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REVIEW ARTICLE

Drivers and Consequences of International Forced Migration: A Narrative Review

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ABSTRACT

International forced migration remains one of the most pressing global challenges, affecting millions of refugees and asylum seekers compelled to flee their homelands due to conflict, persecution, unmet basic needs, or environmental stressors. The humanitarian and policy implications are profound, as host countries must balance limited resources with the responsibility to provide protection and integration opportunities. This narrative review synthesises recent evidence on the drivers and consequences of international forced migration and identifies measures that support adaptation and assimilation. In May 2024, PubMed and Scopus were searched for peer-reviewed studies published between 2019 and 2024, complemented by Google Search to capture reports, guidelines, and policy documents from reputable international organisations. A Population, Exposure, Outcome (PEO) framework guided the search and synthesis, enabling integration of diverse study designs and contexts. The review identified five primary drivers: political instability and conflict, economic collapse, environmental disasters and climate change, social and cultural breakdown, and human rights abuses. Consequences for migrants include economic hardship, weakened social belonging, health challenges, and threats to human security, while host countries experience both strain and benefit. Adaptation measures, such as simplifying asylum processes, providing humanitarian support,

Keywords: *Push and pull factors, Global, Involuntary migration, Refugees, Asylum seekers*

enhancing sociocultural skills, and expanding educational and employment opportunities, were highlighted as essential. The findings underscore the need for governments, NGOs, and international agencies to strengthen asylum systems, embed migrant-inclusive policies, and address under-researched areas, such as climate-related displacement and long-term health outcomes. Future research should adopt mixed-method and longitudinal designs to provide comprehensive evidence for policy and practice.

INTRODUCTION

One in 78 people globally is forced to flee from their homes. This accounts for approximately one per cent of the world's population (United Nations, 2022). This is called forced migration. Synonymous with forced displacement, it is a scenario where people are forced to escape their homes due to various factors, commonly including armed conflicts and wars (The World Bank, 2015). Forced migration can occur domestically (internally) or across borders (internationally). Unlike voluntary migration, which primarily occurs due to the search for economic opportunities, forced migration takes place when people encounter threats, coercion, or violence. They often have no choice but to flee (The World Bank, 2015). By the end of 2022, there were 108.4 million people displaced against their will, representing a 19.0 million increase from the end of 2021. Individuals who are displaced can be categorised according to Figure 1 (United Nations High Commissioner for Refugees, 2023).

The terms "migrants," "refugees," and "asylum seekers" are sometimes used interchangeably, but they have distinct definitions. An international migrant is someone who changes their country of residence, irrespective of the reason behind the change. On the other hand, a refugee is someone who cannot remain in their home country due to fear of persecution, war, violence, or serious public disorder

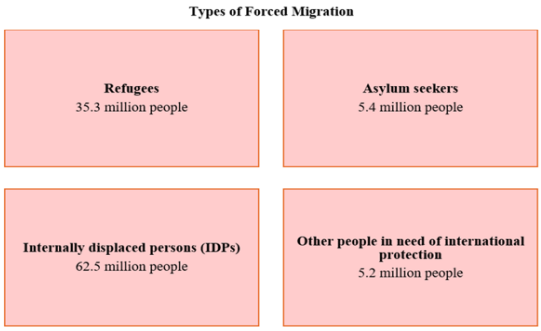

Figure 1: Categories for forced migration as a source from the United Nations High Commissioner for Refugees (2023). Four types of forced migration are identified, which are refugees, asylum seekers, internally displaced persons (IDPs), and other people in need of international protection

(United Nations, 2025). Meanwhile, an asylum seeker is someone who is seeking international protection, and the decision on their request, either for complementary protection or refugee status, is yet to be determined. During this process, asylum seekers are protected. A refugee will have to go through the process of seeking asylum before their status as a refugee is confirmed, but not all asylum seekers will be recognised as refugees (United Nations High Commissioner for Refugees USA, 2025). If an asylum seeker's application is rejected, he must leave the host country unless a humanitarian exemption permits him to stay (Castelli, 2018). Currently, refugees and asylum seekers comprise 37.5% of the forcibly displaced population worldwide (United Nations High Commissioner for Refugees, 2023).

Several reasons are attributed to why people migrate. One of the most recognised theories is Everett S. Lee's "Push and Pull Factors", which identifies four elements influencing migration decisions. The elements are conditions in the origin, conditions in the destination, intervening obstacles, and personal considerations (Lee, 1966). In short, in each area, some features attract people to it (pull), make them stay, or cause them to move out (push). In each of the push and pull factors, three main elements influence the decision to migrate: social and political, demographic,

and economic, as well as environmental and climate migration (European Parliament, 2020). This is illustrated in Figure 2.

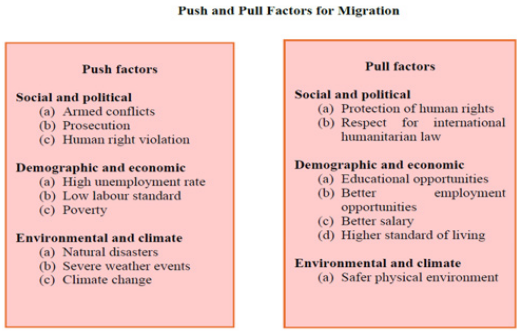

Figure 2: Push and pull factors for migration. Source: Lee (1966)

The current situation of forced migration is indeed worrying. In view of the latest scenario, the following were the questions raised, which led to the development of this narrative review:
(a) Which countries have been affected by international forced migration in the past five years?
(b) What are the drivers for international forced migration in the past five years?
(c) What are the effects of forced migration on the migrants who are involved in the process?
(d) What are the effects of forced migration on the countries that receive or become the host for the forced immigrants?
(e) What are the approaches that the host countries can take?

Although forced migration has been widely studied, the existing literature often focuses on a single region, a specific conflict, or a narrow range of health outcomes. There has been limited synthesis that integrates drivers, consequences, and adaptation measures across multiple regions over the past five years. This gap restricts understanding of the global scope of forced migration and limits the ability of policymakers and humanitarian actors to design comprehensive responses. Therefore, this review aims to synthesise the main drivers and consequences of international forced migration using a narrative review approach, examine their impacts on both migrants and host countries, and highlight adaptation and assimilation strategies that can support displaced populations in rebuilding their lives, including access to education, employment, health services, and sociocultural integration. It also seeks to identify gaps in future research, thereby providing a clearer evidence base for governments, non-governmental organisations (NGOs), and international agencies to strengthen humanitarian and integration policies.

METHODOLOGY

Search process

This narrative review was conducted to synthesise recent evidence on international forced migration, focusing on its drivers, consequences for migrants and host countries, and measures supporting adaptation and assimilation. A structured literature review was undertaken for one week in May 2024 to identify relevant empirical studies and contextual documents. The search strategy employed predefined keywords that were combined using Boolean operators to maximise sensitivity while maintaining relevance. The primary search string used was: (impacts OR consequences) AND (forced migration OR involuntary migration) AND (host countries OR receiving countries). The search was applied to titles and abstracts where applicable. Retrieved records were screened in a stepwise manner, beginning with title and abstract screening, followed by full-text review for eligibility.

Databases

Two major electronic databases were used to identify peer-reviewed literature. PubMed was searched to capture biomedical and public health-related studies. Meanwhile, Scopus was searched to ensure broader coverage across social sciences, migration studies, and interdisciplinary research. In addition, Google Search was used to identify relevant reports, guidelines, and policy documents from reputable international organisations. These

sources were included to complement peer-reviewed evidence and to provide contextual and policy-level perspectives relevant to international forced migration.

Framework

Given the exploratory nature of this narrative review, a Population, Exposure, Outcome (PEO) framework was adopted to guide the conceptual scope and literature synthesis. Unlike intervention-focused frameworks, PEO is commonly used in reviews addressing exposures or conditions and is suitable for synthesising evidence from quantitative, qualitative, and mixed-method studies. Methodological guidance for evidence synthesis recognises PEO as appropriate for questions on exposure, aetiology, and risk, allowing key concepts and search strategies to be defined without restricting study design. Accordingly, PEO has been operationalised in peer-reviewed literature to structure search strategies and inclusion criteria across reviews incorporating diverse methodologies (Stern, 2015).

In this review, the population (P) comprised international forced migrants, including refugees and asylum seekers. The exposure (E) was the experience of international forced migration. The outcomes (O) encompassed contextual drivers for migration (underlying factors compelling migration), consequences for migrants, consequences for host countries, and adaptation and assimilation measures. Host countries are included under outcomes rather than population because they do not directly experience forced migration but are affected by its social, economic, and policy impacts.

