# Health Promotion and Migrant Backgrounds

Theda Borde, Stephan Blümel

*(last update 21 May 2015)*

*Migration* was defined as follows by the Statistisches Bundesamt (Federal Office of Statistics) in 2013: individuals with a migrant background include all “foreign nationals and naturalized former foreign nationals, everyone who moved to the current territory of the Federal Republic of Germany after 1949 as well as everyone born as German in Germany with at least one immigrant parent or one parent born in Germany as a foreign national’.

As the *historical development* shows, the migration of individuals and groups is not a new phenomenon; people have always migrated from one region to another all over the world in search of better living conditions. Up until the first half of the 20th century, Germany was a country of emigration. However, since the 1960s, the Federal Republic of Germany has steadily developed into an immigration country. Similar developments have taken place in other regions of Western Europe. Immigration into Germany and the acceptance of foreign nationals had economic and political as well as humanitarian explanations and proceeded in various phases: in light of the labour shortage as industry expanded, the Federal Republic recruited labour from Italy, Spain, Greece, Turkey, Morocco, Portugal, Tunisia and what was then Yugoslavia between 1955 and 1968. In the 1960s East Germany (GDR) also started employing contract workers with temporary work contracts from Poland, Hungary, Mozambique and Vietnam.

With the consolidation of their residency status in the 1970s, the permanent settlement process of the foreign nationals living in the Federal Republic of Germany began. This process was accompanied by spouses and children moving into the country. A further phase was triggered by Germany’s reunification, and was characterized by the immigration of refugees and “Spätaussiedler’ (individuals with German roots still living in eastern Europe and the former Soviet Union) as well as by people of Jewish faith from eastern Europe.

Today the European Commission pursues a co-ordinated policy of controlling and limiting immigration; however, from a demographic and economic perspective, Germany is dependent on migrants from other countries. New migration trends include the following: east-west migration within the 27 EU member states, short and long-term migration of skilled and unskilled labour, further refugees and family reunifications, as well as “irregular’ immigration from different parts of the world.

For many years now, the *proportion of foreign nationals* making up Germany’s population has been around 9 percent; it should be noted that German citizens with migration experience, such as “Spätaussiedler’ and naturalized residents, are not counted here. Since the category of citizenship that had been used in statistics had become increasingly inappropriate for adequately representing the immigration reality in the Federal Republic of Germany, the 2005 micro-census defined the criterion “migrant background’ for official statistics for the first time (see above). This definition is based on the place of birth and takes into account the generation principle, in other words someone who was born in another country or one of whose mother or father was born in another country has a “migrant background’. Individuals with a one-sided migrant background are those where only one parent was born in another country. The *population with a migrant background* in Germany is 16.3 million according to this calculation, which corresponds to around 20 percent. 6.2 million of these people, or 8.1 percent of the total population, have a foreign nationality. The distribution varies both with regard to region and age group. The percentage of people with a migrant background in some western German cities is almost 40 percent, while it is significantly lower in the states in what was the GDR. The population with a migrant background is significantly younger, and almost one third of all children under the age of five in Germany have a migrant background (Statistisches Bundesamt 2007). In the nature of things, the extent of non-registered migration is not represented in these statistical surveys. It is to be assumed that the majority of “migrants without papers’ entered Germany legally with a visa.

The statistical data at hand show that the level of education and income among the population with a migrant background is less on average than that of the native German population; job insecurity and unemployment are also more common. It must be emphasized that the differences in level of education and employment status within the population with a migrant background are considerable. This group as defined above is extremely *heterogeneous*. The people grouped together here do not just differ by age and gender, education and social position. They also differ by migration-specific factors such as country of origin, ethnicity, voluntary or forced migration, citizenship, legal residency status, length of stay in Germany, German-language skills, time of migration within their life-story, migrant generation (personal migration experience vs. migration by the parent(s)).

There are currently only limited insights and large gaps in knowledge with regard to the influence of the migrant background on health, and on behaviours relevant to health. The research findings we do have give an incomplete, inconsistent and sometimes contradictory picture. This is in part due to the deficits in the data. Health-related studies are often based on a secondary analysis of data that are not primarily obtained for questions relevant to health (e.g. micro-census). Information about social status is often absent and the assessment of the individuals' health status is dependent on the choice of the comparison group. Particularly vulnerable groups (e.g. non-registered migrants, those who do not speak German, and those who are illiterate) are often not reached and for methodological reasons (e.g. in written surveys on in telephone interviews conducted in German) and therefore are unrepresented. In addition, a comparison of the results of different studies is distorted and made even more difficult through the use of different definitions for "migrants' (to which not much thought is usually given).

