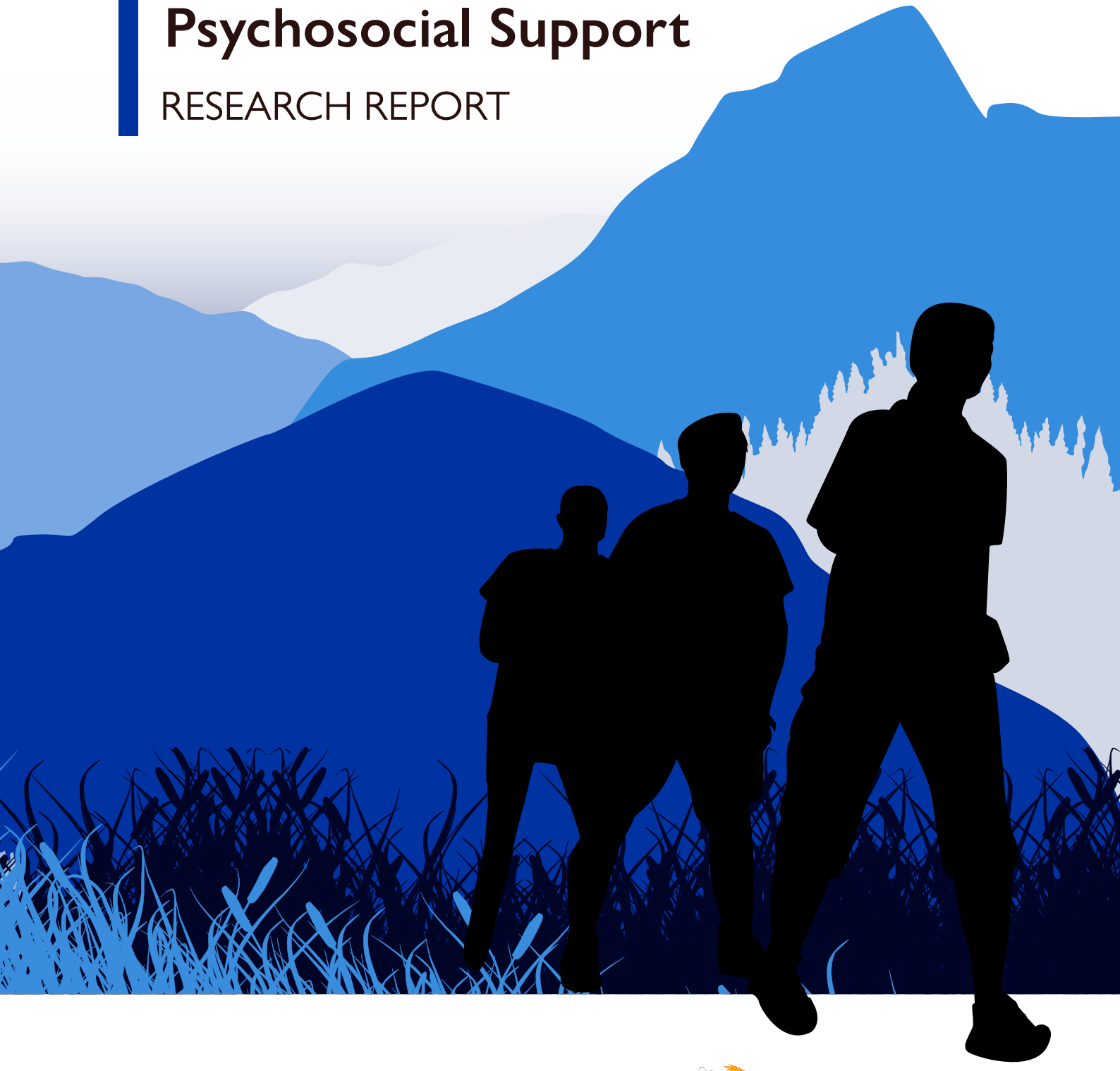
Mental Health Problems of Returned Tajik Labour Migrants and their Experiences Seeking Mental Health Care and Psychosocial Support

RESEARCH REPORT



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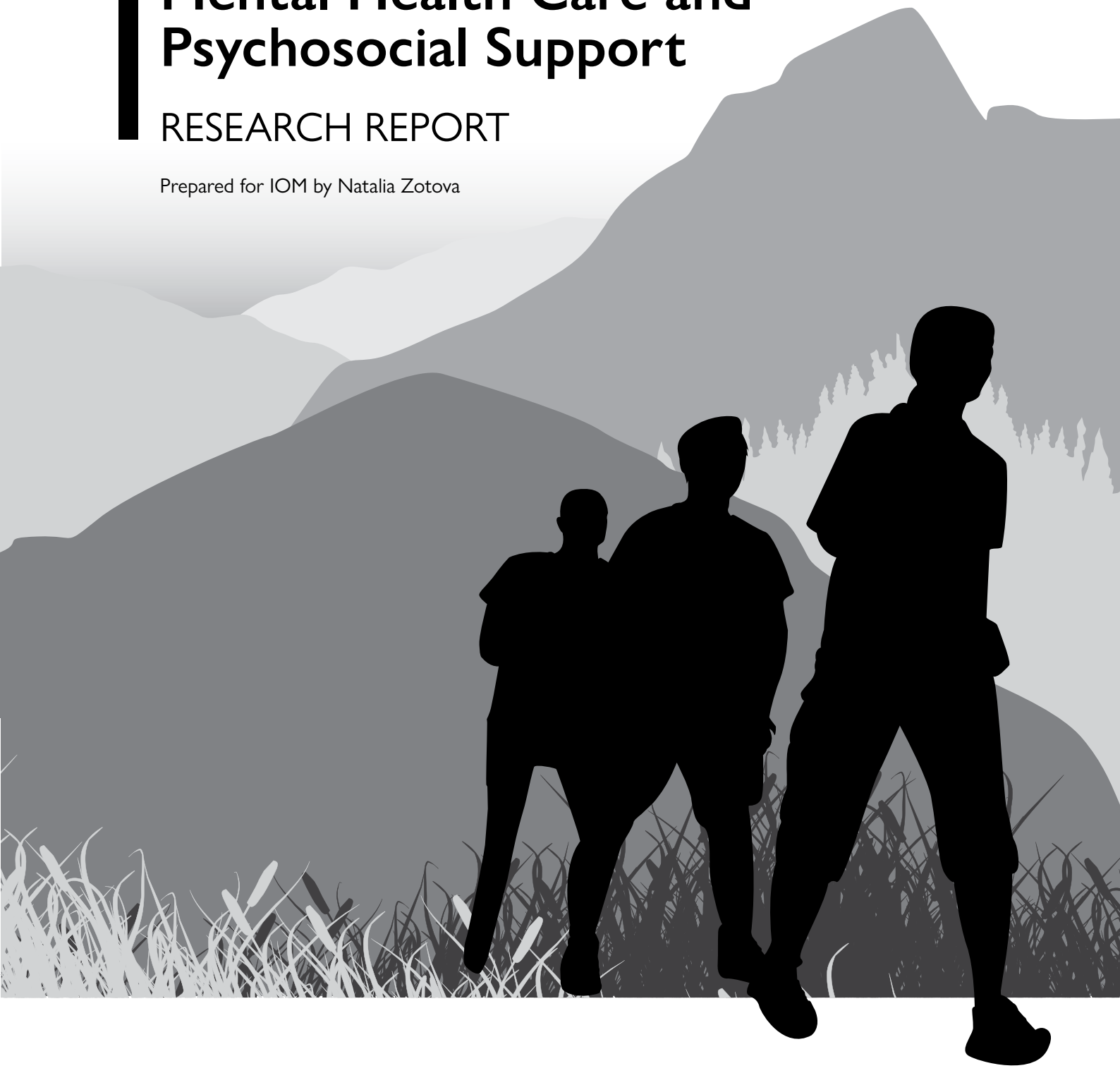
Prepared for IOM by Natalia Zotova



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Abstract

International migration brings multiple benefits to migrants and their families, but it is also a challenging experience that can negatively affect the mental health of migrants. There is a paucity of evidence on the mental health effects of migration from middle- and low-income countries, including the Republic of Tajikistan, a lower middle-income country that has a population of 10 million people. Each year, about 500,000 of Tajikistan's citizens leave the country for employment in the Russian Federation, Kazakhstan and other countries, and 400,000 people return home after living and working abroad. This study was carried out in Tajikistan in 2022 and used an interdisciplinary approach to examine mental health problems among Tajik labour migrants and returnees, and to review existing policies, health-care provisions and social protection services for migrants with mental health issues. Methods employed included a scoping study of the existing literature and expert consultations; a policy review; and four focus group discussions (FGDs) and 50 in-depth interviews (IDIs) with returned labour migrants in the 10 regions of Tajikistan that have the greatest number of returnees. Thematic analysis was used for qualitative data analysis and a socioecological framework was used to identify factors at different levels that affect the mental health of returned migrants.

This study identified gaps in policies and the provision of mental health care and social services for labour migrants in countries of destination and returnees in Tajikistan; poor integration of primary care and mental health care in Tajikistan; and large barriers in accessing services. This study also identified an elevated level of stress among returned migrants associated with migration-related challenges and the treatment gap for mental health problems. IOM recommends developing migrant-centred approaches, including support groups and low-threshold psychological services for returnees, community mobilization programmes to increase awareness of psychosocial well-being and mental health, and developing and implementing integrated protocols for mental health care at the national level.

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List of acronyms and abbreviations

CIS	Commonwealth of Independent States
DMS	Dobrovolnoye Meditsinskoye Strahovaniye (Private Health Insurance in the Russian Federation)
FGD	Focus group discussion
GDP	Gross domestic product
IDI	In-depth interview
IOM	International Organization for Migration
NGO	Non-governmental organization
OMS	Obyazatelnoye Meditsinskoye Strahovaniye (mandatory State-sponsored health insurance in the Russian Federation)
PHC	Primary health care
PTSD	Post-traumatic stress disorder
SSRI	Selective serotonin reuptake inhibitor
STI	Sexually transmitted infection
WHO	World Health Organization

Executive summary

Introduction

In 2021, there were almost 300 million international migrants in the world, comprising almost 4 per cent of the global population. Migration brings multiple benefits to migrants and their families, and contributes to macroeconomic, developmental and demographic outcomes of sending and receiving countries. Notwithstanding its positive effects, experiences of living and working abroad entail numerous challenges that can have a negative impact on migrants' general health and mental health. Health outcomes of large-scale migration is an urgent issue, but the majority of research evidence on psychosocial well-being and mental health of migrants comes from high-income destination countries. While circular migration is very common worldwide, research on the health of returned migrants from middle- and low-income countries is limited, including evidence from Tajikistan.

Background

Tajikistan is a lower middle-income country with a population of 10 million people. Each year, about 500,000 Tajik citizens leave Tajikistan for employment abroad, which amounts to one fifth of the total labour force of 2.5 million people. Over 90 per cent of labour migrants travel to the Russian Federation, while less than 10 per cent move to Kazakhstan and other countries. Women constitute up to 10 per cent of the country's out-migration. In 2020, remittances from Tajikistan's labour migrants amounted to 27 per cent of the national GDP (World Bank, 2022). Tajikistan benefits from labour migration at various levels, but health costs are mostly borne by migrants themselves. Mental health problems and psychosocial well-being have not yet been the focus of research on Tajikistan's returned labour migrants. Notwithstanding the large scope of labour migration, policymakers and donors consider Tajikistan's labour migrants and returnees as part of the general population and are not aware of the specific needs of this population group. IOM Tajikistan jointly with the Ministry of Health and Social Protection and the Ministry of Labour, Migration and Employment of the Population of the Republic of Tajikistan conducted this study to bridge this gap in knowledge. The goal of this study was to gain a better understanding of mental health vulnerabilities and problems among Tajik labour migrants and returnees, and their experiences abroad and at home; and to assess existing policies, health-care provision and social protection services for migrants with mental health issues.

Methods

Carried out in the Republic of Tajikistan in 2022, this study applied an interdisciplinary approach and used methods of public health and medical anthropology. Methods employed included a scoping review of the existing literature and nine expert interviews, a policy review and qualitative data collection from returned labour migrants. Qualitative data from four FGDs and 50 IDIs were collected between May and July 2022 in the 10 regions of Tajikistan with the greatest number of returned labour migrants: Dushanbe, Khujand, Kanibadam, Panjakent, Rudaki, Vahdat, Gissar, Bokhtar, Pyanj and Kulyab. Overall, qualitative data were

collected from 76 returned migrants (47 men and 29 women). The data analysis applied a socioecological framework to identify intersecting factors that operate at different levels and cause distress and mental health problems in Tajikistani labour migrants and returnees.

Results

The scoping study aimed to identify the existing literature on psychosocial well-being and mental health of Tajik labour migrants and returnees; prevalence of common mental disorders; coping and the use of health-care and social services for mental health needs; and to complement findings from the literature with expert consultations. Twenty-six publications in English and Russian were included in the scoping review of the literature, but only a few articles specifically addressed psychosocial well-being, mental health and the use of relevant services by Tajik labour migrants. These publications showed that migrants experienced significant numbers of potentially traumatizing events, had elevated level of stress, and possible indications of depression and post-traumatic stress disorder (PTSD), but had virtually no access to mental care and psychosocial support services in destination countries. No studies focusing on the mental health of returned migrants in Tajikistan were identified. Interviewed experts agreed that international migration is a challenging experience and that mental health vulnerabilities of Tajik labour migrants and returnees merit urgent attention.

Per information from the Ministry of Health and Social Protection of Tajikistan, as of May 2022, there were 44,725 persons with mental disorders in the country, including 10,782 children. National data on mental health problems did not include information on migration backgrounds. In Tajikistan, mental health care remains almost exclusively in the public sector and primarily focuses on inpatient and outpatient specialized psychiatric care. Mental health-care needs more attention from national policymakers and international organizations in the field of financing and training of providers. Mental health needs to be paid more attention in Tajikistan's National Healthcare Strategy 2021–2030 and there is no National Programme for mental health as yet. Per Tajikistan's Code of Health Care, family doctors and primary care providers who have completed special training have the right to diagnose common mental disorders and treat depression. However, in practice, primary care providers often lack training and skills for the provision of mental health care. The Ministry of Health and Social Protection of the Population of the Republic of Tajikistan does not have programmes for the provision of psychosocial services for returned labour migrants. Local administrations could provide limited financial aid to poor families upon request, but no services specifically target returnees or people in distress.

In the Russian Federation and Kazakhstan – major destinations of Tajik labour migrants – access to health care is regulated by national laws and multilateral policies of the Commonwealth of Independent States (CIS).[1] Emergency medical care is free for all citizens of the CIS Member States in the country of their temporary residence, but besides acute conditions, mental health care is not considered an emergency service and is provided on a paid basis. High costs and the lack of or limited medical insurance make access to mental care and other services virtually impossible for labour migrants in the Russian Federation and Kazakhstan.

[1] The Commonwealth of Independent States (CIS) was created in December 1991. Currently, the CIS includes Azerbaijan, Armenia, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federaion Tajikistan, Turkmenistan, Uzbekistan and Ukraine.

FGDs and IDIs with returned migrants showed how exposure to numerous challenges abroad caused significant stress and often continued to affect their psychological well-being upon return to Tajikistan. Micro- and mesolevel factors that affected labour migrants' mental health were the lack of social support in destination countries and work-related problems such as unstable employment, hard work conditions and low pay. Macrolevel structural factors included migration policies and discrimination that shaped migrants' ability to obtain necessary documents, maintain an authorized legal status, and their often-traumatizing encounters with the police.

Stress responses of Tajik returnees most often manifested through somatic symptoms, including headaches and perceived aches in other parts of the body, blood pressure, sleep problems, poor or excess appetite, fatigue and others. Affective symptoms included nervousness, perceived irritability, aggression, no interest in doing things, feeling depressed and suicidal thoughts. Cognitive symptoms included excess thoughts and memory loss and/or inability to concentrate, and social withdrawal was included in the behavioural domain of distress.

Walking in parks or meeting friends, films, music and surfing the Internet helped labour migrants to cope while abroad. Religious practices could also comfort and provide hope to Tajik migrants. About one fifth of men used alcohol and/or smoked to ease their distress. Despite a wide range of coping strategies, labour migrants were unwilling to disclose their psychological and mental health problems to friends and families. Upon return to Tajikistan, being at home surrounded by family and friends helped returnees to cope and improved their emotional condition. Compared with their time spent abroad, returned migrants were more likely to discuss their health concerns with families and seek medical care. Returnees also relied on coping through religious practices.

Tajik labour migrants were not likely to seek medical care for their distress and mental problems in the Russian Federation and Kazakhstan due to high costs and barriers to accessing care. Some participants used painkillers for strong headaches and over-the-counter sedatives. Back in Tajikistan, over a half of participants sought professional help for their physical and mental symptoms of distress, but few were able to see a psychologist. Most participants who sought medical attention received care from family doctors and neurologists, but were often not satisfied with treatment results. Extensive stigma associated with mental illness and mental health care in Tajikistan possibly prevented returned migrants from seeking psychiatric services, but psychological services themselves were not stigmatized. Participants indicated that that they would appreciate available psychological services in the regions and districts of Tajikistan. Government-based social services for returned migrants with psychosocial needs were virtually non-existent in Tajikistan. Community-based organizations for women (mostly non-profit NGOs) were an alternative source of social services and psychosocial support, but none of the female participants turned to these services.

Discussion

This IOM study was the first in Tajikistan and Central Asia to show high levels of stress in returned migrants. Although no validated quantitative measures were applied to assess depression, anxiety and PTSD rates, this study used rich qualitative data to identify important patterns in symptoms and showed that distress manifested through a wide range of somatic symptoms such as headache, elevated blood pressure, fatigue and others. Although returnees needed and sought professional services, most participants did not recognize their condition

as a mental health problem and presented at primary care clinics with complaints about poor physical health and somatic symptoms. Family doctors and neurologists often lacked knowledge and skills to correctly diagnose their condition and treat mental health problems. This creates a very large treatment gap and highlights the need to develop and implement integrated protocols for mental health care, including a list of essential medications with proven efficacy. High levels of stress among returned migrants are an essential public health issue. Possible mental health disorders remain mostly undiagnosed and untreated, which creates health risks for migrants and a cascade of effects for their families and broader society in Tajikistan. Public health and social effects of poor mental health among returned migrants warrant the urgent attention of policymakers and donors.

