

Navigating Vulnerability and Integration: Refugee Resettlement from Rwanda to Third Countries under the Medical Needs Category

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ABSTRACT

Resettlement is a limited resource available to only a fraction of refugees. Selection criteria, set by the United Nations High Commissioner for Refugees and receiving States, may impose conflicting demands on refugees to exhibit both vulnerability and integration potential to be chosen, a phenomenon termed “promising victimhood”. Drawing on empirical data from interviews with 21 personnel from the United Nations High Commissioner for Refugees and Save the Children International in Rwanda, this article explores how medical needs criteria impact the inclusion or exclusion of refugees for resettlement. It finds that the selection criteria favour refugees with treatable conditions and favourable prognoses, thereby excluding those with chronic or fatal illnesses or patients with poor life expectancy. The article argues that such criteria potentially undermine the humanitarian objectives of the resettlement programme by marginalising some of the most vulnerable individuals. It discusses the implications of these findings for global burden-sharing strategies and calls for strengthening the medical infrastructure in asylum countries. The article concludes by questioning whether resettlement, in its current form, can truly serve as one of the three durable solutions for refugees with medical needs, given that it remains an option for only a select few.

KEYWORDS: Refugee Resettlement, Medical Needs, Vulnerability, Integration, Promising Victimhood, Rwanda

1. INTRODUCTION

Nathan was a young refugee in Uganda. He often spoke about the difficulties of life in Nakivale Refugee Settlement and expressed a sense of being lost. With nothing left for him in the Democratic Republic of the Congo (DRC), and his only hope being

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resettlement elsewhere—preferably Norway—he faced significant challenges. He suffered from atherosclerosis¹ and had travelled to a clinic in Mbarara for examinations. Nathan was unable to work, relying heavily on his siblings who managed to earn a modest income through small-scale livelihood activities. Nathan made numerous unsuccessful attempts to get assistance for resettlement from the United Nations High Commissioner for Refugees (UNHCR) and Uganda’s Office of the Prime Minister. Met with long queues and the constant advice to wait, he felt that no progress was being made. The hope for resettlement kept him going, despite stating, “life as a refugee is no life at all”. A year later, Nathan and his siblings were granted resettlement to Europe, based on Nathan’s medical needs. Nathan was finally provided with the necessary surgery for his condition, quickly recovered, and able to take up work and lead a normal life.²

Nathan’s story exemplifies the intricate considerations in the resettlement process. His medical condition, atherosclerosis, necessitated surgical intervention unavailable in Uganda, thus making him a candidate for resettlement based on medical needs. The resettlement process required comprehensive medical documentation and proof of the severity of his condition. Nathan’s condition suggested that a successful surgery could greatly enhance his quality of life, potentially opening new opportunities, including the possibility of joining the workforce. This article investigates how medical needs impact the resettlement selection process for refugees in Rwanda, specifically examining the concept of promising victimhood, whereby refugees must exhibit both vulnerability and potential for integration. The central question guiding this article is how medical needs criteria influence the inclusion or exclusion of vulnerable refugees in Rwanda’s resettlement programmes and what the broader implications are for resettlement as a burden-sharing mechanism among nations.³

For refugees, the chances of being selected for resettlement to a third country are extremely low. Conflicts, human rights violations, and persecution have seen the global number of forcibly displaced individuals reach an alarming record of 110 million. The demand for durable solutions for refugees has never been more pressing.⁴ For those unable to return to their country of origin or integrate into their current country of asylum, the only available durable solution is resettlement. Despite this, only a fraction of the world’s refugees is granted resettlement. In 2023, more than 2 million refugees were projected to need resettlement, while a total of 158,700 refugees were resettled by states with the support of UNHCR. Looking ahead to 2025, UNHCR projects that more than 2.9 million refugees worldwide will need resettlement.⁵ This discrepancy underscores the gap between the need for resettlement and the available opportunities.

¹ Atherosclerosis is a condition where arteries harden due to plaque build-up. If untreated, it can lead to serious health complications such as coronary heart disease, carotid artery disease, peripheral artery disease, and kidney disease.

² I. Bjørkhaug, “Tales of Loss and Sorrow: Addressing Methodological Challenges in Refugee Research in Uganda”, *Forum for Development Studies*, 44(3), 2017, 453–71.

³ Burden-sharing is the distribution of costs and responsibilities among members of a group to achieve a collective goal. While many scholars prefer the term “responsibility-sharing”, arguing that it is more politically correct, the authors will employ the term “burden-sharing”, which they argue better reflects the tangible costs and obligations assumed by States that accept refugee populations, particularly highlighting the substantial contributions of host countries in country of first asylum. Also note that by “vulnerable refugees”, we refer to individuals who are identified by resettlement agencies as having heightened needs due to factors such as age, disability, severe medical conditions, or experiences of trauma. While this article critiques the use and expectations surrounding “vulnerability”, we use the term with caution, recognising the complexity and potential implications of labelling individuals as vulnerable.

⁴ United Nations High Commissioner for Refugees (UNHCR) *Mid-Year Trends 2023*, available at: <https://www.unhcr.org/sites/default/files/2023-10/Mid-year-trends-2023.pdf> (last visited 03 April 2024)

⁵ UNHCR, *UNHCR projected Global Resettlement Needs 2023*, available at: <https://www.unhcr.org/media/projected-global-resettlement-needs-2023> (last visited 19 Aug. 2024); UNHCR, *Data and Statistics: Global Trends*, available at <https://www.unhcr.org/global-trends> (last visited 25 June 2024); UNHCR, *UNHCR: 2025 global refugee resettlement needs spike to almost 3 million*, available at: <https://www.unhcr.org/news/press-releases/unhcr-2025-global-refugee-resettlement-needs-spike-almost-3-million> (last visited 19 Aug. 2024).

Resettlement is an international protection mechanism designed specifically for refugees. UNHCR plays a crucial role in identifying refugees in dire need of resettlement, who are then sent to various recipient countries through their resettlement programmes. In addition to contributing to durable solutions for refugees, resettlement programmes are a way for recipient countries to demonstrate global solidarity and shared responsibility with low- and middle-income countries, which host three-quarters of the world's refugees and other people in need of international protection.⁶ Furthermore, European Union (EU) Member States have shown interest in resettlement for the strategic potential that resettlement programmes offer in resolving the problems of smuggling, high asylum-seeker arrivals and widespread anti-immigrant sentiment. Recent critiques also highlight how western countries point to resettlement as a way to legitimise more restrictive migration controls.⁷ Thus, resettlement can be a strategic tool that allows governments to enhance their humanitarian image while legitimising restrictive border controls. If employed in this manner, resettlement may serve more as a symbolic gesture than an effective burden-sharing response to humanitarian crises, as it might not significantly increase the overall protection offered to refugees. Lutz and Portmann discuss how resettlement policies often balance domestic political pressures with international humanitarian obligations, allowing states to appear committed to refugee protection without significantly expanding asylum opportunities. This reflects a broader trend where liberal democracies reconcile their humanitarian commitments with restrictive immigration policies.⁸

Refugees do not have a right to resettlement, and States are not obliged to share the asylum-related burden by engaging in resettlement programmes. Although the number of resettlement slots (or quotas) may fluctuate, they remain insufficient to meet the growing need for refugee resettlement. As the refugee population in need of resettlement increases, there is a need to carefully examine the policies and practices of the resettlement system. The present study addresses this need by examining the Rwandan context, which hosts approximately 135,000 refugees, mainly from Burundi and the DRC, in six refugee camps. In 2023, 7,826 individuals departed from Rwanda for resettlement to USA, Norway, Canada, France, Netherlands, Sweden, Denmark, Finland, Australia, and New Zealand.⁹ The choice of context is motivated by the lack of empirical data on resettlement from Rwanda and the country's rising prominence in international refugee governance.

This article investigates resettlement selection practices in Rwanda, focusing on how medical needs, as one of the seven resettlement categories used by UNHCR, influence who is selected for resettlement and who is excluded. It is organised to guide the reader through three key sections. Section 2 is based on a set of expert interviews with caseworkers and medical staff from UNHCR and Save the Children International (hereafter "Save the Children"), which is UNHCR's health partner in Rwanda. It explores how prognosis criteria exclude certain groups, particularly those with chronic or fatal illnesses, and patients with prospect of short life expectancy. Section 3 delves into the practical aspects of applying these criteria, highlighting the bureaucratic and logistical challenges faced by medical staff. Section

⁶ International Organization for Migration (IOM), *Resettlement Assistance*, available at: <https://www.iom.int/resettlement-assistance> (last visited 03 April 2024).

⁷ J. Van Selm, *Great Expectations: A Review of the Strategic Use of Resettlement*, Policy Development and Evaluation Service, 2013.

