EU–IOM
KNOWLEDGE
MANAGEMENT HUB

Knowledge Management Hub | Research Fund

Research Study #3 | December 2022

HEALTH AND REINTEGRATION

Returning to Space But Not to Time: A Life Course Approach to Migrants' Health, Continuity of Care and Impact on Reintegration Outcomes

Final Report

EU - IOM KNOWLEDGE MANAGEMENT HUB
returnandreintegration.iom.int

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
SAMUEL HALL
IOM UN MIGRATION
Project funded by the European Union
Project implemented by IOM

This publication was made possible through the financial support provided by the European Union. The opinions expressed herein are those of the author and do not necessarily reflect the views of the European Union.

Publisher: International Organization for Migration
17 route des Morillons
P.O. Box 17
1211 Geneva 19
Switzerland
Tel.: +41 22 717 9111
Fax: +41 22 798 6150
Email: hq@iom.int
Website: www.iom.int

This publication was issued without formal editing by IOM.
This publication was issued without IOM Publications Unit (PUB) approval.

Design: We2 – www.we2.co

Cover photo: Medical staff conduct a health check up on an Ethiopian migrant at a hospital in Bossaso before his return to Ethiopia with IOM's assistance. © IOM 2020 / Muse MOHAMMED

Required Citation: Samuel Hall and IOM (2022). Health & Reintegration – Returning to Space but Not to Time: A Life Course Approach to Migrants' Health, Continuity of Care and Impact on Reintegration Outcomes. Final Report.

ACKNOWLEDGEMENTS

Samuel Hall and the **African Centre for Migration & Society** at the University of the Witwatersrand in South Africa would like to extend their deepest gratitude to the returnees and their household members who gave their valuable time, shared their difficult and courageous stories, and imparted their important knowledge for this study. Without their generous participation, this report would not have been possible. Many thanks in addition to the key informants who shared their experiences, knowledge, and perspectives.

Gratitude is also owed to the expert group for their invaluable time, guidance, feedback and continuous support in this project, which has enriched and strengthened the academic rigour of the study report. Members include (listed alphabetically): Prof Baltica Cabieses, social epidemiologist and senior researcher at the Social Studies in Health Research Programme, Instituto de Ciencias e Innovación en Medicina, Facultad de Medicina, Clínica Alemana, Universidad del Desarrollo, and board member of Lancet Migration Latin American Hub; Prof Priya Deshingar, an internationally recognised authority on migration research and policy analysis with a focus on mobility and health in South–South migration, University of Sussex; Peppi Kiviniemi-Siddiq, Protection Division's regional thematic specialist at the IOM Regional Office for Asia and the Pacific; Prof Cathy Zimmerman, a behavioural and social scientist leading research on migration and health, London School of Hygiene and Tropical Medicine; Dr. Kolitha Wickramage, Global Migration Health Research & Epidemiology Coordinator, Global Migration Health Support Unit, IOM Migration Health Division, Manila.

Research for this study was led by Dr. Nassim Majidi, Dr. Jo Veary, Karen Lau, Francesca Chiavaroli, Hiu Yin Chuah, Shannon Armstrong, with support during the inception phase by Dr. Thea de Gruchy, and with fieldwork coordination and support by Mat Lowe, Vanessa Daurer, Victoria John, Jared Owuor, Tewelde Adhanom, Najia Alizada, and Hakim Atiqee. Thank you to the field team members composed of: Henrique Gasperin, Renata Summa, Julia Chaise, Carolina Salgado, and Ricardo Prata Filho in Brazil; Temesgen Yaekob, Gudina Abashula, Yisalemush Asefa, Medareshaw Tafesse, and Abebayehu Desalegn in Ethiopia; Mariam Glakhoshvili, Ketevan Nebieridze, and Ana Egutidze in Georgia; Ousman Ceesay, Aliasa Jallow, Salimina Bah, and Mat Lowe in the Gambia; Asra Memon, Human Rao, Basim Ahmed, Uruj Waheed, and Mohamad Imtiaz in Pakistan; Lamine Fall, Ndèye Khady Ndiaye, Birahim Dieng and Mat Lowe in Senegal.

The **International Organization for Migration** (IOM) technical review panel at Headquarters, consisting of Silvan Lange, Aleksandra Izydorczyk, Joy Paone, Claudette Walls, Emily Thuo, Phineas Jasi, and Carlos Van der Laat, would like to thank the IOM country offices in Brazil, Ethiopia, the Gambia, Georgia, Pakistan and Senegal for assisting the preparation and implementation of fieldwork. IOM would also like to thank Stine Hyldekjaer at the European Commission's Directorate-General for International Partnerships for her support and inputs.

The International Organization fro Migration, **Samuel Hall,** would also like to thank the European Union for its impetus and funding.

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

FIGURES

TABLES

LIST OF ACRONYMS

COVID-19	Coronavirus disease 2019
CSO	Civil society organization
HIV	Human Immunodeficiency Virus
HRN	Health-related needs
ILO	International Labour Organization
IOM	International Organization for Migration
KII	Key informant interview
LGBTQI+	Lesbian, gay, bisexual, transgender, queer and intersex
MHPSS	Mental health and psychosocial support
NCD	Non-communicable disease
NGO	Non-governmental organization
PTSD	Post-traumatic stress disorder
SGBV	Sexual and gender-based violence
SOGIESC	Sexual orientation, gender identity, gender expression and sex characteristics
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
SSI	Semi-structured interview
SUS	Sistema Único de Saúde
UHC	Universal health coverage
UHCP	Universal health-care programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

GLOSSARY

Access

Access is the "availability, affordability, and acceptability"[1] of health care.

Country of origin

"A country of nationality or of former habitual residence of a person or group of persons who have migrated abroad, irrespective of whether they migrate regularly or irregularly."[2]

Country of transit

"The country through which a person or a group of persons pass on any journey to the country of destination or from the country of destination to the country of origin or the country of habitual residence."[3]

Forced return

"The act of returning an individual, against his or her will, to the country of origin, transit or to a third country that agrees to receive the person, generally carried out on the basis of an administrative or judicial act or decision."[4]

Health

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Furthermore, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[5]

Host country

Often referred to as the *country of destination*, "a country that is the destination for a person or a group of persons, irrespective of whether they migrate regularly or irregularly."[6]

Integrated care

"Integrated care is a concept bringing together inputs, delivery, management, and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency."[7]

Migrant

"An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students."[8]

1 McIntyre D., M. Thiede and S. Birch, Access as a policy-relevant concept in low- and middle-income countries, *Health Econ Policy Law* 4(2), 179-193 (2009), page 179.

2 IOM, Glossary on Migration (2019), p. 39.

3 Ibid., pp. 39-40. Adapted from International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (adopted 18 December 1990, entered into force 1 July 2003) 2220 UNTS 3, Art. 6(c).

4 Ibid, p. 77. Adapted from European Migration Network, European Migration Network Asylum and Migration Glossary 3.0 (2014).

5 WHO, Constitution of the World Health Organization (1946), p. 1.

6 IOM, *Glossary*, p. 39.

7 Gröne O. and M. Garcia-Barbero, Integrated care: a position paper of the WHO European Office for Integrated Health Care Services, *International Journal of Integrated Care* 1(1): 1-10 (2001), p. 7.

8 IOM, *Glossary*, p. 132-133.

Returnee

A person who returns to their community after having moved away "from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons".[9] For the purposes of this study, we will adopt the term returnee to indicate international migrants who have returned to their country or community of origin, voluntarily or not, in subcategories of return described above.

Sustainable reintegration

"Reintegration can be considered sustainable when returnees have reached levels of economic self-sufficiency, social stability within their communities, and psychosocial well-being that allow them to cope with (re)migration drivers. Having achieved sustainable reintegration, returnees are able to make further migration decisions a matter of choice, rather than necessity."[10]

Vulnerability

"Within a migration context, vulnerability is the limited capacity to avoid, resist, cope with, or recover from different forms of harm. This limited capacity is the result of the unique interaction of individual, household, community, and structural characteristics and conditions."[11] "Vulnerability derives from a range of intersecting and co-existing personal, social, situational, and structural factors," and individual's level of exposure "is determined by the interplay of many factors: their sociodemographic characteristics, their capacities […], their location […], and the crisis induced factors"[12] impacting them.

9 Ibid., p. 132.

10 IOM, Towards an Integrated Approach to Reintegration in the Context of Return (2017), p. 3.

11 IOM, *Glossary*, p. 229.

12 Ibid, pp 229-230. See also IOM, Guidance Note on How to Mainstream Protection across IOM Crisis Response (2016), IN/232, pp. 6–7.

Otash is a village in South Darfur where many of its residents have returned, having been spent years in camps for internally displaced persons (IDPs) due to ethnic clashes that date back to 2003. IOM is among the agencies that have supported the return with infrastructure such as water, schooling and health facilities. © IOM 2021 / Muse MOHAMMED

INTRODUCTION

Good health and well-being for all is a basic human right and is recognized as such by the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the United Nations 2030 Agenda for Sustainable Development,[13] in addition to the Global Compact for Safe, Orderly and Regular Migration. Central to good health and well-being is access to integrated care. **Efforts to realize this right and to improve access to care however often exclude migrants**, even when migrants have returned to their country of origin.[14] According to IOM, 58 per cent of migrants in a vulnerable situation assisted to return in 2021 presented health-related needs. This figure exceeded 80 per cent among migrants in vulnerable situations returning to certain regions, including Asia and the Pacific, the European Economic Area, Middle East and North Africa, Eastern Europe and Central Asia.

Engaging with migration – a key determinant of health – is increasingly recognized as a global public health priority. Health responses that fail to engage with migration not only negatively affect the health of people on the move, but also the communities they interact with throughout their migration journey: there is "no public health without migrant health."[15] To ensure the development of appropriate responses, a clear understanding of the relationship between migration and health – both between migrants and the host population, and across different migrant groups – is required. It is imperative that this includes returnees.

Returnees' health and well-being are crucial determinants of sustainable reintegration as poor physical and mental health hampers individuals' or families' ability to become self-sufficient, achieve stability or well-being, as outlined in the IOM definition of sustainable reintegration. Ensuring that the health needs of returnees are met is imperative to facilitate sustainable reintegration.[16] Yet existing research suggests that returnees have limited or inadequate access to medical services and suffer from long-term barriers to health care, including the unaffordable cost of care in many contexts.

Evidence about the health-care needs of returnees, the conditions of the health system, and how these link to sustainable reintegration outcomes is limited. The return of migrant workers with occupational injuries and diseases to their home communities has been an area of interest for scholars and activists historically. However, outside of work that tends to be historical in focus, current research on return, reintegration, and health tends to fall within two trends: (1) the mental health and psychosocial well-being of returnees, particularly in relation to stigma;[17] and (2) a very recent focus on COVID-19 and the return and reintegration process. A broader understanding of the intersection between health needs and reintegration is required to improve the access to health care and create opportunities for sustainable reintegration.

While the body of literature on the health of migrants in the pre-departure, transit, and post-migration stages of the migration journey continues to grow, **literature on return, reintegration, and health, or the health outcomes of returnees, is by-and-large limited,** as are the ways in which these outcomes may be gendered, or related to age, or other social locations. As such, it is important to generate knowledge on the topic and identify good practices that can be scaled to facilitate the reintegration of migrants with poor health conditions.

This report, commissioned by IOM in partnership with Samuel Hall and the African Centre for Migration & Society at the University of the Witwatersrand, aims to fill this gap in the existing literature on the topic, exploring the impact of health needs on sustainable reintegration outcomes and identifying the key factors that intersect to shape returnees' health and reintegration outcomes. While this research project aims to explore the links between health needs, access

13 United Nations, Transforming Our World: The 2030 Agenda for Sustainable Development (2015).
14 WHO, World report on the health of refugees and migrants (2022).
15 No Public Health without Migrant Health, *The Lancet Public Health* 3(6): 259 (2018).
16 IOM, Reintegration: Effective Approaches (2015).
17 Schuster L. and N. Majidi, Deportation Stigma and Re-Migration, Journal of Ethnic and Migration Studies 41(4): 635-652 (2014).

to care and sustainable reintegration for returnees, we use the stages of migration to frame our approach. This allows us to highlight "the multi-staged and cumulative nature of the health risks and intervention opportunities that can occur throughout the migration process, and points to the potential benefits of policy-making that spans the full range of migratory movement."[18]

BACKGROUND

IOM's *Reintegration Handbook* highlights the importance of access to health care for reintegration and of prioritizing returnee's mental health and psychosocial reintegration. Psychosocial reintegration is understood in IOM's integrated approach to reintegration as key to ensuring a returnee's reintegration is sustainable: Consequently, the provision of **MHPSS forms a key component of IOM's reintegration programming**. While not all MHPSS needs among returnees are being fully met, it is noted that IOM continues to make efforts towards it.

In addition to IOM's programming on the psychosocial needs of returnees, **ensuring access to health care more broadly is highlighted throughout research commissioned by IOM and IOM guidelines on supporting sustainable reintegration**, under the social reintegration dimension encompassing access to services. For example, *Returning with a health condition: A toolkit for counselling migrants with health concerns,* an outcome of the *Measures to Enhance the Assisted Voluntary Return and Reintegration (AVRR) of Migrants with a Chronic Medical Condition Residing in the EU* project, as well as IOM's toolkit on *Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return*. In addition, **access to health and well-being is recognized as one of the seven interlinked components of social reintegration**. The others - access to documentation, housing and accommodation, social protection schemes, education and training, food and water, and justice and rights - are all, additionally, social determinants of health.[19] By way of example, the importance of sexual and reproductive health services for returnees, including the provision of post-exposure prophylaxis where appropriate, is provided for within the social dimension of reintegration programming.

> *"Psychosocial assistance at the individual level supports returnees' psychological states […] and their ability to (re)form positive social relationships and networks and cope with (re)migration drivers.*
>
> *– IOM, Reintegration Handbook, p. 86*

Importantly, many of the findings from this part of IOM's work reflect barriers to access, which may not be unique to returnees, but rather experienced by the whole community. This includes, for example, the cost of care. **Understanding what barriers and health-related needs are particular to returnees and return locations, and what are reflective of health systems strengthening more broadly is important to improve programming**. In addition, IOM's engagement distinguishes between health-related needs that fall under the operational scope of social assistance, whereas their focus on mental health and the psychosocial needs of returnees falls under the operational scope of psychosocial assistance. Improving understanding about how physical and mental health outcomes are interrelated for returnees will also serve to improve programming in this regard.

A series of one-on-one meetings were held in March-April 2022 with IOM country offices in the target countries of this study to inform the development of important aspects of the research (sampling strategy, research concepts as well as contextual situations of returnees). Overall, four key themes emerged in the input by the COs related to the health-related needs of returnees:

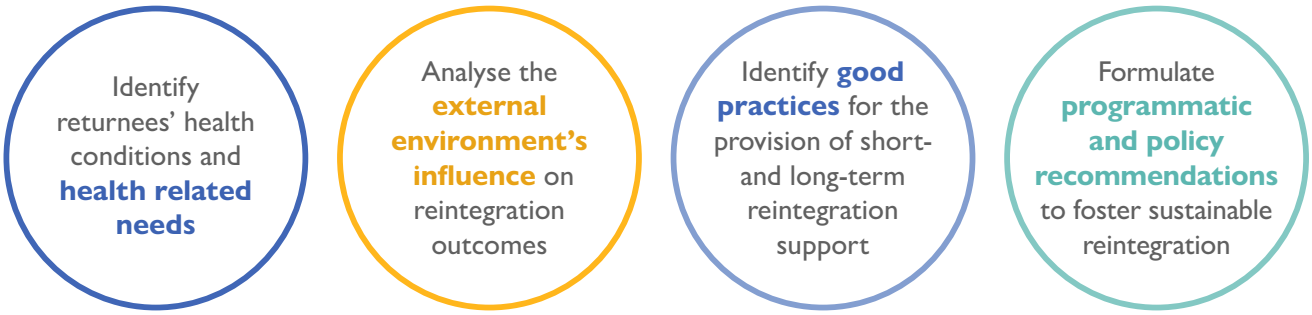
1. Exploring the different health needs of beneficiaries and how these relate to assistance received;
2. Differentiating between health-care programmes and differing population groups' needs;
3. Understanding how access to health care is limited for returnees; and
4. Exploring the link between health-related needs and economic reintegration.

18 Zimmerman C., L. Kiss and M. Hossain, Migration and Health: A Framework for 21st Century Policy-Making, PLoS Medicine 8(5): 1-7 (2011), p. 1.

19 The social determinants of health are the conditions in which people are born, grow, live, work, and age, these circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.

OBJECTIVES

The aim of this research is to explore the links between health needs, access to care, and sustainable reintegration of returnees. Within this, the study has four objectives that link the **returnees' individual health-related needs** (including with regards to mental health), with the **capacities and infrastructures for health services** in the external environment, to **learn from existing practices** and recommend how to improve the **operationalization and standards on health provision in reintegration settings** across countries of origin. This will branch out to include recommendations on the treatment of migrants with health needs across the migration cycle, paying particular attention to gendered, geographical, and developmental - dimensions.



To achieve these objectives, the following research questions were formulated:

Table 1. Objectives and research questions

OBJECTIVES	QUESTIONS
Understand migration as a social determinant of health	1. How does returnees' migratory experience influence health and reintegration outcomes? What are the main determinants of health-care access?
Identify returnees' medical and health-related needs	2. What are returnees' medical conditions and health-related needs? How does intersectionality impact health needs? How are returnees seeking health-related care?
Analyse the social and structural influences on individual health and reintegration outcomes	3. What are structural barriers and facilitators to health care access? How does health systems influence returnees' health and reintegration outcomes?
Formulate programmatic responses to the health and well-being of returnees	4. What are good practices for the provision of health support in reintegration? How can reintegration initiatives be strengthened to better respond to returnees' health needs?

METHODOLOGY

This study followed a three-phased mixed methods approach between March and July 2022. The **inception phase** included a comprehensive literature review[20] to identify evidence gaps, and a review of the methodology and tools by an expert reference group.[21] The **data collection** phase involved primary data collection via quantitative and qualitative methods in six countries. Study participants (both returnees and key informants) were recruited by nominations from each respective IOM country office, along with snowball sampling. A pilot phase was included in each country to test the data collection tools.

Five methods were used simultaneously:

1. **Survey:** A survey on the health-related needs of returnees was administered to returnees in five of the six focus countries. It covered questions on demographics (e.g. age, sex, family status), returnee profiles (e.g. nature of return, duration away, time since return, assistance received), self-reported health status and health access (at pre-migration, pre-return, post-return), and reintegration outcomes (e.g. economic, social, psychosocial). The eligibility criteria were that a returnee must have returned within the last five years and be over 18 years of age;
2. **Semi-structured interviews** with returnees included in terms of eligibility criteria that a returnee must have returned within the last five years, be over 18 years and have either a health condition or have had experiences trying to access care;
3. **Key informant interviews:** KIIs with civil servants, health-care service providers that worked with returnees, United Nations agency and international organisation staff, in addition to local CSOs, NGOs, and community structures were conducted by the research team;
4. **Case studies:** Programmatic case studies to identify reintegration and health programming and better understand emerging best practice were undertaken through SSIs and KIIs; and
5. **Expert reference group:** Academics and global leaders in the field of migration and health were engaged and consulted throughout the study.

DATA COLLECTED BY RESEARCH LOCATIONS

Six countries were selected as research sites in coordination with IOM to reflect a broad geographical scope: **Brazil, Ethiopia, the Gambia, Georgia, Pakistan and Senegal.** While interviews with returnees were conducted in all countries, the HRN survey was only conducted in Ethiopia, the Gambia, Georgia, Pakistan and Senegal. Given the difficulties of identifying beneficiaries in Brazil, surveys were not administered in Brazil. All HRN surveys were conducted in person except in Georgia, where they were phone-based due to practical considerations. Survey data were analysed using descriptive and analytical statistical techniques such as cross-tabulation, t-test, and regression modelling. Semi-structured interviews and key informant interviews were conducted in person in their native languages with voice recordings then transcribed into English. Transcripts were analysed using thematic analysis.

20 The literature review covers academic and grey literature and serves as the basis on which to build the study methodology and research tools. Using a stages of migration approach, the review provides a brief overview of existing bodies of work on migration and health, and how the health-related needs of returnees fit within this literature. It also reviews the current state of knowledge on return and reintegration, much of which is in grey literature that underpins programmatic decision making on return and reintegration.

21 The expert reference group comprised academic experts affiliated with the Migration, Health and Development Research Initiative and relevant IOM regional thematic specialists to provide expert input. Members include (listed alphabetically): Prof Baltica Cabieses, social epidemiologist and senior researcher at the Social Studies in Health Research Programme, Instituto de Ciencias e Innovación en Medicina, Facultad de Medicina, Clínica Alemana, Universidad del Desarrollo, and board member of Lancet Migration Latin American Hub; Prof Priya Deshingar, an internationally recognised authority on migration research and policy analysis with a focus on mobility and health in South–South migration, University of Sussex; Peppi Kiviniemi-Siddiq, Protection Division's regional thematic specialist at the IOM Regional Office for Asia and the Pacific; Prof Cathy Zimmerman, a behavioural and social scientist leading research on migration and health, London School of Hygiene and Tropical Medicine; Dr. Kolitha Wickramage, Global Migration Health Research & Epidemiology Coordinator, IOM Migration Health Division, Global Migration Health Support Unit, Manila.

Table 2. Overview of all data collected

COUNTRY	KIIS	SSIS	HRN SURVEY	TOTAL
Brazil	12	24	0	**36**
Ethiopia	15	16	69	**100**
Gambia	15	17	60	**92**
Georgia	15	17	50	**82**
Pakistan	13	19	59	**91**
Senegal	6	17	58	**81**
Total	**76**	**110**	**296**	**482 respondents interviewed**

ETHICS AND DATA PROTECTION

As this study addresses health issues which may be sensitive in some contexts, the research team has taken every effort to protect the confidentiality and anonymity of the participants' identities. All identifying information has been delinked from the data. Strict procedures have been followed to ensure informed consent was sought from participants. Legal authorization has been sought from the relevant authorities in each country prior to conducting research, which was supported by IOM's country offices. Each local researcher went through a 2 and a half-day training, which included a training on safeguarding and research ethics, particularly for qualitative researchers interviewing returnees. During the fieldwork, researchers provided information to participants on existing feedback and complaints mechanisms, and available health and MHPSS services if necessary. Data protection principles, including those related to data security, access, and retention, have been adhered to throughout the project in accordance with the *IOM Data Protection Manual*.

LIMITATIONS

Even though the data collected during the study is comprehensive and has allowed for an in-depth analysis of the links between returnees' health needs and reintegration outcomes, there are key limitations that must be borne in mind while interpreting the research findings.

- **IOM assisted returnees:** The majority of returnees were IOM beneficiaries (80% in the quantitative data and 65% in the qualitative data), with implications on generalizability and potential bias. This is due to the sampling strategy in which research participants were primarily nominated by IOM country offices[22] (complemented by snowball sampling), and that standards for inclusion into IOM's return and reintegration programming also differs between countries.
- **Representation of returnee populations:** Due to the non-random nature of participant recruitment, the returnees who participated in semi-structured interviews are not representative of the entire returnee population. In certain countries, such as Brazil, the majority of returnees interviewed were voluntary returnees, although key informants have

22 This sampling strategy was adopted in consensus with IOM in order to better understand if there were unmet health needs among returnees receiving assistance and its impact on reintegration outcomes.

observed that forced returnees were more common in their day-to-day experience. Thus certain important voices remain missing in the study.

- **Survey sample size:** Sample size for the quantitative survey is relatively small (n=296),[23] thus subgroup analysis has low statistical power, such as on gender-specific analysis where there were only 55 female returnees in the final sample. Nonetheless, where possible confidence intervals and p-values based on t-tests[24] are reported to enable readers to make better informed judgments.
- **Self-reporting and assessment:** This study has relied on participants' self-reported health status and no objective health measurement was undertaken. There is a possibility of recall bias since participants were asked about their experience in previous stages of migration. This has been minimized by limiting eligibility to returnees who have returned within the past five years, and for the survey, questions on pre-migration were only asked for returnees who have returned within 12 months. Comparisons across countries should also be caveated by the fact that there are cultural differences in the understanding of health and disease as recognized in literature.
- **Cross-sectional survey:** The HRN survey was a cross-sectional study in which questions on health and reintegration were asked at the same time, and hence findings can only be interpreted as associations, rather than causations.