Conclusion and Recommendations

The following recommendations are derived from the findings of this research study. At the level of policy and capacity-building, we recommend the development and implementation of the National Programme of Mental Health in the Republic of Tajikistan and increased funding for both mental health care and primary health care to strengthen the mental health-care system and scale up services to match existing conditions. It is necessary to develop measures to strengthen the collection of national data on mental health and to integrate migration experiences into existing templates for data collection on mental health. It is recommended that a national representative study should be conducted to assess the prevalence of common mental disorders among returned migrants. We recommend coordinated efforts with the World Health Organization (WHO) to adopt international clinical protocols for mental health care (such as WHO mhGAP, part of the global action plan on migrant and refugee health) and to implement them in primary care; and to develop professional training programmes for primary health-care practitioners, family doctors and neurologists to inform and educate them on mental health problems and standards of care. In the view of the lack of clinical psychologists in Tajikistan, there is a need to develop programmes for the education and training of clinical psychologists in medical universities in Tajikistan and to include migrant health in the curricula developed for mental health-care providers. It is also necessary to strengthen cross-border coordination within the CIS in the field of mental health care and include working meetings on the mental health of migrants on the agenda of the CIS Department of Health.

At the level of service provision, it is recommended that low-threshold services be developed that are easily accessible for returned migrants, such as primary care, community and online counselling services. There is a need to better integrate primary health care and specialized mental care, including the adoption of integrated clinical and routing protocols. It is necessary to develop migrant-centred and community-based programmes to enable and support participatory activities and/or support groups of migrants. Community mobilization programmes may include the development of informational and educational programmes for the general population of Tajikistan to raise awareness and normalize the discussion of mental health in society, and to use national and regional TV and radio channels, as well as social media (via Internet) to broadcast educational programmes on psychosocial well-being and mental health, symptoms of stress, counselling and other support mechanisms. It is recommended that online support groups be developed for the general population of Tajikistan and returned migrants, and to invite psychologists to moderate these support groups to provide guidance, advice and counselling; and to work with religious leaders in Tajikistan to raise awareness about psychosocial well-being and mental health and invite them to include information on the importance of psychosocial well-being, stress and its symptoms, coping and other support mechanisms in their sermons.

IOM's vision of a comprehensive, rights-based, sustainable development-oriented and coherent approach to return, readmission and sustainable reintegration, takes into account the health and well-being of individuals, as well as communities of return.[2] According to IOM's integrated approach to reintegration, achieving sustainable reintegration requires holistic and multidimensional approaches that address a range of economic, social, psychosocial and environmental factors and enhance synergies between different interventions at the individual, community and structural levels – see the *IOM Reintegration Handbook* (IOM, 2019). For this reason, there is a need to integrate mental health and psychosocial support (MHPSS) components in return and reintegration programmes at various level, such as during pre-departure and post-arrival counselling (for example having in the team professionals with specific backgrounds and/or training) as well as in terms of reintegration support and assistance. In this regard, it is also important to establish referral pathways and partnerships with State and non-State actors to respond in a mutually beneficial way to the needs of individual returnees and the communities to which they return, while also addressing the structural factors at play. Migrant-centred approaches may include the development of informational materials (flyers, posters) for returnees and their families to raise awareness about the potential psychological implications of migration experiences, distress and its symptoms, and existing MHPSS services. We recommend distributing these materials in primary health-care clinics, centres for healthy lifestyle promotion, resource centres for migrants, NGOs and community-based organizations, and religious and other facilities regularly frequented by returning migrants and their family members; and to develop online versions of these materials to make them more accessible and to distribute them on social media and other platforms used by labour migrants and returnees. We also recommend that educational sessions and support groups be developed and conducted among returned migrants, facilitated by trained psychologists in different regions of Tajikistan.

[2] See the IOM Policy on the Full Spectrum of Return, Readmission and Reintegration (IOM, 2021a).

Chapter 1. Introduction

Today, every eighth person in the world is a migrant or is otherwise displaced, and these numbers are growing (WHO, 2022:ix). The current global estimate is that there were around 281 million international migrants in the world in 2020, which equates to 3.6 per cent of the global population (IOM, 2021b). Although the scope of migration and its influence on health outcomes are urgent issues, research on the health and well-being of migrants and refugees remains fragmented. The majority of research evidence comes from the high-income countries of Europe and North America that host around half of the global international migrant population (IOM, 2021b). International migration brings multiple benefits to migrants and their families, including opportunities to advance socioeconomically and achieve various short- and long-term goals. Migration benefits sending and receiving countries in terms of macroeconomic, developmental and demographic outcomes. Although migrants and left-behind families may enjoy various benefits from their experiences of working and living abroad, migration is a disruptive event that entails numerous challenges that can have a negative impact on migrants' health (Zotova et al., 2021).

There is a growing consensus about the role of migration as a social determinant of health, due to the negative effects of multiple factors (Castañeda et al., 2015:375). Social determinants are recognized as central to health, as they focus on structural and social factors that impact the health of individuals and population groups (Ibid.; Braveman and Gottlieb, 2014:19). The general and mental health conditions of labour migrants are affected by migration policies and precarious legal status, discrimination, challenges finding jobs, low socioeconomic status, poor working and living conditions in the hosting countries, lack of social support, barriers to accessing health care, fear of detention and deportation, and low health literacy, among others (Castañeda et al., 2015; WHO, 2022). Compared with the general population of host countries, migrants are likely to have higher rates of depression, anxiety, post-traumatic stress disorder and psychosis (Harper, 2016; Rousseau and Frounfelker, 2019; WHO, 2022:124).

Evidence on the mental health impacts of migration from middle- and low-income countries is limited, including from the Russian Federation, which ranks fourth among the top destination countries for migrants and hosts large numbers of Tajik labour migrants (IOM, n.d.:9). There is also scarce research evidence on the well-being and mental health of returned migrants. A study from Ethiopia found a high prevalence of common mental disorders among migrants returning from the Middle East, but only a small proportion of return migrants with mental illness were able to access mental health-care services (Tilahun et al., 2020:681). A study from Mexico showed that returned migrants who were undocumented during their stay in the United States were significantly more likely to report that they experienced psychiatric problems, compared with Mexicans who did not migrate (Waldman et al., 2019:1285). Circular migration is very common worldwide, with migrants moving temporarily in search of economic opportunities and then returning to their countries of origin (WHO, 2022:9). The COVID-19 pandemic was also shown to have had a detrimental effect on migrants' mental health (Acharya et al., 2022; Pedrosa et al., 2020; Spiritus-Beerden et al., 2021) This calls for an urgent need to better understand the impact of migration on return migrants' general and mental health, particularly in countries like Tajikistan that have large out-migration and return flows.

Chapter 2. Background

Tajikistan is a lower middle-income country with a population of 9.8 million people in 2021 (World Bank, 2022). According to official statistics, each year, approximately 600,000 people leave Tajikistan for employment abroad, with the vast majority working in the Russian Federation (National Development Strategy, 2016). The number of Tajik labour migrants significantly decreased during the COVID-19 pandemic, but increased thereafter, totalling about 400,000 people in 2021. Over 90 per cent of migrants travelled to the Russian Federation to work, while less than 10 per cent moved to Kazakhstan and other countries. Women constituted up to 10 per cent of Tajikistan's migration flow (Ibid.). In 2020, remittances from Tajik labour migrant workers constituted 27 per cent of the country's GDP (World Bank, 2022) and contributed to dropping the poverty level in Tajikistan throughout the period from 2000 to 2016, from 81.0 per cent to 30.3 per cent (UNDP, 2017). The time that Tajik labour migrants spend in the Russian Federation and Kazakhstan varies and depends on a multitude of factors, including their ability to find jobs and remit, the labour market and economics in receiving countries, and migration policies (Zotova and Cohen, 2020). The Russian Federation's economic recession in 2014 was followed by the shrinking of many sectors in which Tajik labour migrants used to work and caused a decrease in the flow of remittances to Tajikistan (Grigoriev et al., 2016). Similarly, variable migration policies, particularly deportation regimes, and the Russian Federation's re-entry bans that affect up to 300,000 of Tajikistan's natives, constrain their capacity to travel for work and produce insecurity and stress among migrants, returnees and their family members (Zotova and Cohen, 2020).

Tajikistan benefits from labour migration at various levels, but a significant share of the health costs is borne by the migrants themselves. Tajikistan has been implementing health system reforms in recent years, but the Soviet legacy in the organization and governance largely continue to shape the health sector. The Ministry of Health and Social Protection of the Population of the Republic of Tajikistan oversees health-care services at the national level, while local authorities provide services at the regional and district level. Governance is mostly top–down and decentralization of health policy is limited. The majority of health facilities are public and are owned and operated by local administrations. The private sector has been growing, particularly in diagnosis, ambulatory services and dental care, but its share in health-care services is still low (Khodjamurodov et al., 2016:xvi). Mental health care remains almost exclusively in the public sector and primarily focuses on inpatient and outpatient specialized psychiatric care. A 2016 review indicated that mental health care needs more attention from national policymakers in the field of financing, prestige, and adding more providers (ibid.:xiii). Mental health needs to be paid more attention in Tajikistan's National Healthcare Strategy 2021–2030 (WHO, 2020:14). The Government of Tajikistan has not yet developed and adopted a national programme for mental health. The Ministry of Health and Social Protection of the Population of the Republic of Tajikistan does not have programmes for the provision of psychosocial services for returned labour migrants. Since 2019, the Ministry of Labour, Migration and Employment of Population in partnership with Mercy Corps Tajikistan has been implementing a national programme on the socioeconomic reintegration of returned migrants. This programme supports returnees in their employment search, but does not include psychosocial support. In 2020, IOM alongside three other United Nations agencies – UN-Women, UNICEF, and the Food and

Agriculture Organization – jointly initiated a project to help families left behind by migrant breadwinners and returned migrant families in Khatlon region. This programme works with selected families to provide them access to psychosocial, legal and financial services, and also train women to help them to generate income (United Nations Network on Migration, 2020).[3]

An IOM study over 2018–2020 found that among 351 returned migrants (327 men and 24 women) who took part in a survey, 26 per cent mentioned a migration-related health complaint and 35 per cent said they experienced intense stress and emotions related to their migration experience or return. Out of those experiencing psychosocial distress, 78 per cent expressed interest in speaking to a professional about it (IOM, n.d.). However, Tajikistan's national health statistics do not capture data on mental health issues among Tajiks with migration experience. Non-communicable diseases, including mental health and psychosocial problems, have not been a focus of research on returned Tajik labour migrants, therefore there is a gap in evidence, including its gender dimensions. Notwithstanding the large scope of labour migration, policymakers and donors consider Tajikistan's labour migrants and returnees as part of the general population and are not aware of the specific needs of this group of the population.

IOM Tajikistan jointly with the Ministry of Health and Social Protection and the Ministry of Labour, Migration and Employment of the Population of the Republic of Tajikistan conducted this study to bridge the gap in knowledge on mental health and psychosocial needs among returned Tajik labour migrants and the existing support systems.

Objectives

The overarching goal of this study was to gain a better understanding of mental health vulnerabilities and problems among Tajik labour migrants and returnees, their experiences abroad and at home, and to assess existing policies, as well as health-care and social protection services for migrants with mental health issues. Specifically, IOM Tajikistan aimed to:

(a) Identify the existing literature on mental health problems among Tajik labour migrants and returned migrants;

(b) Describe policies related to mental health care for Tajik labour migrants in destination countries and for returned migrants in Tajikistan, and map existing services;

(c) Understand mental health vulnerabilities among Tajik labour migrants/returnees and factors affecting their mental health, coping strategies, the needs of Tajik labour migrants/returnees and how existing health-care and social protection services meet their needs;

(d) Identify the psychosocial support structures used by Tajik labour migrants and returnees in Tajikistan.

[3] The project "Empowerment of 'Families left behind' for Improved Migration Outcomes in Khatlon, Tajikistan", 2020–2022. More information about this initiative is available at https://migrationnetwork.un.org/projects/empowerment-families-left-behind-improved-migration-outcomes-khatlon-tajikistan.

Chapter 3. Methodology

Study design

The study applied an interdisciplinary approach and used the methods of public health and medical anthropology, including a scoping review, policy review, and FGDs and IDIs with returned labour migrants in Tajikistan. The research team consisted of the IOM International Consultant and a local field team in Tajikistan that included the Field Coordinator and study assistants. Data collection was conducted from May to July 2022 (Table 1).

Scoping study

For Objective 1: Identify the existing literature on mental health problems among Tajik labour migrants and returned migrants, IOM conducted a scoping study of the peer-reviewed literature and other published materials on mental health problems among Tajikistan's labour migrants in Kazakhstan and the Russian Federation and returned migrants in Tajikistan, as well as expert interviews. The scoping study used the Arksey and O'Malley framework, which includes six stages of conduct: (a) specify the research question, (b) identify relevant literature, (c) select studies, (d) map out the data, (e) summarize, synthesize and report the results, and (f) include expert consultation (Arksey and O'Malley, 2005).

To answer the research question "What is known about mental health problems among Tajik labour and returned migrants, substance use, coping, and the use of health-care and social services for mental health issues by labour migrants and returnees?", IOM conducted a search of the published literature. The following electronic databases were searched: MEDLINE (PubMed) and CyberLeninka to identify peer-reviewed articles on mental health issues, substance use, and the use of medical and social services by Tajik labour migrants and returnees. MEDLINE search used the following key words and their combinations in English and French: migra*, mental health*, and Central Asia; and a search query (migrant* OR "return migrant" OR "return migrants") AND ("Central Asia" OR "Central Asian" OR Tajikistan) AND ("mental health" OR depressi* OR anxiet* OR PTSD OR "substance use"). The search strategy was applied to titles and abstracts and was not limited in terms of year of publication.

Titles and abstracts of the articles identified on MEDLINE were screened to select publications that met the inclusion criteria: Tajik and/or Central Asian labour migrants, mental health problems and the use of services, and three sites: Kazakhstan, the Russian Federation and Tajikistan. Abstract screening listed all relevant citations using an Excel spreadsheet. Full texts were then reviewed to ensure the articles met the inclusion criteria. Data were organized in an Excel spreadsheet for the analysis of the published literature. The matrix included the following parameters: Authors, title, language, year of publication, document type, country/countries of origin of study participants, country of destination of migrants, study site, population and sample size, objective of the study, design and methods, general results, results focused specifically on mental health of migrants, results focused specifically on mental health of returned migrants, and noted gaps or recommendations.

This matrix was used to analyse data on mental health problems of Tajik migrants and organize synthesized data into three settings: the Russian Federation and Kazakhstan – two major destinations of Tajik labour migrants – and Tajikistan, where migrants return after working abroad.

A CyberLeninka database search was performed using the same principle. Google Scholar was also searched, using the queries mentioned above in English and Russian for non-peer-reviewed literature such as reports, dissertations and others.

As part of the scoping study, IOM also conducted interviews with national and international experts to capture their perspectives on the mental health status of Tajikistan's migrants and to identify existing services and gaps in service provision. Purposive sampling was used to conduct nine interviews with Tajikistan's national and international experts. Inclusion criteria for interviews with experts were: (a) experience researching health and mental health of Tajikistan's labour migrants; or (b) experience providing social protection or health/mental health-care services for Tajikistan's labour migrants in the country of origin or destination; or (c) maintaining an organizational or administrative role in the field of social protection or psychiatric/mental health services to citizens of Tajikistan. Exclusion criteria: being unable or unwilling to participate in the study.

Interviews were conducted from May to June 2022 (Table 1) using the interview guide (Appendix A). Experts provided oral consent. Interviews lasted 35–50 minutes and were audio recorded. No identifying information was audio recorded. There was no incentive for experts to participate in interviews. Participants included mental health professionals (psychiatrists and psychologists), researchers who study migrants' health and mental health, and staff at non-governmental organizations that provide services for migrants. Seven interviews were conducted in person and two were conducted online via Zoom. Eight interviews were conducted in Russian and one interview was in English.

A matrix was developed to organize the key interview data for analysis and the findings were summarized in analytical memos across the following themes:

- The impact of migration on mental health and psychosocial well-being of Tajikistan's labour migrants and factors that affect mental health;
- Experts' opinion on estimated rates of common mental disorders (depression, anxiety, substance use, PTSD) among Tajik labour migrants and returned migrants;
- Possible gender differences in the manifestation of mental health disorders;
- Coping strategies and help-seeking behaviours for mental health problems;
- The role of the family and social networks/community in helping (returned) migrants to cope with mental health problems;
- State and private health-care services and social services that are available for mental health problems among Tajik labour migrants in the countries of destination and Tajikistan;
- Barriers to accessing these services, possible gender differences in the access to services and gaps in services;
- Regulatory, organizational and other measures that are needed to improve the mental health of (returned) Tajik labour migrants and address their health needs.

The six steps of the scoping study allowed for a comprehensive analysis of the available evidence on the mental health problems of Tajik migrants. In the view of the paucity of available evidence, expert consultations complemented the existing literature and helped to understand better the context and to identify the gaps in knowledge.

Table 1. Timetable of the study activities

Timetable	2022								
Activity	March	April	May	June	July	August	Sept	Oct	Nov
Methodology and tool development	V	V							
Training			V						
Scoping study			V	V					
Policy review			V	V					
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Policy review

For Objective 2: **Describe policies related to mental health care for Tajik labour migrants in destination countries and for returned migrants in Tajikistan**, IOM conducted a policy review of Tajikistan's national and international/bilateral policies regulating social protection and access to health-care services for migrants with mental health problems, as well as possible gaps in service provision that can be attributed to migrants' limited rights and poor access to MHPSS for people who have been abroad. IOM reviewed Tajikistan's national health care and mental health-care policy documents and relevant international policy documents that discussed access to and provision of health care and mental health care for migrants in the Russian Federation and Kazakhstan, and for returned migrants in Tajikistan. Tajikistan's national policy documents were identified and retrieved with the help of stakeholders and members of the study's working group. Policy documents of the Commonwealth of Independent Nations (CIS) including the Russian Federation and Kazakhstan were retrieved from the CIS unified register of multilateral agreements (CIS, 2022). Policy review helped to identify what mental health and psychosocial support services exist in Tajikistan and in what capacity (trained staff, services offered, etc.).

FGDs and IDIs

Study setting

For Objectives 3 and 4: **Investigate the factors, issues, problems, coping strategies and needs of returning Tajik migrants with psychological needs, distress and mental health problems, as well as in how far the existing health and social protection services meet their needs; and identify the psychosocial support structures used by Tajik labour migrants and returnees in Tajikistan**, IOM collected qualitative data in the 10 regions of Tajikistan with the greatest number of returned labour migrants (Raimdodov et al., 2018): Dushanbe, Khujand, Kanibadam, Panjakent, Rudaki, Vahdat, Gissar, Bokhtar, Pyanj and Kulyab.

FGDs and semi-structured IDIs were conducted to identify mental health problems and multilevel factors affecting the mental health of returned Tajik labour migrants and to contextualize their needs, coping strategies and use of social protection and health-care services.

