Challenges in the reintegration of return migrants with chronic medical conditions

Assessments conducted in

Afghanistan
Armenia
Azerbaijan
Ghana
Kosovo/UNSC 1244
Mongolia
and Morocco

Government of the Netherlands

International Organization for Migration (IOM)

Return: not necessarily a step backward

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Executive Summary

This report provides insight into the lived reality[1] of voluntary returnees with chronic medical conditions returning to Afghanistan, Armenia, Azerbaijan, Ghana, UNSC resolution 1244-administered Kosovo,[2] Mongolia and Morocco. The report was developed in the framework of the International Organization for Migration (IOM) project "Measures to Enhance the Assisted Voluntary Return and Reintegration (AVRR) of Migrants with a Chronic Medical Condition Residing in the EU". The project was funded by the European Return Fund Community Actions 2011 and co-funded by the Government of the Netherlands.

Responding to the need for more knowledge and resources in the AVRR domain, as described in the Call for Proposals of the European Return Fund Community Actions 2011, this report addresses the challenges faced by migrants with chronic medical conditions upon and after their return to the country of origin and the factors playing a role in the reintegration of this particular group of vulnerable migrants.

By using triangulation, in which experiences of returnees were compared with those of family members, health-care workers and reintegration organizations, the realities of the returnees' lives after return were brought into light. The results show discrepancies between the daily-life reality and the policies in place. Discrepancy is most apparent when examining return migrants' health-care expenses. Although policies allow for free access to public health care, in reality, returnees find themselves unable to afford health care due to the high costs involved. For some of the returnees, this was the main reason for their migration. The factors impeding sustainable reintegration include the high costs of medication and treatment, psychological problems, economic dependency on family, unemployment, and social stigma and health taboos. These factors are interrelated and are sources of stress.

Recommendations therefore focus on reducing stress levels. The most important recommendation is the implementation of psychological support schemes that would strengthen the capacity of returnees to deal with these challenges. Although the everyday stress cannot be avoided, returnees can benefit from programmes that can ease the stress and help them reintegrate into society. The following additional recommendations should be considered:

- Provide psychosocial support and counselling to returnees throughout the entire return and reintegration process;
- Consider the household as the basic unit of support;
- Strengthen the network with existing local organizations, health-care programmes and facilities;
- Assist towards an easy access to medical care and social welfare benefits in the country of origin;
- Harmonize reintegration packages of sending countries;
- Translate medical files into the native language of the returnee;
- Provide health-care support in small fixed increments.

Although returnees face the same health care-related problems and economic circumstances as the general population in the country of origin, they are, in many ways, more vulnerable than the average citizens. In addition to the stress factors mentioned above, this vulnerability is shaped by the stressful migration experience, the lack of real estate or land property (which may have been sold by the migrants to finance their migration), the social stigma attached to return migration in general and the high expectations among community members vis-à-vis the returnees. This report strongly recommends that this vulnerable profile be taken into account in the development of future return policies.

1 *Lived reality* is a social science terminology.
2 Hereinafter referred to as Kosovo/UNSC 1244.

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Assisted voluntary return

This is the administrative, logistical, financial and reintegration support to rejected asylum-seekers, victims of trafficking in human beings, stranded migrants, qualified nationals and other migrants unable or unwilling to remain in the host country who volunteer to return to their countries of origin (IOM, 2011).

Chronic medical conditions

These are conditions requiring permanent or long-lasting medical care, severe handicaps and substance abuse problems, e.g. mental health problems, diabetes, cancer, heart and circulatory problems, HIV/AIDS, or pulmonary problems (IOM, 2012).

Country of origin

The country that is a source of migratory flows (regular or irregular) (IOM, 2011).

Health

Health is a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the objective of living. It is a positive concept emphasizing social and personal resources, as well as physical capabilities.[3]

Host country

The country that is a destination for migratory flows (regular or irregular) (IOM, 2011).

Mental health

This is the state of well-being in which an individual realizes his/her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[4]

Migrant

For the purpose of this report and following IOM terminology, the term *migrant* means any non-national who has migrated to another country in order to establish him-/herself for a prolonged period or permanently. The term *migrant* is often used to distinguish those migrating for "economic" reasons from asylum-seekers or refugees who have migrated in order to find protection from persecution or violence. In this report, we use the term *migrant* to encompass both groups. Where it is necessary to make a distinction between these groups (for example, when speaking about their legal status in the Netherlands), we specify this, for instance, by using the term *asylum-seeker or irregular migrant* (Mommers et al., 2009).

Psychosocial factors

Psychosocial factors, at least in the context of health research, can be defined as the mediation of the effects of social structural factors on individual health, conditioned and modified by the social structure contexts in which they exist (Martikainen, Bartley and Lahelma, 2002).

Reintegration

This means re-inclusion or re-incorporation of a person into a group or a process, for instance, of a migrant into the society of his or her country of origin or habitual residence (IOM, 2011).

Reintegration (cultural)

In the context of return migration, this means re-adoption on the part of the returning migrant of the values, way of living, language, moral principles, ideology and traditions of the country of origin's society (IOM, 2011).

3 Definition from the World Health Organization (WHO), 1946.

4 Definition from WHO, 2002.

Reintegration (economic)

In the context of return migration, this is the process by which a migrant is reinserted into the economic system of his/her country of origin, and able to earn his/her own living. In developmental terms, economic reintegration also aims at using the know-how which was acquired in the foreign country to promote the economic and social development of the country of origin (IOM, 2011).

Reintegration (social)

In the context of return migration, this is the reinsertion of a migrant into the social structures of his/her country of origin. This includes, on the one hand, the development of a personal network (friends, relatives, neighbours) and, on the other hand, the development of civil society structures (associations, self-help groups and other organizations) (IOM, 2011).

Return

In a general sense, this is the act or process of going back to the point of departure. This could be within the territorial boundaries of a country, as in the case of returning internally displaced persons and demobilized combatants; or between a host country (either transit or destination) and a country of origin, as in the case of migrant workers, refugees, asylum-seekers and qualified nationals. There are subcategories of return which can describe the way the return is implemented, such as voluntary, forced, assisted and spontaneous return, as well as subcategories that describe who is participating in the return, for instance, repatriation (for refugees) (IOM, 2011).

Voluntary return

This refers to the assisted or independent return to the country of origin, transit or another third country based on the free will of the returnee (IOM, 2011).

Part I
Background

1.1 Context

This publication is one of the outcomes[5] of the IOM project "Measures to Enhance the Assisted Voluntary Return and Reintegration (AVRR) of Migrants with a Chronic Medical Condition Residing in the EU". The project was funded by the European Return Fund Community Actions 2011 and co-funded by the Government of the Netherlands. The project brought together two European Union (EU) member States – Hungary and the Netherlands – and seven countries of origin – Afghanistan, Armenia, Azerbaijan, Ghana, Kosovo/UNSC 1244, Mongolia and Morocco.[6]

The return of migrants with chronic medical conditions from EU countries can pose specific challenges for governments in both host countries and countries of origin. These challenges are described by the European Commission in the Call for Proposals of the European Return Fund Community Actions 2011 as pertaining to the "lack or absence of reintegration elements in the national return programmes of EU countries" and to the needs of vulnerable migrants for "more advice, guidance and resources to cope with the challenges of reintegration".

The concept of "voluntary return" with the goal of a "humanitarian reintegration" in the country of origin has developed into one of the central instruments of the European migration policy (Lersner et al., 2008; Chu et al., 2008). However, research about the health and well-being of migrants after their return is scarce (Geraci, 2011).

This report captures the findings of research done on the needs of migrants with chronic medical conditions upon and after their return to the country of origin. The research was conducted in Afghanistan, Armenia, Azerbaijan, Ghana, Kosovo/UNSC 1244, Mongolia and Morocco to identify factors that play a role in the reintegration process of this particular group of migrants. The research gives insight into the lives, needs and challenges of migrants with chronic medical problems after their return, and aims to provide recommendations to address these challenges.

1.2 Return migration

Voluntary return and decision making: Why do migrants return?

Migrants thinking about returning are influenced by a number of factors and a complex set of feelings (Geraci, 2011; Lersner et al., 2008). The decision to stay or to return is intensely personal, as well as emotionally and socially charged (Mommers et al., 2009).

There are usually three types of motives for return (Haas and Fokkema, 2010; Lersner et al., 2008): (1) familial–personal reasons; (2) economic–occupational reasons; and (3) social–patriotic reasons. Push and pull factors represent another classification of motives. Push factors can be, for example, the lack of financial resources, an insecure migration status in the host country, discrimination or language barriers. Examples of pull factors include family ties, homesickness and national loyalty. According to Lersner et al. (2008), pull factors play a larger role than push factors in return-migration decisions.

5 The project produced also the handbook *Returning with a Health Condition: A Toolkit for Counselling Migrants with Health Concerns*. It is intended as a kit of basic tools for the use of return practitioners working with migrants with, mostly chronic, or protracted medical conditions in the context of return migration.

6 The EU member States partnering under this project – Hungary and the Netherlands – shared similar concerns and challenges in adequately facilitating return and reintegration of medical cases. Hungary has had limited experience in handling medical return cases. The potential medical caseloads in these two EU member States were reflected in the selection of countries of origin for the project. Afghanistan, Armenia, Azerbaijan, Ghana, Kosovo/UNSC 1244, Mongolia and Morocco were represented at the top of their return statistics.

Health and return migration

The relationship between health and return is not linear. On the one hand, health conditions can be a reason to return, especially if health concerns are contributed to the stay in the host country. On the other hand, health conditions can hinder the return of migrants (Geraci, 2011) due to:

- The poor quality and accessibility of the health-care system in the country of origin, especially in comparison with the health-care system in the host country;
- The inability of migrants with health problems to inform themselves about return possibilities;
- The burden that migrants fear of placing upon their families due to their health problems;
- The lack of a social network in the country of origin.

For example, 13 per cent of migrants in Lersner's (2008) research about the return of migrants with mental health problems in Germany stated that the lack of medical and psychological care in their country of origin was a reason for not returning. In order to make an informed decision about the return of chronically ill migrants, the following questions need to be answered:

- Are health-care facilities accessible, affordable and available? (Geraci, 2011)
- Is long-term availability of medication and treatment guaranteed? (Mommers et al., 2009)
- Is quality and reliability of health care guaranteed? (Mommers et al., 2009)

For migrants with chronic medical conditions, economic and social circumstances are of equal importance (Mommers et al., 2009). The primary concern of return migrants with medical conditions is the affordability of health care. This suggests a close connection between the economic self-reliance of the migrant, and his or her reliance on others for a sustainable return. Having a chronic disease, like HIV/AIDS, can have an impact on an individual's ability to earn a livelihood and be self-reliant, and thus provide for the household's needs. Hence, the economic circumstances determine an individual's ability to access treatment and to ensure adherence to treatment. In addition, a chronic medical condition, especially when stigmatized as in the case of HIV/AIDS, can impact the migrant's social life. Social relations are important to the mental and physical well-being of a person and may also determine his or her ability to earn a livelihood (Mommers et al., 2009).

Providing accurate health information is of great significance in making an informed decision (Mommers et al., 2009). In Mommers et al.'s research about African return migrants living with HIV/AIDS, the migrants changed their decision after they were educated on their chronic medical condition. When first confronted with the HIV/AIDS diagnosis, the African migrants longed to return to their home country to die. After receiving health information, migrants came to the understanding they were not destined to die, but would be able to lead a fairly normal life, which made them reconsider their return decision.

1.3 Reintegration and sustainable return

Assisted voluntary return and reintegration

IOM's Assisted Voluntary Return and Reintegration (AVRR) programme acknowledges the challenges as mentioned above and aims to support return migrants – vulnerable migrants in particular – to tackle those through a range of services that have developed over the years.

AVRR is one of the many services that IOM offers to its Member States in the interest of efficient migration management within and between countries. It aims at orderly, humane and cost-effective return and reintegration of asylum-seekers, denied asylum-seekers and other migrants currently residing or stranded in host countries, and who are willing to return voluntarily to their countries of origin.

This area of IOM expertise has been developed through over 30 years of experience. Since 1979, IOM's AVRR activities have grown to include more than 100 projects, helping individuals return to some 160 countries worldwide. In the past decade alone, IOM has assisted more than 3.5 million migrants to return voluntarily to their home countries. IOM's rationale for its involvement in the facilitation of the AVRR programmes has followed the changing migration realities. In the early years, the IOM programmes merely offered basic support to facilitate return transportation arrangements. They have since evolved into comprehensive programmes integrating a range of services in order to promote the sustainability of returns. As migration has become more complex and circular, a more comprehensive approach to return has been required and implemented.

Currently, IOM carries out AVRR from and to an ever-increasing number of countries and supports reintegration activities in many countries of origin. The conditions in which assistance is provided, and the nature and extent of the resources made available to effectively return migrants and support their reintegration, vary from one country to the next. Beneficiaries of the AVRR assistance include individuals whose application for asylum was rejected or withdrawn, stranded migrants, victims of trafficking, and other vulnerable groups, including unaccompanied migrant children, or migrants with health concerns.

Certain principles apply to AVRR. The first and most critical one for IOM is that it must be voluntary, as required by the IOM Constitution. IOM must ascertain whether returns are voluntary before return arrangements are made under the auspices of the Organization. As a rule, the migrants must receive return counselling to ensure that they are able to formulate an informed decision in choosing the AVRR option. IOM, or its recognized partners, must be able to perform return counselling independently and in an unhindered manner, and in conditions allowing migrants to express their views clearly, irrespective of their status or location.

The AVRR process always comprises arrangement of travel, post-arrival reception, information, referral, onward travel to the home location and immediate reintegration assistance. It may also include information provision and counselling for potential returnees, medical assistance (if necessary) and longer-term reintegration assistance. Since the return of a migrant with health concerns is sensitive, the migrant's current conditions in the host country (which include, for example, severity of medical condition, the medical treatment provided, the migrant's legal status and the availability of services in his or her country of origin) require extensive information provision and counselling. Information about AVRR options and counselling is essential to ensure the informed consent of migrants.

Sustainable return

Sustainable return can be defined as the return to the country of origin with a realistic personal development perspective and the ability to establish a life (Geraci, 2011; Zieck, 2004) in which the migrant secures the political, economic, legal and social conditions needed to maintain life, livelihood and dignity (Omata, 2012). What constitutes a "sustainable return" for migrants can therefore differ according to their own specific circumstances (Mommers et al., 2009).

For the purpose of this study, return is considered sustainable when approached in a comprehensive manner that takes into account pre-departure and post-arrival considerations, encouraging the creation of new opportunities in the country of origin. This approach makes assisted voluntary return more attractive and acceptable to migrants.

Sustainable return and health

In their research on voluntary return of migrants with HIV/AIDS, Mommers et al. (2009) state that sustainable return would be possible if:

- Medical treatment is available and durable access is guaranteed;
- Sufficient income is earned to cover regular expenses for the migrant and his or her family, and to cover medical costs;

- Migrants are placed within a supportive social network and are able to cope with the stigma;
- Migrants have a positive outlook of the future in the country of origin, are motivated and have a proactive attitude.

These conditions are, according to Mommers et al. (2009), interlinked. If one does not materialize, it is likely the others will not either. Sustainable return is therefore dependent on a broad range of circumstances that are closely interconnected (Mommers et al., 2009).[7]

Economic reintegration

The close connection between economic self-reliance, support of a social network on the one hand and a sustainable return on the other hand is evident. An example is Strand et al.'s research (2008) in which Afghan migrants successfully reintegrated with capital and knowledge about running a business. Successful returnees have a background in business, specific skills, and the ability to draw upon family and other networks in setting up, financing and running a business.

Even with a job, the basic needs and health expenses of a returnee might not be guaranteed, as Mommers et al.'s (2009) research on African return migrants shows. Education and skills are also essential for a returnee to survive economically (Mommers et al., 2009). In addition to a supportive network, education and skills, Omata (2012) identifies a third factor that will improve the successfulness of economic integration, namely the transferability of livelihood strategies from the time spent in the host country. These personal assets are most likely to be a key factor in the successful return, if the political situation in the country of origin is stable (Strand et al., 2008).

In conclusion, key determinants for a successful socioeconomic reintegration are:

- Strong social network;
- Monetary resources;
- Education and skills;
- Personal skills to use livelihood strategies from the time spent in the host country;
- Stable political situation.

Social network

Personal connections available upon return are of great importance in securing shelter and daily food, and in ensuring a positive difference in the initial phase of the transition process (Omata, 2012). These immediate connections, such as family and kinship, often serve as the most reliable sources of assistance and become the link to the local labour markets. In his research on returnees in Liberia, Omata (2012) concludes: "For those without meaningful personal contacts in Liberia, [. . .] return and integration turned out to be an extremely harsh experience, as they struggled to secure even the basic necessities for living, such as shelter and daily food. Their level of access to social networks in Liberia played a principal role in determining the degree of their integration."

Return migrants with chronic health problems face additional challenges: their medical conditions could cause an inability to work, making their reliance on social support networks greater. This is especially true in countries that do not have social security schemes in place. As yet, it is not known how many return migrants with chronic medical conditions succeed in being economically independent and providing for their own basic needs, and how many depend on family members after return.

Besides support, a social network also implies obligations (Strand, 2008), which return migrants with health problems might not be able to fulfil. In addition, return migrants might be seen as people who abandoned their countries of origin, or as failures (Geraci, 2011). Their medical conditions might be seen as a financial or social burden on the family, leading to feelings of shame by the returnees. Stigmatized

7 Although sustainable return is an objective in IOM's AVRR programme, the absence of guarantees does not necessarily prevent IOM to provide assistance.

diseases could further prevent migrants from integrating into the larger community (Mommers et al., 2009). As a result, the migrants might not experience a warm welcome upon return.

Research on the support network and economic support is far more extensive than the literature on the psychosocial support that family members and communities are providing. Only Fu and Vanlandingham's (2010) research of Vietnamese return migrants states that "family, elders, community solidarity, and combatants were identified as important sources of psychological support among those youth".

After return

What is the lived reality after migrants with chronic health concerns arrive in their countries of origin? Studies focusing on the return and reintegration of migrants with health concerns are limited. In part, the migrants' state of mind and outlook on life in the country of origin is intertwined with the reason for return and the circumstances that accompanied this decision. In addition, feelings of belonging need to be renegotiated upon return, both at the community and family levels (Albers, 2005; de Bree et al., 2010). Migrants' decades-long stay in Europe has nurtured social norms and expectations that often led to some disappointment upon the return (Haas and Fokkema, 2010). The reintegration of returnees into the country of origin is almost as complicated as the experience of adjusting to a completely new culture and society (Omata, 2012). Little is known about the return migrants' point of view after their return and even less is known about the migrants with health concerns.

1.4 Chapter overview

The next chapter presents the methodological approaches used for the research. Chapter 3 reviews the overall results, with all countries presented together. In the second part of the report, Chapters 4 through 10 describe the research findings per country; these chapters can be read independently from each other. Chapter 11 provides the main research conclusions. Chapter 12 makes recommendations on the sustainability of return and on addressing the needs of return migrants.

Chapter 2 Methodology

2.1 Overview of methodology

The following instruments have been used in gathering information about the factors that play a role in the reintegration process of migrants with chronic medical conditions:

- A quick scan of relevant scientific literature;
- Interviews in seven different countries with individual return migrants with chronic medical conditions, family members, health-care workers, reintegration organizations and local researchers.

This chapter outlines these instruments and presents the selection of the local researchers, setup of the interviews, and the representativeness and generalizability of the research.

2.2 Quick scan of relevant scientific literature

Literature on return migration is extensive. Literature on health and return migration, on the other hand, is less available. Research was limited to the literature published after 2002, provided by databases like PubMed and Google Scholar. The available IOM literature was also included. Quick scan was not a full literature search and should therefore not be seen as an all-inclusive search.

A quick scan of the existing literature on the topics of return migration and return migration and health generated a list of the most important factors playing a role in the sustainable return and reintegration of the target group. This list formed the basic outline for the development of specific templates for the field interviews with the following categories of respondents: (1) returnees; (2) members of a returnee's family; (3) physicians and other health-care workers; and (4) organizations working with returnees. The quick scan was further used as an instrument for the verification of the research results.

2.3 Interviews

Main objective

The main objective of the field interviews was to tap into the migrants' first-hand experience concerning their return and reintegration. As the literature indicates that family members play an important role in the reintegration of returnees, the interviews with family members were expected to add to the information from another's perspective. The triangulation used in the research helped ensure a more complete picture of the lived reality of the migrants, while the interviews with other stakeholders were used to verify the similarities or dissimilarities between stories. In addition to the country context, cultural and tradition factors were taken into account. In hindsight, the interviews provided another valuable research angle: they brought to light discrepancies between the reality lived by the return migrants and their family members and the reality in the context of the health-care systems and policies as presented by health-care workers.

At a later stage, the research leader conducted bilateral interviews with local researchers in order to:

- Gather additional background information;
- Seek clarity on the interview results, for example additional information about returnees, clarification of answers and indications concerning the truthfulness of answers to the field interviews.

The additional information was used by the lead researcher to frame the interview results in the context of the country-specific culture and traditions.

Selection of local researchers and respondents

The research was conducted in Afghanistan, Armenia, Azerbaijan, Ghana, Kosovo/UNSC 1244, Mongolia and Morocco. With the support of local IOM offices, the project recruited local researchers in all the research countries. The assignment of the local researchers consisted of the following tasks: (1) conduct interviews with the four categories of respondents outlined in 2.2., based on instructions and templates provided by the lead researcher in the Netherlands; (2) help identify possible respondents among health-care workers and reintegration organizations; and (3) supply background and general country information.

The returnees were identified using the databases of local IOM offices. In arranging the individual interviews, the local researchers would ask the migrants whether they would be comfortable with being asked and allow family members or members of the community to be interviewed as well. As regards the two professional and institutional categories of respondents (i.e. physicians and other health-care workers, and organizations working with returnees), IOM offices in some of the research countries were able to help with the identification of possible respondents belonging to these categories. In all cases, a local IOM staff member was interviewed to represent IOM as an organization working with returnees.

In three of the countries covered in this study – Afghanistan, Azerbaijan and Morocco – identification of respondents among return migrants was problematic, with the result that fewer than the 17 interviews agreed per country could be conducted in these countries.

- In Afghanistan, the local researcher had to work in very difficult circumstances. The unstable political situation rendered some of the research activities hazardous. Some of the meetings with respondents had to be cut short and thus not all expected input could be collected. Another difficulty was the small pool of available respondents and the severe mental health condition of some of the migrants, which prevented them from participating in the research in a consistent way. These factors resulted in fewer valid interviews being conducted in Afghanistan.
- In Azerbaijan, local regulations require that a research permit be obtained from the relevant government agencies, as part of a bureaucratic process that can take up to two months. The result was that the local researcher had to resort to his own network and to the network of the local IOM office, which limited the scope of the research. The health-care personnel who were able to participate in the interviews did not have experience in working with return migrants. Also, reintegration organizations other than IOM are non-existent in Azerbaijan, which further limited the number and variety of institutional respondents.
- In Morocco, recruitment of migrants to participate in the research was constrained by the stigma associated with the mental and psychological problems experienced by returnees, and by the negative connotations of return migration issues that the migrants themselves and society in general had.

A total of 84 interviews were conducted and included in the research. The distribution of interviews by category of respondent is as follows: 28 interviews were held with return migrants; 26 with members of the migrants' families; 18 with health-care workers; and 12 with reintegration organizations.[8]

Interviews

The interviews with return migrants and their families were intended to provide an insight into the lived reality of chronically ill migrants as experienced post-return. The interview questionnaire was designed based on topics selected through the literature quick scan. A structured questionnaire was chosen, to allow for a comparison between countries, considering that the interviews would be conducted by seven different operators. The questionnaires are presented in Annexes 1 through 4.