1. A LIFE COURSE APPROACH TO RETURNEES' HEALTH NEEDS: ACROSS THE MIGRATION CYCLE

1.1 CONCEPTUAL FRAMING

Migrants' health and well-being depend on the interaction of multiple factors throughout the migration journey including in the post-return phase. Traditionally, concerns around migration and health are centred around the health of migrants in relation to communicable diseases and how migrants spread infection. This has led to policies that focus on the pre-migration stage of migration, specifically through the development of pre-departure medical assessments. However, this does not reflect the **dynamic relationship between the different phases of migration and health**. For instance, during the migration journey, migrants may experience direct health risks including, but not limited to, traumatic events, nutritional deficiencies, dehydration, and exposure to infectious diseases. Subsequently, immigration policies, the legal barriers to migrants accessing services, including health care, an epidemiological profile between the community of origin and host community, access to housing and employment, experiences of xenophobia and discrimination, and whether or not health systems in the host countries are migration-aware and mobility-competent are all factors that affect to what extent migrants are at risk of poor health outcomes.

A key element in understanding how returnees' health changes and can influence reintegration outcomes is considering the dimensions of space and time. Upon return, while returnees often go back to the same space (place) that they have originated from, the time that has passed while returnees were abroad has significant implications on the realities that they return to. Not only have returnees gone through their personal migratory experiences, but the communities that they return to have often also evolved over time, including social support networks and broader societal systems. Such stressors along the migration journey as well as

23 Planned survey sample size was 300 (50 per country), thus final sample size reached the expected size despite Brazil being excluded in the survey as explained above.

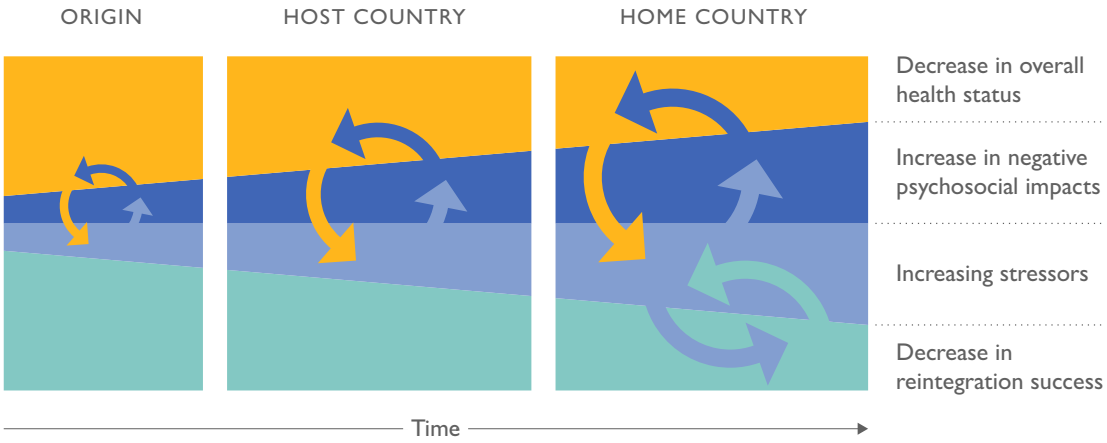
24 Confidence intervals and p-values are used to specify the statistical significance of results based on the sample size of the survey.

at post-return shape returnees' health outcomes and the sustainability of their reintegration.

Based on the study's qualitative and quantitative findings, the framework represented in Figure 1 was developed. This framework captures the interlinkages between health (physical and mental) and reintegration outcomes (economic, social, psychosocial) and key determinants and stressors (individual and household, community, and structural levels) by adopting a life course approach. The conceptual framing relied on the stages of migration and factors of health vulnerability and resilience to frame the approach and detailed below in the literature to highlight "the multistaged and cumulative nature of the health risks and intervention opportunities that can occur throughout the migration process, and points to the potential benefits of policy-making that spans the full range of migratory movement."[25] This proposed conceptual framework captures five key conclusions analysed in this study, which would need to be tested in larger scale studies for validation:

1. Over time, in general, self-reported health status of returnees decreased.
2. Over time, in general, psychosocial stress increased.
3. Along the migratory journey, stressors (i.e. negative social and structural determinants of health) accrued.
4. There is a two-way relationship between health status and reintegration outcomes.
5. Increasing stressors over time resulted in decreasing health status, along with more negative reintegration outcomes.

Figure 1. Conceptual framework of a life course approach to returnees' health and reintegration outcomes



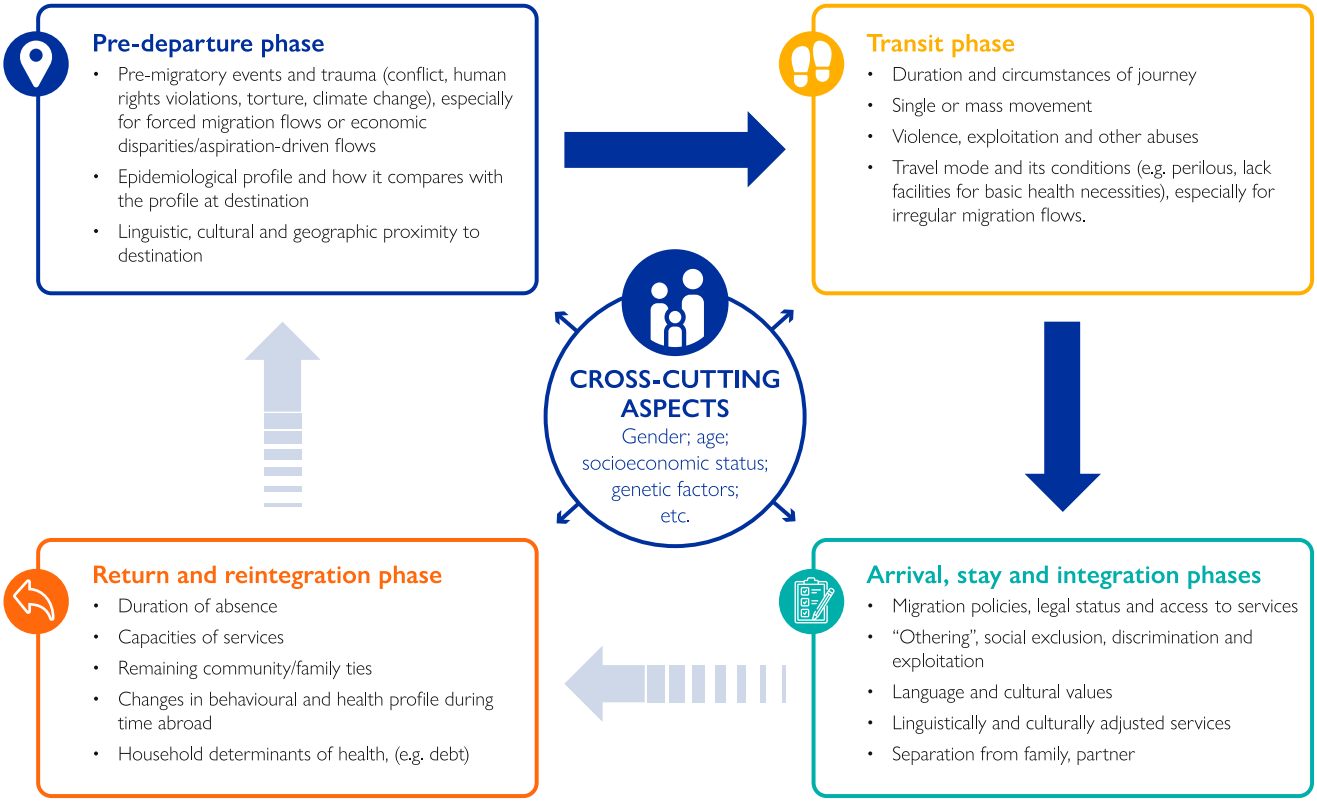
1.2 SYNTHESIS OF THE AVAILABLE EVIDENCE AND LITERATURE REVIEW

This approach is supported by the available evidence. The literature in the field of migration and health is growing and increasingly diverse, particularly in the pre-departure, transit, and post-migration stages of the migration journey. However, as noted in a WHO report, "Despite the importance of a continuum of care, the available research mostly dealt with refugees and migrants in host countries, with much less literature from countries of origin or stages of transit."[26] The return of migrant workers to their home communities with occupational injuries and diseases has been an area of interest for scholars and activists historically, while the current research on return, reintegration and health fills a broader gap in the literature.

25 Zimmerman, Kiss and Hossain, *Migration and Health:* A Framework for 21st Century Policy-Making, p. 1.

26 WHO, Global Evidence Review on Health and Migration: Continuum of Care for Noncommunicable Disease Management during the Migration Cycle (2022), p. 33.

Figure 2. The determinants of migrant health throughout the migration cycle
(Source: IOM, Essentials of Migration Management 2.0)



This framework on the migration cycle foregrounds the importance of formulating interventions that address the health risks faced by a migrant at each stage and how risks intersect and accumulate at the end of the migration cycle - the focus of this research.

Pre-migration: Health status in the pre-migration stage is largely determined by three factors, in addition to genetic and biological factors: (1) the epidemiological profile of the country of origin; (2) the health system and accessibility and quality of health care that the individual has experienced pre-departure; and (3) experiences of trauma, violence, or displacement that may have been a factor in a migrant's decision to migrate. With the exception of migrants who have experienced particular trauma in their country of origin, for example war or persecution as a minority, or are migrating for health-related reasons, scholars have traditionally agreed that at the point of departure a healthy migrant effect is in place. Due to the costs associated with migrating, migrants are likely – at the point of departure and arrival in the host country – to be healthier than those in both the communities they leave behind and arrive to. However, this effect often does not last long after arrival. Consideration must also be given to health care access as a reason for migration. Some research suggests that choices to migrate may occasionally be underpinned by the need to earn to pay for health care for a relative back home, or to access health care in the host country.

Movement phase: The "duration, circumstances and conditions"[27] of the journey between a migrant's place of origin and ultimately their destination impacts a migrant's health needs upon arrival. Many journeys include experiences of violence, periods of waiting and being in transit, and poor access to basic necessities like food. As detention centres and transit camps have emerged as a key response to human mobility, so too has knowledge about the negative impact these spaces have on the health and well-being of migrants. As Zimmerman et al.

27 García-Sierra R. et al., Psychological Distress and Somatization in Immigrants in Primary Health Care Practices, Healthcare 8(4): 1-13 (2020), p. 2.

note "there are clear associations between the length of detention and severity of mental disorders, especially for individuals with prior exposure to traumatic events, which is common among forced migrants."[28]

Arrival and integration: Migrants often arrive in new communities with a health advantage. However, factors prior to departure and during the movement phase, in addition to factors in their host community often mean that this advantage is quickly lost. Factors that affect whether and how quickly migrants are at risk of poor outcomes are, for example, migration policies, and the legal barriers to migrants accessing services, including health care; whether there is a difference in epidemiological profile between the community of origin and host community; gender; access to housing and employment; experiences of xenophobia and discrimination; stress due to the migration process; and whether or not health systems in the host country are migration-aware and mobility-competent. Arrival and integration are often long and convoluted processes underpinned by fragmented migration journeys and long-term periods of transit in third countries. As access to medical services in transit countries is often limited, these journeys take a heavy toll on migrants' health. As a result, migrants may sometimes reach host countries, or return to countries of origin, with untreated physical or psychosocial conditions.

Return: Health outcomes at the point of, or following, return are often the result of the accumulation of experiences prior to migration, during movement, and at the point of arrival and integration. Evidence shows that returnees experience a higher disease burden compared to the general population post-return.[29] The ways in which return happens, by force following detention or voluntarily, and reintegration phase, for example, will impact the health-related needs of migrants and the sustainability of reintegration. In addition, the sustainability of reintegration is often linked to the stigma of return – the implications of this are discussed further in the literature on return and mental health. Furthermore, if a returnee returns home unwell, how the health system is equipped to deal with that disease, will have an impact on the returnee's future health outcomes.

1.2.1 What is integrated care in return and reintegration?

> **Integrated care** *is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency – Gröne and Garcia-Barbero, Integrated care: a position paper of the WHO European Office, p. 7.*

Globally, the lack of migration-aware and mobility-competent health systems – systems that include migration as "a central concern in their design"[30] in addition to poor access to positive social determinants of health, weak public health-care systems and inadequate or poorly implemented policy frameworks mean that certain migrants experience poor health outcomes.[31] As such, it is the context of migration that can negatively affect health as "being a migrant is not in itself a risk to health: it is the conditions associated with migration that may increase vulnerability to poor health."[32] In addition, while migration can affect health, both positively and negatively, health status can also affect decisions to move or not. However, the ways in which this dual relation affects reintegration is poorly understood. **A review of migration-aware health-care systems revealed:**

- A critical gap in facilitating access to health services upon return.
- A gap in adopting a stages of migration approach and only focus on certain (usually earlier) stages of migration.
- Ad hoc responses that involve a range of actors and lack coordination and integration when it comes to health care.

28 Zimmerman, Kiss and Hossain, Migration and Health.

29 Aryal N. et al, Risk of kidney health among returnee Nepali migrant workers: A survey of nephrologists, *Asian Journal of Medical Sciences* 12(12): 126-132 (2021).

30 Mukumbang F. C., Migrant-Health Inequity as a Consequence of Poor Siracusa Principles Implementation in the COVID-19 Era, *International Journal of Travel Medicine and Global Health* 9(4): 155-160 (2021), p. 155.

31 Castañeda H. et al., Immigration as a Social Determinant of Health," *Annual Review of Public Health* 36(1): 375-392 (2015).

32 Wickramage K. et al., Migration and health: a global public health research priority, *BMC Public Health* 18(1): 1-9 (2018), p. 5.

- While more responses have integrated a health dimension, health needs are rarely a focus of reintegration programmes.
- Migrants', including returnees', access to health services are hindered by structural barriers like rural-urban disparities and unaffordable health services or medical insurance coverage which need to be addressed through a broader development intervention.

Different groups of migrants experience different rights and entitlements in relation to health. As a result, some may be able to improve and maintain their health status, while others may face direct health risks. These include, but are not limited to: traumatic events, nutritional deficiencies, dehydration, and exposure to infectious diseases.[33] In addition, lack of access to legal documentation and regular avenues for migration; xenophobia experienced at the hands of health-care providers; language barriers; the time and financial cost of seeking care; shame and fear of stigmatization can be barriers to access to health care for migrants.[34] Irregular documentation status, institutional and interpersonal xenophobia, precarious income strategies, and poor living and working conditions all act as structural barriers to accessing positive social determinants of health. In addition, **social locations like gender, age, and health status often affect the health needs of a migrant** and create additional barriers to access which are reflective of the ways in which countries of destination and origin respond to these social locations.

The heterogeneity of migrants – across and within different migrant groups – and of migration experiences means that assumptions about vulnerability must be tempered. Care must be taken to avoid assumptions that migrants alone are responsible for their health experiences. Rather a recognition of the ways in which the relationship between health and migration are socially and structurally determined is key. Multiple factors can determine the health of migrants and these factors can change – and their impacts accumulate - during different phases of the migration cycle, including during return.[35] Health vulnerabilities and resilience factors are dynamic and change over time and this elevated health status can – if migration is not managed properly – be eroded due to the poor living and working conditions experienced post-migration.

Many public health interventions struggle. Their design, contrary to empirical evidence, is often based on the assumption that populations are static, namely that populations can be continuously accessed at one geographical location and that health-care users will access care and treatment at a single health-care facility over time resulting in both barriers to accessing health care for mobile populations and barriers to adequate responses by health-care facilities. What is clear, however, is that not only do complex and diverse population movements shape health-care usage, but that understanding migration is necessary to successfully drive migration-aware public health interventions. The importance of migration-aware health-care systems that respond to the realities of migration and mobility, therefore, cannot be overemphasized.[36]

This study approached health-related needs in the context of reintegration through the lens of integrated care, a concept "bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency."[37] The fragmented delivery of health and social services has been a long-standing challenge for many national health systems,[38] including in the countries in which this research took place. In addition, access to and quality of health care are among the key indicators of the social dimension of reintegration sustainability, which observes the extent to which returnees have reached social stability within their community.

33 Vearey Jo, C. Hui and K. Wickramage, "Migration and Health: Current Issues, Governance and Knowledge Gaps," in IOM, *World Migration Report 2020* (2019).

34 Mona H. et al., Barriers to accessing health care among undocumented migrants in Sweden - a principal component analysis,*BMC Health Services Research* 21(1): 1-11 (2021).

35 Siriwardhana C et al., Thematic Discussion Paper: Vulnerability and Resilience, 2nd Consultation on Migrant Health: Resetting the agenda (2017).

36 Vearey J., M. Modisenyane and J. Hunter-Adams, Towards a migration-aware health system in South Africa: a strategic opportunity to address health inequity, *South African Health Review* 1(1): 89-98 (2017).

37 Gröne and Garcia-Barbero, *Integrated care: a position paper of the WHO European Office, p. 7.*

38 Kodner D. L. and C. Spreeuwenberg, Integrated care: meaning, logic, applications, and implications - a discussion paper, *International Journal of Integrated Care*: 2(12): 1-6 (2002).

However, little is known about the particular health needs of returnees, or how these are – or are not – being met by health systems. As such, **this study aspired to contribute to a framework that ensures continuity to migrants' fundamental right to health when they return to their country of origin, and to enhance reintegration outcomes and improve the efficiency, and organizational aspects of reintegration assistance available to returnees**.

1.2.2 What diseases have been identified in the literature in relation to migration?

Based on our literature search, existing research on migration and health can be categorized into five key focus areas: communicable diseases, non-communicable diseases, sexual and reproductive health rights, psychosocial and mental health, and more recently COVID-19 pandemic.

Table 3. Overview of the literature in the field of migration and health

FOCUS AREA	OVERVIEW OF LITERATURE FINDINGS
Communicable diseases	– A complex relationship exists between human mobility and the spread of communicable diseases like HIV. – Migrants are often considered a high-risk population in communicable diseases including HIV, tuberculosis and COVID-19 due to the conditions associated with migration. – Policy responses in managing communicable diseases such as HIV fail to engage with the heterogeneity of diverse population movements as well as the broader contextual and structural factors.
Non-communicable diseases	– Limited literature exists on NCDs and migration while they are increasingly framed as 'killer' diseases, particularly of women and in low- and middle-income countries where approximately 75 per cent of NCD deaths occur. – Only 17 articles out of 408 articles dealt with NCDs in a systematic review conducted in 2021 of articles published on cross-border mobility and health across the African continent.
Sexual and reproductive health rights	– While progress is broadly being made to improve access to SRHR for women, girls and LGBTQI+ individuals globally, migrants are often left behind. – Barriers to realizing these rights include both the poor provision of SRH services to all, including the stigmatisation and moralization of abortion, in addition to challenges specific to migrants, for example a lack of documentation and language barriers.
Psychosocial / mental health	– Notwithstanding a significant body of literature on migration and mental health, the distribution is unequal as trauma experienced during the pre-migration phase among forced migrants (primarily refugees and asylum seekers) tends to dominate. – Earlier and current migration stages often play a role in influencing the mental health outcomes among forced migrants.
COVID-19 pandemic	– The pandemic has amplified many of the existing structural challenges experienced by migrants, including many that impact on access to health care and health outcomes. – The 'covidization' of health services – that is the shift in focus to respond to the pandemic – has made access to routine services, like SRH services, additionally difficult for many migrants. – New challenges arise from the exclusion of non-citizens from state responses to the pandemic. – The secondary impacts of the pandemic, such as mobility restrictions and a reduction of economic opportunities, may have an impact on migrants' ability to access health-care services.

Having synthesized the available evidence above, we now turn to a presentation of the data stemming from this research.

Newly arrived returnees from Niger, Tunisia and Mali receive health screenings at their orientation session. © IOM 2022 / Robert Kovacs

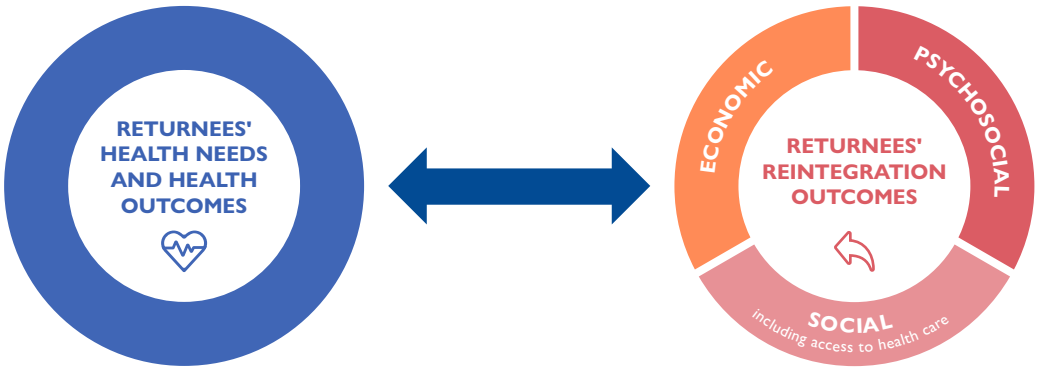
1.3 RETURNEE PROFILES

KEY MESSAGES

1. **A majority of returnees reported good health prior to migration, which deteriorated along the migration journey and post-return.** This was most pronounced among
   - Female returnees
   - Forced returnees
   - Returnees who spent at least six months abroad
   - Returnees who have returned between 1-2 years ago
2. **Exposure to harmful environments during migration had a cumulative effect on the health needs of returnees,** often resulting in a dual burden on long-term physical and mental health, particularly among returnees who had experiences of irregular migration.
3. **Earlier acute health events, such as work-related injuries or physical violence while abroad, often translated into longer term chronic health conditions for returnees, such as chronic pain or PTSD, with knock-on effects on their reintegration success.**

To understand the link between returnees' health needs, health systems and individual reintegration outcomes, this first section reviews the profiles of returnees, and the contexts to which they return, as a backdrop to the following chapters that dissect the relationship between health and reintegration across the three dimensions (Figure 3).

Figure 3. Understanding the link between returnees' health needs, systems and reintegration outcomes



The research team surveyed 296 returnees in six countries and conducted an additional 110 semi-structured interviews.

1.3.1 Socio-demographic profiles

The majority were male returnees – comprising 79 per cent in the survey and 60 per cent in the interviews, which is similar to the overall sex distribution of returnees.[39] The exceptions were Georgia - with 54 per cent males in the survey and 65 per cent in the interviews - and Brazil - with 58 per cent in the interviews who were female returnees (Figure 4). Female returnees in the study sample were more likely to be divorced or widowed, while male returnees were more likely to be single. The proportion of married returnees was similar between male and female returnees. Male returnees were more likely to return on their own (88%) than female returnees (64%) based on the survey sample.

The overall age distribution of the returnee respondents was relatively young. Most were aged between 18 and 35 - comprising 63 per cent in the survey and 60 per cent in the interviews (Figure 5). Particularly for Ethiopia, all returnees in the survey were below 35 years old and all returnees in the interviews were below 45 years old. The exception was Georgia, in which the returnees were generally older, where only 26 per cent in the survey and 6 per cent in the interviews were below 35 years old. Adopting an intersectional angle of both age and sex, the age distribution among male returnees was overall younger than female returnees.

