to be working and active in their communities. Free list respondents also commented on the insufficiency of their pension to cover their daily expenses and needs.

- The health problems respondents listed included both the experience of various illnesses and conditions, as well as difficulties in accessing health care. The most frequently mentioned illnesses and conditions were chronic in nature and included mobility problems, blood pressure problems, diabetes and blood sugar problems, digestive problems, arthritis, and heart disease. Experiences of ill-health and financial hardship intersected in the health access problems that respondents named. These problems namely included prohibitively high costs of prescription medications, high costs of specialist care and surgeries, and inadequate health insurance coverage.

→Free list respondents listed a number of issues that were particularly tied to their IDP status.

- These included a strong desire to return to homelands, recalling and longing for the past, grieving what was lost during the war and displacement, concerns over documentation, inadequate assistance or attention from the government, cramped living conditions in collective centers, a lack of plots, inability to own living spaces, and a fear of eviction.

→Respondents provided information about three levels of functioning: the individual level, the household level, and the community level.

- Free list respondents said that they took care of themselves by performing household chores and taking care of their own health needs, when possible. However, a number of respondents said that they could not do anything to take care of themselves. Respondents supported their families by looking after young children in their households and by contributing financially, mostly through their pension. Participation in the larger community was characterized by helping out in various ways at community gatherings such as weddings and other celebrations, as well as funerals. Community participation also included socializing and conversing with neighbors and friends.

→Free list respondents did not frequently list mental health or psychosocial problems. However there were commonalities in the types of psychological problems that were described across sites.

- These problems included feelings of: nervousness, anxiety, and stress; depression, unhappiness, grief and loss; isolation, hopelessness, and helplessness; irritation, quarreling, and conflict; being a burden to one's family; and abandonment or neglect by the government. It is possible that the individual level experiences of isolation, hopelessness, and helplessness are tied to the more community level experiences of feeling abandoned by the state.

→Key informant interviews provided more insight into these psychological issues from the perspectives of IDP community members, service providers, and other knowledgeable community representatives.

- Interviews demonstrated the importance of older IDPs' perceived roles in the community for older IDPs' overall functioning and psychological well-being. What was also highlighted through key informant interviews, as in the free list interviews, was the salience of displacement related experiences for older IDPs. Difficulties in adapting to new environments, grieving the past and worrying about the future, a sense of inactivity, apathy, and hopelessness, and experiences of trauma were described as permeating older IDPs' daily lives and contributing to IDPs' lowered quality of life and well-being. Informants also stressed the fact that there are not enough programs specifically directed towards helping older adults and older adult IDPs. However, key informants also described a number of coping mechanisms that older IDPs engage in to deal with psychological problems, as well as strategies that families and communities use to provide assistance. The most commonly mentioned coping mechanisms for all psychological problems inquired about were: providing support to each other and receiving support from family and neighbors; relationships with family, particularly children and grandchildren; working and working on plots; talking and sharing problems with each other; and encouraging themselves.

References

Bass JK, Ryder RW, Lammers MC, Mukaba TN, Bolton PA. (2008) Post-partum depression in Kinshasa, Democratic Republic of Congo: validation of a concept using a mixed-methods cross-cultural approach. *Trop Med Int Health*. 13(12):1534-42.

Bolton P, Tang AM. (2004). Using ethnographic methods in the selection of post-disaster mental health interventions, *Prehosp Disaster Med*, 19(1): 97-101.

Weller, S.C. and Romney, A.K. (1988) *Systematic Data Collection*, Sage Publications: Newbury Park, California.

Chapter Four: Instrument Development

A. Purpose and Objectives

The stated goal of the study as originally proposed was "to describe physical and mental health status among shorter-term and long-term displaced older adults in Georgia." In order to accomplish this goal, the first issue to address was how to *measure* mental and physical health. This is a complex issue, due largely to the fact that health is a "latent construct", or an "abstraction that can be assessed [or quantified] only indirectly" (Netemeyer, Bearden, & Sharma, 2003). One of the most common internationally-accepted definitions of health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1946). With regards to mental health specifically, the WHO states that there is no official definition, because cultural differences, subjective assessments, and competing professional theories all affect how it may be defined. It is, however, generally agreed that mental health—like health in general—is broader than simply a lack of mental disorders (World Health Organization, 2001).

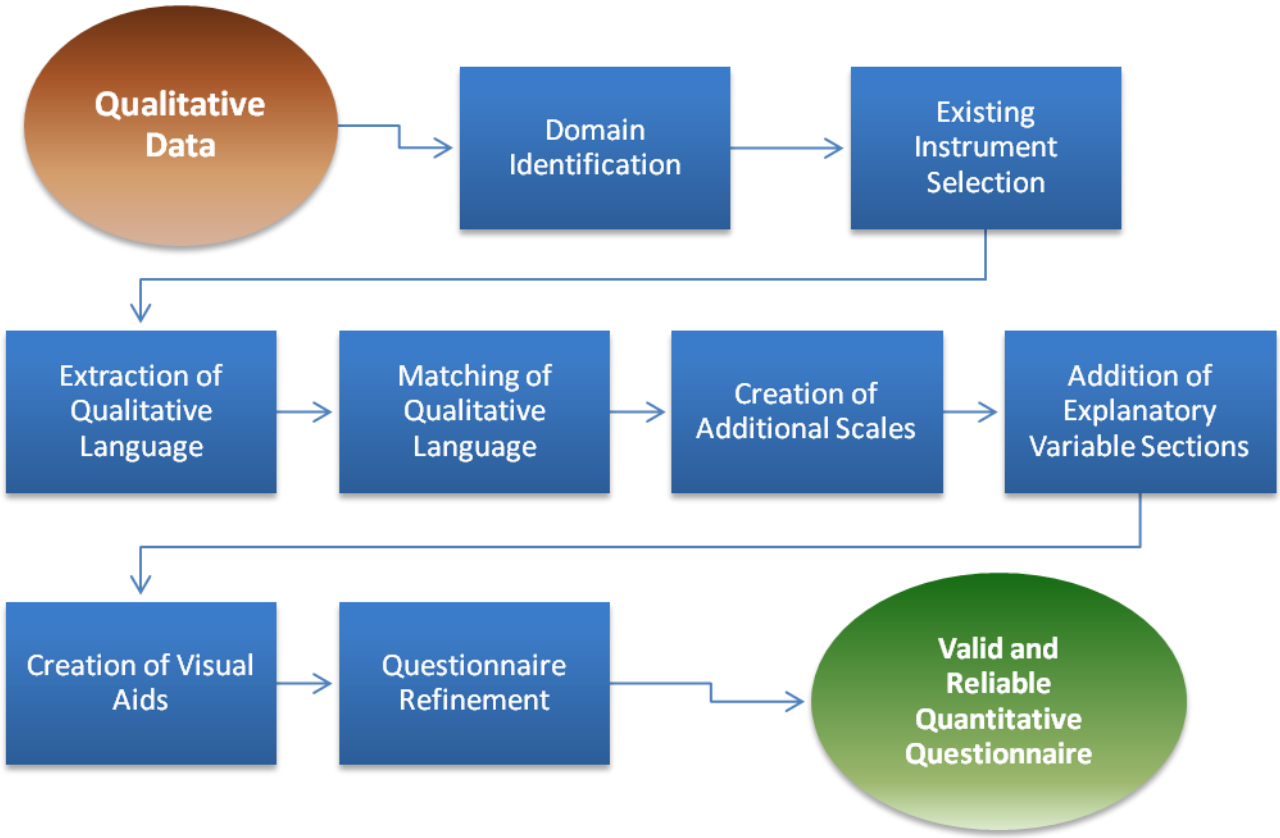
Because health is a complex, latent construct, it is most often recognized—despite definitions to the contrary—in terms of the presence or absence of disorders. Many of these disorders, in turn, are latent constructs themselves, requiring scaling methods (i.e., using multiple observable indicators to measure) and classification (categorizing constructs based on the indicator measurements) for proper measurement (Netemeyer et al., 2003). This poses a number of difficulties for measurement. The latest iteration of the World Health Organization's International Classification of Diseases (ICD-10), which is a coding system used to classify diseases and other health problems, recognizes more than 14,000 distinct conditions (World Health Organization, 2010). Likewise, there is a wide variety of mental and behavioral disorders recognized in the DSM-IV disease classification scheme, which recognizes 374 distinct mental disorders [60]. Clearly, providing clinical diagnoses for each and every one of these physical and mental disorders would be not only cost- and time-prohibitive, but would also be inappropriate for a population-based survey.

The purpose of the methodology described below was to bridge the qualitative and quantitative phases of the study through an instrument development process that would maximize resources while maintaining the validity of the information by determining the most relevant health issues that are common among older displaced populations (i.e., depression, impaired cognition, stress), and measuring them using survey instruments that have been widely used in a variety of settings, but adapted to the unique Georgian context.

B. Methods and Results

The research team undertook an eight-step process (see Figure 4.1) to use data from the qualitative study to formulate a questionnaire that would be not only achieve the stated research objectives in a valid way, but also be suitable for local use. Descriptions from the qualitative data are used to both to shape the content of the overall questionnaire as well as specific scales and questions within the questionnaire. This general method is based on the Design, Implementation, Monitoring and Evaluation (DIME) approach developed and applied in many countries by researchers from the Applied Mental Health Research (AMHR) Group at the Johns Hopkins Bloomberg School of Public Health. The primary purpose of the DIME approach is to provide better evidence for technical assistance to organizations implementing interventions for vulnerable populations in low- and middle-income countries.

Figure 4.1: Instrument Development Process



1. Domain Identification
The qualitative data collection phase involved interviews with key informants knowledgeable about the plight of older adult displaced persons and free listing interviews with older displaced Georgians themselves in three of the regions experiencing the greatest burden of displacement. In the free listing interviews, older adult IDPs were asked to name and briefly describe some of the major problems facing their group and how these problems affect them and their families. Key informants were then asked to comment on some of the common problems that emerged from the free listing. Once the qualitative data collection was completed, several members of the study team—including experts in research among displaced populations, gerontology, mental health, and qualitative methods—performed a preliminary read-through of the qualitative data. The purpose of the exercise was to extract issues related to the health of the populations that were woven throughout the narrative. Subsequent team discussions enabled the team to present their thoughts on the data and reach a consensus on the main themes and domains that were represented in both the key informant and free listing interviews (listed in Table 4.1).

Table 4.1: Domains Represented in the Qualitative Data

Overarching Domain	Sub-domains	Sample Qualitative Quotes
Mental Health	**Depression**	• "[Older adult IDPs] don't have interest in anything. They just live on, nothing else. They try to kill time…Sometimes they work, sometimes they cry to kill the pain." – Key informant • "I wish I was dead; why didn't I die?" – Free list interviewee

		• "These people see no future ahead. They have lost interest in everything." – Key informant
	Anxiety	• "The refugees are very tense; they have no faith in themselves and are not happy for anything." – Key informant • "They see that there is no prospect for them. They see the reality and get scared. They depend on children and grandchildren, who cannot find jobs and do nothing all day long. They also worry about their rights." – Key informant
	Dignity	• "[People] only see [the older IDPs for] what they are today: helpless, poor, and homeless. The only things they have are their memories." – Key informant • "I know some people who keep saying that no one needs them." – Key informant
	Traumatic experiences	• "It is as if their life has stopped there. They live in the past" – Key informant
	Alcohol use	• "If one of them gets any kind of social help, they go and drink the money away." – Key informant
Physical Health	**Functioning**	• "I have fallen down so many times… My legs are useless." – Free list interviewee • "When I feel very bad I don't cook and do nothing" - Free list interviewee
	Access to health services	• "Very often seniors don't tell their children about being ill, they hide their sickness because they are afraid the children would have to support them financially. They tell this to others and ask not to say anything to their children or grandchildren, because they don't want them to know" – Key informant
Background Variables	**Social ties and interactions**	• "It is hard for the seniors to create new circles of friends. All they are left with is their recollections and old relatives; therefore they suffer from lack of communication" • "Village people have been torn apart. People from different villages live in a settlement and neighbors do not even know each other. The old network was decimated. It is hard to communicate. The people from different places are together, they do not know each other. They know nothing about a neighbor's past."
	Household problems	• See discussion below

These extracted themes guided the search for appropriate existing instruments to be used in the quantitative prevalence phase of the study, ultimately providing the bulk of the content of the questionnaire.

2. Existing Instrument Selection

Once measurement domains had been identified, the researchers relied on literature reviews and their experience and knowledge in their respective fields to identify existing instruments that would be suitable to measure the specified domains among the population of interest. In some cases (most notably with depression and anxiety), there were many existing scales to choose from. The research team considered a number of factors related to a potential instrument, including psychometric properties, use in multi-cultural settings, suitability for use among older adults or displaced populations, response options and scoring, and any copyright issues associated with use of the instrument.

Given the age of the study population, the research team was also sensitive to the particular aspects of successful interviewing of older adults. Because the final questionnaire would measure multiple domains using a number of instruments, the length of each instrument was also an important consideration. Discussions with the local partner staff led the research team to conclude that 1 to 1.5 hours would be the maximum desired length of an interview with the older adults in question, as any longer than that which would potentially fatigue the respondents and compromise the integrity of the data. Research has shown that if the special needs of older adults are taken into account—such as respectful and nonjudgmental wording of questions, allowing some additional time for older adults to respond, and adapting to sensory impairments —interviews with older adults can provide equally, if not more, accurate data than is obtained from younger respondents (Domarad & Buschmann, 1995; Rodgers & Herzog, 1987).

Table 4.2 shows the existing instruments that were selected to measure the domains of interest following group discussions of the literature and the considerations noted above.

Table 4.2: Existing Instruments

Domain	Selected Scale Description	Scale Citations
Functioning	The 6-item Activities of Daily Living (ADL) scale is a tool specifically developed to assess the functioning of older adults in areas of self-maintenance. The literature has documented evidence that this measure is a valid and reliable tool for monitoring the health and illness of elderly people, and has therefore been extensively used in both population-based and clinical settings.	Halter, Reuben, Finch, Vaupel, & Kinsella, 2001; S Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963; Sidney Katz, 1983
Depression	This section incorporated the 15-item short form of the Geriatric Depression Scale (GDS). Research has shown that the GDS is well-tailored for older populations—including those suffering mild dementia and physical illness—while at the same time representing a valid and reliable tool for screening depression in the elderly. Responses are given in a dichotomous yes/no format.	Lyness et al., 1997; Sheikh & Yesavage, 1986; J. Yesavage et al., 1983
Anxiety	The 20-item Geriatric Anxiety Inventory (GAI) was developed specifically as a brief, self-reported scale to measure anxiety symptoms among older people in epidemiological surveys. It has been used in multi-cultural settings and been shown to exhibit good psychometric properties while still approachable for older populations.	Pachana et al., 2007; Segal, June, Payne, Coolidge, & Yochim, 2010
Traumatic Events	The Harvard Trauma Questionnaire (HTQ) has been used and adapted extensively among a wide variety of displaced populations. The HTQ is a two-part instrument, one measuring trauma experiences and the other measuring symptoms of post-traumatic stress disorder (PTSD). Because PTSD was not as evident in the qualitative data as other physical and mental health disorders, the research team opted to use only the trauma experiences portion of the questionnaire.	Kleijn, Hovens, & Rodenburg, 2001; R. F. Mollica et al., 1992; Shoeb, Weinstein, & Mollica, 2007; Silove, Steel, McGorry, & Mohan, 1998
Dignity	This section encompassed a dignity scale comprising 18 questions grouped into the dignity subdomains of self-respect, self-efficacy, autonomy, and worthiness. The	Khatib & Armenian, 2010; Simonyan, 2007

	instrument was developed for use and has been validated among displaced populations in the Palestinian Territories and in Armenia.	
Social Ties and Interaction	This section used an adapted version of the baseline instrument used by Experience Corps® to measure older adult social ties and interactions with friends, family and social groups. As with other measures that were selected, the Experience Corps instrument was developed specifically for use with older adults, and has been used in several countries. The instrument examines the number of and frequency of communication with family members, friends, and individuals in other social settings.	Frick et al., 2004; Fried et al., 2004
Health Care Access	The Immigrant Barriers to Healthcare Scale (IBHS) was developed to fill a gap in measures of barriers to care that contribute to health inequities for migrant populations. The IBHS has been demonstrated to be a reliable and valid tool in cross-cultural populations and has been recommended for use among socially and economically disadvantaged groups, such as the older adult Georgian IDPs.	Keating et al., 2009
Alcohol Use	This section consisted of the Alcohol Use Disorders Identification Test (AUDIT) to identify possible problems with alcohol use.	Gomez, Conde, Santana & Jorrin, 1966; Saunders, Aasland, Babor, Fuente & Grant, 1993

3. Extraction of Qualitative Language

In late March 2011, the research team organized a workshop in Tbilisi, Georgia, involving the core team, along with senior staff and interviewers from the local partner, Institute for Policy Studies. The purpose of the week-long workshop was to more closely examine all the qualitative interviews—both key informant and free listing—and to extract language that corresponded to the general themes identified during step 1. Priority was given to delving into constructs that the literature has shown would be particularly sensitive to the local context, namely functioning, depression, anxiety, and trauma experiences. The group was briefed on the specific characteristics of each domain to ensure that all pairs knew what to look for. Lists of household problems were also generated through the same process.

Each individual was assigned a batch of interviews, all of which had been professionally translated into English for the U.S.-based members of the research team, to read through and process. During the reading, individuals filled out excel spreadsheets comprising tabs for each domain of interest. Within a given tab, a researcher wrote key words or phrases in English and/or Georgian related to the domain of interest, a summarizing phrase, corresponding ID numbers for each of the words and phrases in column 1, a frequency count, and any additional notes. Table 4.3 depicts a spreadsheet from one of the Georgian team members that was completed while reading through 3 key informant interviews. While interview processing was done on an individual basis, each person remained in a common room so that questions pertaining to language and domain relevance could be raised to other persons if necessary.

Table 4.3: Qualitative Language Extraction

Key Words/Phrases (Georgian)	Summarizing Phrase (Georgian)	Summarizing Phrase (English)	Interview ID Numbers	Count
გარიყულად გრძნობენ თავს	გარიყულობა	Feeling isolated	T-FKI-15	15
ისინი იგნორირებულები არიან	იგნორირებული	Feeling ignored	T-Ki-14	3
სახლშია გამოკეტილი	სახლშია გამოკეთილი	Stuck at home	T-Ki-14	3
მოწყვეტილია ეს ხალხი ყველაფერს.	მოწყვეტილია ყველაფერს.	Isolated	T-Ki-14	3
დათრგუნულები არიან	დათრგუნულები	Oppressed	T-Ki-14	2
გამოსავალს ვერ პოულობს	გამოსავალს ვერ პოულობს	No solution to problems	T-Ki-14	2
იქ სიკვდილი გვირჩვენია აქ ყოფნასო.	სიკვდილი გვირჩვენია აქ ყოფნასო.	Wish for death	T-Ki-14	1
მიტოვებულები არიან	მიტოვებულები არიან	Feel abandoned	T-Ki-14	1
გაუხარელ	გაუხარელ	Unhappy	T-KI-13	1
მიტოვებულობის განცდას.	მიტოვებულობის განცდას.	Experience of being abandoned	T-KI-13	1
ყველაფერი, რაც მათთან იყო დაკავშირებული წარსულს ჩაბარდა. ფიქრობენ, რომ მათთვის ამ ცხოვრებაში უკვე ადგილი აღარ არის.	ცხოვრებაში ადგილი აღარ არის	No place in life	T-KI-13	2
მარტოობა.	მარტოობა.	Loneliness	T-KI-13	1

4. Matching of Qualitative Language to Existing Scales
After individuals had finished processing the interviews assigned to them, the researchers reconvened into the larger group in order to work together on matching the qualitative language listed on individual spreadsheets to items on the existing scale for depressive symptoms and anxiety, as well as the traumatic experiences section of the HTQ. The study principal investigator led the discussion, which involved displaying the scale for all to see, followed by reading through and discussing each scale item one-by-one. One individual was assigned to act as a scribe to capture the group decisions on scale items.

The primary goal of the matching process was to identify a word or phrase on the spreadsheets that corresponded with the phrasing of each of the scale items. Indeed, the majority of the scale items were represented either directly or indirectly in the qualitative data. Phrases with direct matches in the spreadsheets were underlined in the instrument and the local staff that were present—which included the primary translator—recorded the corresponding Georgian phrase for use in the translation of the scale. In some cases, the qualitative language did not contain an exact translation of the English phrase, but positively matched the underlying concept of the item. In such cases, the phrase was again underlined, and the matched phrase was added,

separated by commas, so that the research team would know that a corresponding concept was used rather than a direct translation. For the small minority of items for which neither a direct phrase nor a related concept was represented in the qualitative, the scale item was translated directly from English into Georgian. Table 4.4 depicts the depression and anxiety scales as notated during the matching process. As an illustration, item 1 of the depression scale contained a term that was gleaned from the qualitative data, item 2 contained language with no correlates in the qualitative data, while items 3, 4, and 5 contained phrases with no direct translation matches, but underlying meaning matches.

Table 4.4: Depression and Anxiety Scale Notation

Depression	Anxiety
1. Are you basically satisfied with your life? (GDS)(Q) **2.** Have you dropped many of your activities and interests? (GDS) **3.** Do you feel that your life is empty, has no meaning? (GDS)(Q) **4.** Do you often get bored, nothing amuses you? (GDS)(Q) **5.** Are you in good spirits, good mood most of the time? (GDS)(Q) **6.** Are you afraid that something bad is going to happen to you? (GDS)(Q) **7.** Do you feel happy most of the time? (GDS)(Q) **8.** Do you often feel helpless? (GDS)(Q) **9.** Do you prefer to stay at home, rather than going out and doing new things? (GDS)(Q) **10.** Do you feel you have more problems with memory than most? (Do you feel your memory is worse than others?) (GDS)(Q) **11.** Do you think it is wonderful to be alive now? Happy to be alive? (GDS)(Q) **12.** Do you feel pretty worthless (useless) the way you are now? (GDS) **13.** Do you feel full of energy? (GDS)(Q) **14.** Do you feel that your situation is hopeless? (GDS)(Q) **15.** Do you think that most people are better off than you are? (GDS)(Q)	**1.** I worry a lot of the time. (GAI) (Q) **2.** I find it difficult to make a decision. (GAI) **3.** I often feel jumpy, can't stay calm (GAI)(Q) **4.** I find it hard to relax, get rid of tension. (GAI)(Q) **5.** I often cannot enjoy things because of my worries. (GAI) **6.** Little things bother, irritate me a lot. (GAI)(Q) **7.** I often feel like I have butterflies in my stomach. (GAI) **8.** I think of myself as a worrier. (GAI)(Q) **9.** I can't help worrying about even trivial things. (GAI)(Q) **10.** I often feel nervous. (GAI)(Q) **11.** My own thoughts often make me anxious. (GAI)(Q) **12.** I get an upset stomach due to my worrying. (GAI)(Q) **13.** I think of myself as a nervous person. (GAI)(Q) **14.** I always anticipate the worst will happen. (GAI)(Q) **15.** I often feel shaky, trembling inside. (GAI)(Q) **16.** I think that my worries, (anxious thoughts) interfere with my life. (GAI)(Q) **17.** My worries (anxious thoughts) often overwhelm me. (GAI)(Q) **18.** I sometimes feel a great knot in my stomach. (GAI) **19.** I miss out on things because I worry too much. (GAI)(Q) **20.** I often feel upset. (GAI)(Q)

GDS=Wording on the GDS, GAI=Wording from the GAI scale, Q=Word/phrase from Qualitiatve

Upon successfully matching language for all the existing scale items, it became clear that there were signs or symptoms of depression and anxiety that were found in the qualitative research, but that were not represented in the existing instrument. The next avenue of discussion for the group was therefore to add items to the scale that were directly derived from the qualitative language. Although there could have been many additions to the scale if each and every item noted in the qualitative data was added to the instrument, only the most commonly and clearly represented items were added to the scale in order to maintain a reasonable level of questions in the final questionnaire. To distinguish between added items and core scale items, the derived

statements were italicized in the questionnaire and marked with the (Q) to denote their origin (see Table 4.5)

Table 4.5: Added Depressive and Anxiety Symptoms

Added Depression Items	Added Anxiety Items
• *Do you enjoy getting up in the morning, getting going?(Q)* • *Do you feel isolated by others?(Q)* • *Do you feel you are a burden to others?(Q)* • *Do you feel like you wish to die?(Q)* • *Do you feel apathetic, have no interests in life?(Q)* • *Do you feel desperate?(Q)* • *Do you feel passive?(Q)*	• *I lose sleep thinking about things (Q)* • *I am afraid to stay home alone (Q)* • *I don't feel secure (Q)* • *I feel estranged, lack of belonging (Q)*

The matching process was performed separately for the depression scale, the anxiety scale, and the traumatic experiences scale, and by the end of the workshop, translated scales had been developed through a collaborative effort of all present. Involving both native English speakers and native, bilingual Georgian speakers in this process increased the likelihood that a precise understanding of the concepts in both languages was represented.

5. Creation of Additional Scales
Certain domains that were identified in step 1, most notably functioning and household problems, can be highly contextual or subject to cultural norms. For these domains, existing standardized scales—most of which have been created in developed countries—would likely not be suitable for older displaced adults in Georgia. For example, certain function scales that have been developed refer to grocery shopping or using the telephone, activities and concepts which do not apply to all settings (Bolton & Tang, 2004). Anticipating this, the researchers specifically included questions in the qualitative phase to elucidate information on functioning, while information on household problems emerged in the more general line of questioning on problems facing older adult IDPs. Step 5 entailed a similar process to step 4, whereby workshop participants read through all the qualitative transcripts to pull out any language that reflects functioning and household problems.

During the qualitative interviews, IDPs and key informants were asked in three distinct questions what tasks older adults routinely perform for themselves, their families, and their communities. Because of the highly relative nature of functioning, we would expect that certain important tasks might be gender- or region-specific. For example, cooking is generally considered a female task in the Georgian context, while farming might be an important task in rural areas, but not the urban areas. Ideally, a separate scale would be developed for each group, such as urban males, urban females, etc. However, out of concern for the length and complexity of the questionnaire the research team chose to create one scale for all older adult IDPs using the most broadly representative function tasks.

Researchers compiled a list of all tasks expressed in the qualitative data, noting whether the task was for self or others. As each task was added to the general list by an individual researcher, the other researchers confirmed whether or not said task was represented in their set of interviews

as well. If a task was found in a separate region than the original task, a respective code was added for that region. A task that was represented in all three regions was deemed to be generally applicable and was therefore included in the final questionnaire (as shaded in gray in Table 4.6). Scaling was based on other studies done with the DIME approach, using a 5-point Likert scale with the addition of a "does not apply" response option in order to allow for opting out of gender- or region-specific tasks. The resulting scale was included in the questionnaire immediately following the ADL noted in Step 2.

Table 4.6: List of Functions, with Final Scale Items Highlighted

Function (English)	Self	Family or Community	Region
Gardening, working on a plot	X	x	Z, G, T
Cleaning the house	X	x	Z, G, T
Cooking	X	x	Z, G, T
Caring for spouse	X	x	Z, G
Trading	X	x	Z, G
Doing home repairs, construction for self or neighbors	X	x	Z, G, T
Shopping for food	X	x	Z, G, T
Looking after grandchildren, children	X	x	Z, G, T
Attending weddings or funerals, celebrations, community events	X	x	Z, G, T
Visiting the doctor	X		Z, G, T
Taking medicine, taking care of health, going to doctor	X	x	Z, G, T
Amusing oneself	X		Z, G
Washing clothes	X	x	G, T
Washing oneself	X		G,
Canning, preserving food	X		Z, G
Caring for animals	X	x	G, Z
Pay bills	X	x	G, T
Keep diet	X		G, T
Collect firewood	X		G
Borrow money for medicine	X		Z, G
Work physically	X		G, T
Social drinking and eating	X	x	G, Z
Look after health	X		G, T
Helping grandchildren with homework	X	x	G, T
Sharing food and crops with neighbors	X	x	G, T
Support, encourage each other	X	x	G, Z
Buying medicine	X		T
Working, bringing in income, trading, construction, taxi driver	X	x	T, Z, G
Go out alone	X		T
Visiting others	X		T
Go to church, honoring deceased, keep religious rituals for dead	x	x	Z,T
Spend pension, sharing money in the family		x	T, Z, G
Taking children out for sports, school, cinema		x	T, G
Cleaning the yard		x	T
Telling names of medicines		x	T
Collecting money in case of need (weddings or funerals)		x	T, Z
Helping in case of need (weddings or funerals)		x	T, G
Socializing with neighbors		x	T, G, Z
Buying things		x	Z

Give advice		x	Z
Cleaning common places		x	Z, G

Z=Zugdidi area; G=Gori area; T=Tbilisi area

An identical process was used to develop a scale of household problems for the displaced persons. These problems related specifically to humanitarians and living conditions for the IDPs, aspects of life that could be targeted during humanitarian or development assistance interventions. The purpose for including this aspect in the survey was to analyze the subsequent quantitative data to determine whether there were any household problems that were particularly associative with adverse physical and mental health outcomes. This could help service providers obtain a better understanding of where and how to target assistance to increase impact. Table 7 shows common household problems of older adult IDPs that emerged from the quantitative data and that were included in the final questionnaire. Respondents were asked to indicate whether the noted condition was "little or no problem", "somewhat of a problem", or "a serious problem" for their household.

Table 4.7: Derived household problem items

Small or cramped living space (Q)
Condition of the house or room (Q)
Inadequate sanitation facilities, such as a toilet or latrine (Q)
Access to toilet (Q)
Access to clean water (Q)
Heating of household (Q)
Not having a plot (Q)
Not having sufficient household items (Q)
Lack of privacy (Q)
No ownership of house/room (Q)
Pension is too small (Q)
Lack of money for medicines (Q)
Food scarcity (Q)
Access to health care (Q)
Unemployment (Q)
Access to insurance (Q)
Access to IDP allowance or social assistance (Q)
Lack of attention from government (Q)

6. Addition of Explanatory Variable Sections
While the questionnaire had already taken much shape and substance by step 6, additional sections were necessary in order to enable the creation of vulnerability profile during the data analysis and to conform to study hypotheses that had been developed based on the literature.

a. Background Information and Screening Questions Background data entered by the interviewer related to the interview ID number and the date and location of the interview. The screening questions established whether the potential respondent is 60 or over and is an IDP, the criteria for inclusion into the study.

Because any randomly sampled population-based survey, particularly those targeting older adults, can expect to sample cognitively impaired individuals, the research team felt that a mental state screener was necessary. The Mini Mental State Examination (MMSE)—which measures global cognitive functioning, covering the domains of memory, attention, language, praxis, and visual-spatial ability—is one of the most commonly used cognitive tests (M. F.

Folstein, Folstein, & McHugh, 1975). The research team determined that the MMSE would be appropriate for inclusion in the questionnaire, as it takes only 5-10 minutes to administer and is therefore practical to use repeatedly and routinely. Research on diverse populations indicate that ethnic and cultural differences need to be taken into account when interpreting and comparing scores (Inzelberg et al., 2007; Ng, Niti, Chiam, & Kua, 2007). After discussion with local psychologists, a cut-off score of 20 was established as the minimum score required to screen people into the interview.

b. Household Demographics This section of questions focused on basic household and respondent demographic information including household size and composition, respondent education and employment, household income, and socioeconomic status measures. Individual items used on the questionnaire have been used in a number of humanitarian settings by researchers from the Center for Refugee and Disaster Response at the Johns Hopkins Bloomberg School of Public Health.

c. Migration History Displacement is associated not only with dislocation from familiar places, people, and pastimes but with relocation to inhospitable shelters and settlements, conditions that are likely to be associated with reduced well-being relative to non-displaced populations. Bland et al. (1997) point out that two important components to the mechanism linking dislocation and certain adverse health impacts of disaster are the duration of displacement and the extent to which the move actually ruptures social networks. On the first count, the Georgian case is extreme; on the second count, it is hypothesized that those in collective centers have experienced a greater rupture, thus may have higher adverse psychological indicators. The migration history section focuses on eliciting information about the locally relevant duration, type, and locations of the various settlements households have lived in since displacement.

d. Physical Health While mental health aspects were well represented by the scales developed through the earlier steps in the process, the research team wanted to go beyond functioning and health care access on the physical health side of the equation. Because no specific physical health problems emerged, a general health measure was desired. After a review of the literature, the research team selected the EuroQol 5-dimension instrument (EQ-5D), which functions as a generic health-related quality of life instrument in population health studies (Rabin & de Charro, 2001). The EQ-5D descriptive system asks respondents to evaluate their health status "today" on five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. For each dimension, a one-to-three scale is used, representing no problem, some problem, or extreme problem. An additional health "thermometer" is also presented to respondents whereupon they rate their general health state at the time of interview. The instrument was selected because not only has the EQ-5D instrument performed credibly in diverse international study settings, but also the fact that in studies among older adults, the EQ-5D has been shown to perform as well as other general measures of health-related quality of life, while at the same time proving to be "easy to complete and attractive for use in an elderly population" (Ankri et al., 2003; Brazier, Walters, Nicholl, & Kohler, 1996; Cleemput et al., 2004; Essink-Bot, Krabbe, Bonsel, & Aaronson, 1997; Hughes, 2007; Jelsma, Mkoka, Amosun, & Nieuwveldt, 2004; Perkins, Devlin, & Hansen, 2004; Schrag, Selai, Jahanshahi, & Quinn, 2000). Moreover, the instrument had been previously used in Georgia, and an official Georgian translation of the instrument was available. Because the EQ-5D is a copyrighted instrument, permission was obtained for use prior to inclusion in the questionnaire.

