

Workshop I - Voluntary return to the Caucasus region

29. – 31. October 2018 in Augsburg, Germany

Workshop report

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Diakonie
Augsburg

Bayerisches Rotes Kreuz 
Kreisverband Augsburg-Land



**Bayerisches Staatsministerium des
Innern und für Integration**

Dieses Projekt wird aus Mitteln des Asyl-, Migrations- und Integrationsfonds kofinanziert. Dieses Projekt wird aus Mitteln des Bayerischen Staatsministeriums des Innern und für Integration kofinanziert.

1. AVRR overview of Europe

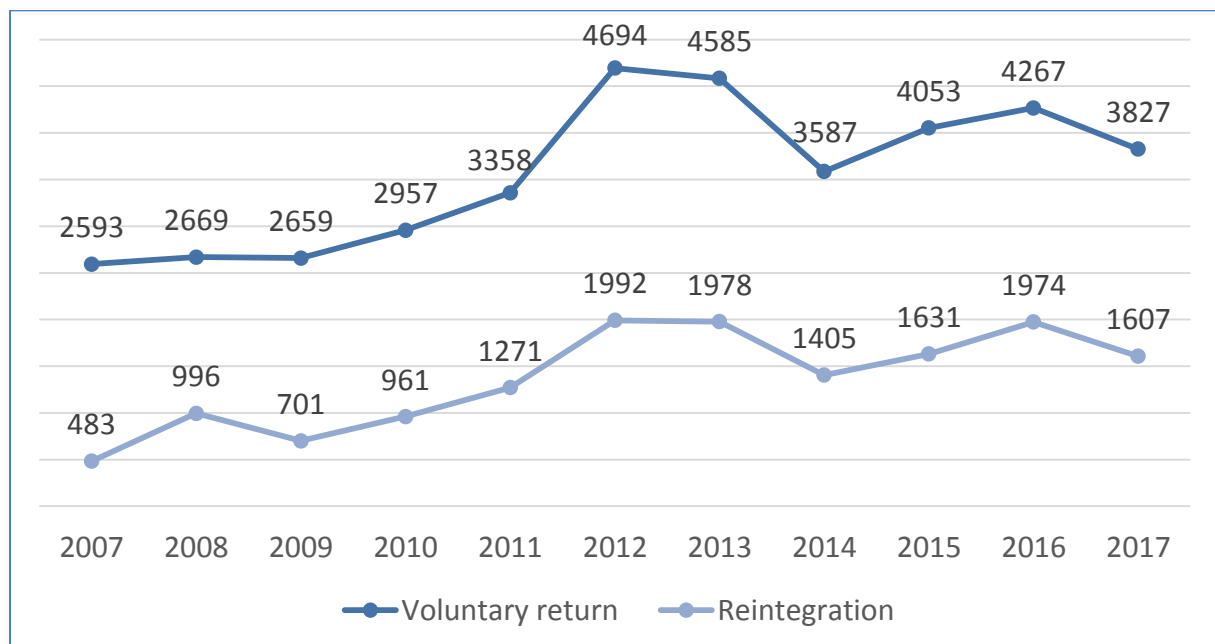
A detailed overview of the AVRR counseling systems is available in the conference reports of the predecessor projects on our homepage: www.caritas-augsburg.de/transnational4

The following document summarizes the presentations of the workshop and shows the results of the working groups which were not modified or rephrased afterwards.

1.1. Belgium

In Belgium the return counselling is not offered by several providers such as Caritas International, Federal Agency for the reception of Asylum Seekers (Fedasil), IOM, cities, etc.. Reintegration counselling is only offered by Caritas International and IOM.

Figure 1: Voluntary return and reintegration numbers from 2007 to 2017 provided by Fedasil



The highest number of reintegration beneficiaries according to nationality in 2017 was:

1. Iraq with 352
2. Georgia with 263
3. Ukraine with 171

Main countries of return in 2017 (numbers from Fedasil):

	Country of return	Number of returns
1.	Ukraine	906
2.	Romania	624
3.	Iraq	377
4.	Brazil	285
5.	Georgia	282
6.	Albania	134

Legal status of returnees in 2017:

Asylum seekers	704	18%
Rejected asylum seekers	938	25%
Irregular migrants	2185	57%

Number of voluntary returns from January until September 2018 is 2426.

News from Fedasil:

- Fedasil wants to focus more on entrepreneurship training for future returnees (Plan Einstein)
- Fedasil sees the importance of pre-departure counselling and wants to expand it
- RIAT – Tool
- Fedasil wants to advertise voluntary return more on social media
- Fedasil sees an increasing demand for assisted return to Syria and wants to prepare for it now

1.2. Austria

AVRR counselling is provided by Caritas in 7 federal states and by the Human Rights Association Austria (VMÖ) in 8 federal states. State counsellors only offer assisted voluntary return in Kärnten.

2017	
Number of voluntary returns in 2017 (BFA – Federal Office for Immigration and Asylum)	5064
Main countries of return in 2017 (IOM)	Iraq (686), Ukraine (348), Serbia (291), Russian Fed. (285), Afghanistan (231)
2018	
Number of voluntary returns in January - July 2018 (Federal Ministry of the Interior)	3030 with the main countries of return Iraq (376) – no further statistics
AVRR statistics of Caritas for January until September 2018	first counselling contacts: 6933 number of voluntary returns assisted by Caritas: 822

News from Austria:

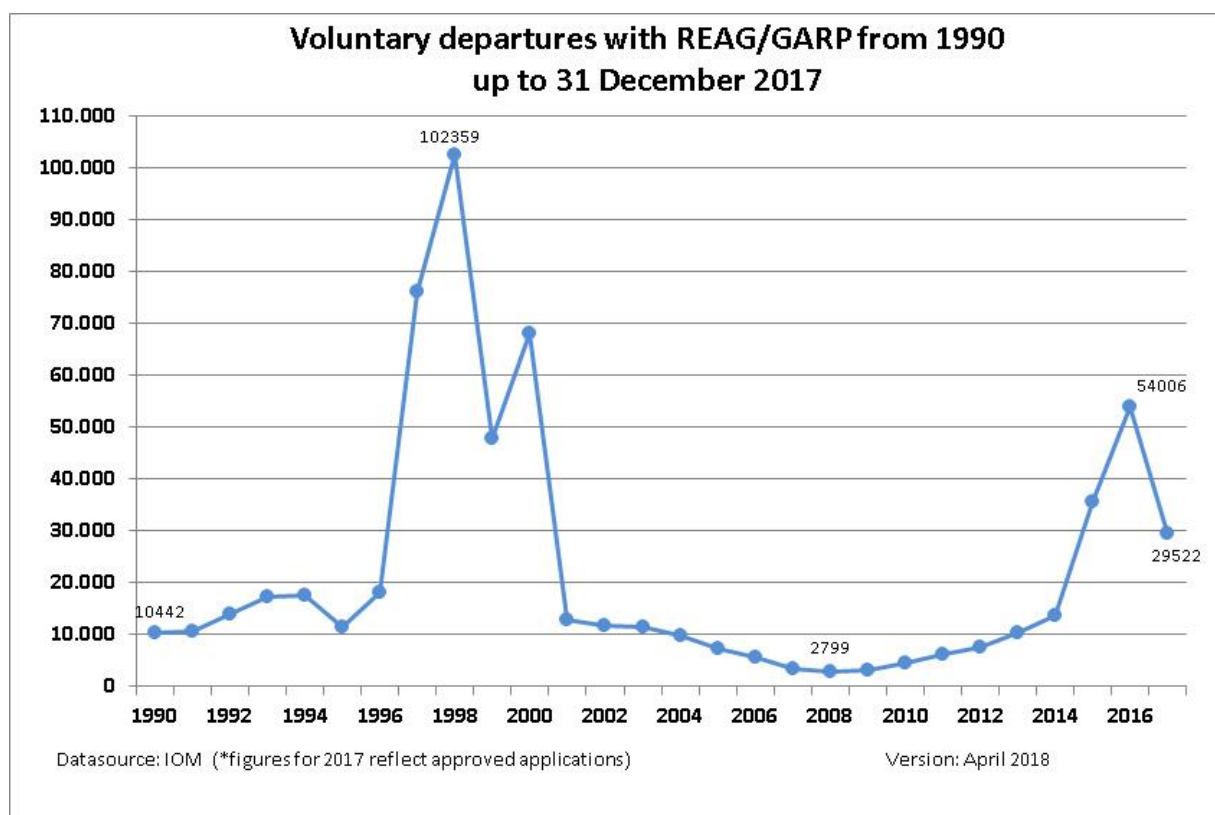
- Government plans to restructure parts of the asylum system in Austria; a new federal agency is planned which might be in charge of return counselling, legal counselling and accommodation for migrants from 2020 onwards (the information is taken from the media)
- New financial incentives for voluntary return (so-called Bonusaktion) for a limited amount of time (2.cycle):
 - Target group: people in their asylum application process or people whose asylum decision is not older than 6 months, from: Syria, Afghanistan, Iran, Russia, Nigeria, Iraq (N.B.: In Syria it can be even longer than 6 months, always individual examination, mostly because of peoples' own funds)
 - Amount: Starthilfe is the same + additional 1000 EUR (max 3000 per family)

- Time: 01.09.2018 – 31.12.2018
- Expansion of reintegration offers with OFI (new; bilateral project): from Sept 2018 Austrian returnees can also go to the local offices of the French Ministry of Interior in the countries of return e.g. Benin, Burkina F., Cote d'Ivoire, Cameroon, Senegal, Togo, etc. (Francophonie) and receive counselling (administrative, legal) + in-kind assistance (until 3000 EUR – accommodation, mini-business, medical costs)

1.3. Germany

Return and reintegration counselling is offered either by welfare organizations or by local or federal immigration offices and in case of Berlin by IOM.

Figure 2: Assisted and financed voluntary returns from Germany



In 2017 the 5 main countries of returnees were by far Albania, followed by Macedonia, Serbia, Iraq and the Russian Federation.

