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HEALTH OF INTERNAL MIGRANTS LIVING IN BISHKEK SUBURBAN SETTLEMENTS AND THEIR ACCESS TO HEALTH CARE

(survey conducted among internal migrants living in suburban settlements of Bishkek City)

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CONTENT

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ABBREVIATIIONS

DFID	the UK Department for International Development
FGP	Family group practice (PHC health facility with one or more doctors)
FMC	Family medicine center (PHC administrative center in rayon)
KSHRSP	Kyrgyz-Swiss Health Reform Support Project
MOH	Ministry of Health
PHC	Primary health care
PRA	Participatory Rural Appraisal

1. INTRODUCTION

«Биз жайлоодо жашаган элдей элебиз» - "Our life is no different from life on summer pastures. " (opinion of a resident of Ak-Bata settlement)

The problem of internal migration in Kyrgyzstan, which still remains wide-scale, is one of the important problems to be addressed by the state and society. Collected for years and unaddressed on time, the social problems of internal migrants contribute to increasing tensions in society. The March "tulip" revolution in 2005 became corroboration to this fact, when the state turned unable to address effectively the problems of poverty, catastrophic stratification of society, as well as the main social problems that included unaddressed problems of internal migrants. The Government had not paid enough attention to the creation of favorable social conditions to internal migrants. This is evidenced by the fact that there are even no exact data on the number of internal migrants in Bishkek City.

Further increase of internal migration is very likely in the coming years, which may negatively affect the socio-economic situation both in rural and urban areas. Rural areas will continue losing the most active, working age people, while the cities will encounter a mass inflow of workforce, what will result, among other things, in further growth of unemployment, poverty and increased exploitation of the physical infrastructure of cities. Social protection of internal migrants, health care in particular, is one of the key problems to address. In this respect, health of internal migrants raises great interest, since health problems of internal migrants in Kyrgyzstan were not studied before. This study was conducted using focus group discussions – a method to obtain qualitative data directly from population.

1.1 BACKGROUND OF INTERNAL MIGRATION IN KYRGYZSTAN

Large-scale migration in Kyrgyzstan began in the 1990s and was, first of all, a response to social insecurity, unemployment and high poverty level in rural areas. The migration statistics within Kyrgyzstan for the period 1991-1996 tells about network migration from all oblasts, except Chui oblast and Bishkek City, which became the network recipients of internal migrants. Later statistics shows lower migration rates between 1996 and 2000. Overall, since gaining independence to 2001 about one third of country's population has migrated, which is equal to over one million of people (UNDP, 2002).

A tendency to migrate from rural areas to cities, observed in the Kyrgyz Republic, is peculiar to most countries in the world and represents a natural process of people's movement from agricultural areas to urbanized, industrial cities. As a rule, growing cities have demand on labor and such a trend solves this problem at the expense of industry and services. Nevertheless, it often leads to extreme overpopulation of cities (Table 1).

Table 1. Internal migration in 1998

Internal migration in 1998, % of population	
South Korea 11.8	Finland 10.0
Australia 7.9	Norway 6.5
Switzerland 6.1	Japan 4.9
Netherlands 4.0	Hungary 4.0
Czech Republic 1.9	Russia 1.8

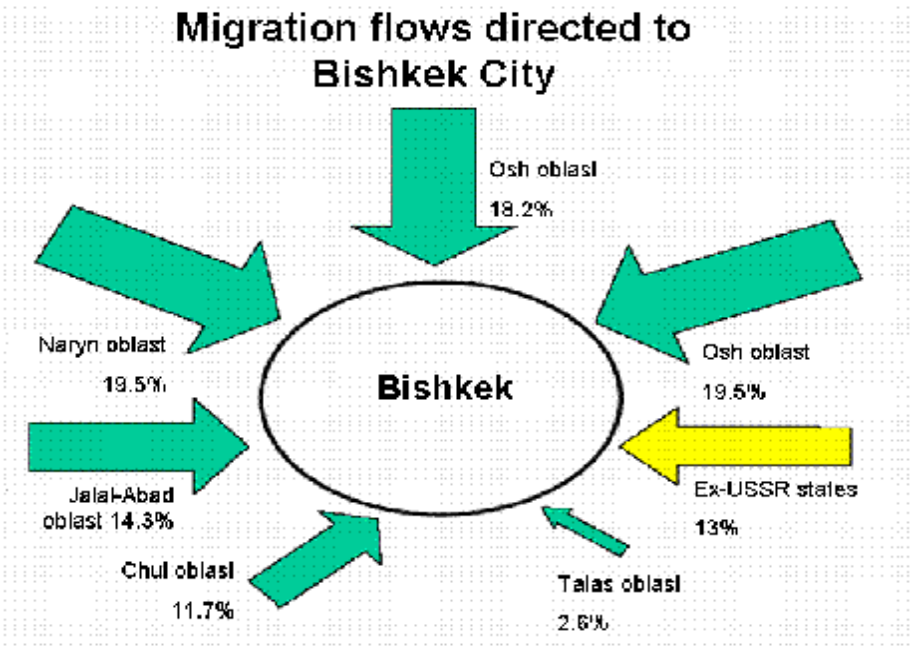
Source: National statistics yearbooks, 2003

However, in the context of Kyrgyzstan, a mountainous country, internal migration, which constitutes about 25% and leads to uncontrollable growth of big cities, puts sustainable development under threat. Another factor that exacerbates the problem is that plain lands make up only 7% of the territory of the republic, the rest is mountains. Internal migration processes in the Kyrgyz Republic have not stabilized yet: multiple housing massifs around cities present a serious problem for stable demographic development of the country, especially in rural areas and small towns.

According to the National Statistical Committee data, over the period 1991-2001 the number of migrants within the republic has constituted 1,143.4 mln people. Of them, within oblast migration (from villages to cities within one oblast) was 470.4 thousands (41%), and interoblast migration (from villages of one oblast to cities of another oblast) was 672.7 thousands (59%). The highest level of interoblast migration is observed in Naryn and Batken oblasts. To the contrary, in Osh and Jalal-Abad oblasts, within oblast migration has the biggest share. All oblasts of the republic are losing population, except for Chui oblast, which is experiencing an inflow of population. Bishkek attracts the biggest number of interoblast migrants: 77% of all incoming persons to the capital originate in rural areas.

In 1999, the International Organization for Migration (IOM) carried out an analysis of the composition of migrants living in Bishkek with the purpose to establish the intensity of migration flows from different regions (Figure 1).

Figure 1 Migration flows directed to Bishkek



Source: International Organization for Migration (IOM) 2002

This figure shows that migrants from the poorest regions of the country prevail in the number of internal migrants. Indeed, poverty, which was growing very rapidly over the last decade, pushed out people to seek earnings and moving to cities. Poverty trend in rural areas is quite easy to describe: it grew until 1998, when it reached its peak. After that, poverty in rural areas was declining in a stable manner. Poverty in cities was changing zigzag-like (Table 2).

Table 2: Poverty and inequity in the Kyrgyz Republic (1996-2001)

	Proportion of the poor, %			Gini coefficient on expenditures		
	Total	**Urban**	**Rural**	**Total**	**Urban**	**Rural**
1996	43.5	30.3	49.6	0.370	0.370	0.350
1997	42.9	22.2	55.3	0.410	0.380	0.360
1998	54.9	42.2	62.4	0.360	0.364	0.341
1999	55.3	42.4	60.0	0.372	0.71	0.362
2000	52.0	43.9	56.4	0.326	0.322	0.323
2001	47.6	41.2	51.0	0.320	0.313	0.351

Source NSC

Poverty level in Bishkek has a smoothly growing trend; it made up 29.9% in 2000 (Table 2). It is suggestive that the growth in poverty level in the city is determined by the population growth in suburban settlements, which makes the biggest share of the poor in the city.

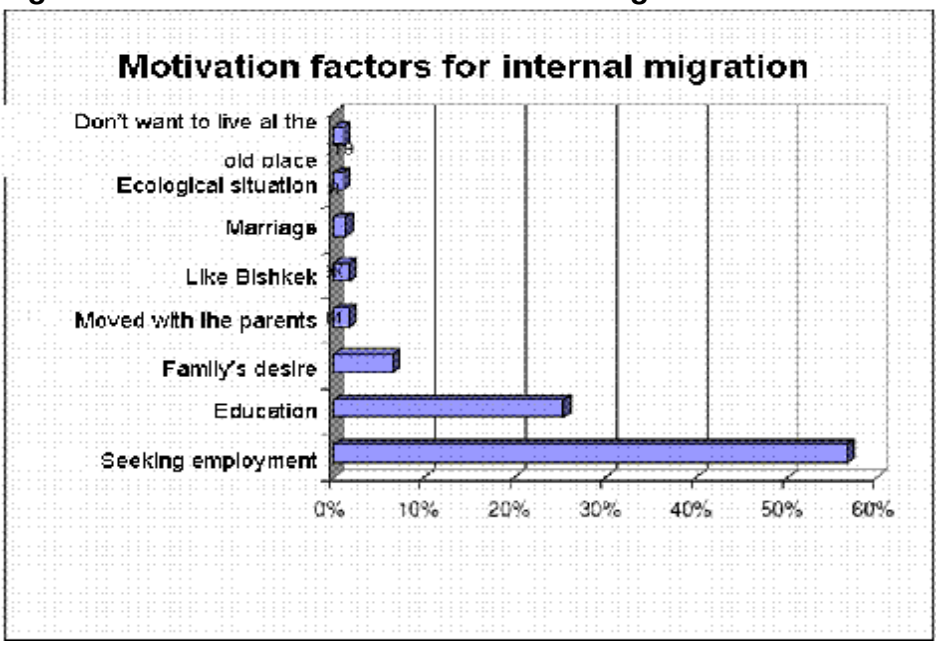
Table 2. Poverty level in Bishkek (%) (1996-2002)

Bishkek	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Poverty level	20.2	...	20.9	27.2	29.9	29.5	28.2
Extreme poverty level	5.4	...	6.5	5.9	5.8	3.1	5.6

Source NSC

Besides, according to the IOM study, the main reasons for internal migration can be grouped as follows: political, social (socio-cultural) and ecological. The survey results show that the main causes of internal migration are economic and socio-cultural. Migrants that moved to Bishkek reported two main reasons for moving:
- Seeking suitable work (57.5%); and
- Education (24%). (Figure 2).