7. Development of Visual Aids

Oftentimes, survey instruments use response patterns, such as Likert scales or functioning degree of difficulty, that are unfamiliar to interviewers and respondents. Visuals aids can help

both groups understand questions and improve the quality and consistency of responses. The Georgia study adopted and translated visual aids that had been used by the AMHG in other studies (see Figures 2 and 3). While in Georgia, this step was not performed until after the validation test revealed certain difficulty in grasping the likert scale response options among some older adults, the research team recommends performing this step as part of the instrument development process.

Figure 4.2: Sample Likert Scale Illustration Depicting Level of Applicability

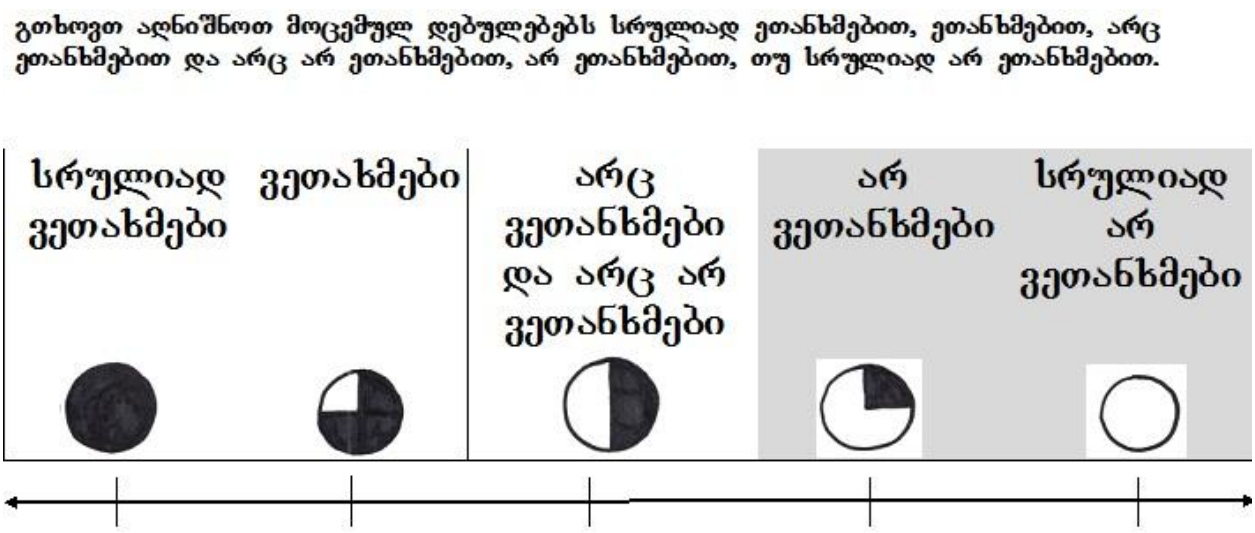
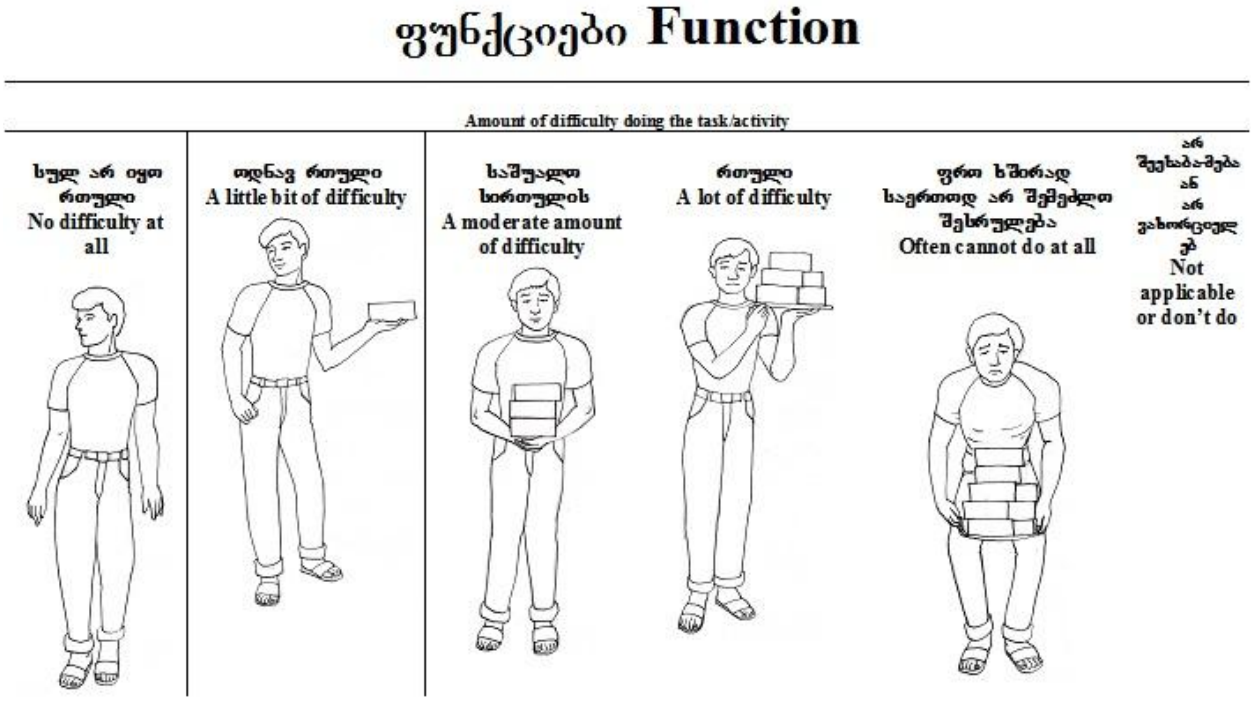


Figure 4.3: Function Illustration Depicting Level of Difficulty



8. Questionnaire Refinement: Back-Translation and Pilot Testing
Steps one through seven produced a full-length, quantitative questionnaire that the research team agreed could successfully meet study objectives. The questionnaire was arranged to produce consistent formatting between all sections of the questionnaire and to make the flow interviewer-friendly. Because several of the interviewers were involved directly in the questionnaire development process, their input helped shape the final questionnaire. The questionnaire was then translated—using the terms derived in steps 4 and 5 where appropriate—collaboratively by a local team of bilingual mental health experts, an approach that has been recommended for translation of questionnaires in international research (Douglas & Craig, 2007). Before moving on to the quantitative phases of the study, however, the research team took additional steps to maximize face validity of the instrument for the interviewers and respondents.

While back-translation alone cannot ensure cross-cultural validity of questionnaires, it has been recommended by a number of experts as an important component proper translating procedure (Beaton, Bombardier, Guillemin, & Ferraz, 2002; Harkness, Pennell, & Schoua-Glusberg, 2004). A local health research expert that was fluent in English and had not been involved in the process of translating the instrument from English to Georgian was asked to verbally back-translate the Georgian instrument into English. A native English-speaking member of the core research team was present and followed the English questionnaire while the back-translation was performed. Discrepancies in meaning were noted, discussed, and where necessary, revised.

Once the final, translated survey instrument had been developed, each interviewer that was to be involved in the quantitative phases of the study administered the questionnaire to a fellow interviewer, followed by a convenience sample of 2 older adults each, to ensure that the question wording, format, and flow were intelligible to the target population and that the survey instrument could be conducted within a reasonable time period. A meeting with the interviewers and members of the research team was organized following the pilot test to propose and discuss changes to the instrument based on issues that arose. While the changes to the questionnaire that emerged during the back-translation and pilot testing were relatively few in number, they significantly enhanced the face validity of the questionnaire.

C. Discussion

The approach described in this paper documents the process of moving from initial qualitative interviews to construction of a study instrument. This process can be used for other population-based surveys to create validated instruments.

The scales and indices used in this study questionnaire were chosen a) to test study hypotheses and b) to reflect the major physical and mental health problems affecting this population as identified in a previous qualitative study, with preference given to instruments that have been specifically developed for use with older adults. Ultimately, the instrument development process described above can be conceptualized as an exercise in directly improving face and context validity—which we might expect could indirectly affect the criterion and construct validity as well—of a quantitative instrument. Both face validity (i.e., a test "looking like it works") and content validity ("the systematic examination of the test content to determine whether it covers a representative sample of the…domain to be measured") have been defined as non-statistical types of validity (Anne Anastasi & Susana Urbina, 1997). Content validity has also been

described as being "concerned with the relevance of the identified research variables within a proposed research project" (Salkind, 2010). One of the major goals of the study in general and this methodology in particular was to ensure that each research variable included in the instrument had the highest level of relevance to understanding the plight of older adult Internally-Displaced Persons (IDPs) in Georgia, while at the same time making it comprehensible to respondents to ensure optimal data quality. In other words, rather than simply selecting domains and scales at will and translating them—the least labor-intensive approach—, the study used a more deliberate approach to generate a questionnaire that would a) be grounded in appropriate local terminology to describe problems (i.e., face validity), b) adequately reflect the most significant physical and mental health problems on the ground (i.e., content validity of the overall instrument), and c) use locally-adapted scales for measurement (i.e., content validity of each individual scale). To be most effective, after careful selection of scales and indices, the resulting instrument should subsequently be validated, then it can be used for population-based surveys or for baseline and follow-up measurements of the presence and severity of the problems being addressed by interventions.

References

Ankri, J., Beaufils, B., Novella, J.-L., Morrone, I., Guillemin, F., Jolly, D., Ploton, L., et al. (2003). Use of the EQ-5D among patients suffering from dementia, *56*, 1055-1063.

Anastasi A, Urbina S. (1997). *Psychological Testing* (7th ed., p. 721). Prentice Hall. Retrieved from http://www.amazon.com/Psychological-Testing-7th-Anne-Anastasi/dp/0023030852

Beaton, D., Bombardier, C., Guillemin, F., & Ferraz, M. (2002). *Recommendations for the Cross-Cultural Adaptation of Health Status Measures*. Rosemont (IL).

Bland, S. H., O'Leary, E. S., Farinaro, E., Jossa, F., Krogh, V., Violanti, J. M., & Trevisan, M. (1997). Social network disturbances and psychological distress following earthquake evacuation, *185*(3), 188-194.

Bolton, P., & Tang, A. M. (n.d.). A new approach to cross-cultural function assessment. *World Health Organization*. Retrieved March 24, 2012, from http://www.who.int/mental_health/emergencies/2.2_key_resource_4_bolton_article.pdf

Brazier, J. E., Walters, S. J., Nicholl, J. P., & Kohler, B. (1996). Using the SF-36 and Euroqol on an elderly population, *5*(2), 195-204.

Cleemput, I., Kesteloot, K., Moons, P., Vanrenterghem, Y., Van Hooff, J. P., Squifflet, J. P., & De Geest, S. (2004). The Construct and Concurrent Validity of the EQ-5D in a Renal Transplant Population, *7*(4), 499-504.

Domarad, B. R., & Buschmann, M. T. (1995). Interviewing older adults: increasing the credibility of interview data. *Journal of gerontological nursing*, *21*(9), 14-20. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/7560817

Douglas, S. P., & Craig, C. S. (2007). Collaborative and Iterative Translation: An Alternative Approach to Back Translation. *Journal of International Marketing*, *15*(1), 30-43. American Marketing Association. doi:10.1509/jimk.15.1.030

Essink-Bot, M. L., Krabbe, P. F. M., Bonsel, G. J., & Aaronson, N. K. (1997). An Empirical Comparison of Four Generic Health Status Measures: The Nottingham Health Profile, the Medical Outcomes Study 36-Item Short-Form Health Survey, the COOP/WONCA Charts, and the EuroQol Instrument, *35*(5), 522-537.

Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). “Mini-mental state”. A practical method for grading the cognitive state of patients for the clinician, *12*(3), 189-198. doi:0022-3956(75)90026-6 [pii]

Frick, K. D., Carlson, M. C., Glass, T. A., McGill, S., Rebok, G. W., Simpson, C., & Fried, L. P. (2004). Modeled cost-effectiveness of the experience corps Baltimore based on a pilot randomized trial. *Journal of Urban Health*, *81*(1), 106-117. Springer.

Fried, L. P., Carlson, M. C., Freedman, M., Frick, K. D., Glass, T. A., Hill, J., McGill, S., et al. (2004). A social model for health promotion for an aging population: initial evidence on the Experience Corps model. *Journal of Urban Health*, *81*(1), 64-78. Springer.

Gomez, A., Conde, A., Santana, J. M., & Jorrin, A. (1966). Diagnostic usefulness of brief versions of Alcohol Use Disorders Identification Test (AUDIT) for detecting hazardous drinkers in primary care settings. *J Stud Alcohol*.

Halter, J. B., Reuben, D. B., Finch, C. E., Vaupel, J. W., & Kinsella, K. (2001). Indicators of function in the geriatric population (pp. 159-179). Washington DC: National Academy Press.

Harkness, J., Pennell, B., & Schoua-Glusberg, A. (2004). Survey Questionnaire Translation and Assessment. In S. Presser, J. Rothgeb, & M. Couper (Eds.), *Methods for Testing and Evaluating Survey Questionnaires* (pp. 453-473). Hoboken, N.J.: John Wiley & Sons.

Hughes, D. A. (2007). Feasibility, validity and reliability of the Welsh version of the EQ-5D health status questionnaire, *16*, 1419-1423.

Inzelberg, R., Schechtman, E., Abuful, A., Masarwa, M., Mazarib, A., Strugatsky, R., Farrer, L. A., et al. (2007). Education effects on cognitive function in a healthy aged Arab population, *19*(3), 593-603. doi:S1041610206004327 [pii] 10.1017/S1041610206004327

Jelsma, J., Mkoka, S., Amosun, L., & Nieuwveldt, J. (2004). The reliability and validity of the Xhosa version of the EQ-5D, *26*(2), 103-108.

Katz, S, Ford, A. B., Moskowitz, R. W., Jackson, B. A., & Jaffe, M. W. (1963). Studies of Illness in the Aged. The Index of Adl: A Standardized Measure of Biological and Psychosocial Function. *JAMA*, *185*, 914-919. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=14044222

Katz, Sidney. (1983). Assessing self-maintenance: Activities of daily living, mobility, and instrumental activities of daily living. *Journal of the American Geriatrics Society*, *31*(12), 721-727.

Keating, S., Carlson, B., Jimenez, S., Estrada, J., Gastelum, B., Romero, T., & Riegel, B. (2009). Psychometric testing of the Immigrant Barriers to Health Care Scale: Hispanic Version. *Nursing & health sciences*, *11*(3), 235-43. doi:10.1111/j.1442-2018.2009.00446.x

Khatib, R., & Armenian, H. (2010). Developing an Instrument for Measuring Human Dignity and Its Relationship to Health in Palestinian Refugees. *World Medical and Health Policy*, *2*(2), 35-49.

Kleijn, W. C., Hovens, J. E., & Rodenburg, J. J. (2001). Posttraumatic stress symptoms in refugees: Assessments with the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist-25 in different languages. *Psychological Reports*. Psychological Reports.

Lyness, J. M., Noel, T. K., Cox, C., King, D. A., Conwell, Y., & Cain, E. D. (1997). Screening for Depression in Elderly Primary Care Patients: A Comparison of the Center for Epidemiologic Studies—Depression Scale and the Geriatric Depression Scale. *Arch Intern Med*, *157*(4), 449-454.

Meissner, H., Creswell, J., Klassen, A. C., Plano, V., & Smith, K. C. (2011). *Best Practices for Mixed Methods Research in the Health Sciences*. Washington, D.C.: National Institutes of Health. Retrieved from http://obssr.od.nih.gov/scientific_areas/methodology/mixed_methods_research/section6.aspx

Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a Cross-Cultural Instrument for Measuring Torture, Trauma, and Posttraumatic Stress Disorder in Indochinese Refugees. *The Journal of Nervous and Mental Disease*, *180*(2). Retrieved from http://journals.lww.com/jonmd/Fulltext/1992/02000/The_Harvard_Trauma_Questionnaire__Validating_a.8.aspx

Netemeyer, R. G., Bearden, W. O., & Sharma, S. (2003). *Scaling Procedures: Issues and Applications*. Thousand Oaks: Sage Publications Inc.

Ng, T. P., Niti, M., Chiam, P. C., & Kua, E. H. (2007). Ethnic and educational differences in cognitive test performance on mini-mental state examination in Asians. *Am J Geriatr Psychiatry*, *15*(2), 130-139. doi:15/2/130 [pii] 10.1097/01.JGP.0000235710.17450.9a

Pachana, N. A., Byrne, G. J., Siddle, H., Koloski, N., Harley, E., & Arnold, E. (2007). Development and validation of the Geriatric Anxiety Inventory. *International Psychogeriatrics*, *19*(01), 103-114. Retrieved from http://journals.cambridge.org/abstract_S1041610206003504

Perkins, M. R. V., Devlin, N. J., & Hansen, P. (2004). The validity and reliability of EQ-5D health state valuations in a survey of Maori, *13*, 271-274.

Rabin, R., & de Charro, F. (2001). EQ-5D: a measure of health status from the EuroQol Group. *Ann Med*, *33*(5), 337-343. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=11491192

Rodgers, W. L., & Herzog, A. R. (1987). Interviewing Older Adults: the Accuracy of Factual Information. *J Gerontol*, *42*(4), 387-394. doi:10.1093/geronj/42.4.387

Salkind, N. J. (2010). *Encyclopedia of Research Design, Volume 1* (p. 473). SAGE Publications. Retrieved from http://books.google.com/books?id=HVmsxuaQl2oC&pgis=1

Saunders, J. B., Aasland, O. G., Babor, T. F., FUENTE, J. R., & GRANT, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption II. *Addiction*, *88*(6), 791-804. Wiley Online Library.

Schrag, A., Selai, C., Jahanshahi, M., & Quinn, N. P. (2000). The EQ-5D--a generic quality of life measure--is a useful instrument to measure quality of life in patients with Parkinson's disease, *69*, 67-73.

Segal, D. L., June, A., Payne, M., Coolidge, F. L., & Yochim, B. (2010). Development and initial validation of a self-report assessment tool for anxiety among older adults: the Geriatric Anxiety Scale. *Journal of anxiety disorders*, *24*(7), 709-14. Elsevier Ltd. doi:10.1016/j.janxdis.2010.05.002

Sheikh, J. I., & Yesavage, J. A. (1986). Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontologist: The Journal of Aging and Mental Health*, *5*(1-2), 165-173.

Shoeb, M., Weinstein, H., & Mollica, R. (2007). The Harvard Trauma Questionnaire: Adapting a Cross-Cultural Instrument for Measuring Torture, Trauma and Posttraumatic Stress Disorder in Iraqi Refugees . *International Journal of Social Psychiatry* , *53* (5), 447-463. Retrieved from http://isp.sagepub.com/content/53/5/447.abstract

Silove, D., Steel, Z., McGorry, P., & Mohan, P. (1998). Trauma exposure, postmigration stressors, and symptoms of anxiety, depression and post traumatic stress in Tamil asylum seekers: comparison with refugees and immigrants. *Acta Psychiatrica Scandinavica*, *97*(3), 175-181. Wiley Online Library.

Simonyan, M. (2007). *Dignity and Health-Related Quality of Life of Adult Residents of Yerevan*. *Health (San Francisco)*. American University of Armenia.

World Health Organization. (1946). *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference*. New York. Retrieved from http://www.who.int/suggestions/faq/en/index.html

World Health Organization. (2001). *Mental health : new understanding, new hope*. Geneva: WHO.

World Health Organization. (2010). International Classification of Diseases (ICD). World Health Organization. Retrieved March 20, 2012, from http://www.who.int/classifications/icd/en/

Yesavage, J., Brink, T., Rose, T., Lumc, O., Huangb, V., Adeyb, M., & Leirer, V. O. (1983). Development and validation of a geriatric depression rating scale: a preliminary report. *J Psych Res*, *17*(27), 37-49.

Chapter Five: Instrument Validation

A. Study Purpose and Objectives

As noted previously, our study used a sequential mixed methods approach, which is commonly used to design a quantitative instrument, and then administered the instrument to a sample population (Meissner, Creswell, Klassen, Plano, & Smith, 2011). The first of three phases was a qualitative phase that was implemented prior to the validation phase described in this chapter, and had significant impact on decisions regarding the development of the instrument as described in the previous chapter. The validation phase described here served as the bridge between the qualitative phase and the final quantitative phase of the IDP study.

Creating an instrument that can adequately assess physical and mental health status of older adult internally displaced persons (IDPs) required a scientific approach. In the case of mental health, for instance, researchers have identified priority information that needs to be gathered for comprehensive assessments in humanitarian settings. Elements include background information on the humanitarian event (e.g., demographics, experiences, health status), trauma events (e.g. rape, torture, death of loved ones, frightening events), mental health symptoms (of the emotional, behavioral, and delusional type), and the mental health resources available in the country (e.g. social networks, mental health infrastructure) (George, 2004). While a thorough examination of the Georgian health system was beyond the scope and resources of the study, the present paper describes a process to validate a questionnaire that could address each of the other elements in part or in whole. The scales and indices used in the study questionnaire were chosen to reflect the major physical and mental health problems affecting this population as identified in a previous qualitative study, with preference given to instruments that have been specifically developed for use with older adults. Because standardized questionnaires were used that were originally designed for other populations, the research team devised a study phase to test them to ensure they are accurately assessing the outcomes of interest in the target population. While there were many components to the final questionnaire, the present paper describes the validation of the depression and function sections of the questionnaire.

B. Study Methodology

The validation study was designed to generate data on the psychometric properties of the instrument, including reliability, face validity, and construct validity. The research team also wished to examine criterion validity of the questionnaire, although doing so for all the scales included in the questionnaire would have exceeded the time and resource constraints of the study. Because depression emerged as one of the most significant issues during the qualitative phase, it represents a complex and culturally sensitive construct, and due to the fact that several items were added to the depression scale based on the qualitative data, criterion validation focused on that condition. The researchers assumed that if the mixed methods approach were to generate a valid depression scale in the local context, then the other scales that underwent the same rigorous methodology would also likely exhibit acceptable local validity.

The validation study was carried out in and around the cities of Gori and Tbilisi, which were purposively selected because they had both a high concentration of IDPs and a mix of old-wave and new-wave IDPs. Staff of two local service organizations—the Charity Humanitarian Centre Abkhazeti (CHCA) and the Georgia Centre for Psychosocial and Medical Rehabilitation of Torture Victims (GCRT), both of whom provide counseling support for IDP populations, including older adults—helped identify potential respondents. These local organizations listed people in their service pool who, in their professional opinion, either had depression or did not,

based on a list of common signs and symptoms of depression. Individuals on the two lists were then contacted in a confidential manner by a local organization staff-member to see if they agreed with the classification that had been made by that organization. In cases in which there was an agreement on the categorization, the individuals were asked if they were willing to participate in an interview using the full questionnaire. In cases where there was disagreement with the categorization—persons representing discordant categorization—the potential respondents were deemed ineligible for the study and no further contact was made.

For the validation study, interviewers completed surveys with a total of 100 people. Eligible respondents had official IDP status as identified by the Government of Georgia and were at least 60 years of age at the time of interview, the threshold age for being considered an older adult in Georgia, as well as the UN cut-off for referring to the older adult population (Gorman, 1999; HelpAge International, 2004b). In households where more than one person met these criteria, interviewers were instructed to select the potential respondent in the household with the next nearest birthdate. Older adults were screened for basic cognitive ability and coherence using the Mini-Mental State Exam (MMSE). Any participants identified by the instrument as not meeting the threshold for cognitive ability (as defined as below the cut-off score of 20) were not included in the study. The interviewers themselves were blinded as to the depression status of their respective respondents. Study participants in both the depressed and non-depressed pre-diagnosis groups were interviewed using an identical questionnaire. At the outset of the study, the research team decided that the instrument would exhibit appropriate criterion validity for depression if there were statistically and clinically significantly different mean scores between those identified with depression and those identified as having none. Clinical significance was based on the magnitude of scores, which were calculated by simple addition of the scores on all questions referring to symptoms of that syndrome.

In addition, other psychometric properties of the depression and function scales were examined to provide further information on the reliability and validity of the questionnaire. In order to measure inter-rater reliability, a sample of 20 persons was re-interviewed 1-2 days later by a different interviewer in exactly the same manner. Re-interviewees were randomly selected.

This simple, effective validation process is one that has been used in many countries with different populations by the faculty of the Applied Mental Health Research Group from the Johns Hopkins University School of Public Health (J K Bass, Bolton, & Murray, 2007; Paul Bolton et al., 2007; Paul Bolton, Wilk, & Ndogoni, 2004). In particular, this approach was developed as an alternative validation process when there is no gold standard, such as diagnosis by a mental health professional, against which to compare results (P. Bolton, 2001).

1. Sample Size

The sample size of N=100 was selected based on a number of JHSPH studies which have demonstrated that roughly 50 persons per category has generally proved an adequate but not excessive sample size for detecting and confirming moderate mean symptom severity differences between those who are said to have a problem and those who are said not to have it. Originally, the sample size for studies similar to the validation phase were derived in consultation with mental health .The research team set out to interview around 25 depressed individuals and 25 non-depressed individuals in each of the two cities. Because it was anticipated that some people would ultimately refuse to participate or exhibit a discordant diagnosis between the local partners and the individual in question, implementing partners were asked to provide lists containing 40 names per group in each city—for a total of 160 names—to ensure meeting sampling quotas. Interviewing was deemed finished once interviewers completed 100 interviews with roughly 50 persons on each list.

2. Study Instrument

During the qualitative phase of the larger study, respondents were asked to identify and describe issues facing older adult IDPs in Georgia. Problems that emerged from the qualitative study include depression, anxiety, low sense of dignity, and experiencing traumatic events. The research team identified a number of descriptions of a significant syndrome consistent with clinical symptoms of depression. In order to measure this issue in this population, we chose the 15-item short form of the Geriatric Depression Scale (GDS), as research has shown that the dichotomous items of the GDS are well-tailored for older populations—including those suffering mild dementia and physical illness—while at the same time representing a valid and reliable tool for screening depression in the elderly (J. Yesavage et al. 1983; Sheikh & J. A. Yesavage 1986; Lyness et al. 1997). While the core scale was left intact, the research team gleaned terms and items expressed during the qualitative phase to not only ensure accurate translation of the tool, but also to create additional items in an attempt to ensure the scales reflected the local context. To ensure optimal translation of the scale, we also used standard translation/back translation methods. The final depression component of the questionnaire comprised 22 questions (Table 5.1).

Table 5.1: Signs and Symptoms Included in the Assessment of Depression-like Problems

Depression Item	GDS	Local
Are you basically satisfied with your life?	X	X
Have you dropped many of your activities and interests?	X	
Do you feel that your life is empty, has no meaning?	X	X
Do you often get bored, nothing amuses you?	X	X
Are you in good spirits, good mood most of the time?	X	X
Are you afraid that something bad is going to happen to you?	X	X
Do you feel happy most of the time?	X	X
Do you often feel helpless?	X	X
Do you prefer to stay at home, rather than going out and doing new things?	X	X
Do you feel you have more problems with memory than most? (Do you feel your memory is worse than others?)	X	X
Do you think it is wonderful to be alive now? (Happy to be alive?)	X	X
Do you feel pretty worthless (useless) the way you are now?	X	
Do you feel full of energy?	X	X
Do you feel that your situation is hopeless?	X	X
Do you think that most people are better off than you are?	X	X
Do you enjoy getting up in the morning (getting going)?		X
Do you feel isolated by others?		X
Do you feel you are a burden to others?		X
Do you feel like you wish to die?		X
Do you feel apathetic, have no interests in life?		X
Do you feel desperate?		X
6Do you feel passive?		X

One way of approaching mental health is in the wellness model developed by Myers, Sweeny and Witmer, which defines mental disability as the inability to properly perform certain core life tasks due to mental health issues (Myers, Sweeney, & Witmer, 2000). In this paradigm, psychological disorders—including depression—are defined not only by the presence of signs and symptoms corresponding to the disorder, but also by impairment in one or more domains of daily function. To provide further evidence of validity, we sought to assess dysfunction by developing a functional impairment scale based on the portion of the previous qualitative phase

that explored local concepts of regular activities for older displaced adults (Paul Bolton & Tang, 2002). The function assessment section of the questionnaire combined questions from the 6-item Activities of Daily Living (ADL) scale (Halter, Reuben, Finch, Vaupel, & Kinsella, 2001)—a tool developed to assess the functioning of older adults—with function measures derived from qualitative interviews with IDPs and local key informants. A set of 12 activities selected from the free lists were added to the questionnaire as a measure of functional impairment (Table 2). Respondents were asked to indicate how much difficulty they had engaging in each activity in the previous fortnight, with responses given on a 5-point Likert scale ranging from '0' for 'no difficulty at all' to '4' for 'so much difficulty that you often cannot do the task.' Respondents were provided the option of a given task being not applicable to their life situation. A dysfunction score was generated for each respondent by summing the scores for each item, and dividing that total by the number of items that the respondent noted were applicable to their situation to provide an average impairment score across items. Higher scores indicated greater overall impairment.

Table 5.2: Activities and Tasks of Displaced Older Adults in Georgia

Activities of Daily Living Items	Bathing (bath or shower) - Receive either no assistance or assistance in bathing only one part of body.
	Dressing - Get clothes and dresses without any assistance except for tying shoes.
	Toileting - Go to toilet room, use toilet, arrange clothes, and return without any assistance (may use cane or walker for support and may use bedpan/urinal at night.
	Transferring - Move in and out of bed and chair without assistance (may use cane or walker).
	Continence - Control bowel and bladder completely by self (without occasional "accidents").
	Feeding - Feed self without assistance (except for help with cutting meat or buttering bread) .
Items Added from Free List Exercise	Gardening or working on a plot
	Cleaning the house
	Cooking
	Doing home repairs or construction for self or neighbors
	Shopping for food
	Looking after children, helping with homework, accompanying them
	Attending weddings, funerals, celebrations, or other community events
	Taking care of your own health, including going to the doctor and taking medicines
	Providing moral support and giving advice to others
	Earning an income (e.g., trading, construction, or other work)
	Sharing pension or other money with the family
	Socializing with neighbors or friends (Q)

While we will only examine the depression and function sections for the present paper, the larger study instrument for the study included 13 sections in total. The Mini Mental State Examination (MMSE) was used to assess cognitive functioning (M. F. Folstein, Folstein, & McHugh, 1975). The MMSE has a maximum score of 30, with higher scores denoting better cognitive functioning; after consultation with the literature and local psychological professionals, a cut-off score of 20 was established as the minimum required to screen people into the interview (Inzelberg et al., 2007; Ng, Niti, Chiam, & Kua, 2007).

3. Data Analysis

The sample N=100 consisted of 56 people who were identified by one of the partner agencies and the person themselves as having locally-defined depression (defined as a "case" of depression) and 44 people identified by one of the partner agencies and themselves as having no depression (defined as "non-cases"). The procedure of having both an agency and the person agree on whether they are a 'case' or not was intended to increase the likelihood that those who are said to have depression do in fact have it. The data generated from the interview with the locally-adapted instrument was used to generate depression and functional impairment scores for each participant.

A number of statistical tests were conducted using the Stata software package to test the validity and reliability of the study instrument. The internal consistency reliability of the scales was tested using the Cronbach's alpha coefficient. The researchers assumed adequate internal consistency was achieved if Chronbach's Alpha exceeded 0.70. The inter-rater reliability was assessed using the Pearson Product-Moment Correlation Coefficient for outcomes on the instrument between the initial test done by a local interviewer, and a retest performed by another interviewer.

Tests were performed to assess both convergent and discriminant criterion validity of the scales. To evaluate discriminant validity, a comparison of cases and non-cases was be done by calculating a t-test to examine whether or not the means of the two groups differ at the $p<.05$ level of significance. The hypothesis was that the mean score for the case group would statistically exceed that of the non-case group. Differences in diagnoses between the two groups were also examined through receiver operating characteristic (ROC) curves to test the sensitivity and specificity of the scales based on the community-provided diagnoses. To evaluate convergent validity, we performed regression analysis with dysfunction as the outcome and depression severity scores as the primary predictor. Large, statistically significant correlations between the measures of depression severity and functional impairment would be taken as evidence for convergent validity.

To identify the specific questions within each domain that contributed most to the covariation in the data, a factor analysis was performed on scales within the questionnaire that sought to measure latent constructs, including the GDS, GAI, ADS, and EuroQOL5. In so doing, the researchers were able to determine whether depression as measured represented a distinct, identifiable construct when compared to the other scales. A factor analysis was also run only on the depression items. The analysis was performed using a principal components analysis to extract the number of components, after which an orthogonal varimax rotation of the factors was performed. A scree plot of the resulting eigen values were plotted to help ascertain which factors should be retained. The authors established a cutoff point of >0.4 for the factor loadings in order to determine if an item loaded successfully to a factor.

C. Results

Although 100 people were interviewed for this study, implementing partners initially included a total of 162 individuals in the lists. In accordance with the decision to not include discordant samples—individuals whose self-diagnosis did not match that of the partner organization—a total of 47 people from the initial lists were excluded from the study. This included 20 individuals in Gori and 27 in Tbilisi. Two people were also excluded—one in each city—because they failed to score above the established MMSE cutoff point. Of those who were deemed eligible for inclusion, one respondent in Gori and nine in Tbilisi refused to participate. The interview team indicated that the discrepancy in refusals between Tbilisi and Gori was largely due to the

fact that the IDPs in Tbilisi were at that time more reluctant to allow outside persons, such as the interview team, to enter collective centers due to the then-ongoing efforts of the Government of Georgia to forcibly move families out of some collective centers throughout Tbilisi. Finally, three respondent households on the Tbilisi list proved unreachable. A certain amount of pre-screening occurred on the part of the cooperating agencies, who reported that they hadn't listed the names of some individuals who they felt were obviously unable to respond coherently to the recruitment script questions. The final sample consisted of 56 IDPs who were pre-diagnosed as depressed and 44 individuals prediagnosed as non-depressed. The sample included 66 females and 34 males.