Study population

Inclusion criteria for FGDs and IDIs participants were (a) ≥18 full years and ≤64 full years; (b) experience working abroad in the Russian Federation or Kazakhstan; (c) returned to Tajikistan no more than two years ago; (d) answered positive to the screening question: "Did you experience psychological/mental health problems or distress connected with your experience of migration while abroad or after you returned to Tajikistan?"; and (e) provided written informed consent.

Exclusion criteria: (a) Did not meet inclusion criteria (a)–(d); (b) unable to provide informed consent.

IOM conducted four FGDs (two with men and two with women; 26 participants in total)[4] and 50 semi-structured IDIs (35 with men and 15 with women). The IDIs sample size was guided by data saturation principles on emerging themes, which estimate that at least 30 individuals need to be engaged in semi-structured interviews to reach data saturation (Guest et al., 2006). The initial sample size in Table 2 for each of the 10 regions followed the same principles developed by the IOM study of disability among returned migrants in Tajikistan and aimed to ensure an equal representation of participants from each region.

Tool development and training

Data collection tools for FGDs and IDIs – recruitment scripts, guides and data collection forms – were designed in English and then translated into Russian and Tajik. Prior to the beginning of enrolment, the study assistants – natives of Tajikistan who have experience collecting qualitative data and are proficient in Tajik and Russian languages – participated in a training at the IOM Tajikistan office. The training included sessions on return migration and understanding the psychosocial implications of return migration; ethical principles of data collection and management, including confidentiality and data protection; and study procedures and materials. The training also included principles of Psychological First Aid. If during an interview a participant disclosed information indicating that they are in intense distress or at risk of imminent danger and/or harm, study assistants would do a risk assessment and provide referrals/contact information to appropriate clinical or social services. During the training, IOM also conducted pilot testing of FGD and IDI interview guides in Russian and Tajik languages. Members of the field team worked in pairs to conduct mock interviews, pre-test the guides and ensure that the questions and their wording were comprehensible to participants. Their feedback was used to finalize the guides for data collection.

Recruitment and data collection

Qualitative data were collected from May to June 2022 (Table 1). IOM conducted four FGDs with returned migrants in the cities of Dushanbe and Khujand (one FGD with men and one FGD with women in each city, respectively). Each FGD had five to eight participants. The study assistants first used their contacts within local communities and administrations

[4] See the ethical considerations section for the reasons for conducting FGDs separately for men and women.

to identify returned migrants. Study assistants used purposive sampling and approached people they personally knew who had migration experience. The participants were asked to refer other returned migrants for initial contact. The assistants then called or met with prospective participants to describe the study and offer enrolment to interested persons for an FGD. The assistants used the script for initial verbal recruitment to describe the study and invite prospective participants (Appendix B). IOM obtained written informed consent prior to the beginning of the FDGs (Appendix C).

The IOM International Consultant facilitated FGDs in Russian in Dushanbe and study assistants facilitated FGDs in Khujand in Tajik language using the FGD guide (Appendix D). FGDs lasted for 45 to 60 minutes and were audio recorded. No identifying information was audio recorded. FGD facilitators were assisted by a study assistant who obtained the consent of participants and took notes during the discussion. The study assistant recorded the location, date and time of the FGD, as well as general sociodemographic information on participants (total number, gender and age) in a separate log sheet (sample sheet in Appendix D). Participants who completed the FGD received a small incentive in the form of a food package to compensate for their time. They were also provided with a list of organizations that provide support and assistance for psychological difficulties and mental health.

Fifty IDIs were conducted in June 2022 (Table 1). Forty-seven IDIs were conducted in Tajik and three in Russian. Due to an ongoing conflict in Gorno-Badakhshan Autonomous Region at the time of data collection in May and June 2022, Tajikistan's Government did not allow entry into the region. Those governmental restrictions and safety concerns guided IOM's decision to conduct interviews in two additional districts in Sughd region and Districts of Republican Subordination (RRS) in place of Gorno-Badakhshan Autonomous Region (Table 2).

IOM conducted 35 interviews with men and 15 interviews with women to account for the gender composition of labour migration from Tajikistan. The gender breakdown of the sample represented the gender composition of migration flows from Tajikistan and ensured that women migrants were included in the in-depth interviews in each participating region of Tajikistan. To ensure a diversity of participants' perspectives, IOM randomly selected three municipalities (*jamoats*)[5] from this list of participating regions and conducted no more than three IDIs in each settlement (*kishlak*).

Table 2. Initial and final study regions and sample size for in-depth interviews

Initial			Final		
Administrative territories	Cities and districts	Sample size, people	Administrative territories	Cities and districts	Sample size, people
Dushanbe	Dushanbe	5 (3 men, 2 women)	Dushanbe	Dushanbe	5 (3 men, 2 women)
Sughd region	Khujand Kanibadam	5 (3 m, 2 w) 5 (3 m, 2 w)	Sughd region	Khujand Kanibadam Panjakent	5 (3 m, 2 w) 5 (3 m, 2 w) 5 (3 m, 2 w)
Districts of Republican Subordination	Rudaki Vahdat	5 (4 m, 1 w) 5 (4 m, 1 w)	Districts of Republican Subordination	Rudaki Vahdat Gissar	5 (4 m, 1 w) 5 (4 m, 1 w) 5 (4 m, 1 w)
Khatlon region	Bokhtar Pyanj Kulyab	5 (4 m, 1 w) 5 (4 m, 1 w) 5 (4 m, 1 w)	Khatlon region	Bokhtar Pyanj Kulyab	5 (4 m, 1 w) 5 (4 m, 1 w) 5 (4 m, 1 w)

[5] *Jamoats* are administrative units in Tajikistan that include five to ten villages with a total population up to 30,000 people.

Initial			Final		
Administrative territories	Cities and districts	Sample size, people	Administrative territories	Cities and districts	Sample size, people
Gorno-Badakhshan Autonomous Region	Khorog Wanch	5 (3 m, 2 w) 5 (3 m, 2 w)			
Total		**50** (35 men, 15 women)	**Total**		**50** (35 men, 15 women)

Note: m=men; w= women

In each participating jamoat, study assistants worked with the local administration to identify returned migrants. Study assistants then called or met with prospective IDI participants and used the initial verbal recruitment script (Appendix B) to describe the study and offer enrolment to interested persons. Written informed consent (Appendix E) was obtained prior to the beginning of the one-on-one IDIs.

IDIs were conducted in Tajik or Russian languages by respondents' choice using the semi-structured IDI guide (Appendix F). Study assistants used prompts and probes when appropriate to invite participants to explain and to provide more context and detail. IDIs were conducted in private rooms that ensured confidentiality and were accessible to people with disability. IDIs lasted from 30 to 50 minutes and were audio recorded. No identifying information was audio recorded. The study assistants recorded the location, date and time of the interview, as well as sociodemographic information on participants in a separate log sheet (Appendix G). After the interview, study assistants thanked participants for their time and help, and provided them with a list of organizations that provide support and assistance for psychological difficulties and mental health. Participants who completed the IDI received a small incentive in the form of a food package to compensate for their time. Data collection and management were overseen by the Field Coordinator.

Data analysis

MAXQDA software was used to manage and code the transcripts. IOM developed a codebook of themes based on iterative readings of the transcripts. The coding scheme and analysis used a socioecological framework and thematic analysis to explore multilevel social, contextual and interpersonal factors that affect the mental health of returned migrants; investigate their coping strategies and needs; and examine their access to services and barriers to access. A socioecological framework is widely used in public health research and practice and is useful for an understanding of factors at different levels that affect the mental health of workers and returned migrants. Socioecological models conceptualize mental health outcomes through interactions of individuals, their environment and larger social systems (Golden and Earp, 2012). The socioecological approach helped to identify multiple factors that influence individuals at micro, meso and macrolevels and shape their mental health vulnerabilities and outcomes. Microlevel factors include individual characteristics, behaviours and relationships with family and friends; mesolevel influences pertain to social groupings such as local communities; and macrolevel factors include broader structural factors such as migration policies and laws, health-care systems and others. IOM analysed the transcripts using the constant comparative method to merge themes until saturation was achieved.

Ethical considerations

Data collection, management and analysis adhered to IOM ethical considerations (IOM, 2004:54). The study design and methodology were reviewed and approved by the IOM Tajikistan technical working group, which included eight stakeholders. The review by

Tajikistan's stakeholders ensured that the study was respectful of the laws and cultural norms and was conducted with professional integrity. The study's field team consisted of local interviewers who were fluent in Tajik and Russian, were experienced in data collection and management, and were knowledgeable of cultural norms and gender-sensitive issues.

IOM conducted FGDs separately with men and women to account for gender differences and the comfort of participants, because men and women may feel more comfortable discussing issues, particularly sensitive topics concerning mental health problems, in gender-specific groups. Male and female study assistants were assigned to conduct one-on-one IDIs with participants of their gender to account for the cultural norms of Tajikistan and to ensure the comfort of study participants while discussing sensitive issues. During the informed consent process, participants were informed that interviews were confidential, that IOM would not collect identifying information, and that any identifying information that was inadvertently recorded would be redacted. Participants were also told that they might skip questions if they were feeling uncomfortable, stop the interview, or withdraw from the study at any time they wished for any reason. Informed consent forms included a communication channel for participants to contact IOM if they had questions, concerns or complaints. Consent forms included the name and the contact of the person responsible for the study at IOM Tajikistan.

Sociodemographic data from FGDs and IDIs were collected and managed according to IOM's Data Protection Principles (IOM, 2010). Data were entered into the study database (log sheets) using the participant's study ID. Only project staff had access to this database. No personal data (name, date of birth, address, marital status, etc.) or identifying details were audio recorded during FGDs and interviews. Participants were only referenced by a study ID in the text transcripts of audio recordings. A cross link from the study ID to patient identifiers was only available to the research team in a separate password-protected folder stored on a different encrypted computer at the IOM Dushanbe office. Participants' consent forms were stored separately from research data in locked filing cabinets on site at the IOM Dushanbe office.

To ensure data verification, validation and confidentiality, study assistants:

(a) Did not audio record any participants' identifying information. Only gender and age (not the date of birth) were included in recorded interviews.

(b) Completed data collection log sheets with participants' study IDs and sociodemographic information and stored them on password-protected computers.

(c) Deleted audio records from their computers when the Field Coordinator completed quality control of the records.

Study assistants transcribed/translated audio records of FGDs and interviews into text files verbatim (word-by-word) in Russian language, using the instructions in Appendix H. Interviews completed in Tajik were translated verbatim into Russian by study assistants as they transcribed the records. The Field Coordinator completed quality control and shared transcripts of FGDs and interviews with the IOM International Consultant. When the International Consultant finished review and quality control of transcriptions, audio records were destroyed. The final data set of the study included transcribed FGDs and interviews in Russian. IOM stripped participants' identifiers from all data before conducting analyses.

Chapter 4. Results

Scoping study

Twenty-six publications (23 peer-reviewed articles and 3 other publications) in English and Russian that discussed any aspects related to the psychological well-being and mental health of migrants were included in the analysis. These articles were published over the past 10 years between 2011–2021. However, there was a paucity of evidence on the prevalence of common mental disorders among Central Asian and Tajik labour migrants, their coping and health-seeking behaviours, and the use of health-care and social services for mental health needs.

Two narrative reviews were included in the analysis. Synthesized evidence on the health of migrants and refugees from the former Soviet Union countries in the Russian Federation was identified, but it did not include studies assessing depression, anxiety or psychotic disorders were found (Bakunina et al., 2020). Zotova's narrative review (2021) indicated that Central Asian and Tajik labour migrants were likely to seek health care only for urgent conditions, pregnancy and childbirth, but they did not view their psychosocial well-being and mental health as important health issues that warranted visiting a doctor, particularly male migrants.

Mental health of Central Asian and Tajikistan's labour migrants in the Russian Federation and Kazakhstan

IOM identified 17 studies from the Russian Federation on the mental health and psychological well-being of labour migrants from Central Asian countries and Tajikistan, and access to health-care services for mental health problems. However, only seven articles focused specifically on mental health issues such as depression, trauma exposure, PTSD and psychological distress among labour migrants.

Specific mental health issues

A cross-sectional study conducted in Nizhniy Novgorod and Kazan among 649 Central Asian migrant women from Kyrgyzstan, Tajikistan and Uzbekistan (Agadjanian et al., 2022) compared depression scores between migrant women who had regularized legal status (Russian citizenship or permanent residence) and those who had irregular legal status (temporary residence or lack thereof) and found that regular migrants had significantly lower levels of depression. A study from Novosibirsk (Ovchinnikov and Sultanova, 2016) among 728 male and female labour migrants from Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan compared the rates of depression and PTSD among religious (those who observe norms of Islam) and non-religious migrants and showed that religion was potentially protective for mental health.

A mixed-methods study from Moscow (Weine et al., 2012) used data from 400 survey questionnaires and 40 IDIs with married male labour migrants from Tajikistan and found high rates of traumatizing events, including being beaten by the police or nationalists; having ill health without access to medical care; lack of food or water; and a lack of shelter. Thirty-four per cent of migrants reported one or two direct traumatizing events, while 32 per cent

reported between nine and eleven indirect traumas, such as witnessing traumatizing events or learning about them from friends/acquaintances. About one quarter of Tajikistan's labour migrants (26%) reported a total of three or more symptoms on the five-item Primary Care PTSD screening scale (PCF-PTSD), suggesting that they were likely to have post-traumatic stress disorder. Using data from the same study, Weine et al. (2013) showed that 13 per cent of the total sample reported drug use and 12 per cent reported having used marijuana, while 31 per cent reported severe alcohol use (>3 drinks a week).

A qualitative study from Nizhniy Novgorod and Kazan among 72 migrant women from Kyrgyzstan, Tajikistan and Uzbekistan (Zotova et al., 2021) identified factors at different levels that caused psychological distress, including gendered vulnerabilities, isolation and lack of social support, worry about their families, poor working and housing conditions, economic hardships, and discrimination against Central Asian nationals in the Russian Federation.

Several studies from Kazakhstan used cross-sectional data from a study among internal Kazakhstani migrants and labour migrants from Kyrgyzstan, Tajikistan and Uzbekistan at an Almaty market. Ismayilova et al. (2014) used data from 450 participants and found that half of external migrants (50%) described their health as poor or fair, compared with 36 per cent of internal migrants. Among external migrants, 15 participants (5.2%) scored above the clinical cut-off score for depression and 25 (8.7%) respondents met the criteria for alcohol abuse. Data from a full sample (n = 1,342) of internal and external migrants (Michalopoulos et al., 2018) showed that compared with Kazakhstani internal migrants, external labour migrants were significantly more likely to report exposure to potentially traumatizing events such as being questioned by migration police/State officials about their migration or work status and being arrested by migration police or State officials.

El-Bassel and Marotta (2017) found that among participants who met the criteria for hazardous drinking, a greater proportion were external migrants from Kyrgyzstan and Uzbekistan. An association between hazardous drinking and coming from Tajikistan was not significant. Ward et al. (2018) demonstrated that external migrants were more likely to report greater overall depression, including feelings of loneliness, hopelessness and worthlessness, as well as traumatizing events, than internal migrants. Traumatizing events were positively associated with depression when controlling for age, income and marital status, but social support was a protective factor. Mergenova et al. (2017) showed that perceived social support was significantly higher among migrants from Tajikistan compared with other external migrants. Tajik migrants also had strong social networks of friends or relatives working in the market in Almaty where the study was conducted.

Other studies on labour migrants in the Russian Federation and Kazakhstan did not specifically address mental health, but some findings were relevant for the topic of mental health and access to health-care and social services. Khodzhiev et al. (2017) showed that mental stress was an essential risk factor in unconventional labour organizations (i.e. labour migration), because migrants had elevated anxiety levels. Amirkhanian et al. (2011) used cross-sectional data from 499 male labour migrants to Saint Petersburg, 71 per cent of whom came from Central Asian countries, mostly Tajikistan and Uzbekistan, and showed that labour migrants from Central Asia had significantly higher levels of depression compared with migrants from Eastern European countries, along with poor social support, but showed low levels of substance use.

Management of mental health conditions

Mokretcova et al. (2016) examined the adaptation of 210 male labour migrants from Uzbekistan in Saint Petersburg. They study found that migrants who intended to return home soon had worse psychological well-being and mental health compared with migrants who intended to stay in the Russian Federation, and suggested that migrants who had poor mental health and intended to return home would benefit from programmes that offered pre-departure psychological assistance. Granskaya and Lizhenkova (2015) investigated stress management among 60 male internal and external labour migrants in Saint Petersburg and found, compared with Russian-born workers, that migrants from Central Asia were more restrained, more cautious and more anxious.

Mental health and access to health care

Weine et al. (2012) showed that Tajik labour migrants did not have access to mental health care in either Moscow or in Tajikistan and argued that mental health care for labour migrants should be a public health priority. Sulchan's qualitative study (2020) analysed the perspectives of 10 key stakeholders (researchers, NGOs, staff of international organizations) on access to health services for labour migrants from Central Asia in the Russian Federation and found limited access to health services among labour migrants, particularly a complete lack of access to mental health services. The study also showed that mental health issues were heavily stigmatized in Russian society. A study from Kazakhstan among internal and external labour migrants (Ismayilova et al., 2014) showed limited access to health-care services among migrants: only about 5 per cent of all respondents indicated that they had a regular physician or doctor. Nearly half (45.2%) of the sample indicated that in the past year they needed to see a doctor, but did not.

Mental health of returned labour migrants in Tajikistan and the use of health-care and social services

No studies specifically addressed mental health and the use of mental health services among returned labour migrants in Tajikistan. Seven publications provided some insights on these issues and the impact of migration on families left behind. A qualitative study (Wood et al., 2021) found that male returnees were exposed to different cultural norms while abroad and may engage in risky behaviours, including heavy alcohol use. Despite experiencing potentially traumatic events in the Russian Federation, Tajik labour migrants often neglected their mental health. The study argued that as returned labour migrants bring home drinking culture and other risky behaviours, they may perpetrate gender-based violence within their households, which suggests the need for interventions that address substance abuse issues, mental health services and job-creation opportunities to improve men's mental health. A qualitative study among returned seasonal migrants in Dushanbe (Luo et al., 2012) found that labour migrants reported drinking alcohol in large parties held in their living quarters while in the Russian Federation.

A qualitative study of the effects of Russia's entry bans among returnees (Zotova and Cohen, 2020) found that migration policies produce a cascade of effects on male migrants' mental health due to their limited ability to meet gendered expectations of masculinity and to provide for their families. Another qualitative study (Zotova, 2020) showed that international migration was challenging and that returned migrants may experience extensive worry and thoughts, and feel upset or depressed. On the other hand, migration can bring positive emotions of fulfilment and self-esteem due to an ability to meet one's goals and develop opportunities for a better life.