The present *insights into the health status and health behaviour* revealed some findings that were more favourable among the population with a migrant background and some that were less favourable compared with the population without a migrant background. Depending on the living and working conditions as well as their health behaviour, diseases of the musculoskeletal system, the cardiovascular system, diabetes, respiratory problems and accidents at work can be more common. Specific health risks are listed for various age groups and migrant groups. Older people with a migrant background are in a worse state of health than older people without a migrant background, for example.

Among children and young people with a migrant background, it was found that there are higher health risks for deaths connected to birth and the first year of life, for (rare) hereditary metabolic diseases, tuberculosis, obesity and eating disorders, mental health issues and accidents, poorer oral hygiene, less physical activity and a decreased likelihood of taking advantage of screening services than among their peers without a migrant background. Children and young people who have had a personal migration experience have lower vaccination rates. However, children of migrant families also exhibit health resources. They are less likely to suffer from asthma, dermatitis and hay fever, and a comparatively smaller number of them smoke. A more recent study has shown that women with a Turkish migrant background use prenatal medical care to a similar degree to women without a migrant background, and they exhibit similarly good results in most perinatal parameters. In addition there was a significantly lower rate of caesarean sections (David et al 2014). A few migrant groups displayed a more favourable breastfeeding behaviour, reduced alcohol consumption (Turkish and Arabic migrant background) and reduced tobacco consumption (girls with a two immigrant parents). A nuanced observation of the interplay of various influencing factors such as country of origin, social status, migrant generation and gender is necessary to counteract specific risks and support health potentials in a targeted manner.

Every migration is associated with stresses and risks but also with opportunities. It could mean escaping difficult living conditions and health concerns, and achieving a better quality of life in the new country. The medical care in the new country could also be better than in the country of origin.

On the other hand, the *migration process* presents a great individual feat of adaptation. During this process, the migrant's personal competencies and norms are often questioned. Specific health risks could arise for migrants, such as psychosocial issues due to separation from family members or as a result of political persecution in the country of origin. In addition, ethnic minorities (with or without a migrant background) are often confronted with discrimination and racism in Germany.

Razum et al (2008) summarize the migration process as follows: “People with a migrant background can exhibit elevated health risks compared with the majority population without a migrant background … It is not the migration as such that makes individuals sick. It is rather the reasons and circumstances of a migration as well as the living and working conditions of people with a migrant background in Germany that can lead to a worse state of health. People with a migrant background have an above-average likelihood of having low socioeconomic status, of working in a job that threatens their health, or of being unemployed, or else they live in unfavourable circumstances. Every one of these factors could cause health impairments, and this is particularly true when several of these factors come together.’

Almost all migrants go through the migration process that Sluzki (2010) depicts in a model that possesses a relatively high degree of transcultural validity (cf. Figure 1).

*Figure 1. Migration process after Sluzki (from Hegemann and Salmann 2010, 110).*

Sluzki divides the migration process into

1. The preparatory phase
2. The act of migration
3. The phase of overcompensation
4. The phase of de-compensation
5. The phase of trans-generational assimilation processes

In each of these phases, which generally tend to last different lengths of time, conflicts can occur that are considered normal in this situation by those affected. However, as stress factors they can lead to psychological problems and even illness, depending on the individuals’ solutions and coping strategies as well as on their resources. The phase of de-compensation is the phase in which people with a migrant background turn to the institutions of the health and help system, in this case the psychiatric-psychotherapeutic care system - often too late and sometimes not at all (Schouler-Ocak 2003).
There are few studies to date that provide information about the *health resources of migrants*. Stable family structures, supportive social networks within a family, extended family and migrant communities as well as problem-solving competencies and trans-cultural competencies acquired through difficult life situations that were overcome and through the migration itself can have a positive impact on the health of people with a migrant background.

*Migration-specific access barriers* with regard to healthcare can be identified for some of the migrants. They have a direct influence on whether they will take advantage of services, on the quality of the care and finally on their health and they can lead to the wrong kind of care, too much care or too little care. These barriers are: poor German language skills, poor reading and writing skills and often a poor understanding of the healthcare system (e.g. older people [women in particular] and immigrants who have recently arrived from another country), and a lack of structures and care concepts that do justice to the socio-cultural diversity of a migrant society. Interpreter services and multilingual information material as well as care concepts that are sensitive to, and accepting of, differences in culture, social situation, gender, age etc., which are part of the standard of good care in other countries of immigration, still have a pilot project character in Germany.