Eligibility criteria

Articles included in this narrative review were required to fulfil the following criteria:

(a) Research articles (quantitative, qualitative, or mixed methods)
(b) Published in English
(c) Open-access articles
(d) Published within the last five years (2019 to 2024)
(e) Focused on international forced migration, in which persons flee from their home countries to other countries, involving the crossing of international borders
(f) Addressed at least one outcome of interest (contextual drivers for forced migration, consequences for migrants, consequences for host countries, and adaptation and assimilation measures within host settings).

Table 1: The PEO framework as a guide for conceptual scope and literature synthesis of the narrative review

Component	Description/ scope
Population (P)	International forced migrants (including refugees and asylum seekers)
Exposure (E)	The experience of international forced migration
Outcomes	(a) Contextual drivers of forced migration (b) Consequences for migrants (c) Consequences for host countries (d) Adaptation and assimilation measures within host settings

Studies were excluded if they were any of the following:

(a) Review articles (narrative reviews, scoping reviews, systematic reviews, or meta-analyses)
(b) Study protocols, validation or reliability of questionnaires, viewpoints, or others

Flowchart of screening

Titles and abstracts identified through database searches were screened for relevance based on the predefined inclusion and exclusion criteria. This is followed by a full-text assessment of potentially eligible articles.

A total of 235 articles were identified through database searches, including 23 articles from PubMed and 212 articles from Scopus. Following the removal of two duplicate records, 233 articles were screened based on titles and abstracts. At this stage, 138 articles were excluded for various reasons. These include review articles (n = 30), studies that focus on internal migration, voluntary migration, or returnees (n = 18), and non-related topics (n = 18). Study protocols,

validation or reliability studies, and conceptual papers (n = 25); inability to retrieve full text (n = 5); and miscellaneous reasons (n =42) were also discovered and excluded. The remaining 95 articles were assessed for full-text eligibility. All eligible articles met the predefined inclusion criteria and were subsequently included in the narrative review. The overall identification screening, identification, and inclusion process is summarised in Figure 3.

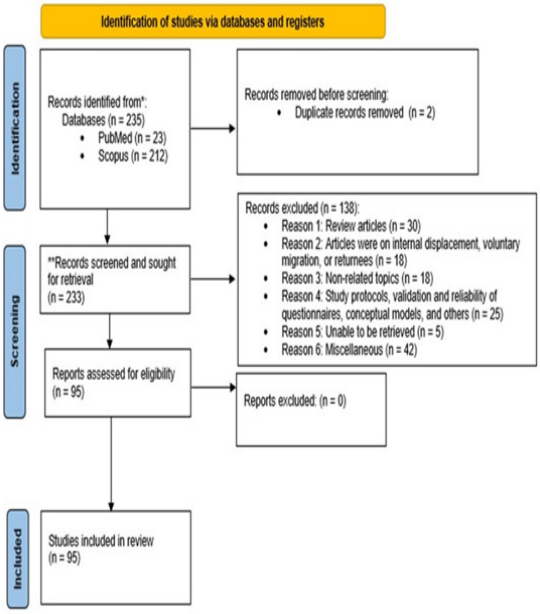

Figure 3: Flowchart of the identification, screening, and inclusion of articles in the narrative review

Synthesis approach and quality assessment

Data synthesis was conducted using a thematic narrative approach. Relevant information was extracted from included studies, including study context, population characteristics, drivers of forced migration, impacts on migrants, impacts on host countries, and strategies supporting adaptation and assimilation.

An iterative process of reading, comparison, and interpretation was undertaken to identify recurring concepts and patterns across the literature. These were subsequently organised into overarching themes and subthemes aligned with the review objectives. The thematic structure enabled the integration of findings across heterogeneous study designs and geographical contexts. This provides a comprehensive narrative synthesis of the current evidence.

Consistent with the narrative review methodology, emphasis was placed on conceptual and thematic integration rather than formal quality scoring of individual studies. Nevertheless, the review primarily drew upon original studies published in peer-reviewed journals, complemented by selected reports, guidelines, and policy documents from reputable international organisations to support contextual understanding.

RESULTS

Countries Affected by International Forced Migration in the Past Five Years

The countries affected by international forced migration are divided into two categories: sending countries (the countries from which the migrants originate) and host countries (the countries that receive the forced migrants).

The sending countries were mainly from the Asian, African, and South American continents. In Asia, sending countries include countries in the Middle East, for example, Syria, Afghanistan, Iran, Iraq, and Palestine (Amini et al., 2024; Bletscher & Spiers, 2023; Ghobrial et al., 2023; Khozaei et al., 2024; Sender et al., 2023; Yang et al., 2023) and in South-East Asia (Myanmar) (Nasar et al., 2023). In Africa, sending countries include Somalia, Rwanda, Congo, and Sudan, to name a few (Makoha & Denov, 2024; Opong et al., 2024). In South America, the majority of forced migrants are from Venezuela (do Carmo Leal et al., 2024; Zaman et al., 2024). Ukraine is a country that has been significantly affected by the migration of its citizens to other countries, mainly within Europe (Kulhánová et al., 2024; Parente et al., 2023).

Receiving countries are mostly neighbours of the sending countries. For example, Jordan caters to Syrian refugees, Turkiye manages refugees from Afghanistan, and Bangladesh accommodates Rohingya refugees from Myanmar (Kurt et al., 2023; Moayerian et al., 2023; Nasar et al., 2023). In Europe, the invasion of Ukraine saw the citizens fleeing to nearby countries such as Czechia (the Czech Republic) (Kulhánová et al., 2024). Venezuelan refugees fled their country to nearby destinations, such as Brazil and Peru (do Carmo Leal et al., 2024; Greene et al., 2024). In addition, countries in North America, for example, the United States of America (USA) and those in Oceania (Australia and New Zealand) also receive refugees and asylum seekers (Charania, 2023; Raphael et al., 2023; Toke et al., 2024).

Drivers for International Forced Migration in the Past Five Years

Multiple, interconnected factors drive international forced migration. These drivers can be categorised into five main drivers. This includes political instability and conflict, economic conditions, environmental disasters and climate change, social and cultural factors, as well as human rights abuses. Understanding these drivers helps contextualise the complex reasons people are compelled to leave their home countries.

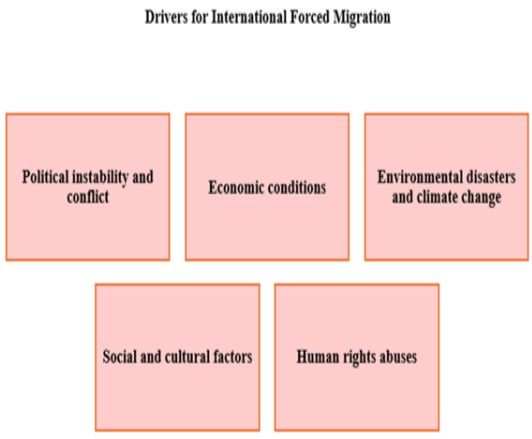

Figure 4: Drivers for international forced migration in the past five years. They are political instability and conflict, economic conditions, environmental disasters and climate change, social and cultural factors, and human rights abuses

(a) Political instability and conflict

Political instability, such as armed conflict, occupation, state fragility, and civil unrest, remains a major driver for international forced migration. Exposure to violence and insecurity compels people to flee when survival becomes impossible. Garcia-Lopez et al. (2024) show that the COVID-19 pandemic intensified political instability in several African countries. Economic collapse, poor healthcare access, and discrimination directly influenced migrants' decisions to leave unsafe environments. Migrants also described their government's failure to provide security or essential services during times of crisis. These accounts highlight how political fragility and weak state protection significantly contribute to displacement. Parente et al. (2023) provide demographic evidence from more than 9,000 Ukrainian refugees who fled during the early 2022 invasion. Their findings show that military aggression, martial law restrictions, and widespread civilian fear led to significant and rapid outflows of people. Most refugees were women and children seeking immediate protection outside Ukraine. The concentrated influx demonstrates how interstate conflict generates swift and compelled migration when national protection collapses.

Sender et al. (2023) further illustrate conflict-driven displacement through the experiences of adolescents living in Baar Elias, Lebanon. Syrian youth described trauma from past violence, restricted mobility due to checkpoints, and instability that disrupted schooling and daily life. These experiences show how prolonged conflict continues to shape post-migration stressors. Together, these studies provide strong, contemporary evidence that political instability, whether through invasion, civil unrest, or governance failure, remains a central driver of international forced migration and continues to shape the lived realities of displaced populations.