News from Germany:

- Program Homeward Bound (Perspektive Heimat) financed by the Federal Ministry for Economic Cooperation and Development and implemented by the Deutsche Gesellschaft für internationale Zusammenarbeit (GIZ) from 2017 onwards: 15 reintegration scouts all over Germany who provide advice for return counselors and act as a bridge between the reintegration programs in the countries of origin and the AVRR counsellors in Germany. Offered for 11 countries by now.
- “Your Country. Your Future. Now!” – Additional housing-related reintegration assistance to the existing financial federal Program StarthilfePlus limited to returnees who apply for the

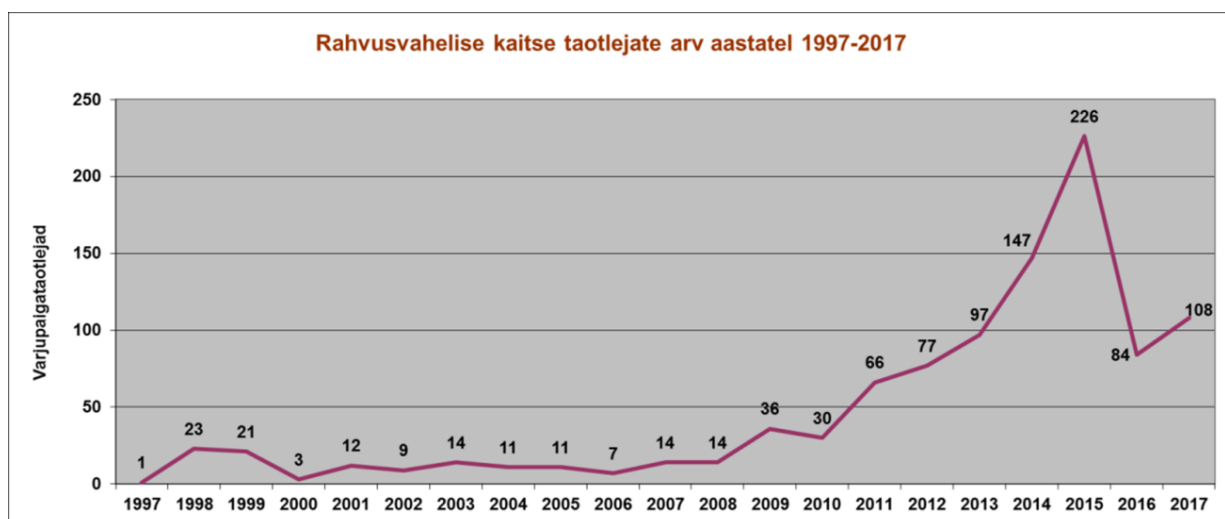
program between 15th of September and 31st of December 2018; families can be supported in kind up to max. 3.000 € as needed; individual persons can be supported in kind up to max. 1.000 € as needed regarding rent, needed constructions, basic furniture and kitchen equipment; it's implemented in the country of origin, coordinated by the local IOM offices.

- Program to support voluntary return to Syria by the Federal Office for Migration and Refugees: 50% of the return costs (plane ticket, travel budget of 500€) and 100% of financial incentives to return (Starthilfe Plus) are co-financed. Voluntary return to Syria is not yet assisted in all federal states of Germany.
- Starthope@home: individual coaching for returnees in Germany to prepare for the local job market or prepare for self-employment and to open small businesses in the country of origin; the coaching usually takes place around 6-8 weeks, but individual shorter or longer sessions are possible; offered for participants of 13 countries in 7 cities or regions in Germany

1.4. Estonia

Return counselling is solely offered by IOM in Estonia.

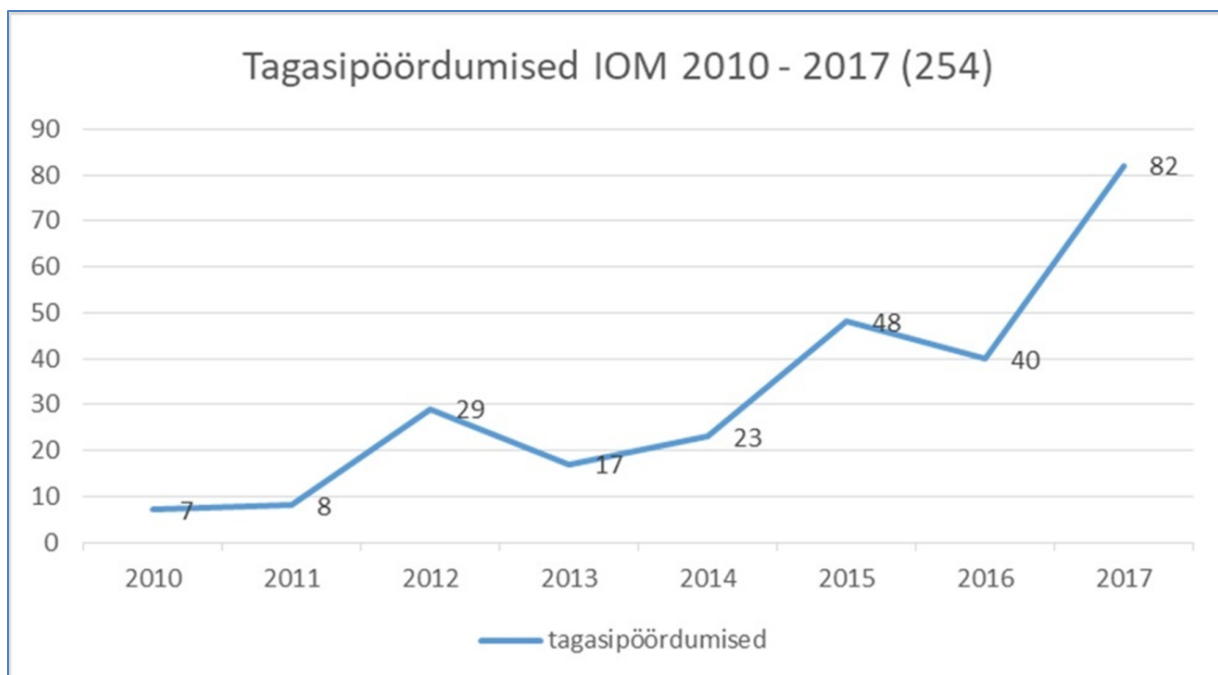
Figure 3: Reception number of refugees (Red Cross Estonia)



Number of voluntary returns from Estonia (Eurostat):

645 third-country nationals were ordered to leave the European Union and 580 people (89,9%) returned

Figure 4: Number of assisted voluntary returns by IOM



Main countries of assisted return from 2010 until 2017 by IOM: Ukraine (78), Georgia (36), Russia (28), Belarus (18), Armenia (15), Lebanon (11)

1.5. Switzerland

AVRR counselling is offered by IOM, the cantons, NGOs such as Caritas.

Number of returns:

	2017	2018 (Jan – Oct)
Reintegration Assistance from Switzerland (RAS):	717	380
swissRepat IOM Movements (SIM):	357 (vulnerable cases)	232
Cantons	172	86
Total	1246	698

Main AVRR countries 2018:

1. Georgia
2. Algeria
3. Gambia
4. Macedonia
5. Serbia

News from Switzerland (Source: IOM Switzerland):

- New Asylum law and new AVRR system in Switzerland: The most important objective of the new approach is to accelerate the asylum procedure while also maintaining the fairness of

the procedure. In principle, Swiss voters already clearly approved introducing faster asylum procedures in June 2013. Furthermore, they stated that accelerated procedures should be evaluated in a test phase. The acceleration of asylum procedures was tested in Zurich between January 2014 and September 2015. The acceleration of asylum procedures will become a reality across Switzerland as from 1 March 2019. About 60 percent of all asylum applications will be legally adjudicated within 140 days and rejected asylum seekers will be returned directly. These procedures are implemented in six regional Federal Asylum Centers (accelerated procedures and Dublin procedures).

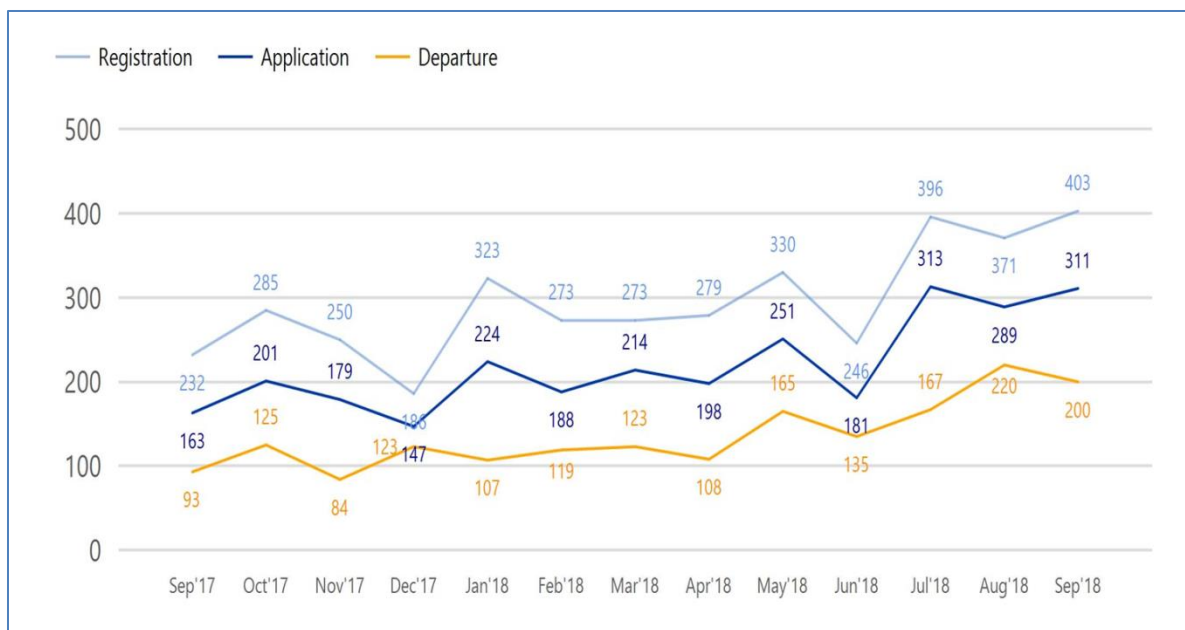
- Independent procedural advice and free legal counsel: at the start of the preparatory phase, every asylum seeker receives independent procedural advice and free legal counsel for the entire duration of the test procedure unless he or she explicitly wants to relinquish this right. This assignment of legal counsel is done prior to the first interview and applies throughout the asylum process.
- New return and reintegration programs, applied in the Test-Centers and in the Federal Migrant Centers in March 2019: New AVRR Modell, 3 steps
 - Phase 1: Before and during the first interview: 1'000 CHF for single persons, 1500 CHF for couples and 2000 CHF for families. If the beneficiaries come from a country marked in blue on the chart, they get additionally an in kind project in the value of 3000 CHF.
 - Phase 2: immediately after the decision: 500 CHF for couples: 750 CHF , families: 1'000 CHF. If the beneficiaries come from a country marked in in blue on the chart, they get additionally an in kind project in the value of 3000 CHF.
 - Phase 3: after a long time of receiving the decision 250 CHF for a single, 375.- for a couple and 500 CHF for a family



1.6. The Netherlands

AVRR counselling is offered by the Dutch Council for Refugees (VluchtelingenWerk), other non-profit organizations which combine professional training and pre-departure counselling, by IOM and the state authorities.