Findings from the Zindagii Shoista (Living with Dignity) (2019) project showed that among 236 participants, almost a half (49%) of men and only 8 per cent of women reported having ever migrated for work. Mental health was poor at baseline, with a mean depression score (CES-D) of 28.5 for women and 17.9 for men (the cut-off point of 21+ means severely depressed and 16+ moderately depressed). About 12.5 per cent of women and 4.9 per cent of men had suicidal thoughts. By end-line, women and men showed a significant improvement in all health measures, for example, the depression score at end-line had roughly halved to 15.1 for women and 6.0 for men.

A cross-sectional study (Pirova et al., 2018) investigated common mental disorders among Tajik women and found that 26 per cent of the 300 surveyed women had moderate or severe depression, 17 per cent had moderate or severe anxiety and 20 per cent had moderate or severe PTSD. Compared with women with non-migrant husbands, wives of labour migrants reported higher rates of depression, traumatizing events, physical abuse in the past year, and lifetime physical or emotional abuse. For women left behind, being older, living together with more people and having a migrant husband were risk factors for depression. The authors argued that higher depression rates among wives of migrants compared with women who had non-migrant husbands may be explained by a lack of male support and companionship, a greater burden of responsibility for their children, and increased family and housing problems.

Insights from key expert interviews

Experts interviewed included two faculty members at universities in the United States of America, a Ph.D. candidate in public health, four psychiatrists, one of them also serving as a volunteer for an NGO assisting Tajikistani migrants in the Russian Federation, one psychologist, and one staff member of an international organization.

Impact of migration on mental health of labour migrants and returnees and predisposing actors to mental health issues

The experts generally agreed that migration was a difficult and potentially traumatic experience due to exposure to numerous challenges in the Russian Federation and Kazakhstan, including discrimination, detentions and the fear of deportation, negative attitudes and hate crimes against migrants, problems with legal status and lack of rights, linguistic and cultural barriers, low wages, job insecurity, hard working and living conditions, poverty, separation from their families and others. Labour migrants can have a range of physical health problems that come from hard work, labour in the cold and other occupational hazards. Chronic health conditions can also deteriorate. Adverse experiences in destination countries can worsen migrants' mental health and trigger depression, anxiety and PTSD, especially in case of traumatic events such as hate crimes, encounters with the police or detention. One expert explained:

> *"Overall, I think the migration experience is very challenging. People are away from their families. People are exposed to a lot of adversity and face discrimination and police, legal issues, poverty and illness, and things like that. Those can be hard on people's mental health. I think migrants feel homesick, they feel afraid and lonely. People may rely on alcohol as coping, a way of dealing with staying away from their families for a long time in Russia; probably they drink more than they would have drunken in their countries. It's not an easy life. They also have a lot of health problems that come from hard work in the cold. Migrants have adverse experiences: discrimination and other factors that affect them. They work for very low wages, sometimes they don't get paid at all, the jobs come and go. The housing is also very*

bad and unstable; just a very hard life. […] So, I think of [Tajik labour migrants'] experiences as on the pretty traumatic side of a generic migration experience." – Faculty member from the United States

National experts from Tajikistan also pointed out that labour migrants may worry extensively about their ability to find a job and earn while abroad even before they travel to the Russian Federation or Kazakhstan. Adverse migration experiences and exposure to traumatizing events in destination countries may continue to negatively affect the psychosocial well-being and mental health of labour migrants upon return to Tajikistan. Many returnees may feel discontent over their limited ability to reach their goals abroad and can start planning their new trip soon after returning to Tajikistan.

Experts also noted the possible negative consequences of migration for the well-being and mental health of family members left behind, particularly women and children. The wives of migrants may also face discrimination from society, risks of abandonment and divorce, economic dependence, and physical and emotional violence in families, especially when husbands return from abroad for a short stay at home. They are also vulnerable to sexually transmitted infections (STIs) caused by risky sexual behaviours of their husbands while abroad. This may cause additional stress, because treatment for STIs is expensive in Tajikistan. Children and adolescents who have migrant parent(s) have a high burden of stress and elevated rates of suicide. Two experts also noted the positive effects of migration due to exposure to a different sociocultural environment, broadened worldview, and the sense of accomplishment and fulfilment that stems from successful migration experiences.

Gender differences

Experts agreed that gender differences exist in the experiences of male and female migrants, but were unsure which population group had higher rates of mental health problems. Men experience multiple problems and adversity, as well as gendered expectations and the need to provide for the family that affect their mental health in the Russian Federation and Kazakhstan and upon return to Tajikistan. Experiences of migrant women often depend on their marital status and on whether they migrate alone or with their husbands or families. An expert elaborated on gender differences in the psychosocial well-being and mental health of labour migrants in destination countries:

"There are differences in men's and women's experiences in migration and in how they respond to challenges. Most Tajik male migrants have a family they care for and this gives them a sense of fulfilment. Women may come alone to work in Kazakhstan, but they are often divorced and leave children behind with their grandparents. These women feel lonely and miss their families; they may have higher rates of emotional problems. Women who migrate alone are also more vulnerable to adverse experiences and abuse. Single women may also be coerced into sex work. On the other hand, women who are shuttle traders travel to Kazakhstan for a shorter time; they have strong connections with families in Tajikistan and can have lower rates of mental and emotional problems compared with labour migrants". – Faculty member, the United States

Access to health and social care services

Experts agreed that labour migrants and returned migrants were not likely to seek professional help for mental health problems and indicated several reasons for this behaviour. First, Tajikistan's population does not recognize and identify mental health problems, due to lack

of knowledge about mental health and heavy stigmatization of mental illness. In the words of one expert: "For most people, mental health is equal to schizophrenia and that's the last thing on earth they would want to admit that they have. Instead, they might say things like: 'I'm having a life problem' or 'I'm having women's problems', etc., rather than characterizing and classifying their difficulties as a mental health problem." Also, traumatizing experiences are not associated with mental health problems, but ideas of depression or stress are more common. Experts believed that Tajiks are more likely to associate distress symptoms with neurological problems rather than mental health problems. Overall, seeking help for mental health is not common in Tajikistan due to the cultural background, attitudes within society, and the internalized and enacted stigma of mental illness.

Labour migrants are not likely to seek help in the Russian Federation or Kazakhstan for fear of being deported in case they see a doctor and have an illness, or due to high costs of seeing a doctor (from RUB 1,500). In the Russian Federation and Kazakhstan, out-of-pocket payments make up 37 per cent and 34 per cent, respectively, of total health expenditures (World Bank, 2022), which makes health-care access difficult for labour migrants. While abroad, migrants can call doctors that they know in Tajikistan to ask for advice or seek help within their social networks in the host countries. Psychiatrists pointed out that mental health problems usually manifest upon their return to Tajikistan (or pre-existing conditions deteriorate in migration) and returned migrants may seek help within a month of return. However, it may take a long time for returned migrants, even if they recognize the need for professional care, to get professional help, because returnees may first seek advice at pharmacies for sedatives and herbs.

Returned migrants seeking professional health care are more likely to present late and only for acute conditions. People search for doctors through their social networks or come to see family doctors at polyclinics and rural health centres, who can also have limited knowledge on the diagnosis and treatment of mental disorders. Experts indicated that primary care providers often refer patients to neurologists within the same primary care facilities, but neurologists often fail to identify mental disorders and refer patients to psychiatrists, and prescribe medications for somatic symptoms. Treatment may not help due to incorrect diagnosis and medication, and patients may end up seeing a psychiatrist after an extended time. Experts also pointed out that due to the lack of knowledge on mental health problems, social attitudes to mental illness, and stigma, it may take a lot of explanation on the part of doctors/psychiatrists to persuade patients that mental health problems need treatment, even for more common disorders such as depression. People also have difficulties in agreeing to take medication, and find it particularly hard to agree to treatment at an in-patient facility or hospital.

Experts noted that infrastructural and logistical barriers can constrain access to care for returned migrants: primary care doctors are commonly overwhelmed, especially in rural areas of Tajikistan, but patients lack money and time to travel to urban centres. Limited knowledge about counselling services, the lack of trained psychologists and the cost of services prevent returnees from seeking help for their psychological difficulties and mental health problems. Overall, key expert interviews identified large gaps in available health-care and social services for the mental health of Tajikistan's general population and returned migrants, and barriers at different levels in access to services. Besides public and private health care, there exist social support services such as NGOs in the Russian Federation and Kazakhstan that provide legal help, advocacy and psychosocial support for labour migrants. For example, the NGO "Nur" has branches in many regions of the Russian Federation and offers various programmes and support for natives of Gorno-Badakhshan region of Tajikistan.

Nur's volunteers also created a telephone hotline that in a way utilizes a telemedicine model. By calling Nur's volunteers, who are at the same time health-care professionals, labour migrants can receive medical advice, recommendations to see a particular doctor, and labour migrants find help through informal networks. Similarly, there are NGOs in Kazakhstan that provide legal help and social support for migrants. In Tajikistan, there are multiple NGOs and shelters that provide help and support for women who experience gender-based violence and problems in their relationships or marriages. Although staff at these centres act more like lawyers than mental health professionals, they provide a lot of support and advocacy for women who seek their help.

Coping and management strategies

Experts believed that male migrants are likely to rely on alcohol and sports, as well as prayer (men and women alike). Men may start consuming alcohol more frequently or use drugs as a way to cope with problems, adversity and being away from their families for a long time while abroad. It is also important to recognize the role of the religious tradition, as people often reach out to Muslim clergy (*mullah*), who pray and read the Koran as part of religious healing practices. Migrants may reach out to their friends and family to share their concerns and seek support. In Tajikistan, there is no tradition or practice to seek care from a mental health professional, so people would rather turn to close social networks for help. However, there is an issue of low mental health literacy and an underestimation of the problems. Families can help if they identify a problem in someone's mental health condition by recommending seeing a doctor and by assisting them to connect with a specialist. However, families are likely to keep information on potential mental health problems to themselves for fear of stigma. Besides close family and friends, psychological problems and mental health are not discussed within the social networks and local communities because of negative attitudes. In the words of one expert, "There's a tremendous amount of stigma about mental health problems, which links to individual and family honour, because people consider mental illness as casting bad light on the family. People will go to great length to protect family." There are also gender differences in help-seeking behaviours. An expert elaborated:

> *"I believe that women are more likely to seek medical attention. They often have manifestations of anxiety and psycho-emotional stress, but women are more active to see doctors, to seek help. In our culture, men may consider seeing a doctor as a manifestation of weakness. Men can think that they cope and do well, while in reality this is not true. In my opinion, men have higher rates of mental disorders than women."* – **Psychiatrist, Tajikistan**

Policy review and mapping of services for mental health problems of migrants

Tajikistan's policies and mental care services

Specialist mental health care in Tajikistan – psychiatric services – is organized according to the two main regulatory documents: Code of Health Care of the Republic of Tajikistan (Code, 2017) and "Collection of Regulations and Legal Acts of Psychiatric Services and Methodological Order and Standards of Organization of Forensic Psychiatric Expertise and Procedures for Providing Psychiatric Care for Persons with Mental Disorders" (Kunguratov et al., 2018). Article 176 of the Code (2017:121) posits that diagnosis of mental disorders is made according to international standards and classifications. Diagnostic methods and medications for treatment of mental health disorders are conducted according to regulations

of the State body in the field of health-care services. Article 181 of the Code (2017:123) describes mental health-care and social services for persons with mental disorders, guaranteed by the State of Tajikistan. Article 182 of the Code (2017:124) delineates mental health-care professionals and facilities. It states that psychiatric care is provided by psychiatric (and psycho-neurological) facilities regardless of their ownership status, in close cooperation with primary health care and social services. Family doctors and primary care providers who have completed special training have the right to diagnose mental disorders and treat depression.

Kunguratov et al. (2018) outline the principles of organization of psychiatric care in inpatient hospitals and outpatient psychiatric and psychoneurological centres, and the diagnoses of mental disorders that should be made according to the international classification of diseases ICD-10 (2018:18). In disagreement with the Code of Health Care, Kunguratov et al. stipulate that initial screening and diagnosis of possible mental disorders can be only done by a psychiatrist in specialized centres and facilities (2018:106–107). Their document states: "Doctors of other specialties, when they see patients with possible cases of mental disorders, can only provide a presumptive diagnosis" (2018:108). These two major policy documents – the Code (2017) and Kunguratov et al. (2018) – do not identify vulnerable population groups for poor mental health, such as labour migrants and returned migrants. While Kunguratov et al. (2018) provide detailed instructions for recording medical histories, migration background is not part of relevant personal events recommended for inclusion in the patient's medical record.

Per information from the Ministry of Health and Social Protection of Tajikistan, as of May 2022 there were 44,725 persons with mental disorders in the country, including 10,782 children. Among them, 22,358 adults and 6,299 children have disabilities. The largest number of people diagnosed with mental disorders were registered in the regions of Khatlon (13,390 people) and Sughd (14,929 people). Data on migration experiences among patients with mental disorders were not systematically collected, but the Ministry of Health and Social Protection of Tajikistan registered 52 returned migrants among patients treated for psychiatric conditions in State mental care facilities from December 2021 to May 2022. Tajikistan has 1,475 inpatient beds for mental health care, including 70 paediatric beds. There is a lack of psychiatrists in the country. The shortage is exacerbated by the brain drain, as health-care professionals leave for the Russian Federation. Currently, there are 78 psychiatrists in Tajikistan, but there is a need for 140 more specialists to staff all of the country's administrative territories and districts and to provide quality service. There are currently 41 public health facilities that provide inpatient and outpatient psychiatric care (Table 3). Our review did not identify private services or facilities in psychiatric care or clinical psychology.

Table 3. Public psychiatric care facilities in Tajikistan

	Administrative Territories	Facilities[6]
1	Dushanbe, city	Republican Clinical Centre for Mental Illness
	Districts of Republican Subordination (RRS)	
2	Rudaki district	Republican Clinical Centre for Mental Illness
3	Gissar district	Psycho-neurology department (in a hospital)
4	Shakhrinav district	Psychiatrist's office
5	Tursunzade district	Interdistrict Republican Centre for Mental Illness
6	Vahdat district	Psychiatrist's office
7	Varzob district	Psychiatrist's office
8	Navabad district	Interdistrict Psychiatric Hospital
	Gorno-Badakhshan Autonomous Region	
9	Roshtkala district	Regional Psychiatric Hospital
	Khatlon Region	
10	Bokhtar district	Psychiatry Centre
11	Balkhi district	Psychiatrist's office
12	Dusti district	Psychiatrist's office
13	Jaykhun district	Psychiatrist's office
14	Pyanj district	Psychiatrist's office
15	Kubadiyan district	Psychiatrist's office
16	Shakhrituz district	Psychiatrist's office
17	Khurason district	Psychiatrist's office
18	Jomi district	Psychiatrist's office
19	Yavan district	Psychiatrist's office
20	Nurek, city	Psycho-neurology department (in a hospital)
21	Kulyab, city	Psychiatry Centre
22	Dangara district	Psychiatrist's office
23	Mir Said Ali Khamadoni district	Psychiatrist's office
24	Farkhor district	Psychiatrist's office
25	Vosei district	Psychiatrist's office
	Sughd Region	
26	Khujand, city	Regional Psychiatric Centre
27	Isfara, city	Regional Psychiatric Hospital
28	Aini district	Psychiatry Centre
29	Asht district	Psychiatrist's office
30	Buston, city	Psychiatrist's office
31	Spitamen district	Psychiatrist's office
32	J Rasulov district	Psychiatrist's office
33	Gafurov district	Psychiatry Centre
34	Gafurov district	Psychiatrist's office
35	Istaravshan, city	Interdistrict Psychiatric Hospital
36	Kanibadam, city	Psychiatry Centre
37	Devashtich district	Psychiatrist's office

[6] Hospitals, psycho-neurology departments in hospitals and clinical centres for mental illness provide inpatient psychiatric care for acute conditions. Psychiatric centres and offices provide outpatient care.

	Administrative Territories	Facilities[6]
38	Istiklol, city	Psychiatrist's office
39	Sangvor district	Psychiatrist's office
40	Zafarabod district	Psychiatry Centre
41	Panjakent, city	Regional Psychiatry Centre

According to the Code of Health Care, primary care doctors have the right to assess patients' mental health, diagnose mental disorders and treat depression (2017:124). In Tajikistan, health-care services are provided at four levels: village, district or city, regional and national. At the village level, primary health care is provided by family doctors, paramedics, nurses and midwives in health-care centres. At the district or city level, family doctors and specialists provide outpatient services. Secondary and tertiary health-care services are provided at regional and national levels (De and Sici, 2020:2). Family doctors play an important role in the public medical system. Primary care in Tajikistan is a nationwide network of health-care facilities, including polyclinics – public outpatient health-care facilities, in which general practitioners and specialists provide care for a wide range of diseases and injuries – in urban centres and semi-urban localities, and smaller health centres in rural areas. According to Tajikistan's Ministry of Health statistics, the use of primary care services makes up 82 per cent of annual requests for medical services. There are over 4,000 primary care facilities in Tajikistan, which employ more than 4,000 family doctors and 8,711 nurses. Polyclinics usually have family doctors and neurologists, among other specialists. However, a very small number of polyclinics in the largest cities (primarily Dushanbe) have trained psychologists. *Jamoat*-level health centres in rural areas have family doctors and nurses; village-level "health houses" may only have nurses available.

Per "Qualification characteristics of a general practitioner (family doctor)" (Ministry of Health, 2005), primary care providers should have "knowledge, skills, and practical skills in the scope of primary health care for prevention, diagnosis, and treatment of common mental illnesses among adults and children" (Ministry of Health, 2005:15). Specifically, primary care doctors should know symptoms of major psychopathological syndromes and borderline conditions; symptoms of common mental disorders in adults and children; symptoms of alcoholism, drug addiction and substance abuse; fundamentals of clinical and psychological examination of patients; and modern methods of treatment of mental illness, alcoholism, drug addiction and substance abuse. Primary care providers should be able to diagnose depression and eating disorders, and identify cognitive, memory and sensory processing disorders, as well as substance abuse among others.

Had an extensive list of required knowledge and skills of primary care doctors been developed 15 years ago, it could have set the stage for a successful integration of mental health services within the public health system for the general population of Tajikistan, including returned labour migrants. However, the scoping study identified gaps in services for mental health problems. Primary care providers and family doctors are overwhelmed, as they see many patients on a daily basis and are underpaid, and may also lack knowledge and experience to correctly identify mental health problems in patients, including those related to their migration experiences. This leads to gaps in diagnosis and treatment of mental disorders and/or incorrect referrals to specialists for a wide range of somatic complaints that can mask mental health problems. National experts in Tajikistan generally agreed that patients were commonly referred to neurologists, rather than psychiatrists or psychologists (if available). This evidence notes an important gap in the routing of patients with presumptive mental health problems.