8 The distribution per country is further presented in Part III, dedicated to individual country assessments.

The local researchers received the necessary instructions by means of bilateral Skype sessions with the research leader in the Netherlands. The local researchers were advised to take the liberty of asking additional questions and/or explore subjects that appeared to be of importance to the interviewees. Some of the researchers did venture to do so, while others felt more comfortable to operate within the confines of the questionnaire.[9]

Before the interview, the respondents were asked to confirm their agreement by signing a consent form; they were also asked the permission to be photographed. All respondents signed the consent form for the interview; some chose not to give their permission to be photographed. Both the migrants and their family members were advised that their participation in the research would not be compensated financially. Instead, they were encouraged to consider it as an opportunity to contribute their experience towards the improvement of return policies for the benefit of future migrants.

Even though all migrants and family members confirmed their understanding of the research conditions, the local researchers reported feeling pressure exerted by the migrants in their attempt to obtain additional support to alleviate their desperate situation. Also, the local researchers noted that some of the migrants may have possibly presented their situation – as to their living conditions or income – as being worse than what the reality suggested, presumably in the attempt to elicit support from the researchers. This observation should be considered in the context of the fact that the living conditions of most of the migrants interviewed could be objectively described as poor.

Based on the analysis of material submitted by the local researchers, the research leader compiled a topic list for open interviews with the local researchers, which were held by Skype. The local researchers were asked to place the interviews in the individual country context and to answer questions that arose during this analysis. In addition, the local researchers were asked to confirm whether they would assess the answers as truthful and reflecting the reality of the migrants' situation.

The topic list discussed with the local researchers included:

- Specific questions about the interviews;
- General questions about the health-care system in the local country;
- General questions about the social security policies in the local country;
- Cultural customs and traditions that may relate to or have a bearing on return migration;
- General personal opinions about the situation of the returnees;
- Own vision on recommendations.

Representativeness and generalizability

All migrants who participated in the research had chronic health concerns but came from different migration backgrounds. It is therefore not possible to thoroughly generalize the outcomes of the research, since a comparison between the different types of migrants could not been made. Moreover, the limited number of respondents and the scope of research put constraints on the representativeness of the outcomes. Nevertheless, the research does provide a good starting point for learning about the reintegration challenges of this category of migrants in the country of origin.

To ensure comparability, a fixed questionnaires setup was chosen while leaving room for additional questions by the local researchers.[10] This approach made possible a comparison between countries and at the same time allowed for the mark of the local context and for the provision of additional information. The local outlook was further enhanced through the interviews conducted by the lead researcher with the local researchers. As a result, the data provides for a general analysis covering all countries, as well as a country-specific analysis, with the latter including the country-specific contexts.

9 The approach of the individual researchers depended on their previous experience with interview methods.

10 The translation into and from the different foreign languages may have led to loss of data. The local researcher translated the questionnaires from English into their local language and reported back to the research leader in English.

The data gathered in the individual countries was relatively small and can therefore not be seen as all inclusive. However, this data does give an insight into the factors that play a role in the reintegration process of chronically ill return migrants.

Recruitment of the respondents limited the representativeness of the research. The migrants participating in the research were identified exclusively based on pre-existing contacts with the local IOM offices and migrants assisted by other organizations were not included.[11] The respondents' link to and personal experience with IOM may have been factors of influence for their perception of the return and post-return experience. The research should therefore not be seen as representative for all return migrants. In addition, the sample of migrant respondents included only returns that were relatively recent, of only 10 months on the average, as respondents with a longer stay – more than two years – in the country of origin could not be identified.

11 To stay within the time frame and budget of the research project, pre-existing contacts within the IOM organization were used.

Part II

Research Results

General research results

This chapter presents the results of all the interviews conducted in the seven countries of origin. However, the focus is maintained on the information provided by the return migrants, with the other interviews– with family members, health workers and reintegration organizations – being used as support data. The purpose of this approach is to keep in the foreground the lived reality and experiences of migrants after their return to the country of origin.

The questionnaires addressed seven interlinked topics:

- The perceptions of the returnees' health, by the returnees themselves and by their social network;
- The returnees' psychological problems;
- The opportunities and limitations inherent to the health-care systems in the countries of origin;
- The role played by the social networks and the support they provide to the returnees;
- An assessment of the returnees' living conditions and needs;
- An assessment of the returnees' economic conditions and opportunities;
- The migrants' outlook of their past and their future.

A total of 28 interviews with return migrants from six countries were analysed, as shown in Table 1. The results from Afghanistan have not been included in this analysis; due to the difficult research circumstances, the data rendered could not be analysed along with the data from the other research countries. The results and conclusions concerning Afghanistan, presented in Chapter 4, include the limited research results, but they are mostly based on the literature scan.

Table 1: General information about the interviewed returnees (all countries)

Return migrant	Age	Gender	Country of origin	Host country	Length of stay in the host country	Length of stay in the country of origin	Medical condition(s)
1	73	F	Armenia	Netherlands	14 y	3 m	Diabetes, high blood pressure, stroke
2	65	F	Armenia	Belgium	1 y	10 m	Diabetes
3	53	M	Armenia	Belgium	1 y 3 m	1 m	Cancer
4	60	M	Armenia	Belgium	4 y	3 m	Cancer, shift spinal disc
5	50	M	Armenia	Netherlands/ Germany	1 y	3 m	Cancer
6	41	M	Azerbaijan	Netherlands	1 y 9 m	3 m	Asthma, thrombosis in legs, epilepsy, nervousness, hallucinations
7	44	M	Azerbaijan	Belgium	4 m	10 m	Liver spots, teeth problems
8	45	M	Azerbaijan	France	9 m	2 m	Psoriasis, AIDS, TB, hepatitis B and C
9	75	F	Azerbaijan	Luxembourg	2 y 5m	4 m	High blood pressure, paralysis
10	51	M	Azerbaijan	France	4 y	2 m	High blood pressure
11	54	F	Ghana	Belgium	1 y	1 y	Diabetes
12	57	M	Ghana	Netherlands	25 y	1y 4 m	Not diagnosed[12]

12 After a stay in the Netherlands as an illegal alien and with no access to the Dutch health-care system, the migrant's health deteriorated and he returned to Ghana to seek a diagnosis.

Return migrant	Age	Gender	Country of origin	Host country	Length of stay in the host country	Length of stay in the country of origin	Medical condition(s)
13	78	M	Ghana	Liberia	25 y	5 m	Stress, age-related health problems, high blood pressure
14	64	M	Ghana	Netherlands	23 y	1 y	Eye problems, piles, stomach problems
15	39	M	Ghana	Belgium	3 y	5 m	HIV
16	47	M	Kosovo/UNSC 1244	Finland	4 m	10 m	Kidney failure (dialysis)
17	63	M	Kosovo/UNSC 1244	Belgium	2 y 6 m	2 m	Had a heart attack, high blood pressure, stress
18	56	M	Kosovo/UNSC 1244	Belgium	1 y 1 m	10 m	Kidney failure (dialysis)
19	65	F	Kosovo/UNSC 1244	Luxembourg	4 m	10 m	Rheumatoid arthritis, high blood pressure
20	30	M	Kosovo/UNSC 1244	Belgium	1 y 1 m	1 y 7 m	Head injury, chronic headache, post-traumatic stress disorder (PTSD), neurological problems
21	58	F	Mongolia	Netherlands	6 m	5 m	Poor vision
22	30	F	Mongolia	Netherlands	8 y	8 m	Neurasthenia, thyrotoxic disease, chronic gastritis, chronic viral hepatitis C
23	60	F	Mongolia	Netherlands	9 m	11 m	Arterial hypertension, chronic heart disease
24	32	M	Mongolia	Netherlands	6 m	16 m	Arterial hypertension
25	61	F	Mongolia	Netherlands	10 m	3 m	Diabetes mellitus type 2, arterial hypertension, chronic ischemic heart disease, arthritis (both knee joints)
26	34	M	Morocco	Belgium/ Netherlands	8 y	3 y	Asthma, permanent bowel problems, nervous breakdown
27	47	M	Morocco	Belgium	7 y	1 y	Diabetes
28	29	M	Morocco	Belgium	4 y	1 y 3 m	TB and asthma
Average	**53**				**5 y**	**10 m**	

3.1 Return migration and health

3.1.1 Deterioration of health

The respondents' reasons to migrate and to return are interlinked and have a bearing on the post-arrival experience for both the migrants and their families. Their reasons also have an impact on their pre-existing health condition and subsequent developments. Almost half of the migrants interviewed – 13 out of 28 – stated that their conditions worsened after return. The other 15 reported that they either did not see a difference or they were feeling better. The reasons to return had an effect on their health, as perceived by the migrants themselves. For example, all respondents from Kosovo/UNSC 1244 left their country with pre-existing medical conditions and in search of a treatment or cure. Unable to obtain legal status in the host country, they returned to Kosovo/UNSC 1244 with their conditions worsened or in a poor state, which returnees attributed to their negative outlook of the

future. Returnees from Ghana, on the other hand, reported an improvement in their state of health: after living in the host countries without a residence permit and therefore unable to access medical services, their reason to return home was directly linked to the deterioration of their health. Once back home, they were able to access the local health-care system, which led to an improvement in their medical conditions.

Affordability and accessibility of medication were the reasons most frequently reported as connected to changes for the worse in the respondents' health. Although health care in the country of origin may be stated to be free of charge, in reality, patients may be expected to pay out-of-pocket money to get the needed medication or services. There are several reasons for this: corruption in the administration; the practice of under-the-table or informal payments, as is the case of Armenia, where services are for free but medication is not always free of charge[13]; the poor quality of medication available through the public channels; and the unavailability of the brand medication prescribed in the host country and the migrants' lack of confidence in the generic medication available as a replacement, not trusted to be as effective. In such situations, the medication has to be purchased from the private pharmacy system, and affordability is not always guaranteed, due to the difference in cost. These are as many reasons for which migrants are not always able to take their medication upon their return, with negative consequences on their health.

CASE STUDY
Susana[14]

"We are not living here . . . we are merely surviving."

Susana, 65 years old, returned 12 months ago to Armenia, after a one-year stay in Belgium. Susana suffers from diabetes, as diagnosed 12 years ago. The diabetes has affected her eyesight and caused additional problems with her heart and kidneys; recently, she was diagnosed with high blood pressure. Susana's decision to leave for Belgium was motivated by the intention to seek medical care for her diabetes. She sold her house and belongings and left her country. She enjoyed the quality of the health care in Belgium, but missed her family too much and decided to return to Armenia. After her return, Susana moved in with her daughter and her daughter's family.

After the return to Armenia, Susana's heart problems got worse and her high blood pressure became extremely high. In the first month after the return, she used up the medication given to her in Belgium prior to her departure. In the respective first month in Armenia, she felt physically well, not in an excellent condition, but well. Susana feels her health deteriorated after she changed the medication. She receives all her medication from a State polyclinic for free. In her opinion, the quality is very bad and not effective enough. Her family and friends are advising her not to use it. She feels she has to resort to private pharmacies because she should not risk taking medication of poor quality which can potentially threaten her already fragile state of health.

Susana visits the hospital twice a month on an average. The medical records she brought from Belgium have proved to be useless, since the local doctors cannot read them. As a result, she would have to undertake new diagnosis tests. Because of problems with her legs, Susana cannot walk very far or for too long. Therefore, she is unable to work. She depends on her daughter and grandchildren to do her daily routines, like bathing and getting dressed. She receives a small pension, which is insufficient to sustain her needs. She is thus in a position to have to choose between buying food and buying medication, since she cannot afford both. Her daughter covers the costs of her treatment. Once in a while, a relative provides some financial help.

13 In part, this has to do with the mixed public–private health-care systems. The possibility to access medication depends on the setup of and architecture of the national health-care systems. In some countries, public health-care services are for free, but the pharmacies belong to the private sector. The same paradox applies with regard to the lists of essential medication subsidized by the State for specific diseases. The medication listed is regulated as free of charge, as determined usually by the Ministry of Health of the respective country, but in reality this is no guarantee that the medication would be also available. In such circumstances, the private sector is the only solution to procure the medication. All countries included in the research feature this essential-list system. These issues are discussed in depth in the country chapters.

14 The name has been changed to protect the identity of the respondent.

Susana feels she is in a better state of mind now that she is taken care of by her daughter and is surrounded by family members. On the other hand, she feels like a burden to her daughter, her daughter's husband and their three children. She feels bad about using their financial resources. As a mother, Susana feels she should be the one providing for her daughter and not the other way around. There are days that Susana feels so bad she just cries and wants to end her life. "I suffer myself and I make my family members and my children suffer with me. I am not very old, but still I don't want to go on living."

3.1.2 Mental health

The returnees' mental health is influenced by the migration experience and related stress factors. Of the 28 returnees interviewed in the research, 22 reported that their mental health deteriorated after their return.[15] Four of the migrants, from Armenia, Morocco and Kosovo/UNSC 1244, confessed of their thoughts contemplating suicide. Some of the returnees had a pre-existing diagnosed mental condition; the others reported that they started feeling distressed or highly strung after their return. In total, the migrants indicated eight different stress factors, the applicability of each differing from one returnee to another.

The eight stress factors were:

- Reasons for returning;
- Length of stay in the host country;
- Length of stay in the country of origin;
- Hardships of everyday life;
- State of the health-care system in the country of origin;
- Pressure from family or social network;
- Outlook of the future;
- IOM procedures.

Reasons for leaving the country of origin and for returning

Migrants' return to the country of origin impacts not only their pre-existing health conditions but also their mental state. For some migrants, the return exerts a great deal of stress. As the Ghanaian cases indicate, while the coming home has given the returnees a feeling of relief as to their health problems, it has also placed them in a dependency situation. These migrants, while abroad, used to be the financial providers for their families back in the country of origin; in contrast, the return has rendered them unable to provide for their families. The Kosovar, Armenian and Azerbaijani respondents went abroad in search of help for their medical conditions. The rejection by the host country triggered feelings of disappointment and failure, and even feelings of desperation in the absence of a cure or treatment available in the country of origin. One striking example is the case of the two Kosovar migrants whose survival depends on the availability of kidney dialysis services in the country of origin and who will need a kidney transplant in the near future. Unable to support their families because of their medical condition, they left Kosovo/UNSC 1244 in the hope of getting a kidney transplant that would permit them to return home in good health and thus make them capable of providing for their families. The lack of solutions towards improving or restoring their health led to acute feelings of disappointment and failure, and to the grim perspective of not seeing a future for their life.

15 Only one of the Ghanaian returnees reported a worse-off state of mental health. All the other migrants chose not to respond to the questions regarding their mental health; those sections were left blank in the questionnaires. In contrast, interviews with the reintegration officers painted a different picture (see the country chapter on Ghana), showing that the returnees do feel a negative psychosocial effect following their return. In addition, the interview with the local researcher revealed all return migrants to be struggling with psychological problems. It appears that the taboo surrounding mental health problems prevented the returnees from talking about them in the interviews. Should the four interviews are included based on this additional information, it would mean that all but two of the 28 returnees are feeling mentally worse off after their return.

Length of stay outside the country of origin

The longer time the migrants spent outside the country of origin, the harder it is for them to readjust. The family structure and the way of living back home have evolved and changed during their stay abroad, in ways they have not been aware of. On the other side, the migrants got used to the life in the host countries, including as regards expectations one can have about health-care standards in terms of quality and range of services available. In general, they are no longer used to the type of struggles inherent in the daily life in the country of origin pertaining to covering daily necessities like food, paying the rent, medication or clothing.

Hardships of daily life

Feelings of stress, uneasiness and nervousness are enhanced by the hardships of daily life in the country of origin. Trying to make ends meet, expectations from family and relatives, re-adjustment to a new environment and reality are all taking a toll on return migrants. The story of Azar is one example of many.

CASE STUDY
Azar[16]

Azar is a 51-year-old male who arrived three months ago back in his natal Azerbaijan after a four-year stay in France, where he worked as a cook in a restaurant. He suffers from chronic high blood pressure, "bad nerves"[17] and insomnia. He decided that he wanted to return to his daughters after learning more about his health problems. Although diagnosed back in 2010, his daughters only found about their father condition after his return.

Azar is using medication he brought with him from France. He has no idea what the costs will be for his medication in the future; he still has a three-month supply left. He did not check the availability of the medication in Azerbaijan before he returned and has not done so since he arrived. Although he realizes he has some psychological issues, he has not looked for help yet. Azar was very pleased with the health care he received in France and is shocked by the quality of care and attitude in the health sector in Azerbaijan, which he is strongly questioning.

No one among his friends or community knows he has health issues. Azar declares this is so because of the kind of person he is – somebody private who would not share his problems with others and who would rather tell people that everything was fine.

His daughters and close relatives gave him a very warm reception upon his return. Other more distant relatives seem to believe that he came back with a lot of money so they have expectations about getting something from him. His daughters help him; he can tell they are trying to shield him from stressful news or events. He is appreciative of the emotional support they give him and therefore tries not to worry them by pretending he is happy and all right. But the reality is different: Azar has been having a hard time and feeling very low since his return home. He blames it on the harshness of everyday life in Azerbaijan, which affects him deeply, not only at the psychological level but physically as well – he can see the effects in his blood pressure. Azar feels alienated in Azerbaijan and believes he would be better off if living among non-Azerbaijani as he finds it difficult to adjust to his "*own country and community*". "The environment is oppressive, all that gossip and violence in the neighbourhood are breeding a hostile environment. You know, it was difficult to make a fair assessment and have correct expectations when looking from abroad. You look at your own country from the side and see different things, but then the reality is not as shown on TV. Had I known that the situation was so bad, I wouldn't have returned. I wish I never went to France and see how life can be there. I think I would have been better off if I had not been anywhere."

16 Azar is a fictive name given to the respondent to protect his identity.

17 As expressed by Azar.

He is working together with IOM on starting an income-generating project. He is thinking about a cow farm. Azar provides for his family (his daughters), but not for relatives. Although Azar would appreciate an improvement in his living conditions, he would rather change the negative environment he is in. At the moment, Azar does not do any work because the French doctor advised him not to stand for long lengths of time.

State of health care

The state of the national health-care system in all the research countries compares poorly with the systems experienced by the returnees in the host countries. The care available to the respondents in the host country was free of charge either because it was State-regulated or because the migrants were part of an asylum procedure allowing for free access to health care and medication. Comparing free-of-charge, good-quality services with poor and expensive services makes it hard for the migrants to accept their lived reality.

This is related to the lack of income to guarantee the needed medication. The stress brought about by not being able to pay for the medication or for diagnostic services is high. In some cases, it is not the affordability that causes extra stress but the availability of medication. Migrants return to their countries of origin with a set of medication described by physicians in the host countries. These are of specific brands. These brands are, according to return migrants, not always available. The physicians stated that in most cases a generic is available. Return migrants, on the other hand, claim their medication is not available or only available outside the public health care sector. This means it is not found on the essential list of medication financed by the government. This research was not able to determine whether the medication is available or not, even not in generic form; or whether the medication, including the generic form, is available but only accessible through the private health care sector. Regardless, lived reality for return migrants is that the stress due to not being able to find the right medication, having to pay for the medication, not trusting the generic brand and not trusting the quality of the medication is real and felt by the migrants. The stress related to availability and accessibility of medication is also related to being able to provide for oneself. This stress is especially felt after the medication they received from the physicians in the host country are close to being finished and the stipend they received from IOM for medical needs in the first six months after their return is coming to a close and still no income has been generated.

Family and social pressure

Family members may also cause stress and feeling of nervousness on return migrants. This is related on one hand to the pressure and expectations from family members. The felt stress is mostly high in cases where the return migrant goes abroad for economic reasons and financially supports the family back in the country of origin. Upon return, a migrant with chronic medical problems is all of a sudden dependent on his or her family members. This situation is mostly applicable to the returnees from Morocco and Ghana. In all cases, the returnees did not feel comfortable telling their family members about their health problems. Usually one or two close family members were aware, but others were not included. In part, the inability to tell is linked to the taboo that is related to the chronic health problem, for example, in case of HIV/AIDS. In addition, the social stigma of failure attached to returnees in general can play a role: those who returned did so because they could not make it in Europe. The felt failure is mixed with feelings of being a shame and a burden to the family. This was, in part, described by returnees from Morocco.

Stigma and taboos

Some medical conditions, such as HIV/AIDS, hepatitis, epilepsy and mental disorders, are associated with stigma. Communication with family members, relatives or the social community has proved difficult or simply impossible. Although all returnees in this situation were able to confide in at least one person about their health conditions, the secrecy of and not knowing how to handle this issue are sources of stress for the migrants, especially if their reason for returning was health-related and this reason cannot be shared with or explained to family members. Reintegration is hampered when the

existing network cannot be used out of fear of stigmatization, and when the limitations to provide for themselves cannot be explained out of the same fear and may compound the risk to become socially isolated.

> Only my mother and wife know about it. My wife got tested, she's also positive with AIDS. No one else knows about my issues [*meaning, the AIDS infection*], not even my brother knows. I don't want them to know, because I am embarrassed by it, it is not a "good disease". (Return migrant, Azerbaijan)

No future

The return migrants' outlook of the future is grim. They do not see that their situation will change any time soon. The economic and political situations and the state of health care pose daily challenges that are not likely to change soon. Most returnees live in impoverished conditions, not seeing any hope that there is a way out for them or their children from this situation. Some return migrants even fear the situation might get worse. The negative attitude towards the future is usually combined with economic dependency on others and the feeling of being a burden.

The IOM procedure

Return migrants are, in most cases, offered two options of medical assistance (based on rules set by the project donor): payment of medicines by IOM to medical clinics or reimbursement upon submission of invoices. In case reimbursement is preferred by returnees, IOM requires proper documentation, which return migrants find tedious and stressful sometimes. For some of them, money is not available to pay the medical invoices out of their own pockets. They reported having to borrow money from others to ensure medical treatment or medication, which brings about negative feelings for them.

In some cases, return migrants questioned the IOM financial reimbursement of medical expenses only being made available to returnees. Return migrants' description of daily life's struggles indicates that oftentimes other family members sharing the household with them also experience (chronic) medical problems. Receiving money to only elevate their own needs while others within the household need it too or even more is difficult, according to the respondents.

3.2 Family dependency

Dependency of return migrants on their direct family members is high.[18] In just a few cases, dependency is on relatives.[19] In this research, all but one of the return migrants depend on their family members to support their daily living expenses, such as housing, food and medication. In contrast, of the 28 return migrants only 17 feel being mentally supported by their family members. Those that do not feel the support of their families bear the feeling of not being understood, the stigma of the chronic illness and the feeling of being a burden. Family members, on the other hand, state that the support they give the return migrants is mostly because of the love for the other; sometimes they talk about feeling obligated, but always with a component of love in it.

Family members stated in general that they were glad that their family-member migrants were returning back to the country of origin, but at the same time feeling worried on how to support them in an already economically strained situation. In part, their worries were also focused on the possible inability of the returnee to cope with this new situation. Relatives and the social community did not seem to play a role in the returnees' life. The connection was not there because of feelings of being alienated, the taboo of the experienced chronic health problem, the experienced psychological problems and the perception that migrants are failures.

In conclusion, we could say that the immediate and sole support system is therefore the direct family members of the returnees. The only exception is Ghana, where traditionally the system of support by

18 Direct family members include father, mother and children.

19 Family by blood other than direct family members includes cousins, aunts, uncles and others.

relatives is different. The blood relatives on the maternal side are seen as the connection between relatives and are supposed to support each other. The limitations towards the interconnection with the social community were mostly related to the angst for the consequences of the taboo that surrounds the health problem.