1. Reliability

When used as a measure of internal consistency, Cronbach's alpha scores should be at least 0.7 and ideally greater than 0.8 (Jum C. Nunnaly, 1978). The alpha for the base 15-item scale was 0.85, improving to 0.90 when all 22 mental health symptoms were included. The removal of only three of the depression items (dropping many of your activities and interests, feeling others are better off, and feeling you are a burden to others) would improve the score, although the difference in the alpha upon removal would be minute for any of the three, at less than 0.002.

The study design also allowed an examination of inter-rater reliability using the Pearson Product-Moment correlation. A total of 20 older adults were re-interviewed by the same interviewer within 2 days of the first assessment. The correlations between the depression scale scores from first interview and the re-interview was 0.83 ($P < 0.001$) suggesting adequate reliability (see Table 5.3).

Table 5.3: Inter-rater Reliability

Measure	Mean (SD) First Interview	Mean (SD) Repeat Interview	Pearson Product-Moment correlation
Depression			
All depression symptoms score	10.20 (4.81)	10.31 (5.98)	0.8286*

2. Face Validity

The study worked to ensure face validity through the study design. A translation-back-translation approach helped ensure that the Georgian version of the questionnaire matched the English. Moreover, during training sessions, interviewers administered the questionnaire to each other and reported back to the research team on any items or phrases that seemed confusing. Interviewers then pre-tested the instrument with older adults to ensure that the instrument was approachable and understandable to the population of interest. A number of minor changes were made to the instrument following these steps.

A high number of missing items when the questionnaire is administered can indicate problems with comprehension or other issues with face validity. Frequency tables for the scales being validated were compiled to examine non-response for any potential patterns or trouble items. A total of only 6 observations of depression symptoms and 1 observation of function were missing across all scale items and all respondents. Because there were 22 depression observations and 18 function observations for each of 100 respondents, this indicates a response rate of more than 99%, which indicates acceptable face validity among the study population.

3. Content Validity

Because content validity has been defined as a non-statistical type of validity that involves "the systematic examination of the test content to determine whether it covers a representative sample of the behavior domain to be measured" (Anne Anastasi & Susana Urbina, 1997)—in this case depression and function—, the research team adopted a study approach that would theoretically help maximize content validity in the Georgian context. As described in the methodology section above, rather than simply selecting a depression scale or function scale validated in another context, the study used a more deliberate approach to generate the scale that would reflect the realities in Georgia. Public health and mental health experts from Johns Hopkins University and the Georgia-based Institute for Policy Studies read through data generated during the quantitative phase to not only use local terminology for the depression scale selected, but also to generate new depression and function items derived from the mental health issues and functional expectations that were expressed among older adult IDPs. In so doing, the expectation was that grounding the scales in local terminology and with items generated locally, the scale would have higher content validity than if this approach was not adopted.

An examination of the response patterns for the function items can help support this assumption. Because it was anticipated that not all older adults would consider the derived function items applicable to their situation—in other words, something that they would regularly do—a response option was given "Not applicable, or do not do". The logic behind this option was that we wanted to measure functional impairment, and we wanted to distinguish between an activity that an adult did not engage in at all from an activity that a person would normally engage in, but could no longer do due to impairment. A high number of "not applicable" responses would seem to indicate an activity that although mentioned in the qualitative, did not have widespread applicability. The authors assumed that any item that had less than 50 percent indicating "not applicable" for either gender would need to be included in the final instrument to ensure content validity (see Table 5.4). Only two of the new function items (looking after children and earning an income) had more than 50 percent in *both* genders indicating the activity did not apply. Simply adopting the well-validated Activities of Daily Living scale, which was also included in the questionnaire, would have omitted the myriad functional expectations that were uncovered using our approach.

Table 5.4: Percent Reporting Function as "Not Applicable"

Function Item	Percentage (Total)	Percentage (Male)	Percentage (Female)
4.7 Gardening or working on a plot	51	41	56
4.8 Cleaning the house	25	65	5
4.9 Cooking	25	59	8
4.10 Doing home repairs or construction for self or neighbors	71	41	88
4.11 Shopping for food	16	12	18
4.12 Looking after children, helping with homework, accompanying them	68	71	67
4.13 Attending weddings, funerals, celebrations, or other community events	24	18	27
4.14 Taking care of your own health, including going to the doctor and taking medicines	14	18	12
4.15 Providing moral support/giving advice to others	9	15	6
4.16 Earning an income (e.g., trading, construction, or other work)	76	65	82
4.17 Sharing pension or other money with the family	12	24	6
4.18 Socializing with neighbors or friends	0	0	0

4. Construct Validity

Because depression is a latent construct that is measured through a scale comprising several items, a factor analysis was performed to examine the underlying constructs that explain the variance of the items in the scale. Two factor analyses were performed: the first incorporated only the depression items and the second incorporated the GAI, ADS, and EuroQOL5 in addition to the depression items. The purpose of the first was to examine the underlying factor structure of just the depression items and the second was to examine whether other latent constructs in the questionnaire loaded onto separate constructs when they were all introduced together. The number of underlying factors in both cases was determined by running a Principle Components Analysis (PCA) and Parallel Analysis (PA), and examining where PCA exceeds PA. For the depression-only analysis, the number of factors was determined to be one, and for the analysis including the other scales, the number of factors was three. Factors were rotated using the orthogonal varimax rotation.

Researchers have cited 0.32 as an appropriate minimum loading for each item, as it equates to approximately 10% overlapping variance with the other items in the factor (Tabachnick & Fidell, 2001). Factor loadings for both models are depicted in Table 5.5, with items below this threshold highlighted in gray. Of the twenty-two items included in the 1 factor model, only 3 scored below the minimum loading (dropping many activities, thinking most people are better off, and feeling like a burden to others). It is also noteworthy that in the 3-factor, multiple scale model, every one of the twenty five anxiety items in the larger questionnaire loaded on the depression items in Factor A, while the dignity items loaded onto Factor B. Moreover, the EuroQOL5D health-related quality of life scale the mental health question, which asked about whether a person felt "anxious or depressed", successfully loaded onto the same factor as the depression items (0.50), whereas the other four items—those dealing with physical health— of that scale loaded onto Factor C.

Table 5.5: Factor Loadings for Depression Items

	1 Factors, Depression only	**3 Factors Depression, Anxiety, Health-related Quality of Life, and Dignity**		
Item	**Factor A**	**Factor A**	**Factor B**	**Factor C**
1 Are you basically satisfied with your life? (GDS)(Q)	0.42	0.32	-0.08	0.18
2 Have you dropped many of your activities and interests? (GDS)	0.22	0.26	-0.05	0.00
3 Do you feel that your life is empty, has no meaning? (GDS)(Q)	0.67	0.61	0.00	0.18
4 Do you often get bored, nothing amuses you? (GDS)(Q)	0.61	0.64	-0.10	0.09
5 Are you in good spirits, good mood most of the time? (GDS)(Q)	0.58	0.59	-0.12	0.14
6 Are you afraid that something bad is going to happen to you? (GDS)(Q)	0.51	0.54	-0.27	0.25
7 Do you feel happy most of the time? (GDS)(Q)	0.64	0.62	-0.06	0.10
8 Do you often feel helpless? (GDS)(Q)	0.64	0.63	-0.01	0.41
9 Do you prefer to stay at home, rather than going out and doing new things? (GDS)(Q)	0.44	0.29	-0.13	0.32
10 Do you feel you have more problems with memory than most? (Do you feel your memory is	0.45	0.40	-0.19	0.36

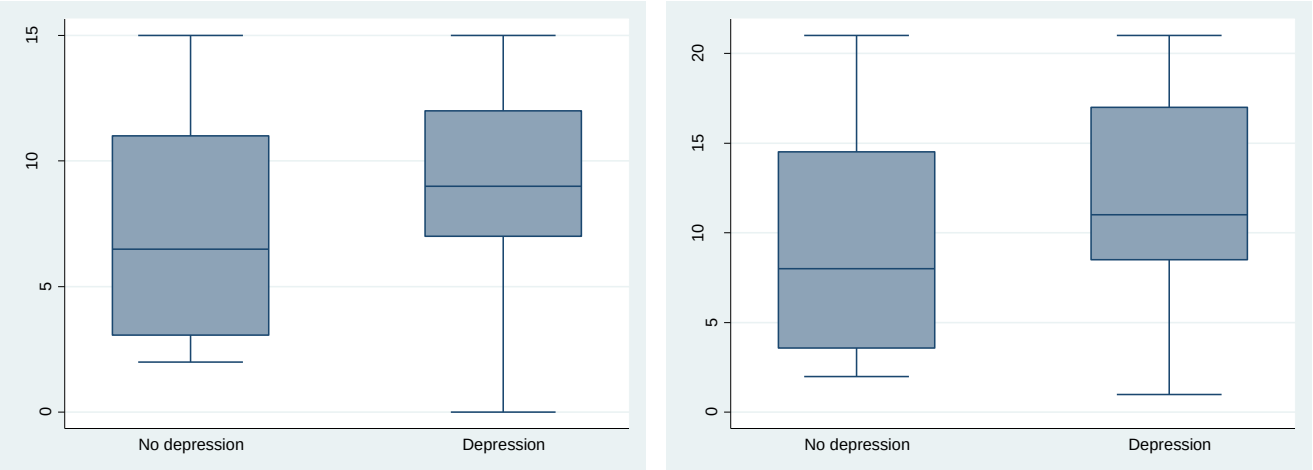
worse than others?) (GDS)(Q)				
11 Do you think it is wonderful to be alive now? Happy to be alive? (GDS)(Q)	0.53	0.41	-0.06	0.20
12 Do you feel pretty worthless (useless) the way you are now? (GDS)	0.40	0.35	-0.09	0.17
13 Do you feel full of energy? (GDS)(Q)	0.63	0.50	-0.24	0.41
14 Do you feel that your situation is hopeless? (GDS)(Q)	0.73	0.62	-0.03	0.34
15 Do you think that most people are better off than you are? (GDS)(Q)	0.21	0.19	-0.08	0.07
16 Do you enjoy getting up in the morning, getting going?(Q)	0.62	0.49	-0.01	0.47
17 Do you feel isolated by others?(Q)	0.41	0.25	-0.17	0.21
18 Do you feel you are a burden to others?(Q)	0.31	0.19	-0.06	0.30
19 Do you feel like you wish to die?(Q)	0.65	0.57	-0.05	0.29
20 Do you feel apathetic, have no interests in life?(Q)	0.73	0.44	-0.11	0.47
21 Do you feel desperate?(Q)	0.71	0.58	-0.16	0.16
22 Do you feel passive?(Q)	0.65	0.51	0.05	0.43

5. Criterion Validity

a. Discriminant: Discriminant criterion validation tests largely depended upon the community organization-provided prediagnoses of depression. While the staff who compiled the lists for the research team were not providing a DSM-IV clinical diagnosis of depression (and therefore do not represent a gold standard), the categorizations they provided nevertheless reflect value judgments of organizations that are familiar with mental health issues, as well as the population of interest. These categorizations were provided by staff of CHCA in Gori, GCRT's Gori office, and GCRT's Tbilisi office. Before assessing criterion validity through a variety of tests, missing values were imputed to estimate the scale scores for respondents with missing observations.

Figure 5.1 depicts exploratory box plots of the mean depression scores between the two prediagnosis groups, both for the core GDS scale as well as the adapted scale. As evident in the plots, the variability among the non-depressed group was much greater than among the depressed group; this is likely a reflection of the relative difficulty the 3 offices had in identifying non-depressed individuals, a fact they reported to the research team upon completion of the prediagnosis exercise.

Figure 5.1: Box-plot of Core GDS Score by Prediagnosis Category



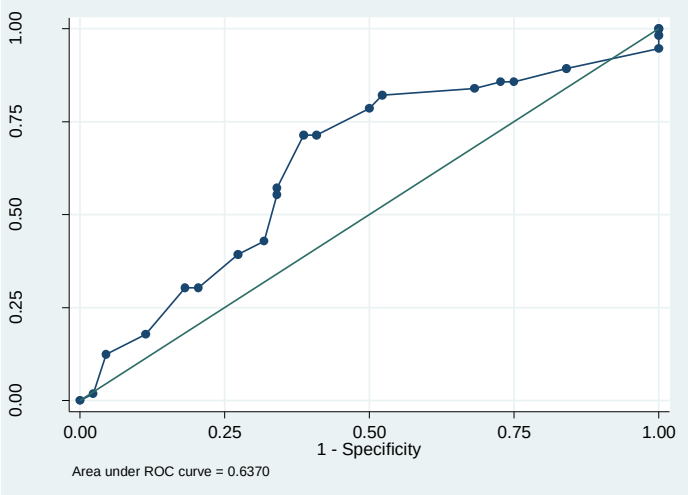
One-tailed t-tests were performed to test the hypothesis of a statistically significant lower mean depression score in the non-depression group as compared to the depression group. T-tests were repeated to reflect gender differences to ensure the criterion validity of the instrument in both genders. As shown in Table 5.6, the means of all permutations of non-depressed groups were lower than among depressed groups, although this difference was not statistically significant among males (possibly due to an insufficient sample size). These results provide positive evidence in favor of the criterion validity of the scale. It should be noted that although a difference was detected in the appropriate direction among males, the instrument seemed less sensitive for them than for females. Local partners suggested that this may be due to the fact that males are more likely to hide symptoms of depression in public.

Table 5.6: One-tailed t-tests of the Mean between Prediagnosis Groups

Scale	Mean, Depressed prediagnosis (SD)	Mean, Non-depressed prediagnosis (SD)	Difference	Hypothesized direction of difference	T-test p-value
Core GDS	8.85 (3.88)	6.98 (4.00)	-1.86	-	0.01
Adapted GDS	11.52 (5.70)	9.08 (5.88)	-2.44	-	0.02
Core GDS, Females	9.31 (3.57)	7.47 (3.85)	-1.87	-	0.03
Core GDS, Males	7.56 (4.51)	6.33 (4.22)	-1.22	-	0.21
Adapted GDS, Females	12.31 (5.26)	9.56 (5.68)	-2.76	-	0.03
Adapted GDS, Males	9.32 (6.42)	8.44 (6.23)	-0.88	-	0.34

A sensitivity and specificity analysis was performed using the receiver operating characteristic (ROC) curve statistical test (Metz, 1978), which allowed us both to examine the performance of the instrument vis-à-vis the prediagnosis, and to determine an optimum cutoff score for categorizing someone as likely depressed. Figure 5.2 depicts the ROC curve for the depression scale using the prediagnosis categories. The ROC analysis suggested that a cutoff score of 8 would maximize the balance between sensitivity and specificity on the core GDS scale, whereas a score of 9 or above would do so on the adapted scale.

Figure 5.2: ROC Curve for depression scale



The value of 0.64 for the area under the curve does not provide strong support for the criterion validity of the instrument. Moreover, the area under the curve differed by site providing the prediagnoses: GCRT's Gori office had an area under the curve of 0.54, whereas both CHCA Gori and GCRT Tbilisi had 0.64. This lower performance from the GCRT Gori office was not unexpected, as staff there had indicated the most difficulty out of the three sites in identifying non-depressed respondents. While this particular test showed poor evidence of criterion validity, it must be remembered that the community diagnoses did not represent a gold standard; therefore, we must also examine aspects of convergent validity to put these results into context. A comparison between the community diagnoses and the categorization provided by the instrument when the score is equal to or greater than 8 shows 33 percent rate of disagreement (Table 5.7)

Table 5.7: Differences in Categorization based on Prediagnosis and the Validation Instrument

		Community Diagnosis	
		Non-Depressed	Depressed
Validation Instrument Categorization	Non-Depressed	27	17
	Depressed	16	40

b. Convergent: Using the cutoff score determined during the ROC analysis, new categorizations could be made, with persons scoring 8 or above categorized as "likely depressed" and those scoring below 8 categorized as "likely not depressed." We then performed t-tests with other scales that we would expect to correlate with depression (i.e., GAI, ADS, and QOL), using both the prediagnosis categories and the new depression category based on the instrument results. In this way, we could compare the relative strength of the community prediagnosis to the instrument's diagnosis, all the while examining the convergent validity of the instrument.

Table 5.8: Differences in Mean Scores on Other Scales between Depressed and Non-depressed Groups

	Scale	**Mean, Depressed (SD)**	**Mean, Non-depressed (SD)**	**Difference (p-value)**	**Hypo-thesized direction of difference**
Community Prediagnosis	Core GAI	13.39 (5.78)	9.52 (6.62)	-3.86 (<0.01)	-
	Adapted GAI	16.42 (7.08)	11.64 (8.05)	-4.78 (<0.01)	-
	ADS	74.38 (12.24)	78.59 (7.52)	4.20 (0.02)	+
	QOL (lower score is better)	9.43 (2.15)	8.48 (2.11)	-0.95 (0.01)	-
	QOL Item 5 (Depression/Anxiety)	2.17 (0.58)	1.96 (0.74)	-0.21 (0.06)	-
Validation Instrument Categori-zation (Score >=8)	Core GAI	15.82 (3.66)	6.21 (5.06)	-9.61 (<0.01)	-
	Adapted GAI	19.31 (4.54)	7.70 (6.27)	-11.61 (<0.01)	-
	ADS	72.11 (11.34)	81.69 (6.29)	9.58 (<0.01)	+
	QOL (lower score is better)	9.98 (2.02)	7.74 (1.67)	-2.24 (<0.01)	-

	QOL Item 5 (Depression/Anxiety)	1.77 (0.68)	2.31 (0.54)	-0.54 (<0.01)	-

The t-tests (Table 5.8) supported the hypothesis that the scales showed a lower mean for those who were prediagnosed as non-depressed when compared to those that were prediagnosed as depressed. The comparison in scores for all the other scales is in the direction expected as well. These relationships are significantly more pronounced when using the instrument diagnosis, indicating that the instrument exhibits even more convergent criterion validity than the community diagnosis itself.

Because mental disorders are most meaningful when approached in the context of functional impairment, a final test for criterion validity was defined in this study as a positive statistical relationship between the depression score and function scores on the ADL scale and the adapted function scale. The scales were analyzed separately due to differing coding schemes; in the case of the ADL, a lower score indicates increased functional impairment (on a scale between 0 and 1), whereas in the adapted scale, a higher score indicates increased functional impairment, (on a scale between 0 and 4). A basic linear regression was performed, which showed that with each 1-point increase on the core depression scale, dysfunction increased by an average of 0.09 points ($p<0.01$) on the adapted scale, whereas function dropped on the ADL scale by 0.01 points ($p=0.03$). These relationships held constant even when gender and age were introduced into the regression model. Higher depressions scores were increased the likelihood of answering "does not apply" to function items ($p=0.002$). T-tests (Table 5.9) further supported the hypothesis that dysfunction was predicted by categorization of depression. Again, the validation instrument categorization proved a stronger predictor of dysfunction than the community prediagnosis.

Table 5.9: Differences in mean function scores between depressed and non-depressed groups

	Scale	**Mean, Depressed (SD)**	**Mean, Non-depressed (SD)**	**Difference (p-value)**	**Hypo-thesized direction of difference**
Community Prediagnosis	ADL	0.91 (0.20)	0.95 (0.14)	.033 (0.18)	+
	Adapted Function	1.06 (0.88)	0.82 (0.73)	-0.23 (0.08)	-
Validation Instrument Categori-zation (Score >=8)	ADL	0.91 (0.22)	0.96 (0.09)	.051 (0.08)	+
	Adapted Function	1.19 (0.87)	0.65 (0.65)	-0.53 (<0.01)	-

D. Discussion

Under ideal circumstances, criterion validity testing of a depression scale would be done with structured clinical interviews by a mental health professional. However, this approach may not be tenable in emergency settings due to the potentially prohibitive cost and time involved, lack of trained professionals, and the potential unsuitability of Western mental health approaches to a local context (Bass, Ryder, Lammers, Mukaba, & Bolton, 2008). By using a mixed methods research strategy we sought to overcome these limitations to identify and validate the existence of a depression-like syndrome among older adult IDPs in Georgia. Using a locally adapted version of a standard depression screener for older adults and a local diagnosis of depression as

a point of comparison, we were also able to establish local reliability and validity for both the concept of the local syndrome and the adapted screener.

The depression scale exhibited acceptable statistical reliability, face validity, and construct validity. For the most part, the depression and anxiety items loaded onto one factor. The depression items that didn't load well may be due to the fact that the items in question are common to all IDPs (i.e., general dissatisfaction with life, feeling isolated, others are better off) or may be conceptualized by the respondents as physical function-related issues (i.e., preferring to stay at home, dropping activities and interests), rather than manifesting depression per se. Likewise, all but three of the newly derived function items were deemed applicable to the majority of older adults in Georgia and therefore, important aspects of function for the local context.

Criterion validity of the depression scale was also demonstrated through a number of statistical tests. While the depression scale performed poorly during the sensitivity and specificity analysis, the other criterion validity statistical tests indicate that the community prediagnoses themselves were the most likely contributors to this fact. Indeed, some of the data even suggested that part of the challenge for obtaining prediagnoses of depression in the Georgian context may be due to the existence of a larger depression-anxiety syndrome in the country. This is supported not only by the factor analysis results whereby the anxiety items and depression items largely loaded onto a single factor, even when other latent constructs were introduced to the model, but also in the fact that the ROC curve for the prediagnosis groups using the GAI as an outcome performed higher than the depression scale, with an area under the curve of 0.68, and in the case of GCRT Tbilisi (where professional psychologists helped provide the community prediagnosis), the area under the curve was well above that for depression, at 0.77. In other words, the community organizations may have conflated this more inclusive syndrome, which in the local terminology was dubbed "nervousness" with depression. Most tellingly, the instrument performed better in convergent validity tests than the community prediagnosis, and crucially, was a significant predictor of dysfunction.

References

Anastasi A, Urbina S. (1997). *Psychological Testing* (7th ed., p. 721). Prentice Hall. Retrieved from http://www.amazon.com/Psychological-Testing-7th-Anne-Anastasi/dp/0023030852

Bass, J K, Bolton, P. A., & Murray, L. K. (2007). Do not forget culture when studying mental health. *Lancet*, *370*(9591), 918-919. doi:S0140-6736(07)61426-3 [pii] 10.1016/S0140-6736(07)61426-3

Bass, Judith K, Ryder, R. W., Lammers, M.-C., Mukaba, T. N., & Bolton, P. a. (2008). Post-partum depression in Kinshasa, Democratic Republic of Congo: validation of a concept using a mixed-methods cross-cultural approach. *Tropical medicine & international health : TM & IH*, *13*(12), 1534-42. doi:10.1111/j.1365-3156.2008.02160.x

Bolton, P. (2001). Cross-cultural validity and reliability testing of a standard psychiatric assessment instrument without a gold standard. *The Journal of nervous and mental disease*, *189*(4), 238. Retrieved from http://journals.lww.com/jonmd/Abstract/2001/04000/Cross_Cultural_Validity_and_Reliability_Testing_of.5.aspx

Bolton, Paul, Bass, J., Betancourt, T., Onyango, G., Clougherty, K. F., Neugebauer, R., Murray, L., et al. (2007). Interventions for Depression Symptoms Among Adolescent Survivors of War and Displacement in Northern Uganda. *October*, *298*(5), 519-527.

Bolton, Paul, Wilk, C. M., & Ndogoni, L. (2004). Assessment of depression prevalence in rural Uganda using symptom and function criteria. *Social psychiatry and psychiatric epidemiology*, *39*(6), 442-7. doi:10.1007/s00127-004-0763-3

Bolton, Paul, & Tang, A. M. (2002). An alternative approach to cross- cultural function assessment. *Social Psychiatry and Psychiatric Epidemiology*, *37*, 537-543.

Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician, *12*(3), 189-198. doi:0022-3956(75)90026-6 [pii]

George, S. M. (2004). Emergency Mental Health Care. In S. Abdallah & G. Burnham (Eds.), . Baltimore: The Johns Hopkins University and the International Federation of Red Cross and Red Crescent Societies.

Georgia Ministry of Refugees and Accommodation. (2010). Introduction. Retrieved December 2010, from http://adjara.mra.gov.ge/index.php?lang_id=ENG&sec_id=175.

Gorman, M. (1999). Development and the rights of older people. In J. Randel (Ed.), (pp. 3-21). London: Earthscan Publications Ltd.

Halter, J. B., Reuben, D. B., Finch, C. E., Vaupel, J. W., & Kinsella, K. (2001). Indicators of function in the geriatric population (pp. 159-179). Washington DC: National Academy Press.

HelpAge International. (2004a). Georgia Community Mobilization Initiative (GCMI): Technical Training and Advice for NGO Grantees on Working with Older People. Tbilisi.

HelpAge International. (2004b). *Ageing and mental health*. (S. Mende, Ed.).

Internal Displacement Monitoring Centre (IDMC). (2010). *Georgia*. Geneva.

Inzelberg, R., Schechtman, E., Abuful, A., Masarwa, M., Mazarib, A., Strugatsky, R., Farrer, L. A., et al. (2007). Education effects on cognitive function in a healthy aged Arab population, *19*(3), 593-603.

Jum C. Nunnaly. (1978). *Psychometric Theory* (2nd ed., p. 640). Mcgraw-Hill College. Retrieved from http://www.amazon.com/Psychometric-Theory-McGraw-Hill-Psychology-Nunnally/dp/0070474656

Meissner, H., Creswell, J., Klassen, A. C., Plano, V., & Smith, K. C. (2011). *Best Practices for Mixed Methods Research in the Health Sciences*. Washington, D.C.: National Institutes of Health.

Metz, C. (1978). Basic Principles of ROC Analysis. *Semin Nucl Med*, *8*(4), 283-98.

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The Wheel of Wellness Counseling for Wellness: A Holistic Model for Treatment Planning, *78*(3), 251-266.

Ng, T. P., Niti, M., Chiam, P. C., & Kua, E. H. (2007). Ethnic and educational differences in cognitive test performance on mini-mental state examination in Asians. *Am J Geriatr Psychiatry*, *15*(2), 130-139.

Sumbadze, N., & Tarkhan-Mouravi, G. (2003). Working Paper on IDP Vulnerability and Economic Self-Reliance. Tbilisi: UNDP.

Tabachnick, B. G., & Fidell, L. S. (2001). *Using Multivariate Statistics*. Boston: Allyn and Bacon.

Chapter Six: Prevalence Study of IDP Older Adults

A. Study Purpose and Objectives

The second aim of the Georgia study was to conduct a prevalence study of physical and mental health problems among older adults, with a particular focus on comparing "protracted" IDP populations with "shorter-term" displaced populations, and comparing urban with non-urban displaced. Using an instrument that was both culturally normed and validated for use with displaced Georgian populations, applied in a randomized survey of a representative population of older adult IDPs, our objective was to obtain reliable measures of physical and mental health status and to examine how these might be associated with key background characteristics such as time in displacement, age, gender, and settlement type.

One of the new policies that the Government of Georgia was implementing in 2011 was an initiative to assist "protracted" IDP populations to move out of "collective centers," a term that includes a range of structures and facilities drafted into service by the government—abandoned factories, unfinished buildings, military bases, schools, clinics, administration buildings, and even hotels, dormitories, spas and summer camps (Holtzman & Nezam, 2006) and integrate them into local communities. Often, though not always, this involved helping IDPs move into "private accommodations," which are privately owned or rented homes or apartments. In some instances, the new policy assisted IDPs to remain as apartment or unit owners in a newly "privatized collective center."

B. Study Methodology

1. Sampling Design
The sampling frame for the prevalence study utilized data from the Georgian Ministry of Refugees and Accommodation (MRA), cross-checked with information from UNHCR and local non-governmental organizations (see Table 6.1), as well as with local information obtained from the qualitative research phase. The study employed a stratified, multistage, cluster sampling design.

a. *Strata*. The population strata for the study initially were two: (1) "Protracted" displaced populations and shorter-term displaced populations, and (2) urban and non-urban populations. The sample size for each population strata was set at 450, with a total sample size of 900 households. In reviewing the settlement patterns of the Wave One (displaced in 1992/93) and Wave Two (displaced in 2008) populations, we found that the "protracted" IDP populations largely were settled in urban areas, while those displaced in 2008 (who still remained displaced as of 2011), were settled mainly in new settlements, which had been established in non-urban and sometimes peri-urban areas (see Table 6.3 below). Given this overlap, and the predominant interest in protracted population displacement, the main focus of stratification for the study was that of displacement wave.

b. *Clusters*. Cluster sampling, defined as "probability sampling in which sampling units at some point in the selection process are collections, or clusters, of population elements" (Kalton, 1983), is most useful when a population is geographically dispersed or when a sampling frame of individuals or households either is not available or is seen as possibly incomplete or inaccurate (Herold & Peavy, 2002). It has thus been widely used in humanitarian settings (Robinson, 2003; Spiegel, 2007; Rose, Grais, Coulombier, & Ritter, 2006). Evidence from rapid nutrition surveys shows that using 30 clusters should

yield reasonably precise estimates (Cochran, 1977; Binkin, Sullivan, Staehling & Nieburg, 1991).

c. *Multistage Sampling Units*. At the first stage, we purposively selected four regions, representing geographically diverse areas of the country where different types of displaced populations had settled. These primary sampling units (PSUs) were Tbilisi, Shida Kartli, Samegrelo, and Mtskheta. (While this excluded roughly half of the Wave One and Wave Two populations, time and resources precluded conducting a fully representative national sample of either group and we feel the results will be largely generalizable.) At the second stage, we selected from each sample region a number of clusters with "probability proportional to size" of the IDP population characteristics of interest: "protracted" vs. shorter-term as well as settlement type (for Wave One, this was "collective center" and "private accommodation"). At the end stage, within each district, we employed a systematic random sampling strategy in the new settlements where Wave Two IDPs lived, and, in areas settled by Wave One IDPs, we began with a randomly selected collective center and conducted a systematic random sample in the center until the cluster quota was filled. IDPs living in "private accommodations" were located using a modified "snowball sample" approach (see Appendix C for details), using either populations living in the "collective centers" or in the neighborhood to help the study team locate older adults in "private accommodations."

Table 6.1. Survey Sampling Frame

Regions	Districts	Number of 1992 IDPs	1992 IDPs in Private Accommo-dations	1992 IDPs in Collective Centers	Number of 2008 IDPs
Tbilisi	Krtsanisi	2,893	2,280	658	42
Tbilisi	Mtatsminda	3,152	2,554	624	24
Tbilisi	Chughureti	6,122	4,167	2,022	46
Tbilisi	Didube	6,915	4,549	2,461	93
Tbilisi	Isani	7,919	5,714	2,343	113
Tbilisi	Saburtalo	10,034	6,680	3,478	96
Tbilisi	Nadzaladevi	11,415	6,731	4,964	248
Tbilisi	Vake	14,922	8,092	6,900	56
Tbilisi	Samgori	13,749	9,956	3,997	141
Tbilisi	Gldani	18,140	14,644	4,020	477
Mtskheta	Mtskheta	1,289	381	9,305	7,999
Samegrelo	Zugdidi	48,544	31,948	16,602	0
Shida Kartli	Kaspi	248	294	314	340
Shida Kartli	Gori	5,011	4,277	6,317	4,559
Total		150,353			14,234
Sources: Georgian Ministry of Refugees and Accommodation, and UNHCR					

Table 6.2 Stratified Cluster Sample

Cluster Number	Wave One	Region	District	Cluster Number	Wave Two	Region	District
1	1992	Tbilisi	Mtatsminda	16	2008	Tbilisi	Nadzaladevi
2	1992	Tbilisi	Didube	17	2008	Mtskheta	Mtskheta
3	1992	Tbilisi	Isani	18	2008	Mtskheta	Mtskheta
4	1992	Tbilisi	Saburtalo	19	2008	Mtskheta	Mtskheta
5	1992	Tbilisi	Nadzaladevi	20	2008	Mtskheta	Mtskheta
6	1992	Tbilisi	Vake	21	2008	Mtskheta	Mtskheta
7	1992	Tbilisi	Samgori	22	2008	Mtskheta	Mtskheta
8	1992	Tbilisi	Samgori	23	2008	Mtskheta	Mtskheta
9	1992	Tbilisi	Gldani	24	2008	Mtskheta	Mtskheta
10	1992	Tbilisi	Gldani	25	2008	Mtskheta	Mtskheta
11	1992	Samegrelo	Zugdidi	26	2008	Shida Kartli	Gori
12	1992	Samegrelo	Zugdidi	27	2008	Shida Kartli	Gori
13	1992	Samegrelo	Zugdidi	28	2008	Shida Kartli	Gori
14	1992	Samegrelo	Zugdidi	29	2008	Shida Kartli	Gori
15	1992	Samegrelo	Zugdidi	30	2008	Shida Kartli	Gori

2. Sample Size
For logistical reasons, we chose to adopt a cluster sample design consisting of 30 clusters with 30 households in each cluster; allowing for three interviews per day, a team of 5 interviewers could complete 15 households per day and one cluster every two days. A target sample size of 900, assuming a conservative design effect of 2, with a confidence interval of 95% and power set at 0.80, enables us to detect a between-group difference in prevalence of at least 0.15 (allowing for a 15% rate for non-response, incomplete interviews, or ineligible households).