The system of healthcare financing and payment for services along with the high share of out-of-pocket payments further complicate access to mental health care for the general population and returned migrants. Health reforms in Tajikistan have aimed to strengthen primary health care (PHC), but it still suffers from underinvestment and low prestige (Khodjamurodov et al., 2016:xiii). PHC services are free and include visits to family doctors, neurologists, and other specialists, if they are available in polyclinics or other primary care facilities. Yet, PHC and mental care need more attention from national policymakers and international organizations in the field of financing and training of providers. On the patient level, lack of integrated mental care policies creates barriers to services due to gaps in routing.

Private mental health-care options are virtually unavailable in Tajikistan due to the small numbers of trained professionals (psychologists and/or clinical psychologists) in most places beyond Dushanbe and other large cities, as well as the cost of services. Non-governmental organizations and State women's centres can provide psychosocial support and advocacy for women, but the small scale of these services and initiatives is insufficient to provide mental health care for all the people who need it.

International policies and access to mental health care for labour migrants in the Russian Federation and Kazakhstan

Kazakhstan, the Russian Federation and Tajikistan are member nations of the Commonwealth of Independent States (CIS) of 10 post-Soviet countries. There are numerous multilateral CIS agreements that regulate their relationships in many fields, including migration. The major document that stipulates provision of medical services to non-citizens and temporary residents, signed in 1997 by the Republic of Kazakhstan, the Russian Federation, the Republic of Tajikistan and seven other CIS Member States, stipulates that emergency medical care is provided free of charge and in the necessary volume to all citizens of the CIS Member States (regardless of their status) in the country of their temporary residence. Non-emergency (planned/elective) medical care for foreign citizens permanently residing in the territory of another State is provided on a paid basis (CIS Secretariat, 1997).

The national legislation of the Republic of Kazakhstan and the Russian Federation aligns with the Agreement and guarantees free provision of emergency medical care (for acute diseases and conditions) for foreign citizens, regardless of their status. However, each country determines the amount of emergency care in its own way, which raises concerns about availability and quality of care. In the Russian Federation, free emergency care for acute conditions (ambulance, emergency care including childbirth, and intensive care) is available for foreign-born individuals without health insurance, but hospitals commonly limit inpatient care for migrants at three days (Demintseva and Kashnitsky, 2016). Migrants' regularized legal status (Russian citizens or permanent residents) allows for health-care access through the use of Mandatory Health Insurance, OMS. Without the OMS State-sponsored health insurance, choices of Tajikistan's temporary labour migrants are limited to emergency care and paid services within State clinics, as well as informal payments to health-care providers or costly private health-care options, including facilities started and operated by Central Asian natives in the Russian Federation's large cities. Since 2010, the Russian Federation's migration laws require that labour migrants purchase private health insurance (DMS) on their own, but basic medical insurance only covers a limited number of services, while most migrants cannot afford purchasing an extended DMS (Sulchan, 2020). Private insurance also requires an agreement between the medical facility and the insurance company. In practice,

insurance companies capitalize on migrants' lack of knowledge about the health system in the Russian Federation, offering them insurance with limited coverage. Labour migrants believe that private DMS insurance provides them with access to health care. However, in practice, providers in public and private health centres may refuse to accept migrants' insurance, because it does not cover particular services or due to a lack of an agreement between the insurer and the health facilities (ibid.).

Kazakhstan has similar legislation regulating access to health care for permanent or temporary foreign-born residents. Foreign citizens permanently and temporarily residing in the Republic of Kazakhstan can only receive medical care on a paid basis (CIS Assembly, 2015). Overall, legislation and health-care policies in the Russian Federation and Kazakhstan, as well as high cost of out-of-pocket and private care options, make access to mental health care for labour migrants from Tajikistan virtually impossible.

Focus group discussions and in-depth interviews with returned migrants

IOM conducted four FGDs and 50 IDIs with returned migrants (76 participants in total) over May–June 2022 (Table 1). Two FGDs were conducted in Dushanbe (one with men, one with women) and two in Khujand (one with men, one with women). FGDs participants were 20–52 years old. IDI participants, 35 men and 15 women, were 19–63 years old (mean age: 37.6) (Table 4). Most IDI participants were married (92%, n = 46), and had secondary education (72%, n = 36). Participants returned home from 1 to 23 months ago (mean time since return: 11 months) after working abroad in the Russian Federation (no one in our sample worked in Kazakhstan).

Table 4. Sociodemographic characteristics of IDI participants

		Men	Women	Total
Age, years (mean)		36.6	39.9	37.6
Education, %	Secondary	74.3	60 .0	74.0
	Vocational	5.7	20.0	8.0
	Higher	20.0	20.0	18.0
Marital status, %	Married	94.3	86.7	92.0
	Single/divorced	5.7	13.3	8.0
Time since return to Tajikistan, months (mean)		11.9	8.9	11.0

Findings from FGDs and IDIs were organized into four main themes: (a) stress factors that affect mental health of labour and returned migrants; (b) the ways participants express and speak about symptoms of distress; (c) coping with mental health problems; and (d) experiences seeking help for mental health problems and availability of health-care and social services.

Participants generally agreed that migration was a stressful experience and indicated that their psychological difficulties and distress manifested during their stay abroad. Men and women also appreciated the positive effects of migration, such as new experiences and an ability to earn and support their families. Notwithstanding these positive effects, returnees spoke about a wide range of factors that caused stress and affected their mental health.

Stress factors

Away from families, worried and isolated

Individual-level factors included being away from families for a long time, isolation and lack of social support. While abroad, labour migrants worried about their loved ones and regularly spoke with families over the phone and/or Internet and received words of comfort and support. However, participants shared that they did not usually speak about their problems and hardships with family. Experienced stress and mental health problems were part of the things that men and women were unwilling to disclose to families. Some of the male participants worked in construction brigades that consisted of fellow Tajik labour migrants from the same part of Tajikistan. Close social ties eased loneliness as the men worked and lived together and discussed all the things that worried them. However, this was not the case for many other men and women whom we interviewed. A male participant remembered:

> *"Loneliness was my biggest difficulty. There were no acquaintances, no friends, no relatives next to me; that was hard. The other difficulty was that I worked with strangers. I was stressed until I could find a common language with them and make friends. It was hard to establish contacts with them".* – **Man, 33, Panjakent**

Work-related problems: difficult to find, hard labour and low pay

Mesolevel factors were linked to employment and working conditions. Labour migrants left Tajikistan in search of jobs and better opportunities to provide for their families and achieve their goals. As such, work-related difficulties become a major stressor that affects migrants' well-being and mental health. Most men worked at construction sites or in the service sector. Migrant women usually had low-paying jobs in supermarkets, hotels and restaurants. Due to problems with legal status, and wide-spread discriminatory attitudes towards Tajik migrants in the Russian Federation, it was often difficult to secure a job. Construction and service jobs commonly entailed hard manual labour, long hours (up to 12 to 16 hours a day), no weekends and days off, and low pay. Migrants were vulnerable to exploitation as employers often paid them less than initially agreed, withheld wages, or did not pay at all. Labour migrants' emotional well-being was directly linked to the ability to earn. An FGD participant succinctly described his feelings:

> *"When we [Tajik migrants] work, we have a lot of strength. We work with pleasure. But when they do not pay us promised wages, that affects the nerves, we lose our health. Family, children, parents wait for the money from us, while we have these problems [wages withheld or unpaid]".* – **Man, 47, Dushanbe**

Participants took pride in their ability to earn while abroad, but acknowledged that hard working conditions, long hours and exposure to a cold climate took a toll on their general and mental health. A female participant who worked as a maid in a hotel and a janitor in a supermarket described how work-related stress caused her mental health to deteriorate, leading to her return to Tajikistan:

> *"The main difficulty there was that my work day lasted 12 hours, from 8 am to 8 pm. I was not allowed to go outside; I stayed in this enclosed space. I felt cut off from the world, to be honest. I felt like in prison; that was very difficult. My employers often demanded that we [migrants] work seven days a week, with no days off. Long work hours made me very tired and affected my health, everything. Because of this, I only stayed in Russia for eight months, and then I returned. Just couldn't be there*

anymore. […] My stress accumulated and, in the end, I could not even lift a blanket to cover myself at night. My hands were trembling, I was shaking, nerves were tense. I had high blood pressure and I felt very bad. I also started having insomnia. I had numbness in my hands at night, while asleep. I don't know if that was from stress, or overwork. My family were very worried and asked me to return before something [bad] happened." – Woman, 52, Gissar

Documents: work permits, residential registration and more

Larger structural factors stemmed from migration policies and caused a lot of stress in labour migrants. The Russian Federation's migration policies require that within 30 days upon arrival, citizens of Tajikistan should obtain a work permit (*patent*) to maintain their authorized legal status and get a job. The lack of a *patent* or other necessary documents can result in detention by the police, deportation and an entry ban to the Russian Federation. Obtaining a *patent* upon arrival is time-consuming, costly and stressful. Labour migrants must obtain a residential registration, pass a medical examination and a Russian language proficiency test, provide finger prints, purchase medical insurance and submit a package of documents along with payment for a *patent*. The cost of the required exams, documents and a *patent* varies across regions, but in Moscow and other major destinations of labour migrants, these combined expenses are high. In 2022, total costs and fees necessary to obtain a *patent* for six months were RUB 48,000–50,000 (approximately USD 700). Participants also discussed difficulties obtaining residential registration due to negative attitudes towards Tajikistan's migrants. FGD participants in the city of Khujand spoke about their problems:

M1: "Tajik migrants were always hiding [from the police] and told them that they needed to do paperwork to get their documents. They said that they need a lot of money on documents and then they will not be able to send money home."

M2: "Due to high costs, many Tajiks do not file paperwork to send more money home."

M3: "Also note that you may rent an apartment and regularly pay your monthly rent, but if you ask the owner to register you in their apartment, they would rather die; they will never agree to register."

M4: "Approximately 80 per cent of the owners do not register us at their apartment, they do not want to register migrants."

M1: "Say you live in the centre of the city, but are registered somewhere on the outskirts [due to inability to register at the place they live, migrants obtain real or fake registration elsewhere]. This causes stress, as they [police] can check your documents at any moment in the street, and without registration, you will have big problems, especially if the police check on an apartment where we are not registered. This means that we can face deportation anytime. This causes a lot of stress." – Men, FGD in Khujand

Encounters with the police

Experiences of Tajik labour migrants with the police were another external factor of stress embedded in larger migration policies and discrimination against Central Asian natives. Encounters with the police in the Russian Federation were stressful and often traumatic. Police routinely stopped migrants for document checks, raided their apartments in search of undocumented migrants, detained them at police stations and threatened them with

deportation. Although the outcomes of everyday encounters with the police varied, stress and fear were pervasive. A male returnee remembered his near-torture experiences:

> *"Police caused me a lot of trouble. I did not have documents, so they would detain me for one or two days at the police station; this was a problem. Anyone would be nervous in a situation when they keep you there for one or two days in a cell with no food, hungry. They did not give me food or water and did not even allow to use the toilet. They said to hold in pee; that I cannot go. They would only let me use the toilet after I loudly protested."* – **Man, 34, Vahdat**

Another participant recounted his nervous breakdown after a police raid:

> *"In Russia, I had a nervous breakdown due to extreme stress. One day, we were sleeping [in a trailer at the construction site]. Without warning, the police rushed in. They began to shout, yell, they had batons in their hands. Wake up! – they shouted. They began to beat the walls with their batons, while cursing and threatening us. We experienced extreme stress. They did not beat us, but they created such an atmosphere of screaming and yelling that it was very scary. They strongly threatened and verbally abused us. They demanded our documents. Then they took everyone to the police station, where there were more threats and shouting. They kept us at the station for two days without food, without water, in the cold. […] I experienced extreme fear. Fear and only fear. Hands and feet were trembling, you cannot resist. You do not know what was going on and how to answer the questions, because you do not know the Russian language. My body was paralyzed with fear; I felt fear all over my body."* – **Man, 25, Pyanj**

Compared with men, migrant women were treated better by the police. They could be stopped for document checks or taken to the police station, but were usually not detained. However, fear of the police and stress were part of women's daily lives in the Russian Federation and could also produce lasting effects on women's mental health.

Negative attitudes and discrimination

Negative attitudes were an essential part of labour migrants' daily lives in the host countries. Participants often spoke about perceived disdain, humiliation and being treated as underclass persons. They were deeply hurt by these negative attitudes and unfair treatment. In the words of one participant: "We are the same humans as locals. I wish we could walk freely, with no fear, and feel equal instead of hiding from the police and being scorned by Russians." Male and female participants provided numerous accounts of discriminatory attitudes that started at border control upon their arrival, and continued into their efforts to navigate the bureaucracy, find employment and apartments for rent, access health care, and many other aspects of their lives. Migrants who had irregular legal status and poor knowledge of Russian were most vulnerable, but even higher education and citizenship did not shield Tajikistan's natives from racialization and negative attitudes. One woman recalled:

> *"Despite the fact that I have Russia's citizenship, people still treat me as a person of a different nationality. The attitude towards me was the same as to other migrants, no difference. Even my higher education did not make any difference. […] This is what you don't like in Russia: when you ask people something, they see that you do not look European, they treat you differently than their own kind. People would not answer, many would basically ignore you. They don't want to listen; they don't want to answer your question. Of course, this irritates a person, it makes me uncomfortable."* – **Woman, 50, Panjakent**

Participants acknowledged that people in the host countries were not uniformly discriminatory towards them; a shared narrative was that "there are good people and bad people". However, a wide spectrum of attitudes of "bad people" towards labour migrants commonly included poor treatment, fraud, unpaid wages, and even violence and hate crimes. Internalized discrimination along with the lack of rights and freedom often caused stress, frustration and perceived hopelessness.

Expressing distress: symptoms of possible mental health problems

FGDs and IDIs with Tajik returnees provided rich insights into the ways they experienced and spoke about distress. Although men and women did not (or were unable to) identify their physical, cognitive and other symptoms as indicators of possible mental health problems, they provided detailed descriptions of their stress responses. Among 186 symptoms and complaints mentioned by participants, 15 repeating symptoms such as "headache", "sleep problems", "irritability" and others were identified. They were organized into four domains of symptoms: somatic, affective, cognitive and behavioural (Table 5). Somatic symptoms were mentioned most often. Participants included them 103 times (55% of all mentions) into their descriptions of distress. Affective symptoms were mentioned 59 times (32%), cognitive symptoms 17 times (9%) and behavioural symptoms 7 times (4%).

Table 5. Percentage of distress symptoms of distress and possible mental health problems among returned Tajik labour migrants

Domains of symptoms	Symptoms	N	%
Somatic	Headache	30	16.1
	Fatigue, no energy	15	8.5
	Aches (all body, muscles, stomach, etc.)	14	7.5
	Sleep problems (insomnia or sleeping too much)	11	5.9
	Blood pressure	9	4.8
	Problems with appetite (no appetite or eating too much)	9	4.8
	"Shaking"	8	4.3
	Spasm and numbness (mostly of hands)	7	3.8
	Somatic, total	**103**	**55.4**
Affective	Nervousness ("nerves")	24	12.9
	Irritability, aggression, loss of control	21	11.3
	No interest or pleasure	8	4.3
	Depressed, low mood	4	2.2
	Suicidal thoughts	2	1.0
	Affective, total	**59**	**31.7**
Cognitive	Thinking a lot	13	7.0
	Memory loss, hard to concentrate	4	2.2
	Cognitive, total	17	9.1
Behavioural	Withdrawal	7	3.8
	Behavioural, total	**7**	**3.8**
Total		**186**	**100.0**

The largest **somatic domain** included eight symptoms: headache, aches (complaints of pain in the whole body, muscle pain and stomach ache), blood pressure, sleep problems (insomnia or sleeping too much), problems with appetite (no appetite or eating too much), fatigue and no energy, "shaking", and spasm and numbness (mostly of hands). Headache was

the most common symptom. About 60 per cent of participants (n = 30) included severe or pervasive headache into their descriptions of experienced distress. In many cases, elevated blood pressure (perceived or real) accompanied headache. Almost one third of participants (n = 15) shared that they felt fatigue. Their energy level was often very low, as participants shared that they "lay flat", "could do nothing because they had no strength", "could not work", "could only sleep". In addition, or separately from headache, participants spoke about aches in different parts of the body, most often in the whole body ("everything ached"), in the stomach or muscles. Problems with sleep (insomnia or excess sleep) and appetite (lack of appetite or overeating) were also common: about one fifth of all respondents included each of these symptoms into their narratives. Finally, 15 per cent of participants (n = 8) spoke about "shaking", usually shaking of hands or perceived trembling of the whole body when they felt distressed. About the same share of participants (n = 7) felt spasms or numbness of hands, but this symptom was only discussed by women.

The **affective domain** of symptoms included nervousness, perceived irritability, aggression or loss of control, no interest or pleasure in doing things, and feeling depressed or in low mood. About half the participants (n = 24) spoke about feeling nervous, but this was a very general complaint that in many cases preceded a detailed description, for example: "When you are stressed, you are nervous." The general assumption was that for many participants, the idea of stress was interchangeable with feeling nervous. For some men and women, however, nervousness lingered close to feeling irritated and easily angered. Over 40 per cent of participants (n = 21), both male and female, shared that while under stress, they felt irritated and could easily initiate an argument, shout, be rude or aggressive. Many participants said that while in distress, they could speak rudely to their parents or family and get into heated conversations. A few participants acknowledged that they could lose control and get into conflicts and fights, or beat their children. Compared with nervousness and irritability, the share of other affective symptoms was relatively low. Eight participants said that they had no interest or pleasure in doing anything. Four people reported that they had low mood and felt depressed. Two men shared that they experienced extreme stress in the Russian Federation and had suicidal thoughts.

Cognitive symptoms included "thinking too much" and memory loss and/or inability to concentrate. One fourth of participants said that they were thinking too much about their problems, which was part of their overall distress. Four people shared that they became forgetful and had a hard time remembering things that they needed or wanted to do, or had difficulty in concentrating.

Finally, the symptom of social withdrawal was included in the **behavioural domain** of distress. Seven participants said that while stressed, they were unwilling to see or talk to someone, even close family or friends.

Coping and sharing their stress and mental health problems with others

All participants said that they experienced distress during migration, but most of them did not identify distress as a health problem that required urgent attention in the country of destination. Men and women used a wide range of strategies and techniques to ease the experienced stress and associated symptoms. Many participants shared that they did nothing or simply "tried to calm myself down". They would walk in parks, watch films or TV, and listen to music or surf the Internet to relax. Many men and women met with friends to spend some quality time shopping or visiting shopping centres, sharing food and drinks, and going to barbeques or fishing trips during summer months. Participants said that these

social activities helped them relax and provided a much-needed break from the stress and worries. Also, over a half of participants shared that as Muslims and believers, they relied on coping through religious practices. Labour migrants regularly prayed and asked Allah for support, which comforted them and provided hope. One male migrant said that his friends, who observed him suffer, invited an Islamic clergyman (*mullah*) to come and read a prayer for him.