Figure 5: Number of migrants voluntarily returned in 2017 and 2018 (IOM the Netherlands)



Main countries of return in Jan – Sep 2018 (IOM): Albania (203), Moldova (163), Iraq (129), Azerbaijan (107), Tajikistan (95), China (56), Armenia (43)

News from the Netherlands:

- Reintegration support limitation for West Balkan and Moldavia, Ukraine, Georgia as well as countries bordering Europe.
- Budget for target groups /extra projects.
- Increased room for counselling.
- New client website Dutch Council for Refugees:
<https://www.vluchtelingenwerk.nl/forrefugees/belangrijke-informatie-je-eigen-taal?language=en>

1.7. Denmark

AVRR counselling is solely provided by the Danish Refugee Council (DRC) in Denmark – 16 counsellors total. The DRC offers two separate types of counselling depending on the legal status of the migrant: repatriation counselling for migrants with a residence permit and return counselling for rejected asylum seekers.

Support options for rejected asylum seekers after return: The support is in kind for approximately 2,670€ and may consist of: airport pick up, initial housing for a few days, vocational training or business startup, medical assistance etc.

Support options for former asylum seekers or immigrants with a residence permit can reach up to 18.000€ if he/she is above 18 years old. 7.300€ will be paid before the departure and the rest after one year. For minors the amount is 5.500€. If a person is above 55 years old, he/she besides the 18.000€ can also receive around 500€ every month for 5 years or 400€ every month for the rest of

the life. Furthermore, it is possible to get support for health insurances, business startup and kids schooling for some limited years in the country of return.

Number of departures (DRC):

	2017	2018 (Jan - Sep)
Rejected asylum seekers	593	348
Asylum seekers who withdraw the application for asylum before a final decision	187	144
Total	780	538

Main countries of return:

	Number of returnees with residence permit in 2017 (DRC)	Number of returnees with residence permit from Jan – Sep 2018 (DRC)
Bosnien-Hercegovina	35	34
Turkey	57	51
Russia	29	33
Somalia	43	29
Myanmar	0	15
Colombia	48	6
Iran	22	7
Total	341	265

News:

- In addition to the ERIN and ERSO programs, the Danish authorities also support Iranian asylum seekers with a cash grant support for business startup with around 3,335€. The money will be paid in cash at Danish Embassy in Tehran. Somali rejected asylum seekers are also supported with in kind support and a small cash grant through DRC.
- The Danish authorities established three departure centers. One for rejected asylum seekers who cooperate with the Danish police about their return. The other departure centers are for those rejected asylum seekers who do not cooperate with the Police about their return. One of these centers is for families, the other one is for single persons and rejected foreigners who can't be sent to their home country.

2. A cultural introduction to the Chechen Republic

The following information is fully taken from the PowerPoint Presentation of Luiza Bazurkaeva, SINTEM, presented during the Transnational Exchange IV Workshop on the 29.10.2018 in Augsburg, Germany:

Country Facts:

Country:	Russian Federation
Federal district:	North Caucasian
Capital:	Grozny
Area:	17,300 km ²
Official languages:	Russian and Chechen
Population appx.:	1,400, 000



Traditional family structure:

- Chechen families are usually large. Normally a family has 3-5 children. There are normally three generations within one family: grandparents, parents and children.
- The family structure is quite hierarchical and patriarchal. The living grandmother or the mother (if she raised children alone) can be the decision maker in the family.
- The parents are responsible for children and they decide what is better for children.
- If there are several sons in the family the youngest one is an heir and he must take care of the parents when they get older or ill.

Traditional values:

There are similar values for every ethnicity in North Caucasus: Honor, Courage, Endurance, Modesty, Hospitality, and Equality

Religion in Chechnya:

The Chechen people are adherents of Sunni Islam. Most of people follow Shafii madhhab (school of jurisprudence). Islam was declared as a state religion in 17th century. There were different religious leaders at different periods who proclaimed Caucasian Imarat as an independent territory and it was in fact the anti-colonial movement under the banner of the Jihad (religious war).

Religion has emerged as an instrument of unity in a break away struggle. Still the Chechens are not typically religious as religious law is not a source of law in Chechnya. Anyway the people of Chechnya have rallied around their Islamic identity through uprisings and wars in an effort throw off the yoke colonialism. Society is divided into three parts according to the identity: religious, secular and adherent to original culture.

Adat:

Adat is a traditional law appeared in pre-Islamic period and still practiced in the society. There were people who used to have life experience and a good reputation in society who could carry out the better solution for each incident in the society.

Adat that do not conflict with Islamic law are applied in daily life. Unfortunately adat are interpreted from the position of power. If the decisions used to be carried out by a group of people, now it can be one person's will that doesn't imply adat.

If the blood feud targeted only the offender in the past, now a full age son or a brother of the offender can become avenger's objective. A woman used to be inviolable and if there was a case of insult, the offender was disgraced.

Reintegration work:

Caritas Moscow is the main service provider who works in ERIN framework located in Chechnya. Caritas Moscow provides service for returnees to Chechnya, Ingushetia, North Ossetia, Dagestan, Kabardino-Balkaria, Stavropol region.

Sintem (Harmony) provides reintegration services for children.

- Business start-up assistance
- Legal advice and referral
- Educational assistance (language courses for children and teenagers)
- Psychological assistance
- Vocational training referral
- Summer camps

3. A cultural introduction to Georgia

The following information is fully taken from the PowerPoint Presentation of Tata Topadze, Caritas Georgia, presented during the Transnational Exchange IV Workshop on the 29.10.2018 in Augsburg, Germany:

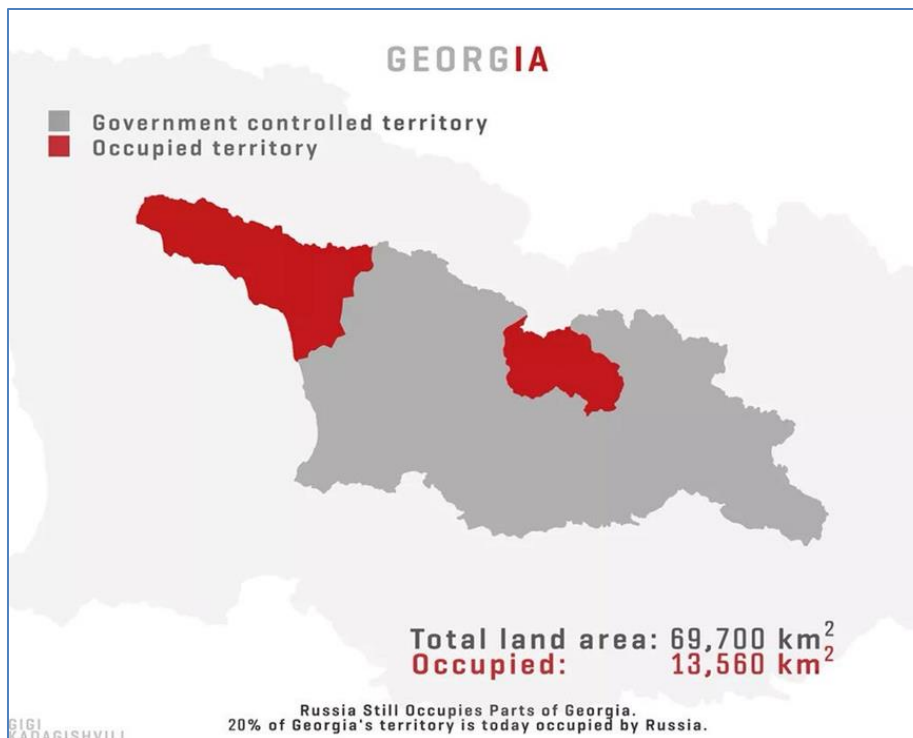
The Georgian language first appeared in writing in about 430 AD in an inscription in a church in Palestine.

Population of Tbilisi is around 1 118 000 people. Tbilisi underwent a lot of innovative construction within the last ten years.

28.10.2018: elections – ruling President Giorgi Margvelashvili was reelected.

120 thousand citizens of Georgia became refugees after the 2008 war.

Now: refugee settlement for refugees from South Ossetia (15.000 persons)



Main reasons for migration:

- Around 263 000 refugees from South Ossetia and Abkhazia
- 21,3% of the population lives below national poverty line (in 2016)
- Unemployment
- Low pension and social allowance – around 60 Euro and 35 Euro per month

Main powerful institution in Georgia is the Orthodox Church: it can impact political decisions and law-making

Apart from the Georgian Orthodox Church, Christianity in Georgia is represented by followers of the Armenian Apostolic Church and Russian Orthodox Church, Georgian Catholic Church, which mostly follows either the Latin rite, Armenian rite and Assyrian-Chaldean rite

4. Chronic illnesses and their impact on return arrangements

The following information is fully taken from the PowerPoint Presentation of Kathleen Nitzsche, Operational Assistant and Team Coordinator from IOM Nuremberg, presented during the Transnational Exchange IV Workshop on the 30.10.2018 in Augsburg, Germany:


Three stages of voluntary return:

1. Pre-departure stage:

- Provision of relevant return-related information (counselling)
- Ability to make a competent decision (capacity to decide, voluntariness of return, informed consent)

2. Transportation stage:

- Assessment of fitness to travel (blood pressure, vital signs, physical and mental condition → avoidance of any logistical disturbances – deviation or delays)
- Modalities of transport (social or medical escort, specific booking class, medical equipment)
- Challenge: if the passenger need extra oxygen during the flight, the airline needs to be informed at least 72 hours in advance)
- Medical forms required by the flight booking agency: IATA (general information for first overview; in cases of rapidly decreasing illnesses this form might need to be filled out more than once in the pre-departure phase) & MEDIF (for each specific airline; usually only once to be filled out shortly before the departure)



Medical Manual Appendix 'E'

Attachment A
Information sheet for passengers requiring special assistance

- Family name First name Title
- Passenger name record (PNR)
- Proposed itinerary From (Airport) To (Airport)
Airline(s) Flight #(s) Class(es)
Date(s) Segment(s)
yyyy/mm/dd
- Nature of illness
- Intended escorts ☐ Yes ☐ No Name Title Age
PNR if different Medical qualification ☐ Yes ☐ No Language spoken
- Wheelchair required ☐ Yes ☐ No Specify wheelchair categories
Passenger own wheelchair ☐ Yes ☐ No Specify wheelchair type Weight & size
Specify Metric or Imperial (e.g. Kg or Lbs, etc.)
- Ambulance needed (to be arranged by the passenger or his/her representative) ☐ Yes ☐ No
If yes, specify name of ambulance company
Name of contact Contact tel. no.
- Meet and assist (if available) ☐ Yes ☐ No If designated person, specify contact
- Other ground arrangements needed ☐ Yes ☐ No
If yes, specify
Departure airport Transit airport Arrival airport
- Special in-flight arrangements needed ☐ Yes ☐ No
If yes, specify:
Stretcher ☐ Yes ☐ No
If yes, specify arranging company
specify at whose expense
Oxygen ☐ Yes ☐ No If yes, specify*
Does the passenger needs to travel with an emotional support animal? ☐ Yes ☐ No If yes, specify
Special equipment provided by the passenger ☐ Yes ☐ No If yes, specify ☐ equipment is autonomous
Special meals ☐ Yes ☐ No If yes, specify
Special seating arrangement ☐ Yes ☐ No If yes, specify
[NOTE: EXIT ROW CANNOT BE USED BY DISABLED/ILL PASSENGERS BECAUSE OF SAFETY REGULATIONS]
- Frequent traveler medical clearance (FREMEC) for this airline ☐ Yes ☐ No
If yes, specify FREMEC number issued by expiry date

* Be advised that some aircraft may be limited in the oxygen flow rate available and that the oxygen may be offered with 'pulsed' flow.