3. Inclusion and Exclusion Criteria
Eligible respondents were at least 60 years old at time of interview, the threshold age for being considered an older adult in Georgia and the UN cut-off for referring to the older adult population (Gorman, 1999; HelpAge International, 2004b). The definition of a household member was someone who slept in the residence the night prior to the interview. If more than one person met these criteria in a given household, interviewers were instructed to randomly select one eligible respondent per household. Older adults identified by screening instruments as being unable to fully participate in the study, including those with severe physical and mental disabilities, could be represented by a proxy member of the household.

C. Study Instrument

As described previously, results from the qualitative research were used to develop a culturally valid instrument for measuring physical and mental health symptoms and daily function among displaced older adults in Georgia. The instrument incorporated a number of scales and measures that, either separately or collectively, measured demographic and background characteristics of displaced older adults, aspects of mental health/cognitive function; physical health, function and mobility; health seeking behavior and health care utilization; social ties and interaction; and alcohol use. The instrument included the following (also see Appendix C):

1. Screening Questions
As noted previously, respondents needed to be aged 60 or older, and to be self-identified as an internally displaced person. They were also asked what year they were displaced and what was their area of origin. In addition, respondents were asked to complete the Mini-Mental State Exam (MMSE) (Folstein, 1975) which measures global cognitive functioning, covering the domains of memory, attention, language, praxis, and visual-spatial ability. The MMSE is made up of 20 items and activities and is scored as a uni-dimensional scale, with higher scores denoting better cognitive functioning. Research with non-Western populations indicates that ethnic and cultural differences need to be taken into account when interpreting and comparing scores (Inzelberg et al, 2007; Ng et al, 2007); in the Georgia study, we used a cut-off score of 23 or lower to exclude the respondent from further interview.

2. Household Characteristics
Self-reported demographic and household information was also gathered, including individual information (age, gender, marital status, education, ethnicity, and employment status); and household information (household size and composition, income source, and economic condition both current and just prior to displacement). In addition, based on problems identified in the free-list interviews, we asked a series of 17 questions about household problems, including adequacy of living space, sanitation, finances, food, health care, and access to insurance and social assistance.

3. Migration History
Respondents were asked to identify the types of places they had lived for more than two months since their displacement, including with a host family, collective center, tent or barrack, rented space, IDP settlement, or other. They were also asked to identify approximately how long they had lived in each type of place.

4. Functioning
This section included two scales.

a. Activities of Daily Living (ADL). This six-item scale asks Yes/No questions about whether the respondent has been able to perform certain daily activities in the past month regularly and independently, including bathing, dressing, toileting, transferring (moving in and out of a bed and chair), continence, and feeding.

b. Older Adult Tasks. From the free-list questions, we included 12 questions that older adults mentioned, including gardening, cleaning the house, cooking, doing home repairs, shopping, looking after children, etc. For each question, respondents were asked whether, in the last month, they could do the task with no difficulty, with a little bit of difficulty, with a moderate amount of difficulty, with a lot of difficulty, or if they often could not do it at all.

5. Physical Health
This section included two scales.

a. EuroQol (EQ-5D and EQ-VAS) (Rabin & de Charro, 2001). This five-item scale asks respondents to state which, from a group of three statements, best describes their health state today. The five questions relate to problems walking about, problems with self-care, problems with performing usual activities, pain or discomfort, and feeling anxious or depressed. They are also asked to look at a scale (like a thermometer) marked 0-100 (the EQ-Visual Analog Scale, or EQ-VAS) with 0 being worst and 100 being best, and indicate where on the scale they would locate their health state today. The EQ-5D

instrument has performed credibly in diverse international study settings (Ankri et al, 2003; Cleemput et al, 2004; Essink-Bot et al, 1997; Hughes, 2007, Jelsma et al, 2004; Luo et al, 2003; Perkins et al, 2004). In studies among elderly, EQ-5D performed as well as other general measures of health-related quality of life (Brazier et al, 1996) while proving to be "easy to complete and attractive for use in an elderly population" (Schrag et al, 2000).

b. Immigrant Barriers to Health Care (Keating, 2009). The BHS asks 11 questions relating to access to health care—including "I have a way to pay for health or medical care," "I can reach the doctor or hospital if I had to go suddenly," and "I have a doctor who understands me and my problems"—and then asks if this statement applies to them rarely or never, sometimes, or most or all of the time.

6. Depression

To measure depression in older adults, the Geriatric Depression Scale (GDS) (Lyness et al, 1997) offers a valid and reliable screening tool, which presents respondents with 15 Yes/No questions, including "Are you basically satisfied with your life," "Do you feel that your life is empty and has no meaning," and "Do you think that most people are better off than you?" To these 15 questions, we added 6 more from the free-list questions, including "Do you feel isolated by others," and "Do you feel like you are a burden to others?"

7. Anxiety

The 20-item Geriatric Anxiety Inventory (GAI) presents respondent with a series of statements which, after hearing them being read, they are asked to say whether it is True or False as a description of themselves during the past week. These statements include "I worry a lot of the time," "I find it difficult to make a decision," and "I often feel jumpy, can't stay calm." Using responses from the free-list and key informant interviews, we mapped some Georgian phrases to the GAI questions and also added 5 additional questions, including "I am afraid to stay home alone," "I lose sleep thinking about things," and "I feel irritated."

8. Traumatic Events

The Harvard Trauma Questionnaire (HTQ) presents respondents with a series of 15 events, after each of which they are asked to state if the event was something which, during their lifetime, they have not personally experienced or witnessed, they have witnessed, or they have personally experienced. These events included "lack of food or water," ill health without access to medical care," having no place to live," "detention," "serious injury," and a "combat situation or war." To this list we added 8 more events identified during the qualitative research, including "destruction or loss of house, livestock or other property," "abandonment by family," "frequent family fights and arguments," "separation from family graves," and "dangerous escape." We noted previously that, because post-traumatic stress disorder (PTSD) was not as evident in the qualitative responses as other physical and mental health disorders, we did not choose the PTSD symptoms measurement portion of the HTQ.

9. Dignity

The Armenian Dignity Scale (ADS), developed for use among earthquake survivors in Armenia but also validated for use among displaced persons (Khatib & Armenian, 2010), presents respondents with a series of 18 statements, to which they are asked to respond whether they strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree. These statements include "I have control over life decisions, such as where to work or when I can leave home," "I am free to act on my beliefs," "I feel that others look up to me," and "I make an important contribution to my community."

10. Social Ties and Interactions
To measure social networks and connections among older adults, we incorporated an instrument used by Experience Corps® (Fried et. al., 2004) which has been used in the United States and several foreign countries (though this was the first use in a humanitarian setting). The instrument starts by asking "How many people do you feel you could turn to for help? For example, get advice, talk over a problem or get help with an errand?" The next 23 questions ask about family structure (number of living parents, children, grand-children, great-grand children) and the number of times the respondent sees or talks on the phone to any of these people at least once every two weeks. Similar questions are asked about other relatives (siblings, cousins, aunts and uncles), close friends, and neighbors, as well as participation in church or religious groups and/or other groups (social clubs, trade unions, community service organizations, etc.) with whom the respondent talks to at least once every two weeks. The instrument also asks about regular attendance of educational trainings or employment for pay on a part-time or full-time basis.

11. Alcohol Use
Because the qualitative research identified problems associated with drinking, we included the Alcohol Use Disorders Identification Test (AUDIT), which was developed by the World Health Organization (WHO, 2001) as a simple method of screening for excessive drinking and to assist in brief assessment. The AUDIT tool asks a series of questions about frequency of alcohol consumption and alcohol-related problems and then asks the respondent to say whether that happens to them never, less than monthly, monthly, weekly, or daily or almost daily. Questions include "How often do you have a drink containing alcohol?" "How often do you have 6 or more standard drinks on one occasion?" and "How often during the last year have you failed to do what was normally expected of you because of drinking?"

D. Respondent Characteristics

For this report we have concentrated on presenting a comparison of survey results by displacement wave, focusing on three main areas—individual and household characteristics (including economic conditions and household problems), physical health (including two measures of health-related quality of life), and mental health (including analysis of depression, anxiety, and traumatic events). This section focuses on key respondent characteristics stratified by Wave One (displaced in 1992/93) and Wave Two (displaced in 2008).

As can be seen in Table 6.3 below, more than 74% of the respondents were female; this may represent some selection bias in the sample though it should be noted that the life expectancy for females in Georgia is 8 years higher than that of males and, for the general population, 2 out of 3 older adults are female. The Wave One group comprised a somewhat higher percentage of females (78.5%) as compared to the Wave Two group (71.2%). The age of respondents averaged 70.4, with slightly higher ages among the 1992/93 displaced as compared to the 2008 sample group.

The average study household size was 3.4 persons, which was virtually the same for the two waves. With regards to marital status, however, substantial differences existed. Overall, 48.1% of the sample population was widowed, though 55.5% among the Wave One group were widowed as compared to 41.1% of the Wave Two sample. These proportions were essentially reversed in regard to those who reported being married and living with their spouse. The percentage divorced was 2.3%, identical among both displacement waves, while the percentage single was 5.9% among Wave One and 1.7% among the Wave Two sample population.

The study population also showed some differences by displacement wave in terms of education. For Wave One, 33.3% had completed university-level education compared to 13.4% of the Wave Two sample. Roughly 60% of both groups had completed at least a technical institute education in Georgia. Among Wave Two, however, nearly 15% had completed no more than a secondary school education, compared to less than 5% of the Wave One sample.

Table 6.3. Respondent Characteristics, by Wave of Displacement

	Total (n=899)	**Wave One** (n=437)	**Wave Two** (n=462)	**Tests of Significance*** (p-value)
Gender* n(%)				(0.012)
Male	227 (25.3)	94 (21.5)	133 (28.8)	
Female	672 (74.7)	343 (78.5)	329 (71.2)	
Age mean(sd)	70.4 (7.3)	70.8 (7.8)	70.1 (6.8)	(0.164)
Origin* n(%)				(<.0001)
Abkhazia	424 (47.2)	415 (94.8)	9 (2.0)	
South Ossetia	475 (52.8)	23 (5.3)	452 (98.0)	
Marital status n(%)				(<.0001)
Single	34 (3.8)	26 (5.9)	8 (1.7)	
Married	412 (45.8)	159 (36.3)	253 (54.8)	
Divorced	21 (2.3)	10 (2.3)	11 (2.4)	
Widowed	433 (48.1)	243 (55.5)	190 (41.1)	
Living area n(%)				(<.0001)
Urban	448 (49.8)	432 (98.6)	16 (3.5)	
Rural	452 (50.2)	6 (1.4)	446 (96.5)	
Education level n(%)				(<.0001)
None	8 (.9)	2 (.5)	6 (1.3)	
Less than Primary	29 (3.2)	7 (1.6)	22 (4.8)	
Primary	27 (3.0)	7 (1.6)	20 (4.3)	
Secondary	88 (9.8)	19 (4.3)	69 (14.9)	
Technical	540 (60.0)	257 (58.7)	282 (61.3)	
University	208 (23.1)	146 (33.3)	62 (13.4)	
Household size mean(sd)	3.4 (1.8)	3.5 (2.0)	3.3 (1.5)	(0.209)
IDP Accommodation** n(%)				(<.0001)
State owned collective center	184 (20.7)	153 (35.5)	31 (6.8)	
Privatized collective center	109 (12.3)	109 (25.3)	0	
Private accommodation	165 (18.6)	165 (38.3)	0	
IDP settlement	431 (48.5)	4 (.9)	427 (93.2)	

* Tests of statistical significance use a $\chi 2$ (chi-squared) test for categorical variables and a t-test for continuous variables
** 1 missing value

As we had noted earlier, rural and urban settlement was almost identically matched with displacement wave, with nearly 99% of the Wave One sample settled in urban areas and nearly 97% of the Wave Two sample settled in rural areas. In terms of settlement type, the differences are also stark. Among the Wave Two population, 93.2% were living in IDP settlements (also referred to as "new settlements") and only 6.8% were living in state-owned collective centers. The Wave One population, on the other hand, was divided among state-owned collective centers (35.5%), privatized collective centers (25.3%), and private accommodations (38.3%).

In terms of current employment status (see Table 6.4 below), the two waves were virtually the same, with about 87% of respondents in both groups reporting that they were not working and not looking for work. Just over 4% said they had regular stable employment.

Asked to compare their current household economic situation with that which existed just prior to displacement, only one or two percent in either group said they could "barely make ends meet" pre-displacement. Compared to Wave One, it appears that the Wave Two population had higher percentages who said that they could afford to buy "only food" or "only food and clothes." Approximately 40% of both groups said that they could "afford durable purchases and holiday" pre-displacement though a much higher percentage (41%) of the Wave One group said they could "afford expensive purchases (car, apartment/house, etc.)" as compared to 13.7% of the Wave Two group.

Table 6.4. Employment Status and Economic Situation, by Wave of Displacement

	Total (n=900)	**Wave One** (n=438)	**Wave Two** (n=462)	**Tests of Signifi-cance*** (p-value)
Current employment status n(%)				(0.112)
Not working / not looking	787 (87.4)	385 (87.9)	402 (87.0)	
Not working / looking	58 (6.4)	22 (5.0)	58 (6.4)	
Irregular / daily work	17 (1.9)	12 (2.7)	17 (1.9)	
Regular / stable work	38 (4.2)	19 (4.3)	38 (4.2)	
Pre-displacement economic situation n(%)				(0.008)
Barely make ends meet	12 (1.3)	2 (.5)	10 (2.2)	
Can afford only food	43 (4.8)	9 (2.1)	34 (7.4)	
Can afford only food and clothes	222 (24.7)	55 (12.6)	167 (36.2)	
Can afford durable purchases and holiday	379 (42.2)	192 (43.9)	187 (40.6)	
Can afford expensive purchases (e.g. car, apartment/house, etc.)	242 (27.0)	179 (41.0)	63 (13.7)	
Current economic situation** n(%)				(<.0001)
Barely make ends meet	675 (75)	309 (70.6)	366 (79.2)	
Can afford only food	152 (16.9)	82 (18.8)	70 (15.2)	
Can afford only food and clothes	68 (7.6)	42 (9.6)	26 (5.6)	
Can afford durable purchases and holiday	4 (.4)	4 (.9)	0 (0)	
Can afford expensive purchases (e.g. car, apartment/house, etc.)	1 (.1)	1 (.2)	0 (0)	

* Tests of statistical significance use a $\chi 2$ (chi-squared) test for categorical variables
** 2 missing values

At time of interview, however, the self-reported economic situation seems to have declined dramatically for both groups. Nearly 80% of Wave Two and over 70% of the Wave One reported they can "barely make ends meet," while 15.2% of Wave Two, and 18.8% of Wave One, said that they "can only afford food." Only about 1% of Wave One and no one in Wave Two said they could afford durable purchases or expensive purchases. In addition to its other burdens, displacement of both longer-term and shorter-term duration has led to economic reversals in the overwhelming majority of IDP households.

Table 6.5. Household Problems, by Wave of Displacement

Problem	**Total** Mean Score (sd)*	**Wave One** Mean Score (sd)	**Wave Two** Mean Score (sd)	**Difference** (p-value)
Small or cramped living space	1.12 (0.03)	1.22 (0.04)	1.03 (0.04)	0.19 (p<0.001)
Condition of the house or room	1.21 (0.03)	1.32 (0.04)	1.10 (0.04)	0.22 (p<0.001)
Inadequate sanitation facilities, such as a toilet or latrine	0.92 (0.03)	1.01 (0.04)	0.84 (0.04)	0.18 (p=0.003)
Access to toilet	0.60 (0.03)	0.67 (0.04)	0.53 (0.04)	0.14 (p=0.02)
Access to clean water	0.51 (0.03)	0.47 (0.04)	0.55 (0.04)	0.08 (p=0.12)
Heating of household	1.27 (0.03)	1.30 (0.04)	1.24 (0.04)	0.05 (p=0.34)
Not having a plot	1.04 (0.03)	1.17 (0.04)	0.93 (0.04)	0.24 (p=0.001)
Not having sufficient household items	1.26 (0.02)	1.17 (0.03)	1.35 (0.03)	0.18 (p=0.001)
Lack of privacy	0.64 0.03)	0.65 (0.04)	0.63 (0.04)	0.02 (p=0.72)
No ownership of house/room	1.41 (0.03)	0.99 (0.05)	1.81 (0.03)	0.82 (p<0.001)
Pension is too small	1.85 (0.02)	1.87 (0.02)	1.83 (0.02)	0.05 (p=0.15)
Lack of money for medicines	1.89 (0.01)	1.87 (0.02)	1.92 (0.02)	0.05 (p=0.05)
Food scarcity	1.58 (0.02)	1.46 (0.03)	1.69 (0.03)	0.23 (p<0.001)
Access to health care	1.47 (0.03)	1.55 (0.03)	1.40 (0.04)	0.15 (p=0.003)
Unemployment	1.53 (0.03)	1.48 (0.04)	1.58 (0.04)	0.10 (p=0.05)
Access to insurance	0.83 (0.03)	1.17 (0.05)	0.51 (0.04)	0.67 (p<0.001)
Access to IDP allowance or social assistance	0.82 (0.03)	0.90 (0.04)	0.74 (0.04)	0.16 (p=0.008)
Lack of attention from government	1.46 (0.03)	1.50 (0.04)	1.43 (0.04)	0.07 (p=0.14)

*sd (standard deviation) shows how much variation or "dispersion" exists from the average (mean). A low standard deviation indicates that the data points tend to be very close to the mean, while high standard deviation indicates that the data points are spread out over a large range of values.

Household problems (see Table 6.5 above) were scored from 0-2, with 0 being no problem 1 being somewhat of a problem, and 2 being a serious problem. Thus, the higher the score, the worse the problem is for the population. The most serious problem overall was a lack of money

for medicines with a total mean score of 1.89. Other problems included pensions that are too small, unemployment, access to health care, and lack of attention from the government. The least serious problems overall (all with mean scores under 1.00) were heating of the household, access to clean water, access to toilets, lack of privacy, access to insurance, and access to the IDP allowance. One of the biggest discrepancies between the displacement waves, interestingly enough, was lack of ownership of their house or room. Among the more recently displaced (Wave Two) the mean score of 1.81 placed in the top three of most serious concerns. For Wave One, many of whom do live in private accommodations, the mean score for house/room ownership was 0.99.

E. Results: Physical Health

Health-related quality of life was assessed using the EuroQol instrument, which comprises 5 questions on health status (EQ-5D), along with a self-rated health score scaled from 0 to 100 (the EQ-Visual Analog Scale, or EQ-VAS). The EuroQol is a frequently-used instrument, which allows for comparisons with other settings.

As noted previously, the EQ-5D is a five-item scale which asks respondents to state which, from a group of three statements, best describes their health state today. For each of five domains—mobility, self-care (washing and dressing oneself), usual activities (work, study, housework, family, leisure activities), pain/discomfort, and anxiety/depression—respondents are asked to rate their level of perceived problem. So, for mobility for example, 1="I have no problems in walking about," 2="I have some problems in walking about," and 3="I am confined to bed." Thus, lower scores equate to better self-reported health. In this single-domain scoring that is presented, the score equals the percentage of respondents who said they had either moderate or serious problems in that category.

For the five-item EQ-5D, Wave One and Wave Two populations tended to provide fairly similar mean scores (though all relatively poor) on physical activities—such as walking about, self care (washing or dressing), and usual activities—as well as levels of pain and discomfort. For feeling anxious or depressed, however, Wave Two scores were significantly higher (0.75 vs. 0.66, p=0.001), a differential between waves that is supported in the other mental health measures.

Table 6.6. EQ-5D and EQ-VAS, by Wave of Displacement

	Total (n=900)	**Wave One** (n=438)	**Wave Two** (n=462)	**Test of significance** (p-value)*
Health mean (sd)				
EQ-5D				
1. Walking about	0.71 (0.45)	0.72 (0.45)	0.71 (0.46)	(0.71)
2. Self-care (washing or dressing)	0.43 (0.50)	0.44 (0.50)	0.42 (0.49)	(0.53)
3. Usual activities	0.75 (0.43)	0.74 (0.44)	0.76 (0.43)	(0.53)
4. Pain/discomfort	0.90 (0.30)	0.88 (0.32)	0.91 (0.28)	(0.17)
5. Anxious or depressed	0.71 (0.46)	0.66 (0.48)	0.75 (0.43)	(0.001)
EQ-VAS				
EQ-VAS Overall Health Score	42.6 (20.3)	42.9 (21.2)	42.3 (19.5)	(0.70)

* Tests of statistical significance use a t-test for continuous variables.

For the EQ-VAS score (the "health thermometer," in which current self-reported health is rated on a scale from 0-100), a lower score means lower self-reported health. Here, health scores are slightly worse among the Wave Two population, though the difference is not statistically significant. What is important to note is the overall low score of 42.6 for the IDP population. A recent 15-country study (albeit mainly showing middle-income to high-income countries, though including neighboring Armenia) showed that average EQ-VAS scores in the countries surveyed ranged from 66.61 to 83.49, with higher scores indicating higher levels of health. Among older adults, the range of averages across all countries was between 63 and 75.

Disaggregating by gender, however, reveals that for both Wave One and Wave Two groups, self-reported health scores are significantly lower among females than males ($p<0.01$). This pattern too, is reflected in mental health measures as will be seen below.

Table 6.7 EQ-5D and EQ-VAS Health Score, by Gender

	Total (n=899)	**Males** (n=227)	**Females** (n=672)	**Test of significance** (p-value)*
EQ-5D				
1. Walking about	0.71	0.52	0.78	p<0.001
2. Self-care (washing or dressing)	0.43	0.33	0.46	p<0.001
3. Usual activities	0.75	0.62	0.80	p<0.001
4. Pain/discomfort	0.90	0.81	0.93	p<0.001
5. Anxious or depressed	0.71	0.59	0.75	p<0.001
EQ-VAS				
EQ-VAS Overall Health Score	42.6	47.5	40.9	p<0.001

* Tests of statistical significance use a t-test for continuous variables.

Focusing on settlement type, we have pointed out earlier (see Table 6.3) that Wave Two comprises almost entirely a population settled in new IDP settlements (n=427) in Mtskheta and Shida Kartli (Gori) while the Wave One sample population is distributed among three types of settlements: state-owned collective centers (n=153), privatized collective centers (n=109), and private accommodations (n=165). For purposes of analysis we have grouped the population living in the privatized collective centers with those living in private accommodations and compared that group with those still living in state-owned collective centers. This focus on Wave One only provides an opportunity to examine settlement type within the context of protracted displacement.

As can be seen from Table 6.8, in terms of EQ-5D measures, those in private accommodations and collective centers scored relatively similarly in terms of walking about, self care and daily activities. Populations in collective centers, however, had greater problems with pain/discomfort and being anxious/depressed than populations in private accommodations (both differences were marginally significant). For EQ-VAS, the "health thermometer" score, populations had a higher overall health score (43.7 vs 41.1, $p=0.10$) than those in state-owned collective centers.

Table 6.8. EQ-5D and EQ-VAS, by Settlement Type (Wave One Only)

	State-Owned Collective Center (n=153)	**Private Accommodation** (n=274)	**Total** (n=427)	**Difference** (p-value)
EQ-5D				
Walking about	0.72	0.72	0.72	0.0 (p=1.0)
Self-care	0.48	0.43	0.45	0.05 (p=0.35)
Daily Activities	0.73	0.76	0.75	0.03 (p=0.44)
Pain/Discomfort	0.92	0.87	0.89	0.05 (p=0.09)
Anxious or Depressed	0.71	0.64	0.66	0.07 (p=0.13)
EQ-VAS				
Overall Health Score	41.1	43.7	42.8	2.7 (p=0.10)

F. Results: Mental Health

1. Mini-Mental State Exam (MMSE)

At the outset of the interview, we offered all respondents the Mini-Mental State Exam (MMSE) which asked them to perform such tasks as recalling the year, date, and month; locating where they are including country, region, and address; repeating the names of three objects; and counting backwards from 100 by 7's. Out of 30 possible points, a cut-off of 23 or below was established for excluding participants. (A score of around 26 is often used for identifying patients who potentially have mild cognitive impairment (Visser, 2006); we relaxed this somewhat to allow for issues in translation and cross-cultural comprehension). Those included in the study were then asked to complete the remainder of the interview. As Table 6.9 shows, the mean score for all participants was 26.1. Wave One and Wave Two scores, while they were statistically significant (p=0.012), were not likely to have clinical significance. This suggests that other differences observed between the displacement waves in the sample are not due to underlying differences in cognitive function.

Table 6.9. Cognitive Health, by Wave of Displacement

	Total (n=900)	**Wave 1** (n=438)	**Wave 2** (n=462)	**Test of Significance** (p-value)
MMSE mean(sd)	26.1 (2.8)	26.3 (2.7)	25.9 (2.8)	(0.012)

2. Depression

One of the focal points of the study was to better understand the mental health issues experienced by the population. During the qualitative phase, interviewees described their problems, including mental health issues, and described situations that coincided with anxiety- and depressive-like symptoms, which led the research team to include scales for those disorders in the questionnaire. Depression is defined as a sad and/or an irritable mood of a greater intensity and duration and causing more severe symptoms and functional disabilities than is normal. It leads to negative thoughts, moods, and behaviors and can even cause specific changes

in bodily functions. An important way of conceptualizing psychological disorders—including depression—is to define it not only by the presence of signs and symptoms corresponding to the disorder, but also by impairment in one or more domains of daily function.

The depression tool selected for inclusion in the questionnaire was the 15-item Geriatric Depression Scale, which was designed specifically for use among older populations. The answers are tallied and a score assigned. Scores above 5 are suggestive of depression, and scores above 10 are very likely depression. While we cannot provide a diagnosis, we did break the study population down into groups that scored 10 or below as "likely not depressed," and those that scored above 10 as "likely depressed."

Adapting these scoring criteria, using the cut-off for possible depression of 8 or above that was obtained during the validation analysis, our study found that Wave One and Wave Two depression prevalence were both quite high (Wave One = 69.4% and Wave Two = 71.9%) though the difference was not statistically significant (p=0.419). Both of these measures are well above the prevalence of depression found in other international settings, which range from 5-35%. Disaggregating by gender (Table 6.11), we found that females in both groups had higher mean depression scores than males (p<0.01); higher female susceptibility to depressive symptoms is also consistent with the literature.

Table 6.10. Depression Prevalence, by Wave of Displacement

	Total (n=900)	**Wave 1** (n=438)	**Wave 2** (n=462)	**Test of Significance** (p-value)
Depression n(%)				(0.419)
Yes	636 (70.1)	304 (69.4)	332 (71.9)	
No	264 (29.0)	134 (30.6)	130 (28.8)	

Table 6.11. Depression Prevalence, by Gender and Wave of Displacement

Gender	**Depression**	**Wave**	
		One	**Two**
Male	Yes	53 (56.4)	78 (58.7)
	No	41 (43.6)	55 (41.3)
Female	Yes	251 (73.2)	254 (77.2)
	No	92 (26.8)	75 (22.8)
	Chi-squared p-value	p=0.002	p<0.001

Looking at settlement type, we found that depression prevalence was about 5% higher in the state-owned collective centers (73.2%) than in the private accommodations (68.3%), though the difference was not statistically significant (p=0.28).

3. Anxiety

Generalized anxiety disorder (or GAD) is characterized by excessive, exaggerated anxiety and worry about everyday life events. GAD often manifests itself through physical symptoms. Anxiety was assessed using the Geriatric Anxiety Inventory, a 20-item scale that also was tailored for use with older adults. Scores above 10 on this scale are suggestive of GAD. According to the results of the scale, nearly 74% of the study population were likely experiencing GAD. Anxiety prevalence was higher among the Wave Two population (76.6%) were higher than those among Wave One (70.3%) and the differences were highly statistically significant (p<0.02). And, as with depression, females were more likely than males to score higher on the anxiety

scale (p<0.01). In terms of settlement type, the anxiety scores were essentially the same for Wave One IDPs in state-owned collective centers and those in private accommodations.

Table 6.12. Anxiety Prevalence, by Wave of Displacement

	Total (n=900)	**Wave 1** (n=438)	**Wave 2** (n=462)	**Test of Significance** (p-value)
Anxiety n(%)				(0.03)
Yes	662 (73.6)	308 (70.3)	354 (76.6)	
No	238 (26.4)	130 (29.7)	130 (23.4)	

Table 6.13. Anxiety Prevalence, by Gender and Wave of Displacement

Gender	**Anxiety**	**Wave**	
		One	**Two**
Male	Yes	51 (54.3)	84 (36.8)
	No	43 (45.7)	49 (63.2)
Female	Yes	257 (74.9)	270 (82.1)
	No	86 (25.1)	59 (17.9)
	Chi-squared p-value	p=0.002	p<0.001

4. Traumatic Events

The study found that IDPs across both groups had experienced a wide variety of traumatic events over their lifetimes. The five most common traumatic events experienced or witnessed by IDPs included loss of property, conflict, separation from family graves, dangerous escapes, and serious illness. All of these were reported, in various combinations, by more than two-thirds of the older IDP population. As Table 6.12 shows, a higher proportion of the Wave One population experienced more of these traumatic events, as compared to the Wave Two population. This suggests two things. One is that the circumstances surrounding displacement in 1992/93 were more violent and prolonged than those that occurred in 2008. The second is that the effects of these traumatic events may have attenuated somewhat over time, given the higher prevalence of depression and anxiety, and the lower health-related quality of life scores, among the Wave Two sample population.

Table 6.14. Traumatic Events, by Wave of Displacement

	Total (n=900)	**Wave 1** (n=438)	**Wave 2** (n=462)	**Test of Significance** (p-value)
Lack of Food or Water n(%)				
Have witnessed	56 (6.2)	27 (6.2)	29 (6.3)	p<0.001
Have experienced	475 (52.8)	262 (59.8)	213 (46.1)	
Ill Health w/out Medical Care n(%)				
Have witnessed	64 (7.1)	32 (7.3)	32 (6.9)	p<0.001
Have experienced	449 (49.9)	247 (56.4)	202 (43.7)	
Homelessness n(%)				
Have witnessed	61 (6.8)	31 (7.1)	30 (6.5)	p=0.03
Have experienced	409 (45.5)	218 (49.8)	191 (41.43)	

Detention n(%)				
Have witnessed	55 (6.1)	29 (6.6)	26 (5.6)	p=0.49
Have experienced	35 (3.9)	14 (3.2)	21 (4.6)	
Serious Injury n(%)				
Have witnessed	68 (7.6)	35 (8.0)	33 (7.1)	p=0.31
Have experienced	269 (29.9)	140 (32.0)	129 (28.0)	
Combat Situation/War n(%)				
Have witnessed	104 (11.6)	39 (8.9)	65 (14.1)	p=0.01
Have experienced	684 (76.0)	351 (80.1)	333 (72.1)	
Rape or Sexual Abuse n(%)				
Have witnessed	12 (1.3)	7 (1.6)	5 (1.1)	p=0.50
Have experienced	0 (0.0)	0 (0.0)	0 (0.0)	
Forced Isolation n(%)				
Have witnessed	17 (1.9)	9 (2.1)	8 (1.7)	p=0.66
Have experienced	95 (10.6)	50 (11.4)	45 (9.7)	
Being Close to Death n(%)				
Have witnessed	25 (2.8)	11 (2.5)	14 (3.0)	p<0.001
Have experienced	455 (50.1)	256 (58.5)	199 (43.1)	
Forced Separation from Family/Friends n(%)				
Have witnessed	14 (1.6)	8 (1.8)	6 (1.3)	p=0.16
Have experienced	257 (28.6)	137 (31.3)	120 (26.0)	
Murder of Family/Friend n(%)				
Have witnessed	88 (9.8)	61 (13.9)	27 (5.9)	p<0.001
Have experienced	157 (17.5)	101 (23.1)	56 (12.2)	
Unnatural Death of Family/Friend n(%)				
Have witnessed	99 (11.0)	59 (13.5)	40 (8.7)	p<0.001
Have experienced	196 (21.8)	119 (27.2)	77 (16.7)	
Murder of Stranger n(%)				
Have witnessed	115 (12.8)	90 (20.6)	25 (5.4)	p<0.001
Have experienced	70 (7.8)	40 (9.1)	30 (6.5)	
Lost or Kidnapped n(%)				
Have witnessed	66 (7.4)	41 (9.4)	25 (5.4)	p=0.01
Have experienced	34 (3.8)	22 (5.1)	12 (2.6)	
Torture n (%)				
Have witnessed	48 (5.4)	23 (5.3)	25 (5.4)	p=0.99
Have experienced	35 (3.9)	17 (3.9)	18 (3.9)	
Destruction or Loss of Property n(%)				
Have witnessed	3 (0.4)	0 (0.0)	3 (0.7)	p<0.001
Have experienced	842 (93.7)	430 (98.2)	412 (89.4)	
Abandonment by Family n(%)				
Have witnessed	19 (2.1)	11 (2.5)	8 (1.7)	p=0.71
Have experienced	63 (7.0)	30 (6.9)	33 (7.1)	
Eviction from Home n(%)				

Have witnessed	13 (1.4)	9 (2.1)	4 (0.9)	p=0.02
Have experienced	55 (6.1)	18 (4.1)	37 (8.0)	
Frequent Family Fights n(%)				
Have witnessed	19 (2.1)	12 (2.7)	7 (1.5)	p=0.17
Have experienced	33 (3.7)	12 (2.7)	21 (4.6)	
Serious Illness of Self or Family n(%)				
Have witnessed	64 (7.1)	23 (5.3)	41 (8.9)	p=0.09
Have experienced	569 (63.4)	287 (65.7)	282 (61.2)	
Separation from Family Graves n(%)				
Have witnessed	5 (0.6)	3 (0.7)	2 (0.4)	p=0.01
Have experienced	767 (85.3)	388 (88.8)	379 (82.0)	
Dangerous Escape n(%)				
Have witnessed	5 (0.6)	2 (0.5)	3 (0.7)	p=0.02
Have experienced	674 (74.9)	351 (80.1)	323 (69.9)	
Acts of Humiliation n(%)				
Have witnessed	12 (1.3)	8 (1.8)	4 (0.9)	p<0.001
Have experienced	412 (45.8)	235 (53.8)	177 (38.3)	

E. Discussion

The overall picture that emerges from the survey of 900 Georgian older adults in displacement is one of people living in poor economic conditions, overwhelmingly unemployed, with serious concerns about the cost of medicines, small pensions and lack of concern from their government. More than half reported experiencing combat or war in their displacement, lacking food and water, being close to death, destruction or loss of property, serious illness, and dangerous escape. Their self-reported health status is less than 50 on a scale of 0-to-100, and majorities express moderate or serious problems with pain and discomfort, walking about, and carrying out usual activities like housework, family and leisure activities. Nearly three-quarters score as likely depressed on a Geriatric Depression Scale normed to the Georgian context, and more than two-thirds score above cut-offs for Generalized Anxiety Disorder, characterized by excessive, exaggerated anxiety and worry about everyday life events.