3.3 Reintegration through work

The quick scan showed that, next to social reintegration, sustainable reintegration is measured in the ability of returnees to find a job and work. To be able to provide for themselves or their family members, return migrants – especially in countries where a social security policy is not in place and one depends on an income to survive – need to work. Of the 28 interviewed return migrants, only three are working and able to provide for their families. Chronically ill return migrants who are not working said their chronic health problem is the reason for the unemployment. Some indicated that they are unable to work altogether, while others said that they have not been able to find a job that will accommodate their needs as chronically ill persons.[20]

Another reason for not being able to work is the age of the return migrant. Some of the return migrants have reached the age of retirement. In this case, returnees receive a small retirement benefit, but this is not enough to provide for themselves. Traditionally, in some countries, such as Mongolia, it is expected that the children will take over the responsibility for the elderly. This is also true for return migrants that have reached the retirement age. In cases where the returnees have been out of the country for a long period of time, they are not eligible for the retirement benefit, since their years of working in the country of origin are not enough. In these cases, the return migrants are not granted any State support and depend entirely on their families' financial support.

> As for migrants in general, the main problem is related to their employment. Although I have to say that it is difficult to find a job for any citizen of Armenia, it is not related to their migration status and they are not discriminated because of their migration history. The next problem is related to housing, because many people sell their houses before departure, and don't have a place to live in when they are back. Some problems arise with education of children; if they missed several years of school here, they have to take some exams for being admitted back. Some children have difficulties with the Armenian language. If people stayed in the host countries for a long time, at the beginning they may also have difficulties with adjusting to the situation in Armenia and need psychological support. But I think it is temporary, because when they find jobs or participate in training when they find their place, they overcome the problems with integration. (Head of French Armenian Development Foundation)

20 It is not unthinkable that in time more of the interviewed return migrants will find a job, since some arrived in the country of origin only a couple of months ago prior to the interview.

Chapter 4 Afghanistan

Due to difficult research circumstances in Afghanistan, the data collected could not be included in the general results. This chapter is intended to provide a view on the challenges faced by returnees with chronic medical conditions in Afghanistan, as based on the available questionnaire results and literature and on an interview with the local researcher. It therefore, by no means, claims to be generalizable or all-encompassing. This chapter touches upon the challenging situation in Afghanistan.

In comparison with all other partaking countries, Afghanistan is the only one with an instable political situation. This is a severe challenge when it comes to sustainable return. Strand et al. (2008) stated that a stable political situation is necessary for sustainable return, mainly because only in such a stable climate new businesses can thrive. This is not the case in Afghanistan. Furthermore, less than 1 per cent of the Afghan returnees suffer from chronic diseases; the majority (9% to 10%) are dealing with psychological issues (as reported by an IOM staff in Kabul).

These two general circumstances set the outline for the difficulties that Afghan returnees face upon return: the availability, accessibility and affordability of health care; the lack of a stable network; and income instability.

4.1 Health-care challenges

The health-care system in Afghanistan has improved in the last decade. However, availability, accessibility and affordability of health care are not guaranteed. In terms of availability, services and medication are not always present, in both public and private health-care facilities. For some diseases, like cardiovascular problems, Afghans who can afford medication resort to treatment outside Afghanistan – in India, the Islamic Republic of Iran, or Pakistan – due to the lack of diagnostic tools and quality drugs in the home country.

The private health-care sector is more advanced than the public health-care system. According to a physician in Kabul who agreed to be interviewed, “the returnees’ income is far too low to permit their referral to private-sector service providers, so we can only refer them to the public hospitals. There, however, because of the low salaries and the lack of equipment, the services are unacceptable. In the private sector, services are good, but they cost too much for the patient.”

> Of course, there is a need for medicine, but I don’t have money to buy them.[. . .] I am borrowing money just to meet my subsistence needs. (Return migrant, male, 54, Afghanistan)

Availability of medication is not always guaranteed. Although generic drugs might be available, their quality is often poor due to fake labels smuggled from abroad.

A recent study by Benelli et al. (2012) indicates that access to health care in Afghanistan is a source of concern: a comprehensive health-care infrastructure has yet to be achieved, and many communities are still living without access to primary health care. According to the World Health Organization and the Afghanistan Ministry of Health, approximately 15 per cent of the population has no access to the most basic health services, while nearly 85 per cent of the population has access (within a two-hour walk) to basic health care. However, a vast majority of these health posts are without medical personnel (Benelli et al., 2012).

4.2 Lack of a stable network

In a country with a protracted war history like Afghanistan, the much needed family and relatives are not always available: they may not be alive anymore, have fled the country or the return migrant may have lost contact with them. If the family is available, returnees may not be accepted. The returnees went away to sustain an income abroad, returning without anything to offer and with a medical condition to care for can be problematic. To a certain extent, there is the idea that they must have done something wrong; otherwise, they would not have been deported. Since a network is very important for survival, the absence of a family network poses serious challenges to migrants' reintegration in Afghanistan.

4.3 Challenges regarding work and income

Returnees who get reunited with their families will face fewer challenges, especially if their family background and financial status can support them. Afghans without this support system need an income in order to meet their daily needs. Afghan returnees in the study of Strand et al. (2008) reported that the lack of security and economic opportunities were the main difficulties. The reintegration grant provided for a business start-up was mostly chosen over training or job referrals. The businesses were usually short-lived; in most cases, they were created for the purpose of receiving the reintegration money. Most of the return migrants in the research of Strand et al. (2008) stated that they were financially dependent on friends and relatives and on their little savings. Most Afghans shared their intention to remigrate due to the lack of economic resources. The ones planning to stay had the assurance of an income through their family network, or from a well-doing small business.

In addition, returnees who have spent a relatively long time in the host country have lost work experience in their previous profession or have found a new profession that cannot be practised in Afghanistan.

4.4 Recommendations

These recommendations stem from both literature and the interviews. Although Afghanistan was not included in the general analysis, the general recommendations in Chapter 12 would also apply to Afghanistan. These are general findings recommended for consideration by all countries dealing with returnees who have chronic medical conditions. The significant additional challenge for Afghanistan is the lack of security, the lack of functional health infrastructure (especially for mental illnesses) and a stable economy. The question that needs to be answered therefore is if sustainable return of migrants with chronic health concerns to a country with the lack of political stability is at all possible.

- The Office of the United Nations High Commissioner for Refugees (UNHCR) should provide tailored assistance to return migrants, especially for repatriates who are likely to be exposed to new types of vulnerability upon return. (Omata, 2012, and local researcher)
- Returnees with diseases like cancer should be well informed about the lack of health-care facilities in Afghanistan and, in some cases, the return should not be facilitated. (IOM staff)
- Financial support for returnees should be extended for at least one year and should be provided indirectly through projects run by third parties, like NGOs. (Local researcher)
- For returning families, the head of the family should return first and only when an income has been secured should the dependents return. (Local researcher)
- All relevant medical documentation should be provided in English. (Physician in Kabul)
- Returnees with medical conditions like diabetes, cancer, HIV and others for which treatment is not available in Afghanistan should not be returned. (Physician in Kabul, local researcher)
- NGOs or local organizations should have the resources to provide services to this vulnerable group, paving the way for suitable jobs, health services and other social connections. These projects should be connected to IOM Afghanistan for professional serving and technical support. (Local researcher)

In total, 18 interviews were carried out in Armenia, of which five were sessions with returnees, five with family members, four with health-care workers, three with local reintegration organizations and one with the local researcher.

Table 2: General information about the interviewed Armenian returnees

Return migrant	Age	Sex	Host country	Length of stay in the host country (years)	Length of stay in the country of origin (months)
1	73	F	Netherlands	14	3
2	65	F	Belgium	1	10
3	53	M	Belgium	1.3	1
4	60	M	Belgium	4	4
5	50	M	Netherlands	1	3
Average	60			4	4

The common chronic medical conditions of the interviewed returnees were cancer, cardiovascular diseases, diabetes, stroke, spine hernia and psychological problems.

5.1 Availability, accessibility and affordability of health care

Availability of health care and medication

The medical care needed by the returnees was available for all but one case. This was a person suffering from cancer.

> I cannot get the treatment that I need in Armenia. I had three surgeries in Syria and my doctor is in Syria. The last time I had the surgery and got the medication [*radioactive iodine*] in 2011, the war had already started. The doctor told me that I could not go there anymore. Thus, because the medication was not available in Armenia, I decided to seek treatment in Europe. I thought I could go to a European country and get my treatment there. But I could not stay in Holland or in Germany, because that required a citizenship and medical insurance. I could not get those. So I decided to come back to Armenia and to contact my previous health provider in Syria. (Return migrant, male, 50, Armenia)

Armenia has both public and private health care sectors. According to the head of a State-owned psychiatric clinic, the medication that they have available is purchased by the Ministry of Health. The centralized purchases are based on lists of essential medication and are for all public clinics. In his opinion, the most problematic aspects are related to the availability and affordability of medication:

> There are some medicines that are not provided by the State system, but would be required for the optimal treatment of a patient. In such cases, the relatives of the patients would buy the medication from pharmacies and pay out of their own pockets. (Head of a State psychiatric clinic)

According to the Head of the State psychiatric clinic, this is a "frequent occurrence". Based on the data collected in this research, it was not possible to determine if the medication was really not available or if the migrants were unable to access medication from a particular pharmaceutical manufacturer through the public system and had to turn to the pharmacies. The opinion of the migrants is that the quality of medication is not guaranteed if they have to resort to generics, and that therefore the needed medication is not available.

> I have to take 10 different types of medicine, but I have only two of them at the moment. They don't have it in the pharmacy. My son went to almost all pharmacies and could not find the ones that I need. Finally, he found one pharmacy where they promised to try to find it. Besides, the medication that I can buy here is different from the medication I used to take there. The quality of medication that I was taking there was high; here I can find only alternatives or generics. (Return migrant, female, 73, Armenia)

Consequently, the migrants feel cheated. Before leaving the host country, they reported that they received information that health care would be free in Armenia and that their medication would be available. While in reality they have to spend money out of their own pockets to get the medication they need.

Availability of treatment was part of the decision to migrate to begin with. Three of the five returnees interviewed left their country of origin to find better health care for already existing medical conditions. None of the migrants disputes over the availability of services. It is mainly the availability of a particular medication they are questioning. They connect availability to affordability of health care, as the next section shows.

Affordability

According to the returnees, affordability of treatment is the biggest hardship for chronically ill individuals returning to Armenia. While the returnees were advised in the host country that their treatment would be free of charge back home in Armenia, they find it not to be true. There are several factors related to this, such as these:

- Medication and services provided by public primary care facilities are subsidized and can be accessed free of charge. However, patients make informal payments in exchange or hoping for better service quality. Informal payments are made to nurses or doctors as a guarantee for better services.
- The medication available through the public system often includes generic drugs. These are more often than not different from the drugs prescribed to the migrant in the host country. The distrust in the quality of generic drugs is high and, as a result, people buy the branded medication out of their own pockets from (private) pharmacies.
- Medication that is not part of the centralized list purchased by the Ministry of Health is therefore not available free of charge. It can be found in pharmacies usually, but it has to be paid for.

> I was concerned about my mom's condition. The problem is that the treatment she took in Holland cannot be found here. I was able to find alternatives here. We checked in pharmacies and compared the information in the description of branded drugs and their corresponding generics. They are not the same. What effect and consequences they will have, I don't know. She has to take a lot of medicines, so when we were in Holland we sought to simplify the medication, so she would take 5 instead of 10 different pills. But the doctor would not allow it, because it was the most effective treatment for her. Now, in Armenia, we cannot find the exact same medication and I don't know how effective these generics can be for my mom. These generics are from Russia or Bulgaria, so they may not be so effective.[. . .] Recently, she's been feeling poorly, I cannot say whether it is because of the treatment, or because of the move back home. (Son of a returnee)

Due to these three factors, returning migrants have to spend money out of their own pockets for their health care. When living in dire economic conditions, such expenditures can weigh heavily on their small budgets. The returnees depend on their families for financial support. In some cases, they qualify for a pension or support from the State, such as the modicum benefits provided for the elderly or for people with disabilities, depending on the severity of the chronic health issues. However, the administrative process to access these benefits is long and heavily bureaucratic. The individual concerned has to apply in person, so the family cannot apply for it before the migrant arrives in Armenia. Moreover, such aid will not cover all the medical costs of the beneficiaries.

Returnees without an individual income have to rely, to a large extent, on financial support from their families. More often than not, the economic circumstances of the family are poor. Mentally, this weighs heavily on the returnees, as one woman stated:

> What can you do here? We are not living here, we are just surviving. I see my daughter's hard life in front of my eyes. I am a mother, I cannot take this lightly. I want to be of help, but how can I help her when I am in need of help myself? (Returnee, female, 65, Armenia)

The affordability of health care can also be hampered by the IOM procedure.[21] As one returnee stated:

> I have to have some money first, to pay the hospital and get an invoice. They reimburse the cost based on the invoice. But if you don't have money to pay for the services beforehand, you cannot use the service. (Return migrant, male, 60, Armenia)

The coordinator of the project "Returns to Sources" of the French Armenian Development Foundation confirms that affordability of health care and of medication can be a hurdle for returnees.

> One of the problems is that people returning from France who undertook medical treatment over there usually bring some amount of medicines with them. If they need more of it, then they have a problem, because the medicines are either not available or are difficult to find, or are very expansive. If the treatment is interrupted and they need to get treatment here, they need financial assistance to be able to get the required medical examinations and treatment. The primary health care is State-funded for all Armenian citizens, but, as you know, there are services that people cannot get in polyclinics, especially in the rural areas. The appropriate specialists may not be available there. So the people are referred to health-care facilities in Yerevan. Consequently, they have to pay for the travel and end up using the private services here. (Head of the French Armenian Development Foundation)

Accessibility

The return migrants do not seem to have any problem when it comes to the accessibility of the health care. They reported a travel time of between 30 minutes up to a maximum of one hour – via public transport, walking or hailing a cab – to avail of the medication or services. Accessibility of health care is limited when one has to rely on the public transport or a cab, and the cost may be too high. Only one of the returnees referred to these costs being too high.

> Because I have difficulties with walking, I cannot use the public transportation. I need to use cabs. I have to go to my polyclinic now, but cannot go, because I cannot even pay for the transportation. (Return migrant, male, 73, Armenia)

5.2 Social network

The nuclear family (father, mother, brother, sister) is the most important network for returnees. Apart from helping out financially and with the bureaucratic procedures, the family is also the main source of emotional support. All of the interviewed returnees depend on their families to provide for their daily needs. As one of the family members pointed out, the family is one's social security:

> In Europe, being on your own is not an issue. They don't need their family's support as we do. Here in Armenia, people in their thirties think about having a child as insurance for when they are old, somebody would take care of them. (Sister of a returnee, Armenia)

Literature about Armenia also indicates that returnees are highly dependent on the social networks. Brunarska et al. (2013) concludes that the main reason behind the lack of statistics on voluntary returns in Armenia is the individual character of this movement: return migrants do not usually count on State support. They rely instead on their own personal networks.

21 See the IOM procedure in Section 3.1.2.

Upon return, migrants fall back on family members who are already economically struggling themselves.

> There are four people in our family [*the returnee, his wife and his parents*] and none of us is able to work. Who can take care of us? Besides, our relatives do not have any obligation to stand next to us every day, they have their own problems. It is only my son who would be able to help us, but he has his own family and children to care for, he cannot take care of all of us. We are not the only family in this situation. (Return migrant, male, 60, Armenia)

In addition, or maybe as a result of the poor economic circumstances, two in five Armenians who have spent one to four years abroad are experiencing a change in the social relationships after their return.

> Everyone is in the same situation. How can they help me? Besides, it is getting more and more difficult to live here now. Even the relatives are not the same. Now you can only count on closest relatives. (Return migrant, male, 50, Armenia).

> In the beginning, they were more compassionate, or they were very interested to hear what and how everything happened. I feel our relationship is colder now. They forget about you, with each day that passes. I don't know, maybe people have changed, generally speaking. I've been away for four years and now I see that everybody is concerned with his or her problems, everyone is sad. It's been already three months since my return and I have not met a single person who would not experience serious problems. I was almost ready to help them myself.[22] (Return migrant, male, 60, Armenia)

The family of the returnees – usually brothers or sisters, or children of migrant parent or parents – provide financial support, help with daily life chores and provide emotional support. Although the returnees are not able to financially contribute, their family members do acknowledge something in return:

> It is not an obligation. It is based on compassion; providing care is mutual. (Sister of a returnee, Armenia)

> Of course, her salary is not enough for all of this. But she gives endless love, care and understanding. (Sister of a returnee, Armenia)

The family was the main reason for returning for two of the return migrants interviewed.

> I was received very well. But they asked me, "Why are you back? Everyone is leaving the country, why have you come back?" *(Laughs)* I only came back because of my family. (Return migrant, male, 50, Armenia)

> I was received very well. Their attitude is very positive. But all my relatives who learned that I had a status there and came back, they all asked me, "Why did you return to this cruel and poor country?" I always reply, "Isn't it clear to you, why? It is impossible to live there all alone." (Return migrant, female, 73, Armenia)

5.3 Psychological problems

All but one returnee from Armenia went to Europe in the hope of getting medical treatment for an already existing medical condition. They returned either because they were refused a permit to stay or because they missed their families in Armenia too much. Returning to Armenia made all migrants feel better and less lonely compared with staying abroad. At the same time, they reported that these feelings were not improved compared with the situation before leaving Armenia.

22 *Researcher's note:* He was joking here and laughed. It was the only time when he smiled during the interview.

Their worries about how to survive and live in Armenia without access to the medication they needed was strongly present. As migrants are being financially supported by their families, their dependence brings about the feeling of being a burden. Migrants described not only their own plight, but also the struggle of their families who are living in a harsh society and an economically deprived environment. Their living expenses and additional medical expenses are having an effect on the entire family. The feeling of being a burden rests on them heavily: "It turns out that I make my daughter, who is taking care of me, suffer along with me. I don't want that." (Return migrant, female, 65, Armenia)

For two of the five returnees interviewed in Armenia, their vision of life and their future is so grim that they do not want to live anymore. As one man describes it:

> I don't have any expectations. I don't have any inheritance to sell and live from. Only a miracle can redress our situation. . . I don't believe in miracles, not even children believe in miracles. I'm just biding my time; I just cannot find the way to put an end to my life. I don't want to harm others. If I do something to myself, it will harm my son and my wife.[. . .] These thoughts are the only thing that keeps me from doing something to myself. Otherwise, I am ready to leave this world today even.[. . .] The other day I even asked a worker working with arsenic in our building to give me some. He figured out what I meant and did not say anything. I don't see any sense of living here. (Returnee, male, 60, Armenia)

> Sometimes I feel really bad, I want to cry and even want to stop my life. I don't want to live. I don't want to live. (Return migrant, female, 65, Armenia)

These people's emotional state and social-psychological problems were due to numerous factors. First of all is that they had high hopes when leaving Armenia to find a cure for their medical problems, so they could (again) provide for their families. This did not happen. They fell back to the same hopeless situation.

> Eighty per cent of the people do not come back because they don't have a place to stay here anymore, because they had sold their houses before they left. Some 15 per cent of them are ashamed to come back because they find it difficult to explain their return to relatives and friends here. Only 5 per cent of the migrants decide to come back, like I did. I advised many of my friends who do want to return but are ashamed to, I told them, come back and just say that you did not like the country, that's all. I know a family there, they moved to Belgium almost 10 years ago. They're close to getting the citizenship but what they want is to come back. There is no place better than Armenia, but here they don't have the conditions to sustain a life for themselves. (Return migrant, male, 53, Armenia)

Secondly, the return migrants found themselves "enriched" from their experience abroad. In the host countries, they received quality medical treatment for free. Back in their country, they cannot but compare the health care and opportunities enjoyed in the host country with the health care and opportunities in Armenia. The outcome of the comparison is grim.

> We were together in Belgium and came back together. Everything has changed. We were joyful over there; here, we are sad. Life was very interesting there; life here is more nervous and stressful, everything is getting more expensive. In Belgium, they provided one with everything one needed: food, clothes, medication, etc. We have not been able to buy any new clothes here since we came back. (Sister of a returnee, Armenia)

> Especially, returnees from European countries are used to good conditions in a health facility. They are surprised to see the conditions here. Our permanent residents are more aware of the conditions and they know there are no other options; the conditions are the same in all psychiatric care facilities. So it is harder for the returnees to get adapted to the conditions. In this regard, it is more difficult to work with returnees. (Head of psychiatric clinic, Armenia)

Thirdly, all return migrants and their families have indicated that back in Armenia, one depends on one's family in order to survive, if not able to provide for oneself. Not being able to provide for themselves or their families feels like a burden to the migrants. Taking care of an extra person with a medical condition in an environment already rife with economic constraints can be most challenging.

Lastly, in some cases, it is not just the return migrant with a chronic medical problem that is struggling with health issues; other family members also face the same problem, and the likelihood of being able to provide for themselves thus diminishes.

> Now I have cancer too and she [*the returnee*] has put aside all her problems and got a job to be able to take care of me and her daughter. *(Starts crying)* I find it very hard, it is killing me. I don't complain. I just want to say that if people leave the country, they do it because they have to do it. (Sister of a returnee, Armenia)

> I see my father suffering from pain all day long, my mother has health issues, too, my wife is sick and has to take 13 different drugs daily because she has diabetes, high blood pressure and goitre. I am the head of the family and, as such, I have to take care of them, but I cannot do anything because of my disability. How are we going to pay for the rent of our apartment? (Return migrant, male, 60, Armenia)

The combination of these factors has a big impact on the morale and well-being of returnees.

5.4 Work and reintegration

For health-related reasons, none of the Armenian returnees were employed at the time they were interviewed. Three of the returnees were, however, at a retirement age and thus entitled to a pension from the Armenian State. But the retirement benefits do not provide sufficiently for them to get by.

> As I mentioned, I am not able to contribute financially to our household, only my wife is employed. I try to help with the household chores, but I am not that helpful, I cannot do any physical work because of my health condition. I don't work and cannot provide my family's living costs. I used to work as an auto electrician. I cannot do the same work now, because of my condition, I cannot do work that requires strong physical effort. I have tried and realized that I couldn't. I have memory difficulties, too. It's hard. Otherwise, I would work on construction or somewhere else. (Return migrant, male, 50, Armenia)

> I receive a pension. I cannot work; I cannot even walk because of my illness. (Return migrant, female, 65, Armenia)

> There are no jobs here in Armenia. Considering my age, I can only work as a taxi driver here. My health condition does not allow me to do work requiring strong physical efforts. And I don't have an uncle to give me the position of a deputy minister.[23] (Return migrant, male, 53, Armenia)

23 *Local researcher's note:* He means that employment is mainly possible based on connections and when one has the protection or backup of an influential person.

5.5 Recommendations from returnees and family members

The returnees and the members of their families were asked whether they had any advice to offer an organization such as IOM for the facilitation of the return of people with a medical condition like what they have.[24]

> It would be nice if there were organizations that could help people with medicines or working on improving the living conditions. . . whatever people need. (Return migrant, male, 50, Armenia)

> Many people go abroad to fix their health problems, so if they need help and the government of the host country covers the cost of the treatment, I would advise them to stay there and at least solve their health problems. So they would be able to recover their health and get the treatment that they really need. As for the return, I am always in favour of it. I love my country. But I think that in Armenia we have a problem with providing services that people need, especially health services, and that we should find a way to solve this problem. If our country cannot provide the services that people need, it should create the conditions allowing them to go to other countries and get what they need. (Sister of a returnee, Armenia)

> My sister and niece told me that when they went to Belgium, there was a programme called "inburgering". You get a detailed introduction to the country: the culture, how the health-care system works, even how to use the public transportation, so everything you need to know for your everyday life. They also help with job search. They highly appreciated these services. My sister and niece stayed abroad for seven years; it was hard for them to reintegrate into the [*Armenian*] society, especially for my niece. It would be nice if she could receive some psychological support. Besides, she cannot even write in Armenian. So it would be good if they had similar programmes here. (Sister of a returnee, Armenia)

5.6 Conclusions

The reintegration of Armenian returnees is undermined by their inability to be self-sustainable and economically independent. This includes their inability to provide for their daily and medical needs. The return migrants' medical conditions will most likely prevent a change in this position of economic dependency in the near future. Although well provided for by their family members, the challenging economic environment makes the support of their family members unpredictable in the long run.