⁸ P. Lutz & L. Portmann "Why do States Admit Refugees? A Comparative Analysis of Resettlement Policies in OECD Countries", *Journal of Ethnic and Migration Studies*, 48(11), 2022, 2515–2539; P. Lutz & L. Portmann, "The Strategic Use of Resettlement Policies by Western Countries" [online], 2022, Eurac Research, Science Blog, available at: <https://www.eurac.edu/en/blogs/mobile-people-and-diverse-societies/the-strategic-use-of-resettlement-policies-by-western-countries> (last visited 09 Sept. 2024).

⁹ UNHCR, *Global Focus*, available at: <https://reporting.unhcr.org/operational/operations/rwanda> (last visited 23 Aug. 2024).

4 engages in a theoretical discussion on the concept of promising victimhood, examining its implications for global burden-sharing and how medical needs criteria impact the inclusion and exclusion of vulnerable refugees. Throughout the article, this comprehensive analysis aims to shed light on the impact of current medical needs criteria on refugee resettlement in Rwanda and the broader global policy context.

1.1. Global refugee resettlement trends and challenges

At the time of writing, resettlement is at a critical moment, having faced a decline in numbers of refugees resettled from its peak in 2016, due to challenges such as the coronavirus disease 2019 (COVID-19) pandemic, anti-refugee sentiment, and restrictive politics.¹⁰ While the Global Compact on Refugees (GCR), adopted by the United Nations (UN) in 2018, emphasises international cooperation, scholars argue that it falls short in addressing the fundamental issues related to equitable burden-sharing.¹¹ The GCR also ensures that the international community aids host countries in recognising refugees within their borders who have needs (including health-related needs) and in setting up the necessary frameworks and protocols to address those requirements.¹² In September 2016, the UN General Assembly adopted the New York Declaration for Refugees and Migrants, reaffirming the importance of international refugee rights and the commitment to strengthening protection and support for people on the move. The Comprehensive Refugee Response Framework (CRRF), which was introduced as part of the New York Declaration, is developed at the country level, rather than globally, and is not legally binding but an expression of political will to “Leave no one behind” (Principle Two of the UN’s 2030 Agenda for Sustainable Development). The CRRF has four key objectives: (1) Ease the pressures on host countries and communities; (2) Enhance refugee self-reliance, (3) Expand third-country solutions, and (4) Support conditions in countries of origin for return in safety and dignity.¹³ While this article focuses specifically on resettlement processes, it is important to note that complementary pathways, such as humanitarian corridors, private sponsorship programmes, and family reunification, are increasingly recognised as essential components of refugee protection. These pathways offer additional opportunities for refugee admission to third countries beyond traditional resettlement.¹⁴

The global resettlement system exhibits disparities between the number of refugees identified as needing resettlement and those who are resettled. Additionally, variations in how countries participate in burden-sharing contribute to ongoing discussions about the effectiveness and sustainability of resettlement as a strategy for refugee protection.¹⁵ This situation unfolds within a complex global context where the efficacy and sustainability of resettlement as a solution to refugee protection are frequently questioned.¹⁶ Notably, the United States witnessed a significant decline in its resettlement efforts under the Trump administration.¹⁷ Meanwhile, the EU and its Member States have shown reluctance to relocate refugees from Greece and Italy across the bloc, contributing to the challenges facing

¹⁰ P.S. Bose, “The Shifting Landscape of International Resettlement: Canada, the US and Syrian Refugees”, *Geopolitics*, 27 (2), 2022, 375–401.

¹¹ M. Ineli-Ciger, “The Global Compact on Refugees and Burden Sharing: Will the Compact Address the Normative Gap Concerning Burden Sharing?”, *Refugee Survey Quarterly*, 38(2), 2019, 115–38.

¹² G.D. Triggs & P.C. Wall, “The Makings of a Success’: The Global Compact on Refugees and the Inaugural Global Refugee Forum”, *International Journal of Refugee Law*, 32(2), 2020, 283–339.

¹³ UNHCR, *New York Declaration for Refugees and Migrants*, available at: <https://www.unhcr.org/what-we-do/protect-hu-man-rights/asylum-and-migration/new-york-declaration-refugees-and-migrants> (last visited 31 May 2024).

¹⁴ UNHCR, *Global Compact on Refugees*, available at: <https://globalcompactrefugees.org/> (last visited 23 Aug. 2024).

¹⁵ UNHCR, *Mid-Year Trends 2023*, available at: <https://www.unhcr.org/sites/default/files/2023-10/Mid-year-trends-2023.pdf> (last visited 03 April 2024).

¹⁶ D.J. Beers, “The End of Resettlement? US Refugee Policy in the Age of Trump”, *Social Sciences*, 9(8), 2020, 129.

¹⁷ A. Chikanda, “Refugee Resettlement in the American Midwest in Challenging Times”, *GeoJournal*, 88, 2023, 917–29.

resettlement initiatives.¹⁸ As Ekstedt and Lundstedt (2024) highlight, the EU has increasingly relied on the standardisation of resettlement processes through tools and frameworks developed by the European Union Agency for Asylum (EUA). These efforts aim to streamline resettlement across Member States, though they also underscore the complexities and challenges involved in achieving equitable burden-sharing within the EU. Countries that have previously been generous in their quotas have recently reduced them significantly. This trend is exemplified by Sweden, which from 2017 to 2022 had a quota of 5,000 individuals annually; this number has been reduced to 900 individuals per year by a new policy introduced after the September 2022 general elections. This reduction came with a substantial shift in Sweden's approach to its resettlement programme, moving from focusing primarily on the vulnerability of refugees to considering their prospects of integration into Swedish society.¹⁹

These developments signify considerable obstacles for the resettlement agenda, which has struggled to gain the momentum anticipated at the 2016 UN Summit for Refugees and Migrants.²⁰ The fluctuating nature of resettlement numbers, largely at the discretion of the receiving countries, underlines the unpredictable and often politically influenced nature of refugee resettlement schemes. Consequently, while there has been a recent increase in resettlement numbers, the overall effectiveness and sustainability of these efforts remain under scrutiny, with a clear need for more consistent and committed global engagement in order to represent a durable solution to more than only a select few.

1.2. Methodology

This study uses a qualitative approach to explore the manifestation of promising victimhood within bureaucratic processes, based on 21 interviews with UNHCR caseworkers and Save the Children medical doctors conducted in 2023 and 2024. Local researchers facilitated access to key informants. We employed a combination of snowball and convenience sampling techniques²¹ to recruit participants. Initial contacts within UNHCR referred other potential participants, expanding the sample through professional networks, while convenience sampling engaged readily accessible participants.

Eleven interviews were carried out during fieldwork in Rwanda in April and May 2023, conducted in three refugee camps, as well as at UNHCR and Save the Children representative offices in Kigali. Following the initial fieldwork and preliminary analysis, an additional 10 follow-up interviews were conducted online in 2024, introducing an iterative dimension to the data collection and analysis. To maintain anonymity, “caseworkers” refers to UNHCR staff at various levels, and “medical doctors” specifically refers to those working in refugee camps or the national office for Save the Children, UNHCR's primary health partner in Rwanda. Given the small pool of informants, we used generic titles and avoided identifying informants. As researchers from a donor country, we were aware of the potential influence of our positionality on data collection. While UNHCR and medical experts interviewed may have an interest in maintaining a positive relationship with donor countries like Norway, we ensured that participants were informed about our independent role and obtained informed consent. This, combined with the mutual

¹⁸ A. Niemann & J. Blöser, “Migration and the Mediterranean: The EU's Response to the “European Refugee Crisis”, in R. Mason (ed.), *Transnational Security Cooperation in the Mediterranean*, Palgrave Macmillan, 2021, 75–113.

¹⁹ Johan Ekstedt & Andreas Asplén Lundstedt, “Wanted Refugees: The Forming of an Instrument Constituency for Refugee Resettlement in the European Union”, *Refugee Survey Quarterly*, 43(3), 2024, 368–85, <https://doi.org/10.1093/rsq/hdae006>. B. Suter & J. Ekstedt, *Resettlement in the ‘New’ Sweden: Potential Consequences of the 2022 Introduction of Integration Criteria in the Quota Refugee Programme*, Fafo Brief, 2023.

²⁰ K. Sandvik & A. Garnier, *How Will the Covid-19 Pandemic Reshape Refugee and Migration Governance?* Prio Blog post, 2020, available at: <https://blogs.prio.org/2020/03/how-will-the-covid-19-pandemic-reshape-refugee-and-migration-governance/> (last visited 23 Aug. 2024).

²¹ R. Atkinson & J. Flint, “Accessing Hidden and Hard-to-reach Populations: Snowball Research Strategies”, *Social Research Update*, 33(1), 2001, 1–4; P. Sedgwick, “Convenience Sampling”, *British Medical Journal*, 374, 2013, 1–2.

dependency between donor countries and UNHCR's work, helped ensure that data collection was balanced and ethically sound. Although the focus was on UNHCR's selection processes across various countries, we remained mindful that our identity as Norwegian researchers could subtly influence discussions.