While this is the overall picture, there are three perspectives on this population that bring different experiences and burdens to light: wave of displacement, settlement type and gender. For many key measures (see Table 6.15), it appears that the Wave Two sample—those displaced in 2008—had higher depression and anxiety scores and lower health scores than their first wave counterparts—those displaced in 1992/93, despite the fact that Wave One respondents reported experiencing higher numbers and proportions of traumatic events during displacement. It might be tempting to conclude from this that time heals some wounds, though, absent any baseline measures at time of displacement, such judgments should be made cautiously.

Another pattern we have observed is that of poorer health and mental health status found among populations living in the state-owned collective centers and better status among populations living in private accommodations. Although Wave Two populations in the aggregate fare worse than Wave One populations on depression, anxiety and health-related quality of life scores, disaggregating the Wave One population by settlement type shows that individuals living in state-owned collective centers had higher levels of depression, more problems on three of five health-related quality of life domains (self-care, pain/discomfort, and

anxious or depressed). The overall health score was also lower for populations living in the state-owned collective centers, compared to those in private accommodations. While these differences were not statistically significant (though marginally so in some cases), the data suggest that state-owned collective centers are likely the least healthy of all possible settlement alternatives for displaced older adults.

Table 6.15. Summary Table of Health Measures, by Wave of Displacement

Domain	Measure	Total	Wave One	Wave Two	p-value
Anxiety	Prevalence of GAD	73.6%	70.3%	76.6%	p=0.03
Depression	Prevalence of likely depression	70.1%	69.4%	71.9%	p=0.42
Health	Walking about	0.71	0.72	0.71	p=0.71
	Self-care (washing or dressing)	0.43	0.44	0.42	p=0.53
	Usual activities	0.75	0.74	0.76	p=0.53
	Pain/discomfort	0.90	0.88	0.91	p=0.17
	Anxious or depressed	0.71	0.66	0.75	p=0.001
	EQ-VAS	42.6	42.9	42.3	p=0.70

Table 6.16. Summary Table of Health Measures, by Settlement Type (Wave One)

Domain	Measure	Total	State-Owned Collective Center	Private Accom-modation	p-value
Anxiety	Prevalence of GAD	70.9%	70.6%	71.2%	p=0.89
Depression	Prevalence of likely depression	70.0%	73.2%	68.3%	p=0.28
Health	Walking about	0.72	0.72	0.72	p=1.0
	Self-care (washing or dressing)	0.45	0.48	0.43	p=0.35
	Usual activities	0.75	0.73	0.76	p=0.44
	Pain/discomfort	0.89	0.92	0.87	p=0.09
	Anxious or depressed	0.66	0.71	0.64	p=0.13
	EQ-VAS "Health Thermometer"	42.8	41.1	43.7	p=0.10

Table 6.17. Summary Table of Health Measures, by Gender

Domain	Measure	Total	Male	Female	p-value
Anxiety	Prevalence of GAD	73.6%	59.5%	78.4%	p<0.001
Depression	Prevalence of likely depression	70.8%	57.7%	75.2%	p<0.001
Health	Walking about	0.71	0.52	0.78	p<0.001
	Self-care (washing or dressing)	0.43	0.33	0.46	p<0.001
	Usual activities	0.75	0.62	0.80	p<0.001
	Pain/discomfort	0.90	0.81	0.93	p<0.001
	Anxious or depressed	0.71	0.59	0.75	p<0.001
	EQ-VAS "Health Thermometer"	42.6	47.5	40.9	p<0.001

Finally, though perhaps most important, we found a consistent difference in depression, anxiety, and health scores between males and females, with women more likely in this sample to experience adverse scores across all of the key health and mental health measures. There are many factors that contribute to this, some universal and some more specific to the Georgian context. It is generally true that females experience higher levels of depression and anxiety than males, and this is true at older ages as well as younger. It is also true that the conflict-related displacement in Georgia has left higher percentages of IDP women widowed or separated from other family members, which could also be contributing to the higher burden of physical and mental health problems in evidence.

References

Ankri, J., Beaufils, B., Novella, J.-L., Morrone, I., Guillemin, F., Jolly, D., et al. (2003). Use of the EQ-5D among patients suffering from dementia. *Journal of Clinical Epidemiology*, 56, 1055-1063.

Binkin, N., Sullivan, K., Staehling, N., & Nieburg, P. (1991). Rapid Nutrition Surveys: How Many Clusters are Enough? *Disasters , 16* (2), 97-103.

Brazier, J., Walters, S., Nicholl, J., & Kohler, B. (1996). Using the SF-36 and Euroqol on an elderly population. *Quality of Life Research*, 5 (2), 195-204.

Cleemput, I., Kesteloot, K., Moons, P., Vanrenterghem, Y., Van Hooff, J., Squifflet, J., et al. (2004). The Construct and Concurrent Validity of the EQ-5D in a Renal Transplant Population. *Value in Health* , 7 (4), 499-504.

Cochran, W. (1977). *Sampling Techniques* (3rd ed.). New York, NY: John Wiley & Sons.

Folstein, M. F., Folstein, S. E.,& McHugh, P. R. (1975). Mini-Mental State: a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*, 12, 189–198.

Fried, L. P., Tangen, C. M., Walston, J., Newman, A. B., Hirsch, C., Gottdiener, J., et al. (2001). Frailty in older adults: Evidence for a phenotype. *J Gerontol A Biol Sci Med Sci*, 56(3), M146-156.

Fried, L. P., Hadley, E. C., Walston, J. D., Newman, A., Guralnik, J. M., Studenski, S., et al. (2005). From bedside to bench: Research agenda for frailty. *Sci Aging Knowledge Environ*, 2005(31), pe24.

Gorman, M. (1999). Development and the rights of older people. In J. Randel et al.(Eds.), *The ageing and development report: poverty, independence and the world's older people* (pp. 3-21). London: Earthscan Publications Ltd.

Herold, J., & Peavy, J. (2002). Surveys and Sampling. In M. Gregg, *Field Epidemiology* (2nd Edition ed.). New York: Oxford University Press.

HelpAge International. (2004b). *Georgia Community Mobilization Initiative (GCMI): Technical Training and Advice for NGO Grantees on Working with Older People*. Tbilisi.

Holtzman, S. B., & Nezam, T. (2006). *Living in Limbo: Conflict-Induced Displacement in Europe and Central Asia*. Washington DC: The World Bank.

Hughes, D. (2007). Feasibility, validity and reliability of the Welsh version of the EQ-5D health status questionnaire. *Qual Life Res* , 16, 1419-1423.

Inzelberg, R., Schechtman, E., Abuful, A., Masarwa, M., Mazarib, A., Strugatsky, R., Farrer, L. A., Green, R. C., & Friedland, R. P. (2007). Education effects on cognitive function in a healthy aged Arab population. *Int Psychogeriatr*, 19(3), 593-603.

Jelsma, J., Mkoka, S., Amosun, L., & Nieuwveldt, J. (2004). The reliability and validity of the Xhosa version of the EQ-5D. *Disability and Rehabilitation* , 26 (2), 103-108.

Keating, S., Carlson, B., Jimenez, S., Estrada, J., Gastelum, B., Romero, T., Riegel, B. (2009). Psychometric testing of the Immigrant Barriers to Health Care Scale: Hispanic Version. *Nurs Health Sci* 11(3): 235-43.

Luo, N., Chew, L., Fong, K., Koh, D., Ng, S., Yoon, K., et al. (2003). Validity and Reliability of the EQ-5D Self-report Questionnaire in Chinese-speaking Patients with Rheumatic Diseases in Singapore. *Ann Acad Med Singapore* , 32, 685-90.

Lyness., JM., Noel, TK., Cox, C., King, DA., Caine, ED. (1997) Screening for depression in elderly primary care patients. A comparison of the Center for Epidemiologic Studies-Depression Scale and the Geriatric Depression Scale. *Arch Intern Med*. 157(4):449-54.

Ng, T. P., Niti, M., Chiam, P. C., & Kua, E. H. (2007). Ethnic and educational differences in cognitive test performance on mini-mental state examination in Asians. *Am J Geriatr Psychiatry*, 15(2), 130-9.

Perkins, M., Devlin, N., & Hansen, P. (2004). The validity and reliability of EQ-5D health state valuations in a survey of Maori. *Quality of Life Research* , 13, 271-274.

Rabin, R., & de Charro, F. (2001). EQ-5D: a measure of health status from the EuroQoL Group. *Ann Med*, 33(5), 337-43.

Robinson, C. (2003). Assessment Methods - Survey. In C. Robinson, & K. Hill, *Demographic Methods In Emergency Assessment: A Guide For Practitioners*. Baltimore: Johns Hopkins University Bloomberg School of Public Health.

Rose, A., Grais, R., Coulombier, D., & Ritter, H. (2006). A comparison of cluster and systematic sampling methods for measuring crude mortality. *Bulletin of the World Health Organization , 84*(4), 290-296.

Schrag, A., Selai, C., Jahanshahi, M., & Quinn, N. (2000). The EQ-5D--a generic quality of life measure--is a useful instrument to measure quality of life in patients with Parkinson's disease. *J Neurol Neurosurg Psychiatry* , 69, 67-73

Spiegel, P. (2007). Who should be undertaking population-based surveys in humanitarian emergencies? *Emerg Themes Epidemiol , 4* (12).

World Health Organization. (2006). *What are the public health implications of global ageing?* Geneva: WHO.

Chapter Seven: Case Study of Chechen Refugee Older Adults

A. Introduction

During the last twenty years, the breakaway republic of Chechnya has experienced two wars, resulting in over 350,000 people leaving Chechnya during this period and seeking shelter elsewhere in Russia, in Europe, or in neighboring countries. As a result of separatist conflicts between Chechnya and Russia in 1994-1996 and 1999, approximately 8,000 refugees, comprising both ethnic Chechen and ethnic Kist, fled southern Russia and arrived in eastern Georgia in 1999 (Human Rights Information and Documentation Center, 2011). While small numbers settled in Tbilisi, the majority settled in Pankisi Valley, Akhmeta municipality, Kakheti region, where Kistin Chechens have been living since the 19th century.

In 1999, Georgia had acceded to the 1951 Convention relating to the Status of Refugees and the 1967 Protocol and, in 1998, the Georgian parliament had passed domestic legislation, the "Law of Georgia on Refugees" (further amended in 2005 and 2011). Among the rights provided to refugees under Georgian law were the right to temporary settlement, food rations, and financial assistance; it did not provide refugees with the right to medical care (UNHCR, 2010a). It was also in 1999 that the UN High Commissioner for Refugees (UNHCR) began its work in Georgia with refugees and asylum seekers, including those from Chechnya.

Since 2002, the number of Chechen refugees in Georgia has been in decline. Some were resettled in third countries, primarily in Western Europe, but many voluntarily returned to Chechnya in two voluntary repatriations movements (in 2006 and 2007) that were organized by the Russian Federation (UNHCR, 2009). By 2008, according to government and UNHCR statistics, the number of Chechen refugees in Georgia had declined to around 1,000. By 2009, there were 848 Kist/Chechen refugees in Pankisi, of whom 6% (including an estimated 32 males and 14 females) were 60 or older (UNHCR, 2010b). By 2012, there were 696 registered Chechen refugees in Pankisi Valley; of these, one third were ethnic Chechens and the rest were ethnic Kist (ECRE, 2011). The Chechen refugees, according to UNHCR, "are of Muslim denomination and traditionally follow a rather liberal way of Islam (although during the last decade, a more fundamentalist approach has gained influence in the valley" (UNHCR, 2009).

UNHCR's work with Chechen refugees started in 1999 and it has been the principal partner of Georgian government in providing protection and assistance to refugees and asylum seekers since then. There have been a number of international and local partners that have also worked with Chechen refugees. World Food Program (WFP) has been present in Georgia since 1993, and provided basic food items to refugees until the end of 2007. UNHCR has supplemented this food assistance with additional food and has introduced a modest allowance scheme. The Norwegian Refugee Council (NRC) has been active in Georgia since 1994 providing protection and assistance to refugees and internally displaced persons; in Pankisi Valley it has provided education to refugee children as well as legal counseling and income-generating projects. For local NGOs, Technical Assistance in Georgia (TAG) has been providing healthcare services to refugees and the Georgian Center for Rehabilitation of Victims of Torture (GCRT) has provided psychological counseling. The Kakheti Regional Development Foundation (KRDF) provides durable solutions for refugees and facilitates integration in the local community through livelihood opportunities and skill trainings. It supports development of various self-reliance programs creating work places and income in Pankisi Valley. The organization also provides legal assistance for local refugees through free consultations. With the support of UNHCR, the Coordination Council of Chechen Refugees (CRCC) was founded in Georgia in 2007 (UNHCR, 2009).

In August 2005, when Chechen refugees in Georgia numbered around 2,500 (including 1,500 ethnic Kist, 900 ethnic Chechen, 23 ethnic Azeris, 31 ethnic Georgians, and a few Russians and Ingushetians), Georgia's Ministry for Refugees and Resettlement announced that it was ready to assist Chechen refugees interested in naturalization and UNHCR quickly pledged material support for the initiative (RIA Novosti, 2005). The process of naturalization, however, became bogged down in government red-tape and was challenged moreover by a 2009 survey showing that, at least among the ethnic Chechens, only 8% wanted to stay in Georgia while 73% wanted to resettle in third countries; figures were somewhat higher for the ethnic Kist respondents, 36% of whom wanted to stay in Georgia and 56% wanted to settle elsewhere (ECRE, 2007; HRIDC, 2006). By 2010, UNHCR reported that 145 Chechen refugees had naturalized (UNHCR, 2010c) with local estimates suggesting that number had doubled by 2011.

In February 2011, UNHCR signed a two-year agreement with the UN Development Program (UNDP), "Integrated Socio-Economic Development of Pankisi Valley," as part of the 2011-2015 UN Development Assistance Framework (UNDAF) plan for Georgia. The objective of the joint program was "1) to assist transitional strategy from direct individual humanitarian assistance to sustainable human development for all communities, including refugees in Pankisi Valley, and 2) strengthen the national system of protection of refugees in a broader humanitarian context of democratic governance, addressing poverty, and promoting sustainable human development in Pankisi Valley, Georgia" (UNDP-UNHCR, 2011). The agreement cited a figure of 848 Chechen refugees as of the latest re-registration by the Ministry of Refugees and Accommodation, of whom 50.3% were female and 49.7% were male, 44% were under 18 and 5.4% were 60 or over, 85% were living with host families and 15% were living in five collective centers.

The joint UNDP-UNHCR program agreement described the general socio-economic situation in Pankisi Valley as characterized by "limited economic activities…low employment and limited market development, predominance of subsistence agriculture…limited access [on the part of refugees and former refugees] to opportunities for income generation, underdeveloped physical infrastructure, and high risk of natural disasters" (UNDP-UNHCR, 2011). Infrastructural problems include an unreliable electric supply and irregular access to safe water and irrigation. Most public facilities, such as schools, hospitals, and health clinics, are in disrepair and have not been maintained for years. There are few public services available and only a few employers that offer limited employment opportunities for local residents. Business, as well as tourism, is poorly developed and agricultural activities do not provide sufficient income for households. Many refugee households primarily depend on money transfers from relatives who are living abroad and on non-monetary and monetary remuneration from agricultural activities. The strategies for the joint program were 1) economic development (primarily through small grants for micro-level entrepreneurship, mostly in agricultural production and crafts); 2) governance (aimed at building capacity of local authorities to plan and implement appropriate interventions; and 3) disaster risk reduction (aimed at better management of environmental threats, primarily from flash floods).

B. Study Design and Methods

A small case study of older Chechen refugees living in Georgia was carried out as a supplement to the larger IDP survey. The case study was intended to parallel the prevalence study by using similar methods to describe the physical, mental health, and social problems of older adult Chechen refugees living in Georgia. Analysis of the case study data provided a descriptive profile of the Chechen refugee population. Specifically, the data describe this population's background characteristics, migration history, current living arrangements, economic status, physical and mental health status, and social support.

The Chechen case study, like the larger prevalence study, used a mixed methods approach to describe the main physical and mental health problems of adult older Chechen refugees. For the qualitative portion of the case study, the research team interviewed 11 key informants (9 females, 2 males), including other refugees, community leaders, local government representatives, NGO workers, lawyers, psychologists and social workers (see Appendix D for the characteristics of key informants).

Key informants were asked seven open-ended questions followed by probing questions leading to in-depth discussion to obtain information about the health and social problems of Chechen refugees. The key informant interview questions were similar to those asked in the IDP key informant interviews but included more questions about services provided by the organizations and reasons providing their stay in Georgia and about the citizenship status (See Appendix D for the full, semi-structured interview guide):

1. Can you tell us about the work carried out by (your) organization?
2. Can you describe the different problems that elderly Chechen refugees face?
3. Others have told us that some older displaced adults feel they are a burden to their families. Can you tell us about this as it concerns elderly Chechen refugees?
4. Others have told us that some older displaced adults feel abandoned, isolated, and not cared for. Can you tell us about this as it concerns elderly Chechen refugees?
5. What kinds of services exist in this region to help elderly Chechen refugees with their problems? What services does your organization provide that help elderly Chechen refugees?
6. How do elderly Chechen refugees help themselves when they have problems? How do family members and people in their social networks support them?
7. What factors influence the decision of the population to stay in Georgia rather than return to homes of origin?

For the quantitative portion of the case study, we used the same survey instrument as the one validated for the Georgian IDP population, though it was translated into Russian to accommodate the specific linguistic needs of the refugee population. Because of the small population size of older adult Chechen refugees (the 2009 UNHCR figures indicated only 46 individuals aged 60 or over), we did not set any target sample size but, instead, tried to find and interview the entire population of Chechen refugee older adults. In the end, despite help from UNHCR staff and local NGOs, we were able to locate only 15 older adults and, even then, needed to relax the age cut-off to include anyone 55 or older.

At end of the survey, we also included four open-ended questions:

1. Can you describe the different problems that elderly Chechen refugees face?
2. What kinds of services exist in this region to help you with your problems?
3. How do you help yourselves when you have problems? How do family members and people in their social network support you?"
4. What factors influence your decision to stay in Georgia rather than return to your home of origin?

B. Results: Key Informant Interviews

As in the larger study, key informant interviews were used to learn more about physical, health and mental health and social problems of Chechen refugees living in Pankisi Valley. Eleven key informant interviews were conducted in both Tbilisi and Akhmeta. Below is the breakdown of the key informants by gender and sites.

Table 7.1 Key Informants

Location	Female	Male
Tbilisi	3	0
Akhmeta	6	2
Total	9	2

Table 7.2 Five Most Frequent Responses by Key Informants

Question	Description/phrase	Frequency
Reasons for staying in Georgia	Political environment/lives are threatened in Chechnya	10
Ways to help themselves	Support from family and others	8
Feeling abandoned/isolated	Elderly Chechens are not abandoned or isolated	6
Burden to the family	Such feelings are quite rare among Chechens	6
Different problems	Stress/neurosis	5

The analysis of the most frequently cited concerns among Chechen refugees showed that health-related, social and economic problems were prevailing. Health-related problems were described as problems typical to the age-group, as well as mental health problems. Under economic and social problems were mentioned poor living conditions and lack of monetary assistance. Responses to the question—"Others have told us that some older displaced adults feel they are burden to their families. Can you tell us if this concerns older Chechen refugees?"—included "such feelings are quite rare among Chechens," and "elderly are pillars of the family; an older person is much respected, he is idolized." Understanding the cultural characteristics of Chechens, including their generally respectful attitude towards older people, may explain these kinds of answers. A few key informants also noted that Chechens do not talk much about this issue.

The majority of respondents mentioned that "elderly Chechens are not abandoned and isolated" when asked if this was a concern among older Chechens. Key informants also admitted that there were very few, almost no, services provided for Chechen refugees. Glorifying the family hearth, and respecting elderly and ancestors are themes that can be found the answers of key informant interviews on the question how elderly Chechens help themselves and how family help them. According to their traditions, family members, close or remote kin look after the elderly in the Chechen population.

One of the last questions asked key informant interviews about the reasons why some Chechen refugees chose to stay in Georgia rather than return to their home country. The majority of key informants responded that the main reason for staying in Georgia is due to the instability of the political environment and the threat of being persecuted by the Kadyrov government upon returning to Chechnya.

Others indicated that they stayed because they were waiting to obtain dual citizenship. It should be noted that responses of couple of key informants revealed that Chechen refugees have to pay 200 GEL (equivalent to $US121) per person to apply for citizenship, which is a substantial amount for this population, especially when considering there are 4 or 5 members per family.

C. Results: Survey Interviews

The questionnaire used in the prevalence study of Chechen refugees was similar to the one used with Georgian IDPs and had several sections that including the Mini Mental State Exam (MMSE), questions about demographic characteristics, migration history, functioning, and

health, health-related quality of life, mental health symptoms, trauma experiences and social behavior assessment questionnaires.

The sample size for the Chechen refugee prevalence study was 15, among which there were 10 males and 5 females, with ages ranging from 57 to 76 and a mean age of 65. Among the population, 40% were married, 27% divorced and 33% widowed. From an education standpoint, 73% had high levels of education with either university or technical institute degrees. All refugees were interviewed in a rural setting, namely the Pankisi Valley. Out of the 15 interviewed Chechen refugees, 9 have been living in Pankisi Valley since 1999, 3 since 2000, and the remaining three since 1995, 2003 and 2005, respectively.

The health-related quality of life was assessed using the EuroQol instrument. The average score on the "health thermometer" portion of the instrument among the study sample was 48.73. According to this instrument, higher scores are indicative of better health. The mean score differed according to gender with a much lower value among women (38.4) than men (53.9).

Mental health problems among Chechen refugees were assessed using the Geriatric Anxiety Inventory (GAI). The average score for the population was 10.99. Males had a much lower mean score of 9.38 compared to women who had a mean score of 14. 2. This is significant as scores above 10 on this scale are suggestive of Generalized Anxiety Disorder.

For screening depression among the elderly Chechen refugees, the study used a 15-item self-report assessment tool, the Geriatric Depression Scale (GDS). The mean score for the population was 8.27; looking at the GDS score by gender, men had a mean score of 7.9 and women had a mean score of 9.0.

Although the health and mental health scores are notably more adverse than the general Georgian population, the anxiety, depression scores among the Chechen refugees were all better than their IDP counterparts (due to small numbers in the Chechen study, only mean scores are presented rather than prevalence and no tests for significance are included). Similarly, the EuroQol health-related quality of life scores were higher than among IDPs in either Wave One or Wave Two. While the results of the Chechen case study are based on a small number of interviews and cannot be compared statistically with the IDP sample, it is interesting to note that the gender differentials paralleled the IDP study (albeit at lower levels). For all three key health measures, Chechen refugee women scored worse than their male counterparts.

Table 7.3. Health Measures: Chechen Refugees and IDP Wave of Displacement

Domain	Measure	Chechen Refugee Older Adults	IDP Wave One	IDP Wave Two
Anxiety	Generalized Anxiety Index (GAI) Mean Score	10.9	12.5	13.3
Depression	Geriatric Depression Scale (GDS) Mean Score	8.3	9.3	9.6
Health	EQ-VAS Overall Health Score	48.7	42.9	42.3

D. Results: Open-Ended Questions

The survey, including the open-ended questions at the end of the instrument, was administered to 15 older adult Chechen refugees, though only 12 respondents provided response to the open-ended questions.

Table 7.4 Age and Sex of Chechen Respondents to Open-Ended Questions

Gender	Age Groups			
	55-59	60 – 69	70 – 79	Total
Male	1	4	3	8
Female	1	2	1	4
Total	**2**	**6**	**4**	**12**

The analysis of the responses showed that the most commonly mentioned problems were related to economic-social and health issues. Economic-social hardships were described as lack of money, poverty and unemployment as well as not having houses; health related conditions were described as having poor health and different troubles typical to older age.

Taking into consideration cultural traditional characteristics of Chechens, it was not surprising to learn from respondent responses that they help each other as they can – they talk to each other, share their concerns and provide morale and financial support as they can. The answers to the questions—"How do you help yourselves when you have problems? How do family members and people in their social network support you?"—clearly show the mutual support among Chechens:

- "In case of hardships we support each other. We help each other as we can, mostly in terms of morale, financially everyone is in a bad state,"
- "We help each other as we can. If there is something to be done physically, we do it. We talk with each other and when we have a possibility, we help with money,"
- "We just share our concerns, how else could we help each other?"

Chechen refugees either did not know anything about services available for them or many of them said that there were no services provided for them in the region. Majority answered that the main reason for staying in Georgia was that Georgia is their home country – this can be explained by the fact that two-thirds of the refugees living in Akhmeta region are Kists from Chechnya, who have historical and cultural connections to Georgia; the typical responses to the question—"What factors influenced your decision to stay in Georgia rather than return to your home of origin?"—were "I was born and grew up here and where else should I go?", "I am from here and where should I go?" and "My parents were from here."

One of the key informants noted that among Kists there are many who lived in Grozny, but they were born and brought up in Georgia. When they are granted citizenship they also get $8,000 support from the UN. Others mentioned children and family members living in the host country being the main reason for staying in the country as well as their old age. Chechen refugees took the opportunity offered by the Georgian government and most respondents mentioned that they had already applied for dual citizenship at the time of interview.

Table 7.5 Responses to Open-ended Questions

Open-ended questions	Description	Answers
What factors influenced your decision to stay in Georgia and not to return?	Family	My daughters and sons married here, where should I go?
		My family is here. I was born and grown up here and where else should I go?
		My mother lives here. I cannot abandon her as she is old. She is 90. I brought my children here, what else should I have done?
		My children are here and I stayed here. My daughters and sons married here. I want only once to go to my native land and see what happens there, and then come back.
	Home country	Georgia is my native country. I was born here and I want to live here till the end of my life.
		I am from here and where should I go. My parents are from here. I am in borrowed house, and let's see what will happen.
		I was born and grown up here. My parents' graves are here.
	Old age	Nobody will take me, as I am old and ill, who will look after me there, so I stay here
		I am old, where shall I go, what could be the reason of my return? I do not have anyone there, I do not have a house there. Here I live in my brother's house, my son died, I have no one, I will stay here until I am pushed out.
How do elderly help themselves?	We help each other	In case of hardship we support each other. We help each other as we can, mostly morally, financially is everyone in bad situation.
		We support each other by talking about our problems.
		We help each other as we can. If there is something to be done physically, we do. We talk with each other and we when we have possibility we help with money.
		We mostly share our problems with each other.
		We just share our concerns, how else could we help each other?
		We mostly share our concerns, talk.
		How can I help with an empty pocket? If someone needs physical help I go. What else can I do?
Can you describe the problems that Chechen refugees face?		Health problems, not having houses, impossibility to return to native land, what could be more important?
		Food and health problems. What other problems elderly persons can have. To these is added the fact that we do not have homes.
		Health service, economic austerity
		Old age, poverty, health problems.
		Health, lack of money, health service, all types of hardship. Main thing is not having money. If we have money we will have everything. Sack of flour costs 30 GEL. I receive only 28 GEL and how could I buy with it everything?
		Housing, income is very restricted. Living in someone's family is the biggest problem for a refugee.
		Unavailability of health services, problems in medical sphere, lack of professionalism on local and central levels.

E. Discussion

The findings of the open-ended questions on the survey and key informant interviews revealed that there are economic, social and health-related problems among Chechen refugees. Social-economic hardships are expressed in terms of lack of money, need for proper living conditions and health services and concerns about unemployment and poverty. Some of the key informants noted that Chechen refugees mostly have high levels of education, they are used to living in urban areas, and in Pankisi Valley, it is very difficult for them to find proper employment, especially for men. Health problems are mainly expressed as general poor health of refugees, age-related chronic health conditions and mental health problems (stress, neurosis).

Analysis of the qualitative data suggested also that elderly Chechen refugees do not feel they are a burden to family, and do not feel they are abandoned or isolated. It is important to take into consideration the influence of strong cultural traditions and norms of Chechen society while analyzing these responses, as there may be some hidden issues that are not coming out because of cultural habits. As one of the key informants noted, "Old Chechens can feel abandoned or isolated though they never show this."

According to the answers of respondents to open-ended questions, there are no services provided to Chechen refugees at the moment. The analysis of responses of key informants mainly confirms this view, but it also is clear that Chechens who have refugee status get the state allowance of 28 GEL per month (equivalent to $US17) and they also have been provided private medical insurance since March 2011. Though some key informants noted that the insurance package is quite good, none of the refugee respondents talked about it and complained about not having access to medical services. The allowance provided by the state is quite low, a point frequently made in the responses to open-ended questions. One of the respondents described the problems that Chechen refugees face:

> *"Health, lack of money, health services, and all types of hardship. Main thing is not having money. If we have money we will have everything. A sack of flour costs 30 GEL. I receive only 28 GEL and how could I buy with it everything?"*

It is also worth mentioning that elderly refugees receive the same state allowance as older adult Georgians but do not get a pension until they obtain citizenship; as noted by one of the respondents referring to older Chechen refugees: "they do not have a pension and what problems could they solve with 28 GEL?" Elderly Chechen refugees become eligible for the standard pension of about 100 GEL (equivalent to $US 60) only after getting citizenship. Considering the fact that most humanitarian programs are phasing out, there is increased need for providing material support to the most vulnerable people (single parents, elderly and people with special needs) who are not able to engage in employment activities.

The key informant responses also mention one service organization, Kakheti Regional Development Foundation (KRDF), which has been functioning in the region since 2002 and provides manifold assistance to Chechen refugees and local community. Their assistance includes free consultations around business (help to write applications and proposals for grants) and legal issues. They run educational programs teaching computer skills as well as Georgian, Russian, Chechen and English languages. Within the organization there is also a women's club. Surprisingly, none of the respondents mentioned anything about the organization, merely answering that they do not know anything about services or stating there are no services provided in the region. Perhaps the reason is that the organization does not provide any specific assistance targeting elderly Chechen refugees.

Almost all key informants noted that most of the refugee-specific programs and projects are either already over or are phasing out. Small business programs that help refugees sustain themselves were named as one of the most effective programs. Most key informants noted that naturalization is also quite effective. Nearly 300-400 refugees already had received Georgian citizenship by June 2011. Most of them moved to Tbilisi and the rest settled elsewhere. The main reasons given by older adult respondents for staying in Georgia are having family members in Georgia, being older, and political reasons including fear of returning to their homeland. Responses to open-ended questions revealed that the majority of respondents had already applied for dual citizenship by the time of interview. Though they have to pay 200 GEL (equivalent of $US121) when submitting an application for citizenship, and they do not receive any special discounts, they say they get support to buy a house or renovate their old one. In addition, after getting citizenship, they have access to social and economic services provided by the state.

The qualitative analysis of open-ended and key informant interviews, as well as the results of quantitative study and a review of available literature on the topic of Chechen refugees living in Georgia, revealed many problems: social, economic and health-related. Poverty, lack of money, and unemployment are the top social-economic problems among older Chechen refugees; not having houses and/or bad living conditions are also concerns, especially for ethnic Chechens who live in collective centers. It is important to note that there is a high prevalence of mental health problems among older adult refugees and some key informants note that there is great need for psycho-social programs for this population.

References

European Council for Refugees and Exiles, 2007. *ECRE Guidelines on the Treatment of Chechen Internally Displaced Persons (IDPs), Asylum Seekers and Refugees in Europe, Revised March 2007.*

European Council for Refugees and Exiles, 2011. *ECRE Guidelines on the Treatment of Chechen Internally Displaced Persons (IDPs), Asylum Seekers and Refugees in Europe, 2011*.

Human Rights Information and Documentation Center (HRIDC), 2006. *Silence Kills: Abuse of Chechen Refugees in Georgia*. Tbilisi, Georgia.

Human Rights Information and Documentation Center (HRIDC), 2008. *Pankisi Deadlock, Plight of Chechen Refugees in Georgia*. Tbilisi, Georgia.

Kakheti Regional Development Foundation (KRDF), 2009. Retrieved April 2012, from http://www.krdf.ge/home.

Norwegian Refugee Council (NRC), 2011. Retrieved April 2012, from http://www.nrc.no/?did=9168164.

RIA Novosti, 2005. "Georgia offers citizenship to Chechen refugees." August 31, 2005.

UN High Commissioner for Refugees, 2009. UNHCR in Georgia: Briefing Note. Retrieved April 2012, from http://www.unhcr.org/4b274bc76.html.

