

## RECOMMENDED READING

Brzoska P et al. 2014

**Reviewing the topic of migration and health as a new national health target for Germany.** Int J Public Health 2014; Nov 12 (subscription required)

(<http://link.springer.com/article/10.1007%2Fs00038-014-0617-z>)

UNODC 2014

**Global report on trafficking in persons.** New York (NY): United Nations Office on Drugs and Crime; 2014

([http://www.unodc.org/documents/human-trafficking/2014/GLOTIP\\_2014\\_full\\_report.pdf](http://www.unodc.org/documents/human-trafficking/2014/GLOTIP_2014_full_report.pdf))

Napier et al. 2014

**Culture and health.** Lancet 2014; 384 (1 November):1607–1639

(<http://www.sciencedirect.com/science/article/pii/S0140673614616032>)

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## OPINION

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### **Noncommunicable diseases and the mental health impact of international migration. Challenges for the 21st century**

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Health today is best conceived as the multi-axial capacity of living systems for survival, growth, regeneration, adaptation to an ever-changing environment, self-regulation, and ability to recover from the debilitating effects of illness, disease or injury. As far as the health of migrant human populations is concerned,

there is growing evidence that both the patterns of health behaviour and vulnerability to various health conditions are in many ways specific to these groups, and different both from the morbidity patterns of the host populations they move into, and the health profile of the populations from which they have moved away. The major axes of these health disparities are: infectious diseases, noncommunicable (or non-infectious) diseases, injuries, mental health problems, and traumatic stress (specifically, post-traumatic stress disorder (PTSD)).

A useful metaphor for migrant health is to think of it as an iceberg, where what is known about it is only a tiny part above on the surface (for example, clinical symptoms), and the far larger part is beneath the surface; that is, unseen by most western-trained physicians and health practitioners.

There are several reasons for these hidden patterns of noncommunicable diseases and mental health conditions among migrants. One of them is certainly the thoroughly complex etymology of both types of illness, in addition to which, their phenomenology is culturally heavily blended.

It is worth remembering that noncommunicable diseases and mental health problems both result from complex interactions between genetic, environmental, social, cultural, behavioural and personality factors that shape the immunocompetence (or -incompetence) of a person throughout their lifespan (1).

Another reason can be found in the communication gap between western-trained health professionals and their migrant patients coming from (often distant) non-western cultures. As Roholof et al. point out, many of these patients expect to be predominantly treated for their somatic symptoms, rather than mental problems, which they hide either from fear (possibly of stigmatization), or because they are unable to vocalize them or are simply unaware of them (2). Often, these somatizations result in misunderstandings and problems in the diagnostic and therapeutic process.

Next, western health and social care systems in most countries are still heavily biased towards a bio-medical model of health and illness; a long-recognized trap into which modern medicine has fallen throughout the last century (3). Finally, migrants tend to experience poorer access to health care compared to the host population. The most vulnerable groups are unauthorized or undocumented migrants and asylum seekers. The prevailing – and largely unchanging – public and official attitude has been to treat them as invaders without rights within host societies, and thus conclude that they should be sent back to the countries from which they came (4).

According to an overview of the situation in 17 Member States of the European Union, published in April 2013 in *The Lancet* (5), migrants coming to Europe seem to have initially lower incidence and mortality rates for cancer than native populations, although the prevalence rates tend to converge over time. Some groups of migrants have higher rates of cancers related to infectious diseases, such as stomach cancer, nasopharyngeal cancer, hepatic cancer, Kaposi's sarcoma, cervical cancer, and some lymphomas. Large variations exist in terms of cardiovascular disease incidence. Substantially higher incidence, prevalence, and mortality rates have been recorded among migrants for diabetes, probably due to a combination of genetic factors, changing environments, and insufficient medical intervention or control.

Lifestyle factors such as obesity are of particular concern, because migrants from low-income countries tend to abandon their traditional dietary habits and adopt a westernized, energy-rich diet and more sedentary lifestyle.