Figure 2 Motivation factors for internal migration



Source: Internal migration in the Kyrgyz Republic. IOM 2001

Despite that most of migrants consider their life in the city to be more successful than in a village, many of them encounter such problems as shortage of financial means even for basic survival, unemployment, insufficient accessibility to health services, education, etc..

1.2. SUBURBAN SETTLEMENTS OF BISHKEK CITY

In spring 1989, as a result of exacerbation of the social tension brought about by a big mass of people who lived in Bishkek for a long time, but had neither housing, nor prospects to obtain one, there took place a self-occupation of lands in different locations around the city. These were mainly the representatives of higher education institutions, academic institutes, and *intelligentsia*. Many of them had not had urban *propiska* (local residence registration) and experienced a lot of various problems. In the summer of the same year, the leadership of the republic and city decided to allocate lands for housing construction. Since then, the building up of so-called housing massifs, or suburban settlements, began. Thus, for the past years, there formed 26 suburban settlements around Bishkek. However, if at the onset houses were built up in these locations by people who had lived in Bishkek for a long time, gradually these settlements became attractive to migrants from rural areas, whose mass inflow began in 1991, when collective and soviet farms were disbanded and a considerable economic recession came about. This process went under the slogans of national-democratic movement and encompassed mainly the most mobile groups of rural youth. The underlying causes of this phenomenon were primarily factors related to difficulties with self-fulfillment in the area of residence. Attempts of the authorities to solve this problem using force proved hardly successful. The exact number of internal migrants settled in Bishkek is not known: some say about 80 thousands of people, others – about 150 thousands, yet others say it is 300 thousands of people. Therefore, the causes of disputes about the number of population in Bishkek are possibly rooted in the fact that

not all migrants permanently living in Bishkek are locally registered, especially in the microregions of builders and dormitories, including student ones. According to the data of the Employment Service of Bishkek, there are only 6,000 people registered in their register in 22 housing massifs of the capital (NSC 1998). It is also known that part of the constructed housing is not documented as complete, and on these grounds inhabitants of such houses do not have local residence registration. Year by year, the load on the city's communal services is increasing, while they are equipped and financed based on the number of permanent (de jure) population of the capital. Unfortunately, as a result of uncontrolled migration, the majority of incoming migrants does not undergo registration.

Over the past 10 years, the territory of the city has grown by 2500 hectares, at the expense of 24 thousands of plots located in the 24 large suburban settlements. Bishkek turned surrounded by suburban settlements, in which over 50% of buildings do not meet the required construction, architectural and seismic norms, even though for the most part all housing massifs do have developed and approved general plans for development. At present, the water coverage in the suburban settlements is 37%, electricity coverage is 56%, and coverage with access ways is 57%, in the words of the chief architect of Bishkek. The building up problems of microregion Ala-Archa, located in the especially dangerous seismic zone affected by the Issyk-Ata break, needs a particular attention. In housing massif Ala-Too, there is construction going on around a so-called "sarcophagus", i.e. burial ground disposal of domestic animals, where animals with anthrax, foot-and-mouth disease, brucellosis and so on are buried. Under the safety norms, it is not allowed to build anything around such burials closer than 500 meters. Nonetheless, the land usurpers are far from observing these safety norms, and this "sarcophagus" is already surrounded by a big number of private houses, whose inhabitants expose their health to risk.

1.3. RESEARCH ASSUMPTIONS AND MATERIAL

As already mentioned above, the main part of internal migrants is represented by people of young and middle age. Consequently, health issues for many of them were of lower priority. However, every citizen is inevitably confronted with the health care system to this or that extent at different stages of her/his life. Any move to a new place, moreover undeveloped and unlived in, is an ordeal for person that may affect her/his health. This fact has become the main cause for carrying out this research. We were interested in the following research questions:

- Is there a relationship between migration and migrants' health? (Are migrants really vulnerable in terms of health risks?)
- If yes, then why?
- What can we do?

Three suburban settlements were chosen for the study:

1. Archa-Beshik settlement – as one of the very first suburban settlements that was set up in 1992. It is situated in the south-western part of Bishkek and territorially refers to Lenin rayon. There are 5,598 homesteads. The population of the housing massif is

23,500 people, of whom only 12,000 people have local residence registration in this rayon. There is a functioning secondary school and public baths in the settlement. Tap water has been accessible for the past four years. During the last few years, the population was served by an FGP located on the territory of the settlement. We evaluated this settlement as the more well-off in terms of infrastructure development.

2. Dordoi settlement – as a settlement with more or less developed infrastructure. It was set up in 2000 and located to the north-east of Bishkek. Territorially it belongs to Sverdlovski rayon. There are 1,021 homesteads. The population according to local residence registration is 3,200 people. However, proximity to "Dordoi" market (one of the biggest wholesale markets in Central Asia) brings about a large number of lodgers, for whom no registration is made. Water supply system was installed in 2004. There is no school, no other public facilities. In June 2005, a new FGP was opened.

3. Ak-Bata settlement – as the "youngest" and poorest settlement with virtually complete absence of infrastructure and minimal living conditions. It was set up in 2003, located also to the north-east of Bishkek, close to Dordoi settlement. There are 900 homesteads. The population is 2,500 people. There is no water supply system. Residents take water from unprotected wells located in two points at different ends of the settlement. Only about 40% of houses have electricity. There are no public facilities at all. Access to public transport is only available in the nearby settlements Dordoi and Kelechek. Residents are enrolled to the FGP located in the settlements Kelechek and Enesai.

1.4 STUDY OBJECTIVES

The researchers had the following study objectives:

- To identify health problems of suburban settlements population;
- To pin down the causes of identified problems and factors contributing to emergence of health problems;
- To explore accessibility of health services in suburban settlements of Bishkek;
- To develop recommendations that will help solve the identified problems.

2. PRESENT STUDY

2.1 METHODS

The method of this study was based on the technique of obtaining qualitative data through discussions in focus groups (Annex 5.1 "Manual on conducting discussions in focus group"). Qualitative research must provide in-depth understanding of the quint-essence of phenomena. It must answer not only the question "how", but mostly the question "why".

The focus group methodology is about learning the viewpoints, opinions of people and their specific experiences through a group discussion led by a moderator on the basis of a pre-structured manual-questionnaire in accordance with the objectives of this study. One focus group consists of 6-10 people selected according to pre-set criteria. The duration of a group discussion is usually 1.5 -2 hours.

Overall, in the three suburban settlements discussions were held in 24 focus groups using the pre-tested manual for conducting discussions.
The main questions were the following:

- What health problems, in your opinion, are most common in your housing massif?

Based on the answers to this question, a list of most common health problems and diseases in this settlement was developed. As a rule, the list included 20 and more items. After that, it was necessary to determine 6-8 most common problems from the list. This was done via ranking the list using a scale from 1 to 10, where 1 is the rarest problem, and 10 is the most frequent health-related problem, respectively.

- What health problems, in your opinion, have the biggest impact on your life?

Problems were assessed based on the biggest impact on health and daily life. This was also done using a scale from 1 to 10, where 1 is a problem with the least impact on health, and 10 is a problem with the biggest impact on human life, respectively. This indicator reflected the “burden” of this or that problem.

- Which factors as causes of diseases could you name?

Answers to this question allowed us to make a list of possible factors and causes of these health problems. These causes were divided into such blocks as (1) economic causes and poverty, (2) environmental factors and living conditions, (3) socio-psychological, and (4) lifestyle factor.

- Please, tell us your opinion about health services provided in your housing massif, and what services people seek when they are ill.

The third question allowed us to identify problems with people’s access to health care in the settlements, as well as the strengths and weaknesses of outpatient and inpatient care services. More specifically, the purpose of this question was to depict a scheme of people’s health care seeking behavior and to understand which health facilities are most important to them.

We also wanted to learn what main barriers to access there were in their housing massif.

2.2. STUDY PHASES

n Development of research instrument

A manual for population (manual-questionnaire for conducting discussions in focus groups) was developed. (see Annex 5.1)

n Pre-testing of the instrument

After development of the instrument, a roundtable was organized for representatives fo the Ministry of Health, MHIF and regional NGOs. Notes, proposals and comments were taken into account. After that, the instrument was piloted on the project team, as well as on the workers who were performing repair works in the building of the project.

n Discussions in focus groups

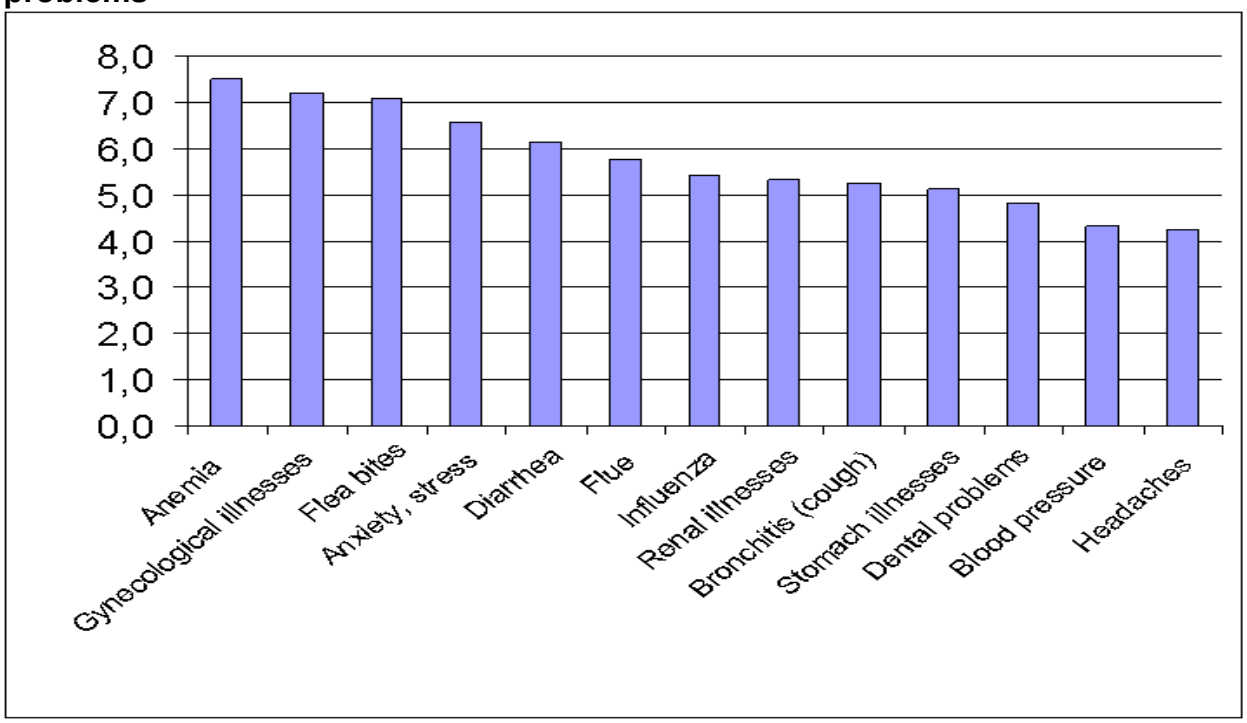
In order to obtain qualitative data, 24 focus groups were formed – eight in each settlement. Every group consisted of 8 to 10 people. In Archa-Beshik settlement, groups were formed by sex and age (men and women, adolescent boys and girls); by income level (low-income and middle-income residents); as well as quarter officers, representatives of NGO and FGP doctors. In Dordoi and Ak-Bata settlements, given virtually no better-off residents, there were formed additional groups of men and women, and groups of pregnant women and mothers with small children were added. Overall, 214 people took part in the study. The quarter officers and NGO representatives helped form the groups and divide them by income level.