Figure 4. **Sex of returnees in the survey by country** (numbers are counts)

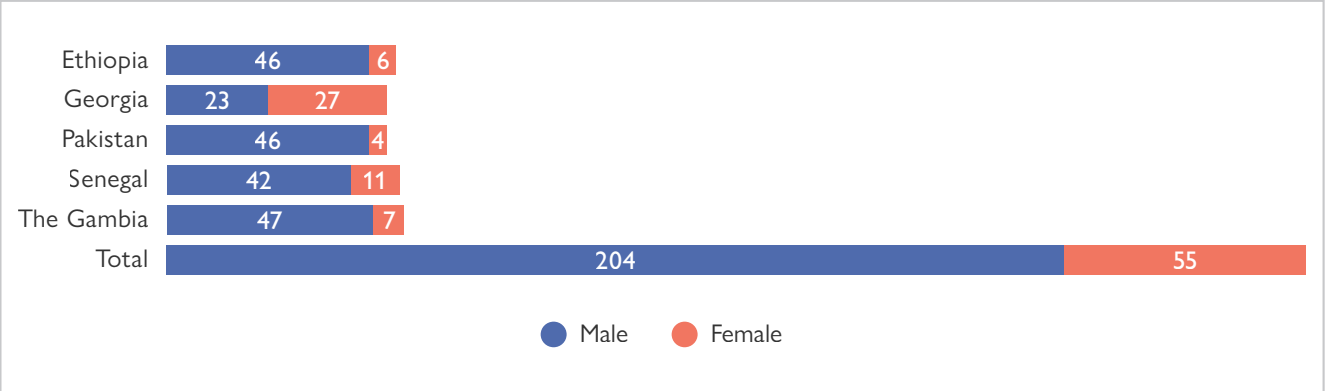
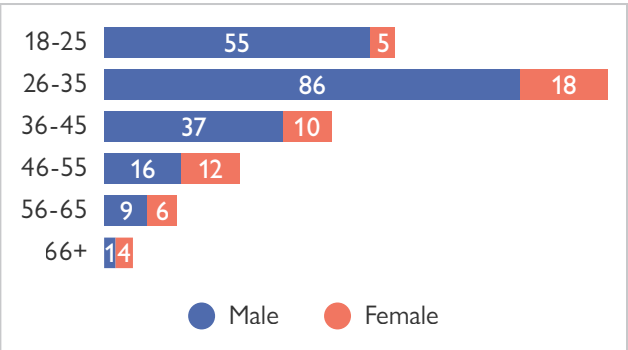


Figure 5. **Age distribution of returnees in the survey by sex** (numbers are counts)

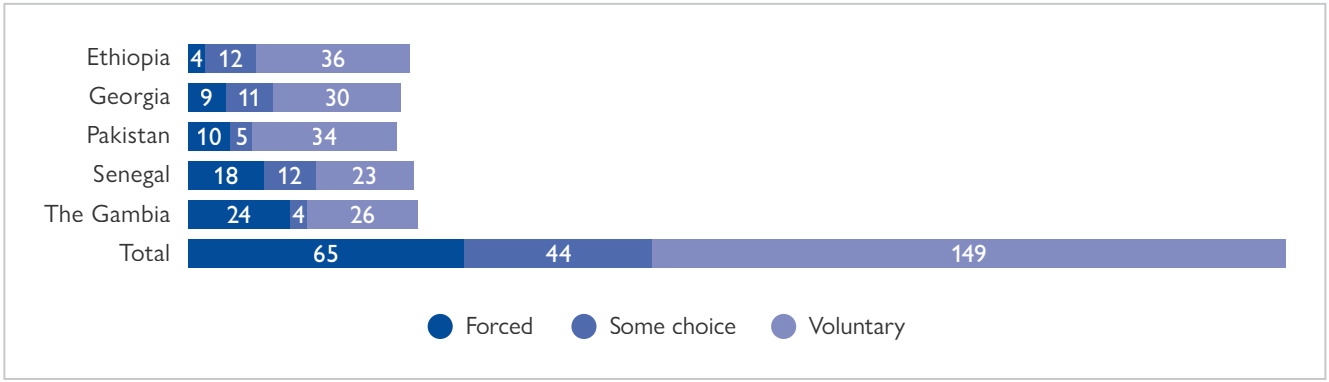


On the spectrum from forced to voluntary returns, the majority of returnees identified themselves as voluntary returnees – comprising around two thirds in both the quantitative and qualitative sample (Figure 6) – although **a range of experiences impacted their return decisions**. The proportion of returnees who self-identified as forced returnees was highest for Gambian returnees (44% in survey and 53% in interviews) and Senegal (34% in survey and 41% in interviews), as well as Ethiopian returnees who were in the qualitative sample (88% in interviews).[40]

39 IOM, Return and Reintegration Key Highlights 2021 (2022).

40 IOM provides reintegration assistance to both migrants who were forcibly returned and those who were assisted to return voluntarily. IOM recognizes that migrants may opt for assisted voluntary return in the face of constrained options in their host countries. Study participants have primarily been referred by IOM country offices and were asked to self-identify the nature of their return, irrespective of whether they were assisted to return voluntarily or were subject to forced return.

Figure 6. Nature of return self-reported by returnees in surveys by country (numbers are counts)



Looking at time away and time since return, around half (54%) of survey respondents have been away for more than two years, and most (65%) have returned to their countries of origin at least one year ago (Figures 7 and 8). For both duration away and time since return, qualitative data was collected in a less precise manner than the survey and thus exact figures are not presented here. Nonetheless, returnees in interviews often indicated the approximate year or general time frame in which they returned, and on the whole, the duration away reported by returnees in the interviews appeared to be longer than those in the survey. The gender distribution for duration away appeared to be similar between male and female survey respondents, while time since return appeared to be shorter for female returnees than male returnees on the whole.

Figure 7. Duration away of survey respondents by sex (numbers are counts)

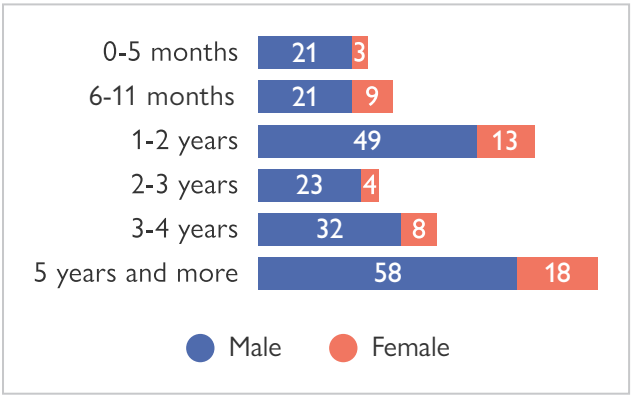
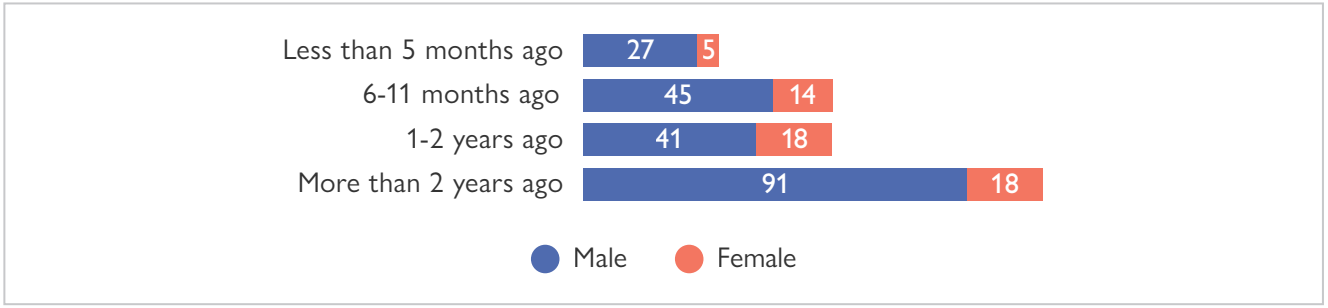


Figure 8. Time since return of survey respondents by sex (numbers are counts)



1.3.2 Context-specific dynamics

Regarding migrants' geographical location, returnees last returned from a diverse group of countries. A minority of returnees reported migrating more than once. Looking at the countries from which survey respondents last returned, Georgian and Pakistani returnees mostly returned from European countries, Ethiopian returnees mostly returned from East African and Middle Eastern countries, while Senegalese and Gambian returnees mostly returned from North African countries (Table 4). Upon return, around equal thirds of returnees in the survey were living in urban, peri-urban, and rural areas. While the majority of returnees lived in the same place since they returned, a sizable portion (38%) in the survey reported living in more than one place post-return.

Table 4. Top five countries from which survey respondents last returned from

ETHIOPIA		GEORGIA		PAKISTAN		SENEGAL		GAMBIA	
United Republic of Tanzania	22 (42%)	Germany	16 (32%)	Germany	21 (42%)	Libya	27 (51%)	Libya	24 (44%)
Djibouti	8 (15%)	France	10 (20%)	Greece	12 (24%)	Morocco	10 (19%)	Algeria	10 (19%)
Yemen	7 (14%)	Switzerland	9 (18%)	Bosnia and Herzegovina	8 (16%)	Algeria	9 (17%)	Mauritania	9 (17%)
Sudan	4 (8%)	Greece	8 (16%)	Saudi Arabia	3 (6%)	Niger	4 (8%)	Morocco	7 (13%)
Saudi Arabia	2 (4%)	Belgium	3 (6%)	Belgium	1 (2%)	Mauritania	3 (6%)	Niger	2 (4%)

The returnees who took part in the study were a heterogeneous group. In view of the relatively small sample size of the HRN survey, findings have generally been analysed collectively and interpreted at an aggregate level by consolidating data from all countries. For this reason, sub-group analysis, such as by sex and nature of return, should thus be interpreted with care, and understood as complementary to the findings and insights gained through the qualitative data.

While respondents reported a diversity of experiences, a point of relative consistency in the data were reports of good health prior to migration, which most indicated had gradually deteriorated during their migration journeys, often worsening further post-return. This pattern is rooted in the diversity of returnees' experiences and is indicative of the structural barriers (both in terms of infrastructures and social attitudes) experienced by migrants in accessing health care. This finding is also in line with the literature around the healthy migrant effect, which observed that the health advantage often experienced by migrants gets quickly lost post-migration.

Each context impacted the quality of returnees' health and how they coped with health needs, which was shown through the survey findings (Figure 9) and also supported by the semi-structured interviews. For instance, Georgian returnees in this study had poorer self-reported health compared to those from other countries because most returnees were older and had pre-existing health conditions before migration, for which access to health care was a primary driver for their decision to migrate (Figure 10).

Figure 9. Returnees' self-reported health status post-return, by country (numbers are counts)

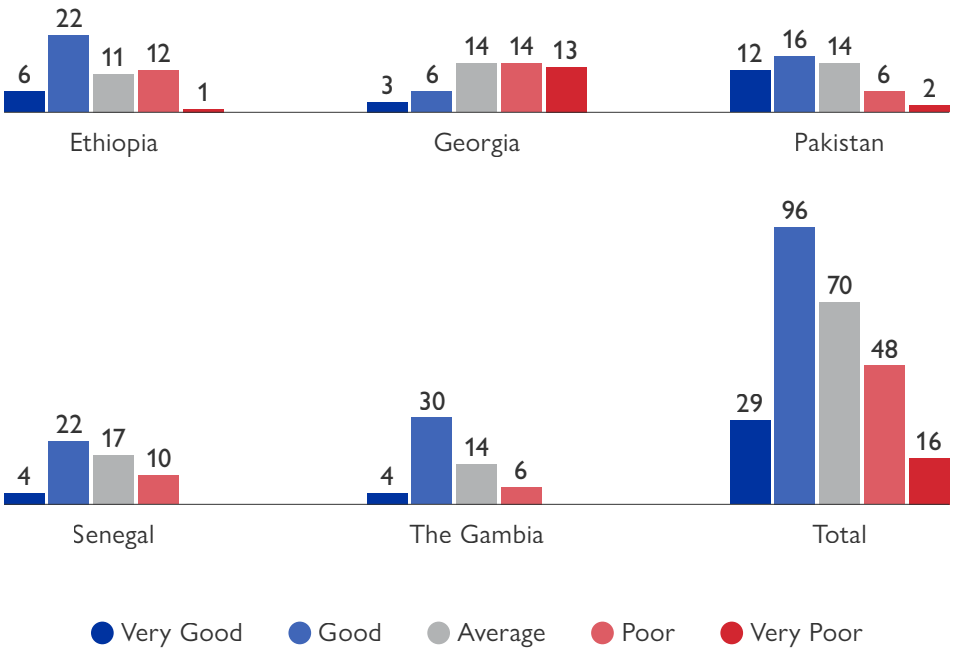
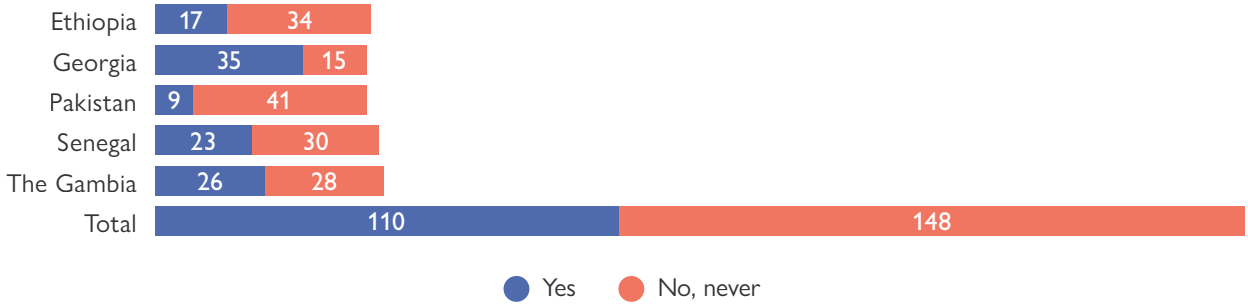


Figure 10. Returnees' self-reported chronic health conditions at post-return, by country (numbers are counts)

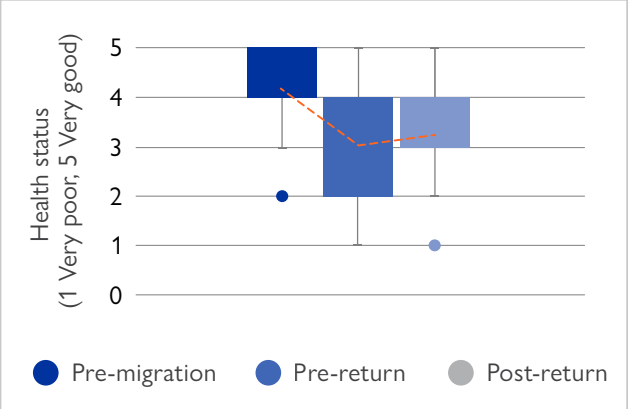


> *There is no positive thing [from my migration that] I experienced. It has deteriorated. Before migration, I was poor and my worry was how to get money. Now I even lost my health. Nothing is worse than losing one's health. My life totally ended in tragedy.*
>
> – *Interviewed returnee, Ethiopia*

1.4 HEALTH STATUS ACROSS THE MIGRATION CYCLE

The vast majority of returnees reported having good health prior to migration, which deteriorated along the migration journey, and remained as such upon return. This health pattern was reported by returnees, endorsed by key informants, and is supported by the survey data (Figure 11).

Figure 11. Changes in self-reported health status among returnees across the stages of migration



The survey with returnees found that only 1 per cent of respondents reported having poor health pre-migration, which increased to 37 per cent at pre-return, and decreased to 25 per cent post-return, although this remains much higher than baseline at pre-migration. This is in line with the literature suggesting that the healthy migrant effect often does not last long after arrival at destination.

The deterioration of health status, including physical and mental health, among returnees along the migration journey. A number of returnees during the interviews recognized the cumulative nature of negative health consequences from their migratory experiences abroad and when they return. The worsening of health was often perceived as a 'loss' among returnees, and in some cases this may be irreversible. A returnee who participated in a semi-structured interview had to undergo a leg amputation due to work-injury while in a host country, while another returnee had a permanent spinal cord injury with excretory system damage due to a gunshot wound when caught in a civil war crossfire during transit in Yemen.

Changes in returnees' health status across the migration cycle were also found to be influenced by various structural and environmental factors. Some returnees mentioned they started noticing physical health problems upon returning to their countries of origin, such as chronic pain due to being victims of physical violence and respiratory illnesses due to poorer health quality post-return. Some migrants returned to their countries of origin in a more precarious health situation than before they migrated. A number of returnees also mentioned experiencing mental health-related issues arising from their migratory experience, which shall be explored further in detail in the sections that follow. While some returnees indicated that their health improved post-return, such as having fewer allergies due to improved weather conditions, this remains the exception instead of the norm.

1.4.1 Pre-migration: Health-related drivers of migration

Migration is a non-linear process and a multitude of factors can influence an individual's decision to migrate, return, and remigrate.

The data collected during the study found that reasons for return were more likely to be health-related than reasons for migrating abroad. This study identified a number of health-related reasons that can either determine or weigh in migrants' decision to return to their countries of origin. These include, but are not limited to:

- Occupational injuries occurred while working in host countries;
- Exploitation and abuse experienced during detention;
- Worsening of pre-existing health conditions in host countries;
- Need to seek health-care service in the country of origin.

CASE STUDY 1: RETURNEE IN BRAZIL

A. is a Brazilian returnee who migrated to Belgium to work in construction. He reported being a victim of labour exploitation and having a work accident in the host country - where he was working irregularly – that caused him a wrist fracture. He did not receive any compensation for the injury and his employer withheld his salary. He was not admitted to a public hospital for the lack of documentation, and could not afford private health-care services. After the incident, and without having received adequate health care, he was no longer able to work and decided to return to Brazil.

Notably, **almost half of the Georgian returnees interviewed stated that their primary motivation to migrate was to access health-care services in host countries**, a percentage significantly higher than in the other countries. Two Georgian returnees mentioned that doctors in Georgia suggested they migrated elsewhere to access treatment which was not available locally or that the treatment quality was low. This indicates that in the case of Georgia, migrants' migratory decisions are, to a certain extent, shaped by structural factors, such as the quality of the health system in their country of origin.

In the other contexts, health was only one of the drivers of migration and return, and several respondents reported moving to seek better economic opportunities.

Even though the migrants who participated in the study reported having better health before migration than in the following stages of their journeys, several of them mentioned suffering from health conditions pre-migration. In some cases, when the health needs of migrants were left unmet in the country of origin or infrastructures were lacking to provide adequate care, health became a migration driver, at least partially contributing to an individual's choice to migrate.

For example, a Senegalese returnee explained that she decided to migrate to seek better medical care following complications that occurred after undergoing female genital mutilation. This case also exemplifies how gender may have a role in health-related migratory decisions at the pre-migration phase.

> *Indeed, at the age of 11, I [was excised]. The operation did not go well; there were complications with after-effects on my genitals. After a long treatment of more than ten years, there were no satisfactory results. I underwent both traditional and medical treatments with no results. I continued to suffer from periodic attacks; when this happens, I suffer pain in my vagina with the presence of a kind of abscess, I cannot walk. I can stay for days without being able to walk. It is on this, after obtaining [my bachelor's degree] in 2015, that my uncle advised me to continue my studies in Morocco so that I could benefit at the same time from their medical platform to get treated. Once in Morocco, the situation did not improve to the point that I could not continue my studies.*
>
> – *Interviewed returnee, Senegal*

1.4.2 During migration (in transit and host countries): Harmful effects of structural factors on health

The study identified a range of health conditions which returnees have reported across the migration journey, including but not limited to: non-communicable diseases, communicable disease, mental health conditions, sexual and reproductive health, preventive health, child health, elderly care, disabilities care, and oral health.

Based on the semi-structured interviews with returnees, it was **alarming to note the frequency of injury-related health problems that occurred while in transit or host countries.** These were most often related to physical violence and abuse while being

trafficked or smuggled Beatings and torture were a common experience among returnees who had been irregular migrants. Another common cause of injuries while returnees were abroad was labour exploitation and poor working conditions, which often resulted in long-lasting work-related injuries. **These long-term problems can turn into chronic health conditions, such as physical disabilities and mental illnesses.**

> *My biggest health concern at the moment is my mental health condition and the functioning of my brain. My brain stops working at random intervals, I don't even know what happens in that moment whether someone is calling me or beating me. I fell down on the ground. (…) Yes, these concerns are related to what happened during migration. (…) I left Pakistan because of a family dispute over land. Some of my cousins were in Greece too. They attacked me twice in Greece with knives. I still have scars on my head. The wounds were deep that really affected my mental health condition and functioning of the brain".*
>
> *– Interviewed returnee, Pakistan*

> *In terms of (physical) health, I have already observed various cases of people who have returned with some health-related problem due to the precarious work conditions they were subjected to in the countries they were living in, mostly developed due to excessive labour effort. I believe that some of the health cases also reflect a somatization of their psychic suffering, the development of a physical disease that is a reflection of their psychological suffering.*
>
> *– Key informant, Brazil*

During migration, returnees interviewed were exposed to various environments or structural factors that had harmful effects on their immediate and long-term health. These factors vary from context to context, but are more often related to poverty, discrimination in the labour market, lack of protection and legal documentation, travel and living conditions in the host country. Respondents also reported being victims of violence and attacks during their journeys or in the host countries, which led to health complications both in the short and long-term.

> *I realized all these health problems when I returned from Libya. Migrants were subjected to beatings randomly on any part of our bodies. Sleeping conditions were very bad as we slept on the ground even when it was wet. Food was not adequate and no medical care was given to even the sick. The security forces were heartless and racist.*
>
> *– Interviewed returnee, the Gambia*

The consequences of these experiences, in terms of physical and mental health, accumulate over time when health needs are not addressed in a timely manner, resulting in long-term negative health outcomes. Examples reported include:

- **Labour exploitation** – bone fracture, loss of limb and amputation, eye injury, skin burns;
- **Slavery and abusive practices** – physical injuries from beatings;
- Living conditions in **refugee camps** – ear infection, triggering of epilepsy episodes;
- Living conditions in **prisons and detention centres** – tuberculosis, physical violence, abuse, starvation, uterus infection
- **Physical violence** (both intentional and unintentional) – gun-related injuries, disabilities.

Table 5. Examples of health conditions mentioned by returnees in semi-structured interviews

	PRE-MIGRATION	IN HOST COUNTRY/ DURING TRANSIT	POST-RETURN
Chronic diseases	Attention-deficit/ hyperactivity disorder, anaemia, asthma, bronchitis, diabetes (type 1 and type 2), epilepsy, hypertension, muscular dystrophy, obesity, osteoarthritis, rhinitis, rosacea	Cataract (elderly), eczema, epilepsy, hormonal problems, stroke	Cancer, chronic diarrhoea, chronic pain from physical injuries, gestational diabetes, hormonal problems, kidney stone
Communicable diseases	Hepatitis C, HIV	COVID-19, ear infection, helicobacter pylori infection, hepatitis C, HIV, tuberculosis	COVID-19 (long symptoms), malaria, urinary tract infection
Others	Angioma, artificial heart valve, gastro-esophageal reflux, herniated disc	Constipation, dental problems, eye conditions, haemorrhoids, kidney problem, migraine, severe acne, skin problems, starvation, weight gain, ulcers	Migraine
Mental illnesses	Depression	Anxiety, depression, insomnia	Depression, PTSD, suicidal attempts,
Sexual and reproductive health	Pregnancy	Genital herpes, pregnancy (and related complications), uterus infection	Miscarriage, postpartum depression, pregnancy complications
Injuries	–	Bone fracture, death, gunshot wounds, paralysis/ disability (due to injuries), physical abuse and violence (beatings from smuggles/ detention officers), skin burns, work-related injury (and other injuries)	Paralysis/disability (due to injuries during migration journey)

1.4.3 Post-return: the "dual burden" of health needs

Upon return to their countries of origin, returning migrants reported facing the 'dual burden' of their long-term physical and mental health problems due to the type of trauma or work experienced during the previous phases of their migration journey. Psychosomatic symptoms (i.e. physical illnesses caused or aggravated by a mental factor such as internal conflict or stress) such as headaches and PTSD were commonly reported by returnees who experienced exploitation or other traumatic events. A further factor that was found to negatively impact returnees' mental health and well-being after return is the social pressure - and consequent stress - felt by migrants who failed to meet the expectations of their families or communities of origin. The dynamic relationships between the migration experience, physical health, and mental health could be understood through the syndemic theory, which stipulates that different health conditions could co-exist simultaneously and interact with each other driven by harmful social conditions.[41]

Overall, mental health care was identified as a key need among returnees, who tend to suffer from psychological stress related to the return experience. Unmet mental health needs were prevalent among interviewed returnees, either because they were not aware of them even though they were exhibiting signs of prolonged psychological distress, or because they were unwilling to seek assistance due to stigma surrounding mental health in the focus countries of the study. Notably, while conducting interviews during the fieldwork phase of the study, members of the research team observed that a number of returnees exhibited signs of mental health distress that warranted medical attention, although returnees did not mention mental health needs at all throughout their interviews.[42] Key informants pointed out that returnees are often in a state of denial, even though it is evident that there are mental health problems, which poses a challenge to interventions. This points to the need for some sort of formal objective screening process to uncover hidden health needs among returnees.