A large number of studies show that people with a migrant background are less likely to take advantage of services in prevention and health promotion (e.g. early screening and precautionary examinations) compared to the population without a migrant background (these figures are average figures with a large span). Migrants are also very unlikely to use self-help groups to support them in coping with an illness.

To ensure that this improves in the long term, individuals working in the field should consider the following questions when *planning and implementing measures*:

*Differentiated target group analysis*: is there a subgroup of people with a migrant background where specific behaviours that pose a threat to health are particularly developed, or who are already particularly affected by a certain disease? Does this target group therefore require a certain type of communication (specific messages and communication routes)? Were other factors taken into account alongside ethnic background and the other factors listed above (such as social situation, gender, age, milieu, migration experiences, residency status)?

*Reachability*: who can get access to these migrant groups and how? It is initially important to expand the expert view to include the specific vulnerabilities and the target group's (health) interests, meaning that the following questions are to be answered: is the problem (e.g. smoking, no vaccinations, poor nutrition), as defined by the individual working in health promotion, a priority for the migrant group in question (e.g. those with an uncertain residency status)? Or are other problems (e.g. lack of a work permit, asylum accommodation, traumas) in the foreground? How can health promoters provide support and help here, and use the trust developed in this process to create interest in preventive services and facilitate access to them?

Since the hitherto "hard to reach' groups can only be inadequately reached through mass-media measures (such as adverts, posters and television spots), personal conversations and advice (personal communication services) are necessary. The following questions need to be answered in this regard: what access options and resources do the health promoters themselves have? What key individuals have access to, and the trust of, the target group and are therefore suitable multipliers in the most different settings in the social sphere, in health, education and leisure? What co-operative partners in the migration field (e.g. migrant self-help organizations and clubs) can assist in this? Is support necessary for the multipliers and co-operative partners (e.g. via bilingual materials, further training, advice) in order to improve access? Could the new media open up new access opportunities (e.g. advice for young people and small ethnic groups living scattered throughout an area)?

*Participation*: how can the participation of the target group be guaranteed in the planning and implementation of preventive and health promotion services - as a significant component of the acceptance and efficacy of interventions? *Sensitivity to migration and culture*: do all measures targeting the general public take people with a migrant background into account, e.g. when it comes to depicting people, names, stories, avoiding clichés ("sensitivity to migration')? Are there additional "culture-sensitive' services above and beyond that for migrant groups with a special need and a special cultural reference (e.g. for subjects such as male circumcision and female genital mutilation)?

Improved services in prevention and health promotion for and with people with a migrant background promote integration and equal opportunities in the field of health and therefore benefit the whole of society.

The following section will introduce as an *example* a summary of the practical work of the project *Aussiedler Suchthilfe und Suchtprävention vor Ort* (2003-2006) at the the Diakonisches Werk Waldeck-Frankenberg in Korbach. The title of the project refers to the prevention of addiction among *Spätaussiedler* (see above) and helping those who already have an addiction problem.
Alcoholism is much more widespread among migrants (especially male migrants) from the former Soviet Union than among the general population. In addition, there is quite a widespread problem of intravenous drug abuse (particularly heroin) among young men between 16 and 30 in isolated milieus; because of a lack of protective measures, there were considerably increased HIV and Hepatitis B and C infection rates.

- In their work of providing education and advice, advice centres have to confront the following *background issues regarding the addiction* and *barriers to access*:
- integration problems and developmental requirements in adolescence
- isolation, peer pressure, code of honour
- historical and cultural significance of alcohol in the country of origin
- uncritical, uninformed attitude to alcohol and illegal drugs
- family dynamic (e.g. family greatly influenced by alcohol, violence and authority, low level of education, secrecy.

In addition, there is a *lack of trust* in advisers and information providers, because:

- they are considered part of a state-run system of sanctions (clients are usually sent by instances such as a court, job centre or employers; a need to protect family matters from the state)
- they do not conduct the “treatment’ widespread in Russia (e.g. suggestive-hypnotic methods) - different understanding of help
- the German language skills are not adequate and addiction problems are a major taboo.

With such a starting point, supporting integration through *social work* has turned out to be the *most effective form of drug prevention*:

- a gradual approach to getting in touch, developing trust through “addiction-specific’ services such as youth groups, excursions, women’s circles, language projects
- proactive social-pedagogic work in schools, church congregations
- providing help for solving conflicts and addressing problems such as occupational orientation, searching for internships and apprenticeships
- conversations, trust with and support from informal circles, self-help groups, other subgroups of migrants (stabilizing factor, help with gradual opening to the outside)
- mediation to home-country structures
- taking into account strengths, protective factors and self-healing forces.