UN High Commissioner for Refugees, 2010a. *Universal Periodic Review for Georgia: Provisional UNHCR input to the preparation of a consolidated UN Background Paper as*

related to the chapter on internally displaced persons, refugees and asylum seekers. Retrieved April 2012, from http://lib.ohchr.org/HRBodies/UPR/Documents/Session10/GE/UNHCR_UNHighCommissionerforRefugees-eng.pdf.

UN High Commissioner for Refugees, 2010b. *Report on the Integration Prospects of the Chechen Refugees in Georgia: Pankisi Valley*. UNHCR Country Office, Tbilisi, Georgia.

UN High Commissioner for Refugees, 2010c. *UNHCR Global Report 2010, Georgia*, June 2011, Retrieved April 2012, from http://www.unhcr.org/refworld/docid/4e523fc70.html

UN Development Program – UN High Commissioner for Refugees, 2011. *Joint Program Document - Integrated Social-Economic Development of Pankisi Valley*. Retrieved April 2012, from http://www.undp.org.ge/files/project_files/prodoc-joint-Pankisi.pdf.

Chapter Eight: Conclusions and Recommendations

A. Overview

One of the greatest legacies of the twentieth century is that people are getting older and living substantially longer. In 2006, 18% or roughly 795,000 Georgians were aged sixty or older. By 2050, that number will increase to well over a million (1,077,000) and account for roughly 36% of the population (UN-DESA, 2006). This change in the population demands that we re-think how to maximize the health and well-being of the aging population. The older Georgian population—and this includes IDPs as well as resettled refugees—represents an untapped resource, with an abundance of knowledge and skills (human capital) along with attitudes, beliefs, and social networks (social capital) that can contribute to society. Indeed, large majorities of older adults not only have the health and functional ability to continue "giving back" to society, but express a desire to do so. Growing evidence also indicates that important health benefits accrue from such continued, active engagement in meaningful activities. These benefits include improved physical and mental health, and enhanced well-being.

From a policy perspective, the term "aging-in-place" means the ability to remain in the current setting as one ages, coupled with the notion that successful aging-in-place involves maintaining a certain degree of competence and control over one's environment (Cutchins 2003). One of the most salient features of disasters for all affected populations, but perhaps especially older adults, is the displacement from home and community, often for extended periods of time. In this sense, what might be called "aging-in-displacement" represents aging-in-place turned upside-down: one cannot remain in a familiar setting as one ages, one may have limited to no control over one's environment, and changes in place and circumstance can be so abrupt and unsettling as to be fundamentally disintegrating.

It has been twenty years since conflict within and on the borders of Georgia produced the first large wave of displaced persons. Many of those people are still living where they "temporarily" settled, though older now and burdened by poverty and poor health. They have since been joined by refugees and by a new wave of internally displaced, many of whom are also older adults. The year 2012, according to a recent UNHCR report, "should herald a crucial transition in Georgia from humanitarian interventions for refugees and IDPs to sustainable longer term development" (UNHCR, 2012). UNHCR has phased out its direct assistance to IDPs and to Chechen refugees. The government of Georgia, international donors, international organizations, and non-governmental organizations and civil society are seeking to shift priorities from ad hoc, short-term relief (however prolonged it has been) to more integrated, development-oriented approaches. The challenge, and one of the key measures of success, will be to do so while maintaining, even strengthening, vital health and social supports for the most vulnerable populations, including older adults. One of the ways to strengthen services for older adults is to support the kinds of programs and policies that promote healthy aging and restore a sense of place to those aging in displacement.

The recommendations below from the Institute for Policy Studies and the Johns Hopkins Bloomberg School of Public Health are based on the results of the research on IDP older adults and Chechen refugee older adults in Georgia, and on discussions about study findings at a July 2011 workshop in Tbilisi, Georgia, which included participants from the Georgian government, PRM, USAID, UNHCR, and a number of local and international non-governmental organizations. The recommendations are directed toward the Georgian government, UNHCR, PRM and other humanitarian donors, and the NGO community and civil society in Georgia.

B. Recommendations

1. Recommendations to the Georgian government.

- For the IDP populations living in protracted displacement, the Georgian government needs to complete its targeted objective to close all the state-owned collective centers and either help residents to move to private accommodations elsewhere or to remain in the newly privatized (and improved) facilities. There is little question that the placement of IDPs in collective centers on the assumption that these would be only temporary facilities pending their rapid return to their homes proved both to be misguided and, in the long-term, harmful to the physical and mental health of the populations who remained for years in these centers. The government of Georgia should also expand home ownership and privatization efforts to encompass the more recently displaced, whether they are living in state-owned collective centers or IDP settlements.

- The government of Georgia should provide transitional income and pension support to IDPs and refugees as they shift from a status-based support system to one that is integrated into national pension and health insurance schemes. These schemes, moreover, in the context of ongoing health care reform need to incorporate a greater sensitivity to the needs of older adults in general and displaced persons in particular.

- The government of Georgia should develop and promote programs to involve older adults as volunteers and counselors in health, education and social welfare programs. One idea is that of an Experience Corps®-like program that trains older adults to work as volunteer mentors in local schools. Another approach is the development of multi-purpose community centers in areas where there are larger numbers of IDP and non-IDP older adults living. These community centers should include "elder-friendly" spaces for meaningful social interaction, informal support groups, and mobile health clinics.

- When preparing for, and responding to, the needs of future displaced populations—whether IDPs or refugees, the government of Georgia should formulate plans, policies and programs that (1) incorporate input from the current IDP and refugee populations and their host communities, (2) address the needs of older adult and disabled populations (including accessibility, social support, etc), and (3) provide for settlement and support services that focus on integration into local communities, even while promoting alternative durable solutions, including return home.

- For Chechen refugees who remain in Georgia, the government should support full and rapid legal integration of Chechen refugees in local communities through registration, documentation, and provision of secure status concluding with naturalization. Steps should include improving refugee registration procedures, helping refugees with limited or no documentation to apply for citizenship or dual citizenship, and making naturalization procedures easier and shorter.

- The government of Georgia should support and promote the integration of geriatric health and social welfare issues into the university education system with a focus on research, policy development and evaluation, and programs for training researchers, policy makers, and health and mental health professionals.

2. *Recommendations for UNHCR (and partners)*

- While the focus of the UNDP-UNHCR joint program for Pankisi Valley on economic development, particularly micro-level entrepreneurship, is appropriate for working-age refugees, UNHCR should supplement that with support for community-based programs that enable older adults to contribute productively as teachers, mentors, and counselors, whether that be in the context of local business development, education, or community health and mental health initiatives.

- UNHCR should work with international partners and with the government of Georgia to develop needs-based, transitional health and mental health support for vulnerable sub-populations among refugees, IDPs and people in IDP-like situations, including older adults, people living with disabilities, and female-headed households. This could include, among other things, short-term assistance to medically needy individuals and access to psycho-social rehabilitation programs.

- UNHCR should continue to provide training and capacity building for national, regional and local authorities to implement more comprehensive and efficient procedures for refugee registration, documentation and, where appropriate, naturalization and local integration.

- UNHCR should continue to support and build capacity for needs assessments among refugees and displaced persons, and for monitoring and evaluation of the programs that serve them, that gathers accurate and detailed information on all vulnerable groups, including older adults, people living with disabilities, and female-headed households, so that program and population data can be disaggregated by age and gender.

- UNHCR should continue to promote the effective implementation of the government of Georgia's state strategy for internally displaced persons, with its two goals of (1) creating conditions for the safe, voluntary and dignified return of IDPs to their homes and/or places of origin and (2) supporting full integration of IDPs into their communities, with decent living conditions and an adequate standard of living.

3. *Recommendations for PRM (and other bilateral and multilateral donors)*

- PRM should coordinate with USAID and other development actors to support the 2011-2015 UN Development Assistance Framework (UNDAF) plan for Georgia, supplementing support for UNHCR and UNDP with funds for independent monitoring and impact evaluation of the two-year UNDP-UNHCR program, "Independent Socio-Economic Development of Pankisi Valley." As noted in the joint program document, "the experiences and results gained through its implementation will be used to develop similar initiatives in Shida Kartli and West Georgia for IDPs" (UNDP-UNHCR, 2011).

- While PRM should support Transitional Solutions Initiatives like the above UNDP-UNHCR joint program in Pankisi Valley, the Bureau should also support needs-based, transitional health and mental health support for vulnerable sub-populations among refugees, IDPs and people in IDP-like situations, including older adults, people living with disabilities, and female-headed households in Georgia. This could include, among other things, short-term assistance to medically needy individuals and access to psycho-social rehabilitation programs.

- PRM should continue to support operations research in Georgia and elsewhere that documents and shares examples of good practice on inclusion of vulnerable groups in population needs assessment, program design and implementation.

- PRM should take concrete steps to first acknowledge then correct the disparity that exists in humanitarian financing between the proportion of the global population who are aged 60 and above (over 11 percent) and/or living with disabilities (over 15 percent) and the proportion of humanitarian aid that targets these vulnerable populations (around 1 percent) (HelpAge International and Handicap International, 2012). U.S. leadership in support of humanitarian aid and transition initiatives would provide a salutary example for other countries and international donors to follow.

4. Recommendations for local and international NGOs

- Local and international NGOs should develop community-level programs that target older IDP mental health needs. Community-based interventions should seek to improve functioning by addressing the roles of displaced older adults in their communities and by providing opportunities where they can actively utilize their skills and knowledge. This could include increasing access to income-generating activities for older IDPs, increasing access to plots and gardens, making better use of older adults' skills and professional training in community projects, connecting displaced older adults with young adults or children for mentorship and teaching activities, and/or establish multi-purpose community centers for older adults to use, along with others to promote inter-generational exchange.

- Local and international NGOs should engage in policy advocacy and program development to promote improved health care access for displaced older adults including extending insurance coverage of medications and developing innovative measures to reach older IDPs, many of whom have mobility problems. For example, mobile health clinics at community centers might help target older adults.

- Local and community-based organizations should establish a network for groups working with older adults, which would include older adult representation, and could promote such things as (1) developing health communication media and efforts directed towards older adults and their specific needs, (2) connecting or building networks across IDP communities, (3) organizing roundtable discussions with government agencies, NGOs, and local communities to discuss social issues, and (3) improving understanding of the social, economic, and health conditions that affect older adults in general and displaced populations particularly.

- When they carry out needs assessments, NGO and community-based programs should use valid and reliable instruments to capture health, mental health, and other key characteristics. These assessments should also collect data on older adults, people living with disabilities, and female-headed households and be able to disaggregate the data by age and gender.

5. An Integrating Approach: the Experience Corps® Model

There are many global health challenges created by a rapidly aging population. Trying to optimize older adults' health status and compress morbidity in the later years to the smallest possible time is one of the major goals. At the same time, two trends threaten the future of society: 1) the increasing proportion of older adults living with chronic illnesses who will require

economic and social support from a decreasing number of workers, and who will need a prepared, educated younger population to sustain the country's productivity, and 2) the relatively poor quality of children's education at a time of increasing need to be globally competitive. Therefore, it would be highly beneficial to Georgian society to create a program that could reengage older adults as active members in schools and communities in ways that may enhance their health and at the same time provide mentoring to children so that they could receive more differentiated instruction that meets their individual needs enabling them to achieve academic success.

The Experience Corps®, a 15-year-old community-based model of senior service to improve the educational outcomes of children, was designed with the above goals in mind. The Experience Corps model creates a "win-win-win" scenario for older adults, children, and schools by providing older adults the opportunity to use their time, skills, and wisdom to volunteer in low-income, urban elementary schools as mentors of children in grades K-3 for fifteen hours a week throughout two academic school years. Experience Corps offers a model for the rapidly burgeoning interest in volunteerism and other forms of civic engagement that seek to expand role options in later life by creating meaningful roles within institutions like the public school system. The underlying goal is to create a more active and healthier older population with roles through which they can make a difference in society, a student population having more educational needs met, and as a secondary benefit of Experience Corps design, enhance the ability to create a positive learning environment in the classroom that results in schools having stronger academic performance.

At the same time, intentionally embedded into the Experience Corps program design is another level of potential benefits: a health promotion program for the older adults. The rationale for this component is that there is substantial evidence that healthy behaviors, including physical activity, social supports and engagement, and cognitive activity, are important to health and prevention of cognitive decline and disability as people age – even into the oldest ages. However, it has proven difficult to attract older adults to participate in health behavior change programs, particularly for sustained periods of time. Those who do participate tend to be of higher socioeconomic status; even among these groups, long-term retention is not high. Those with fewer economic means or lower education appear to have both less ability to participate in and/or less access to health promotion programs and optimal health behaviors.

The Experience Corps program recruits, trains, and places men and women 55 years of age and older as volunteers in public elementary schools, serving children in kindergarten through third grade. Those eligible to volunteer must be literate at the 8th grade level, be high school graduates, meet screening criteria for general cognitive status, and pass a criminal background check conducted by the school system. All volunteers must complete a one-week, 30-hour training program to prepare them for serving effectively in their roles within the schools. Specifically, volunteers are trained in supporting literacy and math skill development and motivation for reading; assisting in school libraries; violence prevention, behavior management, and conflict resolution; and other roles. In addition to providing rigorous training sessions, the program works with the schools' principals and Experience Corps Team Leader to assign the volunteers to classrooms in roles that would meet the school's greatest unmet needs for increasing the success of their students. The program also provides ongoing support, oversight, and in-service training of the volunteers once they are placed in the schools. Adapting this intergenerational model for the Georgian context would provide a timely opportunity for benefitting both the young and the older populations.

C. Conclusion

It is critical that the humanitarian community—including host governments, donors, international organizations, non-governmental organizations, and civil society—in the Republic of Georgia and around the world, take clear and concrete steps to recognize that an aging global population means that, all else equal, the proportion of older adults among displaced populations is also rising. Humanitarian guidelines have begun to focus more closely on older people as a priority vulnerable population, more so because a majority are likely to be female (and possibly single heads of household) and many may also be physically and psychologically disabled (Sphere Project, 2004). It is time now to recognize—and to build this recognition into humanitarian policies and programs—that older adults may have special vulnerabilities but they have special skills and experience that makes them resources, including, even especially, in times of crisis. Re-establishing a sense of "place"—whether that be through return to one's place of origin or integration into a new place—not only helps to restore competence and control to displaced older adults but employs their talents to improve their own lives, those of their family and neighbors, and the welfare of society as a whole.

References

HelpAge International and Handicap International, 2012. *A study of humanitarian financing for older people and people with disabilities, 2010-2011.* London, UK and Lyon, France.

UN Development Program – UN High Commissioner for Refugees, 2011. *Joint Program Document - Integrated Social-Economic Development of Pankisi Valley*. Retrieved April 2012, from http://www.undp.org.ge/files/project_files/prodoc-joint-Pankisi.pdf.

UN High Commissioner for Refugees, 2012. *Georgia: 2012 Regional Operations Profile-Eastern Europe*. Retrieved April 2012, from http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e48d2e6.html.

Appendix A. Qualitative Study Materials

Table 1. Free List Respondent Characteristics

a. Female/Male Breakdown

Region	Female	Male
Tbilisi	15	10
Shida Kartli	14	11
Samegrelo	15	10
Total	*44*	*31*

b. Tbilisi

No.	IDP Status	Location	Place of Origin	Urban or Rural	Type of Accommodation	Gender	Age	Marital Status
1	Protracted	Tbilisi	Abkhazia	Urban	CC	Female	63	Widow
2	Protracted	Tbilisi	Abkhazia	Urban	CC	Female	72	Married
3	Protracted	Tbilisi	Abkhazia	Urban	CC	Female	70	Single
4	Protracted	Tbilisi	Abkhazia	Urban	CC	Male	76	Widow
5	Protracted	Tbilisi	Abkhazia	Urban	CC	Female	71	Widow
6	Protracted	Tskhneti	Abkhazia	Rural	CC	Female	60	Married
7	Protracted	Tskhneti	Abkhazia	Rural	CC	Male	72	Married
8	Protracted	Tskhneti	Abkhazia	Rural	CC	Male	77	Married
9	Protracted	Tskhneti	Abkhazia	Rural	CC	Female	60	Married
10	Protracted	Tbilisi	Abkhazia	Urban	Private	Female	68	Widow
11	Protracted	Tbilisi	Abkhazia	Urban	Private	Female	70	Widow
12	Protracted	Tbilisi	Abkhazia	Urban	Private	Male	79	Married
13	Protracted	Tbilisi	Abkhazia	Urban	Private	Female	74	Married
14	Protracted	Tbilisi	Abkhazia	Urban	CC	Female	75	Widow
15	Protracted	Tbilisi	Abkhazia	Urban	CC	Male	72	Married
16	Protracted	Tbilisi	Abkhazia	Urban	CC	Male	76	Married
17	Protracted	Tbilisi	Abkhazia	Urban	CC	Male	81	Widow
18	Protracted	Tbilisi	Abkhazia	Urban	CC	Female	82	Widow
19	Protracted	Tbilisi	Abkhazia	Urban	CC	Female	80	Widow
20	Protracted	Tbilisi	Abkhazia	Urban	Private	Female	70	Widow

21	Protracted	Tbilisi	Abkhazia	Urban	Private	Male	75	Married
22	Protracted	Tbilisi	Abkhazia	Urban	Private	Female	72	Widow
23	Protracted	Tbilisi	Abkhazia	Urban	Private	Female	72	Widow
24	Protracted	Tbilisi	Abkhazia	Urban	Private	Male	64	Marriage
25	Protracted	Tbilisi	Abkhazia	Urban	Private	Male	63	Married

*CC = Collective Center

c. Shida Kartli

No.	IDP Status	Location	Place of Origin	Urban or Rural	Type of Accommodation	Gender	Age	Marital Status
1	New	Gori	Ossetia	Urban	Private	Female	69	Widow
2	New	Karaleti	Ossetia	Rural	Settlement	Male	83	Married
3	New	Karaleti	Ossetia	Rural	Settlement	Female	65	Married
4	New	Karaleti	Ossetia	Rural	Settlement	Male	82	Married
5	Protracted	Gori	Ossetia	Urban	Private	Female	82	Widow
6	New	Gori	Ossetia	Urban	Private	Female	78	Widow
7	New	Gori	Ossetia	Rural	Settlement	Female	61	Widow
8	New	Gori	Ossetia	Rural	Settlement	Female	78	Married
9	New	Ergneti	Ossetia	Rural	Buffer zone	Female	62	Married
10	New	Ergneti	Ossetia	Rural	Buffer zone	Male	62	Married
11	New	Gori	Ossetia	Urban	Settlement	Male	73	Married
12	New	Gori	Ossetia	Urban	Settlement	Male	72	Married
13	New	Gori	Ossetia	Urban	Settlement	Female	61	Married
14	New	Gori	Ossetia	Urban	Settlement	Female	79	Widow
15	New	Gori	Ossetia	Urban	Settlement	Female	64	Married
16	New	Ergneti	Ossetia	Rural	Buffer zone	Male	62	Married
17	Protracted	Gori	Ossetia	Urban	CC	Female	69	Widow
18	Protracted	Gori	Ossetia	Urban	CC	Female	84	Widow
19	Protracted	Gori	Ossetia	Urban	CC	Female	76	Widow
20	Protracted	Gori	Ossetia	Urban	CC	Male	69	Married

21	Protracted	Gori	Ossetia	Urban	CC	Male	77	Married
22	New	Ergneti	Ossetia	Rural	Buffer zone	Male	80	Widow
23	Protracted	Gori	Ossetia	Urban	Private	Male	78	Married
24	Protracted	Gori	Ossetia	Urban	Private	Female	64	Widow
25	Protracted	Gori	Ossetia	Urban	Private	Male	80	Widow

*CC = Collective Center

d. Samegrelo

No.	IDP Status	Location	Place of Origin	Urban or Rural	Type of Accommodation	Gender	Age	Marital Status
1	Protracted	Vil. Odishi	Abkhazia	Rural	Private	Male	61	Married
3	Protracted	Zugdidi Hospital settlement	Abkhazia	Urban	CC	Female	80	Widow
4	Protracted	Vil. Odishi	Abkhazia	Rural	Private	Female	73	Widow
6	Protracted	Vil. Rukhi	Abkhazia	Rural	CC	Female	94	Widow
8	Protracted	Zugdidi Combinat settlement	Abkhazia	Urban	CC	Female	61	Widow
9	Protracted	Vil. Rukhi	Abkhazia	Rural	CC	Female	74	Widow
11	Protracted	Zugdidi Hospital settlement	Abkhazia	Urban	CC	Male	68	Married
12	Protracted	Vil. Akhalsopheli	Abkhazia	Rural	Private	Female	68	Widow
13	Protracted	Vil. Akhalsopheli	Abkhazia	Rural	Private	Female	69	Widow
14	Protracted	Zugdidi Hospital settlement	Abkhazia	Urban	CC	Male	76	Widow
15	Protracted	Zugdidi Hospital settlement	Abkhazia	Urban	CC	Male	80	Widow
16	Protracted	Zugdidi Combinat settlement	Abkhazia	Urban	CC	Male	71	Widow
17	Protracted	Zugdidi Combinat	Abkhazia	Urban	CC	Female	61	Widow

		settlement						
18	Protracted	Zugdidi Combinat settlement	Abkhazia	Urban	CC	Female	64	Widow
19	Protracted	Zugdidi Combinat settlement	Abkhazia	Urban	CC	Female	73	Married
20	Protracted	Zugdidi Combinat settlement	Abkhazia	Urban	CC	Female	75	Widow
21	Protracted	Zugdidi	Abkhazia	Urban	Private	Female	79	Widow
22	Protracted	Zugdidi	Abkhazia	Urban	Private	Male	69	Married
23	Protracted	Zugdidi	Abkhazia	Urban	Private	Male	60	Married
24	Protracted	Zugdidi	Abkhazia	Urban	Private	Male	67	Married
25	Protracted	Vil. Kakhati	Abkhazia	Rural	Private	Female	78	Widow
26	Protracted	Vil. Kakhati	Abkhazia	Rural	Private	Female	73	Widow
27	Protracted	Vil. Kakhati	Abkhazia	Rural	Private	Male	75	Married
28	Protracted	Vil. Kakhati	Abkhazia	Rural	Private	Male	69	Married
30	Protracted	Vil. Rukhi	Abkhazia	Rural	CC	Female	85	Widow

Table 2. Key Informant Characteristics

a. Female/Male Breakdown

Region	**Female**	**Male**
Tbilisi	12	3
Shida Kartli	7	8
Samegrelo	11	4
Total	*30*	*15*

b. Tbilisi

No.	**Gender**	**Age**	**Profession**	**Position**	**Urban/ Rural**	**IDP Status**	**Wave***
1	F	57	Doctor	Doctor at IDP clinic	Urban	IDP	I
2	F	59	Doctor	Doctor at IDP clinic	Urban	IDP	I
3	F	52	Doctor	Mental health organization doctor	Urban	--	--

4	F	61	Doctor	Unemployed	Urban	IDP	I
5	F	53	Doctor	Medline	Urban	--	--
6	M	26	Lawyer	Republican party representative	Urban	--	--
7	F	59	Psychologist	IDP aid organization representative	Urban	--	--
8	F	51	Psychiatrist	Mental health organization representative	Urban	--	--
9	F	50	Engineer	Local committee member	Urban	IDP	I
10	M	43	Economist, lawyer, expert in conflicts	Local committee head	Urban	IDP	I
11	F	58	Doctor	IDP aid organization representative	Urban	IDP	I
12	F	48	Psychologist	Mental health organization psychologist	Urban	--	--
13	F	63	Psychologist	IDP organization representative	Urban	--	--
14	M	37	Diplomat	Local government representative	Urban	--	--
15	F	56	Physics	IDP organization representative	Urban	IDP	I

*Wave I and II means those displaced in 1991/92 and 2008, respectively.

c. Shida Kartli

No.	**Gender**	**Age**	**Profession**	**Position**	**Urban/ Rural**	**IDP Status**	**Wave***
1	M	56	Topographer	Council member	Urban	IDP	II
2	F	37	Teacher	NGO head	Urban	IDP	II
3	F	35	Philologist	Administrator	Urban	IDP	I
4	F	40	Family doctor	Family doctor	Urban	--	--
5	M	24	Lawyer	Lawyer	Urban	IDP	I
6	F	26	Economist	Office manager	Urban	--	--
7	M	46	Agronomer	Municipality PR manager	Rural	IDP	II
8	M	56	Road specialist	Community head	Rural	IDP	II
9	M	46	Public service specialist	Project coordinator	Urban	--	--

10	F	45	Nurse	Nurse	Urban	IDP	I
11	F	49	Historian	NGO head	Urban	--	--
12	F	43	Economist	NGO head	Urban	--	--
13	M	43	Engineer	Director of an information center	Urban	--	--
14	M	35	Teacher and programmer	NGO head	Urban	IDP	I
15	M	23	Economist, social worker	Social worker	Urban	--	--

*Wave I and II means those displaced in 1991/92 and 2008, respectively.

d. Samegrelo

No.	**Gender**	**Age**	**Profession**	**Position**	**Urban/ Rural**	**IDP Status**	**Wave***
1	Female	44	Lawyer	Community mobilizer	Urban	IDP	I
2	Female	56	Journalist	Public relations worker	Urban	IDP	I
3	Female	64	Doctor	Doctor	Urban	IDP	I
4	Female	49	Nurse	Unemployed	Rural	IDP	I
5	Female	27	Social worker	Social worker	Urban	IDP	I
6	Female	34	Social worker	Social worker	Urban	--	--
7	Male	54	IDP community member	Ex-community head	Urban	IDP	I
8	Male	61	Teacher	Community head	Rural	--	--
9	Female	54	Biologist	NGO head	Urban	--	--
10	Female	56	Economist	NGO head	Urban	IDP	I
11	Male	34	Lawyer	Senior specialist	Urban	IDP	I
12	Male	31	Lawyer	Senior specialist	Urban	IDP	I
13	Female	54	Doctor	Doctor	Rural	--	--
14	Female	35	Psychologist	Psychologist	Urban	IDP	I
15	Female	80	IDP community member	Pensioner	Urban	IDP	I

*Wave I and II means those displaced in 1991/92 and 2008, respectively.

Table 3. Free List Interview Data Collection Form

Georgia PRM Study 2010-11
JHSPH/ IPS
Free List Interview Data Collection Form

Interviewer ID #: _____
Location Type: Urban / Rural
Region: _____ City or Town: _____
IDP Status: Recent (2008 or later) / Long-term (prior to 2008)
Male / Female Age: _____ (years)
Marital Status: Unmarried / Married / Widowed / Separated or Divorced

A. What are the major problems that displaced older adults (60 and over) have?

Problem	Brief Description (1-2 phrases)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

B. What are the major problems displaced older adults have that affect their families?

1. _____	_____
2. _____	_____

3. _____ _____
_____

4. _____ _____
_____

5. _____ _____
_____

6. _____ _____
_____

7. _____ _____
_____

8. _____ _____
_____

9. _____ _____
_____

10. _____ _____
_____

C. What routine tasks do displaced older adults do to take care of themselves?

1. _____ _____
_____

2. _____ _____
_____

3. _____ _____
_____

4. _____ _____
_____

5. _____ _____
_____

6. _____ _____
_____

7. _____ _____
_____

8. _____ _____
_____

9. _____ _____

10. _____ _____

D. What routine tasks do displaced older adults do to take care of their families?

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

6. _____ _____

7. _____ _____

8. _____ _____

9. _____ _____

10. _____ _____

E. What routine tasks do displaced older adults do to participate in the community?

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____
_____

5. _____ _____
_____

6. _____ _____
_____

7. _____ _____
_____

8. _____ _____
_____

9. _____ _____
_____

10. _____ _____
_____

F. Who can you recommend in this community who knows more about these problems?

_____
_____
_____
_____
_____
_____

Table 4. Key Informant Interview Guides

a. Tbilisi

Georgia PRM Study 2010-11
JHSPH/ IPS
Key Informant Interview Guide/ Tbilisi

Interviewer ID #: _____
Location Type: Urban / Rural
Region: _____ Settlement: _____
Male / Female Age: _____ (years)
Profession:_____
Employment/connection with IDPs: _____
Position:_____
Are you an IDP? 1. No 2. Yes, Wave I (prior to 2008) 3.Yes, Wave II (2008 or later)

A. Nervousness
QUESTION: People told us that many older IDPs feel nervous some of the time or often. Can you

tell us more about this?
PROBES:
When does this happen?
When an older person is nervous, what other feelings and thoughts do they have?
What problems are associated with being nervous?
How do older people help themselves when they have this problem of being nervous?
How do other people help them when they have this problem of being nervous?

B. Nothing makes me happy
QUESTION: People told us that some older IDPs feel like nothing makes them happy. Can you tell us more about this?
PROBES:
When does this happen?
When they feel they cannot be happy, what other feelings and thoughts do they have?
What other problems are associated with not being happy?
How do older people help themselves when they have this problem of not being happy?
How do other people help them when they have this problem of not being happy?

C. Feeling abandoned
QUESTION: People told us that many older IDPs feel abandoned. Can you tell us more about this?
PROBES:
When does this happen?
When they quarrel, what other feelings and thoughts do they have?
What other problems are associated with quarreling?
How do older people help themselves when they have quarrel?
How do other people help them when they quarrel?

D. Feeling isolated
QUESTION: People told us that many older IDPs feel isolated. Can you tell us more about this?
PROBES:
When does this happen?
When they feel like they are a burden and cannot help, what other feelings and thoughts do they have?
What other problems are associated with feeling this way?
How do older people help themselves when they feel this way?
How do other people help them when they feel this way?

b. Shida Kartli

Georgia PRM Study 2010-11
JHSPH/ IPS
Key Informant Interview Guide/ Shida Kartli

Interviewer ID #: _____
Location Type: Urban / Rural
Region: _____ Settlement: _____
Male / Female Age: _____ (years)
Profession:_____
Employment/connection with IDPs: _____
Position:_____
Are you an IDP? 1. No 2. Yes, Wave I (prior to 2008) 3.Yes, Wave II (2008 or later)

1. Nervousness
QUESTION: People told us that many older displaced people feel nervous some of the time or often. Can you tell us more about this?

PROBES:
When does this happen?
When an older displaced person is nervous, what other feelings and thoughts do they have?
What problems are associated with being nervous?
How do older displaced people help themselves when they have this problem of being nervous?
How do other people help older displaced people when they have this problem of being nervous?

2. Nothing makes me happy/ Nothing amuses me
QUESTION: People told us that some older displaced people feel like nothing makes them happy or amuses them. Can you tell us more about this?
PROBES:
When does this happen?
When older displaced people feel they cannot be happy, what other feelings and thoughts do they have?
What other problems are associated with not being happy?
How do older displaced people help themselves when they have this problem of not being happy? How do other people help older displaced people when they have this problem of not being happy?

3. Impassivity/ Having nothing to do
QUESTION: Many older displaced persons complained about impassivity/having nothing to do. Can you tell us more about it?
PROBES:
When does this happen?
When older displaced people have nothing to do, what other feelings and thoughts do they have?
What other problems are associated with having nothing to do?
How do older displaced people help themselves when they have this problem of having nothing to do?
How do other people help older displaced people when they have this problem of having nothing to do?

4. Lack of concern
QUESTION: Many older displaced persons complained about the feeling of being abandoned, left without any concern, not cared for. Can you tell us about this affects them?
PROBES:
When does this happen?
When older displaced people feel like they are abandoned, what other feelings and thoughts do they have?
What other problems are associated with feeling this way?
How do older displaced people help themselves when they feel this way?
How do other people help older displaced people when they feel this way?

c. Samegrelo

Georgia PRM Study 2010-11
JHSPH/ IPS
Key Informant Interview Guide/ Samegrelo

Interviewer ID #: _____
Location Type: Urban / Rural
Region: _____ Settlement: _____
Male / Female Age: _____ (years)
Profession:_____
Employment/connection with IDPs: _____
Position:_____
Are you an IDP? 1. No 2. Yes, Wave I (prior to 2008) 3.Yes, Wave II (2008 or later)

A. Nervousness

QUESTION: People told us that many older people feel nervous some of the time or often. Can you tell us more about this?
PROBES:
When does this happen?
When an older person is nervous, what other feelings and thoughts do they have?
What problems are associated with being nervous?
How do older people help themselves when they have this problem of being nervous?
How do other people help them when they have this problem of being nervous?

B. Nothing makes me happy

QUESTION: People told us that some older people feel like nothing makes them happy. Can you tell us more about this?
PROBES:
When does this happen?
When they feel they cannot be happy, what other feelings and thoughts do they have?
What other problems are associated with not being happy?
How do older people help themselves when they have this problem of not being happy?
How do other people help them when they have this problem of not being happy?

C. Quarrel frequently

QUESTION: People told us that some older people quarrel frequently with others – in their family and others, more generally. Can you tell us more about this?
PROBES:
When does this happen?
When they quarrel, what other feelings and thoughts do they have?
What other problems are associated with quarreling?
How do older people help themselves when they have quarrel?
How do other people help them when they quarrel?

D. Burden to family/Cannot help

QUESTION: People told us that some older people feel they are a burden to their families and cannot help them. Can you tell us about how this affects how they feel?
PROBES:
When does this happen?
When they feel like they are a burden and cannot help, what other feelings and thoughts do they have?
What other problems are associated with feeling this way?
How do older people help themselves when they feel this way?