It was uncommon for labour migrants to disclose that they experienced severe stress and specific symptoms to friends, relatives and others. Migrants were more likely to share their broader concerns about their problems with documents, work and living situations. When they called family members who stayed behind in Tajikistan, migrants tried not to worry their loved ones and did not discuss their health concerns. Compared with female participants, men were more likely to keep their problems to themselves, but many men discussed them with friends – fellow labour migrants. Friends and family provided migrants with much-needed support and could help over the phone or in person. Whenever they observed that a migrant's health had seriously deteriorated, close friends or relatives insisted that the migrant saw a doctor or bought medications and often provided money for health care. In serious cases (beyond mental problems, we found a few cases of disease or injury along with mental distress), despite the fact that the family did not understand that the poor health of their loved ones was related to mental health problems, family (and occasionally friends) purchased return tickets for migrants and requested that they should travel home to care for themselves.

Over half of the participants acknowledged that stress related to migration continued to produce a lasting effect on their health upon return to Tajikistan. Returned migrants also shared that being at home around family and friends helped them cope and improved their emotional condition. Upon return, men and women were more likely to discuss their health concerns with families and seek medical care. Although they did not identify experienced symptoms as possible mental health problems due to the stigma of mental disorders and limited knowledge about them, seeking care for health deterioration upon return was deemed appropriate. Families and friends of returned labour migrants in Tajikistan were supportive of the idea of professional help and often helped to find doctors through social networks.

Returnees also relied on coping through religious practices. One fifth of male participants (n = 7) shared that they invited or visited a *mullah* for a ritual healing prayer one or more times upon return to Tajikistan. Returned migrants could also travel to hot springs (n = 2) known for their healing properties. However, turning to health care was the most common option.

Seeking medical help and social services: available and needed services

Labour migrants were not likely to seek medical care for their distress and mental problems in the host countries. They agreed that health care was costly and there were many barriers to accessing it. Although Tajikistan's migrants were required by law to purchase private medical insurance upon arrival in the Russian Federation, it proved to be of no use when men and women sought medical care. In polyclinics and health centres, they often heard from administrators and doctors that their medical insurance was not valid, or they could not accept it to see migrant patients. Among the participants of four FGDs and 50 IDIs, only two women migrants saw a psychologist in the Russian Federation, for out-of-pocket payments. One woman's relatives were very worried about her distress and mental health condition.

In Moscow, they found a health centre for this woman and paid for three appointments for her with a psychologist. This participant liked the quality of treatment and said that it helped her a lot. Another woman went to see a general practitioner in the Russian Federation, who recommended that she consult a psychologist. Five other participants, men and women, saw general practitioners and neurologists while in migration. Usually, they did not seek professional help for their distress, but for acute conditions (asthma and pneumonia) or injury (fracture and trauma). In hospitals or health centres, these patients also learned about accompanying distress and were most often referred to neurologists.

Some of the men and women self-medicated to ease their symptoms, particularly headaches and "nerves". Since severe headaches were a very common symptom, painkillers were among the most popular over-the-counter medications that participants used while in the Russian Federation. Labour migrants relied on cultural health practices for the use of herbal sedatives or sought advice from friends, family or familiar doctors who would commonly recommend similar medications. Valerian root was used most often, followed by glycine, Corvalol, Valocordin and others. Corvalol and Valocordin contain barbiturates, have a sedative effect and are widely used for many symptoms in the cultural health practices of post-Soviet countries, including Tajikistan. A few participants wanted to see a doctor for perceived poor health and distress symptoms, but, besides the two women mentioned, no one could obtain professional mental care while abroad. Another woman shared that she searched the Internet for psychological advice and followed recommendations from a psychologist in the form of a "psychological marathon" (a series of posts with tasks to complete) that was posted on Telegram, a popular social messaging channel. Those recommendations were of great help, as this participant acknowledged. Seven returned migrants (six men and one woman) said that they used alcohol and eight men shared that they smoked cigarettes or *nasvai*, smokeless tobacco widely used in Tajikistan, to ease their distress while abroad.

Returned migrants were willing to seek medical care in Tajikistan. The findings of this study were consistent with the previously discussed gap between primary care and psychiatric care services. Over half the participants (n = 26) sought help for their deteriorated health and distress. However, just two female returned migrants saw a psychologist in Dushanbe for their mental health problems. One of these women said that the services were costly. She was only able to complete one session, but said that it helped her. Another woman arrived in Dushanbe from another district to complete a medical check-up for her problems at Tajikistan's State Medical University. She was recommended to see a psychologist and completed several sessions with this health-care professional. Two other participants said that their family members or acquaintances were trained school psychologists and that their informal help and advice had helped them. The remaining 24 participants who sought medical attention received care from family doctors (n = 2) and the majority were treated by neurologists (n = 22). None of participants saw a psychiatrist for their possible mental health problems.

Although none in the sample sought the help of a psychiatrist, the Ministry of Health and Social Protection of the Republic of Tajikistan shared several anonymized clinical cases of returned migrants who were treated for mental disorders. We include two of these cases in this report:

(a) K., a woman of 35 from a rural area, a baker. She left to work in the Russian Federation in February 2020. For two months, K. was looking for a job as a baker. She shared a room with eight people. In April, K. got a job illegally as a janitor. The owner of the house provided her with a bed in the basement without amenities. K.

received a monthly salary of RUB 15,000. At the end of May 2020, K. was beaten by unknown people when she was cleaning the property early in the morning. She lost consciousness, and when she woke up, she had a headache, nausea, dizziness and vomiting. K. did not seek medical help. Subsequently, her sleep was disturbed, at times it seemed to K. that some people were walking around the basement and talking loudly. K. said that she saw the silhouettes of perpetrators in front of her. K. developed other symptoms of mental disorders. Upon visiting K., her fellow nationals decided to help her return to Tajikistan and bought her a plane ticket. K. was hospitalized for three months in Tajikistan. Currently, K. follows up treatment on an outpatient basis and receives supportive treatment for a diagnosis of residual effects of a traumatic brain injury and psychosis.

(b) S., a man of 30 from an urban area. S. is married and has four children. He lives on odd jobs and does not have permanent employment. S. repeatedly travels to the Russian Federation to work. S. got a job as a labourer on the market; his monthly earnings were approximately RUB 10,000. S. lived in poor conditions in a basement and often could not remit to support his family. His wife was dissatisfied. Due to disagreements in the family and lack of money, S. could not stay in touch with his family in Tajikistan. S. had internal discomfort and said that he had various thoughts in his head about his wife cheating on him. During telephone conversations with his wife, S. often quarrelled with her and accused her of betrayal, threatening reprisals upon his return to Tajikistan. Fellow nationals noticed the inappropriate behaviour of S. (aggressive, restless, could not stay in one place, quit his job) and they decided to send him back home. Upon return to Tajikistan, S. received specialized psychiatric care. Currently, he receives supportive outpatient treatment for a diagnosis of affective-paranoid attacks.

IOM study participants sought help from primary care doctors and neurologists, but not psychiatrists. The results of treatment by non-mental health-care providers – neurologists – varied, but were mostly unsatisfactory. Participants said that the treatment they received helped to ease some symptoms, but they continued to feel unwell. One male returned migrant described his struggles to get quality care and aspirations for professional help in Tajikistan, which were linked to financial constraints for services:

> *"Once I went to the doctor for my nerves. I told him that I was very irritable and I had severe headaches. The doctor said that the headaches were from nerves and gave me medication. I took these pills for ten days, but there was no improvement. Again, I went to the doctor. He gave me treatment and prescribed pills. I bought them and I am currently taking them. I am in treatment for the second time, but my head still hurts. The pain has decreased a little bit, but has not gone away completely. The doctor said it was because I think a lot. In fact, I think a lot about how to pay off my debts. The headache does not go away, it hurts me. If I had money, I would go to the doctor. I would ask the doctor to prescribe me a good, correct, even expensive treatment. I lack money, so, when I see a doctor, I ask him to prescribe cheap medicines. Since the headache does not go away, I would like good, expensive medicines. If I had money, I would probably need injections, maybe a massage for my headache. I need a rest from my pain. Acupuncture might help me."* – **Man, 35, Kyshoniyon**

This was a shared narrative among returned migrants: how incorrect treatment by neurologists and the use of improper medications did not bring relief or further aggravated symptoms of possible mental disorders. A female migrant remembered her experiences of seeking help in Tajikistan:

> *"I am receiving treatment from a neurologist in our clinic. I want people who have such problems to be treated correctly, even by good private neurologists. Because people can get worse, their hands tremble due to improper treatment. This happened to me: at first, when I received treatment, maybe the medication [was] wrong, I got worse, my hands were trembling, I vomited. Then I saw another doctor. He prescribed other medicines and it got better. I want to have competent and qualified specialists. A neuropathologist works in our clinic, so I came to him for treatment. I don't know a psychologist."* – **Woman, 37, Gafurov**

This common narrative among returned migrants – being treated for possible mental health problems by neurologists and hardly getting any better – points at the limited availability and the need for medical and social services for mental health. Besides a few exceptions, for example, when two women went to great lengths to see a psychologist in Dushanbe, returned migrants tend only to use the medical services that are available to them. These tend to be primary care clinics and centres that have family doctors and a neurologist (usually in *jamoat*-level centres). Men and women were unaware of other medical and social services for their needs. A few people mentioned that they knew about psychiatric inpatient facilities, but those clinics were for "mad people". Distressed migrants did not see themselves as someone who would need these services, due to the large stigma of mental illness in Tajikistan. Several men and women said that they were aware of the social services provided by local administrations (*khukumat*) to poor families, but there were no specific services for returned migrants or people in distress. However, a clear need for psychological services was expressed by returned migrants. Moreover, contrary to indications of some participants that Tajikistan's people were unwilling to see psychologists due to cultural beliefs and practices, many men and woman repeated that having psychological services available in their regions and districts would be most welcome.

Government-based social services for returnees with psychosocial needs were virtually absent in Tajikistan. Most FGD and IDI participants said that they were unaware of any social services in their regions and administrative districts and never used such services. Four men and women shared that they heard something about financial assistance for families in need provided by *jamoats*, but did not apply. Two men explained that their family members received one-time financial aid from *jamoats* equivalent to 100 somoni (approximately USD 10 at the time of research) while they were abroad. Community-based organizations for women (mostly non-profit NGOs) were an alternative source of social services and psychosocial support. Although none of the female participants turned to these services, women in Sughd Region of north Tajikistan were knowledgeable about existing options. For example, seven FGD participants in Khujand discussed several women's centres operating in the region and shared experiences of their friends or relatives who had received support, legal advice or other services from those centres.

CHAPTER 5. DISCUSSION

International migration involves a growing number of people worldwide and entails numerous benefits for countries of origin and destination. Cross-national evidence also shows that migration affects both the general and the mental health of migrants through the combined effects of multilevel factors, which has led to a growing understanding of migration as a social determinant of health (Castañeda et al., 2015). There is sparse evidence on migrants' general and mental health from middle- and low-income countries, including Tajikistan, a lower middle-income country with large out-migration and return flows. This study is the first comprehensive analysis of policies, health-care and social services for migrants' mental health, and the impact of migration on returned migrants' mental health in Tajikistan.

The study identified major gaps at the policy level related to the organization and delivery of mental health-care services for Tajikistan's migrants. Labour migrants face many barriers in accessing general and mental health-care services in destination countries. These barriers include problems acquiring necessary documentation, lack of health insurance and/or its limited coverage, high costs of services and treatment, and discrimination against migrants. Returned migrants in Tajikistan face different barriers to mental care. They have access to public health-care facilities and providers, but the quality of services is low. Along with limited knowledge about mental health problems among the population of Tajikistan and the associated stigma, this may leave a significant proportion of common mental disorders undiagnosed and untreated. Tajikistan's national policies and legislation do not include programmes for the development of integrated mental health-care services for the general population and returned migrants.

The findings from this study are consistent with previous assessments of the general and mental health systems in Tajikistan. The WHO-AIMS (2009) report on the mental health system indicated that there was no unified and well-defined mental health policy in the country. Tajikistan's instructions, rules and standards for the provision of mental health legislation were mostly adopted from the centralized Soviet type of psychiatric system and required revision. Only 1 per cent of national health-care expenditures were directed towards mental health. There was no list of essential medicines recommended for mental health disorders. Consumers had to pay out of their own pocket for psychotropic, antipsychotic and antidepressant medications (ibid.:5). In their 2016 review of the health system of Tajikistan, Khodjamurodov et al. (2016:xiii) pointed out that mental health care still received little attention from national policymakers. The WHO 2020 Progress Report on health-related targets in Tajikistan indicated that mental health was not sufficiently covered in Tajikistan's National Healthcare Strategy 2021–2030, which was under development at the time the report was published (WHO, 2020:14). WHO also indicated that data were not readily available on the prevalence of mental health disorders, and that mental health was not receiving public health attention and needed to be considered for inclusion in the list of priorities within the National Healthcare Strategy 2021–2030, including research and data generation on the mental health risk factors in Tajikistan (ibid.:26).

Findings from previous assessments of Tajikistan's mental health system in 2009, 2016 and 2020 held true in 2022, when this study was conducted. The Government of the Republic of Tajikistan has developed and implemented separate National Programmes for several infectious and non-communicable diseases including HIV, tuberculosis and diabetes. However, there is still no national programme in the field of mental health and psychosocial support. Mental health care continues to be underfinanced and suffers from lack of attention from international organizations, stigma, and a lack of trained professionals – psychologists and psychiatrists. There is a discrepancy between Tajikistan's Code of Health Care and the Rules and Regulations for Psychiatric Care regarding the categories of providers who are allowed to diagnose and treat mental disorders (primary care/family doctors versus psychiatrists, respectively). Data on the nationwide prevalence of common mental disorders are not readily available, including data on vulnerable population groups such as returned migrants, women, adolescents and children. There are no integrated protocols for the assessment, diagnosis and treatment of mental disorders that have been developed and adopted by primary health care and specialized psychiatric care. There is no list of essential medicines recommended for providers to prescribe for common mental health disorders, particularly modern selective serotonin reuptake inhibitors (SSRIs) with well-demonstrated efficacy.

However, there are encouraging signs of positive systemic changes. Tajikistan's National Population Health Strategy 2021–2030 has been adopted. The Strategy pays attention to the health of labour migrants and returned migrants and points out that the problems of transborder migration – large out-migration and limited access to basic health-care services – cause risks for the health of migrants and Tajikistan's population in general. The Strategy emphasizes the need to develop relationships with destination countries of labour migrants in the field of public health and access to health-care services. Although the Strategy does not prioritize mental health, including returned migrants' mental health, this essential policy document acknowledges the growing burden of mental health disorders in Tajikistan and gaps in services. The Strategy pays particular attention to the primary health-care reform aiming to improve the quality of care. The list of necessary measures includes, among others:

- Approve the mechanism for the development and adoption of national clinical practice guidelines for PHC services; determine the priority of their development and application;
- Develop and implement clinical practice guidelines for early diagnosis and treatment of somatic, reproductive, infectious, neuropsychiatric and mental disorders, including in adolescents;
- Develop and approve a system for monitoring and evaluating the application of national clinical practice guidelines for PHC services;
- Include an assessment of the application of clinical practice guidelines in the system of accreditation of PHC facilities (Strategy, 2021:26).

Appendix 2 to the Strategy specifies the need to adopt and implement WHO-recommended integrated clinical protocols for the prevention and control of major non-communicable diseases at the primary health-care level. These policy developments set the stage for the integration of the WHO clinical protocols for diagnosis and treatment of common mental disorders in PHC settings.

Despite an urgent need for implementation of these national policies and provisions, at the patient level the study found that workers and returned migrants continue to suffer from lack of access to services and their poor quality. Mental health care is virtually unavailable for Tajikistan's labour migrants in the Russian Federation and Kazakhstan as major destination countries, due to health-care legislation and policies, as well as the high cost of services. Back in Tajikistan, the underfunding of healthcare and stigma of mental illness create barriers to mental health care both for the general population and returned migrants. The lack of integrated mental care policies and routine protocols for patients create large gaps in services, particularly between primary care and specialized psychiatric care.

There is a large gap in the diagnosis and treatment of common mental disorders, which may leave the majority of common mental disorders such as depression, anxiety and PTSD undiagnosed and untreated. The study showed that an alarming rate of returned migrants who sought professional help for their symptoms of distress were improperly diagnosed and treated. Private mental-care options are virtually unavailable in Tajikistan, due to the small number of trained professionals (psychologists and/or clinical psychologists) in most places beyond large cities and the high cost of services. Non-governmental organizations and State women's centres provide services for women, including psychosocial support and advocacy, but the small scale of these services and initiatives are insufficient to improve mental health care for all the people who need it.

The need for mental health care among returned migrants is huge. The findings of the study are consistent with the cross-national literature on the mental health of migrants in destination countries, who were shown to have higher rates of depression, anxiety, PTSD and other disorders, compared with the general population. Possible mental health problems of returned migrants remain undetected and untreated in Tajikistan, with long-lasting health consequences, which may sometimes include debilitating conditions. Evidence from low- and middle-income countries on the mental health of returned migrants is limited, but some studies showed high levels of stress in returning migrants that can lead to the development of psychiatric disorders (Ventriglio et al., 2021:643).

This IOM study was the first in Tajikistan and Central Asia to show high levels of stress in returned migrants. Although no validated measures were applied to assess depression, anxiety and PTSD rates, this study used rich qualitative data to identify important patterns in symptoms that can indicate possible mental health problems. It showed that distress manifested through a wide range of somatic symptoms. These findings are consistent with evidence from different settings on the ways in which people experience and speak about distress and mental health problems. A systematic review of articles discussing symptoms of depression among primary care patients showed that approximately two thirds of patients present with somatic symptoms, including general aches and pains (Tylee and Gandhi, 2005). Due to the high prevalence of somatic symptoms in primary care, depression may be difficult to diagnose and treat in these patients, because they feel an increased burden of disease and rely heavily on health-care services (ibid.: 2005:167). In addition, studies among immigrants from the former Soviet Union in Israel showed that physical health problems or somatic complaints were common manifestations of distress and psychological and psychiatric problems among these population groups. In their study of mental health of Central Asian labour migrants in Kazakhstan, Ismayilova et al. (2014) suggested that migrants had similar patterns in how mental health problems manifested, specifically, high rates of physical health problems and a low percentage of mental health symptoms. The study findings support this argument, that while high rates of somatic symptoms and physical health complaints are prevalent among returned migrants, some of these symptoms can disguise mental health

problems. These results, and particularly the list of the most frequent somatic, affective, cognitive and behavioural symptoms encountered, can be used by primary care and mental health-care providers in Tajikistan for the assessment and early diagnosis of common mental health disorders.