Upon arrival, returnees are met with a warm welcome from their close family members. The acceptance of relatives and the general community, on the other hand, differs from migrant to migrant. The return migrants' mental state of mind seems to pose the biggest constraint for a sustainable reintegration. Participation in society is dependent on the ability to partake in daily activities and on having a positive outlook of the future; the latter is lacking for most of the Armenian return migrants.

24 Not all recommendations made by the respondents were included in this report. Those focused exclusively on getting IOM to address the interviewee's current situation were put aside; only those recommendations that would be generally applicable are presented in this section.

Azerbaijan

A total of 11 interviews were conducted in Azerbaijan.[25] Five interviews were with return migrants, four with family members, one with a local IOM staff and one with the local researcher.[26]

Table 3: General information about the interviewed Azerbaijani returnees

Return migrant	Age	Gender	Host country	Length of stay in the host country (months)	Length of stay in the country of origin (months)
1	41	M	Netherlands	21	3
2	44	M	Belgium	4	10
3	45	M	France	9	2
4	75	F	Luxembourg	29	4
5	51	M	France	48	2
Average	51			22	4

The chronic medical conditions of the interviewed returnees were high blood pressure, paralysis, asthma, thrombosis, epilepsy, AIDS, hepatitis C, hepatitis A, hallucination, nervousness, liver conditions and teeth problems. All the return migrants except for one suffered from multiple chronic illnesses.

6.1 Availability, accessibility and affordability of health care

Availability and accessibility

All interviewed returnees reported that health care and medication were available and accessible, and health-care facilities and pharmacies are easily accessible with public transportation.

> My medicines are not difficult to find. There are pharmacies everywhere, so there is no problem to get them. (Return migrant, male, 41, Azerbaijan)

> I think my wife's medicine will be available. My medicine is available everywhere. (Return migrant, male, 44, Azerbaijan)

Affordability

Azerbaijan has a post-Soviet health-care system in which public health-care facilities coexist with private operators. Like in Armenia, staff in government institutions will expect or downright ask for gratuities from patients as a means to compensate for their low wages. Such informal payments cannot be documented by invoices. Another aspect is that health services and medication are not correlated: this means that although services like physical examinations or check-ups are free of charge (unless one counts the gratuities), the medication that would be prescribed as a result of the examinations will not be free of charge and will have to be bought at a private pharmacy. The exceptions are a number of specific medical conditions, including diabetes, TB and HIV/AIDS, which are listed in a special national health-care programme. However, while the national programme stipulates free care and medication for the citizens registered in the programme, the free-of-charge medication is not always available.[27] In such cases, patients have to get these medicines from private medical facilities and pay for them.

25 See Chapter 2 for methodology.

26 The local researcher indicated that he thought people spoke truthfully, although some may have made exaggerated statements about their income. The returnees and family members were sometimes aggressive in the way they spoke, most probably because they would hope to receive additional assistance by participating in the research.

27 This information was provided by the local researcher.

The returnees report that affordability of health care is problematic.

> My only need now is to get a proper diagnosis. I am concerned that I will later have serious issues with my health. Some tests can cost up to EUR 150–200, and I cannot afford that. I can only afford small expenses; for example, yesterday my daughter needed some medicine for her throat and I had to borrow EUR 32 to get the medicines. I can do it for my kids, but not for myself. (Return migrant, male, 44, Azerbaijan)

> I have visited the doctor. He said, "Your viruses have increased". On top of that, my other health problems got worse, as I can feel it. It is impossible to get treatment. Even if I manage to get a prescription, I cannot afford to buy it. (Return migrant, male, 45, Azerbaijan)

> You know, one has to attend to the basic needs, like clothes. I can choose not to eat meat, but just some soup, and then give that money to him so he can buy something for himself. (Mother of a return migrant, Azerbaijan)

Affordability is influenced by a couple of factors. First, the economic situation in Azerbaijan is poor in general. All returnees interviewed depend on and live with their families or close relatives in impoverished conditions. In some cases, this means that one family member who is employed or has a small pension has to sustain three adults and a number of children.

> I wish I could have provided for more. It is just I cannot do so, as I don't have enough of an income either. (Mother of a return migrant, Azerbaijan)

> There are no State programmes for each disease. The migrants are usually facing a lot of financial constraints. The reintegration money allocated to them can only cover for their needs temporarily after the return. Later on, they are on their own in covering for the medical treatment. This is not sustainable. (IOM employee, Azerbaijan)

Secondly, in most cases, there are other family members in the same household who suffer from chronic medical conditions. Covering the expenses for the medical care of the returnee in the family might mean that another family member's needs would not be met. This can be a source of stress. In some cases, the stress is induced by meeting the strict conditions of the IOM assistance programme which, most of the time, allow the grant to be used only by the returnee.

6.2 Social network

The family and relatives are important for the financial and emotional well-being of the returnees. There is no social security policy in place in Azerbaijan, except for a State programme entitling vulnerable families to financial support. The local researcher describes the system as a corrupt system in which people who are in most need of assistance often do not get it. The family is, therefore, the return migrants' safety net. All returnees were financially supported by their families.

> Before I left, I sold my house in the village. When I returned I was totally broke. Now, we have asked my relative if she would let us live temporarily in her house. (Return migrant, male, 44, Azerbaijan)

> I have supported him [*financially*]. We've been discussing about him getting a part of my shop. (Brother of a returnee, Azerbaijan)

In addition to financial support, return migrants receive emotional support, of which they are very appreciative:

> The support I get from my mom and brother is very soothing to me. (Return migrant, male, 41, Azerbaijan)

My wife always supports me, always calms me down. Moral support is very helpful. (Returnee, male, 45, Azerbaijan)

You know, it is hard to get financial support these days as everybody is in a poor shape, but they [*family*] give me emotional support, moral support. They also take care of me, they say, "don't get nervous, your blood pressure will go up if you do," and things like that. (Return migrant, male, 51, Azerbaijan)

There are two ways about this [*the support*]: one when you feel an obligation to do it, and another when you do it because of love. We do it because of love. (Daughter of a returnee, Azerbaijan)[28]

In general, only close family supports return migrants financially and emotionally. Relatives and the community are not part of the returnees' narratives. The general opinion in Azerbaijan is that those leaving for Europe return rich. These expectations and prejudice in the community generates stress.

My daughters were happy that I was reunited and together with them. My other relatives just assumed that I returned with a lot of money and they even have expectations that I would help them financially. (Return migrant, male, 51, Azerbaijan)

I got some support after I returned. I got a loan from the bank and tried to establish a small business. My brother helped me start the business. I know there are some people around me thinking like, "he went to Belgium, spent all his money there and now he's in trouble". I know that there are such people and I am living with these thoughts. (Return migrant, male, 44, Azerbaijan)

In addition, the experienced health-care problems can raise a barrier between the return migrants and the community. Four in five returnees have not shared their health problems with anyone, except close family members, in part caused by the taboo surrounding the health problems.[29]

6.3 Psychological problems

Not being able to be in touch with the community, the expectations of relatives and of the community, having to readjust to the home cultural environment and financial deprivations all have an impact on the returnees' psychological state. Four in five return migrants reported feeling mentally worse after their return. Their own assessment is that their worse-off state is caused by increased stress.

Because of the hardships of the daily life, simple things are driving me crazy. (Return migrant, male, 45, Azerbaijan)

The mother of the returnee intervenes: Sometimes he would act like mad and I tell him – this is not just bad nerves, this is madness.

You know, when I was in the Netherlands there were things to be stressed about over there, too, but somehow you knew there would be a solution. I don't see any solutions here. My behaviour has almost destroyed my family. Even with assistance from the elders,[30] I could hardly keep my family together. This has affecting me deeply.[. . .] I think my current stressful life here in Azerbaijan makes my nervousness even more intense. (Return migrant, male, 41, Azerbaijan)

Now that we are back, we feel under a lot of pressure because we've lost all our property and thus find ourselves in a difficult financial situation. Our everyday life is taking a toll on us and stressing us out. (Return migrant, male, 44, Azerbaijan)

28 The returnee father allowed his daughter to be interviewed in his presence only, so the daughter's answers to the researcher may have been influenced by the father's presence.

29 This research did not propose to investigate the reasons for the respondents' unwillingness to share their health problems.

30 The local researcher explains that in Azerbaijani tradition the family elders get involved to help bring together a couple when marital problems occur. The elders from both sides get together, discuss the situation and come up with a solution. The solution is then discussed with the couple, who are expected to accept it.

> My psychological issues got worse due to the stress of everyday life. This is affecting my blood pressure as well.[. . .] I think because of the stressful environment. My everyday life is affecting me negatively. I see the aggressiveness in the society that I am living in and feel bad about it.[. . .] It is a pressing environment. All that gossip and the violence in the neighbourhood are creating a hostile environment to live in. (Return migrant, male, 51, Azerbaijan)

From the conversations with the migrants after the completion of the interviews, the local researcher learned that the bureaucratic processes in the Azerbaijani society and the IOM requirements together were an additional stress factor. Only one of the returnees touched on this aspect during the interview.

> I have not been able to start the full treatment yet. Daily issues and problems are keeping me so busy that I cannot spend time and money on my health. I'm still struggling with paperwork. You know, IOM gave me limited time to decide what I want to do with the reintegration money allocated for me. Just one month.[31] In order to get the money, I had to collect so many papers. And in the country like this where you have to bribe people to get the necessary documents. It can take ages to prepare the documentation. So getting those documents ready has made me so busy and stressed that I forgot about my health condition. (Return migrant, male, 41, Azerbaijan)

Lastly, the contrast between the host country and the country of origin plays a role in the mental health of the returnees. Readjusting to the new reality is laden with challenges.

> You know, after I saw how different life is in Belgium, it is hard for me to live here. I cannot drive my car here now. I saw how calm drivers can be over there. Now I am afraid I will get in an accident if I drive a car here. (Return migrant, male, 44, Azerbaijan)

> I wish I didn't go and see life in France. I think it would be better for me if I didn't go anywhere. (Return migrant, male, 51, Azerbaijan)

6.4 Work and reintegration

Only one in five return migrants interviewed was employed. The lack of employment was explained by the health problems and by not being able to find suitable jobs that would accommodate their physical constraints. Some of the migrants might not have been long enough back in Azerbaijan; they were still working on settling in before finding a job.

> Because of my asthma, there aren't many places where I could work. Also, before I used to work night shifts as a security guard, but now I cannot do that because of my wife, she is really scared to be left alone at nights.[. . .] My health does not allow me to take many jobs. Not only that, it is hard to find work in general. You know, I would like to have my little business, but I am not that type of person, and now they have made everything so difficult that I would not even dare think about owning a business. (Returnee, male, 41, Azerbaijan)

As reported by the interviewed returnees, corruption and bureaucracy restrict the returnees' search for employment. In the above narrative, the returnee refers to the circumstances in Azerbaijan for starting up one's own business. Corruption and the complex and bureaucratic processes make it difficult for returnees to venture into entrepreneurship. According to Brunarska et al. (2013), the key aspect of the reintegration problems in Eastern Partnership Countries[32] like Azerbaijan is the difficulty to find a job or to start a business. According to the researcher, the support in this field should be treated as the most effective means to encourage voluntary returns and to facilitate reintegration. As long as the countries of origin are affected by high unemployment, low wages, tough conditions for starting up and running a business, and the lack of a free market, reintegration of return migrants will be hampered. Therefore, the first step should involve the enhancement of labour market conditions that would encourage emigrants to invest in businesses back home, even while still abroad (Brunarska et al., 2013).

31 Due to fixed IOM project periods (in compliance with donor rules), return migrants who enroll in a project close to the project end only have limited time to implement their reintegration plans.

32 The Eastern Partnership Countries include Armenia, Azerbaijan, Belarus, Georgia, the Republic of Moldova and Ukraine.

6.5 Recommendations from returnees and family members

The returnees and their family members were asked whether they had any advice to offer an organization such as IOM for the facilitation of the return of people with a medical condition like what they have.[33]

> The first suggestion to IOM would be to give migrants a bit more time so they can think and don't get stressed out. Secondly, if they give me money for treatment, it shouldn't be only for me but for my family as well. How can I get treated if my child needs treatment? (Return migrant, male, 41, Azerbaijan)

> I am thankful to IOM. It gives me hope to see that such organizations exist. It would be good if IOM contacts people not once a year but several times a year, so the person will not get depressed but find comfort that there is an organization that thinks about him. (Returnee, male, 51, Azerbaijan)

> I think if our living conditions are improved, we would be able to support each other better. (Brother of a return migrant, Azerbaijan)

> For proper care and treatment, it would be good to get more financial support on a sustainable basis. (Daughter of a return migrant, Azerbaijan)

6.6 Conclusion

Similar to the case of Armenian returnees, reintegration of Azerbaijani returnees is undermined by their inability to be self-sustainable and economically independent, including the inability to provide for their daily and medical needs. Upon return, Azerbaijani return migrants are also met with support from family members, but the dire economic situation combined with corruption, including informal payments for health care, and complex bureaucratic processes make living challenging for all family members, including the returnees. According to the interviewed returnees, this is especially true if more than one family member suffers from a chronic medical condition and out-of-pocket money needs to be spent on private health care. In addition, the lack of community ties, culture shock and the migrants' comparison between the situation in the home country and the host country create additional stress factors that hamper the reintegration of the returnees.

33 Not all recommendations made by the respondents were included in this report. Those focused exclusively on getting IOM to address the interviewees' current situation were put aside; only those recommendations that would be generally applicable are presented in this section.

Chapter 7 Ghana

A total of 16 interviews were conducted in Ghana including the following respondents: five returnees, five family members, three health-care workers and three organizations providing support to return migrants.

Table 4: General information about the interviewed Ghanaian returnees

Return migrant	Age	Gender	Host country	Length of stay in the host country (years)	Length of stay in the country of origin (months)
1	54	F	Belgium	1	12
2	57	M	Netherlands	25	16
3	78	M	Liberia	25	5
4	64	M	Netherlands	23	12
5	39	M	Belgium	3	5
Average	58			19	10

The chronic medical conditions were diabetes, HIV/AIDS, piles, high blood pressure and stress.[34]

Three in five Ghanaian return migrants interviewed have been living in Europe for more than 20 years and mostly without a residence permit. With one exception, all return migrants decided to move back to Ghana because of health-related reasons. As irregular migrants in Europe, they had limited access to health care and their decision to return was based on the hope to receive the care they need. Their condition was never diagnosed properly; they could only report a poor state of health and describe the symptoms.

> Home is home. They [*Ghanaian migrants with medical problems*] should come home. Europe is not the place to be when you [*irregular migrant*] are not well. (Cousin of a returnee, Ghana)

7.1 Accessibility, availability and affordability of health care

Accessibility

From the perspective of the returnees, access to health care can be described as rather limited. Many of them return to rural parts of the country where their families still live. There can be a considerable travel distance between their rural residence and the nearest health-care facility. In addition, the long queues at the health-care facilities would add to the time that has to be spent on health care.

> I went to the medical people in Kumasi. It takes about one and a half hours to get there and one and a half hour to get back, so I cannot go there regularly. I go there only when I need to get medicines. (Return migrant, female, 54, Ghana)

> The transport alone – one hour, let's say. But there are long queues at the hospital so it takes a while. (Return migrant, male, 57, Ghana)

> I have to travel more than two hours to get to the health-care facility. Sometimes I walk a little, and then try to get a ride on a passing lorry to continue. (Return migrant, male, 39, Ghana)

34 One of the returnees was not diagnosed with a chronic medical condition. His complaints existed since several years and he had not been able to get a diagnosis since he remained in Europe without a legal permit, which limited his access to health care. In part, his return to Ghana was motivated by the hope of getting a diagnosis for his complaints. Symptoms were long-term existence of not feeling good, vomiting and weight loss.

Availability

The return migrants and their family members did not indicate that there would be a problem with the availability of health care or of the medication needed. In part, and in some of the cases, this might be accounted for by the absence of a proper diagnosis. After their return from Europe, where they had limited or no access to health care, they were still trying to get a proper diagnosis. More research would be necessary on the availability of health care for returnees in Ghana.

Affordability

Similar to all the other countries included in this research, Ghana has a combined public and private health-care system. From the migrants' opinion, the government system is described as fair, but the medication and care available is of lower quality in comparison with those in private health-care providers. If people have the means, they will choose private care.[35] All but one of the return migrants reported being unable to afford the medicines needed. Some recently arrived from Europe and can still rely on a reserve of medicines obtained in Europe. Just like the migrants from the countries presented previously, the Ghanaian returnees are dependent on their families to meet their daily needs, and they correlate their purchase capacity to buy medication with the income of the family.

> Some of the drugs are very expensive. What the national health insurance gave me wasn't good for me. The medicines I and bought are ok, but very expensive. I need money to buy these medicines.[. . .] As of now, it is all about money, for the medicines that are not covered by the insurance. (Return migrant, female, 54, Ghana)

> Here and right now, it is a financial problem that I'm dealing with in regard to my health. It is money that is the problem. The medicines are there, but the money is not. (Return migrant, 64, male, Ghana)

The provision of free-of-charge medication for patients with HIV/AIDS, TB or malaria figures high on the political agenda in Ghana.[36] The distribution of such medication is made via specialized public clinics.

7.2 Social network

Ghana differs from the other countries in this research on two accounts. First, the social network available to the returnees has a different structure, as it is not limited to the nuclear family; it also includes support from the traditional extended family. Secondly, the migrants' outlook of the future and on life in general is fatalistic and influenced by a belief in predestination.

Fatalism and predestination

The returnees' answers to the research questionnaire point to their fatalistic attitude and acceptance of their situation and of the support being given. They do not have high expectations or opinions on the support they should receive; instead, they merely accept what is being offered to them. This strong belief in fatalism and predestination is part of the West African cultural outlook (Ankomah et al., 2011). Additionally, there is the "positive thinking and confession" concept, as part of a cultural norm. suggesting that evil will befall those who think and speak evil about their own situation.

> I think [*medication will be available in the future*] because what you think is what happens, and what comes from your mouth is going to happen. (Return migrant, male, 57, Ghana)

> It is in the hands of God. (Return migrant, male, 39, Ghana)

35 Some migrants and/or semi-literate Ghanaians may have very little or no knowledge about protocols of how medicines are acquired, priced and distributed by the public and private sectors. The private sector may afford to import and sell medicines of different brands from other continents. Some of these medicines are priced higher than those from the public sector. There may be a myth among some Ghanaians in general that a more expensive medicine is of better quality. While the Government regulates the prices of drugs, in general, the private sector does not.

36 The focus on these diseases is possible, thanks to the interest and support from international donors.

Filtered through this outlook, the returnees' answers paint a positive picture: it seems as if they are doing fine, adjusting to and coming into terms with whatever befalls them. However, the interviews with family members, physicians and supporting organizations paint a different picture: the returnees are struggling to readjust; the economic circumstances are difficult for them and their families; depending on others weighs heavily, as is the burden of their health problems and the impossibility to share it – all these constitute a source of stress, the consequences of which are further elaborated in the next section.

Extended family network

The returnees' main reason to go to Europe was to be able to support their families and relatives back in Ghana.[37]

> Oh, I am stuck at the moment. When I was in Europe, I could support them. Right now, they are working and I am not in a position to assist them. (Return migrant, male, 64, Ghana)

> Yes [*I'm glad to be back*]. That place [*Belgium*] is not my country. Here, there are a lot of people to fall on. (Return migrant, female, 54, Ghana)

Traditionally, among some ethnic groups in Ghana, such as the Ashantis, the maternal lineage determines the social support network. This is not limited to the nuclear family; it also includes a broad extended family. Basically, everyone who is blood-related by the maternal line is regarded as part of the family.

> No, he didn't ask me to help, but we are all siblings of one mother and one father. If someone who is not your brother needs your help, you help the person, the more so when it's your own brother. The help I give him is from my heart. And I know that, if I am unwell, he will do the same for me. (Brother of a returnee, Ghana)

> If you do not have medication over there, you should come home. You don't need just medicines; you need emotional support as well. You get that when you are among people who care; you don't get that in a strange land. (Sister of a returnee, Ghana)

> He doesn't need to [*ask for care*]; in our system you try to support your relatives. You have to. I am happy providing him with this care. He is my elder brother. He looked after me, so why can't I do the same? (Brother of a returnee, Ghana)

> I give him financial support; I also support him emotionally by giving him advice and by visiting him. His medical costs are also borne by me.[. . .] We are first cousins and therefore it is my duty to do that.[. . .] As I said, it is my duty to do that. He will do the same for me in a similar situation. We are cousins. His mother and my mother are sisters. (Cousin of a returnee, Ghana)

Families who were supported by the returnees while working in Europe can have high expectations. Sometimes the returnees would be questioned – by relatives and the community – about their reasons for returning. Sharing information about health issues can be problematic. All returnees reported that they confided in only one or two close relatives, but would not be comfortable sharing information with others, partly because of the lack of knowledge about medical conditions, and partly because of the stigma associated with diseases like HIV/AIDS or schizophrenia.

> The only thing I have told my family is that I don't eat sugar. They know I am taking drugs, but nobody knows [*about my health condition*]. I have told them that I don't eat sugar. (Return migrant, female, 54, Ghana)

> My family doesn't know about my health problems. No. I didn't want to scare them, so I didn't tell them anything. (Return migrant, male, 57, Ghana)

37 These migration reasons for Moroccan returnees are comparable to the reasons of the Ghanaians. In this country, assessment of the Moroccan returnees indicated their migration to Europe was also tied to their longing to provide economic support for their families in Morocco.

Although none of the returnees reported feelings of isolation, according to a retroviral care physician, “return migrants are more isolated socially due to fear of stigma in a facility lacking private care”.

As was the case with the returnees from other countries included in this research, it is essential for the Ghanaian returnees to find their family structure in place and intact upon their return. The extended family is their social security; therefore, it would hit them hard if, after years of working abroad, they would find it broken upon return.

To conclude, due to the people’s mindset and sociocultural dynamics, the Ghanaian returnees do not seem to be able to use the full potential of their social network, given their inability to communicate to the network about their reasons for returning and their medical conditions.

7.3 Psychological problems

Only one of the returnees stated she felt better upon return; the others chose not to answer any of the questions related to mental health. In this case, the most interesting part was what was not present in the answers to the questionnaires. In all but one questionnaire, the answers to questions related to mental health remained blank. None of the return migrants seem to be experiencing any psychological problems upon their return. One migrant who did answer the question responded as follows:

> No, no, no, when I came here I am thinking normally; when I was in Europe, I was not. The life there is a little bit crazy. Somebody can call the police and create a problem for you. Here you live normal life, normal life. Over there, life is not good. (Return migrant, male, 57, Ghana)

The return migrant who did state she had experienced psychological problems said she experienced them back in Europe, but they simple vanished when she returned. There are indications in the interviews that returnees are struggling, as one returnee answered a question not related to psychological problems but his arrival in Ghana:

> When I came, the conditions that I went through nearly made me go mad. I had nothing. I had not even clothing. All of the goods I had brought down had been taken away. I was even not having footwear.[. . .] I was thinking too hard. I was very worried. (Return migrant, male, 64, Ghana)

In part, this might also be related to the strenuous conditions the returnees experienced living in Europe. Without a legal status, they might have lived at the margins of society.