Table 5. Free List Interview, Question 1: Problem Categories Across Study Sites, with Number of Listings for each Problem Category

Tbilisi	**#**	**Shida Kartli**	**#**	**Samegrelo**	**#**
Health problems	27	Health problems	42	Health problems	27
No money for medicine	16	No health insurance	12	Poor living conditions	11
No health insurance	15	No money for medicine	11	Lack of money	9
Indifference of others towards IDPs	13	Small pension	11	Unemployment	9
Small pension	12	Unemployment	8	No money for medicine	8
Lack of money	10	Lack of money	8	Small pension	8
Unemployment	9	Poor living conditions	7	Desire to return to Abkhazia	6
High taxes	6	Indifference of others towards IDPs	5	Affording firewood or electricity for heat	6
Desire to return to Abkhazia	5	Desire to return to Ossetia	5	Indifference of others towards IDPs	5
Not owning living space	5	Family members' illnesses	5	Not enough food	5
Poor living conditions	4	Ineffective medical treatment	4	Expensive medical treatment	5
Worries about children	4	Having nothing	4	Not owning living space	5
Poor sanitation conditions	3	Feeling nervous	4	No health insurance	4
Lack of living space	3	Lack of irrigation water	3	Grieving what was lost/ Having nothing	4
Fear of eviction	2	Grieving what was lost	3	Hardship	3
Grieving what was lost	2	Not having gardens	3	Can't go out	3
Not having any privileges	2	Everything is burnt	2	Family illnesses	3
Being unable to visit family graves	2	Lack of living space	2	Can't do anything	3
Feeling depressed	2	Lack of food	2	Fearing the future	3
Ineffective medical treatment	2	Older people have died	2	Not having plots	2
Feeling hopeless	1	Problems of older age	2	Children are unemployed	2
Lack of communication with others and poor integration process	1	Feeling depressed	2	Having nobody/ Loneliness	2
Lack of respect for seniors	1	Can't leave the house	2	Having some help (positive)	2
Difficulty in registering for pension	1	Can't work	2	No assistance	2
		No firewood	1	No help	2
		Can't help grandchild	1	Ineffective medical treatment	2
		Not owning living space	1	Feeling like a prisoner/ Lack of living space	2
				Feeling tormented	1
				Cow died	1
				Getting a stall in the market	1
				Bad harvest	1
				Problems of older age	1
				Not having documents	1
				Nothing makes me	1

				happy	
				Being on a diet	1

Table 6.1. Free List Interview, Question 1: List of All Physical Health Problems Across Study Sites

Tbilisi	#	**Shida Kartli**	#	**Samegrelo**	#
Barely walk	1	Asthma	1	Arthritis	1
Blood sugar	2	Barely move	1	Asthma	1
Blood pressure	2	Barely walk	1	Blind in one eye	1
Can't go anywhere	1	Blindness	1	Blood pressure	1
Can't go outside without a painkiller	1	Blood pressure problems	2	Can't eat everything	1
Cannot run, if something happens	1	Blood sugar problems	1	Cannot eat all kinds of food	1
Can't stand up for 10 minutes	1	Broken leg	1	Cannot get dentures	1
Cannot walk	1	Cannot move	1	Cannot move	1
Cataracts	1	Can't walk without a walking stick	1	Cannot see	1
Diabetes	3	Cannot recall names and facts	1	Cannot stand up	1
Disabled	1	Cannot recall past/Sclerosis	1	Cannot walk	1
Dull hearing	1	Could not get up	1	Cataract	1
Duodenal surgery	1	Diabetes	3	Could not move for eight months	1
Eye problems	1	Discosis	1	Diabetes	2
Eye surgery	1	Eye surgery	1	Difficulties with walking	1
Frequent urination	1	Eyes are sore	1	Feet ache	3
Gallbladder removed	1	Eyes barely work	1	Feet are sensation-less, like wooden stick	1
Growing pains	1	Feet are sore	1	Fell down and broke bone	1
Hardly walk	1	Frequent urination	1	Headache	3
Heart arrhythmia	1	Heart problems	1	Heart disease	1
Heart attack	1	Hearing problems	1	Heart pain	2
Heart ischemic disease	1	Heart disease	1	Heaviness on side	1
Heart problems	2	Hernia	1	Hernia	1
Hernia	2	High blood pressure	1	High pressure	3
Hernia surgery	1	Intestine inflammation	1	Iron in my foot	1
Limb problems	1	Legs are sore	1	Low blood pressure	1
Many health problems	1	Legs are swollen	1	Medicines caused gastric injury	1
Nerve problems	1	Lowered womb	1	Osteochondrosis	1
Neuroma	1	Pain in fingers	1	Pain everywhere	2
Osteochondrosis	2	Pain in joints	2	Pain in my back	1
Paralysis	2	Paralysis	1	Pain in stomach	1
Problems with bowels	1	Pneumonia	1	Paralysis	1
Problems with salts	1	Problems with head	1	Pressure	1
Prothrombin	2	Prostate pains	1	Problem with hearing	2
Rocks in kidneys	1	Rashes	1	Problems with gall bladder	1
Short breathing	1	Stones	1	Problems with nerves	1
Skin problems	1	Stroke	2	Restricted in movement	1
Sore joints	2	Thyroid problems/ Goiter	1		

Sore kidneys	1	Tired	1		
Spine injury	1	Ulcers on legs	1		
Stones in gallbladder	1	Vertigo	1		
Stroke	1	Weight problems	1		
Sugar levels	1				
Tumor on spine	1				

Table 6.2. Free List Interview, Question 1: Categories of Physical Health Problems Across Study Sites

Tbilisi	#	**Shida Kartli**	#	**Samegrelo**	#
Mobility problems	7	Mobility problems	6	Blood pressure problems	6
Diabetes or blood sugar problems	6	Diabetes or blood sugar problems	4	Mobility problems	6
Digestive, including gallbladder, bowel, and hernia problems	6	Vision problems	4	Digestive, including gallbladder and hernia, problems	5
Heart disease or problems	5	Blood pressure problems	3	Other limb problems	5
Arthritis, sore joints, or osteochondrosis	4	Other limb problems	3	Pain	4
Urinary, including kidney, problems	3	Sore joints or fingers	3	Headache	3
Vision problems or cataracts	3	Digestive, including intestine and hernia, problems	2	Heart disease or problems	3
Blood pressure problems	2	Heart disease or problems	2	Vision problems or cataracts	3
Other limb problems	2	Memory problems	2	Arthritis or osteochondrosis	2
Paralysis	2	Reproductive problems	2	Diabetes	2
Prothrombin problems	2	Respiratory problems	2	Hearing problems	2
Tumor	2	Stroke	2	Cannot get dentures	1
Disabled	1	Discosis	1	Falls	1
Duodenal surgery	1	Hearing problems	1	Heaviness on side	1
Hearing problems	1	Paralysis	1	Nerve problems	1
Many health problems	1	Problems with head	1	Paralysis	1
Nerve problems	1	Skin problems	1	Respiratory problems	1
Problems with salts	1	Stones	1		
Respiratory problems	1	Thyroid problems/ Goiter	1		
Skin problems	1	Tired	1		
Spine problems	1	Ulcers on legs	1		
Stroke	1	Urinary problems	1		
		Vertigo	1		
		Weight problems	1		

Table 7. Free List Interview, Question 1: Mental Health and Psychosocial Problems Across Study Sites

Tbilisi	#
Worries about children *My son is in jail. He has been charged 4 years. He was innocent. I don't know how they got the confession out of him. They tortured him all the night long and he finally signed it.* (4) *I have a son/daughter who is single and I worry about it.* (24) *I feel I'm useless this is the biggest problem. Your children don't need you. You cannot give them anything and I feel as a burden. I lost sleep thinking about it.* (25) *It has been a month since my daughter left the country because of unemployment.* (21)	4
Feeling depressed *This is compact settlement. Nothing belongs to us and my child is depressed because of it. We are in very bad situation. Please, understand me right, but we had very good living conditions in Sukhumi. We lived very well and here we feel bad. My boys are educated, I thought they would manage to do something, but still, we live like this.* (10) *I have disposition to depression and this makes my problem graver.* (9)	2
Feeling hopeless *I have no faith in tomorrow.* (25)	1
Shida Kartli	#
Feeling nervous *I was newspaper editor in Tskhinvali, I had a three story house. I opened a newspaper with other refugees and I was an editor for 15 years, then they shut it down. I suffered a lot for it. Now it is in business again and I want to work. I work and it keeps me alive. I go back there, to Tskhinvali, in my thoughts, I analyze what happened there, why it has happened. These thoughts and fear is the worst thing for me. We have no money problems. But the moral condition is bad. I cannot watch TV anymore. I read newspapers, but lately it is causing nerve problems as well.* (23) *Being nervous causes problems. It started after we left Tamarasheni.* (15) *I suffer from nightmares. I think about the past all the time and I suffer.* (12) *They gave us a piece of land, but I had fears in large field, not a single soul was there. I don't know why no one came to work there. I think no one has energy.* (7)	4
Feeling depressed *We are tired of speaking about how it happened; it is bad for us. How many times do we have to recall those events and how they help us? I don't watch TV anymore. They laugh and have fun in TV programs and I cry all the time.* (3) *I am depressed, sometimes I am even lazy to put on my clothes. Yes I have physical problems, but I don't like Gori as well, I cannot get used to living here. Yes, I do all the house routines and I was very active before, but these few years have been hard for me. If I have to go somewhere I start preparing 2-3 days beforehand.* (24)	2
Samegrelo	#
Hardship *Hardship is everyone's problem.* (8) *It is very hard for us to live in such conditions.* (26) *Everyone around suffers from hardships.* (21)	3

Fearing the future *I am constantly scared. I take assistance in advance. I have already spent assistance on medicines, food. I have no idea how I will live now.* (17) *I'm alive today, maybe not tomorrow, I forget everything.* (20) *I will kill myself as I do not know what to do, no money, nothing.* (3)	3
Having nobody/ Loneliness *My son lives in different place. He prefers to be with his wife and kids; but what can he do? He has no money so he cannot come to see me.* (9) *I have nobody. My husband was killed in the war. Nobody supports me. My son also was killed -it was after the war. I try to avoid the place where he was killed* [he was killed in the same building where the respondent lives]. *That year my relatives were thinking that I would kill myself.* (17)	2
Feeling tormented *We are tormented so much, is this a life? We were managing everything together before.* (15)	1
Nothing makes me happy *My husband was killed; my son was killed. I am strained all the time; nothing makes me happy.* (4)	1

Table 8.1. Free List Interview, Question 1: Categories of Displacement Related Problems Across Study Sites

Tbilisi	#
Indifference of others towards IDPs	13
Desire to return to Abkhazia	5
Not owning living space	5
Lack of living space	3
Fear of eviction	2
Grieving what was lost	2
Not having any privileges	2
Being unable to visit family graves	2
Lack of communication with others and poor integration process	1
Difficulty of registering for pension	1
Shida Kartli	#
Indifference of others towards IDPs	5
Desire to return to Ossetia	5
Having nothing	4
Grieving what was lost	3
Not having gardens	3
Everything is burnt	2
Lack of living space	2
Not owning living space	1
Samegrelo	#
Desire to return to Abkhazia	6
Indifference of others towards IDPs	5
Not owning living space	5
Grieving what was lost/ Having nothing	4
Not having plots	2
No assistance	2
Feeling like a prisoner/ Lack of living space	2
Feeling tormented	1
Not having documents	1

Table 8.2. Free List Interview, Question 1: Displacement Related Problems Across Study Sites

Tbilisi	#
Indifference of others towards IDPs *No one remembers us. We do not exist. No one asks about us. Nobody comes, nobody wants us. They only remember us before the elections.* (1) *The seniors are useless for everybody. They are abandoned. We are about to die anyway and who would need us? The government and other organizations have abandoned us.* (21) *We must get aid from the government. We are also refugees.* (22) *The ministry of healthcare does not work very well. The staff is young and they cannot manage things. One cannot enter the ministry of refugee affairs. Nobody cares and no one answers the phone. I used to work there and even I cannot enter the building.* (24) *How can the government take care of people who had a house in Abkhazia, where one room was the same size as this whole apartment? In the Gali region, everyone was wealthy. I had everything in Abkhazia. I am part of this state and the state government gives me the very least. They are to blame for my entire loss.* (25). *The government does not take care about people above 60.* (25) *We are beyond the poverty line. We are jobless. The seniors must have some aid.* (24) *I am discontent with this government. I do not receive aid and I had never received any. Everything I have, I got from my relatives, and I won the lottery.* (20) *Nobody cares about these people. Many of them committed suicide. One woman burnt herself alive, because she had no place to live. However, there is no result. Nobody cares.* (24) *What else can I say? We are abandoned.* (14) *The government has a bad attitude towards refugees. "These are the Shevardnadze refugees." This attitude is not right. People need cordiality and attention. The government must take care of its people. It is their first responsibility.* (24) *A Tbilisi citizen asked me how can I be a refugee in my own country, but I have been forced to leave my house.* (25) *The refugees are outcasts.* (25)	13
Desire to return to Abkhazia *I used to live in Sukhumi, I want to go back there.* (20) *I want to go back. My spouse cannot live here and goes back and forth. He says he is suffocating here. Our house in Gali was burnt, but we have a village cabin and he goes there. I am here. I go down to the yard, go to my sister, visit my son and nothing else. I get nervous when I watch TV. Who will be able to go back? My children don't even want to. They entered elementary school here. "Mother!"* [The daughter starts to talk, the mother laughs] *"Mother always has plans for the old life style. She says what she will take and how will she decorate the house there."* (13) *I want to go home, to Sukhumi. I don't want to die without being able to see my country.* (4) *The problem is that I live here. If I had another apartment, there would be no problem for me.* (7) *I know I will not live long enough to go back to Abkhazia and I hope that my grandchildren will go. I am very sad that I live in another country.* (19)	5
Not owning living space *I have no house in Abkhazia and no apartment here.* (25) *I rent a house. I have no apartment of my own.* (25) *My daughter lives in compact settlements and this is a problem. I don't have my own roof. I live with my daughter.* (20) *I live in someone else's flat. They let us in for some time. We ask for shelter from the ministry, but we have to stay in line. It's been 3 years.* (11) *They don't give us rights on this apartment, they say we'll have rights only if our children*	5

are registered here too, but they have their own families. (7)	
Lack of living space *Many people live in one room. Everyone has their problems. The children, the husband and wife have no separate rooms.* (20) *My grandchild and I live in a one room apartment. I sleep there, terrible… If they could give me money instead of living space or some more living space… I left a big house behind. Those who live in compact settlements get help. We get nothing. I have so much grief that I don't even think about going back [His/her grandchild passed away 8 years ago].* (22) *Our living space has been registered, but it is hard to live in one room. The child has to do the homework, younger people want to live alone, seniors have their habits and there are lots of problems.* (9)	3
Fear of eviction *Every single day I anticipate that they will throw us out of here. We wait to be moved from here.* (15) *The apartment is not legally mine. I don't get why I can't have legal rights on this. I think they wait for private investors. It is terrible. Today I live here and maybe tomorrow I will not!* (8)	2
Grieving what was lost *We left everything there, we walked 22 kilometers. What could we bring with us? My child didn't come with us. I left everything there - everything I collected during my whole life. Sure, we worry about it. "The relative, a brother-in-law, helped them. The son started a business. They collected money and bought an apartment."* (19) *It was hard to leave our fortune and the graves. One even can get upset for breaking a plate, not to mention the whole fortune.* (24)	2
Not having any privileges *I have no privileges for anything, not for power, not for something else.* (3) *I am disabled and I have no privileges at all. Shouldn't we have aid? I served the government for 50 years.* (14)	2
Being unable to visit family graves *I cannot visit my parents' graves in Abkhazia.* (25) *It was hard to leave the graves.* (24)	2
Lack of communication with others and poor integration process *The integration process is very bad. One can sit in the house for the whole day. One can't contact anybody. One has no job and cannot communicate with others.* (25)	1
Difficulty of registering for pension *In 1992 we could not take our documents from Abkhazia and now I have to go to the court to prove I have 25 years length of service, so they will give me an additional 10 Laris. How can I find people to prove it, or when am I to do this all?* (9)	1
Shida Kartli	#
Indifference of others towards IDPs *There is no aid. No one pays attention to old refugees.* (21) *The house is ruined and refugees do not get the compensation.* (6) *I don't have IDP status. They tell me they will give, but no one had come yet.* (6) *We have no aids anymore, they only gave us some flour.* (11) *They don't give us food. Before they used to give us bread, pasta and it helped.* (8)	5
Desire to return to Ossetia *The house I built, the land I had – I prefer to be there. We have never been from Gori. Even the air there is different.* (12) *I want to go back. Yes, they made repairs here and it's not as bad as it used to be, but the village was better and this place is terrible.* (4) *I would go back to Tskhinvali at this very minute and I was the last one to leave. I miss my youth days, I was a cyclist and now I dream about a bicycle that will hold me, I want to feel that old feeling again.* (24) *Even if the whole Gori was mine I would dream about my land.* (11) *We try to get used to this house, but we remember the old house sometimes. We try to get*	5

used to it, what else is left? I want to go back to where I was born and grew up. We cannot raise greens here. What kind of place is this? (13)	
Having nothing *We have nothing in our house, when a guest comes, we need to ask neighbors for plates.* (20) *I had a cow, I left it there, also ducks and 14 nut trees. They had a garden and left everything there. Could not bring anything with them and nothing was here either.* (6) *We cannot buy clothes and shoes. I have no shoes to go to the city. They tell me that I am old and I don't need them anymore. No, I am a proud woman and I need clothes.* (18) *We have no furniture. We even have no normal beds.* (18)	4
Grieving what was lost *We've managed to get out from there, but we lost everything. My brother and my husband were last to leave. They were captured by Ossetians, then one Ossetian recognized them and let them go.* (1) *We had to leave everything there. I had three houses and now I sit here without a job.* (2) *We were left homeless and we had such a good house.* (14)	3
Not having gardens *The gardens are very near to the border line and we can't go there to work.* (9) *We had to go to the city and those who went to villages live better. They have land. We were told we had to go to the city and we have nothing: no bees, no sheep. They were given cattle, we were told we had no right to have them. We plowed some greens and they root it out. At least we could have our own greens. But they said we shouldn't work on this land.* (11) *It is hard for seniors who lived in villages to stay without land to work on. It's hard for them to live without the land.* (12)	3
Everything is burnt *The house is burnt, the furniture, everything is burnt. We have to start over. The cattle-shed is burnt, everything has turned to ashes.* (9) *My house was burnt during the war. I have no funds to rebuild it. I cannot keep my harvest somewhere.* (16)	2
Lack of living space *We live in very bad conditions. We have lack of living space and it's hard. It is unbearable to live in this space, we need a new apartment.* (18) *Can't you see where we live? It requires nerves to bear. We have no living space. This house is very small. We built up a little kitchen for us.* (2)	2
Not owning living space *It has been 20 years since I have lived in this room and want it to be mine. If it was mine I would make repairs, take care of it, but now I don't know when I will be thrown out and taken elsewhere.* (17)	1
Samegrelo	#
Desire to return to Abkhazia *We have no hope to return home.* (1) *Everyone wants to be back, but nobody tells us when it will happen. Everyone prefers to be at his own house - to have firewood, his own house, a place where he was born and raised. It is hard to live in a new place, to adapt to the new circumstances; that's why our situation is so difficult.* (11) *I wish they could send me back home. I am ready to leave everything that I have here; I do not want anything. I want to be at my home.* (24) *I've been an IDP for 17 years. I would like to return home, everything is burnt, became like a forest, my wife is dead, I have 5 children.* (20) *I want to be in my house, I wasn't living poorly. Now my house is burnt. When I became ill I left the house and have not seen it since.* (16) *We want to be back home.* (23)	6
Indifference of others towards IDPs *I wrote to the Ministy of Refugees and Accommodation, but no one answered.* (18)	5

They helped IDPs from Ossetia, but what is the fault of IDPs from Sukhumi? We have nothing in ownership. It was said that they will start building in 2010, but there are only lies. (22) *Nobody helps us. Some people, who had relatives, got assistance.* (26) *I have applied for a house, I have had a number for three years. They have already built houses for others. I was told that they cannot provide me with a house yet.* (26) *The Government jabs at people. For example one of the refugees committed suicide because of Potskho [settlement]. Is it possible to make fun of this? I have very difficult days. I was captured with my 11 year old daughter during the one month in the woods. I barely escaped and now we are in such conditions.* (26)	
Not owning living space *We don't have any property. The house in which I now live isn't mine. If they throw us out from this building I have nowhere to go. So far we are here and I don't know what will happen, everyone has this problem, we have all kinds of limitations.* (18) *Whose is the building I live in? Is it mine? Will they be taking it away? I don't know anything…* (16) *IDPs do not have their own houses. They live in rented apartments or collective centers.* (21) *I do not have my own corner. I have lived at my relatives' house for a long time and now I have problems with them.* (26) *The neighbor gave me this house as a present, but I cannot get ownership of it. I cannot register it legally and this is very bad.* (27)	5
Grieving what was lost/ Having nothing *The Russian left this bed and we are using it.* (24) *My four houses were burnt, my children have nothing to share with me. I have just 120 lari - nothing else.* (3) *I live at somebody else' s house. I have nothing of my own.* (4) *I have lost everything. Here I have done everything myself.* (25)	4
Not having plots *If we had a plot we would work on it and have some harvest.* (1) *I have no plot on which to have a kitchen garden.* (23)	2
No assistance *Before we have been given something, but now – nothing.* (15) *We are told that we are not eligible for assistance.* (24)	2
Feeling like a prisoner/ Lack of living space *Our life is like that of prisoners; some have adapted, but not everyone, some people are very shy. Others have shops, but this is not enough. We are five persons in this room; there is not enough space for us.* (11) *This is a very tiny room, many people live here.* (23)	2
Feeling tormented *We are tormented so much, is this a life? We were managing everything together before.* (15)	1
Not having documents *Our documents and our children's documents are lost. We have to get all of the documents over again but we cannot do it - everything requires money.* (24)	1

Table 9. Key Informant Interview, Topic: Nervousness, All Sites, Categories of Responses (Excluding Responses with Frequencies of 1)

	Tbilisi	**#**
Perceived Causes	Limited access to health services	7
	Difficulty adapting to new situations	5
	Worrying about everything	5
	War trauma	5
	Feeling discriminated against/ Lack of integration	5

	Poverty	4
	Not having medicines	4
	Worrying about children	4
	Feeling unprotected	3
	Worrying about the future	3
	Desire to return	3
	Fear of eviction	3
	Left their own land	3
	Not having anything	2
	Stress	2
	Health problems	2
	Changing residence	2
	Fear of eviction	2
	Not being able to help family members	2
	Current situation is bad	2
Signs and Symptoms	Depression	4
	Blood pressure	3
	Heart problems	2
Effects and Associated Problems	Drinking	2
	Feeling oppressed	2
	Believing the government does not care about them	2
	Denying the present	2
Coping Behaviors	Help from family members	8
	Helping each other	8
	Doing household chores	4
	Social relationships	3
	Cannot help themselves	2
	Looking after children	2
	Trading in market	2
	Shida Kartli	**#**
Perceived Causes	Having nothing to do, including unemployment and inactivity	7
	Money shortage	6
	Remembering the past and their lost homeland	6
	Stress	5
	Grieving what was lost	5
	Unaffordable health care, including expensive medications	4
	Poor living conditions	4
	Depending on their families	3
	Not being able to visit graves	3
	Worrying about their social state	2
	Worrying about getting refugee *[IDP]* status	2
	Unemployment within younger generation	2
	Desire to return	2
Signs and Symptoms	*No descriptions of signs or symptoms were provided by key informants*	--
Effects and Associated Problems	Health problems	8
	Hopelessness	4
	Difficulties with integration	3
	Do not want to do anything	3
	Nobody cares about them	3
	Feeling helpless	2
Coping Behaviors	Help from family members and neighbors	9
	Working on plots	5
	Talking to each other	5
	Organizations rarely help seniors	2

	Samegrelo	#
Perceived Causes	Cannot afford medical treatment	11
	Lack of money	9
	Thrown out of homes/ Having no home	8
	Poor living conditions	5
	Wish to return/ No hope for return	5
	Being alone/ Fearing loneliness	5
	Suffering from loss	4
	Unemployment	3
	Worrying about graves/ being buried in native land	3
	Worrying about children	3
	Cannot support the family/ children	3
	Health problems	2
	No assistance	2
	Cannot do anything	2
Signs and Symptoms* (Responses all had frequency of 1)	Aggressiveness	1
	Could not breathe	1
	Crying	1
	Depression	1
	High blood pressure	1
	Insomnia	1
	Irritated	1
	Pain in breast area	1
Effects and Associated Problems	Shut themselves out of environment	3
	Hopelessness about returning	2
	Feeling unprotected/ abandoned	2
	Family conflicts	2
Coping Behaviors	Helping each other	9
	Working on a plot	5
	Trading and small business	5
	Sharing food	4
	Talking with others	3
	Providing moral support and calming them down	3
	Taking medicine	2
	Encouragement	2

Table 10. Key Informant Interview, Topic: Nothing makes me happy, All Sites, Categories of Responses

	Tbilisi	#
Perceived Causes	Bad living conditions	2
	Not having money	2
	Integration problems	2
	Evictions	2
	Unemployment	2
Signs and Symptoms*	Feeling nothing	1
	Having no hope	1
	Heart disease and stroke	1
	Stress	1
Effects and Associated Problems	Hopelessness	3
	Feeling abandoned/nobody needs them	3
	Feeling apathetic	2
	Feeling oppressed	2
	Depression	2

Coping Behaviors	Sharing their problems	6
	Family cares for them	6
	They cannot help	2
	Shida Kartli	**#**
Perceived Causes	They have lost everything	5
	Cannot work	4
	Bad living conditions	3
	Situation is constant	3
	Missing the lives they had	3
	Being isolated	3
	Health problems	3
	Feeling abandoned	2
	Going through difficulties	2
	No reason to be happy	2
	Social networks have been torn apart	2
	Poverty	2
	Desire to return	2
Signs and Symptoms	Depression	2
	Pessimism and hopelessness	2
	Crying	2
	Being indifferent	2
Effects and Associated Problems	Difficulty starting over and adapting	4
	Suicide	2
	Worsening health	2
	Depending on others	2
	Hopelessness	2
Coping Behaviors	Talking to each other	11
	Cannot do anything	5
	Socializing	4
	Having relationships with children and grandchildren	4
	Agricultural work	3
	Help from organizations and programs	3
	Watching television	2
	Not giving up	2
	Family helps	2
	Taking care of children	2
	Attending dinners	2
	Financial assistance	2
	No one provides help to seniors	2
	Samegrelo	**#**
Perceived Causes	Having nothing to do	4
	No hope for return	3
	No reason to be happy/Do not allow themselves to be happy	3
	Hopelessness	3
	Not being respected or needed	3
	Health problems/Cannot get medicines	3
	Old age	2
	Only happy about children's successes	2
	Loneliness	2
	Being away from relatives	2
	Recalling old times	2
	Not owning residences	2
Signs and Symptoms	Feeling oppressed	2
	Feeling lonely/ like an outcast	2

	Depression Pain	2 2
Effects and Associated Problems	Having no interest Conflict/ Aggression	2 2
Coping Behaviors	Talking and sharing problems with each other Working Others encourage and console them They cannot help themselves Nobody helps	6 4 3 2 2

Table 11. Key Informant Interview, Topic: Feeling Abandoned, Tbilisi, Categories of Responses

	Tbilisi	**#**
Perceived Causes	Government does not take care of them Families do not support seniors Being relocated Feeling useless Seniors need more attention Lack of social relationships Not able to do anything	4 3 3 3 2 2 2
Signs and Symptoms*	Agitation	1
Effects and Associated Problems	Feeling like a burden Aggression Government does not care for them Being depressed Nobody pays attention to them Being isolated Wishing to be dead/Suicide	3 2 2 2 2 2 2
Coping Behaviors	Relatives help Encouraging each other and themselves Cannot help themselves Nobody helps Communicating with family and neighbors Government does not help	6 5 3 3 2 2

Table 12. Key Informant Interview, Topic: Feeling Isolated, Tbilisi, Categories of Responses

	Tbilisi	**#**
Perceived Causes	They cannot find their place here *[cannot integrate]* Negative attitude of the local population towards IDPs Staying inside all the time Thinking that society does not need them They have this feeling constantly Small social circle Lack of support Attitude of society	5 4 3 3 2 2 2 2
Signs and	Nobody needs you You have no function in life	1 1

Symptoms*	You cannot entertain yourself	1
Effects and Associated Problems	Feeling like an outcast Feeling of not being needed	3 2
Coping Behaviors	Family members help them Communication Nobody helps Being active Government does not help Women do housework Society and organizations do not help	8 5 4 3 3 2 2

Table 13. Key Informant Interview, Topic: Having nothing to do, Shida Kartli, Categories of Responses

	Shida Kartli	**#**
Perceived Causes	There are no jobs Inactivity Being alone They have small living spaces It is their constant condition Not having a plot Lack of communication Lack of integration Understanding there is no place for them	8 6 3 2 2 2 2 2 2
Signs and Symptoms	Insomnia Depression Hopelessness Passivity	4 3 2 2
Effects and Associated Problems	Missing the past They worry Insomnia Feeling abandoned They feel bad Bad thoughts Feeling useless Health worsening Whimpering	5 4 3 3 3 2 2 2 2
Coping Behaviors	Talking to each other Getting involved with programs and initiatives We cannot help them/Nobody helps them Working on a plot Neighbors help each other Sometimes family members help Agricultural activities Socializing Organizations providing health care services Financial assistance/subsidies	5 5 4 4 3 2 2 2 2 2

Table 14. Key Informant Interview, Topic: Lack of concern, Shida Kartli, Categories of Responses

	Shida Kartli	**#**
Perceived Causes	Remembering the past	5
	Nobody needs them	4
	They are not abandoned	3
	Health problems	3
	Living apart from their children	3
	They have nothing	2
	Lack of attention from the government	2
	Tension between young and old	2
	Being inactive	2
	Lack of communication	2
	Family cannot help	2
	Being alone	2
Signs and Symptoms	Being isolated	3
Effects and Associated Problems	Feeling useless	4
	Bad relationships between generations	3
	Feeling like a burden	3
	Wanting to return	2
	Desire for life is gone	2
	Being discontent	2
	Hopelessness	2
	Feeling bad	2
Coping Behaviors	Talking with others/Being listened to	7
	Working/Working on plots	6
	They cannot do anything	3
	There is no help	3
	Taking care of children	3
	Attention from family members	3
	Watching television	2
	Some gave up	2
	Having things to do	2
	Doing house chores	2

Table 15. Key Informant Interview, Topic: Quarreling frequently, Samegrelo, Categories of Responses

	Samegrelo	**#**
Perceived Causes	Poverty	7
	Never heard of fighting in the family	5
	Lack of understanding between young and old	4
	They cannot support their families financially	3
	Stress	2
	Living and social conditions of IDPs	2
	Hunger	2
Signs and Symptoms	Isolation	2
Effects	Feeling that nobody needs them	2

and Associated Problems	Being ignored by others	2
Coping Behaviors	Family members/others calm them down Getting away from family Sitting alone	3 2 2

Table 16. Key Informant Interview, Topic: Burden to family, Samegrelo, Categories of Responses

	Samegrelo	**#**
Perceived Causes	Cannot help their families financially Being ill/disabled Not being able to do anything or to help children	6 4 4
Signs and Symptoms	Depression Anxiety Feeling helpless	2 2 2
Effects and Associated Problems	Lack of attention/poor treatment from relatives Having fights Becoming suicidal	3 2 2
Coping Behaviors	Encouraging each other and themselves Visiting each other and talking Working Getting away Listening to seniors Giving advice Helping them get medications	6 5 4 3 2 2 2

Appendix B: Instrument Validation Materials

1. Instructions for List Creation

****Instructions for GCRT and CHCA Staff****
For the Instrument Validation part of this study, we will need to make a list of people who have symptoms of depression and of people who do not have this problem (preferably those considered to have no mental health problems).

Before people start making lists, please read these directions and make sure everyone is clear about the steps for this process and that they have agreed on how to ask people about depression (see step 2 below).

We will need to interview 25 depressed individuals and 25 non-depressed individuals in each of the two cities. Because some people will end up not being eligible, we would actually like 40 names on each list in each site to make sure we will have enough people to interview. We are grateful for your help in making the lists now.

Submitting the Lists:
Each person making a list should email his/her list to the study team field coordinators.

Steps for making the lists:

Please think carefully about the following signs and symptoms. Then, think about people you know who currently do or do not have many of these signs. It is not necessary that someone has all the symptoms, but simply that they have many of them.

Be sure to keep all of this information confidential and private. You should only share this information with program staff for this project.

Step 1:
Instructions: Make a list of people who you think currently have a depressed mood using the following information about symptoms

Depression can be understood as experiencing at least five of the following symptoms most of the time during the past two weeks:

1) You are depressed, sad, blue, tearful
2) You have lost interest or pleasure in things you previously liked to do.
3) Your appetite is much less or much greater than usual and you have lost or gained weight
4) You have a lot of trouble sleeping or sleep too much
5) You are so agitated, restless, or slowed down that others have begun to notice
6) You are tired and have no energy
7) You feel worthless or excessively guilty about things you have done or not done
8) You have trouble concentrating, thinking clearly, or making decisions
9) You feel you would be better off dead or have thoughts about killing yourself

Put their information the excel spreadsheet

Step 2:
Instructions: Make a similar list of people who you think currently do not have any mental health problems.

Put their information on the excel spreadsheet

Step 3:
Instructions: After you have filled in the name, sex, age, address/contact information and columns A and B, contact the person.

Use the recruitment script to explain that this project is working to create a survey for the community as part of a project to better understand the health needs of older adult IDPs, and we are looking for participants who will help us test this survey. Make sure that the respondents understand that the information they provide now and that they provide throughout the project will be kept confidential and private.