This study found that returned migrants needed and sought professional services, although they may not recognize their conditions as mental health problems. There is a need for educational programmes and interventions to enhance knowledge about psychological well-being and mental health among returned migrants and the general population of Tajikistan. Participants acknowledged that they were distressed and needed treatment, as they presented at primary care clinics with complaints about poor physical health and somatic symptoms, but family doctors and neurologists often lack knowledge and skills to correctly diagnose and treat mental health problems. This creates a large treatment gap and highlights the need to develop and implement integrated protocols for mental health care, including a list of essential medications with proven efficacy, and scale up psychological services in Tajikistan.

High levels of stress among returned migrants are an essential public health issue. Possible mental health disorders remain mostly undiagnosed and untreated, which creates health risks for migrants and a cascade of effects for their families and broader society in Tajikistan, including risks of domestic violence and risks for the well-being and mental health of children and adolescents. Public health and social effects of poor mental health among returned migrants warrant the urgent attention of policymakers and donors.

Our study should be considered as having some limitations. Given the study design, we cannot determine the rates of mental health disorders among returned migrants. Although FGDs and IDIs yielded rich qualitative data, a national representative survey is needed to assess the prevalence of mental health problems and to better characterize the long-term effects of international migration on psychosocial well-being and mental health. This study's participants were selected on inclusion criteria, particularly a question on experienced distress or mental health problems associated with migration. Our findings may not be generalizable to experiences of all returned migrants in Tajikistan. Finally, government restrictions prevented access to Gorno-Badakhshan region at the time of data collection. We did not conduct IDIs with returned migrants in this area and their experience may be different.

CHAPTER 6. CONCLUSION AND RECOMMENDATIONS

The following recommendations are derived from this study's findings:

Policy (national and cross-border) and capacity-building

- Develop and implement the National Programme of Mental Health in the Republic of Tajikistan;
- Increase funding for mental health-care and primary health care in the Republic of Tajikistan;
- Strengthen the mental health-care system and scale up services;
- Develop measures to strengthen the collection of national data on mental health and integrate migration experience into existing templates for data collection on mental health;
- Conduct a national representative study to assess the prevalence of common mental disorders among returned migrants;
- In coordination with WHO, adopt international clinical protocols for mental health care (WHO mhGAP, part of the global action plan on migrant and refugee health) and implement them in primary care, including:
  - Validated measures for the assessment and early diagnosis of common mental disorders, translated into Tajik and Russian languages;
  - Routing recommendations for primary health-care doctors to further assess and diagnose patients with presumptive mental disorders and refer them to psychiatric care if necessary;
  - Develop a list for primary care and psychiatric care providers of essential modern medications recommended for patients with common mental disorders, particularly modern SSRI antidepressants and anxiety medications with proven efficacy.
- Develop professional training programmes for primary health care/family doctors and neurologists to inform and educate them on mental health problems and standards of care, including:
  - Somatic and psychological symptoms that patients present in primary care;
  - Early diagnosis and treatment of common mental disorders;
  - Routing protocols for referrals to psychiatric care.
- Develop programmes for the education and training of clinical psychologists and include them in the educational programmes of medical universities in Tajikistan;
- Include migration health in the curricula developed for mental health-care providers;

- Strengthen cross-border coordination within the CIS in the field of mental health care and include working meetings on mental health of migrants in the agenda of the CIS Department of Health.

Service provision

- Develop low-threshold services that are easily accessible for returned migrants: primary care, community and online counselling services;
- Integrate better the systems for primary health care and specialized mental care, including the adoption of integrated clinical and routing protocols; develop routing recommendations for primary health-care doctors to further assess and diagnose patients with presumptive mental disorders, prescribe antidepressant and anxiety medications with proven efficacy, and refer patients to psychiatric care if necessary;
- Develop migrant-centred and community-based programmes, including use of the *IOM Manual on Community-based Mental Health and Psychosocial Support in Emergencies and Displacement* (IOM, 2022) for successful implementation of community-based activities; for example, enable and support participatory activities and/or support groups of migrants. The agenda of these support groups' meetings can include for example psycho-educational elements, including a discussion of migration-related issues such as employment, reintegration, income-generation activities and relationships within the family, among others. Discussions of psychosocial well-being, stress and its symptoms, and information about existing MHPSS services can be part of such peer support group meetings. An integration of the discussion on mental health and psychosocial well-being into migration-related meetings and activities will help avoid the stigmatization of mental health issues and attract more participants.
- According to IOM's integrated approach to reintegration, achieving sustainable reintegration requires a holistic and needs-based strategy that takes into consideration various factors, including the economic, social and psychosocial dimensions of reintegration at the individual, community and structural level (see the *IOM Reintegration Handbook*, 2019). For this reason, there is a need to integrate MHPSS components in return and reintegration programmes at various levels, such as pre-departure and post-arrival counselling (for example having professionals in the team with specific background and/or training), as well as in terms of reintegration support. In this regard, it is also important to establish clear referral pathways and partnership with State and non-State actors to respond to the needs of individual returnees and the communities to which they return in a mutually beneficial way, while also addressing the structural factors at play.

Community mobilization

- Develop informational and educational programmes for the general population of Tajikistan to raise awareness and normalize the discussion of psychological well-being, distress and its symptoms, and mental health in the society, both at the community and family levels;
- Use national and regional TV and radio channels, as well as social media (via the Internet) to broadcast educational programmes on psychosocial well-being and mental health, the symptoms of stress, counselling and other support mechanisms;

- Develop online support groups for the general population of Tajikistan and returned migrants and invite volunteer psychologists to moderate these support groups to provide guidance, advice and counselling;
- Work with religious leaders in Tajikistan to raise awareness about psychosocial well-being and mental health and invite them to include information on the importance of psychosocial well-being, stress and its symptoms, coping and other support mechanisms in their sermons.

Migrant-centred approaches

- Develop informational materials (flyers and others) for returned migrants and their family to raise awareness about the potential psychological effects of migration experiences, distress and its symptoms, and existing MHPSS services. We recommend distributing these materials in primary health-care clinics, centres for healthy lifestyle promotion, resource centres for migrants, NGOs and community-based organizations, and religious and other facilities regularly frequented by returning migrants and their family members;
- Develop online versions of the above-mentioned information materials and distribute them on social media, to be used by labour migrants and returned migrants on social media platforms such as VKontakte, Instagram, Facebook, Odnoklassniki and WhatsApp;
- Use existing websites that provide information for Tajikistan's migrants, such as www.mrc-tajikistan.org and www.rec.tj to include information about the possible psychosocial consequences of migration experiences, distress and its symptoms, and seeking MHPSS services;
- Develop and conduct educational sessions and support groups among returned migrants, facilitated by trained psychologists in different regions of Tajikistan.

APPENDICES

Appendix A

SAMPLE KEY INFORMANT INTERVIEW GUIDE

Thank you for agreeing to talk to me! My name is (introduce facilitator). I work with researchers from the International Organization for Migration. We are conducting a study about mental health and psychosocial support needs among returned Tajik labour migrants. I asked you to join me today so that I can hear your perspectives on a range of issues about mental health of returned migrants, their needs, social and health-care services available for them, and barriers and gaps in access to these services. I am expecting you to respond based on your observations and experience. The findings from our study will help develop recommendations to improve the access of migrant workers to social and health-care services for mental health.

We expect to be together for a total of 45 minutes. I would like to ask your permission to record our conversation on a voice recorder so that I do not forget all the important information that you will share with us today. I hope you don't mind having our conversation recorded, but if you have any objections to being recorded, please let me know and we'll turn off the recorder. All information you provide will remain confidential, and I will not record your name or use it my records and research report.

Do I have your permission to proceed?

Write the following information in a log sheet under a unique interview #:

(a) Place of the interview (district, region, locality).

(b) Date of the interview.

(c) Start time.

Let me first ask where you work and what is your position; this will not be audio-recorded Write the answers in a log sheet under a unique interview #:

(d) Organization

(e) Position

Thank you! We will begin our discussion. Now, I will turn on the audio recorder. Turn on the audio recorder.

1. What is the impact of migration on mental health and psychosocial well-being of Tajikistan's migrants and what factors affect them?
2. How frequent are common mental disorders (depression, anxiety, substance use) among (returned) Tajik labour migrants, according to your experience?

3. What are the gender differences (if any) in mental health disorders in this population?
4. Please tell me what you know about migrants' help-seeking behaviours: how do they cope with mental health problems and where do they seek help?
5. What is the role of the family and social networks/community in helping (returned) migrants cope with mental health problems?
6. What state and private health-care options are available for migrants who have mental health problems in [name of the country]?
7. What other social protection services are available to them?
8. What are the barriers to access these services? Please explain how these barriers operate at different levels. [Probe if not mentioned: structural and institutional factors, legal status, discrimination, stigma, other]
9. What are the gender differences (if any) in access to health care and social services for mental health among (returned) Tajik migrants?
10. In your opinion, what are the gaps in services for (returned) Tajik migrants?
11. What regulatory, organizational, and other measures are needed to improve mental health of (returned) Tajik migrants and address their health needs?
12. Is there anything that we did not discuss today that you think is important for me to know about mental health and the needs of Tajik migrants?

Thank you for talking to me today! I appreciate your time and the information you shared!
Turn off the audio recorder and write the end time in the log sheet.

Appendix B

SCRIPT FOR INITIAL VERBAL RECRUITMENT

[*Use this script to introduce the study to potential participants during an initial in-person or telephone contact prior to the FGD or an interview*]

Hello, my name is [NAME], I am from the research team of the International Organization for Migration, Tajikistan. We are conducting a study on mental health and psychosocial support among returned Tajik labour migrants. We talk to you today because we learned that you worked abroad and returned home not long ago. The main goal of this research is to understand experiences of Tajik migrants, their mental health, and how they cope with problems. If you agree to participate, we will discuss these themes [***For an FGD say: Discuss these themes in a group discussion on [date]***] with you today in a confidential conversation. It will last about 60 minutes. You will receive a food package to compensate for your time. Can I ask you several questions to understand if you are eligible for this study?

[***If their answer is YES, proceed with the questions. Otherwise STOP***]

1. How old are you?
2. Did you work abroad in the Russian Federation or Kazakhstan?
3. How long ago did you return from your last trip there?
4. Did you experience any psychological problems or distress that you think were connected with your life and work abroad during your time there or after return?

[***If this person is eligible***]

Thank you! Based on your responses, you are eligible for the study.

[***For a focus group, provide the date, time, and place of discussion and invite to participate***]

[***For an in-depth interview, read the sentences below***]

But, before you decide whether you should take part in this research or not, I would like to have your permission to explain to you in detail what your participation in the study will mean for you.

Do I have your permission to continue?

[***If the answer is YES, proceed with the informed consent. Otherwise STOP***]

[***If this person is not eligible***]

Based on the information you provided, you are not eligible for the study; sorry about that. Thank you for taking time to talk to us today!

Appendix C

SAMPLE INFORMED CONSENT; FOCUS GROUP

We are asking you to choose whether or not to volunteer for a research study called ***Mental health and psychosocial support among returned Tajik labour migrants***. Your participation is voluntary – it is up to you whether you would like to participate. It is fine to say "no" now or at any time after you have started the study. If you say "no", your decision will not affect any of your rights or benefits. You can stop participating in the study and withdraw your consent at any time.

WHAT IS THE STUDY ABOUT AND HOW LONG WILL IT LAST?
Psychological difficulties and mental health problems are common around the world and, among other reasons, may be connected with international migration. The main goal of this research is to understand the mental health of Tajikistan's citizens who worked abroad, how they cope with problems, and what social and health-care services they use.

WHY AM I BEING ASKED TO PARTICIPATE?
You are being asked to participate in this study because you were identified as someone who worked abroad in Russian Federation or Kazakhstan and returned not long ago by local administration or community liaison. We will use the data we obtain from you to better understand the mental health problems of returned Tajik labour migrants, how they cope with those difficulties, and what resources, social support, and health-care services they use for these problems. In total, 90 people in Tajikistan will participate in this study.

WHAT WILL HAPPEN IF I PARTICIPATE IN THE STUDY?
If you agree to take part of the study, today we will talk as a group about the ways experiences working abroad affect the mental health of returned migrants, how they cope with mental health problems, and about the knowledge and use of different resources and services for these problems, including health care, social services, and availability of services.
We anticipate that this conversation will take a maximum of 60–90 minutes.

WILL THERE BE AUDIO RECORDING?
This group discussion will be audio-recorded. We will never ask for your name so you will not be identifiable. The recording will be transcribed into a text file by the research staff and used to identify themes, common for experiences of returned Tajik labour migrants. The recording will be destroyed when the research team completes the analyses.

WILL I BE PAID ANYTHING TO PARTICIPATE IN THIS STUDY?
You will receive a small incentive in the form of a food package.

WILL IT COST ME ANYTHING TO PARTICIPATE IN THIS STUDY?
There will be no cost to you to participate in the study.

WHAT ARE KEY REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?
There are a few direct benefits of participating: you may better understand your mental health and problems you may have. Another benefit is the opportunity to contribute to the new knowledge about mental health of returned Tajik migrants and social and health-care services available to them.

WHAT ARE KEY REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR THIS STUDY?

You may find some questions you will be asked embarrassing or unsettling. You are free not to answer specific questions or stop your participation at any time. This will not affect your rights in any way. A risk of taking part in this study is the possibility of a loss of confidentiality or privacy, but we have made plans to best protect your confidentiality.

CONFIDENTIALITY

We will work to best protect your confidentiality.
The only people who can see your research records are:

- Researchers and other individuals who work with the researchers;
- Organizations and institutions involved in this research, including those that fund the research, if applicable;
- Groups that review research, such as the IOM leadership.

The purposes of these uses and disclosures are to (1) conduct the study and (2) make sure the study is being done correctly. All of these groups have been asked to keep your information confidential.

WHAT CHOICES DO I HAVE OTHER THAN PARTICIPATING IN THIS STUDY?

You can refuse to participate in the study; your participation is entirely voluntary. You can retract your consent at any time.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?

The person in charge of the study is Ms. Rukhshona Kurbonova. If you have questions, suggestions, or concerns regarding this study, you can contact Ms. Kurbonova at +992-90-505-4300 or by email: rqurbonova@iom.int.

CONSENT TO PARTICIPATE

I have read the consent form and I understand that it is up to me whether or not I participate. I know enough about the purpose, methods, risks, and benefits of the research study to decide that I want to take part in it. I hereby authorize the International Organization of Migration (hereinafter, "IOM") and any authorized person or entity acting on behalf of IOM to collect, use, disclose and dispose of my personal data for the purposes of this research. I understand that I am not waiving any of my legal rights by signing this informed consent document. I will be given a signed copy of this consent form.

Printed name of participant	Signature of participant	Date
Printed name of the person conducting the consent process	Signature	Date

Appendix D

SAMPLE FOCUS GROUP GUIDE

Welcome and thank you for joining us! My name is (introduce facilitator). I work with researchers from the International Organization for Migration. Today with me is (introduce note-taker). We are conducting a study about mental health and psychosocial support among returned Tajik labour migrants. We have requested you to join us today so we can learn from your experiences and hear your perspectives on a range of issues about the mental health of people who worked abroad. All information you provide will remain completely confidential.

Today, the focus of our conversation will be on three key areas:

1. We will talk about your migration experience and its positive or negative impact on your mental health;
2. We will discuss how you cope with these positive and negative impacts and what helps you;
3. We will talk about your use of social and health-care services for psychological problems and mental health.

We expect to be together for a total of 60–90 minutes. I would also like to inform you that we will be recording our conversation on a voice recorder so that we do not forget all the important information that you will share with us today. I hope you don't mind having our conversation recorded, but if you have any objections to being recorded, please let me know and we'll turn off the recorder.

Please note that participating in this discussion is entirely voluntary. You may choose to leave now or any time during our discussion. You do not have to answer any questions if you are not comfortable. We have made arrangements to reimburse you for your time to participate in this conversation. Please feel free to ask any question now or after the discussion. Before we proceed, I will need you to complete the informed consent sheet, which will indicate that you are here of your own free will and voluntarily consent to share your opinions, experiences, and perceptions.

Complete the informed consent form

Thank you! We will begin our discussion.

Note-taker: Complete the log sheet below.

<table>
<tr><td>Date:
Start time:
End time:</td><td rowspan="7">Place of the focus group (city):</td></tr>
<tr><td>Facilitator:</td></tr>
<tr><td>Note-taker:</td></tr>
<tr><td>Total number of participants:</td></tr>
<tr><td>Gender of participants:
☐ Men ☐ Women
Age:
☐ 18–24 y.o. (Number of participants) _____
☐ 25–49 y.o. (Number of participants) _____
☐ 50–64 y.o. (Number of participants) _____</td></tr>
</table>

Now, I will turn on the audio recorder. Turn on the audio recorder.

Let us start by sharing something about ourselves; this will help to know each other a little better. I suggest that each of us tells the group one interesting or fun fact about yourself. I and my colleague can start: [The facilitator and note-taker share one fun fact and invite participants to follow suit]. Thank you for sharing this! Now, let us talk about your migration experience.

1. Please tell me about one thing you remember the most about your migration experience in the Russian Federation [Kazakhstan]. This can be anything: an event, place, feelings, or emotions. Just describe this memory.
2. Could you tell me about problems or difficulties you experienced after you returned from migration?

Now, I will read you two statements. Please tell if you agree or disagree and explain why.

3. Migration (experience working and living abroad) has a positive impact on health.
4. Many people have psychological problems or intense distress linked to migration.

Let me now ask about the way you were feeling. Again, you do not have to answer some questions if you are uncomfortable.

5. If you had psychological problems or distress linked to migration, could you describe in your own words what you were feeling at that time?
6. What caused this condition, in your opinion? [Probe if not mentioned: worry about their family, loneliness/social isolation, work, living conditions, attitudes to migrants abroad, financial concerns]
7. What personal strategies did you use to cope with your mental health problems; what helped you? [Probe if not mentioned: faith, prayer, music, food, exercise]

Now, let us talk about seeking help and advice for mental health problems. Again, I will read you a few statements and ask if you agree or disagree and why:

8. I did not have problems sharing with someone that I had mental health problems or distress.
9. It is hard to find professional help for your mental health problems abroad or in Tajikistan.

Before we finish, I would like to ask:

10. Is there anything that we did not discuss today that you think is important for us to know about mental health and the needs of people who have these problems?

Thank you for talking to us today! We appreciate your time and information you shared!
Turn off the audio recorder and write the end time in the log sheet.