Research clearance was obtained from Norway (Sikt) and Rwanda's National Council of Research and Technology (NCST). Data collection adhered to strict ethical guidelines, including voluntary informed consent and confidentiality measures. Transcripts were anonymised, linked to identities using a shredding key, and securely stored. Interviews were semi-structured to allow flexibility, enabling participants to express their perspectives freely while focusing on themes related to medical needs and bureaucratic processes. We also ensured transparency and built trust by clearly communicating our independent role as researchers and by informing participants that the study was approved at all organisational levels, including by the NCST. The interviews were contextualised within a broader research project on resettlement, complementing other data sources, including discussions with staff specialising in resettlement and medical issues at UNHCR offices in Uganda, the regional office in Nairobi, and the headquarters in Geneva, to provide a broader understanding of the decision-making dynamics.²²

All interviews were conducted in English, an official language in Rwanda. Notably, the interviews involved medical experts within the UN system, where English is the working language. In meetings with medical professionals and caseworkers in the camps, a local assistant was present to provide explanations in Kinyarwanda when necessary. Data analysis included systematic text analysis of transcribed interviews, identifying themes related to promising victimhood, medical needs, and inclusion/exclusion in bureaucratic pipelines. To enhance the credibility of our findings while managing potential biases, respondent validation was employed, allowing key participants to verify data accuracy, without influencing the analysis or conclusions. The decision to rely on interviews rather than observation or participatory methods posed challenges in capturing the systematic nature of bureaucratic practices. To address this limitation, questions were carefully designed to facilitate a discussion about bureaucratic practices and procedures. Given the exploratory nature of this study, we employed thematic analysis guided by Braun and Clarke's framework,²³ using NVivo software for data coding and organisation. Scholars have highlighted the limitations of qualitative interviews, noting the potential gap between bureaucratic discourse and practice.²⁴ Despite these limitations, our methodology provided valuable insights into the role of medical needs in resettlement procedures and practices.

2. RESETTLEMENT SELECTION AND THE MEDICAL NEEDS CATEGORY

Given that resettlement constitutes a limited resource only available to a fraction of refugees, scholars in recent decades have been concerned with exploring what characterises refugees who succeed in the selection processes and ultimately receive resettlement.²⁵ Refugees go

²² Fafo: The future of resettlement: Vulnerability revisited. Available at: <https://www.fafno.no/en/projects/the-future-of-resettlement-vulnerability-revisited> (last visited 16 Sept. 2024).

²³ B. Virginia, and V. Clarke, "Using Thematic Analysis in Psychology", *Qualitative Research in Psychology*, 3(2), 2006, 77–101.

²⁴ E.K. Hahonou & T.M. Martin, "Immersion in the Bureaucratic Field: Methodological Pathways", *Critique of Anthropology*, 39(2), 2019, 122–38.

²⁵ L. Turner, "Who Will Resettle Single Syrian Men?" *Forced Migration Review*, 54, 2017, 29–31; N. Welfens & S. Bonjour, "Families First? The Mobilization of Family Norms in Refugee Resettlement", *International Political Sociology*, 15(2), 2020, 212–31; H. Armbruster, "It Was the Photograph of the Little Boy: Reflections on the Syrian Vulnerable Persons Resettlement Programme in the UK", *Ethnic and Racial Studies*, 42(15), 2019, 2680–99; J.P. Brekke, E. Paasche, A. Espegren & K.B. Sandvik, *Selection Criteria in Refugee Resettlement: Balancing Vulnerability and Future Integration in Eight Resettlement Countries*, Report from Institutt for Samfunnsforskning (IFS) 03/2021, available at: <https://samfunnsforskning.brage.unit.no/samfunnsforskning-xmlui/bitstream/handle/11250/2758744/Refugee%2bResettlement.pdf;sequence=1&isAllowed=y> (last

through a rigorous selection process and must satisfy selection criteria outlined both by recipient countries and by UNHCR. The screening conducted by UNHCR depends on the resettlement case-processing methodology: individual processing or group processing. Group processing, primarily used for submissions to the United States, streamlines cases based on shared criteria like nationality and protection needs. However, the focus of this article is on resettlement through individual processing, which applies to submissions to other countries and US cases not eligible for group processing. This method involves UNHCR resettlement officers using the ProGres data system to identify eligible refugees based on criteria agreed with the resettlement country. Strong coordination between operational data managers and caseworkers is essential to maintain the integrity of the process. However, UNHCR methodology varies according to the operational context.²⁶ Resettlement countries, on their part, provide UNHCR with a Pre-Mission Questionnaire (PMQ), which outlines the admission criteria specifying the regions or refugee populations from which they are willing to accept submissions.²⁷

In the 2000s, UNHCR introduced “categories of vulnerability” within its guidelines and handbooks to standardise the identification and selection of eligible refugees, aiming to depoliticise resettlement decisions across different states.²⁸ These guidelines classify refugees based on factors such as gender and age. While this article focuses on medical needs as a criterion for resettlement, it is important to acknowledge that UNHCR’s methodology also considers a range of other vulnerabilities. These include survivors of gender-based violence, unaccompanied and separated children, LGBTQI+ individuals, persons with albinism, victims of trafficking, and refugees needing resettlement to restore family unity or those with disabilities, irrespective of whether they have life-threatening medical conditions.²⁹ The concept of vulnerability in the resettlement process not only guides street-level bureaucrats in selection but also reflects broader political influences, which can create selective criteria that may exclude those who do not fit narrowly defined categories, underscoring the complexity of its application in practice.³⁰

In recent decades, in light of criticism regarding insufficient protection measures for female and LGBTQI+ refugees, UNHCR has formulated guidelines that recognise and address the distinct protection requirements of these demographic groups.³¹ Subsequently, scholars have raised concerns about a diminished acknowledgment of the hardships

visited 10 May 2024); M. Kocak “Who Is ‘Queerer’ and Deserves Resettlement? Queer Asylum Seekers and Their Deservingness of Refugee Status in Turkey”, *Middle East Critique*, 29(1), 2020, 29–46; K.B. Sandvik, “The Physicality of Legal Consciousness: Suffering and the Production of Credibility in Refugee Resettlement”, in R.D. Brown and R.A. Wilson (eds.), *Humanitarianism and Suffering: The Mobilization of Empathy*, Cambridge University Press, 2009, 223–44.

²⁶ UNHCR, *The UNHCR Resettlement Handbook*, 2023 [online edition], available at: <https://www.unhcr.org/resettlement-handbook> (last visited 31 May 2024).

²⁷ *Ibid.* Resettlement programs in countries like the United States, Canada, and Australia typically do not reject submissions based on integration potential, in contrast to some European countries (e.g. Sweden, Norway, Germany), as well as Japan and Korea. All resettlement countries expect refugees to adhere to national values and laws, including principles like gender equality and prohibitions against practices such as polygamy and female genital mutilation, as outlined in the 1951 Refugee Convention. UNHCR uses a pre-mission questionnaire (PMQ) to assist with the planning and coordination with the different resettlement countries.

²⁸ A. Garnier, K.B. Sandvik & L.L. Jubilat, “Refugee Resettlement as Humanitarian Governance: Power Dynamics. Introduction”, in A. Garner, L.L. Jubilat and K.B. Sandvik (eds.), *Refugee Resettlement: Power, Politics, and Humanitarian Governance*, Berghahn Books, 2018, 1–25.

²⁹ UNHCR, *The UNHCR Resettlement Handbook*.

³⁰ L. Leboeuf, *Humanitarianism and Juridification at Play: ‘Vulnerability’ as an Emerging Legal and Bureaucratic Concept in the Field of Asylum and Migration*, Vulner Research Report 1, 2021.