After you ask Question 1 in the recruitment script (whether the person feels he/she currently has depression), mark their answer in the excel spreadsheet. If they think they have depression, write this in Column C, and if they feel they don't have depression, write this in Column D.

Check to see if what your organization thought and what they thought matches up. For example, a "yes" answer in both Column A and Column C would be considered a match, as would a "yes" answer in both Column B and Column D. Write whether there was a match in Column E.

For those who match, read question 2 in the recruitment script and write their answer in Column F.

If there is a no in either Column E or Column F, the respondents will not be included in the validation study.

2. Example List (for Identifying Depression/Non-Depression Cases)

Name of person making the list: Irakli					Write "Yes" or "No" for each of the relevant columns					
No.	Name	M/F	Age (if known)	Address or how to contact	(A) I think this person has the issue	(B) I think this person does not have the issue	(C) The person thinks he/she has the issue	(D) The person feels they do not have the issue	(E) Is there a match?	(F) The person agrees to be contacted for an interview
1	*Ann Smith*	*F*	*65*	*Knows Maya. Her number is 32 32 31*	*Yes*	*No*	*Yes*	*No*	*Yes*	*Yes*
2	*Jeff Taylor*	*M*	*72*	*Works at SAW safe house #1*	*Yes*	*No*	*Yes*	*No*	*Yes*	*Yes*
3	*Sara Shurton*	*F*	*81*	*Lives at SAW safe house #3*	*No*	*Yes*	*No*	*Yes*	*Yes*	*No*
4	*Joe Jackson*	*M*	*62*	*Lives at 26 Kobuleti Road*	*No*	*Yes*	*No*	*Yes*	*Yes*	*Yes*
5	*Abby Lovett*	*F*	*69*	*Knows Maya. Her number is 32 32 33*	*Yes*	*No*	*No*	*Yes*	*No*	*Yes*

3. Description of Instrument Sections Included in Analysis

Scale	Questions Included
Depression	
GDS depression section score	6.1-6.15
All depression symptoms score	6.1-6.15, 6.16-6.22*
Anxiety	
GAI section score	7.1-7.20
All anxiety symptoms score	7.1-7.20, 7.21-7.25*
Health	
EuroQOL5 score	5.1-5.5
Immigrant Barriers to Health score	5.7-5.17
Dignity	9.1-9.18
Trauma	
HTQ Experiences score	8.1-8.15
All trauma experiences score	8.1-8.15, 8.16-8.23*
Function	
ADL Section Score	4.1-4.6
Other function section score	4.7-4.18*
Household Problems	2.9-2.26*
Alcohol	11.1-11.10

*Additional questions based on qualitative

Appendix C: Georgia Older Adult IDP Household Survey

S1. Screening Questions			
[TO BE READ ALOUD] Before we get started with the full interview, I would like to ask you a series of questions. Please answer the questions to the best of your ability			
S1.1. Are you aged 60 or above?	☐ **1 Yes**	☐ **0 No**	**If respondent answers no to either question, then end the interview.**
S1.2. Are you an internally displaced person?	☐ **1 Yes**	☐ **0 No**	
S1.3. In what year were you displaced from your original home? →			
S1.4. What is your area of origin?	[_] 0. Abkhazia [_] 1. South Ossetia [_] 2. Chechnya/Russian Federation [_] 3. Other		

1. Background Information Data			
1.1 Respondent ID number		1. 4 Cluster Number	
1.2 Interviewer's Name		1.5 Urban or Rural	
1.3 Date of Interview			

S2. Mini-Mental State Exam (MMSE)		
[TO BE READ ALOUD] We would now like to ask you a few questions that have been used in many surveys across the world. Many of these questions may seem a bit strange or silly to you, but we would ask that you please respond as best you can. [READ THE TASKS BELOW. SCORE THE RESULT FOR EACH TASK AND ADD THEM TOGETHER AT THE BOTTOM]	Score	Points Possible
What is the (year) (season) (date) (day) (month)?		5
Where are we (country) (region) (town) (building) (floor)?		5
I will name 3 objects; when I am finished, repeat them after me		3
Subtract 7 from 100, and keep subtracting seven from what is left until I tell you to stop **[NOTE: Allow the person to proceed until 5 subtractions have been made. Correct answers are 93, 86, 79, 72, 65]**		5
Please repeat again the three objects that I listed earlier		3
Name a pencil and watch		2
Repeat the following: "No ifs, ands, or buts"		1
Take a paper in your hand, fold it in half, and put it on the floor		3
Read and obey the following: CLOSE YOUR EYES		1
Write a sentence		1
Copy a pair of intersecting pentagons		1
S2.1. Total score		30

[NOTE TO INTERVIEWER: IF THE SCORE IS 23 OR LESS, THEN THANK THE RESPONDENT FOR THEIR TIME AND END THE INTERVIEW.]

2. Household Demographics

[TO BE READ ALOUD] Now I would like to ask some questions about you and your household. We consider a household member as someone who lives with you and shares at least one meal per day. Not all household members may be related by blood. Please do not include short term visitors or renters as household members.

2.1	What is your age? ⟶	
2.2	What is your gender? **[DOES NOT NEED TO BE READ]**	[_] 0. Male [_] 1. Female
2.3	What is your marital status?	[_] 0. Single [_] 1. Married [_] 2. Divorced [_] 3. Widowed
2.4	a. How many people are currently living in your household, yourself included?	
	b. Does your household currently comprise:	[_] 1. A parent of yours: (number_____) [_] 2. A spouse of yours: [_] 3. Any of your children (number_____) [_] 4. Any of your grandchildren (number_____) [_] 5. Other relatives of yours: (number_____) [_] 6. Any non-relatives (number_____)
2.5	What is the highest level of education you have completed?	[_] 0. None [_] 1. Less than Primary [_] 2. Primary school [_] 3. Secondary School [_] 4. Technical school [_] 5. University
2.6	What is your employment status?	[_] 0. Not working and not looking for a job [_] 1. Not working but looking for a job [_] 2. Irregular / daily work [_] 3. Regular or stable work

2.7 Since January 2011, what have been the sources of income for your household?

Income Source	No	Yes
a. Salary/wages/income activities from regular employment	0	1
b. Irregular work	0	1
c. Income from own business or share in business	0	1
d. IDP allowance	0	1
e. Age/veteran/disability pensions/student benefits	0	1
f. Social assistance	0	1
g. Sales of agricultural products you produce	0	1
h. Assistance (do not pay back) from relatives	0	1
i. Other: _____	0	1

2.8	a. How would you assess the current economic situation of your household (those living with you)? (Make one choice)	[_] 1. We barely make ends meet; we don't have enough money even for food [_] 2. We have enough money for food but buying clothes is harder [_] 3. We have enough money for food and clothes but cannot afford more durable purchases (TV, refrigerator, etc.) [_] 4. We can afford durable purchases and holiday but cannot easily afford really expensive things like a car, an apartment/house, etc. [_] 5. We can afford quite expensive purchases/vacations abroad – a car, an apartment/house, and many more.
	b. How would you assess the economic situation of your household immediately prior to	[_] 1. We barely made ends meet; we didn't have enough money even for food [_] 2. We had enough money for food but buying clothes is harder

	displacement in **[YEAR OF DISPLACEMENT]**?	[_] 3. We had enough money for food and clothes but cannot afford more durable purchases (TV, refrigerator, etc.) [_] 4. We could afford durable purchases and holiday but cannot easily afford really expensive things like a car, an apartment/house, etc. [_] 5. We could afford quite expensive purchases/vacations abroad – a car, an apartment/house, and many more.

[TO BE READ ALOUD] I would now like to ask you a few questions about problems your household may face.

	Household Problems	Little or no problem	Somewhat of a problem	Serious Problem
2.9	Small or cramped living space (Q)	**0**	**1**	**2**
2.10	Condition of the house or room (Q)	**0**	**1**	**2**
2.11	Inadequate sanitation facilities, such as a toilet or latrine (Q)	**0**	**1**	**2**
2.12	Access to toilet (Q)	**0**	**1**	**2**
2.13	Access to clean water (Q)	**0**	**1**	**2**
2.14	Heating of household (Q)	**0**	**1**	**2**
2.15	Not having a plot (Q)	**0**	**1**	**2**
2.16	Not having sufficient household items (Q)	**0**	**1**	**2**
2.17	Lack of privacy (Q)	**0**	**1**	**2**
2.18	No ownership of house/room (Q)	**0**	**1**	**2**
2.19	Pension is too small (Q)	**0**	**1**	**2**
2.20	Lack of money for medicines (Q)	**0**	**1**	**2**
2.21	Food scarcity (Q)	**0**	**1**	**2**
2.22	Access to health care (Q)	**0**	**1**	**2**
2.23	Unemployment (Q)	**0**	**1**	**2**
2.24	Access to insurance, IDP allowance, or social assistance (Q)	**0**	**1**	**2**
2.25	Lack of attention from government (Q)	**0**	**1**	**2**

3. Migration History

		Name of Place	Type of Place	Amount of time (in Months)	Codes for Type of Place
3.1	Can you please name the different places you have lived in for more than two months since your displacement?				**1- With host families** **2- Collective center** **3- In a tent or barrack** **4- Rented place (hotel, apartment)** **5- IDP settlement** **6- Other (Please Describe)**

4. Functioning

[TO BE READ ALOUD] Now I would like to ask you some questions about your ability to perform certain tasks. In the last month, have you been able to regularly perform the following activities independently?

	Activity	No	Yes
4.1	Bathing (bath or shower) - Receive either no assistance or assistance in bathing only one part of body. (ADL)	0	1
4.2	Dressing - Get clothes and dresses without any assistance except for tying shoes. (ADL)	0	1

4.3	Toileting - Go to toilet room, uses toilet, arranges clothes, and return without any assistance (may use cane or walker for support and may use bedpan/urinal at night. (ADL)	0	1
4.4	Transferring - Move in and out of bed and chair without assistance (may use cane or walker). (ADL)	0	1
4.5	Continence - Control bowel and bladder completely by self (without occasional "accidents"). (ADL)	0	1
4.6	Feeding - Feed self without assistance (except for help with cutting meat or buttering bread) (ADL)	0	1

[TO BE READ ALOUD] I would like to continue to ask some questions about your ability to perform certain tasks that older adults in Georgia might perform. For each task, please tell us the amount of difficulty you have had over the past month in completing the task (not at all, a little bit, a moderate amount, a lot, or often cannot do), if the task applies.

	Tasks/Activities	**No difficulty at all**	**A little bit of difficulty**	**A moderate amount of difficulty**	**A lot of difficulty**	**Often cannot do at all**	**Not applicable or don't do**
4.7	Gardening or working on a plot (Q)	0	1	2	3	4	9
4.8	Cleaning the house (Q)	0	1	2	3	4	9
4.9	Cooking (Q)	0	1	2	3	4	9
4.10	Doing home repairs or construction for self or neighbors (Q)	0	1	2	3	4	9
4.11	Shopping for food (Q)	0	1	2	3	4	9
4.12	Looking after children, helping with homework, accompanying them (Q)	0	1	2	3	4	9
4.14	Attending weddings, funerals, celebrations, or other community events (Q)	0	1	2	3	4	9
4.15	Taking care of your own health, including going to the doctor and taking medicines (Q)	0	1	2	3	4	9
4.16	Providing moral support and giving advice to others (Q)	0	1	2	3	4	9
4.17	Earning an income (e.g., trading, construction, or other work) (Q)	0	1	2	3	4	9
4.18	Sharing pension or other money with the family (Q)	0	1	2	3	4	9
4.19	Socializing with neighbors or friends (Q)	0	1	2	3	4	9

5. Physical Health	
(EuroQol) [TO BE READ ALOUD] Thank you. The next set of questions will gather more information about you and how you feel about life in general. Out of the group of three statements, pick the one that best describes your health state today [NOTE: Check only one answer for each question]	
5.1	[_] 1. I have no problems in walking about. [_] 2. I have some problems in walking about. [_] 3. I am confined to bed.
5.2	[_] 1. I have no problems with self care. [_] 2. I have some problems washing or dressing myself. [_] 3. I am unable to wash or dress myself.
5.3	[_] 1. I have no problems with performing my usual activities [_] 2. I have some problems with performing my usual activities. [_] 3. I am unable to perform my usual activities.
5.4	[_] 1. I have no pain or discomfort. [_] 2. I have moderate pain or discomfort. [_] 3. I have extreme pain or discomfort.
5.5	[_] 1. I am not anxious or depressed. [_] 2. I am moderately anxious or depressed. [_] 3. I am extremely anxious or depressed.
5.6	To help people say how bad or good their health is, we have drawn a scale (like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0. We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today. **[NOTE TO INTERVIEWER: Show thermometer card and enter the number matching the point they draw in the box below]** ⟶

(Immigrant Barriers to Healthcare Scale) [TO BE READ ALOUD] Next, we would like to discuss your access to health services. Please tell me how often each of these statements applies to your access to health care.

		Not Applicable	Rarely or Never	Sometimes	Most or all of the time
5.7	I have a way to pay for health or medical care or I have access to free care (BHS)	9	0	1	2
5.8	I can reach the doctor or hospital if I had to go suddenly (BHS)	9	0	1	2
5.9	I have money to pay for medicines (BHS)	9	0	1	2
5.10	I have a doctor who understands me and my problems (BHS)	9	0	1	2
5.11	The office staff understands me and my problems	9	0	1	2
5.12	The office hours are inconvenient (BHS)	9	0	1	2
5.13	I have to wait a long time to see a doctor (BHS)	9	0	1	2
5.14	The doctor spends enough time with me (BHS)	9	0	1	2
5.15	It takes too long to get to the clinic or doctor's office for care (BHS)	9	0	1	2
5.16	The office or clinic staff are nice to me (BHS)	9	0	1	2
5.17	I have a doctor I see regularly (BHS)	9	0	1	2

6. Depression (Geriatric Depression Scale)			
[TO BE READ ALOUD] Thank you. The next set of questions will gather more information about you and how you feel about and react to situations in general. I want to remind you that your answers are kept confidential. Choose the best answer for how you have felt over the past week.			
	Question	**No**	**Yes**
6.1	Are you basically satisfied with your life? (GDS)(Q)	**No**	**Yes**
6.2	Have you dropped many of your activities and interests? (GDS)	**No**	**Yes**
6.3	Do you feel that your life is empty, has no meaning? (GDS)(Q)	**No**	**Yes**
6.4	Do you often get bored, nothing amuses you? (GDS)(Q)	**No**	**Yes**
6.5	Are you in good spirits, good mood most of the time? (GDS)(Q)	**No**	**Yes**
6.6	Are you afraid that something bad is going to happen to you? (GDS)(Q)	**No**	**Yes**
6.7	Do you feel happy most of the time? (GDS)(Q)	**No**	**Yes**
6.8	Do you often feel helpless? (GDS)(Q)	**No**	**Yes**
6.9	Do you prefer to stay at home, rather than going out and doing new things? (GDS)(Q)	**No**	**Yes**
6.10	Do you feel you have more problems with memory than most? (Do you feel your memory is worse than others?) (GDS)(Q)	**No**	**Yes**
6.11	Do you think it is wonderful to be alive now? Happy to be alive? (GDS)(Q)	**No**	**Yes**
6.12	Do you feel pretty worthless (useless) the way you are now? (GDS)	**No**	**Yes**
6.13	Do you feel full of energy? (GDS)(Q)	**No**	**Yes**
6.14	Do you feel that your situation is hopeless? (GDS)(Q)	**No**	**Yes**
6.15	Do you think that most people are better off than you are? (GDS)(Q)	**No**	**Yes**
6.16	*Do you enjoy getting up in the morning, getting going?(Q)*	**No**	**Yes**
6.17	*Do you feel isolated by others?(Q)*	**No**	**Yes**
6.18	*Do you feel you are a burden to others?(Q)*	**No**	**Yes**
6.19	*Do you feel like you wish to die?(Q)*	**No**	**Yes**
6.20	*Do you feel apathetic, have no interests in life?(Q)*	**No**	**Yes**
6.21	*Do you feel desperate?(Q)*	**No**	**Yes**
6.22	*Do you feel passive?(Q)*	**No**	**Yes**

7. Anxiety (Geriatric Anxiety Inventory)			
[TO BE READ ALOUD] Thank you. I will now read some statements about yourself, and would ask that you respond as to whether the statement is true—meaning it describes you, or false—meaning that it doesn't describe you. Choose the best answer for how you have felt over the past week.			
	Statement	**False**	**True**
7.1	I worry a lot of the time. (GAI) (Q)	**0**	**1**
7.2	I find it difficult to make a decision. (GAI)	**0**	**1**
7.3	I often feel jumpy, can't stay calm (GAI)(Q)	**0**	**1**

7.4	I find it hard to relax, get rid of tension. (GAI)(Q)	**0**	**1**
7.5	I often cannot enjoy things because of my worries. (GAI)	**0**	**1**
7.6	Little things bother, irritate me a lot. (GAI)(Q)	**0**	**1**
7.7	I often feel like I have butterflies in my stomach. (GAI)	**0**	**1**
7.8	I think of myself as a worrier. (GAI)(Q)	**0**	**1**
7.9	I can't help worrying about even trivial things. (GAI)(Q)	**0**	**1**
7.10	I often feel nervous. (GAI)(Q)	**0**	**1**
7.11	My own thoughts often make me anxious. (GAI)(Q)	**0**	**1**
7.12	I get an upset stomach due to my worrying. (GAI)(Q)	**0**	**1**
7.13	I think of myself as a nervous person. (GAI)(Q)	**0**	**1**
7.14	I always anticipate the worst will happen. (GAI)(Q)	**0**	**1**
7.15	I often feel shaky, trembling inside. (GAI)(Q)	**0**	**1**
7.16	I think that my worries, (anxious thoughts) interfere with my life. (GAI)(Q)	**0**	**1**
7.17	My worries (anxious thoughts) often overwhelm me. (GAI)(Q)	**0**	**1**
7.18	I sometimes feel a great knot in my stomach. (GAI)	**0**	**1**
7.19	I miss out on things because I worry too much. (GAI)(Q)	**0**	**1**
7.20	I often feel upset. (GAI)(Q)	**0**	**1**
7.21	*I lose sleep thinking about things (Q)*	**0**	**1**
7.22	*I am afraid to stay home alone (Q)*	**0**	**1**
7.23	*I don't feel secure (Q)*	**0**	**1**
7.24	*I feel estranged, lack of belonging (Q)*	**0**	**1**
7.25	*I feel irritated (Q)*	**0**	**1**

8. Traumatic Events

[TO BE READ ALOUD] Thank you. Now we would like to ask you questions about your past history. This information will be used to help us better understand your situation. However, you may find some questions upsetting. If so, please feel free not to answer. The answer to these questions and all information you provide in this survey will be kept confidential. Please indicate whether you have ever experienced or witnessed any of the following events in any location during your lifetime.

		Have not personally experienced or witnessed	Have witnessed	Have personally experienced
8.1	Lack of food or water (H)(Q)	**0**	**1**	**2**
8.2	Ill health without access to medical care (H)	**0**	**1**	**2**
8.3	Having no place to live, "homeless" (H)(Q)	**0**	**1**	**2**
8.4	Detention (H)(Q)	**0**	**1**	**2**
8.5	Serious injury (H)(Q)	**0**	**1**	**2**

8.6	Combat situation, war (H)(Q)	**0**	**1**	**2**
8.7	Rape or sexual abuse (H)	**0**	**1**	**2**
8.8	Forced isolation from others (H)	**0**	**1**	**2**
8.9	Being close to death (H)(Q)	**0**	**1**	**2**
8.10	Forced separation from family members or friends (H)(Q)	**0**	**1**	**2**
8.11	Murder of family or friend (H)	**0**	**1**	**2**
8.12	Unnatural death of family or friend (H)	**0**	**1**	**2**
8.13	Murder of stranger or strangers (H)	**0**	**1**	**2**
8.14	Lost or kidnapped (H)	**0**	**1**	**2**
8.15	Torture Specify :_____ (H)	**0**	**1**	**2**
8.16	*Destruction or loss of house, livestock, or other property (Q)*	**0**	**1**	**2**
8.17	*Abandonment by family (Q)*	**0**	**1**	**2**
8.18	*Eviction from home (Q)*	**0**	**1**	**2**
8.19	*Frequent family fights and arguments (Q)*	**0**	**1**	**2**
8.20	*Serious illness of self or family member (Q)*	**0**	**1**	**2**
8.21	*Separation from family graves (Q)*	**0**	**1**	**2**
8.22	*Dangerous escape (Q)*	**0**	**1**	**2**
8.23	*Acts of humiliation during displacement (Q)*	**0**	**1**	**2**

9. Dignity (Armenian Dignity Scale)

[TO BE READ ALOUD] We would like to ask you questions about how you view yourself, others, and your place in the world around you. There is no correct or incorrect answer to each statement, and this information will be used to help us better understand your situation. Please indicate whether you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the following statements about yourself.

	Statement	**Strongly Agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly Disagree**
9.1	I have control over life decisions and choices, such as where to work or when I can leave home (A)	5	4	3	2	1
9.2	I am free to act on my beliefs (A)	5	4	3	2	1
9.3	I feel that others look up to me (A)	5	4	3	2	1
9.4	I make an important contribution to my community (A)	5	4	3	2	1
9.5	Till now, I am pleased with what I have accomplished so far (A)	5	4	3	2	1
9.6	I try to overcome adversity (A)	5	4	3	2	1
9.7	When I am suffering physically people (other than my family) around me usually do	5	4	3	2	1

	not know it (A)					
9.8	When I make a mistake I take responsibility for it (A)	5	4	3	2	1
9.9	When things go wrong around me (loss of job, broken relationship…) I usually do not blame others. (A)	5	4	3	2	1
9.10	Other people treat me with respect (A)	5	4	3	2	1
9.11	I have a high sense of self-respect (A)	5	4	3	2	1
9.12	I have the freedom to exercise my rights as a human being (A)	5	4	3	2	1
9.13	I feel that I am not a burden on my friends/ family members (A)	5	4	3	2	1
9.14	I do not feel I need to depend on other people around me to get things done (A)	5	4	3	2	1
9.15	I treat people the same way I like to be treated by them (A)	5	4	3	2	1
9.16	I respect other people (A)	5	4	3	2	1
9.17	People around me (family, friends, coworkers) appreciate what I do for them (A)	5	4	3	2	1
9.18	People come to me for advice or for counsel when making decisions (A)	5	4	3	2	1

10. Social Ties and Interactions (Experience Corps® Baseline Instrument)

[TO BE READ ALOUD] We now would like to ask you some questions about your relationships with others. For these questions, we would like to know whom do you usually turn to when you need help.

	Question	**Person Number**	**Gender** 0: Female 1: Male	**Relationship with person** 0:Relative 1: Non-relative	**IDP Status** 0: Non-IDP 1: IDP
10.1	a. Please, tell us about the persons you would turn to in case of the need to fix problems in the house or doing household chores?	**1**			
		2			
		3			
		4			
		5			
	b. Please, tell us about the persons you would turn for help with health-related problems	**1**			
		2			
		3			
		4			
		5			
	c. Please, tell us about the persons with whom you would share your problems and concerns?	**1**			
		2			
		3			
		4			
		5			
	d. Please, tell us about the persons you would turn to for help with shopping?	**1**			
		2			
		3			
		4			
		5			

[TO BE READ ALOUD] This next set of questions is concerned with how many people you see or talk to on a regular basis including family, friends, workmates, neighbors, etc. We are interested in living relatives only.					
10.2	a. How many children do you have (i.e., your own or children you raised as your own)? ***(If 0, skip to question 10.3)*** (R)				
	b. How many of these children do you see or talk to on the phone at least once every 2 weeks? (R)				
10.3	a. How many grand and great-grand children do you have? (R)				
	b. How many of your grand and great-grand children do you see or talk to on the phone at least once every 2 weeks? (R)				
10.4	How many other children - who are not related to you - do you talk to regularly (that is, at least once every 2 weeks) (R)				
10.5	a. Are either of your parents living? (R)	[_] 0. Neither ***(skip to question 10.6)***	[_] 1. Mother only	[_] 2. Father only	[_] 3. Both
	b. Which of your parents do you see or talk on the phone at least once every 2 weeks? (R) ***[INTERVIEWER: Please rephrase to ask about only living parent if they identify only mother or father as living in question above].***	[_] 0. Neither	[_] 1. Mother only	[_] 2. Father only	[_] 3. Both
10.6	a. How many other relatives (e.g., sisters, brothers, cousins, aunts, uncles) do you feel close to? ***(If 0, skip to question 10.7)*** (R)				
	b. How many of these relatives do you see or talk to on the phone at least once every 2 weeks? (R)				
10.7	a. How many close friends do you have? (that is people who are not relatives of yours but who you feel at ease with, can talk to about private matters, and can call on for help) ***(If 0, skip to question 10.8)*** (R)				
	b. How many of these friends do you see or talk to at least once every 2 weeks? (R)				
10.8	a. Do you belong to a church or other religious group? (R)	[_] 0. No ***(skip to question 10.9)***	[_] 1. Yes		
	b. How many members of your church or religious group do you talk to at least once every 2 weeks? (This includes at group meetings and services.) (R)				
	c. In addition to church services, do you participate in any other church-related groups? (R)	[_] 0. No	[_] 1. Yes		
10.9	a. Do you attend any training on a regular basis? (R)	[_] 0. No ***(skip to question 10.10)***	[_] 1. Yes		
	b. How many fellow students or teachers do you talk to at least once every 2 weeks? (This includes at class meetings.) (R)				
10.10	a. Are you currently employed for pay either full or part-time? (R)	[_] 0. No ***(skip to question 10.11)***	[_] 1. Yes, self-employed	[_] 1. Yes, employed by others	
	b. How many people do you supervise? (R)				
	c. Other than those you supervise, how many people at work do you talk to at least once every 2 weeks? (R)				
10.11	How many of your neighbors do you visit or talk to at least once every 2 weeks? (R)				

10.12	Other than any church group you mentioned earlier, do you belong to any groups in which you talk to one or more members of the group at least once every 2 weeks? Examples include social clubs, trade unions, commercial groups, professional organizations, groups concerned with community service, etc. (R)	[_] 0. No	[_] 1. Yes
10.13	In general, what do you expect more?	[_] 0. That everything in life will happen more as you like [_] 1. What you want in life is less likely to happen	
10.14	Generally speaking, would you say that most people can be trusted or that you need to be very careful in dealing with most people?	[_] 0. Most people can be trusted [_] 1. Need to be very careful	

11. Alcohol Use (AUDIT)

[TO BE READ ALOUD] Thank you. Finally we will ask you some questions about alcohol use. Choose the best answer that describes your general use. In these questions, a standard drink refers to 10 grams of pure alcohol, or about 1 glass of wine or 1 shot of vodka.

	Question	1	2	3	4	5
11.1	How often do you have a drink containing alcohol?	Never **[SKIP TO END]**	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
11.2	How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	2 or 4	5 or 6	7 to 9	10 or more
11.3	How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
11.4	How often during the past year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
11.5	How often during the last year had you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
11.6	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
11.7	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
11.8	How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
11.9	Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
11.10	Has a friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

For Supervisors Only – To be completed after the Validity Study Interview: Place an X in either the Yes or No column		
	Yes	**No**
Instrument contains no identifiers of interviewee		
Instrument has a Client ID number		
All items are completed		
This is a follow up interview		
Pre-Interview Diagnosis:		
No elevated symptoms		
Depression		
Signature of Supervisor:		

For Data Entry Only – Write in information at time of data entry		
	Initials of data entry person	**Date**
Instrument entered in database		

b. Instructions for Prevalence Study Sampling

At each site, we will attempt to interview both people in collective centers and people in private accommodations. We determined how many of each type to interview at each site based on the Ministry of Refugees and Accommodations' list. However, we will start sampling at collective center locations. The following are instructions on how to do sampling in each cluster so that we can meet study objectives and fulfill our obligations to the study donor.

Steps to take:

1) Using the excel spreadsheet provided, travel to the collective center or settlement listed for the cluster number. If the collective center is closed or impossible to find, travel to the backup collective center from the "Backup Sites" spreadsheet list. **Only use the backup site that is listed under the same cluster number.**

2) Upon arriving at the collective center, the study coordinator will attempt to determine the number of households living inside that center by asking a collective center authority or residents. Divide the total number of households by the number of people that you will need to interview in that center. The number you obtain will be the sampling interval. Communicate that number to the interview team.

3) After entering the collective center, take your first right and walk to the third door. This will be the first household that you contact. Read the recruitment script. If the household contains an older adult, and the older adult is willing to be interviewed, then begin the interview by reading the consent form. If the household does not have an older adult or is unwilling to participate, move to the household immediately following.

4) Once the first household has been identified, the next interviewer will identify the second household to interview by starting at the first household and skipping the amount of households equal to the sampling interval identified in step 2.

5) Collective center interviews will proceed by repeating step 4 until the collective center quota has been filled (see column H of the "Cluster Sites" spreadsheet). If there were not enough older adults in the collective center to fill the quota, travel to the backup collective center to finish the interviews.

6) While the interviewers are working in the collective center, the study coordinator will talk to collective center authorities and residents to ask them where we can find nearby older adult IDPs living in private accommodations to interview.

7) Travel to the households identified in step 6 to complete the interviews. Once you reach a household containing an IDP in private accommodations, and if more names are required to reach the quota (column I), ask the respondent as well if they know of any nearby older adult IDPs.

8) Repeat step 7 until you have filled the quota of IDPs in private accommodations (see column I of the "Cluster Sites" spreadsheet)

Following these instructions and between the interviews in the collective center and those in private accommodations, you should have a total of 30 completed surveys at each cluster location.

Appendix D. Chechen Refugee Case Study Materials

Table 1. Profile of Key Informants

Respondent No	Settlement	Gender	Age	Profession	Position	Rural/Urban	Refugee Status
1	Tbilisi	F	51	MD	Medical Coordinator	Rural	No
		F	59	Engineer	Director		
2	Tbilisi	F	34	Lawyer	Senior Specialist	Urban	No
3	Tbilisi	F	42	Psychologist	President	Urban	No
4	Akhmeta	F	49	Psychologist	Director	Rural	No
5	Akhmeta	F	46	Economist	Exec. Director	Rural	No
6	Akhmeta	F	25	Lawyer	Laywer	Rural	No
7	Akhmeta	F	31	Psychologist	Coordinator	Rural	Yes
8	Akhmeta	M	45	Journaloist	Chairman	Rural	Yes
9	Akhmeta	F	44	Lawyer	Representative	Rural	No
10	Akhmeta	M	68	Historian	Chairman	Rural	No
11	Akhmeta	F	43	Teacher	Social worker	Rural	Yes

2. Chechen Key Informant Questionnaire

Interviewer ID #: _____ Interviewer Name:

Region: Settlement:

Male / Female Age:

Professional Background: Current Profession:

Are you a refugee? 1. No 2. Yes

1. **Can you tell us about the work carried out by this organization?**
   Probes:
   a. What services does this organization provide?
   b. Who are your beneficiaries?
   c. What services do you provide specifically for Chechen refugees?
   d. How long has this organization been working in this region? Where are your offices located? How many staff work here?
   e. Can you tell me about your position here and what kind of work you do?

2. **Can you describe the different problems that elderly Chechen refugees face?**
   Probes:
   a. What kinds of health and mental health problems do they face?
   b. What kinds of social problems do they face?

3. **Others have told us that some older displaced adults feel they are a burden to their families. Can you tell us about this as it concerns elderly Chechen refugees?**
   Probes:
   a. In your opinion, in what kinds of situations would elderly Chechen refugees feel this way?
   b. When they feel this way, what other feelings and thoughts do you think they have?
   c. What other problems are associated with feeling this way?
   d. How serious do you think feeling like a burden is?

4. **Others have told us that some older displaced adults feel abandoned, isolated, and not cared for. Can you tell us about this as it concerns elderly Chechen refugees?**
   Probes:
   a. In your opinion, in what kinds of situations do elderly Chechen refugees feel this way?
   b. When they feel this way, what other feelings and thoughts do you think they have?
   c. What other problems are associated with feeling this way?
   d. How serious do you think feeling abandoned, isolated, and not cared for is?

5. **What kinds of services exist in this region to help elderly Chechen refugees with their problems? What services does your organization provide that help elderly Chechen refugees?**
   a. Who provides those services?
   b. Which services do you feel have been most beneficial?
   c. How is it decided who receives the services and who doesn't?
   d. Are the services still being provided?
   e. How sustainable are these services?

6. **How do elderly Chechen refugees help themselves when they have problems? How do family members and people in their social networks support them?**

7. **What factors influence the decision of the population to stay in Georgia rather than return to homes of origin?**

8. **Conclusion**
   a. Is there anything else you wanted to tell us or talk about?
   b. Do you have contacts of other service providers in the area whom we may interview?

3. Chechen Refugee Qualitative Questionnaire

Interviewer ID #: _____	Interviewer Name:
Region:	Settlement:
Male / Female	Age:

1. **Can you describe the different problems that elderly Chechen refugees face?**
   Probes:
   a. What kinds of health and mental health problems do they face?
   b. What kinds of social problems do they face?

2. **What kinds of services exist in this region to help you with your problems?**
   a. Who provides those services?
   b. Which services do you feel have been most beneficial?
   c. How is it decided who receives the services and who doesn't?
   d. Are the services still being provided?

3. **How do you help yourselves when you have problems? How do family members and people in their social networks support you?**

4. **What factors have influenced your decision to stay in Georgia rather than return to your home of origin?**
    a. How long do you plan on staying in Georgia?
    b. Have you obtained or do you plan on obtaining Georgian citizenship?

5. **Conclusion**
    a. Is there anything else you wanted to tell us or talk about?
    b. Do you have contacts service providers in the area whom we may interview?