> That is why I said my health was not good. And life was not good and my paper also spoil. I don’t like there anymore. (Return migrant, male, 57, Ghana)

> For me, I think when your health is not good and things are not good for you, you better come home because Europe is not like yesterday. Even the white people themselves, they are finding things difficult. So, if you are fortunate, you find things are difficult because of the EEC. Things are hard because these white people, they always like to help their own people first before the foreigner. Like Yugoslavia, they are all EEC and they will come to Holland looking for job. The white man will try to consider those people before you. When there is a chance, they can give you but there is a little racism in it.[. . .] Yeah, life will be better [here] because in Europe there is no land. You can’t plant. Here you can plant if you are not lazy. (Return migrant, male, 57, Ghana)

> Yes [*I agreed he should come back*]. I was shocked to hear that over there they deny them medication. It is not so here. (Sister of a returnee, Ghana)

This is in contrast to the interviews with the organizations providing support to return migrants, the physician and the local researcher. The return process does contain stressful aspects that weigh heavily on returnees and causes psychological problems. According to them, returnees struggle to readjust, the dependence on others weighs heavily on returnees and the burden of their health problems and the impossibility to share this is stressful. Also, the local researcher indicated that there is a taboo

around mental problems in combination with the local idea that evil befalls those who think and speak evil, which might make it hard for returnees to speak about their mental health problems out loud.

Burden

All interviewed return migrants depend financially on family members or relatives. Only two returnees spoke about the burden they are and their need to become independent.

> No, I am not able to support my family. When my financial situation improves, then maybe I can afford to [. . .]. I only wish to become less of a financial burden to the people I am living with [. . .]. As I said, I would like to establish my independence. I need to be independent since I am unable to support myself now. (Returnee, male, 78, Ghana)

> We are ok. Except that I have to be independent and be able to provide for myself. (Return migrant, male, 39, Ghana)

> When there is a change [*the return of brother*], it is an additional burden. It is a fact of life.[. . .] I can't tell him what support he should give, but my main concern is that he is able to provide for himself. Knowing him as he is, he will like to live an independent life. (Brother of a return migrant)

As stated before, the fatalistic outlook on life seemed to make the return migrants just accept what is happening in their lives. In contrast, the Reintegration Officer from IOM paints a different picture:

> Some become violent because of the inhumane treatment they might have experienced in transit and host countries. Other returnees see themselves as failures, as they are not in the position to support their families, which is usually a push factor for migration; thus, they give up and end up frustrated. Rejection from their relatives, friends, community, etc. is a big challenge since they may become a burden on them. Also, they are misinformed about their country of origin, when they happen to meet the wrong people, so coming back home scares them. For some returnees with health problems who are not fit to look for work, how to access health care is even a problem, depression can set in. Relatives see them as failures. (Reintegration Officer, IOM)

This is very similar to the experiences of return migrants in Morocco.

Stigma and isolation

Most of the interviewed returnees and their families did not feel comfortable sharing health issues with others.

> No. I didn't want to scare them [*family*], so I didn't tell them anything. No. I don't communicate my health to them [*friends and community*]. I keep it to myself. (Return migrant, 78)

> No, it is not right [*to tell others about the medical condition*]. (Sister of a return migrant)

> No, it is not right to tell others. (Brother of a return migrant)

> No, it is not done [*share the medical condition with others*]. There is also stigma, so you don't have to disclose it to anybody unless he wants to. (Sister of a return migrant)

Among all the migrants relatives interviewed, only one – a registered nurse – feels she has enough information about the medical condition of the returnee. The lack of information about medical conditions can reinforce the taboo around some of the medical problems. This stigmatization of health-care problems is also reinforced by research about reintegration problems of returnees with HIV in Ghana (Mommers et al., 2009).

Although none of the return migrants talked about being isolated, of the five returnees, only two stayed with relatives, the others lived alone. This is a contrast to the case in other countries where the returnees in general lived with other family members in one household.

7.4 Work and reintegration

Two in five returnees are working. Of the three returnees who are unemployed, only one stated health problems as a reason. Retirement age and capital are also keeping the others from working. The returnees were not very forthcoming with information about this subject. Their answers to the questions were short.

7.5 Recommendations from returnees and family members

The returnees and their family members were asked if they had any advice for an organization such as IOM in order to better facilitate the return of people with a medical condition.

> They [*IOM*] should try to support migrants to support themselves financially. (Return migrant, 39, male, Ghana)
>
> They should be able to set up a system to facilitate their return and then find a way to settle them. They could make land and tools available to them to farm. (Brother of a returnee, Ghana)
>
> They should not just help people come home. They should at least support them to be able to be functional. If were not for me, he could have died. (Cousin of a returnee, Ghana)
>
> They should also support them medically when they come home. (Sister of a returnee, Ghana)
>
> The organization should provide a lot of counselling and create awareness among stakeholders to meet the needs of returnees. (Health-care worker, Ghana)
>
> How to overcome challenges include: returnees should be provided with strong psychosocial counselling for the person to understand that all is not lost. Government should provide financial support, as it is done in neighbouring countries. Embassies should be well utilized; thus, they should open their doors to educate and update citizens on the economic situation of their country, so that they will appreciate and be comfortable to come to their motherland from time to time to help them establish themselves after some few years of hustling. (IOM employee, Ghana)
>
> Before the migrants return, they should be taken through some counselling; both family and the returnees should be involved. Provision for health insurance should be made available to minimize their hospital costs. For instance, returnees with medical issues should be made to visit the hospital at a lower cost or for free. (Employee, West African Network)
>
> Government should help to identify jobs for skilled and unskilled migrants. If possible, provide financial support to returnees. Family members should be loyal and transparent with assets and monies sent home by returnees to establish themselves and shelter them when they come home. They should love and cherish them when they return home sick and encourage them when they don't succeed. Returnees should open up for assistance, they should not lose hope also; they should take advantage of education opportunities outside and make the best use of their time so that they won't find themselves wanting when they return home. (Director, Research and Counselling Foundation of African Migrants)

7.6 Conclusion

The sustainable economic reintegration of return migrants from Ghana is mostly being challenged by the social stigma about their medical problems. The social stigma and cultural beliefs result in a limited ability of migrants to share with their relatives their real reason for returning (i.e. health situation). This, in combination with high expectations of the extended family, leads to feeling of failure due to their inability to provide for them. As a result, interviewed return migrants have a limited social network they rely on. Possibly due to the Ghanaian fatalistic belief system and the stigma about psychological problems, information on the mental health status as experienced by the return migrants was not found in this research. In order to improve programmes specifically targeting the challenges of return migrants in Ghana, more in-depth research is necessary. To gather this information, establishing trust between the researcher and the return migrant is of great importance.

In total, 18 interviews were held in Kosovo/UNSC 1244. Of these, five interviews were with returnees, five with family members, four with health-care workers, three with reintegration organizations and one with the local researcher.

Table 5: General information about the interviewed Kosovar returnees

Return migrant	Age	Gender	Host country	Length of stay in the host country (months)	Length of stay in the country of origin (months)
1	47	M	Finland	11	8
2	63	M	Belgium	30	12
3	56	M	Belgium	13	10
4	65	F	Luxembourg	3	17
5	30	M	Belgium	13	10
Average	52			13	11

The chronic medical problems of returnees were PTSD, kidney failure, cardiovascular diseases (e.g. heart problems, high blood pressure), stress, rheumatic arthritis and neurological problems due to head injury. Three in five returnees had more than one chronic medical problem. The two who did not have chronic problems had kidney failure.

The situation and experience of returnees in Kosovo/UNSC 1244 is very similar to Armenian and, to some extent, Azerbaijani returnees. In these countries, the health-care system is quite similar. In addition, migrants, in general, left their countries of origin for the same reason – to find treatment for their existing medical conditions. Lastly, the economic environment and the setup of social networks are quite similar.

> When I went there [*host country*], I went with the intention to survive, not to die in my house. I thought just to go out, not to die in front of my children. (Return migrant, male, 47, Kosovo/UNSC 1244)

Four of the five returnees stated that their medical conditions got worse after their return.

> My condition is much worse since I am back from Belgium. I am 35 per cent worse than in Belgium. If I walk 300 to 400 metres, I have to stop. I don't have strength that I had when I was there. (Return migrant, male, 56, Kosovo/UNSC 1244)

8.1 Availability, accessibility and affordability of health care

Availability

In general, return migrants are able to get the medical care they need. The two dialysis patients' future treatment – a kidney transplant – is not available. Both returnees left Kosovo/UNSC 1244 to get a kidney transplant. One returnee stated:

> Dialysis is a treatment . . . dialysis is prolonging your life. Until you get a transplant. I lost this faith. . . . If nothing here, abroad there is help. For example, in France, somebody who was there entered the list for transplantation . . . one person from Mitrovica told me that. [. . .] I would like to thank IOM, they helped me from Prishtina. If I was in their position, if they could sent me back there once again, for treatment, which is the best thing for me. I feel more secure there . . . to heal. I could enter the waiting list for kidney transplantation in one or two years. I can do transplantation and after that to come back healthy, so I could work near my children for five to six years. I can get a job until they grow up. (Return migrant, male, 47, Kosovo/UNSC 1244)

Another returnee said:

> My family received me [*after returning*] well, but they had a kind of stress, because I didn't do kidney transplant. (Return migrant, male, 56, Kosovo/UNSC 1244)

The absence of kidney transplant in Kosovo/UNSC 1244 is confirmed by a physician in the Dialysis and Nephrology Department of a hospital:

> In terms of services, we miss transplantation services at the level of Kosovo. This is one of the reasons why our patients tend to go out of Kosovo. Especially, this is the case with young persons with renal problems.

All but one returnee stated that the medication is available in Kosovo/UNSC 1244.

> Services here in regard to staff . . . I cannot say that are bad, but they miss many things, they miss drugs, for example, Rezonium [*sort of medicament*] is missing, you know against kalium, then my kalium goes up [. . .]. (Return migrant, male, 47)

Just like in Armenia and Azerbaijan, some of the branded medications from Europe are not available in Kosovo/UNSC 1244. If available, they can be found in the private health sector, but – due to the poor economic circumstance and the high price of these medications – they are not accessible for the returnees.

> There are medicaments. You have to buy with money. I can't find here medicaments from Belgium. I am taking substitutes that were prescribed by doctor here. (Return migrant, male, 30)

> Patients get connected with the naming of the medicament, in the package. If that sort of medicament is not available in our market, we explain that they have to start taking medicaments that are available here in Kosovo. But, in general, we don't have problems with that, they understand. (Endocrinologist, Department of Endocrinology, Internal Disease Clinic)

Again, the quality of this generic medication is questioned by the return migrants. Only one mental health-care worker from a public mental health-care institute reported about the availability of medication:

> We are lacking drugs, antipsychotics and our patients many times become decompensated, without drugs. [. . .] Main problems are therapy, medicaments. We are lacking it. Developed countries use more expensive therapy. When migrants come back to Kosovo, we need to continue their treatments with what we have in disposition.

Accessibility

For returnees, health care seems to be accessible. Returnees use public transportation, get a taxi or walk to access medications or services. Estimated traveling time is between 10 and 45 minutes. Two of the returnees are able to use a State vehicle[38] that will bring them for free to the health-care facility.

Affordability

Medications are available in Kosovo/UNSC 1244, but mostly only in the private sector. As a consequence for returnees living in economically deprived situations, medications are out of reach. Availability is therefore compromised by affordability.

Kosovo/UNSC 1244 has both public and private health-care systems. The public health care is free, in the private sector one needs to pay for services. The public health care sector is financed through the Ministry of Health and partially financed by the relevant municipalities. The Ministry of Health determines an essential list of drugs. These drugs are freely available at the public health-care clinics.

38 The vehicle is from the relevant municipality that provides transport mainly for dialysis patients.

But according to the local researcher, a former physician, medicaments are often missing. The patients need to buy the medication out of pocket.

In addition, there is a co-payment fee for the public health-care system. Patients pay for a very small proportion of the services or materials used for diagnostic procedures. For certain types of chronic diseases, the co-payment fee is waived. If a patient chooses to go directly to a hospital to see a specialist, he or she needs to pay an additional fee. When given a referral by a general practitioner, only the co-payment fee is required.

Even if health care is available and accessible, return migrants are not always receiving the treatment they need. This is related to their economically deprived situation.

> I don't have money, I can do the visit but I have to buy medicaments. There are medicaments, but everything is private and you have to buy them. (Return migrant, female, 65, Kosovo/UNSC 1244)

> When you have money, medicaments can be found. When you don't have money, you don't have drugs. It is like this. (Return migrant, male, 63, Kosovo/UNSC 1244)

> To be honest, no, I can`t secure my drugs. I cannot secure half of the drugs I need, because I can't buy those. (Return migrant, male, 56, Kosovo/UNSC 1244)

The health-care workers interviewed confirmed the experience of the returnees.

> All medicaments that we receive we give to patients for free. But there are medicaments out of the essential list, and then you need to buy that drug. (Health worker in a public mental health institute)

> Drugs are lacking, or better to say there is no money to buy drugs, drugs that they need, drugs, they are used to have. (Head of regional mental health-care centre)

Based on the interviews, it is hard to determine if the needed medication is really not on the essential list and therefore not available for free, or if the generic brand is on the list but not trusted or not effective enough according to the return migrants.

8.2 Social network

All but one of the returnees live with direct family members. The family members are providing for the return migrants' daily needs and medical expenses. In some cases, the return migrants receive a small stipend or social security benefit from the government, like a pension or money from the municipality. Even with these social security benefits, returnees still depend on their family members. Their family members are their social security network.

Responses of family members to a migrant's return were mixed:

> When I came back, they didn't receive me with good things. They didn't want me to come back, they were not happy. (Return migrant, male, 47, Kosovo/UNSC 1244)

> They received me well, but they had a kind of stress, because I didn't do a kidney transplant. (Return migrant, male, 56, Kosovo/UNSC 1244)

The return migrants were received with mixed feelings: families were happy to see their loved ones back but were worrying about the consequences of the return

> I was happy that they [*parents*] are coming back, but I was worried. How I am going to cope with expenses, with consequences? There is no help from anybody. With everything, what we have, with what he needs, within our capacities. [. . .] It is an obligation, and a burden, but . . . you have to when you have in mind the situation in Kosovo. When you don't have [*money*], you have to borrow,

> you have to stay without food and buy drugs. He [*father*] cannot stay without drugs, I see him, when he doesn't have drugs for stress, once he didn't, he was stressed you should see him, it is a family problem. I tell you if this continues, I don't know how I am going to do it. It is bad, very bad. (Son of a return migrant, male, Kosovo/UNSC 1244)

In all cases, the returnees had left Kosovo/UNSC 1244 to get treatment for their chronic health problems. All returnees received health care in the host country while their applications for a permit to stay were pending. None of them found the cure they were hoping for. Back home, family members also hoped for a cure for their loved ones' health problems. The lack of this cure has influenced the family members' response:

> I was very sad when I found out he would return. Not that we don't want him, but how to support him.[. . .] There is nothing here, I was hoping that they [*doctors abroad*] will heal him, that he will get his direction. Here, I don't have any hope that he will find a cure. There, medicine is good, he would tell us that he is good.[. . .] Our lives changed a lot. We had fewer expenses, now we have more. All the times, just going down to zero. We spent more. Well, you cannot do without 100 euros a month. I am sick as well, with high blood pressure. I don't buy my drugs. I don't have [*money*]. (Wife of a return migrant, Kosovo/UNSC 1244)

All returnees are financially supported by their family members. None of the returnees is working due to health problems. They depend on this financial support to meet their daily needs. However, in some cases, even with this extra financial support, the returnees' daily needs are not met. IOM's relocation support is important for the survival in the first few months. Feelings of obligation put a lot of stress both on the return migrants and their family members, and when one of the family members has medical problems, too, the household's medical expenses increase. One returnee said:

> They [my family] feel bad because they cannot help me because they themselves are in a miserable condition . . . they feel bad as well. (Return migrant, male, 47, Kosovo/UNSC 1244)

In addition to financial support, returnees receive emotional support, of which they are highly appreciative.

> They are a family with a soul. I had support from all, I am doing well with all, I don't have any problems. Their thinking is how to help me, with their soul, they sincerely think how to help me, but they can't because they are in bad position as well. (Return migrant, male, 56, Kosovo/UNSC 1244)

> My kids love me, they learn, they give me pleasure. When my kids are well, they push me . . . they give me a big support. (Return migrant, male, 47, Kosovo/UNSC 1244)

This emotional support from their families is therefore essential.

Lastly, family members provide help even in daily tasks like cooking dinner, cleaning and giving medication.

8.3 Psychological problems

The families' mental support seems to be essential to the mental health of return migrants. At the same time, the family members' financial support makes them feel like a burden. Three of the five returnees stated that their health problems deteriorated after returning back to their country of origin. For all of them, their mental state got worse after returning. They link the start of their psychological problems to their return to their country of origin.

> In Belgium, I didn't had neurosis. It appeared when I came back. (Return migrant, male, 56, Kosovo/UNSC 1244)

> I started with the drugs for stress when I came back. While I was in Belgium, I didn't have drugs for neurosis. (Return migrant, male, 63, Kosovo/UNSC 1244)

This experienced stress and nervousness is linked to a couple of factors. First, all migrants left the country to find medical help for an already existing health problem. But they returned without receiving the treatment or cure they had hoped for. In two cases, the returnees with kidney failure, this cure was life-saving. By finding a cure or treatment, returnees had hoped to participate again in society, meaning to provide for their families with their own income. Without this cure, dependency on family was adamant and a positive future was taken away.

Also, returnees compared the state of health care in Kosovo/UNSC 1244 with the received care in the host country where all care and medication were for free. In all cases, health care in the host country was perceived as being superior compared with the health care in the country of origin. Respondents commented about the quality and accessibility of care, treatment or services, and completeness of medication:

> In Finland, treatment was very good, if I tell you different, God will kill me, it was very good there.[. . .] Tablets that I used there were complete, nothing was missing. Second, the dialysis apparatus [*machine*] was newer; hygiene, food, everything was perfect . . . it was much better there. Services here in regard to staff . . . I cannot say that are bad, but they miss many things. (Return migrant, male, 47, Kosovo/UNSC 1244)

> While I was there, I had money, I had my doctor. The doctor was near the place where I was staying. Medicaments were free of charge. (Return migrant, male, 63, Kosovo/UNSC 1244)

> I felt much better in Belgium, here is too much stress. Look at the prices of the drugs, this one is 14 euros and 30 cents, this one for heart even more. This one is 9 euros to calm me down, when I go to doctor, every time I go to doctor I spent some 40 euros. Nearly 100 euros every month, my wife is also sick. When we were in Belgium, we were getting all drugs for free. (Return migrant, male, 63, Kosovo/UNSC 1244)

Some returnees were informed about free access to health care and medication. However, upon return, this proved to be not the reality of daily life, resulting in stress and frustration.[39]

> This organization of Belgium in Kosovo, that organization guaranteed for drugs. They told me that when back you will have everything. They waited for me, they drive me home, but I didn't receive any other help, at all. They gave me that money, they gave me, yes. They didn't come to see where I live, and how I am living. Never. They told me, we guarantee for drugs but nothing. (Return migrant, male, 56, Kosovo/UNSC 1244)

> In Belgium, they told me that situation in Kosovo is the same, when it comes to my disease, but their words didn't come true. I am feeling worse since I am back. In Belgium, in the place where I used to reside, I had a doctor there. Here I go everywhere, here it is not good here, not good. (Return migrant, male, 30, Kosovo/UNSC 1244)

> Problems [*of the return migrants*] are the same [*as Kosovars*]. But needs of returnees are bigger, until they re-socialize in our surroundings. Returnees, many times, make comparison of the health care and treatment received in countries from they came back with the ones that we offer here. (Health-care worker from a public mental health-care institute)

Another stressful factor in the returnees' daily lives is the uncertainty of being able to afford their daily needs and medications due to the strenuous economic circumstances. As a result, the return migrants feel they are a burden to their family members.

> It didn't change, when I was back I didn't bring anything with me, except to be a burden for them [*family*]. (Return migrant, male, 63, Kosovo/UNSC 1244)

39 Kosovo/UNSC 1244 does not have a public health-care insurance system established. However, until the 1980s, all ex-Yugoslavian countries had a solid social and health-care insurance system in place. The generations that have lived in that era have the tendency to compare the current system with the old one.

Here I need to think about everything, how to buy drugs, how to buy injections. With 45 euros, can you sustain your family, can you buy drugs? Forty-five euros is my social assistance, what to do first with that money? (Return migrant, male, 56, Kosovo/UNSC 1244)

My psychological problems are very bad, I have problems. Every second night I take a pill to calm me down. I get nervous, I cannot sleep, I worry, I am anxious, how am I doing, I worry, I am getting more older, more sick, a burden for my home, for my family. (Return migrant, female, 65, Kosovo/UNSC 1244)

The inability to adjust back to life in Kosovo/UNSC 1244, the poor living conditions, the uncertainty about the availability and affordability of medication, and the lack of a positive outlook of the future all leave a feeling of nervousness for the returnees.

I am poor, it is like this. I am a little stressed, I get nervous very fast, when I see something bad, I get nervous. It is linked with problems, I don't have drugs, when you don't have, what to do, you get nervous. (Return migrant, male, 56, Kosovo/UNSC 1244)

I get nervous for a small thing. If I get a little nervous, I react badly, I can swear, I shout, I tell heavy words. I am like thinking about something, like what I lost. Why can't I work, why is this happened to me? If I want to get married, how to do about it? I have a kind of blockage and have pain in my head *(touches his head)*. When this gets me, I need to be alone, not to listen to anyone talking. I feel like dreaming, sleeping. When I was in Belgium, I had very good treatment and I was to overcome these problems. I had assistance, I had doctors that didn't make you nervous. Here I became a problem, I go to the municipal authorities, they make jokes out of me, they tell me go there and then there. They make jokes out of me, you feel that they are doing nothing. When I go to a doctor, it's the same. They tell me go to private [*doctor*], and I don't have money for that and for medicaments. In Belgium, I didn't pay a cent. They offered me everything. (Return migrant, male, 30, Kosovo/UNSC 1244)

I cannot sleep, I feel grief, very much, I cannot sleep till 2 after midnight, I cannot sleep. This is for many reasons, because of my health, and then when I think about my age, when I think about my children that I need to push forward (support), I don't have future neither for me neither for my children and family . . . it is like this. (Return migrant, male, 47, Kosovo/UNSC 1244)

When stress gets me, I don't know. I scream to my family members, no one doesn't dare to come in front of me. I have problems with sleeping – I wake up five to six times a night, I need to urinate. I used to fast during Ramadan before, now I cannot. I don't have income, I am used to have money. When I was young, I used to go out. . . . I see some things that I need and I can't buy because I don't have money. I used to work before with textile and I am used to have money with me.[. . .] Everything is related with stress, with not having money . . . being poor. (Return migrant, male, 63, Kosovo/UNSC 1244)

Not seeing a brighter future ahead is also causing nervousness among migrants.

My brother always says, "I am nowhere (no perspective)".[. . .] I desire that he finds himself . . . and finds his direction in life. (Brother of a return migrant)

Having in mind the current situation, I don't believe it will change . . . it is high unemployment. . . . Situation is going down. (Return migrant, male, 47, Kosovo/UNSC 1244)

We have to teach them to accept and cope with the reality here and to cooperate with us. (Health worker in public mental health-care institution)

The psychological problems are affecting family members as well. Living in the same house, they have to deal with behaviour that comes with it. All but one returnee stated that they feel emotionally supported by their family members. In one case, emotional support is vital:

> My brother helps me. I talk to him. If it wasn't for him, for me, just to take the road to forest.[40] (Return migrant, male, 30, Kosovo/UNSC 1244)

8.4 Work and reintegration

Being able to work is an important part of reintegrating into society. None of the returnees was working due to their health problems.[41] One return migrant was physically able to work, but no jobs were available that could accommodate his health-related limitations. In most families, at least one member of the household was working and providing for everyone. One returnee has been a homemaker her whole life and therefore has never worked:

> I never worked, I am a housewife, if someone could help my son, to get a job. (Return migrant, female, 65, Kosovo/UNSC 1244)

The inability to provide for their families weighs heavily on some of the shoulders of the returnees.