3. RESULTS

3.1 HEALTH PROBLEMS OF SUBURBAN SETLLEMENTS POPULATION

The first priority objective of the study was to learn residents' opinions about the existing health problems in suburban settlements. Summarizing all problems named by the residents of the settlements, a list of 49 health problems could be made. Then, respondents were asked to rank these problems using a 10-point scale, where 1 meant the least common problem and 10 meant the most common problem. In a similar manner they ranked the importance of these health problems for a complete, full-fledged life. What was meant were the impact on the quality of life, damage to health, severity of treatment, possibility of cure, burden for both the individual and surrounding people, etc.. Respondents reported both significant and less significant health problems. As a result, their opinions depicted the following.

Figure 1. Opinions of suburban settlements people about most common health problems



It is clear from the figure that the leading health problem is anemia. This fact reflects the situation in the country in general. Interpretation of this disease in residents of the suburban settlements posed no difficulties. It turned out that people are well aware of this problem.

"Anemia stems from low hemoglobin level, malnutrition (deficiency of meat, vitamins, vegetables, fruits and iron in ration) – it causes vertigo and glimpses in the eyes".

It should be noted that the groups of women, quarter officers and low-income residents gave the biggest number of points.
Gynecological illnesses were the second most reported problem. Women's problems were reported by both women and men.
Flea bites were the third most common problem. It was especially reported by the respondents surveyed in summertime.

"All population suffers from fleas and cannot find a drug to cure or means to get rid of them. Fleas in the settlement are everywhere".

The fourth most common problem is anxiety and stress. "*Bash ooruu*" in Kyrgyz means "headache". However, one should not interpret it literally. Residents of the suburban settlements really meant a general anxiety and worries caused by conditions and standard of living, concerns about the future of family, children, etc.. If to translate the true meaning of the term "headache", then one would end up with the notion of anxiety and stress.

"There are very many illnesses related to anxiety, because there is no work to make our living and feed the family. We are always short of money for normal life, permanently seeking for any job and thinking about how to earn money for bread – all these are the source of all our headaches…»

The next in the list are "seasonal problem", such as diarrhea, flue, influenza and related to these frequent renal complications and bronchitis. People are quite aware of and understand the difference between a flue and influenza.
In regard to dental problems, for the most part people meant widespread caries, and much more rarely other dental illnesses.

"There is not a single person who would not suffer from problems with teeth".

Other problems reported in separate groups are also worth mentioning.

For instance, pain in the back (hereby, people made a clear distinction between the pain related to the load on the spine and pain related to renal diseases) or allergy, which was reported in the group of women, girls and quarter officers.

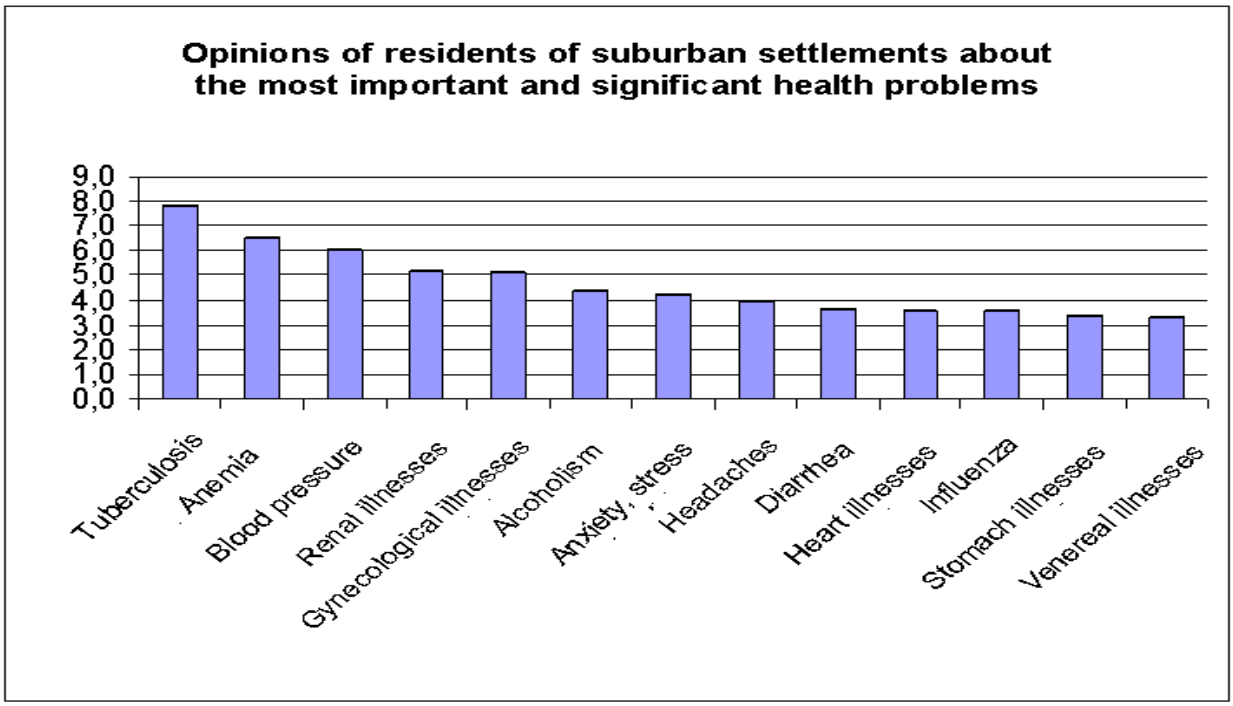
Depression and neurosis were reported by women and people with low income. In a detailed survey, respondents mentioned these problems as a consequence of protracted stress, particularly with stress accompanied by a sharp feeling of uncertainty in tomorrow and often by a feeling of despair.

Tuberculosis was mentioned in almost all groups, but its prevalence, to their mind, was low. Nevertheless, in recent years the number of people affected by tuberculosis is increasing, they said. Parasitic diseases are frequent, helminthiasis in particular. Liver

diseases, diarrhea and hemorrhoids were reported with equal frequency. Venereal and skin diseases were also mentioned.

The next step was to find out to what extent this or that disease impacts all aspects of life of an individual and surrounding people.

Figure 2. Opinions of suburban settlements people by importance and significance of health problems



As shown on the figure, the undisputed leading cause by the extent of impacting human life is tuberculosis. People's opinions about it in all groups were the same. The next problem by significance is anemia. The following fact draws attention: people rank almost the same by both frequency and impact on life.

Blood pressure and renal and gynecological diseases, in respondents' opinion, also have a significant impact on all aspects of life, especially in financial respect due to the expensiveness of drugs. As expected, gynecological diseases are more significant for women and girls. Alcoholism is ranked highest in the groups of women and boys.

"Alcoholism has a negative impact on life, because if someone in the family suffers from it, the whole family suffers (especially in terms of psychological climate), people often lose jobs as a result. All of these lead to depression, suicide, homicide of relatives, etc.."

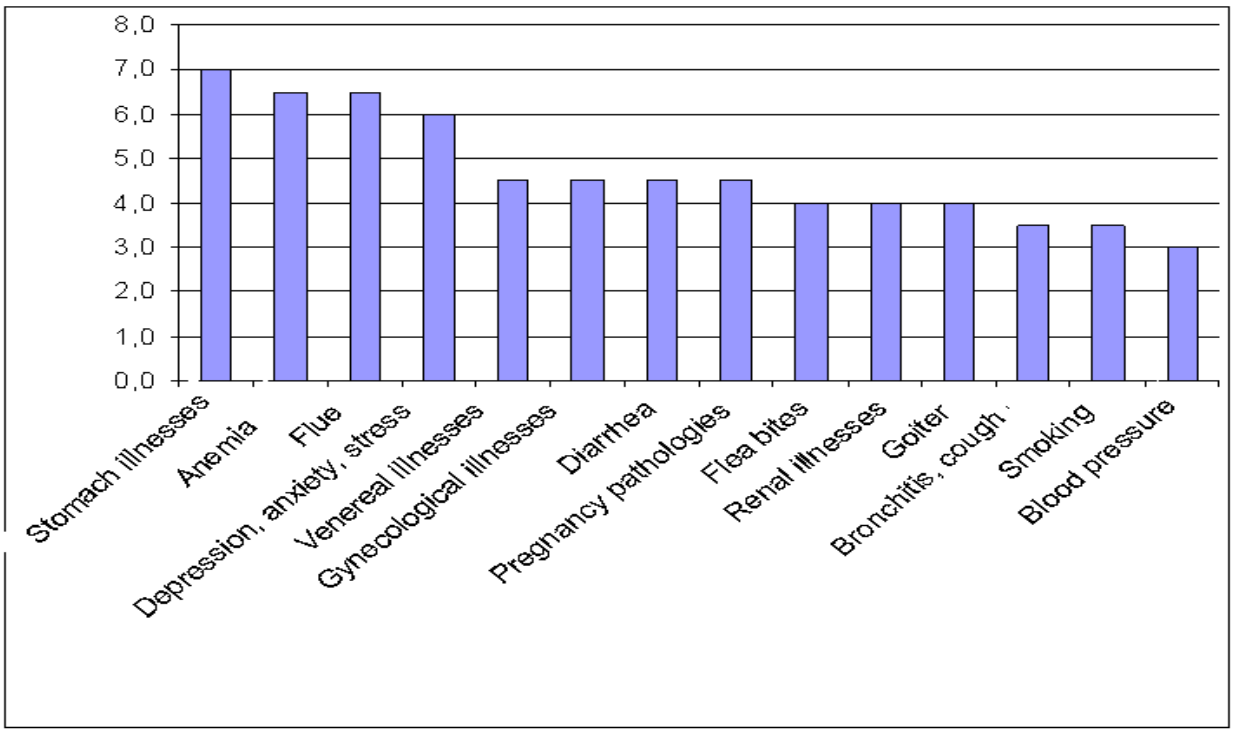
Following alcoholism, anxiety and stress are important, as they reduce the quality of life and may lead to depression. Heart illnesses are ranked as equally important with diarrhea, influenza and stomach illnesses, although in all groups the biggest importance of myocardial infarction was highlighted by men. Heart diseases were also significant in the low-income group.
Separate health problems mentioned in different groups seem interesting. For example, women and girls highlighted the most negative impact of venereal diseases on human life.