³¹ *Ibid.* M. Kocak. “Who is ‘Queerer’ and Deserves Resettlement? Queer Asylum Seekers and Their Deservingness of Refugee Status in Turkey”, *Middle East Critique*, 29(1), 2020, 29–46; N. Welfens, “Promising Victimhood: Contrasting Deservingness Requirements in Refugee Resettlement”, *Journal of Ethnic and Migration Studies*, 49(5), 2023, 1103–24.

experienced by heterosexual men who also encounter suffering and vulnerability.³² Moreover, studies have found that perceived vulnerability has intersectional outcomes affected by identity markers such as gender, age, class, and race.³³ While women and children are often seen as vulnerable, men who are young, able-bodied, single, and heterosexual are often seen as not vulnerable.³⁴ Adding to this complexity, Miriam Ticktin's exploration of the politics of innocence highlights how refugees are often judged based on their perceived innocence or purity, which can shape who is seen as deserving of protection. This framing can further marginalise those who do not fit the idealised image of a vulnerable refugee, reinforcing the narrative that vulnerability is a prerequisite for care.³⁵ Others have criticised the emphasis on identifying and selecting refugees for resettlement based on their perceived vulnerability altogether, asserting that it constitutes a form of epistemic violence that portrays refugees as passive victims, thereby constraining a comprehensive recognition of their agency and resilience.³⁶ Additionally, some critics question the use of a refugee's "suffering body" as a justification for providing care and protection, arguing that positioning vulnerability as a prerequisite for protection undermines refugees' inherent right to protection as human beings.³⁷

2.1. The concept of 'promising victimhood'

While UNHCR and resettlement States aim to prioritise the most vulnerable refugees, studies have found that many resettlement States consider refugees' potential for integration during the selection process. Integration criteria may encompass factors such as perceived potential for economic success in the new host country, considerations regarding security, or assessments of cultural compatibility. A 2021 report analysing the resettlement programmes of eight countries (Australia, Canada, France, Germany, the Netherlands, Norway, Sweden, and the UK) concluded that all countries were "taking into consideration the refugees' future integration or, at least, their ability to cope in the host society".³⁸ This practice continues despite UNHCR urging resettlement States to refrain from utilising integration criteria as a foundation for their selection procedures.

³² V. Buffon & C. Allison, "The Gendering of Victimhood: Western Media and the Sinjar Genocide", *Kurdish Studies*, 4 (2), 2016, 176–96; Turner, "Who Will Resettle Single Syrian Men?"; L. Turner, "Syrian Refugee Men as Objects of Humanitarian Care", *International Feminist Journal of Politics*, 21(4), 2019, 595–616; L. Turner, "The Politics of Labeling Refugee Men as 'Vulnerable'", *Social Politics: International Studies in Gender, State & Society*, 28(1), 2019, 1–23; R.C. Carpenter, *Innocent Women and Children: Gender, Norms and the Protection of Civilians. Perspectives on Politics*, Routledge, 2006.

³³ K. Seibel, "Bureaucratic Birthdates: Chronometric Old Age as Resource and Liability in US Refugee Resettlement", *Refugee*, 32(3), 2016, 8–17; H. Sözer, "Categories That Blind Us, Categories That Bind Them: The Deployment of Vulnerability Notion for Syrian Refugees in Turkey", *Journal of Refugee Studies*, 34(3), 2019, 2775–2803; Turner, "Who Will Resettle Single Syrian Men?"; Turner, "Syrian Refugee Men as Objects of Humanitarian Care"; Turner, "The Politics of Labeling Refugee Men as 'Vulnerable'"; Welfens & Bonjour, "Families First?"; L. Mügge & M. van der Haar, "Who Is an Immigrant and Who Requires Integration? Categorizing in European Policies", in B. Garcés-Masareñas & R. Penninx (eds.), *Integration Processes and Policies in Europe: Contexts, Levels and Actors*, London, Springer, 2016, 77–90; S. Bonjour & J.W. Duyvendak, "The 'Migrant with Poor Prospects': Racialized Intersections of Class and Culture in Dutch Civic Integration Debates", *Ethnic and Racial Studies*, 41(5): 2017, 882–900; C. Roggeband & M. van der Haar, "Moroccan Youngsters: Category Politics in the Netherlands", *International Migration*, 56(4), 2017, 79–95.

³⁴ Turner, "Syrian Refugee Men as Objects of Humanitarian Care"; M. Palillo "Now I Must Go': Uncovering the Relationship between Masculinity and Structural Vulnerability in Young African Men's Stories of Forced Migration", *International Migration Review*, 2023 [online], available at: <https://journals.sagepub.com/doi/full/10.1177/01979183231185124> (last visited 26. Aug. 2024); Welfens, "Promising Victimhood".

³⁵ M. Ticktin, *On Refugees and Innocence*, Public Seminar. 2020 [online], available at: <https://publicseminar.org/2020/01/on-refugees-and-innocence/> (last visited 15 Aug. 2024).

³⁶ D.F. Lorenz, "All Refugees are Vulnerable: Vulnerabilität, Konflikte und Katastrophen im SpiegelPostkolonialer Theorie Zeitschrift f", in C. Dittmer (ed.), *Dekoloniale und Postkoloniale Perspektiven in der Friedens- und Konfliktforschung: Verortungen in einem ambivalenten Diskursraum*, Nomos Verlagsgesellschaft, Baden-Baden, 2018, 60–98.

³⁷ D. Fassin, "The Biopolitics of Otherness: Undocumented Foreigners and Racial Discrimination in French Public Debate", *Anthropology Today*, 17(1), 2001, 3–7; Turner, "Who Will Resettle Single Syrian Men?"; L. Turner, "The Politics of Labeling Refugee Men as 'Vulnerable'", *Social Politics: International Studies in Gender, State & Society*, 28(1), 2019, 1–23.

³⁸ J.P. Brekke et al., *Selection Criteria in Refugee Resettlement*, 10.

The expectation for refugees to fulfil criteria pertaining to both vulnerability and integration could lead to the exclusion of individuals in the direst circumstances.³⁹ Scholars conceptualise this duality as promising victimhood.⁴⁰ The concept is based on the acknowledgement that resettlement programmes operate with both “humanitarian policies with a declared focus on the ‘most vulnerable’ and discretionary immigration control that allows [the resettlement State] to pick and choose refugees”.⁴¹ The concept of promising victimhood serves to highlight the need for refugees to display both vulnerability and assimilability during the selection process in order to succeed.

Promising victimhood is applied as a tool to inform this study and is defined as the contrasting demands refugees face due to “policies and practices that require refugees to demonstrate that they are *currently* vulnerable and at risk, yet willing and able to ‘overcome’ their vulnerability to become law-abiding, self-sufficient and culturally malleable members of their host societies *in the future*”.⁴² This article seeks to explore how the concept of promising victimhood manifests in practice, particularly through the inclusion of prognosis criteria in medical resettlement cases, and its impact on the inclusion or exclusion of vulnerable refugees. By focusing on the often-overlooked area of resettlement based on medical needs and examining the selection mechanisms in Rwanda—a context where these practices are not extensively documented—this research aims to provide new empirical insights into resettlement selection practices.

2.2. The medical needs criteria

Over recent decades, the migration paradigm has undergone a significant shift. Initially, policies were largely driven by economic needs, such as the demand for labour during post-war reconstruction. However, beginning in the 1990s, there was a growing emphasis on humanitarian concerns, leading to a focus on providing protection and care for those affected by forced migration who were unable to access adequate treatment in their home countries. This shift reflects broader changes in how refugees and migrants are categorised and prioritised, as discussed by Zetter, who highlights the increasing complexity and selectivity of modern refugee labels.⁴³ It also reflects a broader trend where the “suffering body” of the refugee or immigrant has become central to discussions of moral and ethical obligations within society exemplified by France.⁴⁴ During the 1950s and 1960s, immigrant labour played a significant role in France’s post-war economic reconstruction. However, during this period, an injured or unwell immigrant who was not able to work effectively was considered undesirable and illegitimate.⁴⁵ By contrast, France began to recognise the need to accept immigrants who could not receive treatment in their home countries. This led to policies that allowed immigrants to stay in France and access free medical care, with their “suffering body” providing them with political legitimacy, even as other grounds for legal stay were increasingly questioned.⁴⁶ In essence, while immigrants held a marginal position in France’s political

³⁹ L. Schiocchet, “Outcasts among Undesirables: Palestinian Refugees in Brazil between Humanitarianism and Nationalism”, *Latin American Perspectives*, 46(3), 2019, 84–101.

⁴⁰ Wellens, “Promising Victimhood”; S. Chauvin & B. Garcés-Mascreñas, *The Myth of Humanitarianism: Migrant Deservingness, Promising Victimhood, and Neoliberal Reason*, Barcelona, 2017, available at: <https://sebastienchauvin.org/the-myth-of-humanitarianism/> (last visited 09 Sept. 2024)

⁴¹ Wellens, “Promising Victimhood”, 1104–05.

⁴² Wellens, “Promising Victimhood”, 1103.

⁴³ R. Zetter, “Labelling Refugees: Forming and Transforming a Bureaucratic Identity”, *Journal of Refugee Studies*, 4(1), 1991, 39–62; R. Zetter, “More Labels, Fewer Refugees. Remaking the Refugee Label in an Era of Globalization”, *Journal of Refugee Studies*, 20(2), 2007, 172–92.

⁴⁴ D. Fassin, “Compassion and Repression: The Moral Economy of Immigration Policies in France”, *Cultural Anthropology*, 20(3), 2005, 1548–1360.

⁴⁵ D. Fassin, “The Biopolitics of Otherness: Undocumented Foreigners and Racial Discrimination in French Public Debate”, *Anthropology Today*, 17(1), 2001, 3–7.