> Economic situation, unemployment, shelter are most important things. There is no money, there is no shelter and there is no drugs. This is most important. When they come back they need to be engaged somewhere, there is no engagement for them. They are not employed and they don't have money. At least if they had a kind of pension (assistance) or a monthly payment, a guaranteed life, basic things. I know a case of a returnee from Mitrovica that asked for social assistance, he was abroad and he was doing okay and then, when he comes back, he becomes a social case. The word social case sound negatively. (Head of the regional centre for mental health, Kosovo/UNSC 1244)

8.5 Recommendations from returnees and family members

All participants in the research were asked if they had advice for an organization such as IOM in order to better facilitate the return of people with medical conditions. Unlike in other countries, the answers of the Kosovar returnees were mostly focused on their own personal situations. They wanted more personal financial assistance and mostly asked to be sent back to the host country.

> I will praise them to keep there [*abroad*] all persons that are in need of medical aid, and not to turn them back. If they turn them back, they should give them more help, not to turn back people and not to help them, neither with social assistance, neither with medicaments. I would like that some requests that I have made for support for return migrants, for health for drugs. (Return migrant, male, 30, Kosovo/UNSC 1244)

> If I was in their position if they could sent me back there once again, for treatment . . . that is the best thing for me. . . . I feel more secure there . . . to heal. I could enter the waiting list for kidney transplantation in one or two years. I can do transplantation and after that to come back healthy so I could work near my children for five to six years. I can get a job . . . until they grow up. (Return migrant, 47, Kosovo/UNSC 1244)

40 *Local researcher's note:* He meant he would end his life or hide from the world.

41 The local researcher in Kosovo/UNSC 1244 suspected one of the return migrants was working in his brother's company. This return migrant was, compared with the others, a little more well-off. The return migrant might have portrayed his situation as more severe in the hope to get more support.

For reintegration organizations, the respondents' recommendations are as follows:

> The return of the person with medical conditions or chronic diseases needs to be coordinated very well, in advance, in order that he or she integrates and gets health services that are needed. Coordination needs to be done between camp settings, IOM services and required services in countries of origin. The list of return persons with medical conditions needs to be treated separately and with high caution. To say it in a simple way, an organized return needs to be coordinated well and especially for this category. (IOM staff)

> The family of the migrant, this is from my perspective the central point. Family here in Kosovo is essential, since families here have strong ties. Families are one of the most important factors, if you are a return migrant and especially if you are sick, you need somebody who takes care of you, give you medicaments. If there is no institutions who take care for you then family is the best. (Employee, reintegration programme URA 2[42])

8.6 Conclusion

Like in Armenia and Azerbaijan, reintegration of return migrants in Kosovo/UNSC 1244 is hampered by their inability to be economically independent and self-sustainable. The difference between the experiences of returnees in Armenia and Azerbaijan and with the experiences of those in Kosovo/UNSC 1244 is that the latter clearly illustrated their mental state. Nervousness and stress were experienced and expressed profoundly by respondents in Kosovo/UNSC 1244. This could be attributed to the cultural openness on psychological topics, the established trust between the local researcher and the respondent, or the high levels of stress involved in returning to Kosovo/UNSC 1244. Although the first cannot be established based on this research, the latter two are possible explanation, which is based on the initial migration reasons. Without treatment available in Kosovo/UNSC 1244, for some returnees, leaving Kosovo/UNSC 1244 was meant to be life-saving. Returning without the necessary treatment weighs heavily upon the returnees' shoulders. As a consequence, not all returnees were met with a warm welcome upon return. In an economically deprived country, the returnees are dependent on their family members for basic needs and health-related expenses. In the short term, it does not seem to be likely that the economic situation in Kosovo/UNSC 1244 will change. To be able to participate in life, Kosovar returnees should gain economic independence, being able to manage their physical and mental health problem, learning how to cope with the stressful living situation and finding ways to connect with the community.

42 The URA 2 project (*ura* means "bridge" in Albanian) offers comprehensive return counselling as well as various measures for the integration, care and support of Kosovar returnees and locals in its Return Centre in Pristina. See http://www.bamf.de/EN/Rueckkehrfoerderung/ProjektKosovo/projektkosovo-node.html;jsessionid=079A5FE4B8159CB02B3A738325E174B8.1_cid368.

Chapter 9 Mongolia

A total of 17 interviews were held in Mongolia, of which five were with migrants, five were with family members, four with health-care workers, two with reintegration organizations and one with the local researcher.

Table 6: General information about the interviewed Mongolian returnees

Return migrant	Age	Gender[43]	Host country	Length of stay in the host country	Length of stay in the country of origin (months)
1	58	F	Netherlands	6 months	5
2	30	F	Netherlands	8 years	8
3	60	F	Netherlands	9 months	11
4	32	M	Netherlands	6 months	18
5	62	F	Netherlands	10 months	3
Average	48			8 months[44]	9

Chronic medical problems reported were neurasthenia, thyrotoxic disease, chronic gastritis, chronic viral hepatitis C, poor vision, arterial hypertension, chronic ischemic heart disease, cancer of the uterine cervix, diabetes mellitus type 2 and arthritis in both knee joints.

Return migrants mostly went abroad as economic migrants, in search of a better life. They returned to Mongolia when facing health problems. This is similar to the situation in Ghana and Morocco. In general, when they return they find the living conditions worse than before they left. Of the five returnees, four said their health problems persisted and one said she felt better.

9.1 Availability, accessibility and affordability of health care

Availability

Of the five interviewed returnees, only one stated that she was lacking the health care she needed. Although general health care and medication for this returnee was available, she was referring to diagnostic services that were missing.

> I am lacking high-skilled physicians to make proper diagnoses. (Return migrant, female, 61, Mongolia)

This was not described by the local researcher. According to her:

> These diagnostic tools are available most of the times in private hospitals, but these are due to their high costs, making them out of reach for the returnees. The public health care is affordable but does not have the right appropriate diagnostic tools.

The psychological health-care services in Mongolia are still in their infancy. Therefore, health-care services are limited. Especially, in rural sites, this is even more complicated than in the capital.

> In Mongolia, physiological consultancy service is not common, in the capital some physiologists provide services as private service. (Return migrant, female, 30, Mongolia)

> In the rural, people have limited access to psychological services.[. . .] Health service are there, yes, psychological support is not. (Psychologist from an institute for psychological consulting)

43 Mongolia was the only country that had more females than males included in the research. According to the local researcher, this was mere a coincidence; she said both males and females migrate and return.

44 The amount of time spent in the host country by the second return migrants has not been taken into account in the average.

Accessibility

For some, accessibility of health care is compromised. There are three factors that limit the accessibility of health care for some returnees. One is the absence of psychological care in rural areas. Another is the traveling time to access a health-care facility or pharmacy. The traveling time of the interviewed returnees was between 30 minutes to two or three hours. The returnees travel by foot or use public transportation. Occasionally, a family member will drive. Three of the five returnees were allowed to use public transportation for free, because they were elderly. Lastly, the national health insurance has limitations in regard to the length of services, especially for chronic health problems.

> The main problem is limitation in health insurance; it allows people to have limited access to State-funded health service. There is a package for a year, this means people cannot continue his or her treatment in State-funded facilities for duration of more than two weeks, stay in a hospital and have treatment for over two weeks. (Surgeon at a specialized public health centre)

Affordability

The Mongolian health care is set up in private and public sectors. The public health care sector is staged in three levels, based on the degree of specialization or care. Level 1 is basic care, while level 3 is highly specialized care. Government policies guarantee free health care for people under 18, elderly above 60 and the handicapped. People who work and pay taxes are insured by government insurance. Return migrants who left the country before starting their careers in Mongolia are not entitled to this insurance. In recent years, private health insurance has started growing.

There are specialized State programmes that cover care for people with cancer, communicable diseases and pregnant women, and also medication for several diseases like HIV, TB and diabetes. The Government has set up an essential list of medication. Those who are covered by government policies, such as children and the elderly, or by the government insurance also receive most of their medications for free. For others, sometimes discounts are given if the medication is on the essential list.

Even if medications are provided for free, patients still find themselves paying out of their pockets. The quantity of the medication received is sometimes not enough and patients run out of medication before the end of the month. One of the women with diabetes experienced this quite often according to the local researcher. She is therefore forced to go to the pharmacy to buy insulin using her own money.

> Having a sufficient supply of medicine is challenging. The supply of medicine, which provides by State Health Insurance is not enough for every day. Therefore, I sometimes purchase tablets from my own pocket. I cannot take every service, which I need. There is not sufficient supply of diabetes medicine. I have financial difficulties; usually I choose private health service and pay by myself. (Return migrant, female, 62, Mongolia)

Often, return migrants use the stipend from IOM for private health-care services since the diagnostic tools are available in private health care. The IOM stipend for health-care coverage is therefore, in some cases, spent in one visit. Private health care is not affordable for the returnees. Public health care, on the other hand, is affordable but has limitations for some who are not covered by the existing policies. Even when covered by policies, free access to health care and medication is not guaranteed.

The lack of diagnostic tools in public health care, the shortage of free medication and the bad quality of public health services are prompting returnees to pay out of their own pockets to get the care they need. Affordability of health care is their main concern.

> It is the lack of financial sources, people could get all kinds of health services in private health service entities. The only constraint is its price. (Return migrant, female, 58, Mongolia)

> Health check and examine in State-owned hospitals require much money, time and the service is poor, bureaucratic. They have too many patients. Private clinics are good, but need more money to pay for the service. In Mongolia, physiological consultancy service is not common, in the capital

some physiologists provide services as private service, which cost MNT 35,000 for per hour. This is really high price for me.[. . .] I cannot pay for it. Some treatment was covered by IOM. Partly I am paying, partly my brother is paying. (Return migrant, female, 30, Mongolia)

Service fee is high to have health assessment and check-up with doctors. I have financial shortage. Some examines such as heart screening, CT, MRI is too expensive, so I cannot take them.[. . .] Health assessment and check-up could be free of charge, if I have them at local State-funded hospitals, but the service is bureaucratic and crowded. Therefore, I prefer go to private doctors. (Return migrant, female, 60, Mongolia)

9.2 Social network

All of the five returnees are dependent on their families for financial and mental support. Mongolia has government assistance for the elderly – males over 60 years old and females over 55 years old. They receive a small retirement stipend. Only Mongolian citizens who worked for more than 20 years are entitled to this. A return migrant who left Mongolia for a long time might not qualify. In addition, there is a social health benefit; a small amount of money for people who are chronically ill and do not qualify for other support.

The support provided by government benefits is small and will not cover daily needs. Family members provide additional support. Traditionally, the extended family is important in Mongolia, as members of both the direct and extended families support each other by sharing a house or an income. This is also to ensure that the elderly are being taken care of. If the elderly do not have relatives, they could end up living on the street. Mongolian culture does not encourage setting up facilities or homes for the elderly; as much as possible, the elderly should be taken care of by their family.

The local researcher noted that none of the interviewed return migrants made use of government support. The bureaucratic application processes are too complicated and time-consuming. Returnees weigh this against the received money and conclude it not worth the time investment. For financial support, they therefore rely on family members.

I am happy to help my mother, I am sure that I do right. I like to help more and more. Currently, I am on maternity leave; therefore, my financial capacity is limited. I support her financially and give her mental strength. (Daughter of a return migrant)

My sister had asked for support, at the same time I feel that I should help her, this is my duty. I feel happy to support my sister, I believe that, I having right position to help my sister, this is my duty, I love to support more if I had more possibility. In unfortunate, my capacity is limited. At the same time, I had fear and happiness when I heard about her return. I was happy to be beside and close with my sister. Also, I had worry about her living and I thought about my limited capacity to provide support for her. (Brother of a return migrant)

I like to support my mother by my full capacity, she is the person whom I love most.[. . .] I am happy to support my mother, I like to support her more and more, even though my living is not good enough to support my mother in all the aspects of her life. I have big family to support, I am single mother with four children, and do not have permanent employment. My income is on and off. (Daughter of a return migrant)

I offered my house to live in and support his feeling and strength of mind. He did not asked for. I offered my support and let his family to live in a house, which is owned by me. I feel happy to help my sibling and share my properties, I think I am doing right. (Brother of a return migrant)

9.3 Psychological problems

The local researcher did not ask questions about the psychological problems the returnees were facing. According to her, the returnees did not have psychological issues. It was mostly stated that mental health care and awareness of psychological problems were on the rise, making them a new phenomenon in Mongolia.[45]

Health-care workers and medical professionals in Mongolia did see specific problems returnees are facing:

> In majority cases, the health problems of permanent residents with chronic diseases have caused by unhealthy habits of them. For the migrants, the disease drives by stress and high work load. (Health-care worker at a district health centre)

> The patients (return migrants) had problems to adapt to the surrounding condition and to communicate with and understand the family members, friends. Yes, for the migrants it was hard to discover their health problems; therefore, their stress is much more than the permanent residents. They spent time out of the country for a while and aimed to earn money, and when they first hear about their health problems, many people lose their hope to have good living. (Psychologist 1)

> They face problems related to adaptation of social life of the country, communication and reunification of families. Returnees lack communication skills, find it difficult to adapt to the Mongolian style of life. (Psychologist 2)

> Returnees are more stressful. Returnees have chronic stress and poor support from the society. (Surgeon)

To gain an insight into the feelings and challenges returnees are facing, the case study of Bayarmaa is presented.

CASE STUDY
Bayarmaa[46]

Bayarmaa is a 30-year-old woman who returned nine months ago after living in the Netherlands for eight years. Before leaving Mongolia, she was diagnosed with thyroid problems, but she did not get treated. In the Netherlands, she felt stressed out and tired, could not sleep at night, lost weight and had no appetite. She felt that she was not always understood. Since her return, her health has improved because of the treatment she has been receiving. The symptoms she had in the Netherlands have disappeared.

In Mongolia, she moved in with her father, brother, sister-in-law and niece. Her father is retired and her brother has no permanent job; her sister-in-law is a homemaker. Living conditions on the outskirts of the city are poor, with no running water in particular. Access to health care is limited due to long travel time, usually up to two hours. Her brother is pushing her to start finding a job, but she feels that her brother does not understand her situation. She knows that from the outside she looks healthy, but she feels nervous, stressful, frightened and disappointed; she cannot be alone, as she cries when left unaccompanied. Bayarmaa has no friends apart from the befriended physician.

She feels she should get more diagnostic testing, since she is not receiving full treatment, and feels she is in need of psychological counselling. Apart from her poor health, she also faces other challenges such as shortage of financial resources due to being unemployed, feeling of

45 Communication with the local researcher was challenging since her English was limited. A colleague interpreted for her. The questionnaires that she did were translated by a third person. This made interpretation hard and could cause translation mistakes.

46 This is a fictive name given to the respondent to guarantee her anonymity.

homelessness and feeling of incapable of adapting to the social life in Mongolia. At times, she feels she cannot communicate with Mongolians.

Her goal for the future is to become healthy, get an education and start her own business. She believes that she needs to be able to communicate in her mother tongue, and that the air and surroundings of her home country will help her to recover.

Bayarmaa's story shows that just like living in the host country, getting readjusted to the social community and life in the country of origin is difficult, stressful and poses problems like communication. Sometimes health complaints get worse as migrants move back to the country of origin, or worse, new ones appear.

9.4 Work and reintegration

Of all the interviewed migrants, only one was working (although seasonal); one was not working due to health problems; the other three were pensioners and thus were not working due to old age. All pensioners mentioned setting up of a small business, increase in retirement benefits and an improvement in the national health insurance system as ways to become self-sufficient. The elderly returnees seemed to be well taken care of within the traditional family network. Children talked about them with love and admiration. Although the need to work was determined by the challenging economic circumstances, it seemed that the family members of the returnees were not expecting them to work and provide an income. The three elderly stated that they try to contribute to the household by, for example, baby sitting and doing household chores.

9.5 Recommendations from returnees and family members

All participants in the research were asked if they could give any advice to organizations such as IOM in order to better facilitate the return of people with medical conditions. Mongolian returnees and their family members, compared with respondents from other countries, were the only ones to recommend a spread of the relocation money. The local researcher also agreed. According to her, this is related to the traditional family structure. As previously stated, by tradition, Mongolians live together with family members of more than one generation. The wages and benefits they receive are pooled for shared use. This is also true for the relocation money they receive. Budgeting the money enough to cover a longer period guarantees stretched income for and contribution to the household. This also avoids instances in which the money will be used for purposes other than for the benefit of the returnee. In addition, the researcher recommended a loan system with a low interest rate to improve the ability of returnees to start a new life without having to borrow money from relatives or banks (which provide loans at high interest rates). Other recommendations are as follows:

> Increase assistance for medical support. The reintegration needs more time, at least three to five years, so do the RAS in several instalments through these years and increase the amount. (Return migrant, female, 58, Mongolia)

> To have a centre to support migrants and provide information. (Psychologist at an institute for psychological consulting)

> To translate the information package, which provided by IOM, into our mother languages, as I know many people have language barrier. For example, I did not fully understand the information and contacted the Caritas very late, because of this I could not get their support. (Return migrant, female, 30, Mongolia)

> To make it possible for returnees to connect returnees with Dutch people, who live and stay in Mongolia. Because the returnees often have learned language and culture of the country, where they used to live and miss it. And to vary the amount of money for medical support depending on the sickness type, length of treatment and local price of the health service. (Brother of a return migrant)

> Governments need to define a policy for them as vulnerable group and define their needs. (Surgeon at a specialized public health facility)

9.6 Conclusion

Like the returnees from Ghana and Morocco, the Mongolian return migrants left Mongolia for economic reasons. Even though they left for the same reason, their reintegration seems to depend less upon an economic independency. Traditionally, extended families live together and share housing and income; in this setting, the elderly are being cared for. Even though poverty is recurring in the return migrants' accounts, the biggest challenges for Mongolian returnees are readaption to the Mongolian lifestyle, reconnecting with family members and the lack of mental health awareness in the Mongolian culture, including the non-existence of a mental health-care infrastructure.

The majority of the returnees in this research are retirees. Traditionally, they are not working; they live with their family members who take care of them. The love and support they receive is strong.

Younger returnees, especially those who lived abroad for a long period, might find it more difficult to readapt to the traditional Mongolian lifestyle than the elderly.

In all cases, reconnecting with family members is challenging. The non-existence of mental health care in Mongolia which the returnees can turn to in these stressful times is even more so challenging. More research is needed to determine the reintegration needs of retirees and younger returnees.

Only three returnees were interviewed in Morocco. The rest of the interviews were with four family members or friends, three physicians and a local IOM staff.[47] Due to the stigma associated with return and mental health issues, returnees with mental health conditions and their family members were more difficult to convince to participate in the research. In total, 11 interviews were conducted. In general, Moroccan returnees are relatively young and have been working in Europe without a legal permit. This is also the case for the returnees that were interviewed during the course of this research.

Table 7: General information about the interviewed Moroccan returnees

Return migrant	Age	Gender	Host country	Length of stay in the host country (years)	Length of stay in the country of origin (months)
1	34	M	Netherlands/ Belgium	8	36
2	47	M	Belgium	7	12
3	29	M	Belgium	4	15
Average	37			6	21

Chronic medical problems of the returnees were asthma, nervous breakdown, permanent bowel movement problems,[48] diabetes and TB.[49]

All returnees interviewed for the purpose of this research stated that their health problems got worse after their return to Morocco.

10.1 Availability, accessibility and affordability of health care

Availability

In Morocco, there are public – including university hospitals – and private health-care facilities. These are mostly located in urban areas. The quality of care in public hospitals is fair. Middle-class families and the wealthy avail of private health care, which is of good quality. University hospitals provide excellent health care, too. Nonetheless, according to a physician in a public medical centre, availability of medication there is unsure:

> I must say that the medications are not always available.[. . .] Sometimes there is a shortage of medicines. The patient is cared for but only in terms of a consultation. The patient is there, but only for medical support and care, but not medications. We are unable to provide such care because we lack the means. (Chief medical officer at a health-care centre)

The lack of (enough) medication has to do again with the financial capacity of returnees. Forced to go to public hospitals that do not have access to all medication, returnees resort to dangerous solutions:

> The Government gives me nothing at a health centre except for insulin. The last time I was at the health centre, they gave me insulin and I was forced to buy other medicine. They gave me two bottles of insulin, not enough for me. Sometimes I buy it and sometimes my mother shares her insulin with me. I have to fight for medicine. It's not like when I was abroad, there at least I was comfortable 90 per cent of the time. (Return migrant, male, 47, Morocco)

47 The local researcher was not available to be interviewed by the research coordinator. Therefore, an IOM staff in Morocco was interviewed to provide context information about Morocco.

48 The returnee stated that he had permanent bowel problems which had not been diagnosed in Europe yet. He was struggling with it and still looking for a diagnosis after return.

49 One returnee stated that he had undiagnosed TB. Even though not diagnosed, it is included in the research since the returnee hoped to find a diagnosis for it and therefore needed access to health care.

In Morocco, there is medical insurance meant for the poor, Régime d'Assistance Médicale aux Démunis (RAMED), which helps them purchase medications. However, none of the interviewed returnees made use of the RAMED card. Usually, this was due to the lack of knowledge of the existence of the RAMED card or the challenging process to obtain the card. The bureaucratic process and the long queues are making it difficult for return migrants with medical problems to avail of this insurance.

Due to the lack of proper health care for the poor, civil society tries to fill the gap. Civil society organizations provide health education for all Moroccan citizens, usually focused on a certain medical problem. One of these is Espoir, an organization dedicated to diabetic patients. According to Espoir, at times, public health-care clinics or institutions in Morocco lack insulin; thus, they resort to more resourceful means of getting medications for patients visiting them:

> Sometimes there is a shortage of insulin. For those people who take drugs in tablet form, what do we do in this case?[. . .] We do this in coordination with doctors, even I go around to doctors to collect and retrieve medical samples that will be used for this kind of case, however long it takes me to make a tour to the doctors and see if there are any medical samples. Sometimes there are problems with some doctors who want to sell these samples. But there are doctors who trust us and give us the samples. (Educator at Espoir)

Accessibility

Accessibility of health care in Morocco is compromised by two factors: income and location of residence. The poor do not always have accessibility to the health care they need. The public health care is available, but not for free and the poor lack means to avail of the care. To improve the accessibility of health care for the poor, the Moroccan Government launched RAMED, a medical assistance plan.

> The private health sector is growing twice as fast as public health sector. The growth of the State is slowing down, it takes on the care of chronically sick people and others, and the private sector is growing. In addition, the numbers of rich are very small. There are more poor people and people who do not have the means to support themselves. So all poor people go to health centres and State hospitals and the rich people go to private clinics. Just recently, RAMED, the medical assistance plan for the deprived, was established, which helps the poor access health care, but at the cost of the State. (Chief medical officer at a health-care centre)

Accessibility of health care in the rural areas is limited.