> *"Before I left Senegal. I had no health problems. I was doing well. But when I was in Sweden, I was so affected by the situation that I spent my time crying. I lost weight. The immigration service took me for tests to see if I had a disease. The results were negative. But I was in psychological shock because of the disappointment and the broken promises. I am still living this situation; I am disturbed mentally.*
>
> *– Interviewed returnee, Senegal*

Preventive health care is another health need that is often forgotten or neglected among returnees. While there are often health screening or medical check-ups before migration and upon arrival in host countries, there are few, if any, similar post-return arrangements for returnees. Therefore, new health needs that have arisen during the migration journey sometimes go unnoticed when returnees return to their countries of origin. For communicable diseases that are left undetected and untreated, this could pose a health risk not only to the returnee but also to their families and communities. While formal health assessments for returnees were not reported in the countries in this study, it is noted that in some other countries pre-departure guidelines exist and efforts are underway for post-return health assessment guidelines, despite challenges including the limited coverage of regular migrants only and associated costs.

In view of returnees' multistaged migration journey across locations, the study found that unmet health needs in terms of lack of continuity of care was an important area of concern. It is common for returnees to have health needs identified in host countries, but treatment or follow-up was inadequate upon returning to their country of origin. For instance, some returnees had received surgery in their host country but were unable to access post-surgical care upon return, while other returnees had begun treatment (such as for hepatitis C) in their host country but were unable to access the medication upon return.

41 Mendenhall E., T. Newfield and A. C. Tsai, Syndemic theory, methods, and data, 295(1): 1-6 (2022).

42 Fieldwork researchers were trained to provide information to participants on available MHPSS services when necessary.

Intersectional lens to understanding post-return needs. Cognizant of intersecting identities, the lens of intersectionality[43] has been applied when analysing how such factors influence the vulnerability and health outcomes of returnees. Following from the returnee profiles described earlier, certain groups of returnees were identified to have poorer health outcomes across the different stages of migration. These include:

- **Female returnees:** The deterioration in health for female returnees was worse than that for male returnees across the migration journey (Figure 12). The difference was found to be most significant at the post-return phase. The intersection of gender with health and reintegration outcomes is analysed in section 2.5.
- **Older returnees:** At the post-return phase, older returnees had increasingly poorer health. Some reported developing age-related disorders, such as cataract. Given that migration is not a linear journey, some returnees would remigrate upon return, sometimes repeatedly. As migrants advance in age during their migration journey, their health needs and vulnerabilities also change alongside. In the case of some returnees interviewed, older age was found to be a protective factor on mental health, as some returnees become more emotionally resilient over time. In other cases, however, older age proved to increase the vulnerability of returnees, especially when other factors came to intersect with the age element, such as having diverse SOGIESC. Older LGBTQI+ migrants and returnees were pointed out as a particularly vulnerable group during the interviews.

> *"This population [LGBTQI+] that works in the sex market has a more restricted working time over their lives. While these people are young, she/he will have a much higher volume of clients than she will after she gets older. It is often possible to find people who have travelled more than once and who no longer have clients because they have aged... and they used to be people who have never taken care of their physical and social health... so this person is excluded from society… especially when there is a combination of several factors in the same context: advanced age, belonging to the LGBTQI+ group, several experiences abroad, etc.*
>
> *– Key informant, Brazil*

- **Forced returnees:** Nature of return was found to be a key determinant of health among returnees. The survey found that the average health of self-identified forced returnees continued to worsen across the migration journey (Figure 13). This was the only group whose health worsened from pre-return to post-return, compared to returnees who self-identified to have returned voluntarily or partially voluntarily. The survey also found that 51 per cent of self-identified forced returnees had chronic health conditions, compared to 41 per cent and 39 per cent for partially voluntary and completely voluntary returnees. The qualitative data indicates that self-identified forced returnees were more likely to be victims of trafficking, labour exploitation, sexual exploitation, or slavery. These exposed returnees to various health risks, including physical violence, sexual violence, substance abuse, psychological trauma, and occupational injuries. Being in detention facilities increased returnees' risk of communicable diseases and exposure to physical violence. Death has also been reported as a result of unaddressed health needs and harsh conditions while being detained or kidnapped during the irregular migration journey. Returnees often did not dare to request for medical assistance while being detained for fear of retaliation and further abuse. Forced returnees often reported long-term health consequences, both physical (such as disabilities, chronic pain) and mental (such as PTSD).

43 Intersectionality is an analytical framework for understanding how aspects of a person's social and political identities combine to create different modes of discrimination and privilege.

CASE STUDY 2: RETURNEE IN ETHIOPIA

J. was an irregular migrant in Yemen who was apprehended by security forces and subsequently detained and imprisoned. While in prison, he was shot amid crossfire between the government and revolutionary forces of the civil war. The injury impacted his spinal cord, resulting in permanent paralysis and damage to his excretory system. He was deported back to Ethiopia and received medical treatment for his gunshot wound at a hospital in Addis Ababa with the assistance of the International Red Cross. However, there is no specialized health centre for follow-up treatment in the area where J. lives and the cost of additional care is too expensive. He is currently unemployed due to his disability.

- **Returnees who spent longer times abroad:** Those who have been away from their countries of origin for extended periods of time found it more difficult to reintegrate upon return, which was a major source of mental health stress. Survey findings also confirmed that the average health post-return was better for returnees who spent less than six months abroad, while those who spent at least six months abroad had much worse health. The long periods of time elapsed while returnees were abroad had implications on their social support network, such as availability of family and friends, as well as ease of adapting to a new environment that they were no longer accustomed to.

> *I came across a different situation from what I expected. When you are gone for so many years, you think that it is the same situation here.*
>
> *– Interviewed returnee, Georgia*

- **Returnees who returned more than one year before participating in the study:** In terms of time since the return, returnees who spent some months in the country of origin often reported more health and reintegration problems compared to those who have just returned. This could be due to the time needed for reality to sink in and for them to acknowledge the poor social support and difficulties in economic reintegration. This highlights the importance of the element of time when understanding returnees' health and reintegration, where a life course approach along the migration journey (including upon return) is highly informative. Survey data found that those who had returned between one to two years had poorer self-reported health than those who had returned less than a year ago.

Figure 12. Changes in self-reported status across the stages of migration, by gender (left)

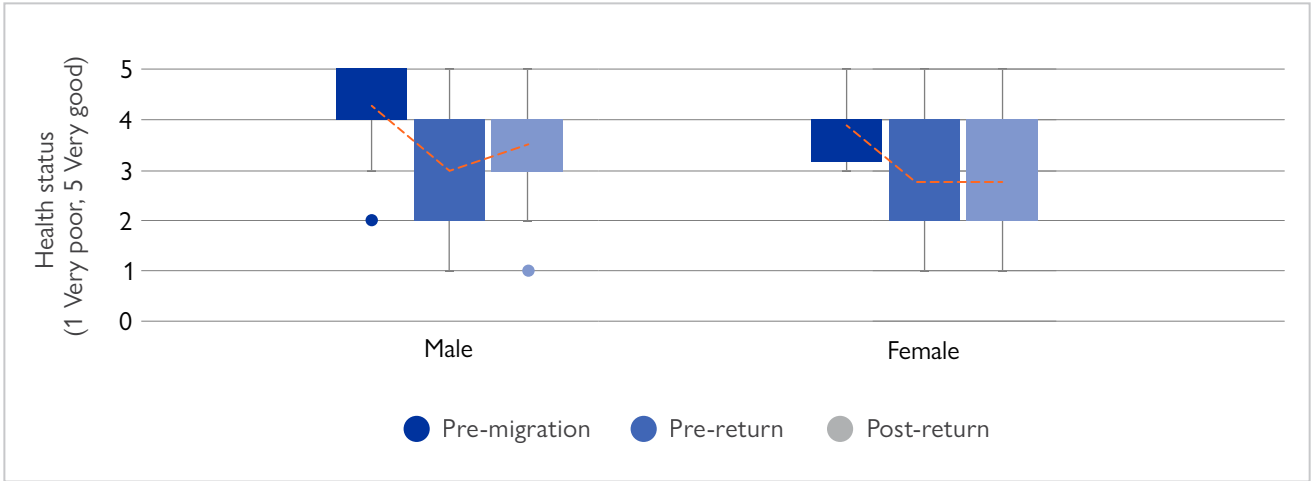
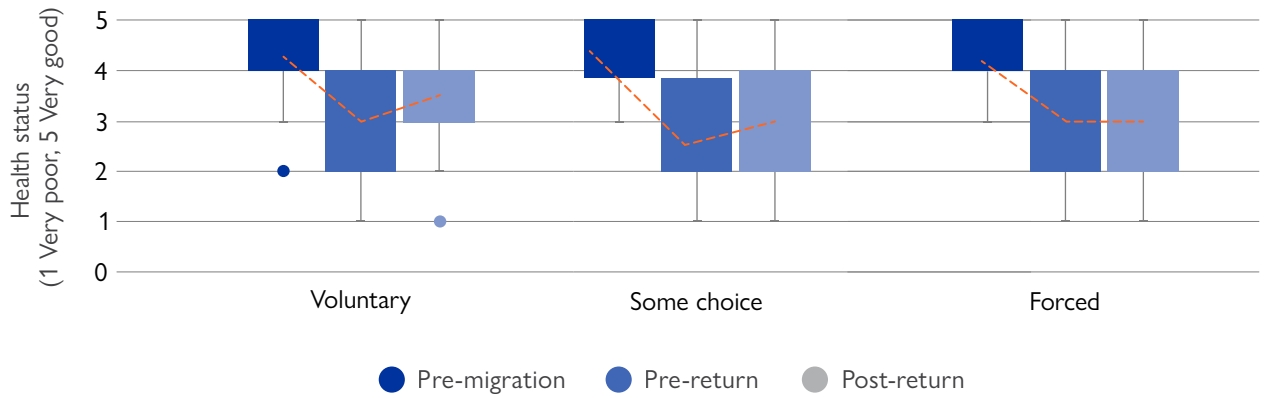


Figure 13. Changes in self-reported status across the stages of migration, by nature of return (right)



2. TWO-WAY IMPACT: HEALTH AND REINTEGRATION OUTCOMES

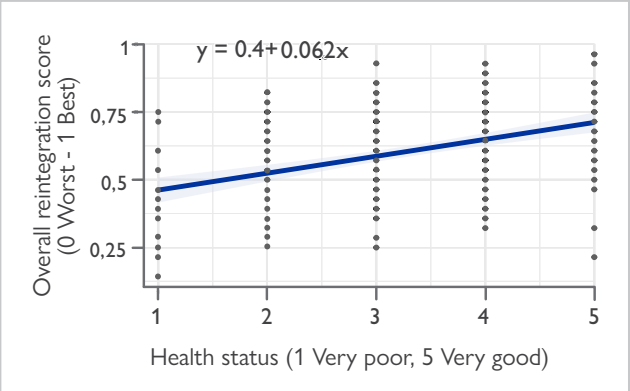
KEY MESSAGES

1. The data indicates a **linear relationship between poor health and poor reintegration outcomes** post-return. A two-way relationship between health and reintegration is mediated by multilevel stressors which may result in vicious cycles.
2. **Poor self-reported health was associated with poor social networks**. Physical and mental health conditions hampered returnees' participation in social activities, while returning to an unsupportive environment was a major contributing factor towards returnees' poor health, especially in cases of "failed migration" episodes.
3. **Returnees' willingness and ability to access health-care services were influenced by multiple individual and structural factors** including stigma and returnee-specific barriers to services.
4. **Economic reintegration was prioritized by returnees over their health needs, with long-term implications on their health and reintegration,** such as delayed treatment reducing capabilities to work and lead a decent life. Being unable to re-integrate economically negatively impacted on the mental and physical health of returnees, while poor health also impeded on returnees' ability to seek employment and business opportunities.
5. The data confirm that **male and female migrants experience migration differently, as they are exposed to different risks along their journeys,** and **different approaches to cope and respond.**

2.1 LINEAR TRENDS BETWEEN RETURNEES' HEALTH AND REINTEGRATION OUTCOMES

There is a linear relationship between health and reintegration in the study sample. The worse the health of returnees at post-return, the worse their overall reintegration outcome becomes. This linear trend was found to be statistically significant using regression modelling ($p<0.001$) (Figure 14). This was based on a composite overall reintegration score computed using the survey data, comprising indicators from each of the three reintegration dimensions (economic, social, psychosocial). Results showed that the worse the returnees reported their health to be at post-return, the worse was their composite reintegration score. Although the cross-sectional nature of our quantitative data meant that a causal relationship could not be implied between health and reintegration, a two-way relationship was identified between the two, which will be explored in the sections to follow.

Figure 14. Trend line (with 95% confidence interval) between self-reported health status post-return and overall reintegration outcome by regression modelling

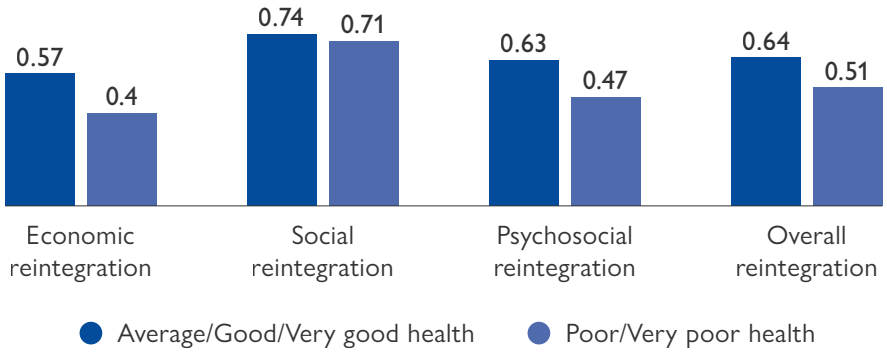


> *This should alarm us as a nation that the rate of return is very huge and when a significant number of women return with mental illness with no effective treatment this has a consequential impact on generations. Even when they get effective treatment there is a probability that a parent does not recover or remain with a permanent illness. Thus, when these ill-treated mentally affected returnees join the society they affect the transgenerational mental well-being of the society.*
>
> – *Key informant, Ethiopia*

The same groups who reported worse health post-return often also reported worse reintegration outcomes. These included female returnees, older returnees, returnees who have returned for a longer time, and returnees who have been away for prolonged periods of time. Returnees who have left their countries for a long time often return and find that the place they have left has changed dramatically and was not what they expected, as reflected in our interviews with returnees and key informants. Our survey also found that returnees who have been away for at least one year had worse overall reintegration outcomes than those who were away for shorter periods of time.

The worse the health of the returnees, the worse the reintegration outcome for that dimension (Figure 15). The qualitative findings from interviews reveal a two-way relationship between health and reintegration, observed across the three dimensions of reintegration. Thus while the main focus of the study is the impact of returnees' health-related needs on reintegration outcomes, it was clear in the data that the reverse direction – namely the impact of reintegration on returnees' health – was equally important. This bidirectional relationship between health and reintegration was analysed at depth in this study, and a multitude of interlinking pathways have been identified between health, health access, economic reintegration, social reintegration, and psychosocial reintegration, which shall be explored in detail in the following sections.

Figure 15. Post-return health status and reintegration outcomes, by each dimension of reintegration



Returnees' health and reintegration outcomes were shaped by and embedded within broader structural drivers of migration, such as policies on irregular migration, detention practices, and health system functioning. These macro-level structural drivers underlay the interacting pathways between returnees' health and reintegration, resulting in either positive or negative outcomes. Individual circumstances at a micro-level, such as gender, length of stay, and social locations, influence returnees' resilience and vulnerability to health and reintegration outcomes, which is moderated by meso-level factors, such as societal stigma and social support.

Building on findings of the mutual interlinkages between health and reintegration, **the study found that returnees were often caught in a vicious cycle of poor health and poor reintegration.** Good health comprises physical, social, and mental health. Without good health, it is difficult to achieve sustainable reintegration. Health conditions such as chronic pain or clinical depression impede returnees' ability to fully participate in a country's economic and social life. Particularly when there are delays in treatment, acute conditions can become chronic. And without successful reintegration, it is almost impossible to have good health. Financial struggles and the lack of social support negatively impact returnees' health, particularly mental and psychosocial health. The data indicates that negative impacts of health and reintegration may accumulate over time and reinforce the harmful effects on each other, which makes it harder for returnees to break out of the vicious cycle as time passes.

Intergenerational impact was an important area of concern mentioned by key informants. The health effects among **returnees who struggle with health and reintegration problems may negatively affect their next generation's health, well-being, and development.** With increasing stressors along the stages of migration, returnees experience worse health status, which negatively impacts on their reintegration success. This has negative knock-on effects on all three dimensions of reintegration (as will be explored in following sections), which impacts on the economic livelihood of members of the household as well as social development of children. From a societal perspective, this should be a cause of concern, which highlights the importance of the health needs and sustainable reintegration of returnees in countries of origin.

Mayoral Office runs Orientation and Assistance Point (POA) in Bogota's bus station where humanitarian partners IOM offer services to Venezuelan refugees and migrants. © IOM 2019 / Muse MOHAMMED

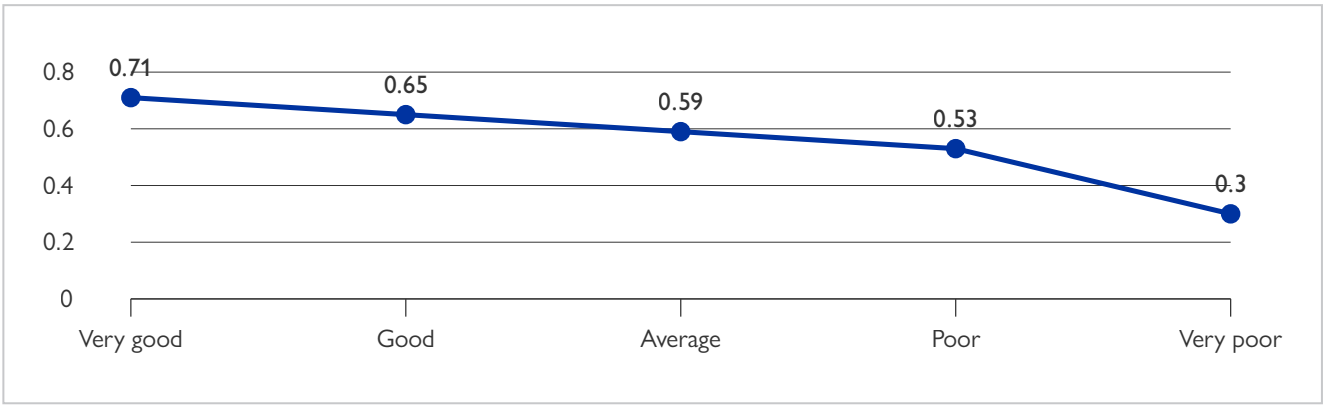
2.2 HEALTH AND PSYCHOSOCIAL REINTEGRATION

The six indicators through which the research evaluated psychosocial reintegration were:

1. Participation in social activities
2. Support network
3. Sense of belonging in community
4. Tensions or conflicts with family since returned
5. Discrimination since return
6. Signs of mental health distress

Psychosocial reintegration is a broad dimension of sustainable reintegration that encompasses emotional, mental, and psychological elements. The psychosocial dimension of reintegration is, by definition, linked to returnees' health and well-being, particularly mental health **Returnees' unmet needs and the lack of access to specialized health care negatively affect psychosocial reintegration** post-return: returnees who reported poorer self-reported health also had poorer psychosocial reintegration outcomes as compared to those who reported better health ($p<0.001$) (Figure 16).

Figure 16. Psychosocial reintegration score by returnees' self-reported health status post-return



> *There are these families [that] after picking up their mentally and physically affected daughter or son or relatives, hide [the disease] from the community and search for health-care services, or take them to religious places, and only reveal [the disease] when the returnees get very well.*
>
> – *Interviewed returnee, Ethiopia*

2.2.1 Impact of health on psychosocial reintegration

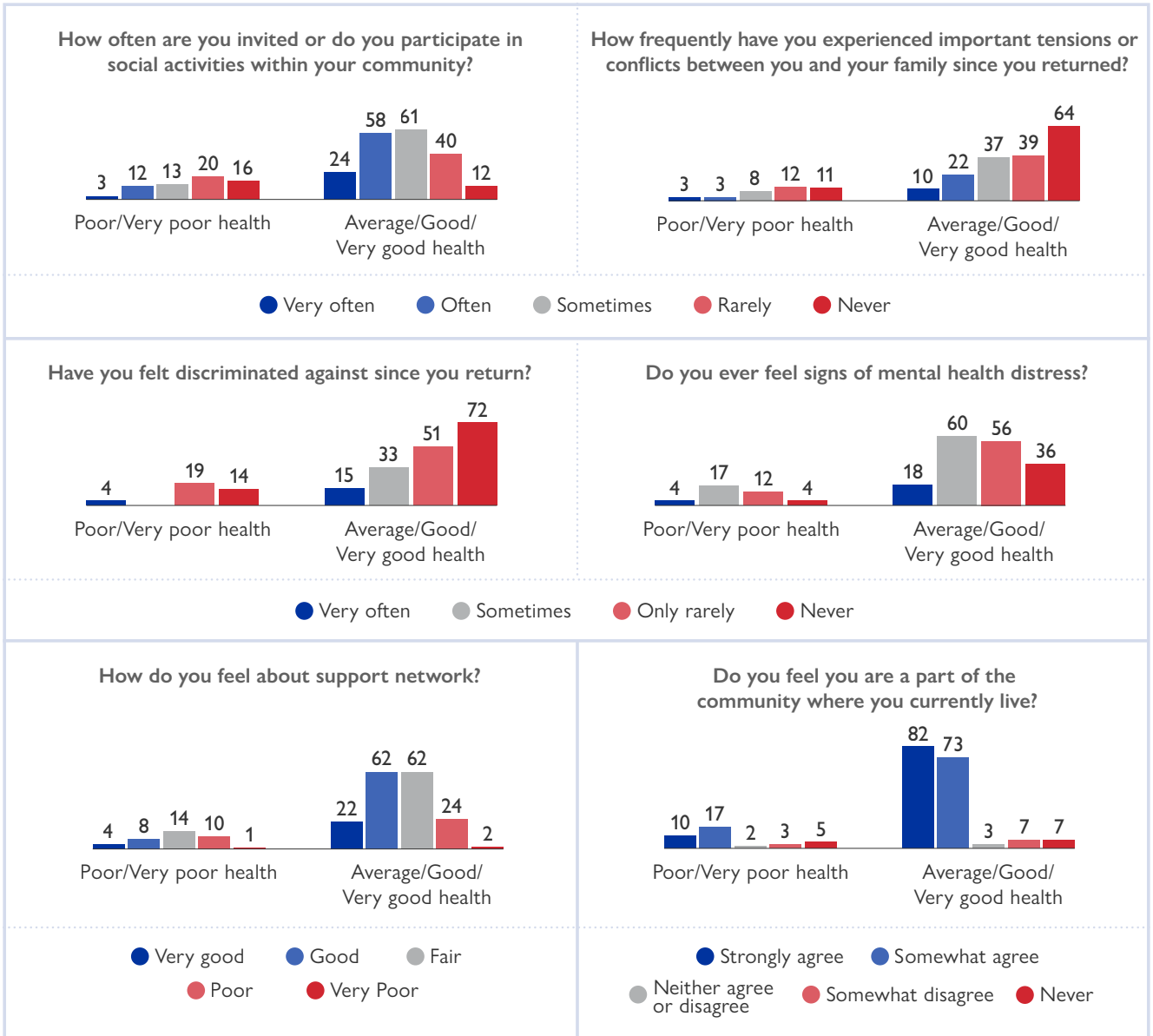
Returnees' unmet health needs were found to negatively impact psychosocial reintegration in several ways:

- **Restricted participation in social activities:** Returnees who suffered from chronic pain or injuries due to their work or trauma experienced while abroad found it more difficult to participate in social activities. One returnee who became obese post-return reported being unable to access adequate medical support and this led to her low self-esteem, which in turn led to her unwillingness to interact socially due to negative body image. Survey findings showed that among returnees who self-reported poor health, 56 per cent of them rarely or never participated in social activities within their communities post-return, compared to only 27 per cent among returnees who self-reported good health.