(b) Economic conditions

Economic instability significantly drives forced

migration when people are unable to secure food, income, or essential services. Collapsing livelihoods make remaining in place unsafe and unsustainable. do Carmo Leal et al. (2024) show that Venezuelan women migrate mainly due to food shortages (54.0%) and poor access to healthcare (37.8%). Many arrive in Brazil with no family income, limited work opportunities, and significant reliance on shelters. These findings demonstrate how severe economic deprivation directly pushes cross-border movement. García-López et al. (2024) report that pandemic-related restrictions reduce employment options and exacerbate financial strain. Migrants describe losing jobs, lacking state support, and facing rising travel costs. These pressures intensify migration decisions and increase reliance on irregular routes. Evidence from Zaman et al. (2024) shows that Venezuelan migrants, especially pregnant women, experience persistent economic insecurity throughout their journeys. Many face hunger, street sleeping, and job loss as they travel, reflecting deep structural hardship linked to deteriorating economic conditions at home. These experiences highlight how worsening socioeconomic instability shapes migration pathways and continues to affect well-being beyond departure. Overall, recent evidence suggests that economic collapse, food insecurity, inflation, and limited access to essential services collectively form powerful pressures that drive people to migrate internationally, while ongoing financial precarity remains a defining aspect of their mobility.

(c) Environmental disasters and climate change
Environmental disasters and climate change are increasingly driving forced migration, particularly in vulnerable regions. Rising temperatures, extreme weather, and declining water and food security make remaining in place difficult. Reuveny (2021) shows that climate impacts, including droughts, rainfall variability, storms, and heat anomalies, increase migration pressures in developing countries. These stressors reduce livelihoods, weaken food supplies, disrupt healthcare, and increase exposure to diseases. The model further demonstrates that large climate shocks can raise migration flows even when healthcare services are functioning. Climate migrants may arrive with heightened health risks from extreme weather, food shortages, or pollution. These risks can worsen in host regions when health systems face resource strain or reduced service capacity. Reuveny (2021) also finds that climate-linked environmental decline can increase conflict risk in both origin and destination regions, indirectly enhancing migration by reducing safety and access to essential services.

Only one included study examined climate-related migration drivers, indicating limited evidence despite growing global concerns about climate-linked displacement. Overall, recent evidence shows that environmental degradation and climate-related disasters contribute to forced migration by undermining safety, reducing resilience, and narrowing adaptation options.

(d) Social and cultural factors
Social and cultural breakdown in origin countries strongly drives international forced migration. When community structures fail, social protection collapses, and everyday life becomes unsafe, families cross borders in search of dignity, safety, and stable social belonging. Acarturk et al. (2021) describe Syrians facing severe social violence, including sexual abuse, physical harm, loss of family, and lack of shelter. These social harms dismantle protective community networks, pushing people to flee internationally.
Kurt et al. (2023) highlight Afghanistan's sociopolitical transformation, which involves coercive governance that restricts rights, disrupts daily life, and intensifies community-level insecurity. These conditions reflect social oppression that forces families to seek safety across borders. Bartsch and Rulofs (2020) note that many refugees originally escape human rights violations and persecution based

on gender or ethnicity within their home societies. Such social coercion undermines fundamental freedoms and drives people to migrate internationally.

Mwanri et al. (2023) demonstrate that Burmese refugees, who have experienced decades of displacement in camps, face entrenched social exclusion and prolonged insecurity within their origin contexts. These conditions signal systemic social persecution that triggers long-distance flight. Panagiotopoulos and Pavlopoulos (2023) emphasise that violence, oppression, and community instability at origin disrupt social identities and family structures. This loss of social continuity creates powerful pressures for international escape. Overall, social and cultural harms, including persecution, community violence, coercive governance, social exclusion, and breakdown of protective networks, are major drivers of international forced migration. People leave when their societies cannot ensure safety, dignity, or meaningful social belonging.

(e) Human rights abuses

Human rights abuses in origin countries consistently drive international forced migration. South Sudanese youth described killings, abductions, torture, and sexual violence during the civil war, making escape essential for survival. These abuses included beheadings, mass shootings, and attacks on civilians (Makoha & Denov, 2024). Women seeking asylum in Ireland reported rape, beatings, torture, and public humiliation inflicted during conflict, which directly triggered their international flight (Murphy et al., 2021). Forensic assessments show that many asylum seekers present injuries rated "highly consistent" or "typical of torture," demonstrating exposure to severe pre migration violence (Franceschetti et al., 2023).

Conflict also intensifies harmful practices that prompt migration. In Yemen, adolescent girls faced heightened child marriage risks after conflict escalation, motivating protective relocation. Rohingya refugees reported military attacks, village burnings, and killings in Myanmar, driving mass displacement (Elnakib et al., 2023). Persons in Senegal whose sexual orientation or identity placed them at risk encountered discrimination and threats to their safety, prompting migration for protection (Broqua et al., 2021).

Syrian migrants described war-related abuses, including bombardment, family loss, coercion, and physical danger that made departure unavoidable (Taşdemir et al., 2020). Population level evidence shows that many refugees flee after experiencing persecution, violence, and traumatic conflict related harms in their origin countries (Hvidtfeldt et al., 2020). Women in Northern Uganda likewise reported previous exposure to violent conflict and displacement before seeking safety elsewhere (Rustad et al., 2021). Collectively, these studies demonstrate that international forced migration is often a protective response to killings, torture, sexual violence, coercion, and conflict related threats in countries of origin.

Consequences of International Forced Migration

International forced migration has a wide range of effects on the migrants themselves and the countries that receive them. These consequences can be categorised into five major categories: Economic, social, political, health, and human security.

(a) Consequences of international forced migration on migrants

(i) Economic consequences

International forced migration generates significant and persistent economic hardship for displaced populations across multiple host countries. Refugees in Sweden experienced increasing long term unemployment over time, with hazard ratios rising from 1.98 to 2.78 across three cohorts (Kirchner et al., 2022). Newly arrived refugees faced the greatest

labour market barriers because their short residence duration limited job access and stability (Kirchner et al., 2022). Afghan asylum seekers in Austria also encountered severe employment restrictions due to insecure legal status and work bans that hindered economic planning (Kantor et al., 2023). Eritrean refugees in Germany faced language barriers and overwhelming administrative demands, which reduced their employability and created financial penalties due to misunderstandings of official letters (Gebresilassie et al., 2022).

Across different contexts, displaced groups mainly entered informal, low wage and unstable labour markets. Syrian refugees in Jordan relied on seasonal agricultural work, which provided low wages, unpredictable hours, and employer-controlled conditions (Moayerian et al., 2023). Venezuelan migrant women in Brazil experienced similar precarity, as only 5.1% held formal jobs and most relied on irregular employment (do Carmo Leal et al., 2024). Severe income deprivation was prevalent in Boa Vista, where 66.0% of respondents reported no family income during the previous month, and 68.0% resided in emergency shelters due to limited local economic opportunities (do Carmo Leal et al., 2024). Afghan refugees in Austria also reported financial insecurity due to delayed welfare payments and limited work opportunities, which intensified daily stress (Kantor et al., 2023).

Gender and geography further shaped these economic consequences in distinct ways. Eritrean men in Germany expressed that unemployment reduced their sense of identity and social role within their communities (Gebresilassie et al., 2022). Venezuelan women in Brazil faced additional challenges related to caregiving responsibilities, restricted autonomy, and reliance on cash-transfer programs for survival (do Carmo Leal et al., 2024). Border areas such as Boa Vista offered significantly fewer employment prospects than Manaus, deepening localised economic vulnerability for recent arrivals (do Carmo Leal et al., 2024). Syrian farmworkers in Jordan lived in isolated agricultural settings, which strengthened their dependence on employers and reduced their mobility (Moayerian et al., 2023). Brazil's universal health system improved access to healthcare but did not reduce unemployment or persistent poverty among migrants (do Carmo Leal et al., 2024). Overall, these findings indicate that forced migration leads to lasting economic disadvantage, driven by legal precarity, informal labour conditions, language barriers, and unequal regional opportunities, which often persist long after arrival.