2017-08



Attachment B – part one

Information sheet for passengers requiring medical clearance
(to be completed or obtained from the attending physician)

1. Patient's family name First name
Date of birth Gender Height Weight
2. Attending physician name E-mail
Telephone Fax
(mobile preferred), indicate country code and area code
3. Diagnosis (including date of onset of current illness, episode or accident and treatment including hospitalization, specify if contagious). Be as specific as possible

If surgery, specify nature Date of surgery
4. Current symptoms and severity (include most recent pulse, respiratory rate, and blood pressure if available)
5. Will a 25 to 30% reduction in the ambient partial pressure of oxygen (relative hypoxia) affect the passenger's medical condition?
(Cabin pressure to be equivalent of a fast trip to a mountain elevation of 2400 meters (8000 feet) above sea level) ☐ Yes ☐ No ☐ Not sure
6. Additional clinical information
 - a) Anemia ☐ Yes ☐ No If yes, give recent result in grams of hemoglobin
 - b) Psychiatric disorder ☐ Yes ☐ No If yes, see part 2
 - c) Seizure disorder ☐ Yes ☐ No If yes, see part 2
 - d) Cardiac condition ☐ Yes ☐ No If yes, see part 2
 - e) Normal bladder control ☐ Yes ☐ No If no, give mode of control
 - f) Normal bowel control ☐ Yes ☐ No If no, give mode of control
 - g) Pulmonary condition ☐ Yes ☐ No If yes, see part 2
 - h) Does the patient use oxygen at home ☐ Yes ☐ No
If yes, specify
 - i) Oxygen needed in flight? ☐ Yes ☐ No If yes, specify*
7. Escort – Is the patient fit to travel unaccompanied? ☐ Yes ☐ No
If no, would a meet-and-assist (provided by the airline to embark and disembark) be sufficient? ☐ Yes ☐ No
If no, will the patient have a private escort to take care of his/her needs on-board? ☐ Yes ☐ No
NOTE: IF YOU ANSWER NO TO THIS QUESTION, THE AIRLINE WILL LIKELY REFUSE THE PASSENGER AS IT IS THE RESPONSIBILITY OF THE PASSENGER TO PROVIDE THE ESCORT
If yes, who should escort the passenger? ☐ Doctor ☐ Nurse ☐ Other medical ☐ Other
If other non-medical, is the escort fully capable to attend to all the above needs? ☐ Yes ☐ No
8. Mobility – a) Able to walk without assistance ☐ Yes ☐ No
b) Wheelchair required for boarding ☐ Yes ☐ No If yes, specify
c) Can the passenger sit upright for take-off, landing, and emergency? ☐ Yes ☐ No
9. Medication list (use generic names and dosage)
10. Prognosis for the trip ☐ Good ☐ Poor
Any other relevant comment

* Be advised that some aircraft may be limited in the oxygen flow rate available.

2017-08



Attachment B - part two

Information sheet for passengers requiring medical clearance
(to be completed or obtained from the attending physician)

1. **CARDIAC CONDITION** ☐ Yes ☐ No
 - a) Angina ☐ Yes ☐ No Date of last episode
 - Is the condition stable? ☐ Yes ☐ No
 - Functional class of the patient?
 - ☐ No symptoms ☐ Angina with strenuous efforts ☐ Angina with light efforts ☐ Angina at rest
 - Can the patient walk 50 meters at a normal pace or climb 10-12 stairs without symptoms? ☐ Yes ☐ No
 - b) Myocardial infarction ☐ Yes ☐ No Date
 - Complication? ☐ Yes ☐ No If yes, give details
 - Test done? ☐ Yes ☐ No If yes, type of test and result
 - Can the patient walk 50 meters at a normal pace or climb 10-12 stairs without symptoms? ☐ Yes ☐ No
 - c) Cardiac failure ☐ Yes ☐ No Date of last episode
 - Is the patient controlled with medication? ☐ Yes ☐ No
 - Functional class of the patient?
 - ☐ No symptoms ☐ Shortness of breath with strenuous efforts
 - ☐ Shortness of breath with light efforts ☐ Shortness of breath at rest
2. **PULMONARY CONDITION** ☐ Yes ☐ No
 - a) Recent arterial gases? ☐ Yes ☐ No Date of exam
 - If yes on ☐ Room air ☐ Oxygen If on oxygen, specify (please select)
 - Results, pCO₂ pO₂
 - If no, saturation by pulse oximeter
 - b) Does the patient retain CO₂? ☐ Yes ☐ No
 - c) Has his/her condition deteriorated recently? ☐ Yes ☐ No
 - d) Can the patient walk 50 meters at a normal pace or climb 10-12 stairs without symptoms? ☐ Yes ☐ No
 - e) Has the patient ever taken a commercial aircraft in these same conditions? ☐ Yes ☐ No
 - If yes, date Did the patient have any problems
3. **PSYCHIATRIC CONDITIONS** ☐ Yes ☐ No
 - a) Is there a possibility that the patient will become agitated during the flight? ☐ Yes ☐ No
 - b) Has he/she taken a commercial flight before ☐ Yes ☐ No
 - If yes, date of travel Did the patient travel ☐ alone ☐ escorted?
4. **SEIZURE** ☐ Yes ☐ No
 - a) What type of seizures?
 - b) Frequency of the seizures
 - c) Date of last seizure?
 - d) Are the seizures controlled by medication ☐ Yes ☐ No
5. ☐ I confirm that I have received permission from my patient to communicate this information

Physician signature

Date


Note: Cabin crew are not authorized to give special assistance (e.g. lifting, feeding, help with the use of toilets) to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in first aid.
Important: Fees, if any, relevant to the provision of the above information and for carrier-provided special equipment are to be paid by the passenger concerned.

8/2012

CLEAR FORM

WARNING: this button will erase ALL entries

send

		MEDICAL INFORMATION SHEET — (MEDIF)		(for official use only)	
To be completed by ATTENDING PHYSICIAN		This form is intended to provide CONFIDENTIAL information to enable the airlines' MEDICAL Departments to assess the fitness of the passenger to travel. If the passenger is acceptable, this information will permit the issuance of the necessary directives designed to provide for the passenger's welfare and comfort. The PHYSICIAN ATTENDING the incapacitated passenger is requested to ANSWER ALL QUESTIONS. Enter a cross "x" in the appropriate "yes" or "no" boxes, and/or give precise concise answers. COMPLETING OF THE FORM IN BLOCK LETTERS OR BY TYPEWRITER WILL BE APPRECIATED.			
		- The form must be returned for: <div style="border: 1px solid black; width: 150px; height: 30px; margin: 0 auto;"></div> (Carrier's Designated Office)			
Airlines' Ref. Code MEDA81	PATIENT'S NAME, INITIAL(S), SEX, AGE				
MEDA82	ATTENDING PHYSICIAN - Name & Address				
	- Telephone Contact: Business: _____ Home: _____				
MEDA83	MEDICAL DATA: - DIAGNOSIS in detail (including vital signs) - Day/month/year of first symptoms: _____				
	Date of operation: _____ Date of diagnosis: _____				
MEDA84	- PROGNOSIS for the flight(s): _____				
MEDA85	- Contagious AND communicable disease? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify: _____				
MEDA86	- Would the physical and/or mental condition of the patient be likely to cause distress or discomfort to other passengers? No <input type="checkbox"/> Yes <input type="checkbox"/> Specify: _____				
MEDA87	- Can patient use normal aircraft seat with seatback placed in the UPRIGHT position when so required? Yes <input type="checkbox"/> No <input type="checkbox"/>				
MEDA88	- Can patient take care of his own needs on board UNASSISTED* (including meals, visit to toilet, etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/> If not, type of help needed: _____				
MEDA89	- If to be ESCORTED, is the arrangement satisfactory to you? Yes <input type="checkbox"/> No <input type="checkbox"/> If not, type of escort proposed by YOU: _____				
MEDA90	- Does patient need OXYGEN** equipment in flight? (If yes, state rate of flow) No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Litres per Minute Continuous? No <input type="checkbox"/> Yes <input type="checkbox"/>				
MEDA91	- Does patient need any MEDICATION*, other than self-administered, and/or the use of special apparatus such as respirator, incubator, etc.? (a) on the GROUND while at the airport(s): No <input type="checkbox"/> Yes <input type="checkbox"/> Specify: _____				
MEDA92	(b) on board of the AIRCRAFT: No <input type="checkbox"/> Yes <input type="checkbox"/> Specify: _____				
MEDA93	- Does patient need HOSPITALISATION? (If yes, indicate arrangements made or, if none were made, indicate "NO ACTION TAKEN") (a) during long layover or overnight at CONNECTING POINTS en route: No <input type="checkbox"/> Yes <input type="checkbox"/> Action: _____				
MEDA94	(b) upon arrival at DESTINATION: No <input type="checkbox"/> Yes <input type="checkbox"/> Action: _____				
MEDA95	- Other remarks or information in the interest of your patient's smooth and comfortable transportation: None <input type="checkbox"/> Specify if any: _____				
MEDA96	- Other arrangements made by the attending physician: _____				
NOTE(*) Cabin attendants are NOT authorized to give special assistance (e.g. lifting) to particular passengers, to the detriment of their service to other passengers. Additionally, they are trained only in FIRST AID and are NOT PERMITTED to administer any injection, or to give medication.			IMPORTANT: FEES, IF ANY, RELEVANT TO THE PROVISION OF THE ABOVE INFORMATION AND FOR CARRIER-PROVIDED SPECIAL EQUIPMENT(**) ARE TO BE PAID BY THE PASSENGER CONCERNED.		
Date: _____		Place: _____		Attending Physician's Signature: _____	
PASSENGER'S DECLARATION I HEREBY AUTHORIZE _____ (Name of nominated physician) to provide the airlines with the information required by those airlines' medical departments for the purpose of determining my fitness for carriage by air and in consideration thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fees in connection therewith. I take note that, if accepted for carriage, my journey will be subject to the general conditions of carriage/fairlifts of the carrier concerned and that the carrier does not assume any special liability exceeding those conditions/fairlifts. I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage.* (Where needed, to be read by/to the passenger, dated and signed by him/her or on his/her behalf.)					
Place: _____		Date: _____		Passenger's Signature: _____	

3. Post-arrival stage:

- Continuity of care in the destination country (Availability of treatment in general, accessibility for the individual returnee)
- Appropriateness of return (informed consent)
- Reintegration assistance

Critical aspects of return arrangements:

- Clinical picture and current state of health
- Duration of travel and level of strain (incl. ground travel to/from airport)
- Mode of transport
- Access to appropriate medical care during travel and post-arrival

Overview of chronic illnesses and traveling:

- a) Chronic heart diseases (e.g. coronary heart disease, heart valve disease, cardiomyopathy, congenital heart disease, etc.)