> A returnee who lives in a village or rural area will suffer. In rural areas, there is the problem of access; the lack of transportation to go to the doctor as well as the lack of infrastructure (roads, water, etc.). Health-care staff refuses to go and work in rural areas under these conditions and with patients who are wary of or who oppose health services. (Chief medical officer at a health-care centre)

In addition, accessibility of health-care information is compromised for the returnees. As the chief medical officer at a health-care centre stated:

> A returnee is a very sensitive person. This is a person believed to have vision or ambition, like you, but he isn't taken into consideration and he doesn't have a place here in Morocco. It is very difficult to treat and cure him. First, he doesn't have the language. He has his first language, but it is the custom and habits that are lacking. In general, if you're not trying to really listen to the returning migrant, you're not going to facilitate his access to care. Here, the relationship plays an important role in the ease of access to care. He has no information on health-care facilities. Here in Morocco, there is a problem with access to information. The migrant comes for a consultation and to get information on health-care services. Sometimes he can pay, but he does not know how to access medical help: buy this or do that, he knows nothing. He is lost over here in comparison to the foreign country he was in. Over there, people came to him with the information. In Morocco, people have to search out the information themselves. (Chief medical officer at a health-care centre)

Another factor that discourages returnees to access public health care is the long waiting time for appointments. The lack of free access to specialized or more comprehensive services compromises the care for long-term treatment for the chronically ill.

> The care system is not capable of providing long-term care or treatment for people with chronic health problems. The challenges facing the health system are comprehensive care and [*lack of*] free access to other external health services, such as radiology, cardiac monitoring and coordination between the various health services, public and private. (Privately practising physician)

Accessing health care becomes easier when one has personal connections within the health-care facilities, shortening the waiting time. The state of the health-care system in Morocco in general is challenging, especially for the vulnerable group of returnees with chronic medical conditions. The care for these migrants is compromised by the lack of policies that better meet their needs.

> Moroccans believed that it is the migrant who should assist the State since the migrant left to get rich abroad. Now, we see the opposite. These are migrants who have returned to their country of origin and need help on various levels. So we are not ready. We have not yet created a political system to see how we can meet the needs of these returnees with chronic health conditions. We don't yet have a vision. The health-care system is static. It has not changed to meet the challenges of caring for returnees with chronic health conditions. So it is us who adapt to the returnee. Health personnel adapt and not the health system. In general, there should be a difference between the treatment of migrants and the treatment of other citizens who are poor and needy. The returnees, they are part of a different culture trying to adapt to a new environment. We must help returning migrants – politically, socially, psychologically. This has not yet happened in Morocco for returning migrants. It isn't specific. (Chief medical officer at a health-care centre)

Affordability

The interviewed return migrants and their families live in poverty. This has big implications on the accessibility of health care and has negative implications on their health. As stated before, all returnees said that their health deteriorated after their return. Lack of financial means is, according to them, the biggest factor.

> My health problems worsened in Morocco due to the lack of means and support. It was different in Belgium, where my problems diminished while I was freely taking medications[. . .]. In Mohammedia and in Morocco, I can only get ventolin. Other medications are available but expensive. My health problems are getting worse because of the lack of resources and lack of access to care and treatment.[. . .] Here in Morocco, I get nothing, there is no medical support for either physical health or mental health. If you have the means, you live, but if you do not have the means, you die. If you have an income, you can afford care in private clinics. If not, you go to the public health centre and you wait and wait in line for two or three hours. You're sick and you have pain and you have to wait. Once you arrive at the hospital, they give you a shot and ask you to leave. That is care here in Morocco. (Return migrant, male, 34, Morocco)

> The last time I went to see the doctor; my glucose level was 11, while it should not exceed 7. Seven is the maximum. I went to the doctor. He told me that this is too much. He told me that I have to take medication and go on a special diet and have an ophthalmologic visit. I also needed to consult with a cardiologist because of my cholesterol levels. If not, I could get to a state where I only see black [*blind*], God protect me. I told him that I do not have the means. He wrote an order for me to have consultations for my kidneys, my eyes and my heart. I have long contemplated these consultations. I went to see an ophthalmologist who asked me for 500 dirhams; the cardiologist, 600 dirhams; and the kidney specialist, 300 dirhams.[50] I asked where I could get 1,500 dirhams for these three controls. I turned the page and I threw out this order. I trust in God and there is only one death. That's the problem.[. . .] I make choices, such as when the doctor asked me to take medication and my children needed food, I bought food for my children. So I forget about the medications and the monitoring and give priority to food and schooling for my children. If I see my children happy, it makes me well mentally. (Return migrant, male, 47, Morocco)

50 The national minimum wage is around MAD 2,650.

So the only solution for your care and treatment is money. And there is no money. God help us. (Return migrant, male, 29, Morocco)

The lived reality is that in the daily life of returnees, there is scarcity of money. The financial assistance provided by IOM for the medical care of migrants for the first months after their return does not seem to always connect to this lived reality as one returnee described. Additional money that is not available needs to be used to get payments reimbursed. These experienced difficulties with reimbursement of money from IOM were also noted by returnees in other countries.

As I said, it was my father who helped me [*financially*] to make the consultation and take medications. I send the invoices to the IOM. They send me money or they send it directly to the physician. It's difficult. We pay the travel expenses and the cost of sending the invoices. I now have bills that I have to send them. You must go to the post office to send invoices and wait for the money. It takes a lot of time. For example, to request the rest of the funding that I was granted, I have to contact them by phone, they can tell me that the manager is on vacation or is not in the office. I contacted the office the week after; I was told the manager was not yet in the office. If you are at the office, she says she will contact you and you have to wait for hours and sometimes days. Like that, time passed. I'll see how they help me receive the 800 euros that remain in the contract. I expect the manager to contact me to explain how this will happen. (Return migrant, male, 29, Morocco)[51]

Since returnees often have to borrow money from family members, they are the most affected when the reimbursement process is taking time. This potentially could put a strain on the family support system.

10.2 Social network

All returnees depend financially and for their daily needs on their family members. Although initially being welcomed warmly by family members, the poor circumstances and the stigma surrounding returnees weigh heavily on them and how they are treated by the community.

Morocco has a large diaspora across the world. The social marginalization starts in the country of origin to begin with, pushed them to migrate and risk all in search of a better life in Europe. So they were neither integrated in Morocco nor were they as irregular migrants in Europe, and it is a vicious cycle ending up with them not being accepted back into their country of origin to facilitate their reintegration. On their return, they are re-victimized because of marginalization and neglect of the authorities. Not only the authorities, also civil society has a great responsibility in this. In Morocco, in every city, there is a large number of migrants, either legal or illegal. So, it is a visible community, but it is forced to be forgotten and neglected by various actors. (IOM staff)

The stigmatization of society portraying return migrants as failure, and, in some cases, the stigmatization of their health problems, is part of their experience, leaving them to lead a marginalized life.

Few people around me know my health problems. Fear of being stigmatized sometimes makes me run and hide in order to take two puffs of ventolin. I feel ashamed. I do not tell them my health problems. Here in Morocco, people see those who have retuned sick from abroad as bad. They may not want to drink after me even though asthma is not a contagious disease. As for my colleagues, I have not informed them. They will not help me. As you know, in Morocco, if you tell people about your problems, they will view it as negative, they will not support you. It does not make sense to tell them. I cannot tell them that I am sick because they will not give me any support. (Return migrant, male, 34, Morocco)

Of all countries in this research, the stigmatization and marginalization of returnees in Morocco was most hardly felt and prominent in their stories. Despite this stigma, the returnees are mostly supported

51 Reintegration work in IOM Morocco (Rabat) is understaffed, and funding based on small service fees only covers staff costs for one person. It can therefore be difficult to cater to the personal needs of each returnee. Consultations in IOM Morocco are carried out on the phone. Returnees are normally not received at the door. The standard procedure for a payment takes around two weeks.

by their family members; this does not mean though that they always feel understood. Constant financial and emotional support is of great importance.

> We need to note the importance of family support to facilitate the acceptance of migrants in their old/new social environment. The majority of migrants who are assisted financially but not supported by their families have little to no chance at succeeding their social reintegration. Among these cases, there are people who have returned to live in the street, as they were rejected by their families. There are two important "stabilizing factors" for reintegration of returnees with chronic medical conditions: family support and financial assistance. The role of the family is essential. It was instrumental in the successful cases. (IOM staff)

The stigmatization and marginalization leads to isolation and social exclusion, both by the community and even by the family.

> No, I have no friends now. My only friend is now in Belgium. Here, I want to have friends, but I do not know how. When I'm in the street, I always keep my head down. With all my problems, I try to adapt to the new environment. With all the people talking about me, I prefer to isolate myself.[. . .] If I know in advance that, if I discuss my problems with someone, who I am sure will make fun of me, then why would I talk at all. They will not help, on the contrary. They will ask you what you did with the money you earned during those eight years. Thus, it is better not to speak with anyone. I talk to myself.[. . .] I only have my brother-in-law that I talk to about my poor physical and mental health. He is educated and well aware of what I'm going through. He is the only one close to me. He is the only one who listens to me and understands me. Other family members do not want to listen to me. They see that my health condition is weird. I do not want anything from them but silence. (Return migrant, male, 29, Morocco)

> No, it's my family that welcomed me. Friends and neighbours laugh at me, they say I'm lazy and that others have become wealthy there. It hurts me and I avoid them. Friends behave normally; I see them in a café. Sometimes I feel that they are hypocrites. One of my friends told me that I'm not smart. The other men have managed to buy cars and houses while I've failed to do the same. You know, here in Morocco, the family is a private area not to touch. Here, in Morocco, if you start telling people your problems and express all the ills you suffer, if you explain that you're unemployed and you need help, people will not respect you . . . no one will respect you and they will laugh at you.[. . .] All the family members are concerned with my health in their own ways and suffer when they see me sick and in crisis, but they do not have the means to help. Everyone has a family, children and a lot of responsibility. (Return migrant, male, 34, Morocco)

The return migrants are seen by society as a burden to their families. They are not seen as bringing anything constructive to society. Thus, they feel the same way about themselves and their situation.

> I cannot wait for him to help, hoping that he will take care of me in the future. It will be difficult because his physical and mental health deteriorates. Even if he is cured, he cannot have children, if he was married, or rent an apartment or find ways to survive. (Mother of a return migrant)

> Members of my family! Poor people . . . there are only my sisters and my brother, who can give me support. They are all married and live far away. There is my mother, an old lady and diabetic on top of that. I am the one who provides her with mental support and I try to keep my suffering to myself. When my father passed away, may God rest his soul. I thought a lot about my family and I thought I could help them with this project [*referring to migration to Europe*] . . . my family is still waiting for help from me. (Return migrant, male, 47, Morocco)

> The level of welcome has changed. The warm welcome is gone. I do not talk to them about my problems, I avoid them. If someone asks me how I live I tell them that I am fine, if not they will stigmatize me and judge me. They will talk about how I was and how I have become. They will say poor Amed.[52] I hate to hear that. What can I do? I greet them and it's over. (Return migrant, male, 47, Morocco)

52 This is a fictive name given to protect the identity of the returnee.

10.3 Psychological problems

All return migrants are feeling mentally less stable and more stressed out after their return. The most stressful thing for them is living in poor conditions – not seeing positive change in the future, stigmatization of health conditions and failure as a returnee, isolation and alienation from society, and lack of adequate accessible health care.

> I'm gutted on the inside. Mentally I'm wiped out. If they give me support it would be like a battery that is charged. (Return migrant, 37, Morocoo)

Financial situation

Returnees live in poor slum-like neighbourhoods with no income. Their inability to work due to health problems and the bad economic circumstances result in poverty. In a country where health care is expensive, lack of income is a potential deadly situation. This puts pressure on returnees and their families and creates stress, leading to frustration, physical complaints and, in some cases, outbursts of anger.

> Yes, I became more nervous. It is the lack of financial resources that makes me nervous. I look at my sick mother who needs to be treated by a doctor and I cannot do anything for her. It is normal to be frustrated in my helpless situation. If I get angry, my neck starts to hurt, then my head hurts and then my shoulders cramp. These psychological problems are related to stress and my life situation. For example, since 2010, I have not been able to make annual visits to a cardiologist or eye doctor. Just a cardiology visit costs 900 dirhams but I have to go to Casablanca and until now I do not have the means to go. I can only make an appointment to visit the public hospital. (Return migrant, male, 34, Morocco)

Isolation

The stigma about returnees and their conditions like psychological and mental health problems are marginalizing the patients. This is associated with feelings of guilt and failure both from the returnees end and the family and community. After living for some years abroad, returnees lose their ties with the country of origin, making them feel like they do not fit in society anymore. This creates situations in which either the returnee is isolated from society or out of protection, or fear isolates him or her.

> First, I am weak mentally. In all my life, I never have any problems with anyone in the family or on the street. Now, relations with family members are deteriorating. I prefer to be alone. I am no longer patient. I tell my parents that I prefer to be alone, so that I don't disturb them with my presence. In addition, if I sit with you, I could say something that you will not accept. When I told them that I am mentally ill, my parents tell me what you tell me. They do not know what it means to have a mental illness. (Return migrant, male, 29, Morocco)

> I have a few friends. It is not like before. In fact, I have a problem, God knows its magnitude. Someone may see me as a normal person, but I live with the problem and it is internalized. I avoid friends and other people. I am often alone. I isolate myself. In general, I do not live well. For now, I just want to stop worrying about my health. I want to find some relief. However, there is no one who can help me. My standard of living has dropped completely. I lost weight. I am angry more quickly. I pray to God to heal me and protect me. Wherever you may go, there are people who want to talk to you, maybe someone will insult me, "Amed,[53] why did you came back?" Comments like this. At this point, I try to live alone. I live in my solitude and alone. I isolate myself. Why? Because when I am alone, I release myself [*can let go of everything*[54]]. It is this loneliness that affects me emotionally and I did not realize it. In the future, I will be more affected. (Return migrant, male, 47, Morocco)

The feeling of being alienated and not fitting in plays an important role. Even though the returnees have been back on average of almost two years, this still has not changed.

53 This is a fictive name given to protect the identity of the returnee.

54 Explanation given by the researcher.

> He returned to Morocco and has had a lot of health problems. He did not know how to fit in here in Morocco.[. . .] One says live so you don't die. We barely live. (Wife of a return migrant)

> Yes, there is a difference between local people and migrants who are returning with chronic diseases. The poor do not have the means. My patient asked me as soon as he walked into my office if I could wait for payment until he could collect the money for the consultation; I sympathize with him, perhaps others will not. I see that these people are weak mentally and socially. They are vulnerable, they can do anything. They are thrown back into their country of origin where they feel alienated. (Privately practising physician)

> No outlook of the future; I see the future as a black page. (Return migrant, male, 29, Morocco)

The combination of lack of income, deteriorating health, psychosocial problems and isolation reinforce each other and seem to spin out of control like a downward spiral. Return migrants lose faith in a better future, increasing their stress levels, and for some, creating a situation where suicide seems to be the only solution.

> Of course, what generates these psychological problems. This is the problem, and then there is another, plus another. The result is this "explosion" of psychological problems. I have a lot of various problems. There is illness, money problems . . . you see a simple little thing you want to do, but you do not have the means with which to do it. You see all the doors around you closed. All the exits are closed. You get mad because there is no solution. There is no solution. Not one hand that can help you. So you take charge and take on a big responsibility. Someone else may explode. If God gives you patience and you're thinking, you can resist. (Return migrant, male, 47, Morocco)

> I have a lot of stress and I constantly think and wonder. When I lay down, I'm just thinking about my situation, I can no longer stand up.[. . .] You know, I was thinking about another thing and then, I was back in this thing, without finding solutions. I cannot find solutions. I think, but I cannot find a solution. And I'm getting annoyed despite my patience.[. . .] I lost everything after eight years of working in terrible conditions, being homeless and living in difficult conditions. I have finally gained nothing abroad and nothing in my country. The only thing left is to think about an end to my life. I'm starting to get the idea of ending my life. The idea haunts me. I tried everything, I have depression, and the only thing left is to end this life. Satan made me think of suicide in my head. To fight against that, I tell myself that tomorrow maybe okay. I'm still waiting for aid and support. I live in an area where there is more crime. Its residents are drug addicts. I grew up in this neighbourhood and I've never caused anyone any problems including my family. It's hard for me to steal or sell drugs for money. The only thing to do is to isolate myself at home, with my daily stress and my family who do not understand the problems.[. . .] Mentally, I'm tired. If I cannot find solutions, I have to end my life. I have suffered and others are suffering with me. The only solution left is to end my life. (Return migrant, male, 29, Morocco)

Lack of health care and psychological treatment

The returnees emphasized not having access to medical treatment for their apparent physical chronic problems. All of them also recognized their need for psychological treatment. For the returnees without financial resources, access to mental health care is impossible. The returnees had also been living in the host country under stressful circumstances. The lack of access to the required health care and the discontinuation of medication have taken their toll on the returnees.

> I was given medicine against stress in the Kingdom of Belgium, but here there is nothing. Here, in Morocco, there is no medical support. There is a big difference between Morocco and the Kingdom of Belgium in terms of listening, comprehension and counselling of patients. (Return migrant, male, 34, Morocco)

> I need to visit a psychologist. I have to. I suffer too much. How long can I handle this? It is too much! How many years can I resist? A year? Two? Three? Too much. I need to see a psychiatrist. In Belgium, I went to see the psychiatrist, a neurologist and for the slightest thing. Even if I had a sexual problem, I went to the neurologist. I talked to him. He listened to me. He examined me with

instruments. I left feeling relieved and happy. Here, it is as if I fell into the sewer and I am sinking further and further. Psychological repression, that's my problem.[. . .] So to stay calm I have to talk to a psychologist. You need a minimum of 1,000 dirhams for two sessions. How do I do that? So you hide everything and let yourself go. Before I need support for my psychological problems. I need to confront my physical problems. I need my body to be healthy. I need health consultations for the rest of my life. I must see a specialist for my heart and for my eyes. This will allow me to follow a good path. This will soothe and relieve me emotionally. (Return migrant, male, 47, Morocco)

10.4 Reintegration and work

None of the returnees are working currently, all due to health problems. Their health problems make it impossible for them to work. Or even if they are still capable of working, they cannot find jobs that take their health restrictions into consideration. Two of the returnees have had some irregular income, by taking on either legal or illegal jobs for a short period. The lack of medication and the inappropriate use of medication are the reasons a migrant is not able to hold on to a job.

> The last time, I was employed. I passed out at work because of hypoglycemia. It happened once, and then twice, then a third time before the boss told me it was too much. He fired me. He told me that I cannot work like this. I was a security guard. I told myself that I could work and live and support my children and take my medication, but this still happened four more times and in two different jobs. (Return migrant, male, 47, Morocco)

10.5 Recommendations from returnees and family members

All respondents were asked if they could give any advice for organizations such as IOM in order to better facilitate the return of people with medical conditions. These were their ideas:

> IOM should strengthen psychological support. It should also increase the amount of financial motivation; it would help these people make the decision to return without fear. (Return migrant, male, 34, Morocco)

> I need facilities for work since I have so many ideas. I learned a lot abroad and I speak foreign languages. I heard rumours about the fact that there are Dutch companies. I always wondered why the people who helped us return voluntarily to our country do not help us find work in foreign companies, to see first if there are companies there who can hire us and guide us. (Return migrant, male, 29, Morocco)

> There should be a centre for returning migrants where the migrant can go and be directed to the appropriate health service. Migrants have the right of access to information. It is up to them to know their rights. (Chief medical officer at a health-care centre)

> The first thing is the management of human and material resources. Good governance in the domain of health care is important. Bring the concerns of returning migrants with chronic diseases to health politics with the aim of encouraging the participation of different stakeholders. (Chief medical officer at a health-care centre)

> The State should provide support in terms of free services and grant migrants a RAMED. The State and civil society must inform returning migrants and educate health services and the general public as to the health conditions of migrants. (Physician practising private health care)

> So, we urgently need to discuss publicly the issue of return migrants and encourage more civil society organizations to adopt this cause. (IOM staff)

10.6 Conclusion

Like in all other countries included in this assessment, the economically deprived situation and the inability to be financially independent are limiting factors for returnees in Morocco. However, social exclusion and the stigma about their health problems and their return migrant status are inhibiting the reintegration the most. While migrants in other countries can count on the moral support of their family members in these challenging times, the Moroccan returnees lack the feeling of being supported and welcomed back within their close families. Although they are financially supported and are allowed to stay in their own homes, returnees do not feel understood by their families and therefore live a relatively isolated life. Sustainable reintegration in Morocco is therefore possible only when return migrants are socially accepted and the stigma of health problems is removed. Only then will it be possible for returnees to work on being financially independent and reintegrate into the community again.

Part III

Conclusions

11.1 Conclusion

Previous chapters have presented narratives of return migration experiences and have given insights into the lived reality and daily struggles of return migrants and their families. Although the recruitment of respondents poses limits on the representativeness of the research, the data gives us guidance on the challenges return migrants with chronic medical conditions face trying to reintegrate into their countries of origin. These interlinked challenges include the high costs of medication and health care, psychological problems, economic dependency on family, unemployment and stigma. This chapter provides recommendations to address these challenges.

Affordability of health care and medication

Affordability of health care is one of the most challenging situations for returnees with chronic medical conditions. Although availability and accessibility of health care were problematic in some of the countries, affordability of health care was felt hardest by all returnees. As a result, out-of-pocket money is spent on diagnostic examinations, medications and health-care services. These high costs limit migrants' access to health care, with potential serious consequences for people with chronic medical conditions, leading to potential complications that will increase the need for medical care and therefore medical expenses.

In addition, physicians in the country of origin are requesting that medical records from the host country be accessible to them. Although returnees bring their medical records, they are usually only available in the host country's native language. As a result, diagnostic testing has to be repeated, which leads to high medical expenses for the returnee.

The inability to pay for the high cost of health care, the lack of income, dependency on others and the lack of a promised free access to health care result in high stress levels for both the returnees and their family members. The lack of free access to health care and medication that the returnees have experienced is caused by a number of factors: the country's essential list does not contain the medication needed by the returnee; the health system in the country of origin is corrupt, thus under-the-table payments are the norm; migrants have no confidence in the quality of medication accessible in public health care; and diagnostic exams are only available in private health care. While in the host country access to free medical health care had been promised, this was not fulfilled upon migrants' return, resulting in returnees bearing feelings of disappointment and being cheated upon. The lack of access to medication in the country of origin also results in dangerous situations in which medications are taken inconsistently or not at all.

Corruption in the health-care system has no room in IOM's reimbursement programme. Since under-the-table fees are not recorded in invoices issued by medical facilities and to be submitted to IOM for reimbursement, returnees resort to paying these under-the-table amounts out of their own pockets or seek the more expensive private care instead where under-the-table fees are not common.

In addition, the impoverished living conditions, the experienced chronic medical conditions of other household members and the multiple chronic conditions the returnees are quite often dealing with make health-care expenses high, relative to the total household income. This situation puts the returnee in a dilemma as to which to prioritize at a given time – basic needs such as food or health needs such as medication, or who within the household needs medical attention first in case another family member is also in need of health care. Since IOM's financial assistance for health care is exclusively allocated for returnees, as mentioned by return migrants, when other household members need treatment too, this can lead to inner personal conflicts for the returnees, increasing their stress levels.

Psychological consequences of returning

Returning to the country of origin is stressful for returnees. Stress-inducing factors indicated by returnees were readjusting to the life in the country of origin, reconnecting with family members, living in an economically and socially challenging environment, lacking financial means for medication, being chronically ill, dealing with disease-related taboos, managing community pressure to fulfil a certain role and pre-existing psychological problems. The applicability of each of these factors differs from person to person and depends on how one copes with each of them. These stressful elements result in the returnees bearing feelings of being a burden and having a shattered outlook of the future.

Regardless of how many of these factors are applicable, the overwhelming majority of the returnees feel an increase in stress levels and nervousness after returning. Readjustment[55] to the life in the country of origin is challenging and in some ways even paralyzing. Returnees express having, among others, outbursts of anger, insomnia, nervousness and thoughts of suicide.