(ii) Social consequences

Forced migration weakens social belonging due to legal precarity, discrimination, and limited participation opportunities (Kantor et al., 2023). Migrants in Utah reported that belonging depended on factors such as language, community ties, and cultural familiarity, rather than legal status alone (Soto Saavedra et al., 2023). Displaced Syrians in Lebanon reported experiencing discourteous communication and reduced access to services, which eroded trust in institutions (Khalifeh et al., 2023). Asylum seekers and refugees (ASR) in Italy experienced "suspended time," prolonged documentation delays, and isolation in reception centres that disrupted daily functioning (Marchetti et al., 2023). Urban Congolese adults in Nairobi faced xenophobia, police extortion, and fear of travelling for care, contributing to a psychological distress rate of 52.8% (Tippens et al., 2021). Individuals from Senegal seeking asylum in Mauritania and identifying as part of a sexual minority group lived in marginalised areas, faced social stigma and monitoring, and experienced interruptions in medical follow up during long resettlement waits (Broqua et al., 2021). Refugee youth in German Physical Education (PE) classes were stereotyped as threatening boys or vulnerable girls, limiting participation and belonging (Bartsch & Rulofs, 2020). Migrants in Spain experienced prolonged

social isolation, loneliness, and a lack of stable support networks during the pandemic era reception, which harmed mental health (García López et al., 2024). Studies further show that resource scarcity and bureaucratic obstacles increase exclusion in forced migration contexts (Al Ajlan, 2023). Research has highlighted that loneliness mediates the link between weak social ties and a reduced quality of life among refugees in Germany (Belau et al., 2021).

Social participation is limited when asylum systems create distance between migrants and local institutions (Gebresilassie et al., 2022). Older Syrian refugees in Lebanon encountered food insecurity, economic dependence, and social isolation during overlapping crises (Hachem et al., 2022). Ukrainian women refugees in the Czech Republic reported poor well-being linked to limited social contacts, material hardship, and difficulties seeking help (Kulhánová et al., 2024). Asylum seekers in Sweden experienced greater exclusion when facing financial hardship and weak social support (Sengoelge et al., 2022). Migrant students in sport settings reported racialised discipline and assimilation pressure, limiting cross-group friendships (Bartsch & Rulofs, 2020). Asylum seekers identifying as part of a sexual minority group in Mauritania faced layered stigma, limited networks, and fragile informal support, intensifying isolation (Broqua et al., 2021). North Korean migrants reported that digital technology helped maintain social connections, although digital inequalities limited full participation in community life (Yoo & Jang, 2023). Evidence from diverse contexts indicates that restrictive systems and weak social protection structures exacerbate exclusion, whereas stronger community support and cultural mediation enhance opportunities for social belonging (Kantor et al., 2023).

(iii) Political consequences

Political consequences for migrants arise when their legal status influences their ability to participate in institutional, civic, and community structures within the host society. The study by Soto Saavedra et al. (2023), conducted in the United States of America (USA), shows that legal status strongly influenced migrants' ability to "incorporate and participate" in daily life. Undocumented participants described feeling "hindered" and powerless, reflecting exclusion resulting from restricted work rights, limited recognition pathways, and fear of deportation. Complex immigration processes consumed time and financial resources, and several migrants experienced prolonged family separation during legal adjustments, demonstrating how political systems created instability for displaced individuals.

Migrants who later secured permanent residency reported clearer rights, stronger security, and improved confidence when interacting with institutional systems in the USA. These changes supported long-term planning and increased feelings of legitimacy within public environments. However, Soto Saavedra et al. (2023) noted that permanent status alone did not guarantee political belonging, as some residents continued to face racial exclusion and institutional distrust that limited their participation. Local institutions helped counter restrictive federal frameworks by offering information, cultural navigation, and supportive networks that strengthened migrants' political inclusion.

These findings are shaped by the study's focus on a single USA state, which limits broader generalisation. Self reported narratives may omit individuals who avoid public engagement due to fear or precarious status. Moreover, Soto Saavedra et al. (2023) examine belonging rather than direct political participation, meaning that political consequences must be interpreted through lived experiences rather than formal measures of civic involvement.

(iv) Health consequences

International forced migration increases

communicable disease vulnerability because forcibly migrated populations often live in overcrowded, poorly ventilated shelters where infections spread rapidly. Chickenpox affected 7.0% of residents in Elliniko, 4.1% in Malakasa, and 2.9% in Raidestos, showing intensified transmission under limited immunisation capacity. These patterns suggest that refugee camp environments can sustain prolonged transmission beyond expected seasonal norms (Scales et al., 2024). Forced migration also enables the cross-border movement of antimicrobial-resistant bacteria, as illustrated by forcibly migrated refugees in Germany carrying diverse methicillin-resistant and methicillin-sensitive Staphylococcus aureus strains, including Middle Eastern lineages that persist years after resettlement. This persistence suggests disrupted healthcare access during transit and inadequate surveillance in the countries of origin (Creutz et al., 2022). Pregnant women living with Human Immunodeficiency Virus (HIV) experienced antiretroviral interruptions due to border closures, documentation difficulties, and xenophobic mistreatment, undermining Prevention of Mother to Child Transmission (PMTCT) adherence during the coronavirus disease 2019 (COVID-19) pandemic. These structural barriers worsened maternal and infant outcomes by limiting counselling, medication supply, and follow up services (Bisnauth et al., 2022). Children from countries lacking robust immunisation systems face increased vulnerability to vaccine-preventable diseases in humanitarian settings with constrained preventive care (Altare et al., 2022). Although these studies rely on observational designs that restrict causal inference, they collectively demonstrate how environmental, structural, and systemic constraints heighten the risks of communicable diseases among forcibly migrated populations.

International forced migration increases non communicable disease (NCD) vulnerability because uprooted populations often face disrupted healthcare, unaffordable services, and fragmented continuity of care. Among forcibly displaced Syrians in Jordan, a multidisciplinary NCD programme achieved early improvements in hypertension and diabetes control, yet required substantial organisational resources and free care to sustain these outcomes (Ansbro et al., 2021). Mean systolic blood pressure decreased by 12.4 mmHg and fasting glucose by 1.12 mmol/L within six months, showing that high quality care is possible only under intensive support structures (Ansbro et al., 2021). Seasonal deterioration in blood pressure and fasting glucose highlighted environmental stressors interacting with forced migration related instability. Forced migration also increases cardiovascular disease risk because adherence to long term therapy is difficult in crisis affected settings. In Lebanon, switching forcibly migrated patients with atherosclerotic cardiovascular disease to a fixed-dose combination improved adherence from 63.0% to 86.0%, despite the COVID-19 pandemic and economic collapse (Ansbro et al., 2023). Reductions in non high density lipoprotein cholesterol and systolic blood pressure further illustrated the value of simplified regimens under strained conditions. However, both studies relied on resource-intensive humanitarian models that may be difficult to replicate within overstretched national systems, thereby limiting scalability (Ansbro et al., 2021, 2023). The articles collectively show that forced migration amplifies NCD risks by destabilising treatment continuity, while effective care often depends on expensive, externally supported programmes.

International forced migration exposes migrants to profound nutritional insecurity because economic exclusion, limited aid, and disrupted food systems reduce access to adequate diets. Evidence from single female household heads experiencing forced migration in Bangladesh shows that only 36.0% received rations, and 35.0% reported reduced food consumption during the lockdown, demonstrating severe gaps

in nutritional support (Nasar et al., 2023). Venezuelan migrants in Trinidad and Tobago reported even harsher outcomes, with 61.9% classified as severely food insecure using the Food Insecurity Experience Scale, reflecting structural barriers linked to irregular employment and high living costs (Saint Ville et al., 2022). Nutrition related mortality risks among internationally migrated populations are also evident, as refugee surveys reported global acute malnutrition at 12.0% and under five mortality at 0.89 deaths per 10,000 children per day, indicating persistent food insecurity despite access to humanitarian systems (Ogbu et al., 2022). These findings are methodologically robust within their contexts; however, two studies used convenience sampling, specifically Nasar et al. (2023) and Saint-Ville et al. (2022), which limits the representation of highly vulnerable migrant subgroups. The multi-country analysis by Ogbu et al. (2022) strengthens comparative insights but lacks displacement-duration data, which influences nutritional deterioration and service access. Despite methodological differences, all studies converge on a clear conclusion that forced migration intensifies nutritional vulnerability through poverty, weak social protection, and insufficient humanitarian coverage.