Pre-departure stage	usually no impact on ability to make competent decisions
Transportation stage	Transportation stage: history/high risk of heart failure?, ability to cope in an aircraft environment (reduced pressure & oxygen saturation), reaction to stress (e.g. first time flying, questioning by border police, baggage handling) → risk of shortness of breath, chest pains, etc.
Post-arrival stage	availability of medication and specialized treatment facilities (e.g. for stent implantation, Bypass surgery)

- b) Infectious diseases (e.g. HIV/AIDS, Hepatitis, Tuberculosis, Meningitis, etc.)

Pre-departure stage	capacity to decide may be impaired, possible treatment necessary prior to departure to reduce risk of infection
Transportation stage	Acute cardiac or pulmonary symptoms?, is the infection communicable via skin grafts, airborne contaminants, or blood and mucosa? → risk assessment for other passengers and/or medical escort
Post-arrival stage	Is there a public health risk for the receiving community?, Availability of medication and specialized treatment facilities → high risk of long-term consequences (e.g. Hepatitis B & C linked to liver cancer, pulmonary TB can cause damage to other organs, etc.)

- c) Substance abuse (e.g. heroin addiction, alcoholism, addiction to pain killers, etc.)

Pre-departure stage	Capacity to decide usually impaired depending on severity → necessity of legal guardian?
Transportation stage	Withdrawal symptoms → endangerment of self and/or others? → severity of physical withdrawal?, risk of smuggling substances, usually medical escort necessary
Post-arrival stage	Availability of rehabilitation centers, social environment intact? → risk of stigmatization, homelessness, etc.

Summary

- Chronic illnesses can have an impact on one or more stages of the return procedure
- Health-related issues should never be disregarded in favor of the wish to return as they may jeopardize a successful and sustainable return
- The sooner health-related concerns are addressed during return counselling, the better an appropriate return may be arranged

Group work – Preparing return: Aspects to consider and to discuss with the client when he or she wants to return voluntarily with a chronic illness:

Counsellors understanding of the client's health condition	<ul style="list-style-type: none"> ▪ Complications ▪ Progress of the disease ▪ Necessary medication ▪ Expert opinion from treating physician ▪ Level of possible client's participation ▪ Possibility to work ▪ Legal guardian ▪ Motivation ▪ Fit to Fly questions → counsellor already has to have an idea about the ability to fly e.g. pregnancy or terminal stage of life
Flight	<ul style="list-style-type: none"> ▪ Medical or social escort + explanation to the migrant ▪ Airline regulations ▪ Documents for customs (when transporting medication) ▪ Logistics (wheel chair, oxygen)
Access to medication in CoR	<ul style="list-style-type: none"> ▪ Availability ▪ Accessibility ▪ Quality of medication ▪ Prescription requirement ▪ Additional costs
Client's understanding of own health condition	<ul style="list-style-type: none"> ▪ Stigmatization ▪ Understanding of the illness/ awareness of the illness ▪ Acceptance of the situation ▪ Willingness to take medication
Medical reports	<ul style="list-style-type: none"> ▪ Translated, legalized reports ▪ Summaries of medical letters ▪ Fit to fly certificate ▪ Additional reports e.g. blood type ▪ In case of addiction: questions about aggressiveness and dose
Favorable or necessary environment/ structure in CoR	<ul style="list-style-type: none"> ▪ (medical) equipment (e.g. fridge for insulin) ▪ Access to public transport ▪ Locality (e.g. hilly area counter-productive for heart diseases) ▪ Social benefits/ availability of health care system ▪ Local food distribution ▪ Accommodation
Social network	<ul style="list-style-type: none"> ▪ Family & network ▪ Stigmatization ▪ Willingness to take care of the returning client ▪ Capacities for caring for the client ▪ Economic situation ▪ Level of rejection
Client's self-care	<ul style="list-style-type: none"> ▪ Food / nutrition

	<ul style="list-style-type: none"> ▪ Healthy life style ▪ Positive attitude ▪ Understanding of political and economic and cultural situation in CoR
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5. Overview health care system in the Caucasus

The following information is fully taken from the PowerPoint Presentation of Risatul Islam, Chief Medical Officer from IOM Ukraine, presented during the Transnational Exchange IV Workshop on the 30.10.2018 in Augsburg, Germany.

What is Health?

Health, as defined by the World Health Organization (WHO), is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."



What is Health Care?

Health care is the maintenance or improvement of health via the prevention, diagnosis, and treatment of disease, illness, injury, and other physical and mental impairments in human beings.

Types of health care

Basic Primary Health Care Secondary Health Care Tertiary Health Care	Additional Home Based or Community Care Emergency Health Care
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Primary Health Care:

(PHC) they are the basic first level of contact between individuals and families with the health system. The general practitioners, the family physician, the physiotherapist are the usual primary health care providers. Immunization, basic curative care services, maternal and child health services, prevention of diseases are the type of services provided by phc's. Family planning, health education, provision of food and nutrition and adequate supply of safe drinking water may also be included in their services.

Secondary Health Centre:

Health care services, at such centers are provided by medical specialists. They may not have first contact with patients. Depending on the policies of the national health system, patients may access these services through physician referral or self-referral. Secondary health care providers include cardiologists, urologists, dermatologists and other such specialists. The health care services include acute care, short period stay in a hospital emergency department for brief but serious illness. There may be secondary care providers who do not work in hospitals - psychiatrists, physiotherapists, respiratory therapists, speech therapists and so on.

Tertiary Health Centre:

This is a specialized consultative health care for inpatients. The patients are admitted into these centers on a referral from primary or secondary health professionals. Tertiary health care is provided in a facility that have personnel and facilities for advanced medical investigation and treatment. Services provided include cancer management, neurosurgery, cardiac surgery and a host of complex medical and surgical interventions. Advanced diagnostic support services and specialized intensive care which cannot be provided by primary and secondary health centers are available at the tertiary health centers.

Health Care System:

A healthcare system can be defined as the method by which healthcare is financed, organized, and delivered to a population. It includes issues of access (for whom and to which services), expenditures, and resources (healthcare workers and facilities). The goal of a healthcare system is to enhance the health of the population in the most effective manner possible in light of a society's available resources and competing needs.

Four basis models for health care systems:

The Beveridge Model	The Bismarck Model
<p>Named after William Beveridge, the daring social reformer who designed Britain's National Health Service.</p> <p>In this system, health care is provided and financed by the government through tax payments, just like the police force or the public library.</p> <p>Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government.</p> <p>These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge.</p>	<p>Named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century.</p> <p>Despite its European heritage, this system of providing health care would look fairly familiar to Americans.</p> <p>It uses an insurance system -- the insurers are called "sickness funds" -- usually financed jointly by employers and employees through payroll deduction.</p>

The National Health Insurance Model	The Out-of-pocket Model
<p>This system has elements of both Beveridge and Bismarck.</p> <p>It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into.</p> <p>Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler administratively than American-style for-profit insurance.</p>	<p>In this model citizen have to pay for every health services from their own money.</p> <p>Unfortunately most of the underdeveloped country has such kind of health care system.</p>

What was the health care model in Caucasus during former Soviet Union era?
The Semashko Model:

Healthcare services belonged to the state, and healthcare professionals were paid by the state. Services were usually free. The health care system was under the centralized control of the state, which financed services by general government revenues as part of national social and economic development plans. Main focus was communicable disease prevention.

Was every service really free of cost? No, there were several informal off the record payment modalities like gratitude payment, bribe and etc. was there.

Up until the 1960s, the Soviet health system achieved genuine progress in reducing infant and overall mortality, by allocating medical personnel across the national territory, by improving conditions for childbirth, and by tackling infectious diseases.

Problems with Soviet health care began to emerge in the 1970s, because the system, focused on the prevention of infectious and parasitic diseases and on increasing the number of hospital beds, failed to take account of the need to combat chronic diseases (diabetes, cardiovascular disease, etc.) and make the necessary policy changes.

What was the major drawback of the Semashko Model?

- Main focus was infectious diseases prevention
- No developed primary care service
- Main concentration was admitting patient in hospital rather giving out patient service.

Gradually Semashko model collapsed.

After the Soviet Union era:

In the 1990s, the severe economic crisis that followed the breakup of the Soviet Union left all the former Soviet republics in extremely difficult financial situations. There were drastic cuts to all social spending, including health care. So question of Health Care System Reform have arisen among the all Caucasus countries.

Health care systems nowadays in the Caucasus region:

Armenia

- Are going through a health sector reform
- decentralized the health care
- Currently having a modified out of pocket modality
- The reforms formalized fee-for-service payments,
- But a Basic Benefit Package (BBP) of free health care is there for welfare recipients, young children, and other population groups (including orphans, children from large families, disabled people, veterans, and Chernobyl “liquidators”), with the potential to be extended gradually to a larger section of the population.
- Free maternal and child health care and the extension of free medical checkups and basic benefits for children up to the age of seven.
- Private health insurance is available in the country but covering mainly a tiny portion of the population. Mainly employers of the private and international organizations providing such for employees. Premium is very high so out of reach of mass population.
- Rural area is still out of basic and specialist health care presence.
- Primary Health Care System not fully developed yet.

Azerbaijan

- Azerbaijan’s health system is still based on the Soviet model of free consultations and care.
- Azerbaijan has maintained a centralized health system.
- The Ministry of Health is responsible for the healthcare system.
- The majority of medical facilities, which include public hospitals as well as pediatric and adult polyclinics, are state-owned and services are free of charge.
- Polyclinics offer outpatient services only, while hospitals and specialized clinics offer both outpatient and inpatient services.
- In rural areas, primary healthcare is usually provided by the village doctor (feldsher). However, professional primary and secondary care is available throughout Azerbaijan at private clinics and hospitals, which have modern equipment. Fee-for-service payments, which already existed informally, were formalized for some specialist care in 1994 and again in 1998.
- Some medical treatments, for example oncology, can be obtained at state hospitals only. Reproductive health and maternity services are offered at women's consultation centers.
- Private medical establishments are growing very rapidly; while they are licensed by the Ministry of Health, they are otherwise independent.
- The large oil companies have developed their own health systems for their employees, which are independent but subject to authorization from the Ministry of Health.