"Venereal diseases are dangerous because they cause disability, transmit to children and some of their types (AIDS) may lead to death".

At the same time, men in only a few groups mentioned this problem. Toxicomania (snuffing glues) was mentioned in the group of boys who ranked it highest along with alcoholism. In the group of women, the highest rank was given to depression and neuroses. Cancer was mentioned in only two groups (girls and FGP doctors) that ranked it highest.

Opinions of FGP health workers presented a somewhat different picture.

Figure 3. Opinions of FGP about the most common health problems



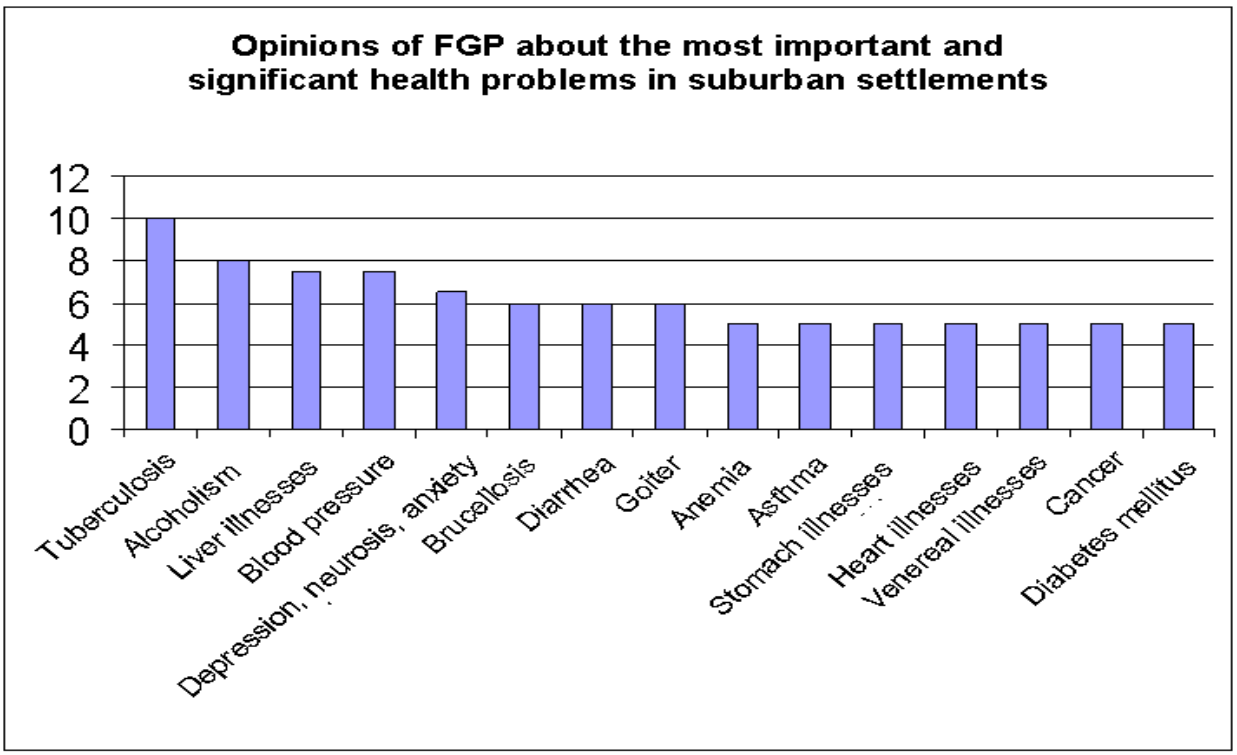
According to this figure, the most common problems are stomach diseases. Anemia goes second by frequency along with flue, in doctors' opinion.
Depression, anxiety and stress are also one of the most frequent problems in a suburban settlement. Doctors ranked venereal and gynecological illnesses as similar in the list of health problems, as well as pregnancy pathologies and diarrhea. Doctors attribute high prevalence of venereal illnesses to lodgers. They also noted that most patients undertake self-treatment or have no treatment at all. Goiter represents an interesting fact as it is mentioned only by doctors, who rank it high. Bronchitis, smoking and blood pressure are the next in their list, which is also different from the opinions of residents.

Opinions of FGP doctors about the most important and significant health problems also differed somewhat from the opinions of the residents, although tuberculosis is ranked by them highest, just as by residents. Then follow alcoholism, and, possibly related to it, liver diseases. Blood pressure, depression and neuroses are next in the list. Such diseases as cancer and diabetes mellitus were reported only in the group of FGP doctors, therefore if counted in only two groups these would be ranked highest.

The comparison of the findings of this study with the study implemented by the Kyrgyz-Swiss Health Reform Support Project in two oblasts of the republic – Naryn and Talas oblasts. Over 27,000 households (80%) in all rayons of these oblasts were included in

the analysis. Anemia, hypertension, brucellosis, influenza, women's diseases, alcoholism and dental illnesses were identified as priorities. Overall, the priority problems coincided with those found in suburban settlements of Bishkek. However, the problem of anxiety and stress reported by the majority of residents in the suburban settlements was not mentioned by rural areas. Perhaps, this suggests that there are a number of problems related to adaptation process in the new setting and setting up at the new location.

Figure 4.



No less interesting is the comparison of statistical data on the morbidity structure in Bishkek and, in particular, on FMC serving the suburban settlements under study.

Thus, in Bishkek, as well as on the territory of the suburban settlements served by the FMC № 12 and № 14, morbidity indicators in accordance with the answers of respondents ranked as follows:

- breathing organs diseases (including bronchitis and cough)
- circulation organs diseases (including blood pressure and heart diseases)
- urogenital system diseases (including gynecological and renal diseases)
- digestive system diseases (including stomach and liver diseases)
- blood diseases (including anemia).

One may conclude that overall the data obtained from the residents of the suburban settlements as a result of the qualitative study on health problems corresponds to the statistical data for Bishkek city. The difference between the data is in priority diseases. Assuming that a lot of people with anemia simply do not refer for medical care, the true morbidity doe not correspond to the official data. On the other hand, diseases of the breathing and circulation organs, as well as diseases of the urogenital system and digestive system are a more serious reason to visit a doctor. It is also possible that certain role in this dissonance is played by the fact that the majority of residents in

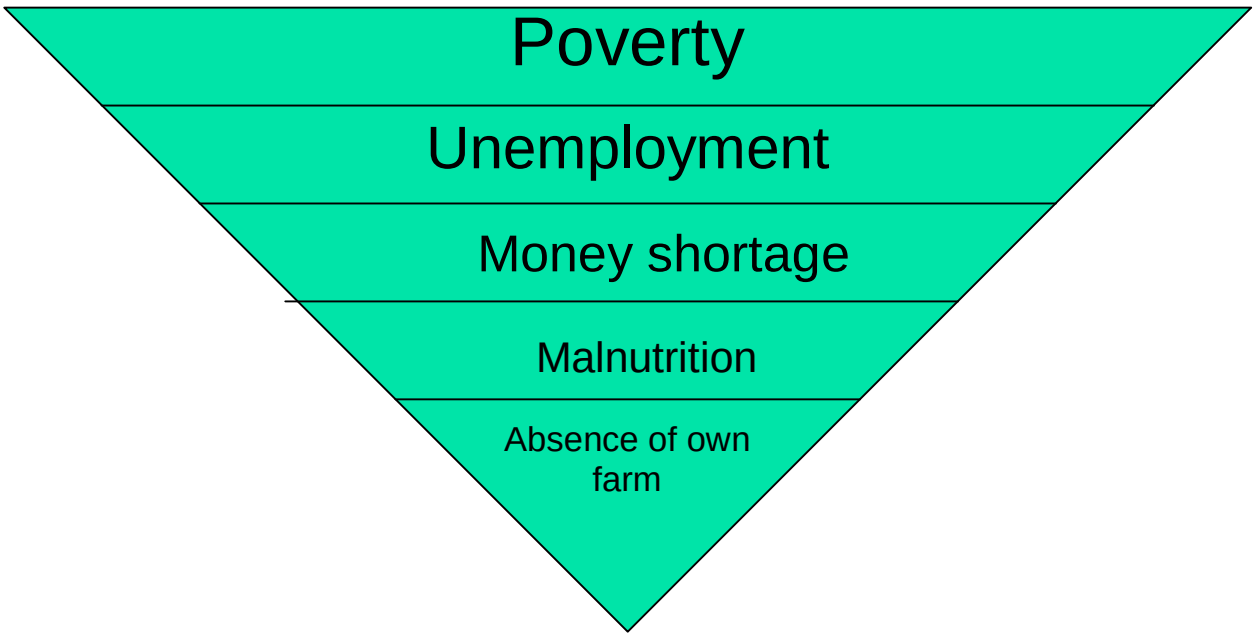
suburban settlements encounter financial barriers in accessing medical services, which we are discussing further on.