The use of municipal structures and existing networks (potentially joining in with projects by other providers), co-operation with important partners (such as Spätaussiedler advice centres, educational institutions, youth workers, social services, clubs, lawyers, probation officers) and the elimination of prejudices as well as training are important.

The same is true for the *inter-cultural opening* of the institution (such as confronting one’s own sociocultural imprinting, advice and involvement of members of the target group, learning foreign languages, employing staff who are native speakers).

In addition, the *integration of addiction-specific contents* into the cited measures is necessary by:

- respecting the problems of explicit, target-group-related addiction prevention (a feeling of discrimination, repression, lack of acceptance, defensiveness, making it a taboo)
- avoidance of publicity measures and specific preventive events only for Spätaussiedler
- integrative strategies to put across addiction and (necessary) substance-specific information.

*Further examples* from the practical work are accessible via the further reading suggestions and web addresses.

***References:***

*Beauftragte der Bundesregierung für Migration, Flüchtlinge und Integration (ed.), Gesundheit und Integration, ein Handbuch für Modelle guter Praxis, Berlin 2006;*
*Berrut S/Blümel S/Erath A, Beispiele der Aufklärungsarbeit im Bereich Migration, in: Bundesgesundheitsblatt, vol. 49, no. 9, Heidelberg 2006, 898 ff.;*
*Borde T, Migration und Gesundheitsförderung - Hard to reach? Neue Zugangswege für "schwer erreichbare" Gruppen erschließen, in: Bundeszentrale für gesundheitliche Aufklärung (BZgA) (ed.), Migration und Gesundheitsförderung, Ergebnisse einer Tagung mit Expertinnen und Experten, Gesundheitsförderung konkret, vol. 12, Cologne 2009, 18-31;*
*Bundesamt für Gesundheit (BAG) in Zusammenarbeit mit Gesundheitsförderung Schweiz, Migrationsgerechte Prävention und Gesundheitsförderung - Anleitung zur Planung und Umsetzung von Projekten, Bern 2008;*
*David M, Borde T, Brenne B, Ramsauer B, Henrich W, Breckenkamp J, Razum O. Perinataldaten von türkeistämmigen Migrantinnen und deutschen Frauen im Vergleich - Ergebnisse einer prospektiven Studie in Berlin. Geburtsh Frauenheilk 2014; 74: 441-448*
*Dil O, Erfahrungen und Konsequenzen aus der Arbeit mit Aussiedlern, Projekt Aussiedler Suchthilfe und Suchtprävention vor Ort (2003-2006) der Beratungsstelle bei Suchtmittelproblemen des Diakonischen Werkes Waldeck-Frankenberg, Korbach 2007;*
*Razum O/Zeeb H et al., in: Robert Koch-Institut, Migration und Gesundheit. Schwerpunktbericht der Gesundheitsberichterstattung des Bundes, Berlin 2008, 129;*
*Schenk L/Neuhauser H/Ellert U, Kinder- und Jugendgesundheitssurvey (KiGGS) 2003-2006, in: Robert Koch-Institut, Kinder und Jugendliche mit Migrationshintergrund in Deutschland, Beiträge zur Gesundheitsberichterstattung des Bundes, Berlin 2008;*
*Schouler-Ocak M, Besonderheiten in der psychiatrischen Versorgung von MigrantInnen, in: Borde T/ David M (eds.), Gut versorgt? Migrantinnen und Migranten im Gesundheits- und Sozialwesen, Mabuse Verlag, Frankfurt am Main 2003, 153-166;*
*Sluzki EC, Psychologische Phasen der Migration und ihre Auswirkungen, in: Hegemann T/Salman R (eds.), Handbuch Transkulturelle Psychiatrie, Psychiatrie Verlag, Bonn 2010, 108-123;*
Statistisches Bundesamt, Bevölkerung und Erwerbstätigkeit, Bevölkerung mit Migrationshintergrund, Ergebnisse des Mikrozensus 2012. Wiesbaden 2015, 6-8

***Internet addresses:***

- www.bundesregierung.de *(Integrationsbeauftragte)*
- www.bzga.de *(Bundeszentrale für gesundheitliche Aufklärung)*
- www.gesundheitliche-chancengleichheit.de *(Praxisdatenbank "Gesundheitsförderung bei sozial Benachteiligten")*
- www.rki.de *(Robert Koch-Institut)*

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

back to overview