Georgia

- Georgia, like other former Soviet states, could no longer afford a Soviet-style, cradle-to-grave healthcare system.
- Georgia has huge health care system reform in last 15 years,
- In 1991, private spending became the major source of health service financing
- In 1995, state declared no more free of charge medical service.
- In 2007, they totally shut down the Semashko Model and moved to an insurance based health care model.
- Almost 80 % of the states hospital and medical service was sold to private sector to renovate and stablish quality health care,
- From 2013 Georgia has moved to universal health care model.
- UHC means, healthcare is provided by the government (in most cases through private-sector providers) and financed by the government through tax receipts.
- UHC mainly cover primary care and specific health care.

- Citizens still have to do co-payment out of their pockets.
- Specialized service and medicine may not always available.

What are key points we need to keep in mind while planning medical return to Caucasus?

- Lack of primary health care service may result in unnecessary hospitalization.
- Patient may not able to choose own physician and hospital
- Theoretically medical service is free but in reality patient may need to purchase specialized service and own medicine.
- Specialized service and necessary medicine may not always available.
- Informal payment like gratitude money, bribe, no way of reimbursement.

6. Health care details Georgia and Chechen Republic

6.1. Georgia

The following information is fully taken from the PowerPoint Presentation of Tata Topadze, Caritas Georgia, presented during the Transnational Exchange IV Workshop on the 30.10.2018 in Augsburg, Germany:

Reintegration service:

1. Medical research (request of medical attestation from the host country for referral to medical establishments in Georgia in case of tuberculosis, hepatitis and other chronic diseases)
2. Research of available medication, analyses of prices, duration of treatment, doses
4. Facilitate access to medical treatment
5. Follow up during 6 month

Available services:

- Centre of Mental Health and Prevention of Addiction
- National TB Centre
- Infectious Diseases and AIDS Centre
- Tbilisi Cancer Centre
- Different referral clinics to other medical establishments

Insurance:

State insurance applies to citizens of Georgia from birth to 18 years of age and for the retired people, for the rest of the segment, the state has developed various health care programs where it is possible to use various services with different payment percentage

For example - tonsils surgery for habitant of capital will be covered by Government at 70% and rest 30% person has to pay himself

For region payment divide by 80%-20%

6.2. Chechen Republic

The following information is fully taken from the PowerPoint Presentation of Luiza Bazurkaeva, SINTEM, presented during the Transnational Exchange IV Workshop on the 30.10.2018 in Augsburg, Germany:

1. Medical research for each case
2. Analysis of health care establishments
3. Referral to social services engaged in the process (health insurance)
4. Assistance during medical reintegration
 - For every Russian citizen medical care is available for free if he/she obtains health insurance
 - There are two types of health insurance available in Russia compulsory health insurance and supplementary health insurance.

Compulsory health insurance	Supplementary health insurance
<ul style="list-style-type: none"> ▪ Obligatory ▪ Quality of medical services is low because conditions arise from state social program ▪ Medical assistance and medication provided at basic level. ▪ Medical establishments are determined by insurance fund ▪ Financing of insurance is provided in particular by voluntary contributions, taxes and state budget. ▪ Covers treatment of common chronic diseases ▪ Standard medical examination and diagnostics are included ▪ There is a long waiting list and patients are required to register in advance in an the hospital at the place of residence. ▪ Low quality medication and assistance, waiting in line, analogues of medicals that are used abroad 	<ul style="list-style-type: none"> ▪ Optional ▪ Insured person chooses comfortable conditions and pays for them thus the quality is much higher ▪ Various options to receive additional medical assistance and preventive medical care ▪ Insurance company chooses various medical establishments that provide a wide range of qualified medical assistance. ▪ The source of financing is insured person or employer ▪ Covers all diseases mentioned in insurance contract ▪ Standard medical examination and diagnostics are included into contract but there can be time limitations for each examination ▪ Ill people receive assistance at once and can apply to any hospital they have chosen and mentioned in the contract ▪ High quality assistance, no waiting in line, medicals of better quality.

Facts:

- Quality of medical care is very low because of human resources aren't well qualified

- No supplementary health insurance is available in Chechnya
- People prefer to receive medical assistance in Moscow, Saint Petersburg, Rostov and other bigger cities
- The costs for treatment grow and become unaffordable

Process of gaining medical assistance/quota:

1. Referral from the therapist
2. The first commission reviews the application (3 days)
3. The second commission is gathered by the local ministry of healthcare. Application is reviewed and sent to the next stage within 10 days
4. The third commission gathered at hospital where the medical care will be provided decides to give quota or not

7. Conflicts within Chechen families

The following information is fully taken from the PowerPoint Presentation of Luiza Bazurkaeva, SINTEM, presented during the Transnational Exchange IV Workshop on the 30.10.2018 in Augsburg, Germany:

Pre-marital relationships between men and women in culture and law

- Young people have very modest relationship. They do not express their feelings and emotions towards each other in public. They cannot see each other alone. There must be witnesses of their meetings. They can see each other in the streets, in the cafes and other public places. In rural areas there is a tradition that they see each other in the house of relatives or neighbors' house.
- No sexual relationship is allowed out of matrimony, for both men and women.
- If the couple decides to get married a man sends relatives (in practice, these are women from men's family) who make proposal and express the man's will to marry this girl or woman.

Marriage

- A man who decides to marry a girl or a woman must pay a bride price.
- The early years of 2000 were marked by the increase of "bride – kidnappings". Normally such marriages ended with divorces and this caused another issue.
- A bride price for an unmarried girl is higher than for a girl who has already been married. These bride kidnappings made the young girls "once" married and no matter if they had sexual relationship or not. There was a strong outcry among victims of this tradition, so the government carried out the law according to which an abductor is to pay a huge fine.
- The termination of this custom resulted in another – early marriages. Early marriages led to divorces because the girls under 15 weren't able to cope with family life duties.
- Sintem arranged a campaign against early marriages attracting media and government's attention with the media and the new law was adopted – a girl is prohibited to get marry until she finishes school.

- The increasing cases of HIV/AIDS brought the society in other requirements before the couple gets married. Thus a man and a woman should provide a medical certificate that they have no STD or HIV/AIDS. Otherwise the religious official refuses to contract the marriage.
- The religious marriage ceremony is prior to the civil ceremony. Otherwise the marriage isn't consumed.
- The traditional law does not ensure that spouses have equal access to property jointly acquired during marriage and for matrimonial property to be equitably distributed between the spouses upon termination of the marriage.
- The norms of family law do not provide for a pre-nup.

Divorce and custody

- Family doesn't force a woman to remain in abusive relationship. She can return to her family. She can build up new relationship and get married again.
- In most cases children stay with fathers according to traditional law. If a man decides to have a family, he must take full responsibility for his family. He is responsible for bringing up new society members and will respond if his children break moral standards or law.
- Divorce is a normal phenomenon in the society. In some regions a woman cannot divorce as she becomes a person unable to make a family by default. Chechen society doesn't stigmatize a woman in case of divorce.
- Women often cannot see children, especially when they get remarried. The issue is an outcome of individual moral choice.

Domestic violence in Chechnya

- 11 % of women are beaten regularly
- 28 % get slapped and kicked
- 8 % are victims of sexual abuse

DOMESTIC VIOLENCE DECRIMINALIZING LAW adopted in 2017:

Application ↓	<ul style="list-style-type: none"> ▪ No administrative investigation/no expertise ▪ The court might reject the application
Administrative liability ↓	<ul style="list-style-type: none"> ▪ Fine (which is usually paid from the family budget) ▪ 15 days detention
Application ↓	<ul style="list-style-type: none"> ▪ Must be made not later than a year since first application ▪ A victim should gather all proofs for investigation

Assistance for victims of violence and vulnerable groups

- NGOs are the only assistance providers for girls and women. No legal institution at the local level and state level which provides assistance.
- Possible victims of "honor killing" should be transferred to another region and the victim should hide her identity in any case.

- No shelter for domestic violence victims in Chechnya. The region is small and it is impossible to hide a woman with children somewhere in Chechnya, even in neighbor regions.
- Lack of regular funding for the shelter. If NGO wins the grant there can be allocations for shelter. The only shelter in Chechnya is for women released from prison.
- There are cases of ethnical discrimination of Chechen women, so they cannot be referred to other parts of Russia.

Family reunion project implemented by the local government in 2017

- Events arranged for family support and consolidation of the family as a fundamental entity of the society – 9815
- Number of divorced couples – 4536
- Reunited families – 1519
- Couples who refused to reunite – 1927
- Families that cannot reunite because of religious aspect – 839
- Number of children in reunited families – 3469
- Number of minors in broken families – 4624 (with fathers – 3071, with mothers – 1553)
- Number of documents that prove responsibility for child's rearing given by women – 789 (normally they are given by men from a woman's family)

Working groups – Counselling advice:

What could be signs of possibly on-going cases of domestic violence? What could be signs of women who cannot ask for help openly in a counselling session with the whole family?

- Bruising, etc. – physical evidence
- Subdued woman, husband dominating the counselling session
- Person/ client is not in touch
- Women aren't asked for their opinion and/or never seen in the office
- Woman doesn't say a word
- For a counsellor it is difficult to recognize a victim (get advice from a psychologist)
- Information from social workers
- Body language
- Depression, anxiety
- Person is always accompanied by the partner, never alone
- No spontaneous answers, tension, nervousness, extreme shyness

To what kind of organizations would a counsellor refer the wife or children in need prior to the departure and after arrival in the Caucasus?

Prior

- Women's counselling, legal counselling
- Women's rights organizations
- Organizations involved in protection and/or domestic violence (crisis centers)
- Welfare organizations
- E.g. Solwodi, Caritas, Sintem, Nadeschda organization for human trafficking and forced prostitution
- Doctors
- Lawyers
- Psychologists

After	<ul style="list-style-type: none"> ▪ Social workers ▪ Reintegration projects for vulnerable persons ▪ Empowerment NGOs ▪ Safe house
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How can the counsellor contact or communicate with the victim without the husband noticing? How can the counsellor create an individual counselling setting in order to verify or to rebut the impression?	
	<ul style="list-style-type: none"> ▪ Counsellor should be prepared to follow up and be aware that a process has started which we don't know necessarily how the woman will react ▪ To choose an unsuitable time for the husband (during working hours) for the next counselling session ▪ To invite the woman to sign a document which is needed for the return application ▪ To use special forms to reveal the woman's situation (working with psychologist) ▪ One on one counselling sessions as "standard procedure" but risk that the clients will not attend ▪ Women group talks ▪ Through social services in the camp ▪ Ask the husband to go outside to speak to the woman alone or find a "reason" why the man must come with you to let your colleague speak to the woman (with translator) ▪ Contact an expert of domestic violence to discuss the next steps

8. Overview of substance-related addictions and counselling advice

The following information is fully taken from the PowerPoint Presentation of Dr. rer. nat. Dietmar Czycholl presented during the Transnational Exchange IV Workshop on the 31.10.2018 in Augsburg, Germany:

Definition:

- Substance-related disorders are disorders of intoxication, dependence, abuse, and substance withdrawal caused by various substances, both legal and illegal.
- These substances include: alcohol, amphetamines, caffeine, inhalants, nicotine, prescription medications that may be abused (such as sedatives), opioids (morphine, heroin), marijuana (cannabis), cocaine, hallucinogens, and phencyclidine (PCP).