⁴⁶ *Ibid.*

economy, they gained centrality in its moral economy as the immigrants became a subject of discussions about values, ethics, and social justice within society.⁴⁷

In the context of refugee resettlement, a medical need is considered for refugees who cannot receive adequate treatment for their condition in their current country of asylum. However, being eligible for resettlement under this category involves a comprehensive assessment that goes beyond the mere unavailability of treatment. Factors such as the severity and urgency of the condition (diagnosis), the lack of available treatment in the asylum country (treatment), the potential for improvement with treatment (prognosis), and informed consent with expressed wish of the individual to be resettled are all taken into account.⁴⁸

Existing literature extensively covers refugees' health status post-resettlement and reveals a complex interplay between mental and physical health challenges. Korntheuer et al. show that refugees often suffer from mental health issues, such as PTSD, depression, and anxiety, in combination with physical health problems arising from pre- and post-migration stressors. Notably, factors like social support, gender, age, and education level play critical roles in influencing refugees' health-related quality of life.⁴⁹ However, there remains a notable gap in understandings of how medical needs influence the resettlement process itself. While studies highlight the importance of specialised healthcare services and improved healthcare delivery models, they less frequently address how health considerations shape resettlement selection policies and practices.⁵⁰ This points to a need for deeper exploration of the interplay between refugees' medical needs and the impact these have on their eligibility for resettlement.

The proportion of refugees resettled under the submission category of medical needs remains a small percentage. Resettlement States do not want more than five per cent of cases to be medical or to have medical needs.⁵¹ Resettlement policies have historically placed refugees with disabilities in a liminal position.⁵² On one hand, disabilities can exclude individuals from resettlement unless presenting as acute medical emergencies.⁵³ On the other, specific quotas for medical needs may facilitate resettlement opportunities for families with disabled members.⁵⁴ This duality reflects a broader challenge within resettlement frameworks to adequately recognise and respond to the medical and support needs of refugees with disabilities.⁵⁵ The resettlement experience for refugees with disabilities is influenced by an intersection of medical, social, and legal factors. Despite quotas for refugees with medical needs, there exists a systemic segregation between settlement support and specialised disability services. Research by Korntheuer et al. finds that in both Germany and Canada, this gap often results in inadequate access to essential health care, rehabilitation, and assistive services. The medical assessment processes used in resettlement can overlook less visible disabilities, complicating access to necessary services.⁵⁶ Medical Needs is one of seven submission categories used by UNHCR for refugee resettlement, with other categories addressing various individual protection needs and strategic priorities for durable solutions. In 2023,

⁴⁷ D. Fassin, "Another Politics of Life is Possible", *Theory, Culture & Society*, 26(5), 2009, 44–60.

⁴⁸ UNHCR, *3.7 Medical Needs. UNHCR Resettlement Handbook*. available at: <https://www.unhcr.org/resettlement-handbook/3-resettlement-submission-categories/3-7-medical-needs/> (last visited 17 Oct. 2023).

⁴⁹ A. Korntheuer, M. Hynie, M. Kleist, S. Farooqui, E. Lutter & M. Westphal, "Inclusive Resettlement? Integration Pathways of Resettled Refugees with Disabilities in Germany and Canada", *Frontiers in Human Dynamics*, 3, 2021, 668264.

⁵⁰ M.P. Iqbal, R. Walpola, B. Harris-Rozas, J. Li, S. Mears, J. Hall & R. Harrison, "Improving Primary Health Care Quality for Refugees and Asylum Seekers: A Systematic Review of International Approaches", *Health Expectations*, 25(5), 2021, 2065–94.

⁵¹ Interview, UNHCR caseworker.

⁵² Older refugees and refugees with disabilities can be resettled under the category "Legal and/or Physical Protection Needs". However, it is out of the scope of this article to include the implications of this category.

⁵³ Korntheuer et al., "Inclusive Resettlement?"

⁵⁴ M. Crock, B. Saul, L. Smith-Khan & R. McCallum, *The Legal Protection of Refugees with Disabilities. Forgotten and Invisible*, Edward Elgar Publishing, 2017.

⁵⁵ Korntheuer et al., "Inclusive Resettlement".

⁵⁶ *Ibid.*

UNHCR staff estimates that Medical Needs was the primary category for less than 2 per cent of global submissions. By contrast, nearly half of the submissions were based on Legal and/or Physical Protection Needs, and 42 per cent fell under categories such as Women and Girls at Risk, Children and Adolescents at Risk, or Survivors of Violence and/or Torture.⁵⁷

3. IMPLEMENTATION OF THE MEDICAL NEEDS CATEGORY IN RWANDA

UNHCR's mandate to protect refugees and find durable solutions for them is central to its commitment to ensuring their safety and wellbeing. However, at any given time, these durable solutions are accessible to only a limited number of people. Even after resettlement is granted, refugees may endure years of waiting before being transferred to their resettlement country. Furthermore, UNHCR's capacity to resettle refugees is contingent upon the policies of resettlement countries. As noted by a UNHCR caseworker in Rwanda, "everything starts with their [the resettlement state] commitment". The resettlement countries not only set quotas for the number of refugees they are willing to accept; they also establish eligibility criteria for acceptance. Significantly, several resettlement States outlines criteria related to integration, the definition of which may differ among various resettlement States. A UNHCR caseworker acknowledges that "criteria for integration can impact individuals with disabilities, medical conditions and large families". While the challenge of resettling large families can sometimes be mitigated by dividing them into smaller units, less flexibility exists for negotiating around disabilities and medical conditions.

3.1. Medical referrals for resettlement from Rwanda to third-countries

The administration of refugee response efforts in Rwanda is a collaborative effort between UNHCR and the Ministry of Emergency Management (MINEMA). Additionally, several UN agencies and non-governmental organisations (NGOs) are involved as UN implementing partners. Save the Children currently leads health initiatives across all refugee camps, in addition to undertaking other tasks related to protection within the camps. Save the Children has several doctors and nurses placed in healthcare centres in the refugee camps. The medical staff in the camps are often the first persons to initiate the process of resettlement based on medical needs. Typically, this process starts at the health centre in the refugee camp, when a patient consults a nurse about a health issue. If a nurse considers a case to be beyond their expertise, they will refer the patient to the lead doctor overseeing healthcare in the camp. If the lead doctor also determines that the case surpasses their expertise or capabilities, the patient will be referred to the district hospital, also known as the secondary-level hospital. If the cases are also beyond the expertise of the doctors at the district hospital, the patient is then referred to a tertiary-level hospital with specialised resources, often a hospital in Rwanda's capital Kigali.

If the medical team at the tertiary-level hospital finds that the required treatment is either unavailable or prohibitively expensive within Rwanda, this is reported back to the lead doctor in the refugee camp along with the medical results. This report documents that a specialist has recommended this patient as eligible for treatment outside of Rwanda. Then, Save the Children convenes a medical committee, consisting of doctors stationed in various refugee camps in Rwanda, personnel from Save the Children's headquarters in Kigali and UNHCR protection staff. The committee meets either in-person or via video conference. The committee evaluates the situation and, if it identifies grounds for resettlement, proceeds

⁵⁷ Interview, UNHCR caseworker.

to forward a Medical Assessment Form (MAF) to UNHCR. The MAF contains comprehensive details on the health condition of the specific refugee and includes a recommendation regarding the timeframe for medical intervention. It is prepared by the lead doctor in the refugee's camp. Subsequently, the MAF undergoes review by the UNHCR Public Health officer stationed in Kigali, who provides feedback and comments. Following this, the lead doctor revises the MAF accordingly. The doctor then submits the MAF to the UNHCR field office responsible for the refugee camp where the refugee in question currently resides, which forwards the case for consideration by a resettlement country. The MAF remains valid for a period of up to 6 months.⁵⁸

3.2. The long journey to diagnosis for an MAF

Medical needs submissions are based on a medical examination and a referral from a medical doctor, presenting an attractive pathway for refugees. Many refugees express the desire to undergo a medical assessment in the hope of qualifying for resettlement. Despite frequently receiving private medical reports from refugees, UNHCR only accepts evaluations conducted by their medical partners.

Embarking on the path to resettlement due to a medical condition presents a paradox: one must be robust enough to navigate the process, yet sufficiently unwell to qualify for a MAF. To be eligible for resettlement due to a medical condition, one must undergo a rigorous process involving several examinations, referrals and evaluations to obtain a referral for treatment in a resettlement State. Qualifying for resettlement on medical grounds does not guarantee that a refugee will be resettled. First, a refugee must be examined by a medical doctor in their camp. It is important to note that some camps have only one medical doctor for every 15,000 refugees. Even though these doctors are assisted by other medical staff in the camp, it can be a long wait to get a referral consultation by a specialist in the tertiary-level hospital.

