



MIGRATION AND HEALTH

NEWSLETTER



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MIGRATION AND MENTAL HEALTH

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Wars, civil disorder, collapse of national economies, environmental degradation and natural disasters will continue to produce large numbers of refugees and internally displaced people, and permanent and temporary migrants. Although the dynamics of migration are complex, and dependent on broad political, social and economic issues, the key driver of both migration and population health differentials is inequity. Increasing inequities will result in increased pressure for migration and in increased disparities in health status and access to health services. Many of the factors that result in a decision to migrate, or that force people out of their homes as refugees, are the same factors that are associated with increased vulnerability to the development of mental health problems.

In the countries of destination immigrants and refugees generally have poorer access to health services than the host population. Although there is a body of research to support these contentions in some countries, such as Australia, Canada, the USA, and the UK, we know very little about mental health status and ac-

cess to mental health services of immigrants and refugees in most parts of the world. In some cases, this lack of knowledge is due to simple indifference to their needs. However, in developing countries, where most refugees are, there is little capacity to examine the needs of the domestic population let alone the needs of immigrants or refugees, or to respond with appropriate mental health services.

Work carried out by the World Health Organization and the World Bank has highlighted the enormous burden of disability imposed by mental disorders on the world's population. Mental disorders represent five of the ten leading causes of disability worldwide; amounting to nearly one-third of all health-related disability. This burden exacts an enormous toll in terms of suffering, individual and family dysfunction, and economic loss. Despite the high prevalence of mental disorders (lifetime prevalence of 20-25 per cent) and the availability of effective treatments, only a small minority of those in need receive even the most basic treatment. While mental disorders affect people in all groups of society

in all countries, the poor, immigrants and refugees are disproportionately affected.

In the context of large scale international and internal rural-urban migrations, the profound economic, social and cultural transformations that are occurring across the globe, and enormous burden of disability associated with mental disorders, health systems face a number of challenges in meeting the mental health needs of immigrants and refugees.

The first is the development of mental health policy that ensures equitable access to mental health services for all groups in a society. In many national mental health systems migrants, refugees and asylum seekers are excluded from existing health service arrangements either as a matter of national health policy or through neglect. However, there is a more general problem. Forty-one per cent of countries do not have a mental health policy, 25 per cent of countries have no mental health legislation, and 28 per cent have no separate budget for mental health. Of those that do have a specific mental health budget, 36 per cent allocate less than 1 per cent of their health

budget to mental health. Within this sorry state of affairs it is not likely that the specific needs of immigrants and refugees will be appropriately attended to. There is an enormous amount of work to be done to put mental health on the agenda of governments and international organizations.

The second is in the area of research. It is generally true that we know least about those populations, or sections of populations, with the greatest needs. Systematic, coherent and international collaborative research is required to better understand the mental health needs of immigrants and refugees and how those needs are most effectively met. Unfortunately, neither mental health nor the problems of immigrants are high on the list of priorities of national research funding bodies or of the large philanthropic foundations.

The third area is education. Health professionals should be active in improving their own capacity to work effectively with immigrants and refugees. Relevant training programmes have been developed and are increasingly available through distance modes. [See: <http://www.vtputu.org.au/> and <http://www.atmhn.unimelb.edu.au/>].

There is also a need to develop community education and health promotion programmes that will ensure that immigrants and refugees are knowledgeable about protecting their own health, and are aware of, and can gain access to, the health services they require. Immigrant communities should be assisted to become active participants in the design, operation and evaluation of mental health services.

Health, including mental health, is a primary good and a fundamental condition for the full exercise of rights and liberties. The mental health needs of immigrants and refugees have been too long neglected in national health policies and health delivery systems, in the operations of international organizations, and in the training and practice of health professionals. There is an urgent need for mental health to be seen in a new light, as central to all attempts to improve the health of populations.

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The University of Melbourne, Australia

IOM RESEARCH

HEALTH ASSESSMENT TOOL FOR FITNESS TO TRAVEL

During the 1999 conflict in Kosovo, thousands of people were displaced from that province and many of them arrived in The former Yugoslav Republic of Macedonia (FYROM). As the political and physical pressure increased within the FYROM to provide a safe solution for the displaced persons, the United Nations High Commissioner for Refugees (UNHCR) called an in-

ternational humanitarian evacuation programme (HEP). The International Organization for Migration (IOM) with other collaborators organized the movement of 91,000 people to third countries under this programme. A health assessment tool was designed, validated and implemented to appraise immediate health issues that would have impaired these persons' extended travel by air. The tool was a colour coding system: green – no significant health issues; yellow – non-urgent medical issues; red – urgent medical issues

requiring routing follow up on arrival in the host country. The data was captured to document the fitness to travel health status of the refugees before departure, and forwarded to the receiving health authorities. This pre-information assisted the receiving host country in preparing for the arrival of refugees with potential health conditions. The authors report that out of 41,652 fitness to travel assessments, some 4,000 persons required medical assessment upon arrival and of these about 1,000 needed urgent care.