3.2 CAUSES OF IDENTIFIED PROBLEMS

The residents were asked a question about he primary causes of health problems.
Multiple various causes were obtained as a result, which we grouped into separate blocks (socio-economic and environmental factors, life conditions, psychological problems and lifestyle).

The following figures schematically show on the reversed pyramid the most important, in people's opinion, causes of identified health problems, by priority – from the most important down to the least important.

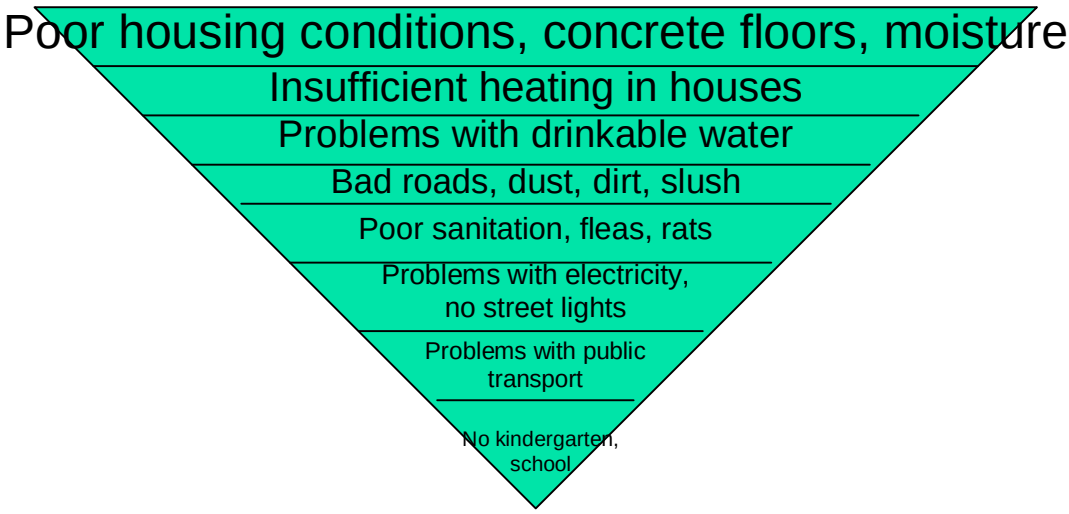
1. Socio-economic conditions



The base of the pyramid presents the most frequently reported cause of health problems. Then follow other causes descending to the top of the pyramid. The most important causes of health problems are poverty and unemployment, with the resulting consequences, such as shortage of money, malnutrition and inability to have own farm.

The cause of many problems, not only health ones, is poverty. If you have no work, all your time is occupied by thinking about how to survive. Those who eat sausage and cheese do not live here. I am ready to perform any kind of work, but there is no work whatsoever. At times you ask yourself why live at all, why have children? (man, 32 years old, Dordoi)

2. Environmental factors and life conditions



Virtually all respondents mentioned poor living conditions. Even in the best developed suburban settlement Archa-Beshik the share of fully developed houses does not exceed 20-30%. Over 80% of respondents were unanimous in reporting concrete floors and moisture in houses. The problem with drinking water is most acute in Ak-Bata settlement, where people take water from one source. Herewith, the most far away house is three kilometers away from the well. The well itself is not protected from pollution. There were some comments that

there had been cases when people had to take out sewage, dead bodies of animals, etc. – all followed by mass poisonings.

In all three suburban settlements, there are no asphalt roads. Roads are one of the biggest discomforts.

"Roads are dusty in summer, dirty and mired in autumn and winter." (woman, 40 years old, Archa-Beshik)

Because of the dirt, some residents put on plastic bags which they take off before entering the house or public transport. Children walk barefoot in the dirt, wash their feet before entering school and only then put on their footwear.

Children walk barefoot under rain, then walk up to the road and wash their feet in a ditch, put their footwear on and take a minibus (adolescent, Dordoi).

The sanitation problem is the most acute in Dordoi settlement. It is explained by closeness of the largest in the country clothes market. Garbage stays practically indisposed and gives home to rats to fleas. There were cases when rats attacked kids. Such facts are also testified by the DSSES data on 94 cases of rat bites. The problem with fleas is very widely spread, in all of the settlements. People are trying to address it on their own, but usually their efforts yield no positive results. Here a problem in Archa-Beshik settlement must be noted. The problem is related to proximity of the south-western municipal cemetery. The settlement is right near to it and there is high risk that subsoil waters from the graveyard area will penetrate into the sources of drinkable water.

The problems with electricity, namely frequent power interruptions, especially in wintertime, were reported by the residents of all three settlements. They were also concerned by the absence of street-lights. In their words, this is taken advantage of by the criminal elements to plunder passers-by and steal property.

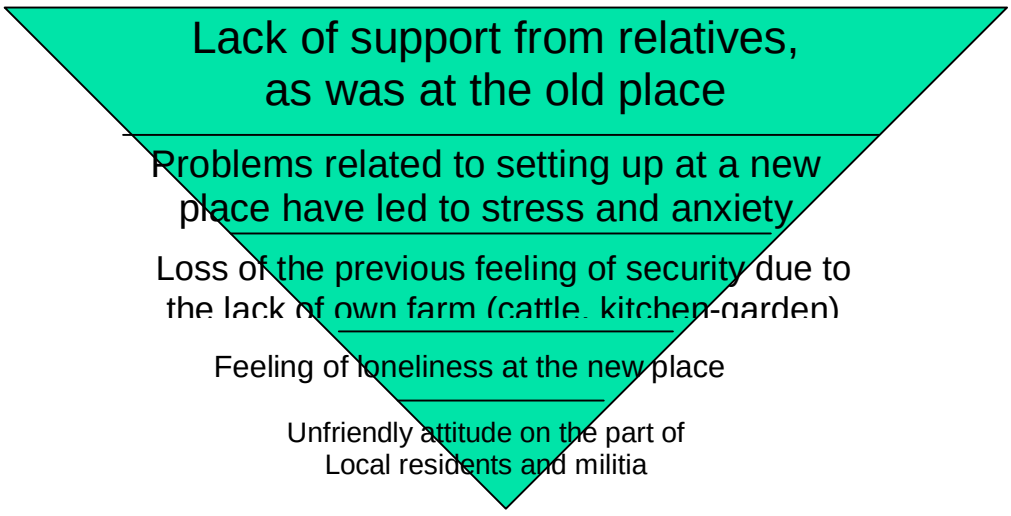
The problem with public transport was most important to residents of Ak-Bata settlement. They have to walk to a neighboring settlement Dordoi or Enesai to get to the city.

As said above, there are no schools in Dordoi and Ak-Bata settlements. In regard to kindergartens, no kindergarten is found even in the developed Arch-Beshik. Taking into account young age of the majority of families, construction of kindergartens in the settlements would be a great help and contribution to the residents. As many women mentioned, they would be able to earn money if they had a chance to leave their small children with good care.

Absence of schools in Dordoi and Ak-Bata settlements is also an indirect cause of health problems, in people's opinion, especially in the future.

In schools children are taught the basics of health lifestyle. But our children do not go to school, because we do not have money. And they have to help making a living. But I want them to study. (man, 38 years old, Ak-Bata)

3. Psychological factors



As shown on the figure, absence of support from relatives, as it used to be at the old place, became the main psychological factor affecting health. Many respondents mentioned that. Support from relatives was expressed in all relations, but primarily during holidays and mournful events, such as family celebrations and funerals. People shared facts when they had felt uneasy to refer for help to their neighbors or ask them something, as they were not acquainted.

The reason for anxiety and stress, in the opinion of many residents of suburban settlements, was in the problems related to setting up at the new place. Hereby, all respondents reported the primary euphoria on the event of purchasing their own piece of land in the city. It was regarded as a big achievement. At some point, they felt as if they became urban citizens. But soon other feelings came that were connected with the problems of setting up at the new place. In the context of general aggravation of the economic situation, the new settlers found it difficult to find resources to purchase construction materials. Under the city plan, new houses in the suburban settlements had to be constructed in accordance with the architectural plan, but in reality only a small percentage of houses (from 5% to 15%) were constructed in accordance with it. As a result, many owners of these houses were refused in issuance of house books, as the *Bishkekglavarhitektura* (Bishkek Chief Department on Architecture) cannot take responsibility for compliance of these houses with the minimum construction norms.

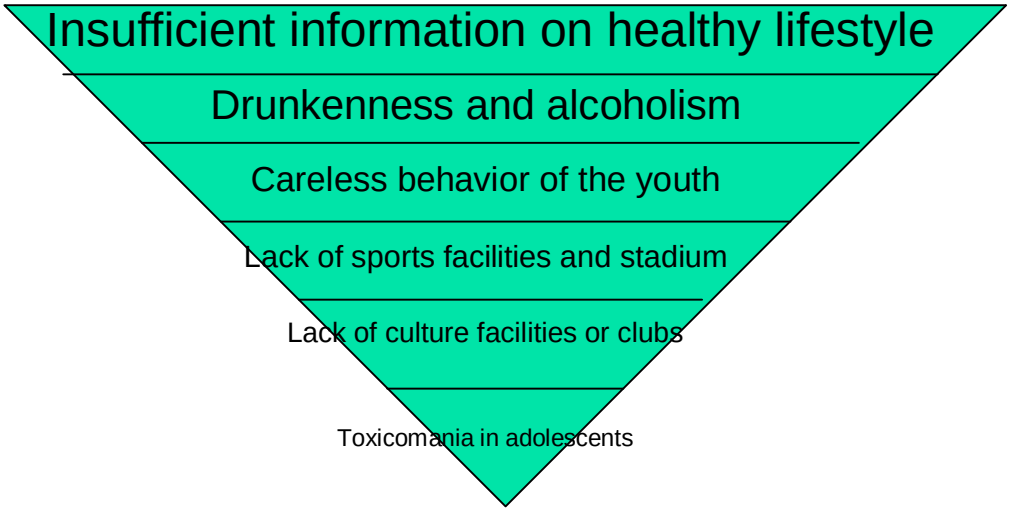
Those who had had a farm at the old residence reported loss of a feeling of material security due to the absence of their own farm. It was difficult for them to realize the fact that they had to buy all products.