- **Stimulants:** nicotine, cocaine, amphetamines, piperazines (BZP), caffeine
- **Depressants:** alcohol, barbiturates, BZD
- **Hallucinogens:** LSD, mescaline, psilocin, DOB, harmin, DMT (Ayahuasca) etc.
- **Entactogens:** MDMA (ecstasy), MDA, MBDB, 2C-B, piperazines (TFMPP, mCPP), PMA etc.
- **Cannabinoids:** THC
- **Dissociative anesthetics:** Ketamine, PCP
- **Narcotics:** opioids
 - natural: morphine
 - synthetic: phentanyl, heroin, meperidine, methadon, oxycodine
- **Others:** inhalants, sedatives and hypnotics

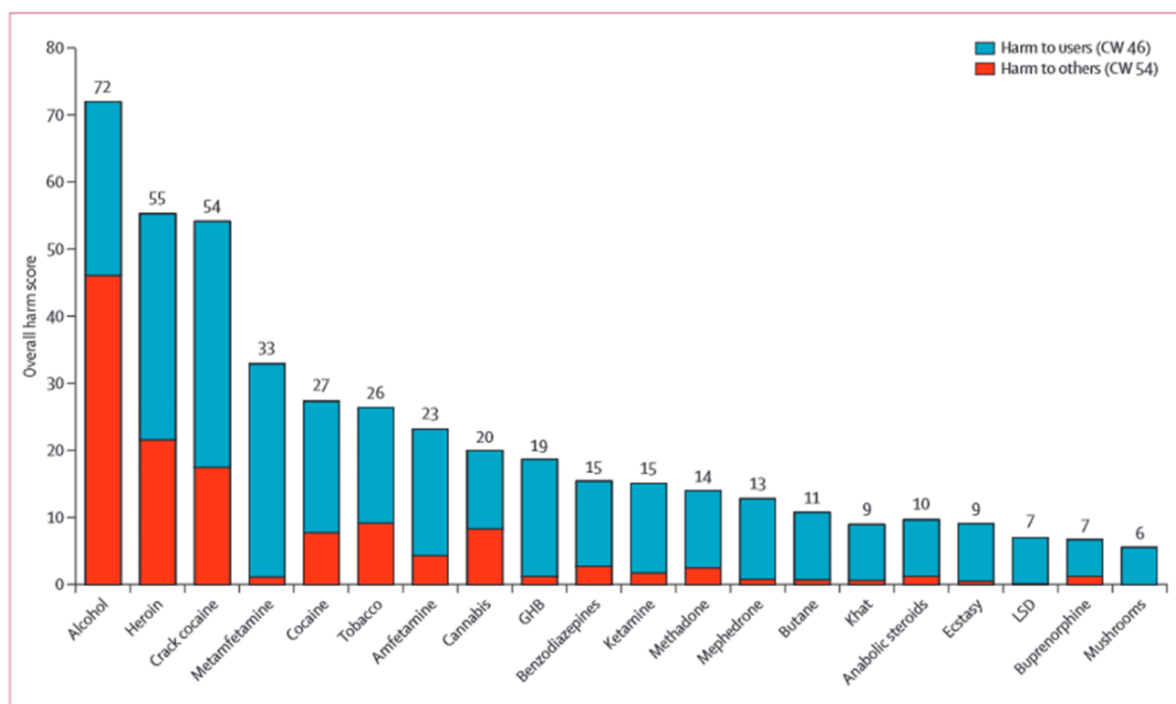
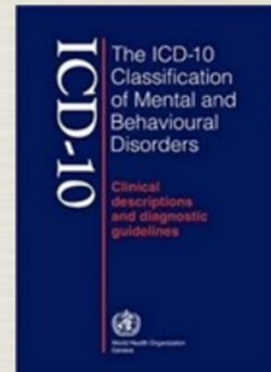


Figure 2: Drugs ordered by their overall harm scores, showing the separate contributions to the overall scores of harms to users and harm to others
 The weights after normalisation (0–100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for all the criteria to others, 54). CW=cumulative weight. GHB=γ hydroxybutyric acid. LSD=lysergic acid diethylamide.

Mental and behavioral disorders due to psychoactive substance use



- F1x.0** - Acute intoxication
- F1x.1** - Harmful use
- F1x.2** - Dependence syndrome
- F1x.3** - Withdrawal state
- F1x.4** - Withdrawal state with delirium
- F1x.5** - Psychotic disorder
- F1x.6** - Amnesic syndrome
- F1x.7** - Residual and late-onset psychotic disorder
- F1x.8** - Other mental and behavioral disorders
- F1x.9** - Unspecified mental and behavioral disorder



Alchoholemia [%]	Effects
0.02-0.03	Mood elevation, slight muscle relaxation
0.05-0.06	Relaxation, decreased reaction times, impaired fine motor functions
0.08-0.09	Impaired balance, speech, vision, muscle coordination, euphoria
0.14-0.15	Severe impairment of motor control as well as psychic functions.
0.20-0.30	Severe intoxication, minimal control of motor or psychic functions
0.40-0.50	Unconsciousness, deep coma, dead from suppression of breath center

Substance Disorders:

- Substance use disorders include abuse and dependence.
- Substance-induced disorders include intoxication, withdrawal, and various mental states (dementia, psychosis, anxiety, mood disorder, etc.) that the substance induces when it is used.

Substance Dependence:

- Substance Dependence is characterized by continued use of a substance even after the user has experienced serious substance-related problems. The dependent user desires the substance (“craving”) and needs more of the substance to achieve the effect that a lesser amount of the substance induced in the past.

Tolerance:

- This phenomenon is known as tolerance. The dependent user also experiences withdrawal symptoms when the substance is not used.
- Withdrawal symptoms vary with the substance, but some symptoms may include increased heart rate, shaking, insomnia, fatigue, and irritability.

Substance Abuse:

- Substance abuse is continued use of a substance in spite of school- or work-related or interpersonal problems, but the user has not gotten dependent on the substance. The individual who abuses a substance may experience legal problems and may have problems fulfilling responsibilities, such as caring for a child.

Intoxication:

- Intoxication is the direct effect of the substance after an individual has used or has been exposed to the substance. Different substances affect individuals in various ways, but some of the effects seen in intoxication might include impaired judgment, emotional instability, increase or decrease in appetite, or changed sleep patterns.

Four Mental and Emotional Withdrawal Symptoms:

- Anxiety: Anxiety, panic attacks, restlessness, irritability
- Depression: Social isolation, lack of enjoyment, fatigue, poor appetite
- Sleep: Insomnia, difficulty falling asleep or staying asleep
- Cognitive: Poor concentration, poor memory

Six Physical Withdrawal Symptoms:

- Head: Headaches, dizziness
- Chest: Chest tightness, difficulty breathing
- Heart: Racing heart, skipped beats, palpitations
- GI: Nausea, vomiting, diarrhea, stomach aches
- Muscles: Muscle tension, twitches, tremors, shakes, muscle aches
- Skin: Sweating, tingling

Dangerous Withdrawal Symptoms:

- Alcohol and tranquilizers produce the most dangerous physical withdrawal. Suddenly stopping alcohol or tranquilizers can lead to seizures, strokes, or heart attacks in high risk patients. A medically supervised detox can minimize your withdrawal symptoms and reduce the risk of dangerous complications. Some of the dangerous symptoms of alcohol and tranquilizers withdrawal are: grand mal seizures, heart attacks, strokes, hallucinations, delirium tremens (DTs)

Substance-related and addictive disorders:

Encompasses 10 separate classes of drugs

1.	Alcohol
2.	Caffeine
3.	Cannabis
4.	Hallucinogens
5.	Inhalants
6.	Opioids
7.	Sedatives, hypnotics & anxiolytics
8.	Stimulants
9.	Tobacco
10.	Other (or unknown) substances

Substance Use Disorders: Diagnostic Criteria

1. Substance often taken in larger amounts or over a longer period of time than intended (impaired control)
2. A persistent desire or unsuccessful efforts to cut down or control use (impaired control)
3. A great deal of time spent in activities necessary to obtain the substance, use it, or recover from its effects (impaired control)
4. Craving, or strong desire or urge to use (impaired control) (New criteria)
5. Recurrent use resulting in failure to fulfill major role obligations at work, school, or home (social impairment)
6. Continued use despite having persistent or recurrent social/interpersonal problems caused or exacerbated by use (social impairment)
7. Important social, occupational, or recreational activities given up or reduced because of use (social impairment)
8. Recurrent use in situations which is physically hazardous (risky use)
9. Use is continued despite knowledge of having a persistent or recurrent physical/psychological problem likely to have been caused or exacerbated by use (risky use)
10. Tolerance: the need for markedly increased amounts of substance to achieve intoxication or desired effect, or a markedly diminished effect with continued use of same amount (pharmacological)
11. Withdrawal: a characteristic syndrome, or use to relieve or avoid withdrawal (pharmacological)

Biological Treatment of Substance-Related Disorders:

Agonist Substitution	<ul style="list-style-type: none"> ▪ Safe drug with a similar chemical composition as the abused drug ▪ Examples include methadone for heroin addiction, and nicotine gum or patch
Antagonistic Treatment	<ul style="list-style-type: none"> ▪ Drugs that block or counteract the positive effects of substances ▪ Examples include naltrexone for opiate and alcohol problems
Aversive Treatment	<ul style="list-style-type: none"> ▪ Drugs that make the use of abused substances extremely unpleasant ▪ Examples include antabuse for alcoholism and silver nitrate for nicotine addiction
Adjunctive Treatment	<ul style="list-style-type: none"> ▪ Pharmacological treatment of underlying pathology (e.g. depression or anxiety)
Efficacy of Biological Treatment	<ul style="list-style-type: none"> ▪ Such treatments are generally not effective when used alone

Psychosocial Treatment of Substance-Related Disorders:

Inpatient vs. outpatient care	<ul style="list-style-type: none"> ▪ Data suggest little difference in terms of overall effectiveness ▪ For severe dependence, brief inpatient care and intensive outpatient after-care is the current standard of care
Community Support Programs	<ul style="list-style-type: none"> ▪ Alcoholics Anonymous and related groups ▪ Developed by Bill W. as structure for recovering alcoholics to support other alcoholics ▪ Twelve-steps and twelve traditions ▪ Endorses total abstinence as goal ▪ Most successful self-help program ever conceived
Debate over controlled use vs. complete abstinence as treatment goals	