- **Social seclusion by family:** In certain cultures where mental illnesses or physical disabilities are considered social taboos, returnees with these health conditions were reported to be "hidden" by their family from the community due to fear of stigma and feelings of shame. This has important implications on returnees' reintegration as this hindered returnees' participation in social and economic activities.
- **Consequences of mental health distress:** On the other hand, returnees with psychological distress reported that this hampered them from being able to socialize and connect with their families and communities. Returnees expressed that they noticed themselves being more easily irritable and agitated from daily interactions with others, which was only noticeable post-return and created difficulties in getting along with others.

Survey findings confirmed that returnees who self-reported poorer health status also reported lower participation in social activities within their communities, poorer support network, and lower sense of belonging in the community (Figure 17). Whereas the differences between returnees who self-reported poorer or better health status in terms of experiencing family conflicts, discrimination, and mental health distress were less noticeable.

Figure 17. Key indicators of psychosocial reintegration, by returnees' self-reported health status post-return



> *About mental health and psychosocial support, the issue is that there are a number of cases where "About mental health and psychosocial support, the issue is that there are a number of cases where people don't even accept the condition and they're unable to register that it is a thing. There is a lot of stigmatization attached to this. For their physical illness, they will be ready to talk about that. But if you bring up mental health and stress history, you will feel that they're not comfortable talking about it. There is way too much stigmatization. Returnees are too scared to be labelled.*
>
> – *Key informant, Pakistan*

> *There are these families [that] after picking up their mentally and physically affected daughter or son or relatives, hide [the disease] from the community and search for health-care services, or take them to religious places, and only reveal [the disease] when the returnees get very well.*
>
> – *Interviewed returnee, Ethiopia*

2.2.2 Impact of psychosocial reintegration on health outcomes

The health impact of stigma due to returnees not achieving their "migratory objectives" was raised by the majority of respondents in the survey and the qualitative data. As described by a key informant, the failure to achieve the migration goal and falling short of returnees' own, or their families' and friends', expectations often result in feelings of guilt, shame, and frustration, which has significant negative consequences for returnees' mental health. These have been previously discussed in the literature on the stigma of return.[44]

> *When they come back, they are affected by the fact that they could not fulfil their dreams. And this is why they need psychosocial counselling.*
>
> – *Key informant, Pakistan*

This study contributes to this evidence by shedding light from a health angle both from qualitative and quantitative findings. The survey found that among returnees who felt to be part of the community, 85 per cent reported good health, compared to a somewhat smaller percentage (64%) who did not feel to be part of the community. The returnees interviewed often faced unrealistic expectations from their families or friends on the economic success of migration. When returnees came back to their countries of origin without meeting such expectations, they often faced prejudice in the community as they were expected to be financially better off. While there are societal expectations on the myth of the "successful migrant" story, in reality, key informants have expressed that such successful migration stories are actually rare ("If I put it in percentages, just about 1 per cent of migrant workers succeed when they return home", said a key informant). Returnees experienced discontent and disapproval from families or friends when they were unable to repay them for funding returnees' migratory expenses. Returnees often developed mental health problems due to the stress caused by not meeting such expectations and societal stigma. This was especially difficult for returnees who "failed" before even reaching their desired destinations, often those who went through a smuggling route and were arrested before ever arriving at their host country. In some rare cases, as indicated by key informants, the reverse occurred, in which returnees' families had misused remittances and when returnees came home, they could not find the money which could have been used to pay for health services.

Apart from stigma from external sources, some returnees interviewed expressed **self-imposed expectations and pressures** due to not meeting their own migratory objectives. These include a sense of responsibility to take care of family upon return, not being able to support family financially, comparison of their own "failure" with those of their acquaintances, and feelings of guilt for not having met migratory expectations. Such **self-perceived stigma and discrimination often results in low self-esteem**, **which causes mental health distress** as well as withdrawal from social interactions and activities, reinforcing a vicious cycle.[45]

44 Schuster and Majidi, *Deportation Stigma and Re-Migration.*

45 Habtamu K., A. Minaye, A. and W. A. Zeleke, Prevalence and associated factors of common mental disorders among Ethiopian migrant returnees from the Middle East and South Africa, *BMC Psychiatry* 17(144): 1-11 (2017).

The research findings clearly suggested that **returning to an unsupportive environment was a major contributing factor towards returnees' poor mental health, including at the family, peer, and community levels.** This is supported by survey data in which the poorer the perception of support network among returnees, the poorer was their self-reported health. Some returnees expressed that they expected to receive better social support upon return to their country of origin, which however was not always the case, and sometimes led to mental health issues or the exacerbation of physical health problems, such as obesity due to lack of motivation and physical activity. In some cases, returnees were outrightly rejected by their family. A returnee interviewed was evicted out of her home by her father since she returned "empty handed", which caused her to suffer from high levels of mental stress and insomnia. **Returnees also experienced reverse cultural shock and challenges in assimilating back into their communities.** The readjustment and re-adaptation required upon return was sometimes a surprise to some returnees, since the reality they were returning to had significantly changed after their migration, and their country was no longer the place they had left, causing them mental distress.

> *I always tell my patients... they go back to space, to the city where they used to live and everything else... but they don't go back to "time".*
>
> – *Key informant, Ethiopia*

Duration of migration and time since return were found to be moderating factors for psychosocial reintegration. The qualitative findings show that returnees who had been away for longer times experienced a loss of social support upon return, whereas returnees who had been away for a shorter period had more positive experiences of return, as they could still rely on a social support network. A returnee interviewed explained that both his parents passed away while he was away from home and when he returned to his country of origin he found out that his siblings had taken all the remaining belongings.

Age was another moderating factor identified in the data. Mental health needs were greater among younger returnees, since their parents were often dissatisfied with the outcome of their migration and lack of financial stability upon return, while older returnees were often better socially supported by their families, usually by their children.

> *At community level sometimes I feel stigmatized by peer groups and some elders who see me as a failure. [It] is very difficult for me sometimes to cope in the community due to the eyes they set on me since returning from my journey.*
>
> – *Interviewed returnee, the Gambia*

> *The other problem is that since I returned from my journey I got very stressed. I got angry very early and was ready to fight anybody coming my way. I was not like this prior travelling but now I am very stressed. Even my family is very much worried about my situation.*
>
> – *Interviewed returnee, the Gambia*

On the other hand, positive psychosocial reintegration was found to contribute towards returnees' health. Returnees reported that being able to contribute to their communities of origin gave them a sense of connection, and participation at the community level (such as joining choir and exchange community services) had a positive influence on returnees' mental health.

2.3 HEALTH AND SOCIAL REINTEGRATION

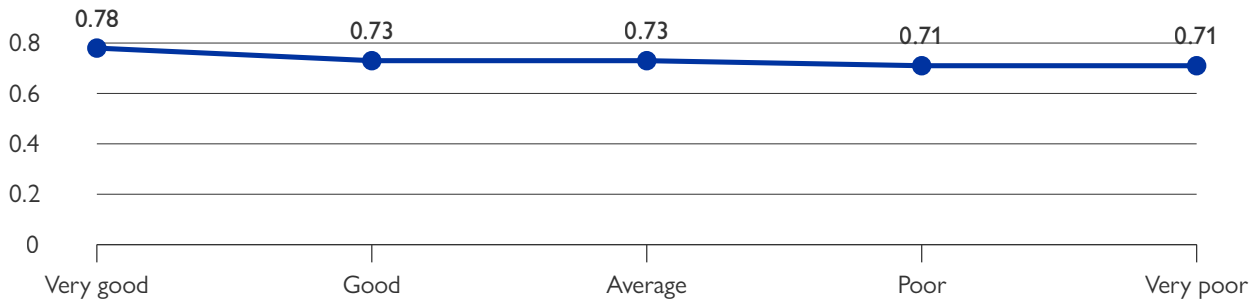
The five indicators through which the research evaluated social reintegration were:

1. Access to health services
2. Access to housing
3. Access to safe water and food
4. Access to justice and law enforcement
5. Ownership of identification document

The relationship between health and social reintegration was primarily in the direction of the effects of social reintegration on returnees' health.

Returnees who reported poorer health also had poorer social reintegration outcomes as compared to those who reported better health, although the difference was relatively small compared to the economic and psychosocial dimensions (Figure 18). The data collected also shows that returnees who have been away for at least one year had worse social reintegration outcomes than those who were away for shorter periods of time. While returnees who came back for at least six months had worse social reintegration outcomes than those who returned less than six months.

Figure 18. Social reintegration score by returnees' self-reported health status post-return



2.3.1 Returnees' access to health services across the migration cycle

> *If I go to a health-care centre after migration, people may judge me as if I am HIV positive or something like that… The judgement that the community put on me has to some extent caused me not to go to the health-care centre.*
>
> – *Interviewed returnee, Ethiopia*

Some issues related to access to health care are specific to returnees and are augmented as a result of being a returnee, as compared to general access issues shared by both returnees and the general public in countries of origin.

Table 6. Barriers to accessing health care that are specific to returnees and those shared by the non-returnee population

BARRIERS SPECIFIC TO RETURNEES	BARRIERS FACED BY RETURNEES SHARED BY THE NON-RETURNEE POPULATION
• Denial of care because health condition (such as accident) occurred overseas • Discrimination against returnees who were victims of trafficking • Misconceived perceptions towards returnees in relation to sexually transmitted diseases • Financial difficulties in affording health service when returnees are not economically reintegrated • Lack of information on how and where to access care, particularly if returnees have been away for prolonged periods • Lack of documentation or identification papers, particularly if returnees have been away for prolonged periods • Language barriers, particularly if returnees have been away for prolonged periods	• Cultural barriers due to stigmatization of certain health conditions (such as mental health) • Lack of health insurance • High costs of health services, including medication • Long waiting time • Lack of specialist in local area • Medication shortage or unavailability • Transportation costs associated with accessing health care

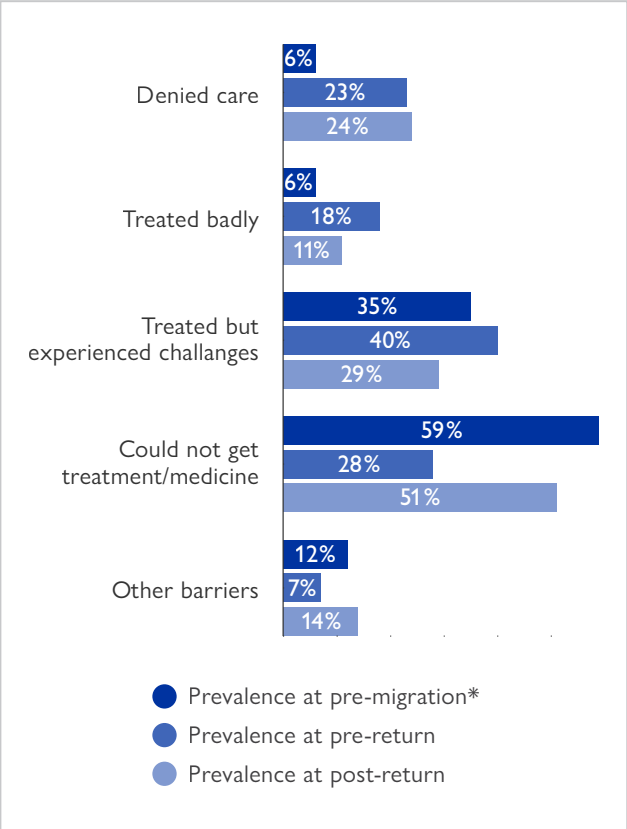
In this section we seek to understand *where* returnees access health care. Returnees most commonly sought care at hospitals across their migration cycle and upon return, of which public hospitals were more commonly accessed than private hospitals. The second most commonly accessed health-care facility was clinics, of which private clinics were used much more commonly than public or NGO clinics. Some returnees sought care through traditional medicine or healers, and other service providers (such as international organisations). **The primary consideration among returnees when seeking care was affordability. In most circumstances, public hospitals were often the first point of contact for returnees**. However returnees were sometimes denied care for a multitude of reasons post-return, such as lack of legal documentation.

This denial upon return only echoed previous denials faced along the migration journey: the most common barrier identified was not being able to get treatment/medicine. In transit and host countries, migrants generally experienced challenges such as language barriers, neglect at the hands of local authorities, which often resulted in delayed or denied treatment (Figure 19).

> *We just arrived here in Brazil… if we could find health assistance for my husband and daughters, it would be wonderful. Another thing is that I still could not regularize the IDs [identification documents] of my two daughters that were born [in Belgium] because I have no conditions to go to Brasilia to do it, I could not translate their school transcripts either.*
>
> *– Interviewed returnee, Brazil*

When compared to 6 per cent at pre-migration stage, 23 per cent and 24 per cent of returnees reported being denied care in transit and host countries and post-return respectively. Returnees also reported being treated badly more often during pre-return and post-return, as compared to the pre-migration stage. These barriers were experienced by returnees on top of non-specific barriers also shared by the non-returnee population, including high costs of medication and lack of specialists.

Figure 19. Most common barriers to health care reported by returnees post-return



* Only asked if respondents left their country of origin less than 12 months ago.

> *In my three years stay [in Zambia], I did not access health care because nobody cares about migrant prisoners. As I said, I have been in the desert [during transit] and in prison. Although I needed it, I did not get access to health care. Not speaking English is one factor not being able to access health care in addition to their ignorance [of our rights to health care]. In our desert stay, it is a luxury to request health care service.*
>
> – *Interviewed returnee, Ethiopia*

Barriers to accessing health care are conventionally categorized into five dimensions: affordability, accessibility, availability and accommodation, acceptability, and appropriateness.[46] Depending on each of these dimensions, returnees may or may not be able to actually utilize health services. For instance, public health services could be free to returnees in their countries of origin upon return, however it may still be inaccessible due to the long distance and high transport costs among returnees who struggle to reintegrate economically. The survey indicated that returnees found it more difficult to access health care at pre-return in host countries and at post-return in countries of origin, compared to pre-migration. This implies that returnees faced additional barriers when accessing care, which were not faced by the general population. These barriers were evidenced in interviews with returnees:

- **Affordability:** Affordability of health care was related to returnees' legal status in host countries. For instance, returnees who were asylum seekers in Switzerland and France were provided with free health care. In terms of work terms and conditions, only those in formal employment may be protected by health insurance, however often this is insufficient to cover health expenses and hence returnees were still unable to access needed care. At post-return, some returnees began treatment in the host country but were unable to access medication post-return due to high costs or unavailability in their country of origin. Returnees often face financial difficulties in accessing health services, especially when they are not economically well integrated or if they are not well supported by their family upon return. In some countries of origin, whether or not one is a returnee has relatively little impact on health-care access. For instance in Pakistan, data showed that being a returnee or not is often not a major determinant of whether one can access health care, but socioeconomic status is. Returnees with good financial support do not face much difficulty when accessing care, whereas returnees with poor financial standing face similar barriers as non-returnees who are also less economically well-off. Some returnees may not mention that they are returnees in order to be treated better by health workers.
- **Accessibility:** While in host countries, returnees faced various structural barriers to health care arising from individual circumstances as well as more contextually based on their host countries. It was common for returnees to report experiencing

46 Levesque J., M. F. Harris and G. Russell, Patient-centred access to health care: conceptualising access at the interface of health systems and populations, *International Journal for Equity in Health* 12(18): 1-9 (2013).

xenophobia or discrimination from health workers in host countries, as well as language and cultural barriers. For instance, one returnee mentioned that mental health was a taboo in Japan (host country) and hence found it difficult to access mental health services. Some returnees also had a lack of information on where and how to access health services in host countries. At post-return, some returnees reported barriers include the lack of information on how to access services, lack of documentation or identity papers, and language barriers, especially if returnees have spent many years abroad. In terms of travel time, the survey found that only 10 per cent of returnees had to travel more than one hour to health facilities at pre-migration, which increased to 20 per cent at post-return, implying that there were higher direct and indirect transport-related costs when returnees accessed health care.

- **Availability and accommodation:** At pre-return, some returnees reported that the lack of paid sick leave during weekdays implied that they were unable to access public health services since these were only open during weekdays. There is often limited access to health care at all in prisons or detention facilities, and if any the quality of health care was reported to be low. As for the transit stage, a number of returnees reported that there was virtually no access to health care. Thus the right to health is virtually non-existent for irregular migrants who are in transit. It was not uncommon that irregular migrants had not accessed any health services at all throughout their migration journey despite having health needs, and only accessed health services upon return to their country of origin.
- **Acceptability:** At pre-return, irregular migrants often reported fear of seeking care, and when they do seek care they are often asked to pay for high fees that they could not afford At post-return, some barriers that were specific to being a returnee were related to culture and social norms. Returnees found it difficult to discuss sensitive health topics upon return, such as sexual health and mental health, due to social taboos. There is often discrimination and stigma towards returnees who were victims of trafficking or sex workers. The fact that returnees are known in their local communities upon return could pose a barrier to accessing health care, especially for health issues such as sexually transmitted infections which may cause gossip in the local community. Whereas the anonymity of being in a foreign country was a facilitating factor for returnees to health care in their host country.
- **Appropriateness:** Some barriers faced by returnees post-return were related to continuity of care. For instance, one returnee was unable to continue post-surgical rehabilitation upon return because he was told that the accident and surgery occurred outside of the country of origin. Other barriers were related to the appropriateness of treatment. One returnee indicated that he was given expired cancer medicine which he reluctantly accepted since he did not have other options. While another returnee indicated that he was not given the right medications post-return as compared to the medications he had been taking pre-return.

When returnees were unable to access public health services due to a number of financial, structural or logistical problems, they reported resorting to different coping strategies. In some instances, returnees had to pay out-of-pocket to access either public or private health care, and if they were not financially supported by their family or friends, they often sought alternative solutions.

Returnees from more than one country mentioned using IOM business grants to pay for their treatments. Some returnees self-purchased medications either in pharmacies or through other informal channels, more affordable than hospitals or clinics. Other returnees attempted to expedite their access to health care through personal or social connections.

A number of returnees from Brazil, Ethiopia, the Gambia, Pakistan, Senegal reported seeking health care through traditional medicine for several reasons:

- Traditional medicine is generally more affordable and accessible than modern medicine. In some cases, returnees resorted to this option even when they had reservations on the effectiveness of traditional medicine, and for financial reasons only. For example, a returnee reported self-treating using traditional medicine for cancer, despite being aware of its lack of effectiveness, only because he was not able to afford chemotherapy.

- In some countries, it is common to seek mental relief through traditional healers. In such cases the use of traditional medicine is understood as a cultural practice rooted in social norms, which can lead to health complications when used as a substitute for modern medicine, rather than complementary to it. It is also important to note that in some instances, returnees preferred traditional medicine over modern medicine, especially when they believed that their health problems could not be treated by modern medicine, or when doctors were unable to diagnose their health problems.
- The use of traditional medicine to address returnees' health-care needs was found to be more common in rural areas, where it is much easier for returnees to access traditional healers than doctors in hospitals or other health-care facilities.

On the other hand, some returnees reported that their experience with traditional medicine was negative and hence no longer using it. For example, a returnee used traditional medicine to treat the chronic pain caused from beatings while he was detained, but he decided to stop using it after some complications occurred. In general, providing more health education to returnees could enable them to better understand their health needs and how to best address the needs given their circumstances.

2.3.2 Impact of health-related needs on social reintegration outcomes

The impact of health on social reintegration – defined as access to social services – was primarily mediated via returnees' access to health services. In some countries, returnees face societal stigma and discrimination, especially those who have been victims of trafficking, which impacts on returnees' help-seeking behaviour. One example is Ethiopia, where returnees are often believed to have HIV, and hence reluctant to seek health care for fear of discrimination. Another example is Brazil, where some returnees who had been victims of trafficking did not feel that they "deserved" to be treated for free like the rest of the public upon return. This indicates that returnees would sometimes internalize societal stigma and discrimination, refusing to accessing health care, with indirect negative consequences on their overall health.

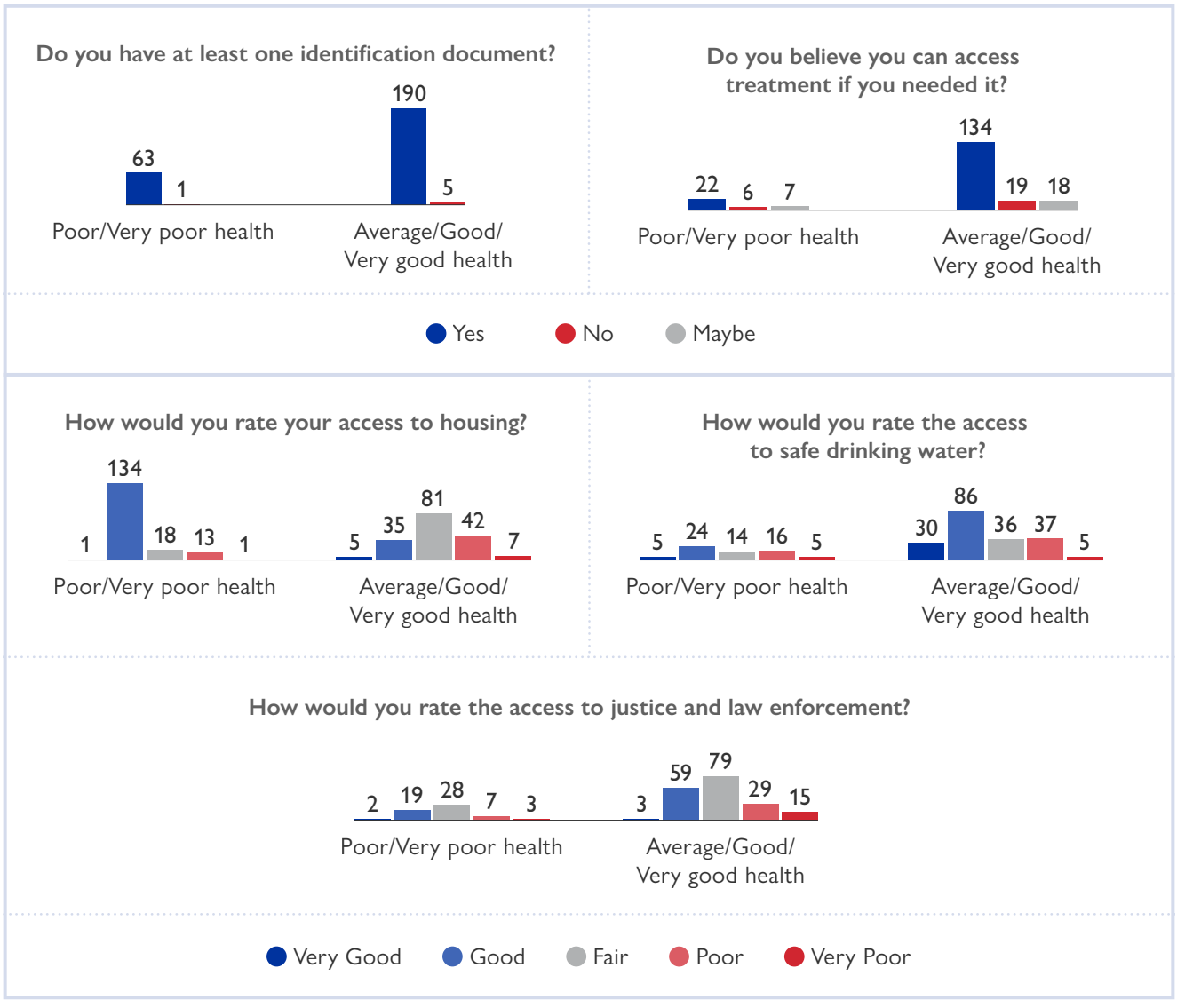
Separating external barriers to accessing health care (which have been explored in the section above) from internal barriers, the study found that **returnees' health conditions played a role in influencing their willingness to seek health services due to different types of health-related internal fears**. Some returnees felt that they could not express themselves openly about their health needs for fear of discrimination. Several returnees from the Gambia expressed that disclosing their health problems was an equivalent to a disclosure of their "failure" to reach their desired migration destination, hence reluctant to share with others for fear of gossip and social ostracization. Similarly, some returnees were unwilling to seek medical care for their health needs because the cause of their medical problems might reveal that they have been irregular migrants, such as a Senegalese returnee who had a gunshot wound while crossing borders. Some returnees, including those from Ethiopia and Pakistan, were reluctant to open up on personal health issues, including mental health, because they felt that others would not understand their situation. On the other hand, some returnees, particularly from Georgia, were reluctant to share their health problems because they did not want to "bother others" and that they believed their health problems were as common as other non-returnees, such as hypertension. Other returnees, however, considered having health problems as a negative social label associated with lower social prestige and hence reluctant to disclose nor seek care.