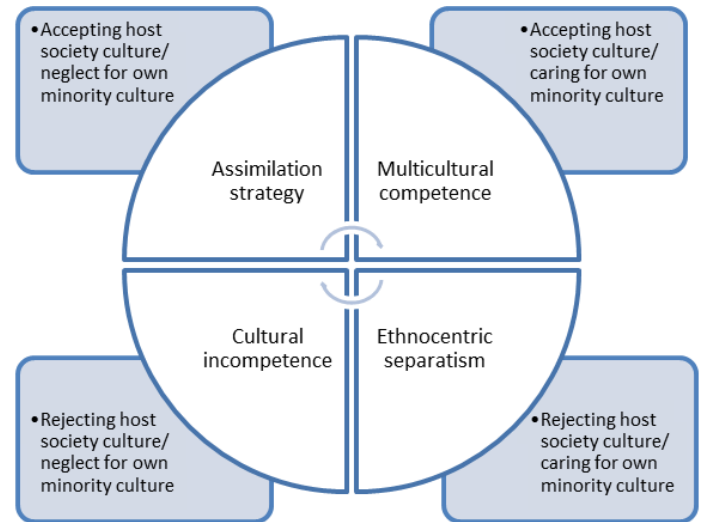
Not until the late 1980s and early 1990s was much attention given to mental health aspects and impacts of migration; that is, until new waves of refugees and asylum seekers had emerged from crisis areas, first coming from the Indo-Chinese refugee crisis, followed by the demographic catastrophe around the former Yugoslav Republic of Macedonia and neighbouring countries. Large numbers of these forced migrants were heavily traumatized (6) and – worse still – no assessment of their mental state was carried out and the notion of mental health issues was largely ignored (as can still be the case today), both by immigration services and public health officials.

Bhugra and Jones published one of the first summary reviews of studies from the 1980s and 1990s (7) highlighting the existence of significant diversity in the prevalence rates of 3 major groups of mental disorders, compared both among themselves and with those of the general population in countries of origin and host countries: (a) schizophrenia; (b) other common mental health problems, such as depression and anxiety disorders; and (c) suicide and suicidal tendencies. “When people migrate from one nation or culture to another”, maintains Bhugra in another paper (8), “they carry their knowledge and expressions of distress with them. On settling down in the new culture, their cultural identity is likely to change and that encourages a degree of belonging; they also attempt to settle down by either assimilation or bi-culturalism”. The rather well-known rule from cultural anthropology can also be added here: the larger the gap between a migrant's root culture and the culture of a receiving mainstream society, the greater the risk of facing cultural identity crises. Some groups may cope better with such crises, in a healthy and constructive way, whereas many others run into a complex mix of devastating feelings of isolation and social exclusion, known by the generic term rootlessness (9).

A new framework of understanding has come to light; deeper in terms of the origin both of noncommunicable diseases and mental health problems in the context of 21st century international migration.

The point is that in “new” waves of migration we find a massive influx, not only of individuals and individual families, but entire large communities, with their religions and ideologies from traditional community-based (*Gemeinschaft*) types of cultures (from non-western societies) into modern individualistic, social contract-based (*Gesellschaft*) cultural settings (western societies), to use this differentiation first introduced by German sociologist Ferdinand Tönnies over a century ago (1887) (10). Today we talk about a clash of civilizations (or culture clash) (11), rather than about the melting pots of different cultures envisioned by many for the “new worlds” over the years, decades and centuries. Rather than drawing any particular conclusion, this brief overview comes to a close with a simple diagram (Fig. 1) highlighting the fact that most migrant communities and ethnic/cultural minorities in modern Europe sit at a crossroads of identity formation, both for themselves and for their children.

**Fig. 1. Migrant and minority groups at a crossroads of cultural identity formation in modern Europe**



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