International forced migration consistently heightens mental health burden through interacting pre migration trauma, post migration stressors, structural barriers, and social marginalisation, with vulnerabilities shaped by gender, age, socioeconomic position, and context. Among people experiencing forced migration, high levels of anxiety (36.1%), depression (34.7%), and post-traumatic stress disorder or PTSD (19.6%) were identified using validated mental health measures. Post-migration stressors, such as economic hardship, unmet support, safety concerns, and legal barriers, strongly predicted common mental disorders (Acarturk 2021). Migrants with Enduring Personality Change after a Catastrophic Event (EPCACE) or PTSD did not show excess all-cause mortality, while psychotic disorders did (Bager 2023). Worse mental health, as measured by the Kessler 6, resulted in a 11.9% reduction in employment and a 22.8% decrease in weekly income, with stronger effects among individuals without social networks, and partial mitigation from government support (Dang 2023). Syrian children experienced universal trauma, and 48.6% faced highly salient events, and relational resilience showed an inverse association with depression (Dehnel 2022). Afghan refugees valued Problem Management Plus, although standardised scales did not accurately reflect the lived intensity of problems, which reduced outcome validity (Kantor, 2023). In Iran, anxiety related to COVID-19 increased stress that mediated higher depression, and social cohesion and positive mental health reduced these effects (Khozaei 2024). Access barriers, including long waiting times, interpreter shortages, administrative gatekeeping, stigma, and limited literacy, hindered care, while lay-delivered Problem Management Plus improved access (Kiselev 2020; Wimer 2024). Asylum seekers described a frozen life marked by uncertainty and rumination, and peer caregiving and self-care served as protective strategies (van Eggermont Arwidson 2022; Murphy 2021). Women at risk demonstrated persistent PTSD, anxiety, depression, and somatisation, and post-migration difficulties and low trust predicted distress, which required early gender responsive and loss-informed care (Vromans 2021). Integration challenges, including language barriers, administrative burdens, housing insecurity, and discrimination, increased distress and reduced participation, which made integration policy function as public mental health policy (Walther 2021; Kurt 2023). Registry evidence identified a higher risk for common mental disorders among women, people with lower education, people of Iranian origin, and people presenting somatic symptoms, which required pro-active, culturally competent screening (Yang 2023). Adolescents in Lebanon experienced unsafe public spaces, housing

insecurity, and mobility restrictions, which affected girls and differently abled youth more severely (Sender 2023). A pooled analysis revealed that short-term improvements depended on the context, and specific traumas and poor social conditions predicted worse outcomes (Purgato, 2022). Refugees receiving United States safety net care had lower NCDs, but higher PTSD, which supported ongoing mental health screening (Raphael 2023). In Uganda, refugees testing for HIV showed higher prevalence of PTSD, anxiety, and limited social support than nationals (Klabbers 2022). Many studies were observational or relied on self-report, which introduced confounding factors and measurement bias, thereby limiting causal inference. However, longitudinal, pooled, and registry approaches strengthened the evidence and highlighted the need for contextual validation of key mental health scales (Kiselev 2020; Yang 2023; Purgato 2022; Vromans 2021). Overall, the findings demand integrated, culturally responsive, gender sensitive, structural supports and more rigorous and contextually valid measurements to mitigate mental health harms and improve outcomes for people experiencing forced migration.

Evidence indicates that forced migration increases vulnerability to harmful alcohol and substance use through trauma, disrupted support systems, and unstable living conditions. South Sudanese refugee youth in Uganda describe drinking to manage intrusive war memories, grief, and ongoing settlement stress. They also link alcohol use to cultural disruption, limited prospects, and the widespread availability of inexpensive home brewed alcohol. This study offers a rich narrative depth but relies on a small youth sample, which limits its broader applicability (Makoha & Denov, 2024). Syrian migrants in Turkey report substance and alcohol use driven by unemployment, discrimination, challenging work environments, and easy access to low cost synthetic drugs. Their accounts highlight workplace pressures, peer influence, and untreated trauma as contributors to addiction. The study benefits from diverse data sources, yet reliance on self reported behaviour may understate hidden addiction, and its focus on specific migrant settings limits broader contextual comparison across other migrant populations (Taşdemir et al., 2020).

Evidence shows that forced migration creates significant barriers to accessing specialised care due to financial, structural, and socio-cultural constraints. Afghan migrants with disabilities in Iran experience reduced access to physical rehabilitation services, referred to as PRS, because of high treatment costs, inadequate insurance, and limited availability of specialised centres outside major cities (Amini et al., 2024). Participants also report low health literacy, limited awareness of service entitlements, and fears of arrest that discourage engagement with specialised care. These findings provide detailed insights into the multi-layered barriers, although their application is limited by the qualitative approach and the focus on migrants already connected to rehabilitation facilities (Amini et al., 2024). Forced migration also disrupts maternal care access among Karen women in Australia, who face linguistic barriers, unfamiliar health systems, and inconsistent access to trained interpreters during specialised pregnancy care (Toke et al., 2024). Women describe avoiding appointments when interpreter support is absent, highlighting how communication gaps directly limit the use of specialised services. This study offers rich accounts shaped by community participation; however, its small sample size from a single cultural group limits its broader applicability (Toke et al., 2024). Together, these studies show that forced migration magnifies barriers to specialised care by intersecting financial hardship, limited information, and cultural and legal vulnerabilities. Their findings underline the need for accessible, culturally informed, and legally inclusive specialised care systems for migrant populations.

International forced migration significantly disrupts sexual and reproductive health (SRH) by reducing knowledge, limiting service access, and intensifying gendered vulnerabilities across humanitarian settings. Evidence from Uganda shows that the modern contraceptive prevalence rate (mCPR) reached 30.2%, with refugee users at 28.2%, revealing persistent structural and sociocultural barriers to family planning use. Family planning use increased with primary education, livelihood skills, and residence of three to five years, although the cross-sectional design limits causal interpretation (Achola et al., 2024). Adolescents experiencing forced migration frequently reported poor SRH literacy, including frightening and confusing first menstruation experiences caused by absent preparatory knowledge. Findings also highlighted frequent street harassment in dense urban environments; however, the single-site sample limits the broader generalisability (Korri et al., 2021). Healthcare provider bias, male control over contraception, and stigma towards premarital sexual activity restricted adolescents' decision-making, yet reliance on adult stakeholder accounts may underrepresent adolescents' voices (Fahme et al., 2021). Quantitative evidence linked sexual initiation to older age, male sex, marriage, and school dropout, demonstrating schooling's protective effect, although self-reported behaviours may include desirability bias (Bukuluki et al., 2021). Cross-country survival analyses indicate that forced migration does not universally increase child marriage, with increases observed in Yemen but declines in Lebanon and Nepal. However, comparator variability complicates the pooled interpretation (Elnakib et al., 2023). Overall, these studies offer recent and specific findings, but vary in methodological rigour, underscoring the need for context-responsive SRH programmes that strengthen SRH literacy, address provider bias, and expand adolescent-friendly access.

International forced migration has profound consequences for maternal health. Zaman et al. (2024) show Venezuelan women experiencing xenophobia in healthcare and frequent violence during pregnancy. Weigel and Armijos (2023) report that Venezuelan refugees in Ecuador had 36.0% lower odds of adequate antenatal care and higher risks of preterm and low birthweight infants. Rustad et al. (2021) found that South Sudanese refugees in Uganda were 6.0% less likely to receive antenatal care but 8.0% more likely to deliver in facilities. However, once socio-economic and demographic controls were applied, refugee status itself did not remain a significant predictor of access. Rawal et al. (2021) highlight Rohingya women in Bangladesh, where 28.9% received no antenatal care and 85.2% delivered at home, often with complications. These studies collectively reveal that forced migration increases maternal risks through poor access, discrimination, and inadequate services. Yet, methodological strengths and weaknesses differ. Zaman et al. (2024) rely on qualitative narratives, offering rich insights but limited generalisability. Weigel and Armijos (2023) use national registry data, providing robust statistical evidence but lacking contextual depth. Rustad et al. (2021) employ household surveys, balancing quantitative and perception measures, but their findings weaken after adjustment for confounders. Rawal et al. (2021) combine surveys and interviews; however, their data predate the most recent influx, which limits their timeliness. Overall, these recent studies strengthen the literature by providing empirical evidence across Latin America, Africa, and Asia. However, each has limitations in scope, representativeness, or contextualisation (Zaman et al., 2024; Weigel & Armijos, 2023; Rustad et al., 2021; Rawal et al., 2021).

International forced migration contributes to a wide range of other diseases, including surgical conditions, injuries, and somatic symptoms. Enumah et al. (2021) examined surgical utilisation in the Nyarugusu refugee camp, Tanzania, over twenty years.