> *I have travelled under trying conditions; I have spent nights walking and sleeping in the desert. Once we were ambushed, our car was shot at and I was wounded in the knee. I never had a treatment for this knee injury and it is still paining me very seriously. Once in Libya the living conditions were bad and hard. I worked as a mason. The sea crossing to Italy was not easy. I am currently feeling all these after-effects. For example, I cannot stand for a long time because of my knee injury and I have been facing this pain since the time our car was ambushed. I did not seek help. I think it's getting even more tiring because I can't find anyone to address my concerns. I did not ask anyone for help for fear that they might know of my condition... I've been self-medicating with painkillers like paracetamol since 2019.*
>
> – *Interviewed returnee, Senegal*

Returnees who were not able to seek health care post-return had worse health than those who were able to seek health care. 24 per cent of respondents who were unable to seek health care also reported having poor health, while only 14 per cent of those who were able to seek health care reported poor health (Figure 20).

Apart from the negative effects of barriers to accessing health care on returnees' health, discussed in previous sections, this study also identified other aspects of poor social reintegration which had negative health consequences (i.e. poor access to social determinants of health). Poor housing conditions were commonly reported to have negative health consequences on returnees' health across the migration journey. Returnees who have been detained while in transit or in their host countries often reported being held in crowded and unhygienic facilities, with poor water sanitation and a risk of cross contamination. This has led some returnees to acquire communicable diseases, including tuberculosis and ear infections. Post-return, the survey found that 23 per cent of returnees with good self-reported health reported good access to housing in their communities, compared to only 13 per cent among those with poor self-reported health. Similarly, in terms of quality of housing, 28 per cent of returnees with good self-reported health rated their standard of housing as good, compared to only 22 per cent among those with poor self-reported health.

Figure 20. Key indicators of social reintegration, by returnees' self-reported health status post-return



CASE STUDY 3: RETURNEE IN BRAZIL

S. was attacked and robbed near the low-income housing complex that he lived in after returning to Brazil from Portugal. He reported that the assault was due to prejudice because he had migrated abroad.

> *Most people think that if we leave Brazil, we have an obligation to return as a millionaire. Then to see a person who has returned and doesn't have much money is considered a failure. People are prejudiced because I immigrated and returned. I was not happy in Brazil and I went there to try my hand at life. It did not work and I came back. And the violence I suffered - which I have scars from until now - was because of this. Prejudice for having migrated.*

S. filed a police report following the incident and took a forensic examination. However, that has been the extent of the legal follow-up. He has described an increase in anxiety and depression following his return to Brazil and hopes to eventually go back to Portugal once his three-year restriction on migrating again is lifted.

Malnutrition was also a common problem faced by returnees during different stages of their migration journey, particularly in prison or detention facilities. In some cases, chronic malnutrition has led to muscle wasting and a weaker immune system, with long-term consequences on returnees' health as well as reintegration outcomes. A returnee in the Gambia reported returning emaciated due to limited food and water during his previous migration experience, which has negative implications on his ability to reintegrate. Poor access to legal systems and justice was also reported by a returnee to have significant negative physical and mental health consequences, as detailed in the case study below.

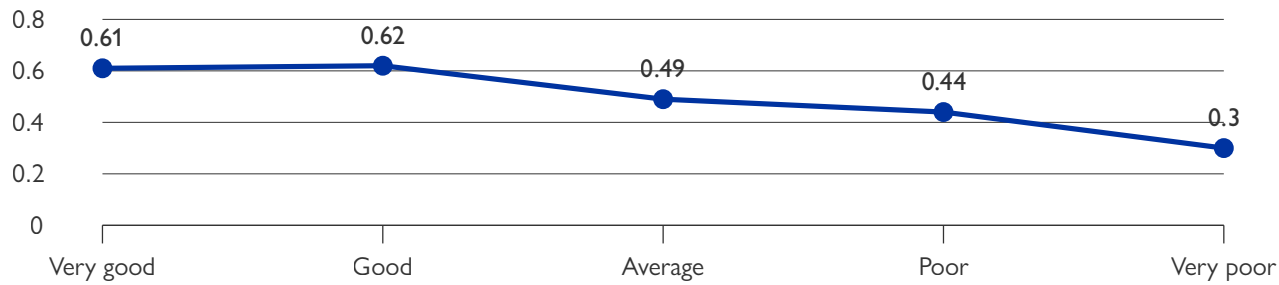
2.4 HEALTH AND ECONOMIC REINTEGRATION OUTCOMES

The four indicators through which the research evaluated economic reintegration were:

1. Satisfaction with current economic situation
2. Access to employment opportunities
3. Currently earning
4. Unemployment

Economic reintegration was found to be worse among returnees with poorer health status post-return (Figure 21). The effects of returnees' health needs on economic reintegration can be categorized into direct and indirect ones. In terms of direct effects, returnees with unmet health needs often reported difficulties in finding employment or maintaining their businesses. One returnee who received an IOM business grant explained that he was unable to operate his street vending businesses consistently due to his recurring health problems. This is particularly true for returnees with mental health disorders or chronic pain caused by traumatic events occurred during their migration journey. In turn, this leads to fewer earnings, resulting in a lower ability to afford health services, again creating a vicious cycle. The research findings also identified several cases of unemployment due to disability, most often from occupational injuries or physical violence while abroad. This created a vicious cycle as financial constraints due to unemployment posed further challenges in seeking health care for these returnees.

Figure 21. Economic reintegration score by returnees' self-reported health status post-return



> *If you have no clue about when you are going to do a treatment you need, if you don't know how much you are going to pay for it, if done privately... How are you going to build your future plans if there is a health-related urgency holding you back? It affects them tremendously.*
>
> – *Key informant, Brazil*

In terms of indirect effects of health on economic reintegration, **returnees reported spending a significant portion of their income on health expenditure (such as medications), limiting the amount of resources they could invest in their businesses.** As mentioned above, several returnees mentioned diverting their IOM business grants to medical purposes as a last resort. Moreover, when the returnees interviewed were uncertain about their future health improvement and prognosis, including associated financial costs, this hindered their planning in terms of economic reintegration, since it became difficult for them to predict their future health expenditures and ability to work for earnings.

On the other hand, some returnees reported how addressing their health needs benefited their economic reintegration (Figure 22). **When returnees' health needs were adequately addressed, they were able to find employment and secure a source of income upon return.** Paying for health-care services was also a motivating factor for some returnees to seek employment opportunities after returning to their country of origin. In hindsight, some returnees were aware that once they lost their health, this would be irreversible and that it was not worth losing one's health for uncertain economic gains.

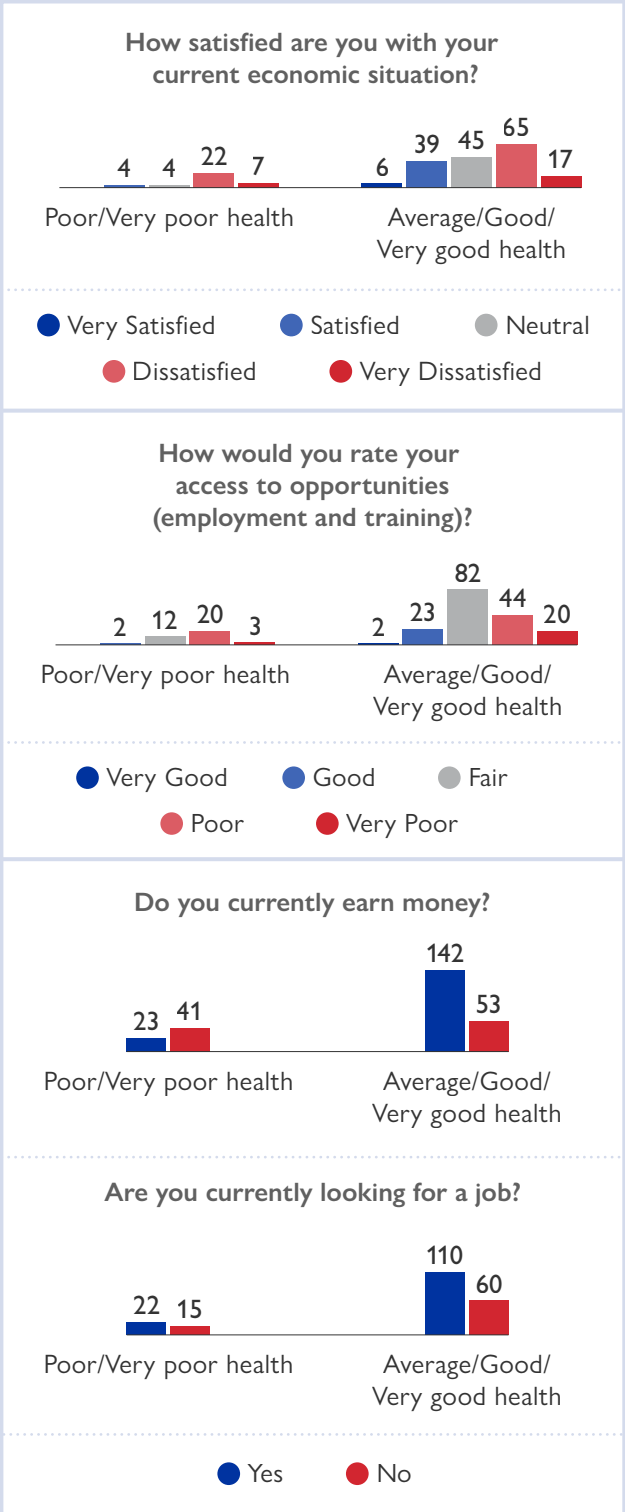
CASE STUDY 4: RETURNEE IN PAKISTAN

A. returned to Pakistan with IOM support after several years of working as an irregular migrant in Türkiye and Greece. While in Greece, he suffered two knife attacks due to a family dispute with some of his cousins who were also working there. He has reported a variety of long-term health issues as a result of the assault, including mental health problems, reduced brain functioning, and poor digestion. IOM provided A. with 400,000 Pakistan rupees (ca. 1,800 United States dollars) as part of his reintegration assistance and he used the money to buy two buffaloes. However, he had to sell one of them to finance his medical treatment and now worries that he will need to sell the second one for the same reason. A. is currently unemployed as a result of his poor health.

> *I have been jobless since the time I came back. I received some money (around 400,000 rupees) from IOM. I bought two buffaloes with the money. But, I have sold one for my treatment and I fear that I will have to sell the other one too for my treatment. My health has not allowed me to do any kind of work since the time I came back.*

Newly arrived returnees from Niger, Tunisia and Mali receive health screenings at their orientation session. © IOM 2022 / Robert Kovacs

Figure 22. Key indicators of economic reintegration, by returnees' self-reported health status post-return



2.4.1 Impact of economic reintegration on health outcomes

Across almost all countries, the study identified a pattern of economic reintegration overshadowing returnees' health needs. Returnees' desire for economic reintegration often takes a higher priority over their health and social needs, with implications on the timeliness of care and support sought and thus received. Survey findings show that returnees who reported poorer health also had poorer economic reintegration outcomes, as compared to those who reported better health, and the difference was statistically significant. Poor economic reintegration negatively affects returnees' health directly and indirectly.

Direct effects of economic reintegration on returnees' health are primarily related to mental health. Many of the returnees expressed that being unable to reintegrate economically upon return caused them great stress and led to serious mental health conditions. For example, returnees who had stable jobs prior to their migration were unable to find the same kind of employment after return, and had to take up jobs that were different in nature as compared to their original profession, which caused them to feel a sense of loss of self and identity. This created stress for returnees, who exhibited physical symptoms, including insomnia and sleeping disorders. Even though some returnees benefited from IOM assistance and business grants, this support was not deemed enough for them to secure a livelihood and sustain a business.

Returnees who were unable to succeed financially while abroad often returned to their countries of origin with few financial resources. Being unable to repay their families or friends who funded their migration and accumulating other debts was a huge source of stress and pressure among returnees. One Ethiopian returnee interviewed expressed suicidal ideations because of this, which is indicative of the severity of the problem.[47]

Returnees who have children reported facing additional stress upon return, given the fear of their children being perceived as 'poorer' than their peers This added an extra financial burden on the returnees to provide for their children and avoid social judgement, which compounded their mental health problems.

47 Fieldwork researchers were trained to provide information to participants on available MHPSS services when necessary.

On the other hand, positive economic reintegration has shown to benefit returnee's health directly through better mental well-being and sense of fulfilment. This also contributes towards better social reintegration and has positive effects on returnees' coping and mental well-being upon return.

> *IOM supported me to get a job, generate income and be a real person. I have also reconciled with my sisters. Psychologically I have been fine since I started my job. I am okay with meeting friends, community members, church etc.*
>
> *– Interviewed returnee, Ethiopia*

The indirect effects of economic reintegration on returnees' health are mediated through access to health care, including affordability and accessibility. Other than the few countries of origin with free universal health coverage (such as Brazil), returnees have to pay out-of-pocket for health services in most countries. And even countries with universal health coverage, there are often still charges for certain health services, such as medications. Returnees who have recently returned, especially those who had been irregular migrants, often have very limited financial resources and it takes time for them to reintegrate economically. Hence, they are at a "dual disadvantage" of both poor health status (from accumulation of health risks over the migration journey) as well as financial barriers to accessing health care. The combination of these results in delays in treatment and thus further exacerbates their health conditions.

Another indirect effect of poor economic reintegration on returnees' health-care access is mediated through accessibility barriers. Even if health services are free for returnees, many returnees have reported that they were unable to access these services due to the distance and high transport costs. Unemployment or financial difficulties pose additional barriers to health-care access since many returnees could not afford the transportation costs to and from health facilities, particularly for chronic conditions that require regular follow-up. One returnee expressed that she could not access free HIV medications provided by the public system because she was unable to afford transportation costs.

Continued lack of success in economic reintegration could cause delays in medical diagnosis and treatment, resulting in a vicious cycle of poor health and poor employability. Some returnees have indicated that they would consider remigration if they continue to be unemployed, even though they had medical problems such as cancer, and some were even willing to bear the health risks of irregular migration and detention after having experienced it already in previous migration journeys.

On the other hand, **positive economic reintegration has a positive impact on returnees' health indirectly by enabling returnees to be able to pay for their health care**. This allows returnees to be self-reliant in seeking care for their health needs in a more sustainable way.

2.5 GENDER AND HEALTH

Gender is a key determinant of health, and existing literature demonstrates that reintegration is a highly gendered process.[48] In this study, gender disaggregated data have been collected to understand and analyse the interplay between returnees' health needs and reintegration outcomes from a gender lens.[49]

2.5.1 Gender specific needs and outcomes

The data confirm that **male and female migrants experience migration differently, as they are exposed to different risks along their journeys**, and **different approaches to cope and respond**.

Sexual and gender-based violence impacting reintegration

During migration, among the cohort interviewed for this study, female migrants were generally more vulnerable to sexual abuses and exploitation, while men were often exposed to assaults by security forces or bandits, which have a direct impact on their physical and mental health. Accounts of SGBV reported by returnees in interviews almost entirely occurred

48 EU-IOM Knowledge Management Hub, Comparative Reintegration Outcomes between Forced and Voluntary Return and Through a Gender Perspective (2021).

49 Across countries, 79 per cent of the respondents to the survey identified as men, and 21 per cent as women.

during the migration phase, instead of pre-migration or post-return. In some instances, male returnees during interviews described their observations of the trauma experienced by female migrants through SGBV along the migration journey.

> *In Mauritania people got sick and felt stressed from the difficulties of the journey. In the camps male and female were separated and women were sexually abused by the [Mauritanian Security Forces]. They asked you to offer them sex and if you refused you were subjected to additional difficulties such as denying you food, medical attention or putting you to severe detention conditions.*
>
> *– Interviewed returnee, the Gambia*

Sexual and reproductive health needs impacting reintegration

Female returnees are exposed to more health-related risks upon return and during their reintegration, which extend to the field of SRH. Miscarriage, both while in host countries or post-return, was reported by several female returnees across different country contexts, which often resulted in mental health distress. In some contexts, returnees were not willing to disclose their miscarriage to their family due to associated stigma. One female returnee mentioned that she sought medical care to access contraceptive injections.

Gendered chronic health conditions and psychosocial stress

Female returnees were found more likely to report chronic health conditions than male returnees across all three stages of migration and female migrants interviewed referred suffering from the following conditions: genital herpes, uterus infection, miscarriage, postpartum depression and other pregnancy complications. **Psychological stress was also identified among female returnees** who mentioned missing their marriage or reproductive window due to migration.

Table 7. Sex and chronic health conditions

GENDER	PRE-MIGRATION CHRONIC HEALTH CONDITIONS				PRE-RETURN CHRONIC HEALTH CONDITIONS				POST-RETURN CHRONIC HEALTH CONDITIONS			
	No		Yes		No		Yes		No		Yes	
Female	5	63%	3	37%	22	40%	33	60%	17	31%	38	69%
Male	59	92%	5	8%	123	61%	79	39%	131	65%	72	35%
Total	**64**	**89%**	**8**	**11%**	**145**	**56%**	**112**	**44%**	**148**	**57%**	**110**	**43%**

2.5.2 Factors contributing to gender-based reintegration outcomes

Social norms and perceptions of female migration

Across contexts, **social norms** and the stigma associated with migration were found to play a significant role in the deterioration of health of both female and male returning migrants, who reported feeling reluctant to access health care services. For example, in the Gambia, traditional understandings of gender-related dynamics discourage women from receiving health-care services, including psychosocial support from health-care providers of the opposite sex.

As for the issue of stigmatization, in some societies, **risk-taking is more acceptable among men than women**; thus, female returnees who decide to migrate face more stigma and social pressure than men upon return. The qualitative data shows that the stigma against female returnees was especially prominent in rural areas - where female migration is often associated with sex work - and it prevented them from accessing health-care services. However, the qualitative data indicates that in Brazil men also refrain from seeking health care when related to sexual health, because of

stigmatization and fear of judgement, especially in cases of diseases contracted during sex work.

In terms of power structures, female returnees were often found to be **in a subordinate position compared to their husbands** and in-laws before migration, or to depend on them financially, which did not change during migration, so that women generally found themselves more vulnerable to the negative effects of ill health and poor reintegration than men upon return. Female returnees were also found to have poorer psychosocial and economic reintegration outcomes compared to male returnees at a statistically significant level. In female-headed households, female returnees who had to take care of the children alone were often supported by their family, either financially or by caring for the children while returnees were at work.

Access to health care

Overall, female returnees reported more difficulties in accessing health care than male returnees while in their countries of origin (pre-migration and post-return), while male returnees mentioned facing more barriers while in host countries (pre-return). In patriarchal societies, it is easier for men to access public health services than women, who may need to either go with their husband or father, and if they go alone they are likely to face more challenges than their male counterparts. In more liberal societies, such as Senegal, gender is less of an issue for returnees in terms of health-care access.

In Brazil, respondents highlighted the additional health risks faced by returnees from LGBTQI+ communities, whose migration was often found to be related to sex work, leading to higher risk of contracting sexually transmittable infections or other sexually transmittable diseases.

Table 8. Sex and access to health care

GENDER	PRE-MIGRATION BARRIERS ACCESSING HEALTH CARE				PRE-RETURN BARRIERS ACCESSING HEALTH CARE				POST-RETURN BARRIERS ACCESSING HEALTH CARE			
	No		Yes		No		Yes		No		Yes	
Female	6	50%	6	50%	14	64%	8	36%	27	54%	23	46%
Male	22	67%	11	33%	61	56%	49	44%	94	61%	61	39%
Total	**28**	**62%**	**17**	**38%**	**75**	**57%**	**57**	**43%**	**121**	**59%**	**84**	**41%**

2.5.3 Coping mechanisms from a gender perspective

Several common threads were identified among female returnees with respect to their coping strategies for health needs, which largely revolve around family support.

- Female returnees' access to care was often tied to their partners' economic situation, for instance health insurance provided under the husband's employer. In certain cases when the husband could no longer work due to illness, female returnees would take up odd jobs to help pay for treatment for the husband and children. When the female returnees could not afford health care on their own or through their partners, their parents (more commonly the father, with exceptions) would pay for their health services.
- Such support varied across country contexts. For instance, Georgian female returnees received stronger social support from their family and community in general, as compared to those in Senegal.
- Female returnees with adult children often depended on them for support, while those with younger children were sometimes supported through the in-laws who helped pay for medical care.
- There were instances in the interviews in which female returnees without any social support resorted to begging or charity services.
- Female returnees were more likely to report seeking care through traditional medicine for mental health conditions, such as anxiety and depression.

KEY MESSAGES

1. Countries' health systems and universal health coverage influenced returnees' health and reintegration outcomes. Across their migration journey, returnees often experienced a **discontinuity of care and a drop in quality of care post-return.**
2. Gaps in the formal health-care system were filled by **IOM, NGOs and CSOs as the main providers of health-care assistance for returnees.**
3. Awareness remains low among key stakeholders that returnees' health and reintegration outcomes are closely interlinked and as a result, **many migration and health programmes and policies are siloed.** Sustainable interventions will require migration-aware systems and recognition of the interdependence between health and reintegration.

3. STRUCTURAL INFLUENCES AND POINTS OF INTERVENTION FOR SUSTAINABLE REINTEGRATION AND HEALTH

3.1 HEALTH SYSTEM VARIATIONS AND (DIS)CONTINUITY OF CARE

Migrants experience living in different countries throughout their migration journey, each of which has its unique health system. The returnees often compared the health systems between host countries and countries of origin, and their experiences when accessing or trying to access them.