Completion of the referral pathway described above (examinations by a nurse and doctor in the camp, and then by doctors at secondary-level and tertiary-level hospitals) can be a challenging and time-consuming process. Once this is completed, a refugee must wait whilst a committee is formed and evaluates the case against several resettlement criteria. If the committee should recommend transfer to a third country, the refugee faces a further waiting period before they can depart. This is a period of great uncertainty for the individual. It can happen that a resettlement State accepts the case fairly quickly, but according to the medical doctors in the camps, it is typically a time-consuming process involving an unknown waiting time, particularly when it is not considered an emergency case. One of the informants in the study highlighted the challenges associated with the resettlement of cases categorised as "emergency" under the medical needs criteria. Due to lengthy processing times in many countries, it is rare to successfully resettle refugees with immediately life-threatening conditions that require medical intervention within 1 month. For these individuals, resettlement can be literally lifesaving, but unfortunately, many die in the country of asylum due to the lack of necessary medical care. Consequently, the medical doctors describe how waiting for resettlement can be extremely challenging for their patients.

If a refugee is granted resettlement, they enter a new phase of limbo. They often wait a substantial amount of time (sometimes years) before they can embark on the physical journey to the safe third country. This waiting time is caused by several bureaucratic processes. Once the MAF has been completed, there are several factors which needs to take place

⁵⁸ UNHCR, 3.7 *Medical Needs*. *UNHCR Resettlement Handbook*.

before the refugee with a medical need, and its family, are resettled. One UNHCR caseworker describes the complexities involved in the uncertainty of waiting for resettlement as follows:

One issue is the amount of time it takes for UNHCR and the refugee to receive a decision. The biggest problem is certain countries [...] that hold on to them for months and months without giving us answers. There can be a million and one reasons why it takes so long, even when a case has been accepted. You can get into this terrible cycle, particularly for people who need additional support, where the resettlement country needs to find more resources to accommodate them. So you have all these different people who need to coordinate on time. You need to get your medical checks done, but then the security checks can expire [before the completion of medical checks]. You can get stuck in these terrible cycles of just looping through getting the checks done over and over again, which I've unfortunately seen a lot. (UNHCR caseworker)

Molly Fee discusses how this waiting period is marked by significant uncertainty and can result in material, emotional, and physical costs for the refugees involved.⁵⁹ As Fee highlights, prolonged waiting times can have detrimental impacts on refugees' lives, emphasising that even temporary waits can lead to significant hardships. Fee's study on Iranian religious minorities in Vienna awaiting resettlement to the United States illustrates how uncertainty and extended periods of idleness can create new forms of precarity for refugees, impacting their mental and physical wellbeing as well as their financial stability. Similarly, our study also indicates that a refugee's diagnosis, which is the reason for being selected for resettlement, can deteriorate during this time of waiting. Informants in this study have known of patients dying while waiting to leave. This reveals a second paradox: The very process meant to provide relief can exacerbate the suffering it aims to alleviate, highlighting the complex interplay between health, bureaucracy and time in the lives of refugees. While the system aims to assist the most vulnerable, delays in resettlement often prolong their suffering, undermining its humanitarian objectives.

Ozkul and Jarrous illustrate how the inherent challenges and delays in resettlement create false hope and exacerbate the difficulties faced by refugees, thereby contributing to their suffering rather than providing immediate solutions. UNHCR's efforts are often hampered by the complexities of coordinating with multiple host countries, each with its own criteria and timelines for accepting refugees. This lack of synchronised and transparent communication regarding the criteria for aid and resettlement decisions forces refugees to rely on rumours and their interpretations to navigate the system.⁶⁰ Our study also shows that the disparity between refugees' expectations for obtaining a MAF and the actual selection process can lead to conflicts between doctors and refugees. A medical doctor stated:

It [resettlement] is now more difficult. Right now, in this situation, we are in Rwanda. It makes our work more difficult because we have many patients with conditions that we cannot treat and they need help, and they need special care, which we do not have. We receive a lot of complaints, and sometimes we get into conflicts with the patients we treat. If one of the patients gets the opportunity to be resettled on medical grounds and the others

⁵⁹ M. Fee, "Lives Stalled: The Costs of Waiting for Refugee Resettlement", *Journal of Ethnic and Migration Studies*, 48 (11), 2020, 2659–77.

⁶⁰ D. Ozkul & R. Jarrous, "How do Refugees Navigate the UNHCR's Bureaucracy? The Role of Rumours in Accessing Humanitarian Aid and Resettlement", *Third World Quarterly*, 42(10), 2021, 2247–64.

don't, the patients who aren't selected do not understand that we have no role in the choice [...] So sometimes we get into conflicts. (Medical doctor, Rwanda)

Prolonged waiting periods and the unpredictability of outcomes can further deteriorate refugees' mental and physical health. Refugees with serious health conditions that qualify them for resettlement may see their health worsen or even die while waiting for bureaucratic procedures to conclude and a suitable host country to accept them. For patients with medical needs who are not eligible for a MAF or are unlikely to be accepted even if a MAF is submitted, alternative resettlement avenues are pursued by UNHCR caseworkers, such as through protection needs or family reunification. Such decisions fall within bureaucratic practices of caseworkers rather than the mandate of medical professionals.⁶¹

3.3. Exclusion based on an unfavourable prognosis

A third paradox is present in the consideration of prognosis and life expectancy. As mentioned above, the Resettlement Handbook sets out conditions that must be met in order for UNHCR to submit a refugee to a resettlement State under the medical needs submission category. One of these relates to prognosis. When evaluating if a refugee satisfies the prognosis criteria, it is assessed whether “there is a favourable prognosis that treatment (including supportive rehabilitation and healthcare) and permanent residence in the country of resettlement would significantly improve the health condition and/or disability or lead to an improvement in daily functioning and quality of life.”⁶² In practice, this means that the likelihood of a refugee, with a certain prognosis, to be accepted by the resettlement state is evaluated by Save the Children medical staff, and possibly UNHCR caseworkers, before initiating a referral for resettlement under the medical needs category. The perceptions of medical doctors regarding the health system in Rwanda highlight significant challenges. These perceptions are based on their direct experiences with the limitations and capabilities of the healthcare infrastructure in the refugee camps and surrounding areas. Doctors often face difficulties in providing adequate care due to limited resources and the bureaucratic complexities involved in referring patients for resettlement. One of the medical doctors in Rwanda explained it simply: “Is the condition really such that resettlement will improve [full recovery of] the life of the person we are referring? If no, no need to do a MAF. If yes, do a MAF.” This statement underscores the doctors' need to carefully evaluate the prognosis of patients within the constraints of the available medical system.

Another doctor noted that even when receiving a report from the tertiary-level hospital, which recommended resettlement for a refugee, the committee may decide not to submit a MAF due to a poor prognosis.⁶³ The paradox lies in the reality that the category intended to prioritise those in dire need of medical resettlement—individuals with severe health conditions—excludes some of the most vulnerable because their prognosis is not favourable. In practice, this means that refugees with chronic or fatal conditions, are not considered for resettlement opportunities. One of the medical doctors explained that providing a MAF was not an assurance that resettlement would take place for the patient: “Another challenge, most of them [refugees] think that getting a MAF is an assurance that they will get resettled, they are not aware of the resettlement criteria, when the resettlement will be done and who will be resettled first, that is also one of the main challenges we are facing.” The doctors involved in the resettlement process must adhere to strict guidelines that prioritise medical

⁶¹ A detailed examination of these practices is beyond the scope of this article.

⁶² UNHCR, *3.7 Medical Needs. UNHCR Resettlement Handbook*.

⁶³ According to medical staff in Rwanda, the Committee very rarely decided against the MAF, as the criterion of prognosis is considered at all stages of the process, from the camp clinic to the examination at the tertiary hospital.

needs. These guidelines also align with integration potential, which limits the doctors' ability to refer patients who have significant medical challenges that could potentially make them a burden to the receiving country. As a result, the guidelines tend to favour refugees with better health prognoses, leaving little flexibility for considering those with severe medical conditions.