Refugees underwent 74.0% of 10,489 operations, with Caesarean section accounting for 79.4%. After the 2015 influx of Burundian refugees, surgeries among Tanzanians fell by 38.0%, reflecting how sudden demographic changes reduce host access. The study benefits from a large dataset, though retrospective logbooks may limit accuracy. Opong et al. (2024) explored the experiences of ten refugee women in Uganda living with vaginal fistula for between two and fifteen years. Causes included obstructed labour, rape, and cancer. Women reported stigma, abandonment, poverty, and suicidal thoughts, even after surgical repair. Rich qualitative narratives highlight profound physical and social consequences, although the findings are not generalisable. Kantor et al. (2023) studied Afghan refugees in Austria and identified somatic complaints such as pain and fatigue alongside post-migration stressors. Standardised measures did not align with problem severity, showing the importance of subjective reporting. The adapted Problem Management Plus intervention was positively received, though limited by a small sample size. Collectively, these studies demonstrate that forced migration intensifies surgical demand, injury-related trauma, chronic gynaecological conditions, and somatic symptoms. Outcomes are shaped by health system capacity, cultural sensitivity, and the availability of psychosocial support (Enumah et al., 2021; Opong et al., 2024; Kantor et al., 2023).

(v) Human security consequences

International forced migration severely compromises human security, which encompasses protection from violence, discrimination, and threats to dignity. Franceschetti et al. (2023) demonstrated that asylum seekers in Italy often present injuries consistent with torture. Yet, medico-legal assessments showed only slight inter-observer agreement, with Fleiss' Kappa as low as 0.17. More experienced practitioners achieved substantial agreement, underscoring that inadequate training jeopardises fair asylum decisions and undermines physical security. Khalifeh et al. (2023) revealed that displaced Syrians in Lebanon faced systemic discrimination in healthcare, including discourteous communication and unequal treatment, which eroded trust and heightened insecurity. Such institutional bias directly threatens refugees' access to essential services, weakening their social security. Mourtada and Melnikas (2022) found Syrian refugee women in Lebanon altered fertility preferences due to overlapping crises, including inflation, unemployment, and reduced aid. Women expressed fears for their children's well-being and delayed childbearing, reflecting insecurity in both family and community life. Collectively, these studies show that forced migration exposes individuals to torture, biased institutions, and reproductive vulnerability, all of which erode human security. Strengths include qualitative depth and empirical specificity, while limitations involve context-specific findings and restricted generalisability. Overall, evidence demonstrates that human security is compromised when migrants face violence, institutional discrimination, and constrained reproductive autonomy (Franceschetti et al., 2023; Khalifeh et al., 2023; Mourtada & Melnikas, 2022).

(b) Consequences of international forced migration on the host countries

(i) Economic consequences

International forced migration creates substantial economic challenges and opportunities for host countries. Mourtada and Melnikas (2022) showed that Lebanon's overlapping political, economic, and pandemic crises intensified national strain. Inflation reached 84.9% in 2020, with food prices rising by 402.3%, destabilising markets and reducing purchasing power for Lebanese citizens. Unemployment rose sharply, and nearly 89.0% of refugee households lived below the Survival and Minimum Expenditure Basket, thereby increasing their reliance on humanitarian aid and stretching the

capacity of host governments. Khalifeh et al. (2023) highlighted that systemic healthcare bias towards displaced Syrians in Lebanon burdened host health systems. Discriminatory practices created inefficiencies in resource allocation and undermined institutional trust, further complicating national service delivery. Ghobrial et al. (2023) found that Egypt missed opportunities to fully integrate Syrian healthcare workers due to restrictive licensing policies. Many were forced into informal labour, which limited their contribution and exposed them to exploitation. Yet, the study also emphasised a positive outcome: Syrian healthcare professionals were generally accepted by Egyptian patients and colleagues, and their presence helped address workforce shortages, particularly during the COVID-19 pandemic. Collectively, these studies demonstrate that host countries face dual economic consequences: escalating financial strain due to inflation, unemployment, and increased service demand, alongside the potential benefits of integrating skilled refugee professionals into national systems. Strengths include recent empirical data and context-specific insights; however, limitations involve restricted generalisability beyond Lebanon and Egypt (Mourtada & Melnikas, 2022; Khalifeh et al., 2023; Ghobrial et al., 2023).

(ii) Social consequences

International forced migration reshapes the social fabric of host countries, often intensifying pressures on cohesion and community relations. Mourtada and Melnikas (2022) demonstrated that Lebanon's overlapping crises have reduced citizens' willingness to support refugees, thereby weakening solidarity and creating social fatigue. Lebanese landlords threatened evictions when rent was unpaid, straining landlord-tenant relations and eroding trust within communities. Host families, once able to provide informal loans or assistance, became less supportive due to their own financial insecurity, which undermined neighbourly reciprocity and community resilience. The influx of refugee labour into agriculture altered local employment patterns, generating competition and reshaping perceptions of fairness in the job market. These changes disrupted traditional social roles and contributed to tensions between citizens and refugees, complicating integration efforts. The study highlights that forced migration interacts with national crises to intensify social strain on host populations, not only through economic hardship but also through weakened social cohesion. Strengths include detailed qualitative evidence and specific findings that link refugee vulnerability to the pressures of the host community. Limitations involve restricted generalisability beyond Lebanon and reliance on focus group discussions, which may not fully capture broader host perspectives (Mourtada & Melnikas, 2022).

(iii) Political consequences

International forced migration has significant political implications for host countries, influencing asylum governance and institutional processes. Franceschetti et al. (2023) showed that medico-legal assessments of torture victims directly influenced decisions of the Territorial Commission, Italy's authority for refugee status determination. Inconsistent evaluations, with overall agreement measured by Fleiss' Kappa at 0.17, created challenges for maintaining consistency in asylum procedures. Greater reliability was achieved among experienced practitioners, with agreement rising to 0.72 when combining more than five years of practice and over fifty cases examined. These findings suggest that variability in medico-legal assessments can place additional pressure on host institutions to strengthen training and standardisation. The study highlights that dissemination of the Istanbul Protocol and investment in professional expertise are politically significant, as they support transparent and credible asylum processes. Strengths include empirical analysis of interobserver reliability and its clear link to political decision-making. Limitations involve restricted generalisability beyond Italy and the absence of formal training among

participants, which may have influenced variability (Franceschetti et al., 2023).

(iv) Health consequences

International forced migration produces significant health consequences for host countries, creating both challenges and opportunities. Khalifeh et al. (2023) demonstrated that systemic healthcare bias in Lebanon placed an additional strain on host health systems, as discriminatory practices against displaced Syrians reduced the fairness of service provision and affected confidence in healthcare delivery. These inequities complicated resource allocation and highlighted vulnerabilities within national health structures. Enumah et al. (2021) demonstrated that in Tanzania, host populations utilised 26.0% of all surgical services provided in Nyarugusu refugee camp between 2000 and 2020. This reflects a positive aspect of facility sharing, where Tanzanians benefited from free access to camp-based surgical care, including Caesarean sections and general procedures. However, the influx of Burundian refugees in 2015 resulted in a 38.0% reduction in Tanzanian surgeries, illustrating how sudden demographic shifts can limit host access when capacity is exceeded. Collectively, these studies highlight two key health consequences: increased strain on host systems due to discrimination and demand, alongside positive spill-over effects where shared facilities improve access for host communities. Strengths include recent empirical data and detailed analysis of institutional impacts; however, limitations involve context-specific findings that are restricted to Lebanon and Tanzania (Khalifeh et al., 2023; Enumah et al., 2021).

(v) Human security consequences

International forced migration affects human security in host countries by challenging systems designed to safeguard safety, dignity, and protection. Mourtada and Melnikas (2022) showed that overlapping crises in Lebanon heightened insecurity, as refugees' reliance on overstretched communities reduced the ability of households to maintain stable living conditions. Eviction threats and withdrawal of informal support created vulnerabilities that extended beyond refugees, undermining the sense of safety for Lebanese families as well. Franceschetti et al. (2023) demonstrated that medico-legal assessments of torture victims in Italy influenced asylum outcomes, with overall agreement among practitioners at 0.17, rising to 0.72 among experienced professionals. Such variability highlights risks to human security when protection mechanisms are inconsistent, as asylum seekers may face uncertainty in accessing safety while host institutions struggle to uphold reliable safeguards. Together, these studies emphasise that forced migration magnifies human security challenges by straining housing, justice, and protection systems, requiring host countries to strengthen mechanisms that ensure safety and uphold humanitarian standards. Strengths include recent empirical evidence and clear links between forced migration and security concerns in the host country. Limitations include restricted generalisability beyond Lebanon and Italy, as well as reliance on qualitative or context-specific samples (Mourtada & Melnikas, 2022; Franceschetti et al., 2023).