In addition, there is gap in the shared stories between family members and returnees. Returnees did not share their experiences in the host country with their family members. The longer a returnee stayed in the host country, the less common ground there is between the returnee and his or her family members, and the harder it is for the returnee to adapt back into society. Therefore, returnees and their family members are in need of long-term psychological support and frequent follow-ups. The key is to mentally prepare the returnees and teach them how to deal with the challenging circumstances they will face. Indeed, the majority of the factors faced by the returnees are unchangeable and part of the general economic, social and political development of individual countries.

Social network

In all countries, the nuclear family is the returnee's social security support system, with the exception of Ghana, where the maternal extended family is included. For the first few months after return, the relocation money received from IOM is sufficient for the returnees to support themselves. Afterward, they will have to depend on family members for their financial needs. In addition, they receive housing, love and moral support from their families.

Relatives and the broader social community are less evidently part of the returnees' life. Return migrants focus mostly on their close family members. This level of relationship of returnees with their relatives and the community is attributed to the pressure and stress caused by these parties. The general idea of a migrant returning rich or affluent increases these community expectations, expectations that the returnees are not able to fulfil.

Migrants who have been in the country of origin as returnees for more than one year are still dependent on family members. Their inability to find a job, either due to health issues or high unemployment rates, was usually given as the main reason for this dependency. In relation to this is the lack of a good working social security safety net. The complicated bureaucratic application processes and corruption limit migrants' access to the social security benefits that are in place. When returnees or their family members are entitled to social security benefits, the stipend they receive is usually too small to support all their needs.[56]

In some countries, there are already existing traditional support systems in place to compensate for the lack of social security benefits. In Mongolia, for example, nuclear and extended families traditionally live together in one household. As a household unit, they support each other, including the elderly. Regardless of how the family structure is organized, the extra financial costs, health prejudices and the inability to live up to expectations put pressure on the returnee's support system.

55 Although it is tempting to use the word *readjusting*, some remigrants have been away from their countries of origin for so long that the term *adjusting* seems to be more applicable.

56 This includes both the daily needs and medical expenses.

Reintegration through work

The majority of the returnees are not working, thus contributing to: i) the high unemployment rate in the country of origin; ii) cases of inability to work due to health problems; iii) the number of retirees; iv) and unfavourable bureaucratic and corrupt circumstances to start a business. The data of this research indicates that the length of stay in the country of origin does not seem to be of influence on the employment rate of returnees with chronic health problems. More long-term research is necessary to determine if the unemployment rate indeed does not change in time. Long-term research in which economically stable countries are compared with unstable countries could give some more insight into the true cause, for example, the lack of a social network or health being an inhibitor to one's ability to work.

Elderly returnees are faced with challenges, too. Since they have reached the retirement age, in most countries, they are not given an opportunity to work. Retirement benefit policies also have limitations in some countries. The number of years of work in the country of origin determines one's eligibility to receive the benefits – returnees who previously worked in the host country even without a work permit but have not worked for a certain number of years in the country of origin will not be able to receive the retirement benefits. Consequently, this increases the financial pressure on the family members who support the returnees.

The collected data in this research cannot identify the challenges faced by different subgroups of returnees. Therefore, additional research is necessary to determine which subgroups face the biggest challenges upon return. For example, it is unclear how the reintegration of female returnees with children is hampered.

Taboo and stigma

Social taboo and stigma is hampering the reintegration of return migrants in some of the countries. Social taboo and stigma was mentioned in Azerbaijan, Ghana, Mongolia and Morocco. This does not indicate that this is not happening in any of the other countries covered in this research. Taboo and stigma is surrounding specific medical conditions and the status of return migrants in society. When taboo and stigma is part of society, reintegration is very limited and returnees are excluded from society to a certain extent. Teaching returnees how to deal with these situations of pressure and social exclusion is very important.

11.2 Recommendations

As a result of the interlinkage of the challenges faced by return migrants, sustainable return can only be reached when multiple factors fall into place. Most importantly, the general economic conditions and the state of health care in the country of origin should be improved. These long-term changes and the inability of the returnee to influence these as an individual allow for a return process that will prepare the returnee to face these challenges. Recommendations of returnees, family members, physicians and reintegration organizations have been provided in previous chapters.

The following recommendations – which aim to make return more sustainable and the processes better adjusted to the needs of return migrants – are based on the outcome of the general analysis, taking these recommendations of other stakeholders previously mentioned into account. Local circumstances, tradition and culture should be considered in all of these recommendations

- **Implement psychosocial support and counselling for returnees.** This should be an integral part of the total return process, which should start in the host country and continue after the returnees' arrival in the country of origin.

  This support should include:
  - Empowerment training;
  - Health education;
  - Training on how to manage stigma and family and community pressure.

- **Take the household as the basic unit of support in return policies.** Since the household is an important part of a returnee's support network, it is recommended that the allocated resettlement funds and services be open to all members of the household when needed.
    - Resettlement funding, including schooling, business support and financial health-care support should be open to returnees and their family members.
    - It is recommended that part of the funds be allotted for the preparation of the returnee's family to provide the family with information or education on the return process, the returnee's challenges and the returnee's chronic health condition.

- **Strengthen IOM network** with already existing local organizations, NGOs, civil society, health-care programmes and facilities, and UNHCR. This aims to:
    - Provide a readily available network surrounding the returnee and his or her family;
    - Optimize the information exchange between organizations about the returnee's needs;
    - Implement education of civil society on stigmatized medical conditions;
    - Create public awareness about return migration and returnees;
    - Implement IOM procedures of systematic analysis on the availability and accessibility of the needed medication and treatment for the returnee prior to return to the country of origin.

- **Assist with strengthening the capacity of returnee policies** in the country of origin to guarantee returnees easy access to medical care and social welfare benefits.

- **Harmonize IOM return packages** for all returnees regardless of the host country to guarantee the same return assistance package.

- **Translate medical documents to preferably the language of the country of origin** before return in order to ensure a smoother transition with the local health-care system and reduce the costs for the returnees.[57]

- **Provide IOM health-care support in small fixed increments** spread over a certain number of months (cash payments in advance and collection of invoices afterward).

57 Most important is to choose a language that physicians in the country of origin are able to read, and at the same time ensure that a language is chosen for which translators are available in the host country.

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Annex I. Interview with the return migrant

Instructions

At the beginning of the interview, the following information should be given to the return migrant:

- This research is done to improve the procedure helping people with chronic medical problems returning to their country of origin. It will not be able to change the circumstances the migrants are currently living in.
- Your (return migrant's) information will be treated with confidentiality and respect. Your personal information like name, age, etc. will be changed in the final report. You will be anonymous.
- Request the return migrant if he/she is willing to sign an informed consent form.
- Ask the return migrant if he/she is comfortable with pictures being taken from them and their living conditions. Make sure they understand they can refuse both. If they don't feel comfortable being photographed themselves, ask if photographing living conditions is OK. Have them sign the consent form.

Location of the interview: The interview should be held in a place that is comfortable for the return migrant, a place where he/she feels free to speak, preferably without relatives being present, since their presence could influence the migrant's answers. If this is not possible, write down who was present at the time of the interview.

The questions in this interview should all be answered. If necessary, please feel free to further explore an answer by asking more exploratory questions. This would apply mainly to subjects that you think mean a lot to the returnee and not all has been said. Just make sure you keep the main focus in mind: to inventory factors that play a role in the reintegration process of migrants with chronic medical conditions. Also, make sure the returnee is comfortable answering the questions and note down the extra questions asked.

Outline of interview with return migrant:

- In total, a minimum of five returnees (and their relatives or support network; see other interviews) need to be interviewed. If you are able to find more returnees and are able to interview them within the time given to you, you are encouraged to do so.
- These returnees should be less than three years back in the country of origin.
- Have chronic medical problems. These medical problems could be physical or mental.
- Should be 18 years and older.
- If you have a photo camera available and the consent of the return migrant, pictures of the return migrant and their living conditions should be taken.
- Answers to the questions below should all be fully transcribed if possible. I would like to receive a verbatim report of each interview. Make sure you write down the corresponding questions down first. This is especially important if you find yourself mixing up the sequence of the questions during the interview.

General information

Name:

Age:

Sex:

Educational level (years in school):

Country where they stayed prior to returning:

Length of stay outside home country:

Since when back in the country of origin:

City, village or region where the migrant is residing:

Type of chronic medical condition(s):

Health

1. What were the health problems for which you needed permanent treatment in the country you resided in before returning to your country of origin?[58]
2. When did this/these health problem(s) start?
3. What do you know about this disease/handicap?
4. Did the health problems get better, worse or stayed the same when you came back to your country of origin?
5. Why do you think your health problems got better or worse?
6. Do your family or relatives know about your health problem?
7. How do your family/relatives feel about your health problems?[59]
8. Do your friends or people in the community know about your health problems?
9. How do they feel about it?

Health care

1. What kind of care do you need for your medical condition?
2. Are you able to get the care you need since you came back to your country of origin?
3. What are you lacking in your country of origin?
4. What are the costs involved for the care you receive?
5. Are you able to finance the costs for care and medication yourself?
6. Is it possible to get government assistance for the medical treatment you receive?
7. Are you able to get the medication you need?
8. How far/long do you have to travel to receive treatment/get medication? (x hours)
9. How often do you have to travel to receive the treatment?
10. What means of transport do you use?
11. What are your travel costs?
12. What is your or your family's income?[60]

58 Interviewers are requested to substitute country of origin in the questions for the country the return migrant is residing (e.g. before returning to Afghanistan, Ghana or Morocco).

59 Additional information for the researcher: This question is meant to find out if there are any negative or positive feelings about the health-care problem itself within the social network. With this, we would like to get clearer answers if there is taboo surrounding the health problem of the migrant.

60 This question needs to be adjusted to the living situation of the migrant. If the migrant is living alone, asking for his or her income is enough. If the migrant is living together with family or relatives and they are providing for them, the question should be focused on the whole family's income (more people could be earning money).

13. Do you think your medication will be still available in the future?
14. Do you think your treatment will still be available in the future?
15. Will you and/or your family be able to afford your treatment and medication in the future?
16. Are there any expectations/indications that your financial situation will change in the near future?

Psychological problems

1. Are you experiencing psychological problems/health problems/or other term (use the word for psychological problems that is used in everyday language in Morocco) next to the health problems for which you need permanent care?
2. What kind of psychological/health problems are these? (As a researcher, think in terms of psychological problems so please ask additional questions if you feel the question is not answered. These health issues can also be pure physical like headache, pain in shoulders/neck etc., and also depression or feeling of tiredness).
3. Are these health problems in your opinion related to stress or your living situation in your country of origin or in the country you lived in before?
4. If so, in what way are they related? Or why are they related in your opinion?
5. Do you feel you receive enough support and understanding from your family in regard to these problems?
6. If not, what is the support you would need?
7. If yes, what is the support they provide you with that is helpful?
8. Do you need any medical attention/treatment in regard to these problems?
9. Are these treatments the same as in the country you lived before?
10. If so, in what way do they differ?
11. Are the treatments or medical support you received in the country that you previously lived in sufficient?
12. Is the treatment or medical support you receive in your country of origin sufficient for this problem?
13. If not, what kind of support/(medical) care would you need?
14. Did these problems influence your decision on moving back to your country of origin?
15. If yes, in what way did they influence this decision?
16. How did these psychological problems/health problems change after returning to your country of origin? Did they get worse/better?
17. Why do you think these changes occurred?

Social network/family

1. Who is living with you right now or who are you living with right now?
2. Did you live in the host country with direct relatives?
3. Did they (all) travel back with you?
4. Who among your relatives are living in your country of origin?
5. How were you received by them?
6. If no relatives are living with you in your country of origin, how did friends or the community receive you?
7. Have you received support from relatives since you came back?
8. If yes, what kind of care or support do they provide?

9. If no, did you get support or receive care from others?
10. What kind of support or care did they provide?
11. Can you discuss your health problem/s with relatives and friends/acquaintances?
12. If not, why is it difficult?
13. What is the general perspective of people in your country about your health problem/s?
14. In what way did the relationship with your relatives change when you returned to your country of origin?
15. Are you able to provide your family and relatives with what they need?
16. If not, what problems are you facing with providing for them?
17. What circumstances need to be changed for you to be able to provide your family and or relatives with what they need?[61]
18. Do you think your relatives/acquaintances are able to support you in the future?[62]

Living conditions

1. Can you describe your living situation – your house, village/town/city; do you live alone or with (direct) relatives, etc.?
2. What are the challenges you are facing living here?
3. Are everyone's daily needs like food and housing met by the people who live with you?[63]
4. Are you able to contribute to the household (financially or by doing household chores)?
5. Do the living conditions of you and your family need to be improved?[64]
6. If yes, how could the living conditions be improved?

Work/Economic situation

1. Did you receive any reintegration funds?
2. If so, how much?
3. Are you working right now? If yes, what kind of work?
4. If not, what are the reasons you are not working? Is this health related or otherwise?
5. Did you work before you returned to your country of origin?
6. If yes, what kind of work?
7. Upon return, did you receive help to find a job or start a business?
8. If yes, who or what organization helped you?
9. What kind of assistance did they provide?
10. Was this assistance sufficient?
11. What kind of assistance do you need to be able to provide for yourself and your family sufficiently?
12. If you are (already) able to fully provide for yourself, is there any additional support you could use to improve your living conditions?

61 Additional information for the interviewer: Think in broad terms – financially, socially and emotionally. The subjects that are important might differ per country/community.

62 The support meant depends on prior conversations. Support may include daily health care, food and financial aid, among others.

63 This can be direct family members, and also relatives or friends depending who the migrant is living with.

64 If the migrant is not living with direct family members, you can ask about the relatives or friends that are taking care of or supporting the migrant. Stay within the context of the household or living conditions.

Past and future

1. Which organizations (in your country of origin and in the host country) facilitated your return and reintegration?
2. What exactly did they do for you?
3. Are you satisfied with the support you got?
4. What positive changes have you been experiencing since you moved back?[65]
5. What were the expectations you had about your return while still in the host country regarding work possibilities, family support and treatment for your health problems?
6. Were the expectations met? To what extent is life different from what you expected?
7. Looking back, would you have made the decision to return to your home country knowing how your life turned out here? Why would or wouldn't you?
8. How do you see your future in your country of origin in regard to your health and work?
9. Are you planning to stay here?
10. What would you advise a fellow country(wo)man with the same medical problem/s living abroad when she/he is thinking about returning to your home country?
11. Do you have any advice for an organization such as IOM in order to better facilitate the return of people with a medical condition like yours?

65 These changes could be focused on, for example, more family (emotional) support, community support and health-related support, as well as better living conditions like housing. Try to ask this question in the broadest perspective. Ask multiple questions if you have to and ask why and how questions to follow up. For example: In what way is the support of your family a positive change?

Annex II. Interview with a family member/relative/ friend of the return migrant

Instructions

Make sure you choose to interview one of the most significant caretaker or person that is closest to the return migrant. If there is no family or relative available, you could choose someone from the return migrant's social network of friends. You could ask the return migrant who you should interview. Who is the person in your personal surrounding who could tell me most about you and your situation? Make sure to ask the returnee if it is OK to interview this person.

Location of the interview: The interview should be held in a place that is comfortable for the family member/relative or friend, a place where the interviewee feels free to speak, preferably without the return migrant being present, since his or her presence could influence the answers. If this is not possible, write down who was present at the time of the interview.

The questions in this interview should all be answered. If necessary, feel free to further explore an answer by asking more questions. This would apply mainly to subjects that you think mean a lot to the family member/relative or friend and not all has been said yet. Just make sure you keep the main focus in mind: to inventory factors that play a role in the reintegration process of migrants with chronic medical conditions. Also, make sure the interviewee is comfortable answering the questions and note down the extra questions asked.

At the beginning of the interview, the following information should be disclosed to the return migrant:

- This research is done to improve the procedure helping people returning to their country of origin. It will not be able to change the circumstances the return migrant are currently living in.
- Your (family/relative/friends) information will be treated with confidentiality and respect. Your personal information like name, age, etc. will be changed in the final report. You will be anonymous.
- Request the return migrant if he/she is willing to sign an informed consent form.
- Ask the family member if he/she is comfortable with pictures being taken from them and their living conditions. Make sure they understand they can refuse both. If they don't feel comfortable being photographed themselves asks if photographing living conditions is OK. State on the informed consent if only one of the two is possible prior to signing the form.

Outline of interview with return migrant:

- In total, a minimum of five family members/relatives or friends need to be interviewed. This means one person from the support system of every return migrant you have interviewed. If you are able to find more return migrants and are able to interview them in the time given to you, you are encouraged to do so. Also, try to interview a family member or relative of each additional returnee.
- The family member/relative or friend needs to be directly involved in some way with the caretaking of the return migrant.
- If you have a photo camera available and have the consent of the returnee's family, pictures of family and their living conditions should be taken.
- Answers to the questions below should all be fully transcribed if possible. I would like to receive a verbatim report of each interview. Make sure you write down the corresponding questions down first. This is especially important if you find yourself mixing up the sequence of the questions during the interview.

Interview with family/relative/friend

This respondent will be recommended by returnee. Preferably, this person will be interviewed without the presence of the returnee. This is to make sure that the family member, relative or friend can speak freely. Only in cases in which this is not possible for reasons of care for person or otherwise the returnee can be present. Explicitly note, however, if this was the case.

General information

Ask for the general information such as name, age, sex and education level.

Health

1. When and how did you learn about the health problems your relative/friend (x) is experiencing?[66]
2. What do you know about the disease of x?
3. Do you have the feeling you have enough information about his/her health problems?
4. What are you able to tell your community about the health problems of x?

Care

1. Do you provide care for x?
2. What kind of care? Health care, financial assistance, other?
3. Did x ask you to provide this care for him/her?
4. Or did you offer the care yourself?
5. How do you feel about offering this care?
6. Do you feel any obligation to be a care provider (e.g. in the light of close family ties or past assistance rendered to you by x or other reasons)?

Support and living conditions

1. In what way are you supporting him/her?
2. What changed in your living conditions when x returned?
3. How much are your extra costs in providing for x?
4. Is x able to support your family like you would expect from him/her?
5. If not, in what way is the support different? What are you expecting from your family member?

Past and future

1. When did you find out x was coming back to the country (of origin)?
2. How did you feel when you heard x was coming back to the country (of origin)?
3. Did you have any concerns about the return migration that concerned your life, for example, health, providing care or financial assistance, etc.?
4. Did you agree with this decision?
5. What would help you in the care for your relative/friend?
6. What would you and x need in order to be able to provide the best possible care for x?
7. What would you advise a fellow country(wo)man with the same medical problem as x living abroad when she/he is thinking about returning to your home country?
8. Do you have any advice for an organization such as IOM in order to better facilitate the return of people with a medical condition like what x has?

66 Make sure to use the return migrant's name to avoid confusion.

Interview with health-care workers

Instructions

It is important to find health-care workers who:

- Work within both physical health-care setting and mental health-care setting. Preferably, choose two health-care workers from each.
- Talk to someone who has experienced treating return migrants. If you must, you could find them through the return migrants you have interviewed. Ask the return migrants or their family members where they are being treated.

At the beginning of the interview, the following information should be disclosed to the health-care workers:

- The goal of the research: to improve the return migration procedure for people with chronic medical conditions.
- Their information will be treated with confidentiality and respect. Ask if people wish to stay anonymous and make sure to write down!
- Ask if it is OK to take pictures from the health-care setting (this can be done indoor and outdoor). Also, if they do not wish to stay anonymous you can ask to take a picture of them.
- Make sure the health-care workers understand that the interview is focused on return migrants with chronic health problems (chronic health problems being defined as a disease of long duration and generally slow progression such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, as well as mental health-care problems such as PTSS, chronic depression and psychosis).

The questions in this interview should all be answered. If necessary, please feel free to further explore an answer by asking more questions, especially if you feel a subject is very important for the interviewee. Just make sure you keep the main focus in mind: to inventory factors that play a role in the reintegration process of migrants with chronic medical conditions. Also, make sure the health-care workers are comfortable answering the questions and note down the extra questions asked.

These questions need to be asked in health-care facilities that provide health care for both physical and mental conditions, preferably, health-care facilities with experience in providing care for returnees.

General questions

1. Can you explain what kind of care your health-care facility is providing?
2. What are your responsibilities within this health-care facility?

General state of care

1. Can you explain more about the state of the health care in your country? (how is it funded; state/private or both, what is the quality of care provided)
2. Is there a difference in health care in rural compared to urban areas? If yes, what is the difference in your opinion?
3. Do people have a free choice in which health facility they can receive their care/treatment?
4. What are the aspects influencing the choice for a health-care facility or provider?

5. Is the health-care system able to provide for long-term care/treatment/support for chronic health problems?
6. If not, what are the challenges the health-care system is facing when providing care for people with long-term chronic problems?

Return migrants

1. Do you have experience with providing care for return migrants? (If the answer is no, the other questions are irrelevant).
2. With what kind of chronic medical problems are they coming to your facility?
3. Are you familiar with the kinds of health problems return migrants are presenting in your facility?
4. Do you have the feeling you have enough information/knowledge about the chronic health problems return migrants are experiencing?
5. If not, what kind or health problems would you need more information about?
6. Do you experience a difference between permanent residents with chronic diseases and returnee patients?
7. If so, what is the difference in your opinion?
8. What would you, as a health-care provider or health-care facility, need in order to provide this group of return migrants with the optimal care?
9. Is this different from the care for the same group of patients who did not go abroad?
10. Is there a government-financed health programme in this country?
11. If so, are return migrants eligible to avail of this programme when returning to their country of origin?
12. Does this health-care programme's reimburse scheme cover long-term chronic problems?
13. What do you see are the biggest hurdles for return migrants needing long-term chronic care/ treatment, for example, for HIV/AIDS, diabetes, hepatitis, cancer? (Name chronic diseases depending on the kind of facility you are at.)
14. What are the challenges you see for returnees with chronic health problems in regard to getting the medical care they need?
15. How do you think these challenges can be overcome?

Annex IV. Interview with a reintegration organization

Instructions

It is important to find organizations who offer reintegration programmes that:

- Have a history record of experience in reintegrating return migrants. Talk to someone who has experience working in the field with reintegrating return migrants. If can't find them otherwise you could find them through your return migrant. You will find a question in the questionnaire for the return migrant about the organization that provided their reintegration.
- Preferably find a local organization, if they are not available choose otherwise and state in the transcription of the interview the reason you choose this organization.
- Interview three employees from three different organizations of which one should be IOM. If three different organizations are not available, you can interview within one organization. Please state so in the transcription of the interview why you did so and make sure you interview people with different job descriptions.

At the beginning of the interview, the following information should be disclosed to the employee or a reintegration programme:

- The goal of the research is to improve the return migration procedure for people with chronic medical conditions.
- Their information will be treated with confidentiality and respect. Ask if people wish to stay anonymous and make sure to write down!
- Make sure the employee understand the interview is focused on return migrants with chronic health care problems which means. . . .

The questions in this interview should all be answered. If necessary, feel free to further explore an answer by asking more questions, especially if you feel a subject is very important for the interviewee. Just make sure you keep the main focus in mind: to inventory factors that play a role in the reintegration process of migrants with chronic medical conditions. Also, make sure the health-care workers are comfortable answering the questions and note down the extra questions asked.

Employees in reintegration programmes

1. What organization are you working for?
2. What is your role within this organization?
3. What kind of services does your organization provide for return migrants?
4. How many return migrants does your organization help on average every year?
5. How many of the assisted return migrants are people with chronic health problems?
6. What are the challenges for returnees in general and returnees with health problems in particular when it comes to reintegration (e.g. finding work and adjusting within the community)?
7. How can these challenges be overcome in your opinion?
8. What kind of role is there for your organization, the government of your country, the family of the migrant and the migrant him-/herself?

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