In the UNHCR handbook, the policy does not differentiate by age, however, in practice, the assessment of life expectancy favours younger patients:

So, when you have limited opportunities, you have to weigh them carefully. You might think, if I have to protect someone given these limited options, who do I prioritise? Should it be a person in their 60s with a life expectancy of less than 70 years, or a young child of 15 to 20 years? These are the difficult decisions that come with limited opportunities [...] There are certain illnesses that you find which make people quite vulnerable and in need of resettlement, but in the end, you cannot resettle them because you have to prioritise someone with a better prognosis. (Medical doctor, Rwanda)

Children with a medical condition who have a favourable prognosis are likely to be resettled. Medical doctors and UNHCR caseworkers note that children in need of specialist surgeries, like those for the heart, brain, or spine, are often given priority in the resettlement process. This prioritisation is grounded in the expectation that, although these conditions require urgent care, the care is likely to result in a positive health outcome. As a medical worker indicates, the decision of which child is granted access to resettlement is influenced by factors such as the patient's age, the curability of the condition and the expected outcome post-treatment: "A child [in need of] heart surgery will be prioritised, for example. But a patient who will only survive one year, has a bad prognosis [and will therefore not be prioritised for a MAF]". As such, children with conditions leading to a poor prognosis, such as a short life expectancy, are typically not prioritised by the resettled State, and thus are difficult to process for resettlement:

I had one child with a congenital genetic disorder, which is not in the criteria, and I presented it to the Committee. This Committee approved for this case to be put in the [medical needs] category, but we are still waiting for a country to accept this child. I tried myself [to treat the child], but this child has a genetic disorder that cannot be treated in Rwanda. So, [I asked the Committee] if there's any possibility somewhere to treat this child, the Committee approved, and I filled out the form. It is still waiting there for the UNHCR to find any country to accept this child. We have not got the solution yet, but at least we got the approval [from the Committee]. (Medical doctor, Rwanda)

The limited access to resettlement results in a policy where the medical needs of children, particularly when conditions are treatable, are prioritised to ensure they receive timely and effective healthcare. This enables not only their recovery but also their development into healthy young persons. Meanwhile, conditions deemed chronic, incurable, or to have a poor prognosis—such as advanced cancer, and patients in need of organ transplants or kidney dialysis—are less likely to be accepted by a resettlement State. UNHCR informants particularly highlighted that patients requiring organ transplants are in practice never approved for resettlement. This may be due to the challenges posed by receiving countries, including legal restrictions and long waiting lists for their own citizens.

Patients with disabilities or conditions, such as Down syndrome and cerebral palsy, are often not considered eligible for resettlement under the Medical Needs category and may

instead be submitted under the Protection Needs category. Consequently, medical professionals will hesitate to issue a MAF based on medical needs for such cases. In addition, a medical doctor highlighted the challenge of resettling children with Down syndrome under the medical needs category, stating: ‘These children are often born with many diseases. Heart, kidney. Many say they cannot survive more than seven years. It is a waste of time to bring the case to the Committee’. This approach can result in children not being put forward for resettlement because their cases are likely to be challenging to resettle in a third country.

The same mechanisms are found among the older refugee groups: the medical needs category does not favour elderly people, as they have an inherent chance of having difficulties recovering and therefore have worse prognoses than children. One medical worker said:

[...] some ladies have bone problems. This can be treated, but it is often very expensive. When the patients are 70 plus years old, even if they do an operation, they cannot return to normal life. Then we can help them here [...] Another criterion is the age of the patient. The patient may need other support, maybe they are 80-90 years old. These cases are less likely to be accepted. Most of the patients are not productive, and I heard that in these resettlement countries, they want people who can be productive.

3.4. Promising victimhood in refugee resettlement

This operational logic in resettlement practices introduces a notion of promising victimhood, where the eligibility for resettlement relies on the individual’s illness being serious enough to necessitate leaving the asylum country but not so severe that recovery is unattainable. Thus, the resettlement system tends to favour individuals who, despite their vulnerabilities, have a high chance of recuperation and subsequent contribution to the society of the resettlement country. This approach, applied during the initial stages of selection by UNHCR and its partners, aligns with the broader conceptual framework that prioritises the “suffering body” of refugees primarily when there is potential for a full and expedient recovery. As one caseworker described it: “the easiest cases to resettle are the ones [medical needs] that can be a quick fix”. The prioritisation based on the potential to become resourceful members of society means that refugees’ long-term health and development outcomes become a factor in their resettlement eligibility. This can lead to situations where children and adults with chronic conditions or disabilities, who might benefit significantly from the resources available in resettlement countries, are left behind. The staff involved in evaluating medical needs are themselves frustrated by the slim chance patients have of being selected based on those needs. One medical doctor noted the limited capacity for medical resettlements:

For resettlement on medical grounds, we [the whole country] have the opportunity to submit only 50 cases per year. It is like a drop in the in the ocean [...] So this makes it very difficult to prioritise, which [patient] is first in line and which order to be followed. So those are the challenges we are facing. (Medical doctor, Rwanda)

The task of advocating on behalf of refugees in need of medical help can feel overwhelming. The respondents expressed that while their task was to write an MAF, they were not informed about the follow-up after submission. The waiting time, combined with the lack of information about the process, made it difficult to respond to patients’ questions about when and where they would be resettled. This uncertainty caused considerable stress on the

doctors. Another doctor reflected on the challenges of not knowing the next steps for his patients, expressing his concerns as follows:

We do MAFs for many persons who never go [to the country which have accepted them] for resettlement. Maybe around five per cent of them go. Most of them stay here. I do not know why. Resettlement for us [medical staff] is a big question. I do not understand it myself. (Medical doctor, Rwanda)

The prognosis criterion causes a prioritisation of certain kinds of medical cases. Caseworkers often encounter ethical dilemmas as they strive to align humanitarian principles with the practical demands of resettlement States. This conflict can result in moral distress when decisions made do not align with the medical doctor's values of fairness and equity. Thus, given the limited quota they were able to resettle, one of the medical doctors we interviewed reflected on the potential for medical teams in countries of asylum to treat more refugees if they were provided with better medical facilities:

But if we can equip these countries with the necessary resources, many patients could be treated where they are [in exile]. I do not agree with [support] the notion that we are not registering [writing a MAF] these people because we cannot afford their treatment here. If we can afford this treatment here, there would be no need for them to be resettled.

4. IMPLICATIONS OF MEDICAL NEEDS FOR BURDEN-SHARING

Refugees with severe medical conditions or disabilities may be prioritised for resettlement due to their vulnerability and their need for specialised care unavailable in their current location. However, this is not always the case: refugees with medical needs which fit the criteria may still risk being deprioritised or excluded from resettlement programmes if they are not perceived to be a good fit for the host State. This can exacerbate disparities and leave vulnerable refugees ineligible for resettlement because of the very vulnerabilities that supposedly should prioritise them.

The implications of using medical needs as a resettlement submission category extend beyond the resettlement process itself. They raise questions about equity, fairness, and the broader goals of resettlement as a strategy for burden-sharing. While prioritising refugees with medical needs can be seen as a humanitarian imperative, it also underscores the challenges of distributing scarce resources among many vulnerable candidates, as well as the responsibilities for refugee protection and assistance shared among States and organisations.

4.1. Resettlement as a burden-sharing mechanism

The term “burden-sharing” often refers to the discussion surrounding the perceived and actual disparities in how the costs and responsibilities of managing displaced persons and refugees are distributed among countries. While governments primarily categorise asylum-seekers in terms of expenses and therefore focus on *burden-sharing*, UNHCR and NGOs emphasise the need for protection and favour the term *responsibility-sharing*.⁶⁴ The term “burden” appears in the Preamble of the 1951 Refugee Convention, referring to the “unduly heavy burdens” placed on certain host countries, necessitating intervention from the

⁶⁴ J. Milner, *When Norms are not Enough: Understanding the Principle and Practice of Burden and Responsibility Sharing for Refugees*, Centre for International Governance Innovation, Paper No. 2, 2016.

international community. Resettlement has traditionally been viewed as a method of sharing responsibilities with the host country.⁶⁵

Burden-sharing, in the context of refugees, is the principle through which the diverse costs of granting asylum assumed by the host State are more equitably divided among a greater number of States.⁶⁶ It is an integral part of comprehensive solutions and can take different forms depending on the crisis, ranging from bilateral assistance and the provision of human resources to the temporary admission of refugees or resettlement.⁶⁷ In the scholarly discourse on international burden-sharing for refugees, Milner discusses the challenges of international cooperation, emphasising the discretionary nature of State contributions in the absence of binding commitments.⁶⁸ He argues that realist scholars focus on the State-centric nature of international politics, positing that States primarily act in their self-interest, leading to an *ad hoc* and uncoordinated approach to refugee burden-sharing. His findings resonate with realist assertions that international cooperation is mostly driven by national interests rather than altruistic compliance with global norms or legal obligations.⁶⁹ However, liberal theorists advocate for the importance of international institutions and norms in fostering cooperation among States.⁷⁰ Milner critically engages with this perspective, acknowledging normative frameworks like the 1951 Refugee Convention that embrace burden-sharing but also highlights the gap between normative commitments and actual practices.⁷¹

Milner discusses resettlement as a form of physical burden-sharing, highlighting it as an expression of international solidarity in sharing the refugee burden. Despite this recognition, he points out that resettlement efforts are significantly insufficient, falling short of meeting the global needs identified by UNHCR. Ineli-Ciger's analysis extends this discussion by examining the GCR as a response to these challenges.⁷² She critiques the GCR for its voluntary nature and questions its effectiveness in addressing the normative gap in international refugee law regarding burden-sharing. Ineli-Ciger argues that while the GCR represents a step forward in establishing a framework for international cooperation, it lacks clear mechanisms to ensure that States contribute fairly and consistently to refugee protection and assistance.