DISCUSSION

International forced migration is shaped by diverse pressures that vary across regions and populations. The evidence reviewed demonstrates that a single, universal factor does not drive displacement, but rather context-specific forces that interact in complex ways. Conflict and political instability remain the most dominant drivers in the Middle East and Eastern Europe, with Syria, Afghanistan, and Ukraine providing clear examples of how armed violence, occupation, and governance failure lead to large-scale displacement (Parente et al., 2023; Sender et al., 2023). This is consistent with the International Centre for Migration Policy Development's Migration

Outlook 2025, which highlights Afghanistan, Syria, Gaza, and Ukraine as key conflict-driven displacement hotspots (International Centre for Migration Policy Development, 2025).

In Africa, human rights abuses and civil wars are central, with killings, abductions, and sexual violence reported as primary triggers of migration (Makoha & Denov, 2024). The Africa Centre for Strategic Studies similarly notes that escalating conflict and governance fragility continue to drive intracontinental displacement, even as off-continent migration declines (Williams, 2025). Economic collapse is the leading driver in Latin America, where Venezuelan migrants consistently cite food shortages and poor access to healthcare as decisive reasons for cross-border movement (do Carmo Leal et al., 2024; Zaman et al., 2024). The International Organisation for Migration's World Migration Report 2024 confirms that Latin America and the Caribbean face displacement primarily linked to economic instability and governance crises (International Organisation for Migration, 2024).

In South Asia, persecution and social exclusion dominate, particularly in Myanmar, where Rohingya refugees fled military attacks and systemic discrimination (Elnakib et al., 2023). Climate change acts as an amplifying driver in vulnerable regions, especially in Africa and South Asia, where droughts and extreme weather exacerbate existing fragility (Reuveny, 2021). UNHCR's No Escape report further demonstrates how climate shocks interact with conflict, pushing vulnerable populations into displacement (United Nations High Commissioner for Refugees, 2024). Recent reviews of the climate–disaster–conflict nexus also highlight how environmental stressors and armed violence reinforce each other, creating complex displacement contexts (See et al., 2025).

These regional contrasts highlight that while conflict dominates in the Middle East and Africa, economic collapse is most evident in Latin America, and persecution is central in South Asia. Climate stressors cut across regions, intensifying other drivers rather than acting alone. Recognising this heterogeneity is crucial for designing tailored policy responses and avoiding over-generalisation in global debates on forced migration.

The consequences of forced migration are supported by evidence of varying strength. Mental health outcomes are among the most consistently documented. Studies demonstrate elevated rates of depression, anxiety, and post-traumatic stress linked to post-migration stressors such as legal precarity, unemployment, and discrimination (Tippens et al., 2021; Kantor et al., 2023). These findings are reinforced by systematic reviews and global estimates, which confirm that common mental disorders are highly prevalent across refugee populations (Turrini et al., 2017; Charlson et al., 2019; Priebe et al., 2016). Mental health, therefore, represents one of the most robustly evidenced consequences of forced migration.

Maternal health disparities are also strongly evidenced. Venezuelan migrants in Brazil and Ecuador report lower antenatal care coverage and worse pregnancy outcomes compared to host populations (do Carmo Leal et al., 2024; Greene et al., 2024). Similar findings are observed among Rohingya refugees in Bangladesh, where antenatal care remains extremely low and home births predominate (Elnakib et al., 2023). These results are supported by large registry and survey datasets, providing strong empirical backing for maternal health as a critical area of concern. Contradictory findings, however, exist. In Uganda, refugee women exhibited higher facility delivery rates despite lower attendance at antenatal care (Weigel & Armijos, 2023). This suggests that health system capacity and local context, rather than refugee status alone, shape maternal outcomes.

Communicable disease risks among displaced populations are frequently

documented through camp-based surveillance and outbreak reporting. Chickenpox outbreaks in Greek camps illustrate how crowding and limited immunisation capacity sustain transmission (Scales et al., 2024). Similar patterns are visible in humanitarian emergencies, where cholera resurges across multiple regions, driven by conflict, poverty, and gaps in case management and timely care, underscoring challenges in Water, Sanitation, and Hygiene (WASH) and vaccination in displacement settings (World Health Organisation, 2025). Field briefings from UNHCR on cholera in refugee settlements further highlight the need for rapid funding to stabilise sanitary conditions and sustain outbreak control measures (United Nations High Commissioner for Refugees, 2025).

NCDs recur across humanitarian contexts, with programme data showing early improvements in hypertension and diabetes control under structured, free care and simplified regimens (Ansbro et al., 2021; Ansbro et al., 2023). Operational guidance outlines practical approaches for integrating NCD services in displacement settings, including task-sharing, essential medicines, and continuity-of-care pathways adapted to resource constraints (United Nations High Commissioner for Refugees, 2020). Integrated health education has been linked to behavioural engagement and chronic disease risk reduction in host communities (Powell et al., 2021), complementing service delivery models.

Substance use and long-term social integration outcomes are less frequently quantified but remain essential. Qualitative accounts among Syrian migrants in Türkiye describe alcohol and substance use linked to unemployment, discrimination, and untreated trauma (Taşdemir et al., 2020). South Sudanese refugee youth in Uganda report alcohol use as a coping response to war memories and settlement stress, shaped by cultural disruption and availability of home-brewed alcohol (Makoha & Denov, 2024). Public health guidance emphasises migrant-inclusive health systems and equity-oriented screening and prevention across communicable and non-communicable conditions, including mental health and substance use, to protect both displaced and host populations (Centres for Disease Control and Prevention, 2025).

Over the past five years, forced migration has been primarily driven by war and armed conflicts. Most affected individuals are refugees and asylum seekers who flee unwillingly because they have no choice but to seek safety in other countries. Approximately 70.0% of forced migrants fled to their neighbouring countries. Also, an estimated 70.0% of forced migrants are catered by the low- and middle-income countries (United Nations High Commissioner for Refugees, 2023). A safe and dignified return remains largely unattainable, as only 339,300 refugees were able to return home in 2022 (United Nations High Commissioner for Refugees, 2023). Most forced migrants remain in host countries. Thus, measures such as simplified asylum processes, humanitarian support, sociocultural skill development, education, employment, and health management are essential for adaptation and assimilation.

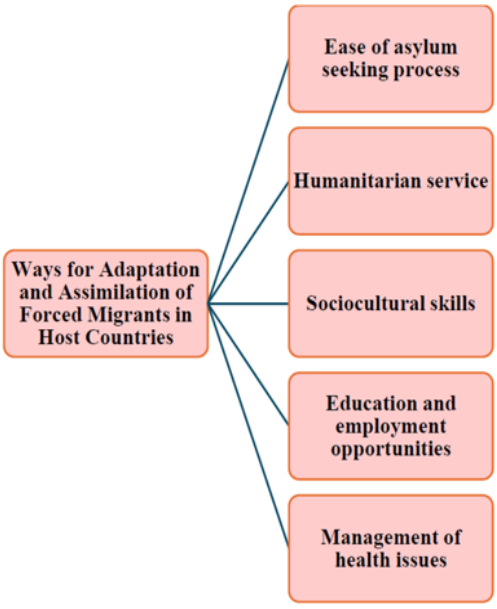

Figure 5: Ways for adaptation and assimilation of forced migrants in host countries. These include the ease of the asylum-seeking process, provision of humanitarian services, sociocultural skills, opportunities for education and employment, and management of health issues.

Ease of asylum-seeking process

Asylum processes should be simpler and faster, ideally under one year, because longer waiting time increases the risk of psychiatric disorders (Hvidtfeldt et al., 2021).

Provision of humanitarian service

Many refugee camps are operated by humanitarian service providers, such as those in Cox's Bazar, Bangladesh. They assist the host countries' response to the refugee crisis by working with refugee groups, training refugees as volunteers, and collaborating with community and religious leaders. Restricted services limit their ability to support refugees, with strict screening processes and difficult referrals to tertiary centres (Krishnan et al., 2022). Apart from refugee camps, emergency facilities should also be established to accommodate irregular migrants (García-López et al., 2024). Most importantly, the provision of a welcoming atmosphere when migrants first arrive is paramount to alleviating their anxiety, as sheltering has a positive effect on mental health (Caroppo et al., 2023).

Sociocultural skills

One of the most essential elements in cultural adaptation is language. The provision of language classes is a double-edged sword, as it can help with adaptation in host countries and improve mental health, especially among refugee youths (Meyer et al., 2023). Host communities should learn basic phrases in migrants' languages to improve cultural sensitivity and communication during critical situations, such as medical diagnosis (Lindheimer et al., 2020).