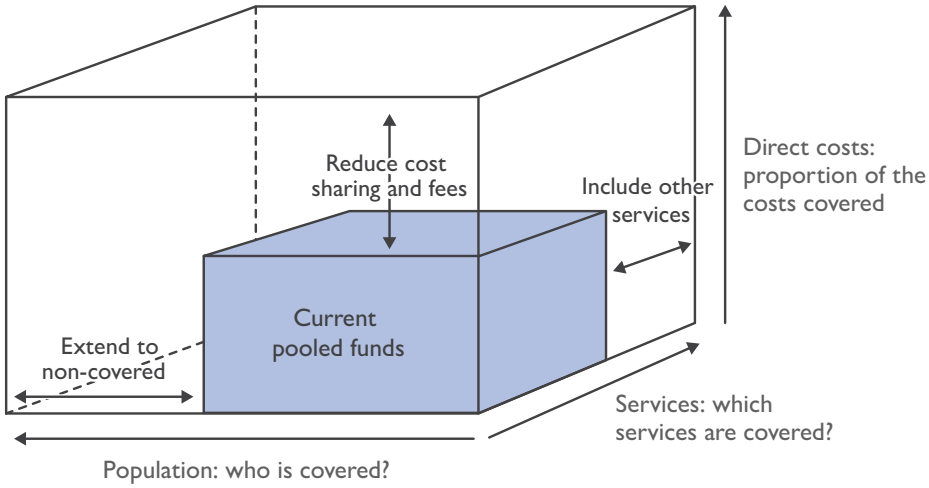
Whether there is universal health coverage in origin, transit and host countries was found to be a structural determinant of returnees' health.

Universal health coverage is a comprehensive health system approach that includes three dimensions: population covered, services covered, and proportion of costs covered (Figure 23). This provides a helpful framework for the analysis of returnees' positive and negative experiences when transitioning from one health system to another health system along their stages of migration. A summary of each focus country's health system and migration profile is at Annex 1.

> *Most of these people return from countries that don't have a universal health system such as the [Sistema Único de Saúde] with the exception of people who were living in the UK, in Canada. Usually, other health systems are very restricted, private. So, these people arrive here with health issues that they wouldn't have here, due to lack of treatment there. People who were in irregular conditions in those countries and cannot access the health system and they return to Brazil with health problems, or even due to health issues, because they know they will [get] treatment [here]. Specific conditions such as HIV, cancer... sometimes they don't get proper treatment there. Sometimes they also meet problems with documents, if the documents are no longer valid, or for any other reason.*
>
> – *Key informant, Brazil*

Universal health coverage means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.

Figure 23. Three dimensions of universal health coverage (Source: WHO)



In each country studied, the health system structure influenced returnees' access to health care and health outcomes, having knock-on effects on returnees' reintegration outcomes (see Annex 1):

- In Brazil, the SUS facilitated many returnees' access to public health services, and despite some gaps, the affordability and quality of care received by returnees was generally much improved post-return as compared to pre-return.
- In Ethiopia, the public health-care system is limited in terms of infrastructure and equipment to conduct advanced medical tests, hence returnees were often referred to private sector services that they were not able to afford.
- In Georgia, there is a universal health coverage programme especially for returnees, thus returnees who met the eligibility were able to access subsidised health services upon return. However, some returnees still expressed struggling to pay for health services with the limited pension funds.
- In Pakistan, the Sehat card was often quoted as a positive development of the country's universal health coverage, as it enabled returnees to access more affordable health care post-return.
- In Senegal, the quality of health services was also often described by returnees as poor, with long wait times and high cost of care constituting key barriers to access.
- In the Gambia, the quality of health services was often referred to by returnees as low and substandard, there was also limited availability of mental health specialists and facilities in the country.

> *Especially in countries that don't have free health care... People lost their jobs and could not access health care. Therefore, health has become a priority item in the choice of return, due to the existence of the SUS. People knew that if they got COVID[-19], if they had any problems, they wouldn't have a health service to turn to. We have observed this since the first flights of returnees who disembarked in Brazil.*
>
> *– Key informant, Brazil*

In countries without universal health coverage, returnees often experienced delayed care or no care at all with long term health consequences. **The variation in health systems across time and thus the care received by returnees created issues related to quality and continuity of care.** For instance, several returnees have mentioned that they have begun taking regular medications for their chronic conditions (such as hepatitis B) in their host countries, but were unable to continue their medication post-return due to different reasons (such as high cost of medication, unavailability of medication in country of origin). Due to their migration experiences, returnees often changed their perceptions towards the health systems of their countries of origin. They often made comparisons between the health systems and services in their host countries and countries of origin. Some changes were positive, such as better appreciation of their country of origin's universal health coverage system as in Brazil. Some changes were negative, particularly when returnees received better quality of care in their host countries. While some changes were mixed, depending on their particular experience pre-return and post-return. Returnees' changes in experiences of health systems can be broadly categorized into two main groups:

3.1.1 Returning from a mature health system to a less mature health system

Returnees experienced a drop in quality of health care received when returning from their host country back to their country of origin. Common reasons included:

- Lack of specialists in their local areas
- Non-coverage of services under the public health system (such as dental care)
- Longer waiting times for health services
- Delayed treatment due to high health costs, poorer quality of care, and shortage or unavailability of medication.

This drop at times turned into critical incidents. One Brazilian returnee had a heart attack while waiting for cardiology follow-up post-return. One Georgian returnee mentioned that he had been given expired chemotherapy injection by his doctor knowingly because these were the only remaining stock. Another Georgian returnee mentioned receiving mental health services in Switzerland for free but was unable to continue treatment post-return due to high costs.

In several incidents, returnees described how the poor quality of health service they received in their countries of origin had led to harmful health effects:

- One Pakistani returnee was reluctant to seek health care after losing her daughter due to medical negligence in Pakistan.
- One Georgian returnee found that the care provided by the doctor in his host country post-return was substandard and even harmful. He found out by consulting with other overseas doctors virtually.
- Another Georgian returnee expressed that she was considering remigrating to Germany again in order to access free medications there, which were unavailable in Georgia.

> *"The quality of health care in Italy including the reception you get from the doctors is better [there] than in Senegal where the welcome and the treatment are always substandard. On the other hand, in Libya also we did not dare to go to the hospital because you would run the risk of being caught and thrown in jail. So, there is limited access to care in Libya for us [migrants] and the quality of care in Libya compared to Italy is also sub-standard.*
>
> *– Interviewed returnee, Senegal*

3.1.2 Returning from a less mature health system to a more mature health system

Although this is less common, **some returnees – primarily from Brazil – found that the affordability and quality of care received had improved upon returning to their country of origin from their host country**. Common reasons included free health services, free medications, shorter waiting times, and perception of improved quality of care due to less discrimination. One Brazilian returnee was able to access HIV treatment post-return. Another Brazilian returnee expressed experiencing xenophobia while at health facilities in the host country, which was no longer an issue upon return and hence the quality of care received was better. One Georgian returnee mentioned that her thyroid condition

was misdiagnosed while in Greece and was only correctly diagnosed by an endocrinologist in Georgia. Another Georgian returnee indicated that there was no universal health coverage in Greece for migrants and medical fees were high, whereas upon return to Georgia she was able to access subsidised health services. In other cases, primarily in Georgia, returnees reported that the quality of health services received both in their host country and country of origin were good, hence there were no issues with continuity of care.

3.1.3 Health system factors influencing returnees' health and reintegration

Costs of medication was an important aspect related to affordability of care under the framework of universal health coverage. Returnees reported that they received medications free of charge in their host countries (such as Germany), whereas it is unaffordable or sometimes even non-existent in their countries of origin (such as Georgia).

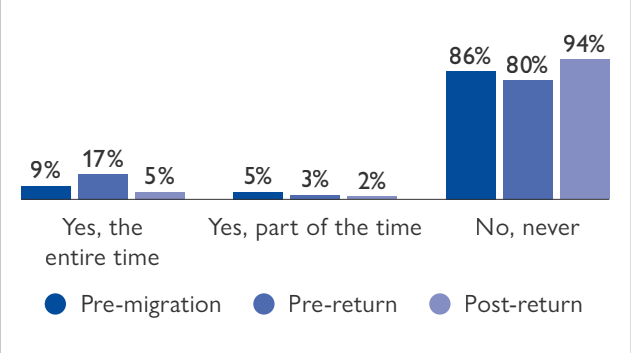
Key informants in several countries have highlighted the regional differences in health services accessed by returnees. In Brazil, there is no official policy at the state level, thus health services accessed by returnees are managed at the municipality level, where non-state actors collaborate with state actors to provide services and training to address the mental health needs of returnees. One province stood out in terms of being migration-aware at the public policy level (the Rio Doce region in Minas Gerais State in Brazil).

Returnees' health literacy and knowledge of the public health system also had a mediating role between the health system and their access to care. Some returnees were not aware that their entry point into the public health system should be at the primary care level, rather than specialists at the secondary care level, resulting in barriers and misunderstandings when accessing health care, such as in Brazil.

The likelihood of successful economic and social reintegration is influenced in many ways by the availability of universal health coverage and quality of health system in the countries of origin. In Brazil returnees have better access to free health services and medication through SUS, so they do not have to pay out-of-pocket for medical expenses. The shorter waiting times also enable returnees to attend to their health needs in a timelier fashion, which is conducive to their economic productivity and social reintegration. Whereas in the Gambia, medication is not provided in the public health system which must be purchased separately, which becomes a significant expense for returnees who have chronic health problems, thereby limiting their ability to grow their business.

Health insurance coverage was an important structural determinant of returnees' health, both in terms of health outcomes as well as reintegration outcomes (access to health service and economic reintegration). For instance, returnees reported that they received health insurance while in France pre-return, whereas costs for health services were high in Georgia post-return. Returnees commonly reported having no health insurance while in host countries. Whereas for some returnees who had health insurance provided by their employer, the coverage was insufficient and hence still unable to access needed treatment. Our survey findings showed that a higher proportion of self-identified forced returnees were not covered by health insurance compared to that of voluntary or partially voluntary returnees. In particular, across all countries, 86 per cent of self-identified forced returnees did not have health insurance prior to migration, which reduced slightly to 80 per cent during pre-return phase, but increased significantly to 94 per cent upon post-return (Figure 24) From our data, health insurance clearly illustrated the interlinkage between reintegration and health, since successful economic reintegration – such as securing a job – implied that returnees were protected by health insurance from their employers and able to afford health care.

Figure 24. Health insurance coverage across stages of migration among forced returnees



CASE STUDY 5: RETURNEE IN BRAZIL

L. migrated from Brazil to Portugal with his wife in search of better economic opportunities. However, he experienced job exploitation from an employer who took advantage of his undocumented status. He was forced to work long hours with no days off. Their situation was exacerbated by the COVID-19 pandemic, which delayed the processing of his paperwork and limited his ability to find another job or apartment. They were able to return to Brazil with the support of the IOM's voluntary return and reintegration programme. IOM paid for their return tickets and assisted them to reopen the barber shop that they had operated prior to migrating. Additionally, IOM helped L. to access psychological counselling sessions in order to work through the traumas that he experienced during his migration journey.

> *"I would like to put a signboard on the front of my shop, stating that: "This barber shop is now working because of the support we received from IOM support for returnees". I am very proud to say that. That a reintegration project helped to reopen this shop. I came back with a totally different head.*

CASE STUDY 6: RETURNEE IN ETHIOPIA

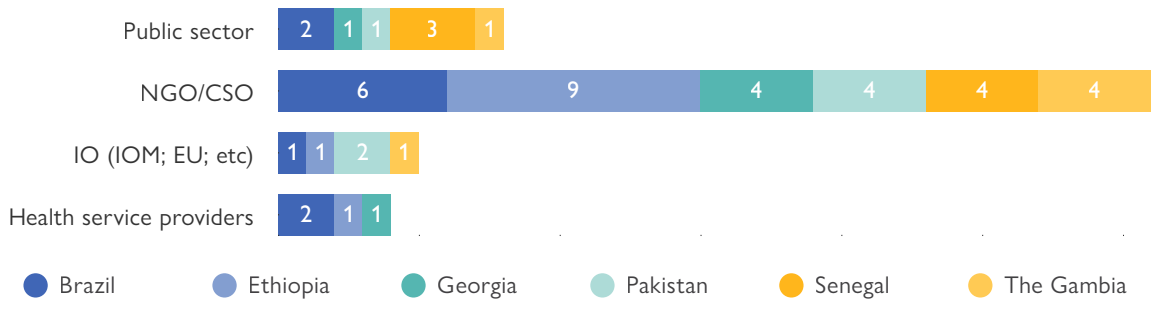
N. returned from Yemen to Ethiopia with the support of IOM. He became seriously sick due to complications from his diabetes while in prison in Yemen and was referred to IOM by Yemeni police. Since his return to Ethiopia, he has been receiving medical care under referral of IOM at Jimma University. Additionally, IOM assisted him in starting a small trading business.

3.2 EXISTING POLICIES AND PROGRAMMATIC RESPONSES TO RETURNEES' HEALTH NEEDS

3.2.1 Mapping of support by different stakeholders

A mapping of existing health-related programmes and services provided to returnees was conducted in each of the six countries studied. The mapping was primarily based on semi-structured interviews and key informant interviews, complemented by an online search for relevant services in each focus country. The criteria was limited to programmes and services with an explicit health focus. A total of 47 programmes/services have been identified across the six focus countries (Figure 25).

Figure 25. Mapping of health-related policies/programmes by country and sector



The main providers identified across contexts include IOM, NGOs and CSOs, private health service providers, and the public health sector. Where there were gaps in the formal health care system, IOM, NGOs and CSOs were the principal providers of health-care assistance for returnees.

A diverse range of health-related services was identified, including psychological counselling services (face to face, online), financial assistance for health needs (e.g. medication, surgery), medical in-kind assistance (e.g. medications, medical supplies), health education and information, training and capacity building of health workers, referral services, reminders for medical consultations and other types of indirect support (such as reintegration assistance, shelter provision, food security).

3.2.2 Identified good practices

Based on the mapping of programmes and services and from the interviews with returnees and key informants, good practices have been identified, as summarized below to address the gaps in the five dimensions of access to health care:

- **Affordability:** Non-state actors, including IOM, NGOs and CSOs, played an important role in filling the gap in public health care by providing financial support to returnees to access health care. In some countries, IOM provided reimbursement for medical expenses (such as up to 1,500 euros for Georgian returnees), to fill the transition gap while returnees are waiting to be reintegrated into the local public health system. Medical services covered included consultations, medications and diagnostic tests. A more recent example of NGO support was a Pakistani returnee who received NGO financial support to pay for his COVID-19 treatment. Some host countries provide financial support to returnees' post-return health needs for a limited duration of time so as to ensure continuity of care, such as France and Switzerland.
- **Accessibility:** IOM country offices facilitated returnees' access to health care by answering returnees' queries related to health needs and access prior to return and providing them with relevant information to facilitate their return. In some countries, such as Pakistan, the government has signed memoranda of understanding with NGOs and/or CSOs to support returnees, including medical needs, and NGOs/CSOs have well established support structures and referral pathways in place to assess returnees' health needs and to provide assistance accordingly. Psychological counselling services were offered both face-to-face or online by health-care providers.
- **Availability and accommodation:** IOM's counselling services were widely taken up by returnees. IOM country offices also assisted returnees to acquire needed medication by coordinating import of medicine from the host country (Germany) since it was not available in Georgia.
- **Acceptability:** Returnees appreciated IOM's assistance because they reported that they felt dignified with receiving support. Some NGOs provide assistance to returnees whether their return was voluntary or forced.
- **Appropriateness:** IOM sent medical doctors to accompany returnees with health conditions during the flight back to Georgia. IOM also funded air transport of medical equipment such as wheelchairs for returnees with disabilities. Some non-state health providers provide specialist care specifically for female returnees, including obstetrics and gynaecology.

The financial assistance provided by IOM or other non-state actors, even though in small amounts, sometimes has a large impact on returnees' health outcomes since timely care could be accessed. However, in some instances returnees were not able to differentiate between the different organizations that supported them on health needs, such as mixing up IOM with state migration agencies While our study has identified a number of good practices on the support provided to returnees on health and reintegration, some gaps remain, as discussed in the next section. With regards to assistance provided by IOM, returnees have reported variations and non-continuous support, such as medications being covered in some cases but not in others. Transport fees to medical appointments were also not covered by IOM. Some returnees have reported delays in health-related reimbursement of assistance. This is particularly a problem for returnees with limited financial resources, as they are required to first pay out-of-pocket for health services before seeking reimbursement from IOM, and in some cases this poses a financial barrier to accessing health care. Despite the existence of IOM support and other reintegration assistance, many returnees still struggled to afford medical care and some had to use IOM business grants as a last resort.

CASE STUDY 7: RETURNEE IN GEORGIA

N. was an irregular migrant in Greece when she noticed her health deteriorating. (i.e. hair falling out, difficulty sleeping, dry skin). She sought health care in Greece, but the doctors there misdiagnosed her with neurosis. Following a virtual consultation with an endocrinologist in Georgia, she was correctly diagnosed with a thyroid issue and subsequently returned to Georgia to undergo surgery. N. had previously planned to return to Georgia with the support of IOM's return and reintegration programme. However, she needed to use part of the funds allocated to her under the IOM business grant framework in order to pay for the procedure. N. is currently unemployed and is financially dependent on her two sons. Her business plan of working in cosmetology did not come to fruition as she was advised against working with the laser hair removal machinery due to concerns regarding radiation exposure after her surgery.

CASE STUDY 8: RETURNEE IN SENEGAL

M. migrated from Senegal to Germany and developed psychological problems while living in an asylum-seekers camp there. Camp authorities took him to a medical centre for periodic psychotherapy sessions and he was prescribed medication. However, he could not afford to continue taking the medication after his return to Senegal. While IOM granted him 30,000 CFA francs (ca. 45 United States dollars) to purchase his prescriptions, the total cost of the medication came out to 18,000 CFA francs (ca. 27 United states dollars) per month. The cost was too much and he has not taken the medication in over a year. He has continued to attend psychotherapy sessions at a local hospital, but noted that the quality of care is poor there.

> *When I came back to Senegal, the medicines were expensive because I had to spend 18,000 CFA francs per month; it was difficult and my income did not allow it. I received only one assistance from the IOM for about 30,000 CFA francs. I even had to sell my phone to buy these medicines. I have not taken my medication for over a year now.*

In Georgia, a medical return and reintegration pilot scheme for assisted voluntary medical return from France to Georgia, funded by the French Office for Immigration and Integration showed the following key lessons learned, that can be applied across the board to reintegration and medical assistance:

- Establish and strengthen partnerships with medical service providers to facilitate referrals.
- Schedule appointments in multi-profile clinics and have agreements in place with provider clinics for expedited procedures.
- Expand the pool of available escorts to accommodate the needs of beneficiaries.
- Coordinate the import and supply of medication through pharmacy networks to mitigate effects of potential medical deficits.
- Draft contracts for paramedical personnel for home care.
- Cooperate and liaise with relevant clinics to ensure immediate inclusion of substitute treatment.
- Liaise with family members to establish and identify immediate needs upon arrival.

Medical staff conduct a health check up on an Ethiopian migrant at a hospital in Bossaso before his return to Ethiopia with IOM's assistance.

CONCLUSION: GAPS AND OPPORTUNITIES FOR INTERVENTION

Based on this study's analysis of returnees' health needs and how individual health and reintegration outcomes are influenced by social and structural factors, three key gaps and opportunities for intervention are highlighted:

Health needs assessment and continuity of follow-up

Several key informants stressed the need to place a stronger emphasis on the health needs of returnees when engaging in return and reintegration procedures. A clear gap identified in the literature review, supported by interviews and survey data, is the current **lack of post-return screening tools or procedures to assess the health of returnees** (including mental health and physical health). Throughout the study, there was little mention of health assessments conducted prior to returnee's return in the interviews, referred to by some key informants as a formal method to identify returnees' health needs and facilitate continuity of care. Although migrants assisted to return usually undergo a basic fitness to travel assessment for safe transportation offered by IOM, the nature of such assessment is different from and less comprehensive than a formal health needs assessment with the aim of identifying unmet health needs for the purpose of ensuring continuity of care.

Returnees who received IOM assistance have generally expressed appreciation for the health and economic reintegration support provided. However, in several instances, returnees reported that there is a lack of - or very limited - follow-up processes. This resonated with the findings related to returnees' economic reintegration. Key informants noted that while IOM provided financial support to returnees, they could have benefited more from it if there was a closer follow-up system in place to ensure sustainable reintegration since, in many cases, returnees could not achieve economic reintegration due to issues related to managing their businesses, with knock-on effects on affordability of health care. Hence, **several key informants recommended strengthening the follow-up and monitoring of IOM health and reintegration support.** In line with emerging practice arising from the COVID-19 pandemic on the use of telehealth services by stakeholders, including IOM,[50] the development of new technologies could present an opportunity for strengthening health assistance follow-up processes, particularly for returnees who are geographically distant from health facilities. Recent developments in digital health initiatives, such as IOM's electronic Personal Health Record,[51] could facilitate the transfer of medical records across the stages of migration and support return location care.

Holistic support for returnee health and reintegration

As indicated by the research findings on the close interlinkages between health and reintegration, it is important to consider both health and reintegration needs in a holistic manner when thinking about interventions for returnees. **A number of key informants expressed that there was a lack of coordination between stakeholders working for returnees' reintegration and health needs.** For instance, in Ethiopia, separate actors focus on psychosocial support, health, and economic reintegration activities, without much coordination or collaboration, making the reintegration process for returnees disjointed. Lack of coordination among the key actors managing return and supporting returnees' reintegration and health-care providers can lead to duplication of services and poor service provision. For this reason, ensuring effective referral mechanisms and channels of communication among stakeholders in the migration and health sector is critical to meeting returnees' health needs and facilitating their sustainable reintegration.

50 IOM, Migration Health Annual Report 2021 (2022).
51 See IOM, Electronic Personal Health Record website here.

Several respondents pointed to a lack of understanding among authorities about the link between returnees' health and reintegration needs. Key informants emphasized the importance of providing holistic support, instead of only focusing on health or economic integration. As indicated by interviews with government representatives, the relevant stakeholders and authorities tend to work in silos, either focusing on the health or the economic aspect of reintegration, which are under the mandate of different actors. Across contexts, key informants stressed the need to generate awareness of the intersection of health and reintegration and encourage stronger inter-agency collaboration.

The study findings strongly call for the need to recognize the close interdependencies between health and reintegration to fully understand returnees' health and reintegration needs and design points of intervention. **A holistic approach that considers the various dimensions of health and reintegration and their linkages is necessary to ensure returnees' sustainable reintegration.** Overall, there is a need for wider recognition of health-aware return and reintegration programming. Returnees' health needs must not be considered nor addressed in isolation, but as part of and interlinked to broader social, economic, and psychosocial functioning and reintegration that is shaped by cultural and structural factors. This requires a whole-of-society response. Such programming should be considered in context with global policies and frameworks both related to migration and health, including IOM's *Health, Border and Mobility Management Framework* and its *Policy on the Full Spectrum of Return, Readmission and Reintegration* to bridge between the two and to ensure synergy when designing and implementing interventions.

Need for migrant-sensitive health systems

While in-kind support or financial assistance provided by IOM or non-state actors was often crucial for returnees' acute health needs, such an approach proved to be not sustainable in the long run, especially when subsidising returnees' access to public health services. Also, the availability of health assistance provided by IOM or other non-state actors was often dependent on donor funding, with implications of continuity of service. Moreover, from an accountability perspective, it is more difficult to monitor the quality of care provided by non-state actors.

Key informants emphasized **the need for systems strengthening in order to cater for returnees' health and reintegration.** Since medical expenses are often associated with high costs, key informants generally agreed that it is more sustainable to integrate returnees into the public health system Where IOM and non-state actors would facilitate such integration is by providing complementary assistance, such as transport subsidy for those returnees who are unemployed so as to be able to access public health care. This is particularly relevant for returnees with long-term health conditions, since they would require regular follow-up and continuity of care, as compared to returnees with acute or one-off health needs. In view of the differences in health systems and universal health coverage in each country, a context-sensitive approach by IOM is more appropriate to address returnees' health needs taking into the local context, rather than a one-size-fits-all approach. For instance, in the Sudan, IOM and the European Union launched a pilot initiative to unable returnees to access health care under the country's national insurance scheme.

Where 'migrant-sensitive health systems' are recognized, this is often focused on the inclusion of migrants in countries of destinations, such as in the Migrant Integration Policy Index,[52] rather than considering the needs of migrants across the migration journey, including returnees post-return back to countries of origin.