The burden assumed by a resettlement State extends beyond merely the number of refugees with medical needs or their diagnoses, reflecting the State's responsibility towards refugees' welfare post-resettlement. Thomson, on the other hand, conducts a critical examination of the concept of burden-sharing in relation to refugees and their resettlement journey.⁷³ She highlights the lived experiences of refugees and the frequently overlooked challenges they face, especially during the resettlement journey. Thomson argues that the typical conversation on burden-sharing, centred around States, neglects to recognise the substantial burdens borne by refugees. Different States have different follow-up methods post-resettlement, which may have implications for the short- and long-term costs involved in resettling refugees with medical conditions. For instance, in Norway, comprehensive health-care coverage is provided to resettled refugees, and they have the same rights and

⁶⁵ J. Van Selm, "The Strategic Use of Resettlement: Changing the Face of Protection?" *Refugee*, 22(1), 2004, 39–48.

⁶⁶ J. Milner, "The Principle and Practice of Burden Sharing with Africa. Refugees, the State and the Politics of Asylum in Africa", in J. Milner (ed.), *Refugees, the State and the Politics of Asylum in Africa*, St Antony's Series, Palgrave Macmillan, 2009, 39–60.

⁶⁷ M.J. Thomson, "The Invisible Burdens of Burden-Sharing", *Frontiers in Human Dynamics*, 4, 2022, 668321.

⁶⁸ J. Milner, *When Norms are not Enough*.

⁶⁹ R. Dowd & J. McAdam, "International Cooperation and Responsibility-sharing to Protect Refugees: What, Why and How?" *International & Comparative Law Quarterly*, 66(4), 2017, 863–92.

⁷⁰ C. Soh, M. Kim & Y. Yu, "The Emergence of New Resettlement Countries: A Human Rights Norm Cascade?" *Journal of International and Area Studies*, 24(1), 2017, 105–24.

⁷¹ Milner, *When Norms are not Enough*.

⁷² Ineli-Ciger, "The Global Compact on Refugees and Burden Sharing.

⁷³ Thomson, "The Invisible Burdens of Burden-Sharing".

entitlements to benefits and welfare services as the non-migrant population. The Norwegian healthcare system offers universal health coverage with minimal out-of-pocket expenditures, with general practitioners acting as gatekeepers to more specialised medical services. Still, refugees face challenges including stressors from resettlement, a mismatch in expectations, communication barriers, and building trust within unfamiliar healthcare systems.⁷⁴ Conversely, upon arrival in the United States, refugees are eligible for resettlement benefits, including short-term health insurance for up to 8 months and a medical examination recommended by the Centers for Disease Control and Prevention (CDC) within 90 days of arrival. After the 8 months of short-term health insurance, access to health care and insurance for refugees varies widely. Many may become uninsured or underinsured, potentially using low-cost or free clinics or emergency departments for care. Studies have indicated that resettled refugee adults in the United States have higher odds of having a chronic disease compared with non-refugee immigrant adults, with an increased risk for conditions like diabetes and hypertension.⁷⁵

4.2. The moral economy of resettlement

The moral economy of the resettlement regime reflects a balance between humanitarian obligations and the political, economic, and strategic interests of States. While resettlement serves crucial protection functions for at-risk refugees and can support the broader international protection framework, it is also subject to the geopolitical interests and policy priorities of individual resettlement countries, often leading to a precarious and unequal system of refugee protection and resettlement.⁷⁶

The resettlement system's State-centric nature means that the number of refugees resettled is ultimately decided by national governments. UNHCR can advocate for more resettlement offers, but it does not have the authority to determine the number of places available. This leads to a structurally fragmented regime, where individual States develop and apply their own selection criteria based on their national interests, although informed by UNHCR's assessments of vulnerability and protection needs.⁷⁷ While UNHCR has attempted to standardise these criteria, focusing on particular protection needs and vulnerabilities, each participating State ultimately has the discretionary power to set its own criteria. This situation introduces uncertainty and unpredictability into the selection process, potentially undermining fairness and the needs-based approach intended by UNHCR.⁷⁸

Refugee resettlement involves significant costs due to the need to identify and select the most vulnerable individuals, manage their migration, and invest in their long-term integration. This process entails spending on technologies for identification, selection, mobility, and settlement. Additionally, it necessitates considering the political economy of humanitarian ethics, which includes deliberations on optimising the use of available funds to maximise the protection provided to the greatest number of individuals.⁷⁹ This is also recognised by the UNHCR caseworkers. One of the caseworkers reflected on the role of the resettlement State:

⁷⁴ J. Haj-Younes, E. Abildsnes, B. Kumar & E. Diaz, "The Road to Equitable Healthcare: A Conceptual Model Developed from a Qualitative Study of Syrian Refugees in Norway", *Social Science & Medicine*, 292, 2022, 114540.

⁷⁵ G.S. Kumar, J.A. Beeler, E.E. Seagle & E.S. Jentes, "Long-Term Physical Health Outcomes of Resettled Refugee Populations in the United States: A Scoping Review", *Journal of Immigrant and Minority Health*, 23, 2021, 813–23.

⁷⁶ A. Suhrke & A. Garnier, "The Moral Economy of the Resettlement Regime", in A. Garner, L.L. Jubilat & K.B. Sandvik (eds.), *Refugee Resettlement: Power, Politics, and Humanitarian Governance*, 38, 2018, 244–53.

⁷⁷ *Ibid.*

⁷⁸ Brekke et al., *Selection Criteria in Refugee Resettlement*.

⁷⁹ Sandvik & Garnier, *How Will the Covid-19 Pandemic Reshape Refugee and Migration Governance?*.

All States, you know, the people making these decisions, we expect them to have the best interests of these refugees at heart, right? They are just working within the confines of their systems, and they have to calculate the costs of long-term care to ensure they are not disadvantaging their own citizens who need that care as well. (UNHCR caseworker)

The intricate process of prioritising refugees often favours those with better integration prospects, potentially sidelining individuals with urgent medical needs unless they also meet other criteria. Thus, economic and integration considerations of host States can, at times, overshadow purely humanitarian obligations. Thomson illustrates this point, emphasising how the State-centred approach to burden-sharing often excludes the direct needs of the refugee populations.⁸⁰ Consequently, the prioritisation of medical cases may be compromised in favour of those perceived to be more economically viable or easier to integrate, highlighting a tension between ethical imperatives and practical constraints.

5. CONCLUSION

This article set out to examine how UNHCR's medical needs resettlement submission category impacts the inclusion or exclusion of vulnerable refugees in Rwanda's resettlement programmes and the implications for resettlement as a strategy for burden-sharing. Refugees, especially those from conflict zones or impoverished regions, often become symbols in broader humanitarian narratives, invoking sympathy and moral discussions about the duty of wealthier nations to protect and support vulnerable populations. The analysis reveals that, while medical cases are considered for resettlement, resettlement remains a scarce resource for those in need of medical treatment in Rwanda. However, it is important to note that this study does not include direct perspectives from refugees themselves, which limits the ability to fully understand the range of motivations and desires that refugees might have for resettlement, beyond their medical needs. Refugees' desires to resettle likely encompass a complex array of reasons, including safety, family reunification, and opportunities for a better life, which this study could not fully capture. The application of promising victimhood in the medical needs category complicates this narrative, revealing a selection mechanism intended to help the most vulnerable refugees but, in practice, marginalising some of the most vulnerable individuals due to their poor prognoses. This study has highlighted the paradoxes inherent in the resettlement process, particularly in managing medical cases, revealing a system that can paradoxically exclude those it aims to protect.

Through the lens of promising victimhood, the research shows that the resettlement system, while initially designed to prioritise the most vulnerable, often inadvertently prioritises those who can demonstrate potential for recovery and integration, leaving behind those with chronic or fatal conditions. This creates a critical tension between the aspirational goals of global burden-sharing and the operational realities of resettlement programmes, which are influenced by political, economic, and social considerations. Additionally, the findings underscore the urgent need, as requested by medical doctors, to enhance medical infrastructure and access in countries of asylum. By supporting or strengthening existing healthcare systems within the country of first asylum, we can provide essential treatment locally, reducing the dependency on resettlement as the sole solution to meet critical medical needs. This approach not only supports the health and wellbeing of refugees but also alleviates some of the pressures on global resettlement programmes and benefits host populations, promoting a more sustainable and equitable distribution of resources.

⁸⁰ Thomson, "The Invisible Burdens of Burden-Sharing".

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