Alcohol addiction treatment in 3 steps:

The alcohol treatment program consists of the following steps of treatment:

1. Intervention
2. Detoxification
3. Rehabilitation

Outside healthcare system:	In healthcare system:
<ul style="list-style-type: none"> ▪ Contact centers ▪ Social welfare institutions ▪ Therapeutic communities ▪ After-treatment centers ▪ Harm reduction 	<ul style="list-style-type: none"> ▪ Acute states (detox, withdrawal symptoms, toxic psychosis) ▪ Therapeutic programs (ambulant, in psychiatric centers, clinics) ▪ After-treatment programs

<ul style="list-style-type: none"> ▪ Family therapy ▪ Counseling 	<ul style="list-style-type: none"> ▪ Substitution therapy ▪ Family therapy ▪ Counseling
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Substitution therapy



- Pharmacological intervention directed towards involvement of withdrawal symptoms and craving
- Opiates and nicotine
- Per oral administration of medication (or plasters with nicotine)
- Methadone, Subutex (0.4mg, 2mg and 8mg; buprenorphine for per oral use), Temgesic (0.2mg and 0.3mg; buprenorphine for parenteral administration), Diolan (ethylmorphine HCl), heroin, nicotine
- Special centers or physicians
- Helping with motivation to undergo other treatments (resocialization)
- Minimization of risks associated with drug use, criminality, social problems etc. = harm reduction

Indication:

- Severe and long lasting dependence on high doses of opiates, or combined addiction
- Repeated unsuccessful attempts of treatments

Factors that support involvement in the program

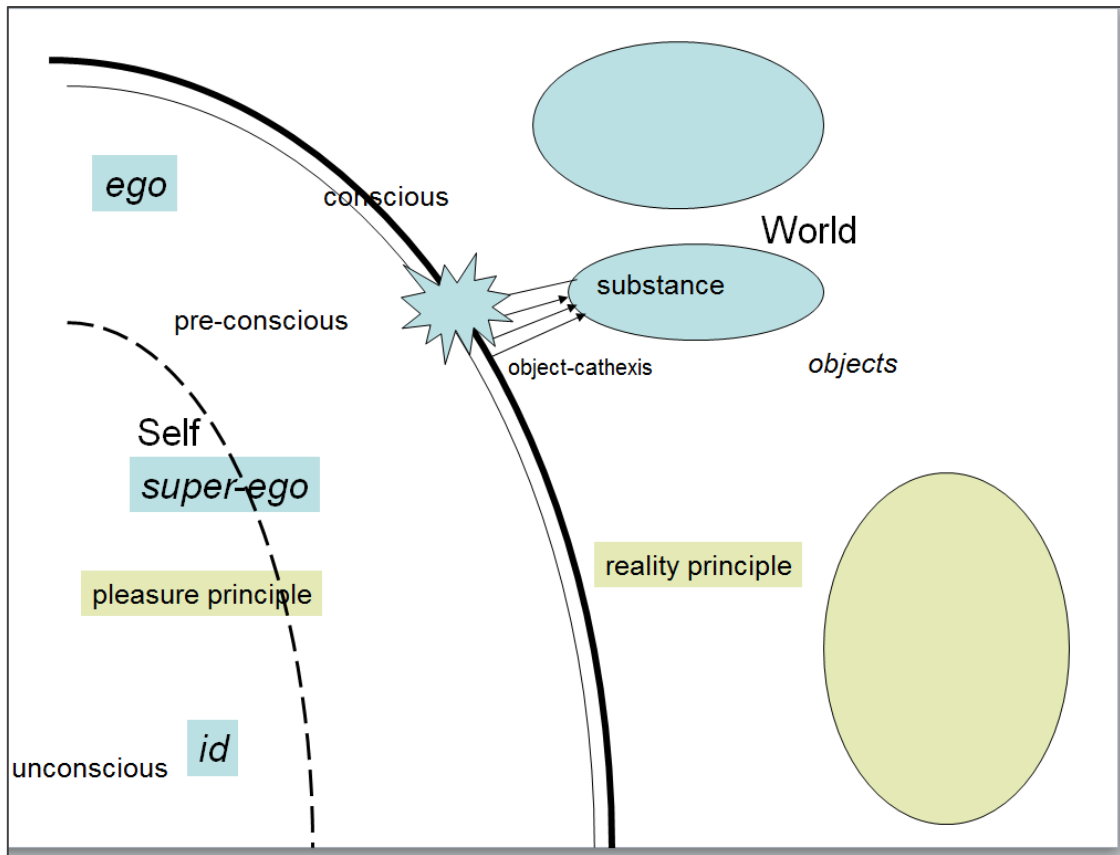
- Anamnestic positive experience with substitution therapy
- Opioid dependence in HIV positive patients, repeated criminal activity associated with the drug use, if normal treatment is not possible
- Treatment of pregnant patients if detoxification is not possible

Harm reduction



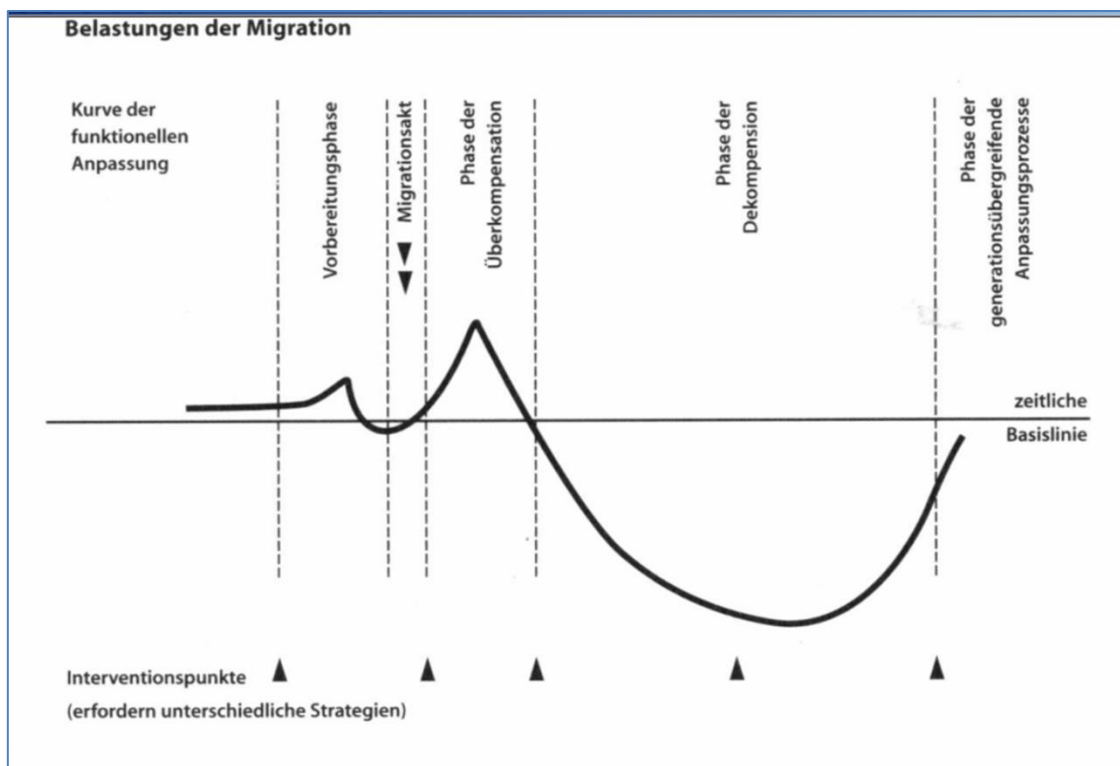
= Minimization of risks

- Exchange of used needles for sterile ones, supplying condoms, sterile water, citric acid, cellulose filters etc., substitution therapy, drug testing (e.g. Ecstasy tablets testing on raves which serves also as a contact method)
- In an institution or as a street-work
- Prevention of transmitting infectious diseases (HIV, hepatitis)
- Countries where it was restricted, e.g. Ukraine – extremely high incidence of HIV and hepatitis among i.v. drug users (90% or more are positive)
- Minimizations of tromboembolic complications, endocarditis, sepsis
- Contact with clients that are difficult to target (serves as a attractor)



Psychological impacts of processes of migration and remigration:

Migration means – in any case – trauma and crisis. (Grinberg & Grinberg, 1991)



9. Relevant manuals and papers

Manuals regarding organizing the return of a vulnerable person such as a chronically ill or drug abusing person:

Title	Facts & link
Returning with a health condition: A toolkit for counselling migrants with health concerns	Published by IOM the Netherlands in 2014 https://publications.iom.int/books/returning-health-condition-toolkit-counselling-migrants-health-concerns
Challenges in the reintegration of return migrants with chronic medical conditions	Published by IOM the Netherlands in 2014 https://publications.iom.int/books/challenges-reintegration-return-migrants-chronic-medical-conditions
Rückkehr und Reintegration von vulnerablen Personen: Handbuch	Only available in German or French Published by IOM Switzerland in 2016 https://publications.iom.int/books/ruckkehr-und-reintegration-von-vulnerablen-personen-un-guide-pratique
An offer to all who would like to help someone close to them: Alcohol, medication, tobacco, illegal drugs, addictive behaviour	Second edition published by the Deutsche Hauptstelle für Suchtfragen e.V. in 2014 http://www.dhs.de/fileadmin/user_upload/pdf/Broschueren/Ein_Angebot_an_alle-Englisch.pdf

Papers regarding voluntary return to the Caucasus region:

Title	Facts & link
Country of Origin Information Report Russian Federation: The situation for Chechens in Russia	Published by the European Asylum Support Office (EASO) in 2018 https://www.easo.europa.eu/news-events/situation-chechens-russia
Referral guide for reintegration of returnees in Armenia	Published by IOM Armenia in 2016 https://publications.iom.int/books/referral-guide-reintegration-returnees-armenia
Country Fact Sheets	Published and updated by IOM Germany Available also in English https://www.returningfromgermany.de/de/countries
Post-Soviet Transformations of Health Systems in the South Caucasus	Written by Sophie Hohmann and Cécile Lefèvre Published in Central Asian Affairs 1 (2014) Journal http://booksandjournals.brillonline.com/content/journals/10.1163/22142290-00101005
Assessment of health related factors	Published by IOM Armenia in 2013

affecting reintegration of migrants in Armenia	https://publications.iom.int/books/assessment-health-related-factors-affecting-reintegration-migrants-armenia
Drug use among asylum-seekers from Georgia in Switzerland	Published by IOM Switzerland in 2010 http://www.ch.iom.int/de/publications