In the village, one can survive for two months even without a single tyiyn, as there is a kitchen-garden and cattle, one may count on relatives after all. And here, in the city, it is impossible to make even one step without money (man, 45 years old, Archa-Beshik)

Almost all settlers experienced a feeling of loneliness after they moved. Even adolescents told that, especially girls. It was especially prominent in times when people had to face the indifference of the bureaucratic apparatus in order to register different documents and in other situations related to legalization of their residence at the new place.

Similar in meaning were mentions of unfriendly attitude from local inhabitants and law machinery workers. They often heard such notions that because of them theft and other criminal activities increased.

4. Lifestyle



in regard to lifestyle, people showed unanimity in the opinions. First of all, they lack information on healthy lifestyle. If previously they could get this or that piece of information from different sources (radio, television and newspapers), at present the state, in their opinion, does not pay enough attention to this important factor, which can considerably impact people's health. Many remembered the Soviet times, when there was a morning exercises program on radio, program "Health" and "Den Sooluk" magazine. They also mentioned accessibility of newspapers and journals. Currently, even newspapers became inaccessible to the majority of residents of suburban settlements.

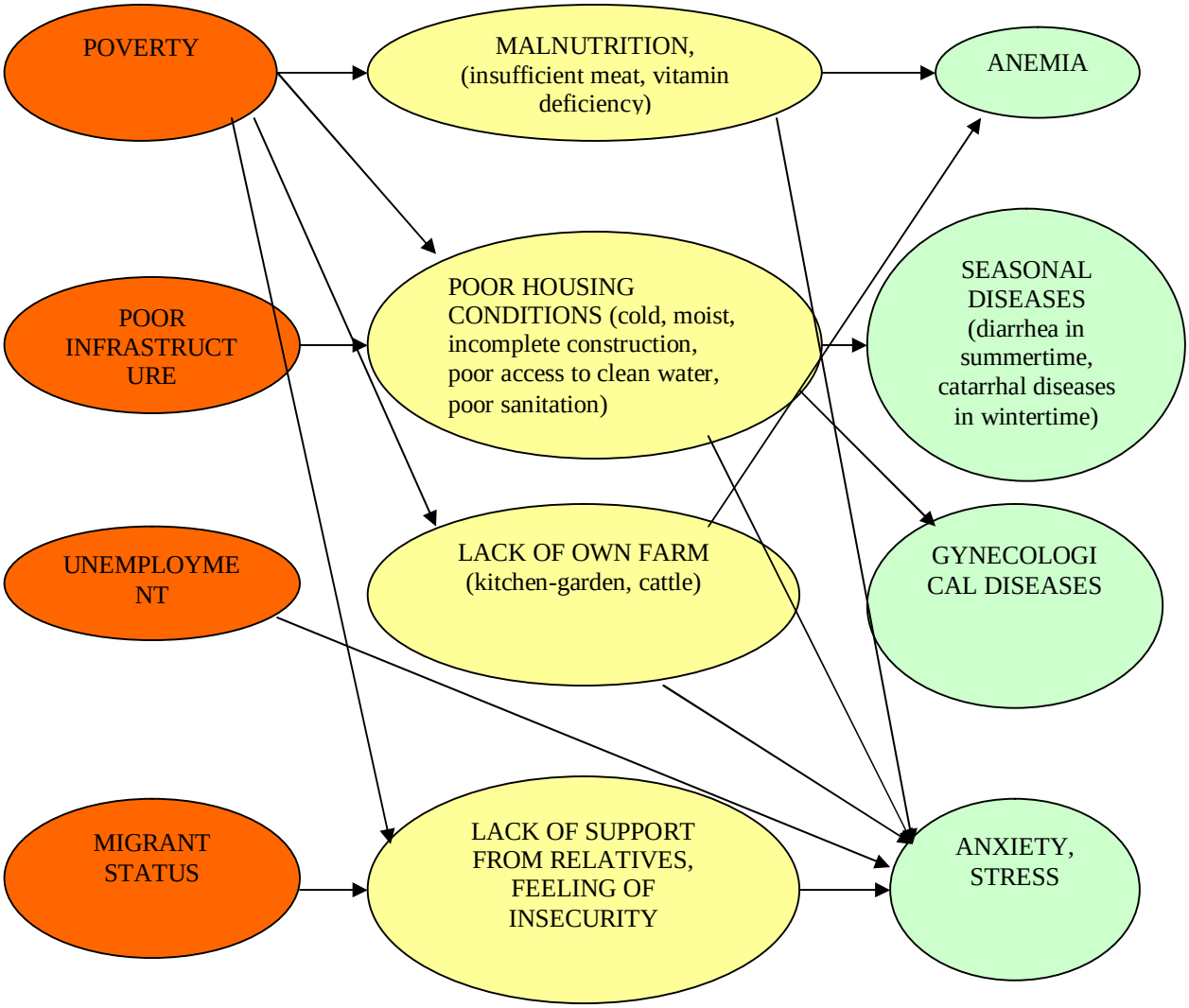
Hard-drinking and alcoholism, in people's opinion, are another factor that not only affects health, but also all aspect of social life, especially family life. Women and adolescents accentuated the importance of alcoholism as a risk factor. At the same time, they all reported that in recent few years the level of hard-drinking in the suburban settlements has been decreasing. They could not provide any sensible explanation to this fact though.

Frivolous behavior of the youth was mainly reported by women. They pointed out that such behavior was shown by both young girls and young boys.

Absence of sports grounds and stadiums, as well as culture facilities was mentioned by the quarter officers and adult residence as a factor that may affect health. As comparison, they brought up examples of the villages they came from. In every village, there existed the above-mentioned attributes of a populated settlement and, in fact, they quite effectively functioned.

Toxicomania was mentioned by adolescent boys. Its prevalence, in their opinion, was not high, but nevertheless it does exist among adolescents. In regard to drug use though, no cases were reported in the residents of the settlements.

In the analysis of separate diseases, people reported the following causes. The most common and frequent problems along with the general causes were anemia and seasonal diseases. Stress and women's diseases were reported as more specific causes. Poverty was named the most significant factor, which is also the strongest determinant in the structure of causes of multiple health problems.



3.3 ACCESSIBILITY OF HEALTH CARE TO RESIDENTS OF SUBURBAN SETTLEMENTS

The third part of our study was to learn the opinions of inhabitants of suburban settlements about health services provided in their settlements. We also tried to learn what medical services people seek and where they refer to when they fall sick. All participants of focus groups were asked similar questions, except for FGP doctors.

This let determine the behavioral patterns of people with simple and more complicated conditions, as well as to learn their opinions about the accessibility of health services. For the most part, people accentuated strengths and weaknesses of the FGP serving the territory of Archa-Beshik settlement, an FMC located on the premises of the City Hospital #4, and other city hospitals. As said earlier, discussions were held in seven groups asking similar questions. For an FGP a presentation was made, which reflected the opinions of the previous groups about the accessibility of health services.

Respondents in all seven focus groups answered the question ‘What do people do when they have a simple illness, a flue, for instance?’ by saying that they take treatment at home. Hereby, they take self-treatment, performing generally accepted procedures

(drink tea with raspberry jam). In men's focus group, respondents said that in such cases they take drugs from their home medical kit. That is, one may speculate that a certain percentage of population purchases generally known drugs in advance, in case some family members have health problems.

After obtaining responses to the question 'What would you do, if your flue developed into a serious illness with complications, such as permanent cough and high temperature?', it became clear that respondents mainly do not visit a doctor, but rather, as they said "If it gets too bad, we observe a bed regime". In two groups there were responses that if the condition does not improve, they refer to doctors-acquaintances, nearest doctors-neighbors. In case of children's illnesses though, in all focus groups people reported inviting an FGP pediatrician or visiting him themselves. Their non-referral to a doctor in such situations they motivated by shortage of money for admission or tests and drugs.

Based on the answer to the question what they do if they suddenly need emergency medical care, we found out problems related to ambulance visit. The causes of these problems, as mentioned in all groups, were absence of communications, telephone in houses, lack of exact addresses, and poor roads. A lot of storied were told in relation to ambulance care, for example:

"My brother was beaten up so badly that he needed emergency care, but we could not call the ambulance, because there was no telephone, and we could take him to a health facility, because we had no resources to do that. And when we finally got to call, they simply did not come, because: a) it was far away for them, and b) the ambulance did not have gas for the car, while we had no addresses here in the settlement" (women's group).

Almost in all cases of emergency conditions, residents have to find ways to deliver patients to a hospital on their own.

"We did not have such a notion as to cal ambulance, because it is useless, and if suddenly we are confronted with such case, we go to the hospital ourselves. Ask a neighbor who has a car or take taxi".

As we found out from the respondents, there were no cases when an ambulance visited Archa-Beshik settlement. There were cases, however, when ambulance came only the next morning after the call.

Death cases due to the absence of emergency care were reported in three groups: in two of them (in the group of boys and group of girls) child deaths were mentioned, while in the other group (quarter officers) – death of a 46 years old man.

"Once our neighbors' small kid fell sick. The ambulance did not come. As a result, the kid died from influenza complications."

The question whether people refer to FGP doctors revealed that FGP are visited only to see a pediatrician or take kids for vaccination, and sometimes to see a gynecologist.

"We do not know our family doctor, did not even refer to him. But we know the pediatrician well – we always take our children to him or for vaccinations. Sometimes we refer to a gynecologist."

Many respondents linked their non-knowledge of the family doctor to the absence of a permanent therapist doctor.

"You come to see a family doctor. (S)he refers you to have tests. You come back with the results of the tests – there is already another doctor. You ask what happened to the previous doctor and hear that (s)he "does not work". In this manner three doctors have already changed, so you really have no desire to see a therapist doctor".