Education and employment opportunities

Attending school improves a migrant child's mental health status, provides a sense of belonging, introduces and adds civil knowledge, and offers refuge to affected adolescents (McDiarmid et al., 2021; Pérez-Aronsson et al., 2019). In addition to education, employment opportunities should also be offered (Makoha & Denov, 2024) (Makoha & Denov, 2024). In Sweden, the Public Employment Service offers jobs to refugees and asylum seekers but has been advised to place greater emphasis on their mental health needs (Larsson et al., 2022). Policies should simplify and shorten employment applications for skilled forced migrants so that migrants benefit from improved quality of life and host countries gain needed expertise (Aydiner & Rider, 2022) (Aydiner & Rider, 2022). Migrants should be equipped with job-searching skills, such as preparing a curriculum vitae and developing interview skills, to improve their chances of being employed (Llinares-Insa et al., 2020).

Management of health issues

Health issues of forced migrants are various. Efforts that can be taken include providing health financial security through health insurance, offering a positive healthcare experience, leveraging the innovation of technology, and addressing the mental health needs of migrants.

(a) Health insurance

Health services are essential, as numerous health effects are present due to forced migration. The host countries need to balance the requirements to provide health services to their citizens with managing the healthcare of the forced migrants they cater to. One strategy is to establish insurance coverage for refugees, as practised by Iran. This implementation began in 2015, but it was not without its challenges. Challenges included household-based premiums, long wait times for benefits, difficulty setting premiums for non-vulnerable refugees, and significant cost differences between public and private healthcare. Among the improvements made were reducing the current premium rates, removing household size from the premium computation, and

collecting premiums from non-vulnerable refugees on a monthly basis (Shahabi et al., 2023). As for undocumented immigrants, prosperous and developed regional countries should play a larger role in financing health services for the group (Etemadi et al., 2023)

(b) Positive healthcare experience

Studying displaced populations' demographics and epidemiology helps host countries provide appropriate care, as shown by findings that most Ukrainian refugees in Italy were women and minors (Perente et al., 2023). Positive healthcare experiences are achieved when information is culturally appropriate, and migrants' questions are addressed attentively. For immunisation, refugee parents feel responsible for protecting their children's health and following the host country's vaccination schedule. They also have a more positive experience in host countries such as New Zealand, but they would like to have a more friendly experience when receiving health services. In Germany, women-only mother-children centres (MIKA) support refugees by providing child healthcare, social support, and skills for assimilation and resilience, including language and vocational activities. Although there is room for improvement, this programme has been endorsed for expansion by the involved participants (Zehetmair et al., 2021). Involving migrants in intervention design improves inclusion and suitability, as seen in the engagement of refugee youth in an alcohol prevention programme (Makoha & Denov, 2024).

Hygiene promotion effectively reduces communicable diseases, as shown in Ethiopian refugee camps using behaviour-centred design to improve cleanliness practices (Mekonnen et al., 2023). An integrated primary health care service, which comprises both preventive and curative approaches (such as emphasis on WASH), should be applied in refugee camps. Services provided by Malteser International along the Thailand-Myanmar border have resulted in a reduction in malaria, dysentery, watery diarrhoea, and lower respiratory tract infections over the past 18 years (Mohr et al., 2022). This approach may also be a better option in host countries where the integration of immigrant health services is not possible.

For NCD control, combining medications into a single pill improves adherence and clinical outcomes, as shown by fixed-dose therapy for cardiovascular disease in a Syrian refugee camp in Lebanon (Ansbro et al., 2023). Ideally, NCD care should address short, intermediate, and long-term goals, although current efforts mainly focus on immediate needs (Ansbro et al., 2022). Orientation and formal information about the host country's health system are also imperative to help forced migrants access treatment for their chronic diseases (Haderer et al., 2021). Innovations, such as integrating NCD services with mental health awareness, have also proven successful in controlling chronic diseases (Powell et al., 2021).

(c) Leveraging on technology

Giving digital technology education can help with subjective well-being and adaptation process of migrants in their host countries (Yoo & Jang, 2023) (Yoo & Jang, 2023). Digital tools, such as the Children's Immunisation App (CIMA), can improve vaccination adherence in humanitarian settings, although their implementation remains challenging (Khader et al., 2022).

(d) Mental health

Refugees face many stressful predicaments before, during, and after settling in host countries (Brunnet et al., 2022). There needs to be strategies to target the post-migration quality of life and provide strong social support to involuntary immigrants, as these factors significantly contribute to their mental health and well-being (Schilz et al., 2023). For mental health well-being, screening for psychological distress is also recommended at least twice during migrants' resettlement period (Hollifield et al., 2021

Social belonging, cohesion, support, and connectedness with family, communities, and services are vital for helping forced migrants cope with mental health challenges (Bletscher & Spiers, 2023; Khozaei et al., 2024; Kovács et al., 2023; Meyer et al., 2023; Mwanri et al., 2023; Panagiotopoulos & Pavlopoulos, 2024). Building resilience is essential, as is providing a suitable environment to support it. This can be achieved by incorporating communal activities that include group gatherings, online interactions, and hobbies (Dangman et al., 2021; Nagi et al., 2021). Trust-building strategies to manage the trauma experienced by refugees should be constructed, as they tend to trust the citizens of host countries more than they trust one another (Al Ajlan, 2023). Caregivers should also practice a diversity-sensitive approach to enhance trust in refugees (Haj-Younes et al., 2022). In addition, the provision of interpersonal counselling, which can be given by non-specialists, needs to be considered to support mental health in migrants (Greene et al., 2024).

Despite the breadth of recent evidence, significant gaps remain in current research on international forced migration. Climate-related displacement is underrepresented, with few empirical studies directly linking environmental stressors to cross-border migration despite growing global concern (International Organisation for Migration, 2024; Thompson, 2019). Longitudinal data on NCDs and substance use among displaced populations are limited, restricting understanding of long-term health trajectories. Evidence on host-country impacts is uneven, with stronger documentation of economic strain than of positive contributions such as workforce integration. Comparative studies across regions are scarce, making it difficult to generalise findings beyond specific national contexts. Finally, methodological diversity, predominantly characterised by cross-sectional and qualitative designs, limits causal inference and comparability. Addressing these gaps requires investment in multi-country, longitudinal, and mixed-methods research, alongside stronger integration of climate science, health systems data, and policy evaluation to inform comprehensive responses to forced migration.

CONCLUSION

This narrative review identified five major drivers of international forced migration in the past five years: political instability and conflict, economic collapse, environmental disasters and climate change, social and cultural breakdown, and human rights abuses. The consequences for migrants include persistent economic hardship, weakened social belonging, health challenges, and threats to human security. Host countries experience both strain and benefit, facing increased service demand while also gaining from refugee contributions in labour and skills. Adaptation and assimilation measures, such as simplifying asylum processes, providing humanitarian support, enhancing sociocultural skills, and expanding educational and employment opportunities, remain essential for sustainable integration.

For policymakers and international agencies, these findings underscore the need for coordinated responses that strike a balance between humanitarian protection and long-term integration. Governments must strengthen asylum systems, ensure equitable access to health and education, and reduce discrimination in host communities. International organisations such as United Nations High Comissioner for Refugees and International Organisation for Migration should continue to support host countries through technical assistance, funding, and policy guidance, particularly in contexts where resources are limited. NGOs play a crucial role in bridging service gaps, offering community-based support, and advocating for the rights of migrants.

Several research gaps remain. Climate-related displacement is underrepresented in empirical studies despite its growing importance. Longitudinal data on NCDs, maternal health, and substance use among displaced populations are scarce, limiting understanding of long-term trajectories. Evidence on host-country impacts is uneven, with stronger documentation of economic strain than of positive contributions. Methodological diversity, characterised by a predominance of cross-sectional and qualitative designs, limits causal inference and comparability across regions.

Future research should prioritise mixed-method and longitudinal studies that capture both immediate and long-term outcomes of forced migration. Comparative analyses across regions are necessary to identify context-specific drivers and consequences. Integrating climate science, health systems data, and policy evaluation will strengthen the evidence base.

Actionable recommendations include governments simplifying asylum procedures and embedding migrant-inclusive health and education policies, as well as NGOs expanding culturally sensitive psychosocial and livelihood programmes. Meanwhile, international agencies such as the United Nations High Commissioner for Refugees, the International Organisation for Migration, and the World Health Organisation are coordinating global frameworks for climate-related displacement and migrant health. Moreover, researchers are adopting mixed-method and longitudinal designs to address evidence gaps. By linking drivers, consequences, and adaptation strategies to policy and research priorities, this review provides a foundation for more effective responses to international forced migration.

CONFLICT OF INTEREST

The authors declared that there was no conflict of interest involved in the preparation, writing, and completion of this narrative review.

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