52 Solano G. and T. Huddleston, Migrant Integration Policy Index 2020 (2020), available at www.mipex.eu.

RECOMMENDATIONS

Based on the study's findings as well as gaps and opportunities identified, the following recommendations are proposed to enhance returnees' access to health care and to improve their health and reintegration outcomes. While some of the actions recommended are taking place in some countries, there is a need for more widespread and systematic uptake.

Implementing Actors

IOM IOM
ILO ILO
WHO WHO
CIV Civil society
STA State actors
DON Donors

Build a continuum of care across different stages of the migration cycle

IOM STA Conduct health needs assessment pre-return and post-return to identify returnees' existing or health needs.

IOM WHO Develop a training module for health workers to create migration-aware health systems with recognition of health needs across the migration journey, including returnees' post-return.

IOM WHO ILO Explore the feasibility and conduct pilot projects on innovative means of health insurance for migrants along the migration journey, such as cross-border health insurance and collective health insurance.

IOM WHO STA CIV Facilitate the realization of migrants' and returnees' right to health (includeing access to public health services) across the stages of migration.

Fund gender specific initiatives on reintegration and health

IOM WHO Develop a training module for health workers specifically on gender-specific health needs across the migration journey.

IOM STA Ensure health needs assessment (including mental health screening) are conducted by trained personnel of the same gender as the returnee.

Strengthen transnational information sharing and safeguarding

IOM WHO STA Facilitate the safe and confidential transfer of medical records and/or information from pre-return to post-return phase, taking into account differences in languages and names for pharmaceuticals and procedures.

IOM Expand IOM's pilot project on the electronic Personal Health Record system to ensure that returnees' health records are available at transit and destination countries, as well as in countries of origin upon return.

IOM Develop a leaflet or information package containing information on how returnees can access public health services and other returnee health support post-return.

IOM Develop an individual care plan for migrants with health-related needs prior to return that is linked to their reintegration needs.

Reinforce screening and referrals upon return

IOM STA Conduct mental health screening for returnees at baseline and at a regular interval to assess changes in mental health status.

IOM Develop a longer-term psychosocial well-being programme for returnees who experience mental health distress due to not being able to meet their own or families' expectations.

IOM Facilitate telehealth services (such as teleconsultation with a specialist) for returnees who may face barriers in access to care.

IOM Provide transport subsidy to returnees with health needs who have financial difficulties.

Align reintegration and health programming

IOM Strengthen follow-up support to returnees who have long term health needs, such as referring or signposting those who are unable to access health care or medications to health service providers.

IOM Strengthen follow-up support to returnees who have received economic reintegration assistance from IOM, particularly returnees who struggle to maintain their businesses post COVID-19.

IOM Reinforce training on financial and management skills for returnees who have received economic reintegration assistance from IOM, particularly those who are unable to access health care due to unaffordability.

IOM Identify economic opportunities for returnees with work-related injuries or disabilities that might limit their ability to easily seek employment.

IOM WHO Devise a set of health indicators to be included into routine IOM monitoring surveys across the stages of migration

IOM Create peer support networks for returnees with health conditions for mutual encouragement and information sharing.

IOM Raise awareness of returnees' needs and reduce stigmatization among government officials and local communities to which returnees return.

IOM Strengthen recognition of health-aware return and reintegration programming among key stakeholders working for migrants' return.

IOM Promote awareness among key stakeholders on a more holistic approach towards health and reintegration.

Strengthen governance and synergies in policies on migration and health

IOM STA Collect and share anonymized and gender- and age-disaggregated data on the health needs and outcomes of returnees to monitor migration and health trends.

IOM WHO STA Mainstream migrant-awareness into health systems policies at national, regional, and international levels.

STA CIV Establish formal collaboration arrangements between national actors and civil society to address returnees' health and reintegration needs.

DON Combine reintegration with development funding that supports the public health system – reintegration and development actors can collaborate with an entry point in the health sector.

Future directions for research

A follow up **longitudinal study** would offer further insights on how returnees' health and reintegration outcomes continue to interact to produce deteriorations or improvements over time.

In view of the self-reported nature of this present study, studies using **objective measures** can confirm the findings from this study. These could include both physical health measures (such as body mass index and blood pressure) and mental health measures (such as Patient Health Questionnaire screening test).

A follow-up investigation into **gender transformative or gender sensitive interventions on health and reintegration** would support interventions that address gender inequities in reintegration.

ANNEX 1. OVERVIEW OF HEALTH SYSTEMS IN THE STUDY'S FOCUS COUNTRIES

BRAZIL

In Brazil, there is universal healthcare coverage via the *Sistema* Único *de Saúde*, Brazil's unified health system, which grants access to health care to all individuals regularly residing in the country, including migrants. This has been identified as the most robust health-care system among those objects of the study. In fact, as a part of this system, Brazil has a well-organized primary health-care system. Even though the SUS has steadily been improving since its establishment in 1988, mobilizing sufficient financing has been a constant challenge and has consistently undermined efforts to realise UHC.[53] In addition, family health– a cornerstone of this system – only covers about 65 per cent of the population, illustrating stark disparities and inequities in access to care across the country.[54]

The outbreak of the COVID-19 pandemic in Brazil has disrupted the health-care system and created challenges to the provision of basic routine services.[55] The response to the pandemic has been hampered by health-care worker shortages and limited resources, including limited equipment and difficulties in obtaining medicines.[56]

Existing literature suggests that migrant status is not the most important factor in predicting health outcomes in Brazil, which is confirmed by the study's findings. Migrants in the country tend to experience the same barriers faced by nationals, especially after the disruption caused by the COVID-19 pandemic.

ETHIOPIA

Prolonged conflicts in the country have disrupted the pre-existing health system. Government responses towards the COVID-19 pandemic have also become less of a priority as compared to the escalated war in Tigray.[57] However, the government has undertaken several initiatives such as the Community Health Extension Program and the Health Insurance Strategic Plan to strengthen the health-care system and to achieve UHC by 2030.[58] One of the state initiatives is to expand the Social Health Insurance and Community-based Health Insurance schemes which provide free-to-access public health-care services to the members.[59] Nonetheless, significant out-of-pocket expenditure in Ethiopia suggests that many remain uninsured.[60] It is noted that IOM Ethiopia will pilot the government-led Community-based Health Insurance scheme among selected returnees, which could pave the way for access by more Ethiopian migrant returnees.

Provision of health-care services to refugees in the country is supported by UNHCR and other humanitarian actors. Ethiopian migrants are highly vulnerable to health risks during their migration journey, as well as when they are in their host countries. The *kafala* system under which migrant workers are regulated in the Gulf Cooperation Council countries, Jordan and Lebanon also excluded them from the national labour legislation, which in turn heightened their risk of exploitation by the employers.[61] Instances

53 Spektor M., Brazil: Polarizing Presidential Leadership and the Pandemic, Carnegie Endowment for International Peace (2020).

54 Organisation for Economic Co-operation and Development, Primary Health Care in Brazil, OECD Reviews of the Health Systems (2021).

55 Bahamondes L. et al., Assessment of the availability of sexual and reproductive healthcare for Venezuelan migrant women during the SARS-CoV-2 pandemic at the north-western border of Brazil-Venezuela, *Journal of Migration and Health* 5(1): 1-5 (2022).

56 Bahamondes, *Assessment of the availability of sexual and reproductive healthcare*.

57 Tesfay F. and H. Gesesew, How conflict has made COVID-19 a neglected epidemic in Ethiopia', Ethiopia Insight (22 September 2021).

58 ILO, Mapping of the National Social Protection System in Ethiopia, including Social Health Protection – Final Report (2021); UNHCR, Ethiopia Refugee Program Strategic Plan Public Health Sector (2014 – 2018).

59 Lavers T., Towards Universal Health Coverage in Ethiopia's 'developmental state'? The political drivers of health insurance, *Social Science & Medicine* 228(1): 60-67 (2019.

60 Borde M. T. et al., The burden of household out-of-pocket healthcare expenditures in Ethiopia: a Systematic review and meta-analysis, *International Journal for Equity in Health* 21(14): 1-20 (2022); Mirutse M. et al., The burden of household out-of-pocket health expenditures in Ethiopia: estimates from a nationally representative survey (2015–16), *Health Policy and Planning* 35(8): 1003-1010 (2020).

61 Aoun R., COVID-19 Impact on Female Migrant Domestic Workers in the Middle East, Inter Agency Standing Committee (2020).

of exploitation, trafficking, abuse, and gender-based violence were reported particularly for migrants in Gulf countries.[62] This was exacerbated during the COVID-19 pandemic, as thousands of migrants were abruptly dismissed from their employment and left stranded in the host countries with limited access to health care.[63]

GEORGIA

Nationals and foreigners in Georgia are equally entitled to the right to health care.[64] The introduction of a universal health care programmein 2013 marked an important milestone in the Georgian health-care system. The UHCP aims to improve the access to public health care for all legal residents in Georgia, including all foreigners and displaced persons who are officially registered in Georgia.[65] However, it is important to note that public health care is not entirely free of charge under this programme[66] and it covers only certain health services which are subsidized by the government.[67] Further, the emphasis on the legal status may cause further marginalization of irregular or undocumented migrants who are often the most vulnerable in the society. Similarly, this discriminatory practice was observed in the early stage of the COVID-19 pandemic as some foreigners were denied access to the vaccine. This policy was revoked later in August 2021.[68]

While the UHCP has expanded public health-care coverage to most of the population, gaps in terms of low public investment and quality in primary health care remain to be addressed. There is still heavy reliance on out-of-pocket payment for health-care services albeit some reduction following the implementation of UHCP, leaving low-income households vulnerable to catastrophic health-care spending.[69] High health-care costs can also hinder reintegration of returnees. In fact, health-care expenditure was the fourth largest component in how remittances were spent among remittance receiving households in Georgia.[70]

PAKISTAN

The health system in Pakistan, which is characterized by a serious lack in number and quality of health-care workers, inadequate resource allocation, and deficient access to quality health care for all segments of the population, is ill-equipped to offer quality health-care services to migrants and returnees.[71] A vast majority of the Pakistani population pay out-of-pocket for private health care given chronic underfunding of the public sector.[72] Even where medication or care is provided free of charge in the public sector, frequent stock-outs and the inaccessibility of public health-care workers often render the private sector a patient's only option.

62 Anbesse B. et al., Migration and mental health: a study of low-income Ethiopian women working in Middle Eastern countries, *International Journal of Social Psychiatry* 55(6): 557-568 (2009); Jamie F. O. M and A. H. Tsega, Ethiopian female labor migration to the Gulf States: the case of Kuwait, *African and Black Diaspora: An International Journal* 9(2): 214-227 (2015); Demissie F., Ethiopian female domestic workers in the Middle East and Gulf States: an introduction, *African and Black Diaspora: An International Journal* 11(1): 1-5 (2017).

63 Getachew S., "Ethiopian Workers Are Being Expelled from Saudi Arabia and UAE on Coronavirus Suspicions", Quartz (14 April 2020).

64 Parliament of Georgia, On the Legal Status of Aliens and Stateless Persons, issued on 5 March 2014.

65 UNHCR, State Universal Healthcare Programme in Georgia (2020).

66 UHCP offers different health-care packages based on the income of each person and only socially vulnerable groups are eligible for the full package. Among the services covered are emergency care, at which 70-100 per cent of its total costs are covered. The treatment of HIV, hepatitis C and tuberculosis, as well as insulin for diabetes patients, are free of charge. Dialysis is also available in big cities and is free of charge. A state-funded methadone substitution programme is available free of charge. At an initial phase, only a check-up or enrolment fee of 70 Georgian lari (ca. 25 United States dollars) has to be paid. Medical costs for childcare (up to the age of 5) are partially covered depending on the type of illness.

67 Government of Georgia, Social Service Agency, "Universal Health Care" website here; UNHCR, *State Universal Healthcare Programme in Georgia*; World Health Organization. Regional Office for Europe, European Observatory on Health Systems and Policies, Richardson E. and N. Berdzuli, Georgia: Health System Review, World Health Organization Regional Office for Europe (2017).

68 Tolerance and Diversity Institute, "Statement on the Vaccination of Foreign Nationals and the Limitations for Indian Students" available here; "Foreigners Living in Georgia Able to Receive Coronavirus Vaccines in Three Clinics", Agenda.ge (3 August 2021).

69 Goginashvili K., Nadareishvili M. and T. Habicht, Can people afford to pay for health care? New evidence on financial protection in Georgia, World Health Organization Regional Office for Europe (2021); Richardson and Berdzuli, *Georgia: Health System Review*.

70 State Commission on Migration Issues, Brief Migration Profile Remittances (2016).

71 Kurji Z., Z. S. Premani and Y. Mithani, Analysis Of The Health Care System of Pakistan: Lessons Learnt And Way Forward, *Journal of Ayub Medical College Abbottabad* 28(3): 601-604 (2016); Hassan A., K. Mahmood and H. A. Bukhsh, Healthcare System Of Pakistan, *International Journal of Advanced Research and Publications* 2(3): 211-216 (2016); World Health Organization & Alliance for Health Policy and Systems Research, Primary health care systems (prismasys): comprehensive case study from Pakistan, World Health Organization (2017).

72 Legido-Quigley H. et al., Patients' experiences on accessing health care services for management of hypertension in rural Bangladesh, Pakistan and Sri Lanka: A qualitative study, *Plos One* 14(1): 1-23 (2019).

Migrants in Pakistan are not entitled to public health-care services and the government also does not provide critical health services such as psychosocial support and preventive screening for emigrants.[73] These gaps in migrant-sensitive health services in Pakistan were addressed by several international organisations, such as WHO, UNHCR and IOM, along with a number of national NGOs which conducted health assessments for migrants and returnees.[74] These challenges in the health-care system of Pakistan and policy regulations have implications for improving the health and social well-being of migrants in Pakistan.

SENEGAL

The health-care system in Senegal has been undergoing a transformation towards UHC since 2012. The government demonstrated strong political will in improving the health-care system as part of the campaign promises made by Senegal's President in 2012 and 2019.[75] Two key focuses in Senegal's UHC plan were to improve health service coverage particularly in traditionally underserved areas and to expand the Universal Health Insurance Policy that aims to improve financial access to health services. Three types of health insurance schemes exist in the country: (1) schemes attached to formal employment, (2) programmes that provide health care free of charge, and (3) community-based health insurance. Nevertheless uptake has been slow and limited, and disparities remain in terms of access to health particularly in rural areas and health financing.[76] Some literature also underscored the need to strengthen services delivery in terms of reproductive health and mental health in Senegal.[77]

One of the main issues identified in Senegal is the mental health problems associated with cross-border migration. The high expectation towards better life outcomes following migration often causes immense pressure on migrants. As a result, returnees who fail to meet such expectations might struggle with psychosocial issues upon return. [78] This is exacerbated by the stigmatization of mental illness and limited mental health services in Senegal. While the COVID-19 pandemic heavily affected the health system in Senegal, support from external actors including The World Bank, WHO and UNICEF, contributed to strengthening the government response towards the pandemic.[79]

THE GAMBIA

Ensuring access to health services at all levels (primary, secondary and tertiary levels) based on need, for all persons irrespective of nationality and migratory status, is one of the guiding principles of the National Migration Policy (2020–2030) and the National Health Policy (2012–2020) of the Gambia. The Gambia has also prioritized health in its National Development Plan (2018-2021) and primary health care is free at the point of service. However, reduced fiscal spending in the last decades culminated in less funding for the public health sector with far-reaching consequences. Two decades after the *Abuja Declaration* in 2001, the Gambia is still unable to meet its pledge of increasing health spending to 15 per cent of its annual budget.[80]

73 IOM, Health Vulnerabilities of Migrants from Pakistan: Baseline Assessment (2015).

74 Gushulak B. D. and D. W. MacPherson, The basic principles of migration health: Population mobility and gaps in disease prevalence, *Emerging Themes in Epidemiology* 3(3): 1-11 (2006).

75 Paul E. et al., An assessment of the core capacities of the Senegalese health system to deliver Universal Health Coverage, *Health Policy Open* 1(1): 1-8 (2020).

76 Daff B. M. et al., Reforms for financial protection schemes towards universal health coverage, Senegal, *Bulletin of the World Health Organization* 98(2): 100-108 (2020).

77 Foley E. E., Overlaps and disconnects in reproductive health care: global policies, national programs, and the micropolitics of reproduction in northern Senegal, *Medical Anthropology* 26(4): 323-354 (2007); Monteiro N. M. et al., Policy perspectives and attitudes towards mental health treatment in rural Senegal, *International Journal of Mental Health Systems* 8(9): 1-9 (2014); Parmar D. and A. Banerjee, How do supply - and demand-side interventions influence equity in healthcare utilisation? Evidence from maternal healthcare in Senegal, *Social Science & Medicine* 241(1) (2019).

78 Petit V., Forced Returns of International Migrants in Senegal: Family Dilemmas Facing Mental Illness, *Revue Europeenne des Migrations Internationales* 34(2-3): 131-158 (2018); IOM, "When Returning Home Is a Deadly Journey, "Shame Is the Returnee's Worst Enemy"" (1 March 2019).

79 World Bank, "World Bank Financing Helps to Support Senegal in the Fight against COVID-19" (13 September 2021); Andriamasinoro L. F., "Mitigating the Impact of COVID-19 on Children and Families in Senegal" (23 March 2022); Kayouli E., "Japan and UNICEF Partner to Support Senegal in Its COVID-19 Response" (24 October 2021).

80 African Union, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Disease (2001); Government of the Gambia, Ministry of Health, The National Health Laboratory Services Strategic Plan 2021-2025.

External donations played an instrumental role in bridging the gap in public health funding, with almost half of the total health funding (45%) in 2017 sourced from external donors.[81] This was exacerbated during the COVID-19 pandemic. On top of limited resources and contested priorities, public resources were further stretched thin to cope with the global health crisis and economic downturn that follows.[82] Existing challenges in the health-care financing and delivery systems have implications for improving the health of migrants and the general population who are faced with an increasing trend of non-communicable diseases.[83]

To complement the Government of the Gambia's efforts, IOM provided capacity building and support in the areas of water sanitation and hygiene, infection prevention control, public health laboratory services, and MHPSS. Further support has been provided in the development of standard operating procedures to support front-line health and border officials. The first national framework on MHPSS needs of migrants and returnees, and a training curriculum on MHPSS for learning institutions were developed for the Government of the Gambia to support the sustainable and holistic reintegration of returnees in the country.

81 Ibid.

82 Omotosho T. O. A. et al., COVID-19 challenges: The Gambia situation and probable solutions, *World Journal of Advanced Research and Reviews* 7(3): 70-76 (2020); Sers C. F. and M. Mughal, Covid-19 outbreak and the need for rice self-sufficiency in West Africa, *World Development* 135(1): 1-2 (2020).

83 Omoleke S. A., Chronic non-communicable disease as a new epidemic in Africa: focus on The Gambia, *The Pan African Medical Journal* 14(87): 1-9 (2013).

REFERENCES

Aldridge, R., Nellums, L., Bartlett, S., Barr, A., Patel, P., Burns, R., Hargreaves, S., Miranda, J., Tollman, S., Friedland, J., & Abubakar, I.
2018 Global patterns of mortality in international migrants: a systematic review and meta-analysis. *The Lancet*, *392*(10164).

Castañeda, H., Holmes, S., Madrigal, D., Young, M., Beyeler, N., & Quesada, J.
2015 Immigration as a Social Determinant of Health. *Annual Review of Public Health*, *36*(1).

Dekeyser
2021 Fostering and Strengthening Interlinkages between Sustainable Development and Reintegration Programmes

Davies, A., Borland, R., Blake, C., & West, H.
2011 The Dynamics of Health and Return Migration. *PLOS Medicine*, *8*(6).

Diker, E., Röder, S., Khalaf, M., Merkle, O., Andersson, L., & Fransen, S.
2021 Comparative Reintegration Outcomes between Forced and Voluntary Return and Through a Gender Perspective.

García-Sierra, Rosa, María Isabel Fernández-Cano, Josep María Manresa-Domínguez, María Feijoo-Cid, Eduard Moreno Gabriel, Antonia Arreciado Marañón, Francesc Ramos-Roure, Jordi Segura-Bernal, and Pere Torán-Monserrat
2020 Psychological Distress and Somatization in Immigrants in Primary Health Care Practices." *Healthcare* 8, no. 4: 557. https://doi.org/10.3390/healthcare8040557.

Gröne, Garcia-Barbero, and WHO European Office for Integrated Health Care Services
2001 Integrated Care: A Position Paper of the WHO European Office for Integrated Health Care Services

Habtamu, K., Minaye, A., Zeleke, W.
2017 Prevalence and associated factors of common mental disorders among Ethiopian migrant returnees from the Middle East and South Africa. BMC Psychiatry 17(1).

IOM
2017 Towards an Integrated Approach to Reintegration in the Context of Return.

IOM
2019 Reintegration Handbook - Practical Guidance on the Design, Implementation and Monitoring of Reintegration Assistance.

Kodner, D., & Spreeuwenberg, C.
2002 Integrated care: meaning, logic, applications, and implications--a discussion paper. *Int J Integr Care*, *2*.

Levesque, J., Harris, M., & Russell, G.
2013 Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health*, *12*(18).

Mendenhall, E., Newfield, T., & Tsai, A.
2022 Syndemic theory, methods, and data. *Soc Sci Med, 295*.

Mona, H., Andersson, L., Hjern, A., & Ascher, H.
2021 Barriers to Accessing Health Care among Undocumented Migrants in Sweden - a Principal Component Analysis. *BMC Health Services Research*.

Mukumbang, Ferdinand C.
2021 Migrant-Health Inequity as a Consequence of Poor Siracusa Principles Implementation in the COVID-19 ERA. *International Journal of Travel Medicine and Global Health* 9, no. 4: 155–60. https://doi.org/10.34172/ijtmgh.2021.26.

Schuster, L., & Majidi, N.
2014 Deportation stigma and re-migration. *Journal of Ethnic and Migration Studies, 41*(4).

Siriwardhana, C., Roberts, B., & McKee, M.
2017 *Thematic Paper: Vulnerability and Resilience in Migration Health. Report Commissioned by IOM for the 2nd Global Consultation on Migration and Health*.

Solano, Giacomo, and Thomas Huddleston
2020 Health: Migrant Integration Policy Index (MIPEX). www.mipex.eu.

Vearey, J., Hui, C., & Wickramage, K.
2019 Chapter 7 - Migration and Health: Current Issues, Governance and Knowledge Gaps. In *World Migration Report 2020*. IOM.

Vearey, J., Modisenyane, M., & Hunter-Adamsiv, J.
2017 Towards a migration-aware health system in South Africa: a strategic opportunity to address health inequity.

WHO
2022 Global Evidence Review on Health and Migration: Continuum of Care for Noncommunicable Disease Management during the Migration Cycle,.

Wickramage, K., Vearey, J., Robinson, C., & Knipper, M.
2018 Migration and Health: A Global Public Health Research Priority. *BMC Public Health, 18*(1).

Zimmerman, C., Kiss, L., & Hossain, M.
2011 Migration and Health: A Framework for 21st Century Policy-Making. *PLoS Medicine, 8*(5).

IOM health teams assist a woman who cannot get out of her car due to high blood pressure. © IOM 2022 / Léo TORRÉTON

Samuel Hall

Samuel Hall is a social enterprise that conducts research, evaluates programmes and designs policies in contexts of migration and displacement. Our approach is ethical, academically rigorous, and based on first-hand experience of complex and fragile settings. Our research connects the voices of communities to changemakers for more inclusive societies. With offices in Afghanistan, Germany, Kenya and Tunisia and a presence in Somalia, Ethiopia and the United Arab Emirates, we are based in the regions we study. For more information, please visit www.samuelhall.org.

EU-IOM Knowledge Management Hub

The development and production of this research study is supported by the EU-IOM Knowledge Management Hub (KMH), which was established in September 2017 under the Pilot Action on Voluntary Return and Sustainable, Community-based Reintegration, funded by the European Union. The KMH aims to strengthen learning across return and reintegration programmes, and support the harmonization of approaches, processes and tools under the EU-IOM Actions addressing migrant protection and sustainable reintegration in Africa and Asia and beyond.

Project funded by the European Union
Project implemented by IOM