A reason not to refer for a health service to a family doctor is not only the instability of personnel, but also that there are no normal conditions in FGP, even, for instance to have tests – one has to travel to the FMC twice: to have tests and to pick up the results, to wait for weeks when there are no such problems with the doctors-acquaintances. They consider this to be more reliable and quicker. There were respondents who reported that they only visit those acquaintances that work at tertiary level. During a meeting with the quarter officers, it was suggested to open in Archa-Beshik a fully functioning policlinic that would be equipped well and have a laboratory-diagnostic room, as well as posses a full set of narrow specialists. It is necessary to note that in depicting the weaknesses of FGP the doctors themselves agreed with the above-mentioned opinions of the residents. They emphasized that absence of an FGP laboratory was a big problem to them:

"…it is very difficult to work – it takes too long to get test results. Quite often, patients cannot go to the City Hospital #4 twice. Then we have to travel there to pick up the results, even though it goes beyond our job description". (During a meeting with FGP)

Based on the answers, one may understand that the respondents go to FGP mainly to see a pediatrician, as in all focus groups people responded that they know the pediatrician and a pediatric nurse, because they often go with their children to have them inoculated, examined. They also come with home visits in case of need, perform patronage. Some women respondents refer to FGP for gynecological care. They answered the question whey they rather go to doctors-acquaintances than refer to FGP by saying that firstly, they do not have pay their acquaintances; secondly, there is a long line for doctor's admission: they have to wait, which causes a number of discomforts; thirdly, FGP does not have necessary equipment for examination, nor a laboratory. As a result, they have to go to an ODD to have tests, which takes both the time and double amount of money (for admission to an FGP doctor and to ODD for tests and transport costs). As mentioned above, people do not refer to FGP mainly due to the absence of a laboratory-diagnostic department. In the focus group of the quarter officers a respondent suggested to set up a fully functioning policlinic, which should have its own laboratory, diagnostic department and all narrow specialists. The doctors themselves confirm that it is the main problem, as they currently have to send patients (even severe ones) to have tests to other diagnostic centers or to a city hospital.

"Patients have to travel twice to an ODD in order to have tests and to collect the results which many patients do not do because they do not have necessary resources. It takes time, and patient's condition is worsening or the patient does not come for the second visit. It creates a big problem in our daily work."

We bring up the most typical notion by a participant from the women's focus group:

"If one needs a narrow specialist, why bother going to FGP? Besides, there is a narrow corridor there, a long line, while there is no laboratory, ultrasound and X-ray machines and fluorography. Even when you take children to see a pediatrician or for vaccination, you are afraid to get them infected as a result of the mixed admission".

Respondents in the focus groups had different opinions about payment for admission to FGP doctor. For example, in the women's focus group, there were arguments about payment for admission: some said admissions in FGP were free of charge irrespective of to which doctor one refers, while others said: "One has to pay for all rendered services, 10 soms for a syringe, around 20 soms for examination, and 30 soms for tests". But in the focus groups of middle-income people and quarter officers there were responses that payment for admission is only made at the first visit if patient is not enrolled. In this case the amount to be paid is 20-30 soms, but doctors take all, regardless of enrolment, which was also confirmed by FGP doctors.

"…When patients come to us, we ask them if they are enrolled, we do not ask for propiska – local residence registration. If they are not enrolled, we enroll them, open up their personal file - for these patients have to pay 20 soms. After that, they are entered in our register, and we have no right to charge anything for admission".

From the focus group of adolescents we obtained answers that they know the pediatrician and nurse very well and invite doctor home when necessary. Also, there is a medical point at school, where schoolchildren can be examined and accompanied to a hospital in emergency cases. For general medical examinations the nurse from the medical point goes to FMC together with the schoolchildren.

Taking into account answers to the question 'Have you referred to a tertiary level health facility in Bishkek?' it became clear that all respondents prefer to refer to the tertiatry level facilities indeed, motivating it by better quality of medical services. The most optimal variant is when you have an acquaintance at the hospital. If you do not have such, people try to find a doctor and build good relationship with her/him for further cooperation in the future. In emergency cases, for instance, under labor, traumas, strong headaches, high temperature in children, etc., as mentioned above, people had to get to the hospital on their own.

We asked respondents to highlight strengths and weaknesses of hospitals. The obtained data showed that almost all who took interview from reported that in the admissions department of the hospital, patients are treated unfriendly, the admissions process is very long, especially in emergency cases, when people go to hospitals on their own.

"Once my wife had such a terrible headache that we had to go the hospital by car. There, however, they did not take her, even did not examine her. Instead, they treated her very rudely and it took them ages to call a doctor, who suggested that we should purchase drugs from him after examination".

"If you go on your own car, the hospital would not take you, but if you come on ambulance – there is no problem with admission. The problem is though that ambulance does not come to us".

"In the admissions department of the Maternity House #6 a woman that had labor was not admitted simply because she had not been registered".

It became clear from responses that there is a big problem with informal payments. Many people said that without money (apart from co-payments) doctors would simply not treat you well enough. Even if the doctor is an acquaintance, the patient has to thank her/him in order to receive good, full treatment and attention. An example:

"I had a hemorrhoids operation at the hospital and I had to pay 500 soms unofficially to the anesthesiologist, 2000 soms to the doctor and also every time to nurses for dressing".

The question 'Did you pay yourself or was payment asked by the doctor?' was answered as follows:

"Wardmates already know how much every doctor charges. They discuss among themselves what, to whom and for what to pay. There is already a pre-set rate to thank the doctor.

From this it is clear that patients pay the doctor for services themselves. In respondents' words, this way they express their gratitude and the reason fro that is in patients' uncertainty about guaranteed correct treatment and good attitude of health personnel. As they said:

"No more care about money, the most important thing is to cure".

The last remark suggests that for hospitalization people not only save money, but also seek acquaintances who then need be thanked too.

"We had the following case. A surgical intervention was necessary and we had to agree with a doctor-acquaintance on 2500 soms and only that s(he) got to make an operation".

When we were learning opinions about co-payment, we had different responses: from positive to negative reactions.

"My grandfather was hospitalized with a burn. We paid 830 soms as co-payment, 80% of necessary drugs were provided by the hospital, the remaining 20%, which were not available at the hospital, were purchased by us. Then, upon the discharge we also thanked the doctor".

It was evident that this respondent told about the usefulness of co-payment, but even in such case there were elements of informal payments. Also, people pointed out double payment, when they had to pay both the co-payment and a 'thank you' payment to the doctor. During the discussion with men's focus group, there were responses that doctors actually explained to patients that the funds raised through co-payment go to the budget and doctors receive very little, therefore patients try to thank their doctor separately.

Summarizing it can be said that overall the primary health care for the inhabitants of suburban settlements may be considered accessible. Residents of the settlements are served by FGP doctors, but at the same time there are the following problems:

1. Low financial ability of suburban settlements residents to seek medical care.

The expenditure priorities for residents of suburban settlements are food, construction materials and transport. Many respondents noted that they would rather wait it through or rely on "the off-chance" than refer to health services.

Poverty is to blame for everything: let alone drugs, at times there is no money for bread. For example, I have varicose veins. I referred to a family doctor got prescriptions for 270 soms, but did not buy anything. We live on chance earnings, my husband daily goes out to seek for a job, but, as a rule, returns home without earnings (woman from Dordoi)

Only in those cases, when it is truly impossible to get along without qualified medical care, they have to refer to health facilities. Herewith, it means that they will have to

allocate a significant amount from their scanty family budget or more likely to borrow money for treatment.

2. Inaccessibility to ambulance care.

Summing up the people's opinions about ambulance services, one may conclude that it is practically inaccessible for the following reasons:

- Absence of exact addresses
- Absence of telephone-machines
- Remoteness from the city and bad roads

Ambulance never comes, because we do not have exact addresses and also because of other excuses: lack of gas, etc. There was a case, when a deputy fell down and hurt his leg. Ambulance was called, but it did not come! (man, Ak-Bata)

3. Insufficient functionality of FGP

Absence of diagnostic equipment at FGP and FMC makes the residents of suburban settlements refer to other health facilities in the city.

"Why would I refer to FGP? I have to wait for tests results there for five days, while in other city hospitals I can be examined within one day".
"FGP only perform blood and urine tests. To have all other tests, ultrasound and X-ray one has to go to the city, which is inconvenient". (woman from Archa-Beshik)

"We do not have a laboratory, ultrasound or X-ray, therefore our patients have to travel to FMC to have tests, but the patients often say they cannot go there twice (to pick up the results) (they do not have money to pay for transport or they feel really bad). FMC laboratory workers come only once a week to collect tests. Also, there is no direct route from FGP to FMC" (FGP doctors, Archa-Beshik)

Respondents also told about insufficient coverage of outreach by family doctors. Many people brought up the example of district doctors during the Soviet time that regularly carried out such work on their districts. At the same time, residents understood the real situation in the settlement and the discomfort and difficulties the family doctors encounter. Barriers to outreach work by family doctors are:

- long distances within a suburban settlement,
- absence of FGP transport,
- bad roads.

FGP doctors, in turn, advocated the abolishment of outreach work as an absolutely ineffective and obsolete system. At the same time, patronage of infants is done at the previous level which the residents told about themselves.

1. IMPERFECT MECHANISMS OF SERVING INTERNAL MIGRANTS BY THE PHC SERVICE

Under the existing legislation, enrolment of the population to FGP is done on free basis within the FMC serving the territory where patients have local residence registration. Free of charge, under the framework of the State Guaranteed Benefits Package

(SGBP), FGP provides health services to the enrolled population irrespective of their local residence registration. Services not included in SGBP can be received by citizens in FGP on paid basis, according to the approved price list.

Thus, FGP of the suburban settlements have to serve unenrolled internal migrants (including pregnant women and children) on the basis of residence certificates issued by quarter officers. This category of population is registered in a separate book, not entering them into the enrolment database, although financing of FGP is provided only for the enrolled population. It means that FGP doctors render services to unenrolled migrants at the expense of the enrolled urban population (consultations, tests, drugs), and receive no remuneration for extra workload.

3.4 OPINIONS OF SUBURBAN SETTLEMENTS RESIDENTS ABOUT FGP/FMC AND HOSPITALS PERFORMANCE

The objectives of this study were also to find out the extent of people's satisfaction with the services of primary and secondary care providers.