Appendix E

SAMPLE INFORMED CONSENT; INTERVIEW

We are asking you to choose whether or not to volunteer for a research study called ***Mental health and psychosocial support among returned Tajik labour migrants***. Your participation is voluntary – it is up to you whether you would like to participate. It is fine to say "no" now or at any time after you have started the study. If you say "no", your decision will not affect any of your rights or benefits. You can stop participating in the study and withdraw your consent at any time.

WHAT IS THE STUDY ABOUT AND HOW LONG WILL IT LAST?
Psychological difficulties and mental health problems are common around the world and, among other reasons, may be connected with international migration. The main goal of this research is to understand the mental health of Tajikistan's citizens who worked abroad, how they cope with problems, and what social and health-care services they use.

WHY AM I BEING ASKED TO PARTICIPATE?
You are being asked to participate in this study because you were identified as someone who worked abroad in the Russian Federation or Kazakhstan and returned not long ago by local administration or community liaison. We will use the data we obtain from you to better understand the mental health problems of returned Tajik labour migrants, how they cope with those difficulties, and what resources, social support, and health-care services they use for these problems. In total, 90 people in Tajikistan will participate in this study.

WHAT WILL HAPPEN IF I PARTICIPATE IN THE STUDY?
If you agree to take part of the study, today we will ask you questions about your experiences working abroad, your feelings and emotions, your mental health problems, and your use of different resources and services for these problems, including health care, social services, and availability of services.

We anticipate that this conversation will take a maximum of 60 minutes.

WILL THERE BE AUDIO RECORDING?
This confidential one-on-one interview will be audio-recorded in a private room. The recording will be assigned a unique number, and we will never ask for your name so it will not be identifiable. The recording will be transcribed into a text file by the research staff and used to identify themes, common for experiences of returned Tajik labour migrants. The recording will be destroyed when the research team completes the analyses.

WILL I BE PAID ANYTHING TO PARTICIPATE IN THIS STUDY?
You will receive a small incentive in the form of a food package.

WILL IT COST ME ANYTHING TO PARTICIPATE IN THIS STUDY?
There will be no cost to you to participate in the study.

WHAT ARE KEY REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?
There are a few direct benefits of participating: you may better understand your mental health and problems you may have. Another benefit is the opportunity to contribute to the new knowledge about mental health of returned Tajik migrants and social and health-care services available to them.

WHAT ARE KEY REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR THIS STUDY?

You may find some questions you will be asked embarrassing or unsettling. You are free to not answer specific questions or stop your participation at any time. This will not affect your rights in any way. A risk of taking part in this study is the possibility of a loss of confidentiality or privacy, but we have made plans to best protect your confidentiality.

CONFIDENTIALITY

We will work to best protect your confidentiality.
The only people who can see your research records are:

- Researchers and other individuals who work with the researchers;
- Organizations and institutions involved in this research, including those that fund the research, if applicable;
- Groups that review research, such as the IOM leadership.

The purposes of these uses and disclosures are to (1) conduct the study and (2) make sure the study is being done correctly. All these groups have been asked to keep your information confidential.

WHAT CHOICES DO I HAVE OTHER THAN PARTICIPATING IN THIS STUDY?

You can refuse to participate in the study; your participation is entirely voluntary. You can retract your consent at any time.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?

The person in charge of the study is Ms Rukhshona Kurbonova. If you have questions, suggestions, or concerns regarding this study, you can contact Ms Kurbonova at +992-90-505-4300 or by email: rqurbonova@iom.int.

CONSENT TO PARTICIPATE

I have read the consent form and I understand that it is up to me whether or not I participate. I know enough about the purpose, methods, risks, and benefits of the research study to decide that I want to take part in it. I hereby authorize the International Organization of Migration (hereinafter, "IOM") and any authorized person or entity acting on behalf of IOM to collect, use, disclose and dispose of my personal data for the purposes of this research. I understand that I am not waiving any of my legal rights by signing this informed consent document. I will be given a signed copy of this consent form.

Printed name of participant	Signature of participant	Date
Printed name of the person conducting the consent process	Signature	Date

Appendix F

SAMPLE INTERVIEW GUIDE

Welcome and thank you for joining us. My name is (introduce facilitator). I work with researchers from the International Organization for Migration. We are conducting a study about mental health and psychosocial support among returned Tajik labour migrants. We have requested you to join us today so we can learn fromyour experiences and hear your perspectives on a range of issues about mental health of people who worked abroad. All information you provide will remain completely confidential.

Today, the focus of our conversation will be on three key areas:

1. We will talk about your migration experience and its positive or negative impact on your mental health;
2. We will discuss how you cope with these positive and negative impacts and what helps you;
3. We will talk about your use of social and health-care services for psychological problems and mental health.

We expect to be together for a total of 60 minutes. I would also like to inform you that we will be recording our conversation on a voice recorder so that we do not forget all the important information that you will share with us today. I hope you don't mind having our conversation recorded, but if you have any objections to being recorded, please let me know and we'll turn off the recorder.

Please note that participating in this interview is entirely voluntary. You may choose to leave now or any time during the interview. You do not have to answer any questions if you are not comfortable. We have made arrangements to reimburse you for your time to participate in this conversation. Please feel free to ask any question now or after the discussion. **Before we proceed, I will need you to complete the informed consent sheet, which will indicate that you are here of your own free will and voluntarily consent to share your opinions, experiences, and perceptions.**

Complete the informed consent form

Write the following information in a log sheet under a unique interview #:

(a) Place of the interview (district, region, locality).

(b) Date of the interview.

(c) Start time.

Let me first ask you a few general questions; this will not be audio-recorded. Write the answers in a log sheet under a unique interview #:

(d) What is your gender?

(e) What is your age (full years)?

(f) What is your level of education (primary school, secondary school, vocational school, university/college)?

(g) What is your marital status (single, married, separated/divorced, widowed)?

(h) How many months ago did you return from abroad?

Thank you! We will now begin the discussion; I will turn on the audio recorder. Turn on the audio recorder.

Let us start from your migration experience.

1. How long did you work in the Russian Federation [Kazakhstan] and what was your occupation?
2. What was your legal status in the Russian Federation [Kazakhstan]?
3. Could you tell me about problems or difficulties you experienced while abroad?

Now, let me ask about your mental health.

4. You said that you had psychological problems or distress that you think were linked to your experience of migration abroad. Did this happen abroad or after your return?
5. Could you describe in your own words what you were feeling at that time? Please give me as many details as possible.
6. How did your body respond when you had psychological problems/were distressed?
7. What caused this condition, in your opinion? [Probe if not mentioned: worry about their family, loneliness/social isolation, work, living conditions, attitudes to migrants abroad, financial concerns]
8. Did you tell someone how you were feeling? Why/why not? Please explain. If YES, with whom did you share?
9. If you shared with someone your mental health problems or distress, please tell me how they responded and/or provided care and support for you?
10. How did your poor mental health condition affect your family?
11. What personal strategies did you use to cope with your mental health problems; what helped you? [Probe if not mentioned: faith, prayer, music, food, exercise]
12. From our experience talking to people in other places, we learned that some may start drinking or using drugs when they are distressed. Did you try to cope in this way? Please tell me about that.
13. When you had mental health problems, did you see or consider seeing a doctor for this condition? If YES: How did this visit/consultation go and what did the doctor say? What treatment or medication did the doctor recommend or prescribe? If NO: Why not?
14. What help or services did you need, but did not find when you were distressed?
15. How long did this condition last, overall?
16. Since then, have you felt in the same way again? If YES: What caused this condition to return, in your opinion? [Probe if not mentioned: worry about their family, work, living conditions, attitudes to migrants abroad, financial concerns]

Finally, let us talk about seeking help and advice for mental health problems.

17. I hope you are feeling fine these days. But if you have mental health problems again, what will you do? Please explain. [Probe: seek help/support from friends/family/health-care providers, other]

18. What social protection and health-care services (public or private) are available for people like you [who experience mental health problems and distress] in your community? Pease tell me about them.
19. Do you access these services? Why/why not? Please explain.
20. What services do you think are needed for people who have mental health problems in your community or district?
21. Is there anything that we did not talk about today that you think is important for us to know about mental health and the needs of people who have these problems?

Thank you for talking to us today! We appreciate your time and information you shared!
Turn off the audio recorder and write the end time in the log sheet.

Appendix G

SAMPLE LOG SHEETS FOR DATA COLLECTION: INTERVIEWS

Log sheet to be complete by study assistants in the field

Interview #	Name of the interviewer	Place of the interview (district, region, locality)	Date of the interview	Start and end time	Language of the interview	Sociodemographics of the participant					Date record sent to coordinator
						Gender	Age	Education	Marital status	Months since return to Tajikistan	
1											
2											
3											

Appendix H

TRANSCRIPTION, TRANSLATION AND DISPOSAL OF AUDIO RECORDING

Focus groups will be conducted in Russian; in-depth interviews will be conducted in the language of respondent's choice: Tajik or Russian. The language of transcriptions will be Russian.

Research staff in Dushanbe team will be responsible for the transcription of focus groups interviews and in-depth interviews in Russian. Within seven days of the interview or focus group, a member of the research team will finalize the transcription in Russian, using the general formatting instructions below. If the interview is in Tajik, it will be translated into Russian by the transcriptionist. The transcripts will be shared with the International Consultant on the same days they are completed. The International Consultant will conduct quality control of the transcripts. Audio recordings will be kept until after one week (7 days) after all transcriptions are complete and will be then promptly destroyed. No identifying information other than gender and age (not birthday) will be included with the focus group interview and in-depth interview transcription.

The research team members shall transcribe/translate all focus group interviews and in-depth using the following formatting:

1. Calibri 12-point font.
2. Single-spaced text; one space in between questions and answers.
3. 2.54 cm top, bottom, right, and left margins.
4. All text shall begin at the left-hand margin (the only indents should be between the **Q/A**: and the text of the interviewer's question or participant's response – see below).
5. Entire document shall be left justified.
6. Use only a single space between every period and the start of a new sentence.
7. Pages shall be numbered on the bottom right corner of each page.

Labelling Transcripts

Interview transcripts shall include the following labelling information at the top of the document:

Focus groups:
Focus Group ID #: (1 or 2)
Focus Group Date: dd/mm/yyyy
Duration of the focus group: [# of minutes]
Name of Transcriptionist/Translator:
Number of participants, gender and age (e.g. Eight (8) women, age 20–56):

Interviews:
Interview ID #:
Interview Date: dd/mm/yyyy
Name of the interviewer:
Duration of the interview: [# of minutes]
Language of the interview:
Date of the transcription/translation: dd/mm/yyyy
Name of Transcriptionist/Translator:
Gender and age of the participant (e.g. Woman, 31 y.o.):

Documenting Comments

Comments or questions by the Interviewer should be labelled with a **Q**: at the left margin and the text of the question or comment that follows shall be indented. Use the tab key for the indent.

Any comments or responses from participants should be labelled with **A**: at the left margin with the response indented.

Example:

Q: Thank you for talking to me today. Before we begin the interview itself, let me confirm that you understand that your participation in this study is entirely voluntary and that you may refuse to answer any questions.

(Use one space between questions and answers)

AF1: Yes, I had read it and understand this. (This example is for a focus group, where you shall label each respondent with a unique number, for example, F1 (female 1), F2 (female 2), and so on. In an interview transcription, simply use Q: for questions of the interviewer, A: for answers of the respondent).

AF2: I also understand it, thank you.

Q: Do you have questions before we proceed?

End of Interview
The transcriptionist shall indicate when the interview session has reached completion by typing END OF INTERVIEW in uppercase letters on the last line of the transcript. A double space should precede this information. Erase any additional space after END OF INTERVIEW to prevent additional blank pages from appearing at the end of the document.

Transcribing
Audiotapes shall be transcribed **verbatim** (i.e. recorded word for word, exactly as said), including any nonverbal or background sounds (e.g. laughter, sighs, coughs, snaps fingers, and other background noise or disruptions).

- Non-verbal sounds shall be typed in parentheses, for example, (short laugh), (group laughter).
- Filler words such as hm, huh, uh huh, um, yeah, whoa, uh oh, ahah, etc., shall be transcribed.
- Other sounds made by the individual in order to imitate the sound of something they are referring to shall be transcribed verbatim in italics and explained in parenthesis.

Example:
A: It was like whooosh (participant imitates a bird flying away) and I was so relieved!

- All words shall be transcribed as the individual said them. The transcript shall not be "cleaned up" by removing slang and errors, or reorganizing sentences (i.e. there should be no editing while transcribing).
- Transcripts should not be "cleaned up" for content, but it is important to use proper grammar and punctuation that will help the analyst to work with the text.

Inaudible Information
The transcriptionist shall identify portions of the audiotape that are inaudible or difficult to decipher. The transcriptionist should indicate a small inaudible segment by typing the phrase [inaudible] in square brackets.

Example:
You cannot be sure you hear all Russian words correctly, sometimes the meaning simply [inaudible].

If the transcriptionist is unsure that they deciphered the word correctly, he/she should add their educated guess followed by a question mark.

Example:
You cannot be sure you hear all Russian words correctly, sometimes the meaning simply [inaudible; disappears?].

If a lengthy segment of the tape is inaudible, unintelligible, or when no one was speaking, the transcriptionist shall record this information in square brackets. In addition, the transcriptionist shall provide a time estimate for information that could not be transcribed.

Example:
[Inaudible: 2 minutes of interview missing]

Overlapping Speech
If individuals are speaking at the same time and it is not possible to distinguish what each person is saying, the transcriptionist shall indicate this with the phrase [cross talk] in square brackets.

Example:
A: People do not always take turns; they may start speaking at the same time and it's hard to understand who said what [cross talk].

Pauses
Indicate short pauses (a two- to three-second break) between phrases or statements by three periods.

Example:
A: When I first arrived in Moscow, I felt like … you know … absolutely lost.
Indicate a substantial speech delay (more than 5 seconds) with a "long pause" in parentheses.

Example:
A: It was really hard to work and live in Kazakhstan; my children stayed at home and I also lived in very bad conditions – there were 9 other people in the apartment. (Long pause) I am not sure I will ever want to return.

Sensitive Information
If the respondent uses their own name or the name of their friends or family during the discussion, the transcriptionist shall replace this with this person's initials in quotes when this first happens and explain who this person is. For example, a friend's name Parviz should read: "P" [participant's friend].

Example:
A: "P" [participant's friend] helped me a lot while in Russia; I did not feel lonely."
Others' names, locations, organizations, and so on, should be indicated with an equal sign (=) before and after sensitive information.

Example:
A: =Dilbar= wanted to travel to =Lipetsk= with me, but =Karim= [Dilbar's husband] did not agree to that.

The transcriptionist/translator shall highlight any unfamiliar, unknown, questionable, or unconventional words in yellow italics and add a note in red text in parentheses to indicate that the translation/intent of this phrase or word is unknown, or to make a suggestion as to what the text might mean. While translating unknown words/terms from Tajik into Russian, keep the original word in Tajik, highlight it in yellow and add your comment in red text in parentheses.

After the ENTIRE document has been transcribed/translated, the transcriptionist/translator must check all interview transcripts before sending them to the data manager/International Consultant.

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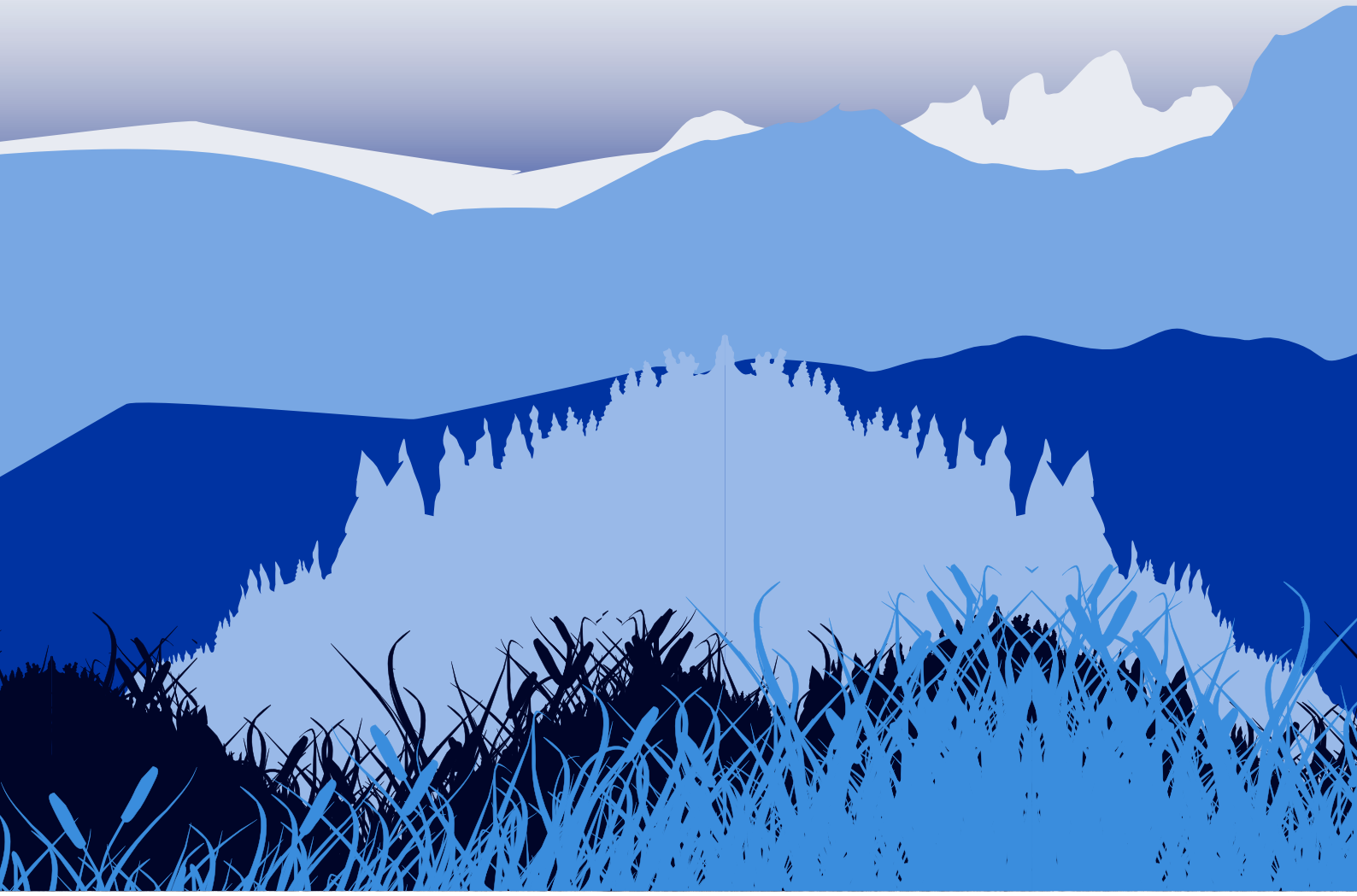

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