Evaluation of FGP/FMC

Strengths	Weaknesses	Disputable points
• Pediatrician conducts medical examinations, patronage of infants and outreach examination at home • Never refused primary health care • Provide referrals to a hospital • Free immunization	• Crowdedness in FGP, very narrow corridor, cues. Mixed admission (children + adults) • No laboratory, ultrasound and X-ray at FGP and FMC.	• Many people do not know their family doctor. • Friendly/unfriendly attitude of health personnel. • Drugs are available under the humanitarian aid • Free services are provided to children

Evaluation of hospitals

Strengths	Weaknesses	Disputable points
• Regime is well observed: treatment is good, prescriptions and procedures are done on time.	• In separate maternity houses there exist informal payments. • After making a co-payment, people have to purchase drugs. • Unfriendly attitude, especially in the admissions department. • No care for severe patients as before. People have to provide care themselves.	• The conditions at hospital are better than at home (food, warmth) • Double payment, i.e. in addition to co-payment, patients pay doctors. • Health personnel sell their own drugs at higher prices than in pharmacies. • Health facilities require repairs. Many people in one ward. • Friendly attitude of health personnel, free services to the poor (operations, maternity) in some facilities. • 70% of drugs in hospitals under co-payment. • Children are treated free of charge. • No use in the insurance policy in terms of drug provision. • No treatment without an acquaintance or money • In emergency cases, no admission of patients who came on their own – only if brought by ambulance or with a referral. • Hospitals do not provide beddings. If provide, these are very old.

4. CONCLUSIONS AND RECOMMENDATIONS

Health of internal migrants living in suburban settlements of Bishkek city is subject to the influence of additional negative factors related to moving and setting up at the new place. The main reasons of existing health problems of the residents of such settlements are poverty and its consequences, such as malnutrition, poor housing conditions and low financial capacity to refer to health care. Other, no less important reasons are undeveloped infrastructure of the settlements, problems with access to clean drinkable water, anti-sanitation and insufficient functionality of FGP that serve the new housing massifs.

Solution of the existing problems are possible only given a comprehensive approach, with participation of the Government, municipal and local administration bodies, NGO and community organizations. Joint activities of all stakeholders will let solve the main problems in the suburban settlements.

4.1 RECOMMENDATIONS TO THE MINISTRY OFHEALTH

- To improve mechanisms of medical services provision to internal migrants.
  It is necessary explore an opportunity of financing FGP that serve suburban settlements not based on enrolled population, but based on actually served population. As the situation in the settlements is different from that in the city, where the problem of internal migrants is not as acute (for example, in Dordoi settlement up to 70% of residents are lodgers).
- Further strengthening of the PHC and public health services in the suburban settlements.

As the study showed, the most residents of the suburban settlements prefer to refer to other municipal health facilities than to their FGP. This is connected with poor equipment with laboratory and diagnostic equipment, high instability of personnel in FGP and often low trust in the competence of FGP doctors.

The KSHRSP experience of organizing community health committees seems interesting to test in suburban settlements. It should let actively involve people in solving problems related to health.
It is necessary to develop a set of measures in cooperation with the municipal services on timely disposal and utilization of garbage from the territory of the settlements, as well as on eradication of fleas and rats.

4.2. RECOMMENDATIONS FOR INTERSECTORAL COOPERATION

- To assess the poverty level in suburban settlements for targeted support on the part of the state and donors

It is necessary to conduct a household survey in suburban settlements aiming to determine the actual poverty level. Available data on poverty (World Bank survey) is based on subjective opinion of the residents of suburban settlements.

- To curtail unemployment among internal migrants

Rayon and city authorities should consider opportunities to create jobs for internal migrants, support private entrepreneurship and initiative on sites more actively, scale up microcrediting and provide loans to the needy.

- To improve the mechanism of accounting and registration of domestic migrants

The registration system must provide objective information on migrant population and support the willingness of all domestic migrants to get registered and not scare them with a punishment for non-observance of this norm;

- To improve the infrastructure of suburban settlements

The municipal development services have to add to the list of priority programs measures to improve the infrastructure of suburban settlements. Some of the priority measures must be construction of water supply systems, additional power substations, and asphalt roads.

5. ANNEXES

5.1 MANUAL-QUESTIONNAIRE FOR DISCUSSION IN FOCUS GROUPS

MANUAL FOR DISCUSSION IN FOCUS GROUPS – HEALTH OF MIGRANTS LIVING IN SUBURBAN SETTLEMENTS

Main questions	Possible hints	Notes
1. What health problems, in your opinion, are most common in your housing massif?		Moderator assistant makes up a list of all the named diseases and health problems on the desk, leaving empty space near each to allow ranking by frequency and importance. It is very likely that people will be confusing diagnoses of illnesses with symptoms and that the categories will coincide. We will stick to the language used by people themselves and will not impose the "correct medical terminology". Goal – to obtain a list of 20 health problems
	You have named [e.g. lung disease]. Could you, please, describe in detail what symptoms are inherent to this disease?	The terms people will be using are not likely to correspond to the clinical names of illnesses. When it is necessary, ask respondents to explain what they mean under this or that illness and/or its symptoms, so that the whole group would use the terms consistently and we could make comparisons with other focus groups.
	You have not mentioned any diseases that cause sufferings [e.g. to children, women, men, elderly people], so let us focus on this population group. Which diseases are most common among [children, women, men, elderly people] in your community?	
	Now we would like to rank diseases that you have just named in descending order by their frequency in your settlement. Let us use a scale from 1 to 10, where 1 means very rare diseases and 10 means frequent or common diseases. My colleagues will be using priority marks manipulating them between 1 and 10 on the desk, depending on your opinion. Let us take the first disease from the list…	Moderator assistant uses a scale from 1 to 10. S(he) manipulates the priority marks and fixes them when general agreement is reached… Moderator carefully observes the achievement of a true agreement and not only listens to the opinion of loud persons.
	Which diseases in this list have ***the biggest impact on your daily life***? Which diseases have the biggest impact on your ability to live a fully-fledged life, make	Moderator assistant uses a scale from 1 to 10. S(he) manipulates the priority marks and fixes them when general

	your living, take care of your family and enjoy your leisure time? We are going to use the scale from 1 to 10 again. 1 would mean little influence on daily life, and 10 would mean a big impact on daily life. My colleagues will be using priority marks manipulating them between 1 and 10 on the desk, depending on your opinion. Let us take the first disease from the list…	agreement is reached… Moderator carefully observes the achievement of a true agreement and not only listens to the opinion of loud persons. When people name a specific disease, but do not make their point clear, ask a hint-question why they chose this disease. **à** You said [e.g. high blood pressure], why did you choose it? How does [high blood pressure] it affect your ability to enjoy a fully-fledged life? If it is difficult to evoke a discussion, you may use an additional hint-question. Choosing a disease that has the biggest impact on your life, you may think of such factors as pain, stress, possible death, loss of work, need in care, financial expenditures caused by the disease.
	If we take the first five diseases from the list, does the situation differ from that in your community?	
2. Now we would like to better understand what is the cause of your illnesses in your opinion?		
	Let us take the most common disease, which is [e.g. high blood pressure]. What are the main causes of [e.g. high blood pressure]?	Take frequency or burden of disease and move from one disease to another along the first 5-6 diseases or until you collect enough causes. If some categories are not covered in the structure, give a hint to them. At this phase, do not get into detail on health services, if they are brought up, list them and leave for further discussion.
	People often name ***socio-economic situation*** **and** ***poverty*** as one of the main causes of diseases. In your opinion, are these also a factor in your community? Could you, please, give examples from your housing massif of how exactly socio-economic conditions and poverty affect health and cause diseases? [if difficult to answer, you may hint them at such examples as low salary, poverty, unemployment, malnutrition, poor working conditions, etc.]	

	People often name ***environmental factors*** **and** ***living conditions*** as one of the main causes of diseases. Could you, please, give examples from your housing massif of how exactly living conditions may be a cause of diseases? [if difficult to answer, you may hint them at such examples as water supply, sewerage, heating]	It is necessary to learn well about the infrastructure of the rayon: what infrastructure is available and which is not there.
	People often name ***psychological factors*** **and** ***social factors*** may also be the main causes of diseases. Could you, please, give examples from your housing massif of how exactly psychological and social factors may be a cause of diseases? [if difficult to answer, you may hint them at such examples as stress, lack of social support]	It is necessary to learn how staying in the capacity of a migrant settler affects mental health: specific fears, anxieties and stress; It is necessary to learn how the social safety network, which they had relied upon earlier, broke down after moving to the city; what the new social safety net is.
	There are many studies that show that ***lifestyle*** influences health. Under lifestyle we mean frequency of smoking, healthy diet, moderate alcohol consumption, drug use, regular physical exercises. Do you think these factors pose a problem in your community? How do people in your community follow [more/less healthy] lifestyle in Bishkek, if compared to your previous residence?	Learn about the availability of products, especially among the poor and compare them with rural areas. Learn about drug abuse problem, if they agree to talk about it.
3. Now we would like to learn your opinion about health services provided in your housing massif and for what health services people refer when they fall sick.		
	What do people in your housing massif do when they have a simple illness, a flue, for instance? What would you do if your flue would develop into a serious illness with complications, such as permanent cough and high temperature? What would people in your housing massif do if they had a chronic illness, for example, diabetes or high blood pressure? What would people in your housing massif do if they needed emergency medical care (e.g. infarction or heart attack?)	The purpose of this survey is to depict the scheme of people's health care seeking behavior and understand which health provider is the most important to them. We would like to know which referral strategies for primary health care they employ in case of simple illnesses, as well as where they refer to for specialty health care. In the women's group, ask hint-questions about pregnancy

	What would you do if this happened in the middle of the night? Are most people in your housing massif enrolled to FGP? Why and why not? How often do people visit FGP? Have you ever referred for health services to tertiary level facilities in Bishkek? Why/why not?	
	We know that in many rayons of Kyrgyzstan, people do not often refer for health services, when they actually need them. Does it happen in your community as well? What are the main reasons why people do not refer for health services when it is necessary? Could you, please give examples and tell similar stories?	Allocate enough time to identify which main barriers to access there exist in the housing massif
	Now we would like to focus on FMC in your housing massif. Could you, please, list what you like about services rendered by FMC and what you do not like?	Moderator assistant must make lists on two different desks + and – aspects of FMC services
	You mentioned xxx hospitals, to which people refer to receive specialty care for more serious illnesses. Could you, please, list again what you like about services rendered by these facilities and what you do not like?	Moderator assistant must make lists on two different desks + and – aspects of FMC services
	We would like to refer to the two lists of negative aspects of health services, which you have defined. We would like to ask you what you would suggest as the most important and least important priority problems that need to be addressed by the state.	Describe the method