According to the authors, the health information collected through the assessment tool was useful to health care providers at the receiving end.

MacPherson D.W., J.E. M. Weekers, B.D. Gushulak et al., "Description of a fitness to travel health assessment evaluation tool for displaced Albanian Kosovars in The former Yugoslav Republic of Macedonia", *JECH*, 56(3):238-239.

DNA AND IMMIGRATION: THE ETHICAL RAMIFICATIONS

Family reunification is important to the welfare of immigrants as family units have a better chance of integrating into a new country. However, with global economic slowdowns, governments are requiring more documentation that qualifies migrants for family reunifications.

Since identity documentation is not common in various developing countries, many immigrant-receiving nations are using DNA technology to provide proof of family relationships. Although DNA testing can assist immigrants and refugees by helping family reunification when documentation is insufficient, the authors state that there are ethical concerns that need to be considered in this context. For example, families are not always biologically related, moreover, there is no universally recognized definition of family. In fact in many cultures "family" involves a large range of biological relatives and members socially rather than biologically related.

DNA testing can thus divide the family unit, and affect especially the children involved. In addition, requests for DNA testing can be discriminatory, as it appears that certain

ethnic groups are required to take DNA testing more than others.

Furthermore, not everyone is able to provide DNA test results as, on the one hand, the tests are very expensive and many people cannot afford them and, on the other hand, there may be religious constraints to submit DNA testing.

The authors conclude that DNA testing should be reserved as a very last resort and that immigration authorities need to be aware of the potential to disrupt a family unit when recommending biological testing. If testing is requested, the authors recommend that adequate counselling be provided to prepare the applicants with repercussions of the results.

Taitz J., J.E.M. Weekers, and D.T. Mosca, "DNA and immigration: the ethical ramifications", *Lancet*, 359:794.

REVIEWS OF RESEARCH

MENTAL HEALTH

Sequelae of the September 11 Terrorist Attacks in New York City

Severe psychological effects are usually seen after disasters causing loss of life, property damage and financial strain. According to the authors, the attacks of 11 September 2002 in New York City had all these features, which suggested that the psychological sequelae are important and may be long-lasting.

This study was carried out to determine the frequency of psychopathologic disorders in Manhattan after 11 September. The authors focused on post-traumatic stress disorder (PTSD) and depression, the two most commonly studied psycho-

logical sequelae of trauma and disasters. They interviewed a sample of some 1,000 adults, five to eight weeks after the event, and found that 7.5 per cent of the respondents reported symptoms consistent with the diagnosis of current PTSD, and 9.7 per cent reported symptoms consistent with the diagnosis of current depression.

Further, the survey showed that the frequency of PTSD was higher among the persons who were most directly exposed to the attacks or their consequences than among persons who were less exposed. The findings also showed that social ties have a positive role in mental health. After a disaster, a low level of social support seems to be linked to PTSD and depressive symptoms. The authors suggest that intervention addressing the

initial reactions to a disaster may help prevent the development of long-lasting psychological sequelae. In general, PTSD in most trauma most victims and in the general population seem to decrease substantially within three months after a traumatic experience may fully remit.

However, the ongoing threat of terrorist attacks may affect both the severity and the duration of these psychological symptoms. The authors conclude that future research in New York City should determine the prognostic role of the factors associated with PTSD and depression in their study.

Galea S., J. Ahern, H. Resnick et al., "Psychological sequelae of the September 11 terrorist attacks in New York City", *N Engl J Med*, 346(13):982-987.

WOMEN'S HEALTH

Impact of Immigration on Women's Health

This study of the social and health status of women from the Former Yugoslavia was carried out in Queensland, Australia. The participants were mostly refugee women who had arrived in Australia between 1991 and 1996. The researchers used a social network sampling procedure as it was thought the most appropriate approach to reach the targeted communities and establish a good rapport with women. The study was conducted between 1996 and 1997.

The aim of the research was to explore the relationship between pre and post-immigration experiences in Australia and places of origin, and the impact they had on the women's health status and health needs. The authors state that an earlier study carried out by the Bureau of Immigration, Multicultural and Population Research resulted in a positive picture of health among recently arrived (conducted between three and six months after arrival) immigrants from the former Yugoslav republics. However, the data collected by the present study indicated that a significant number of women rated their health status as poor or fair. In contrast to the previous study, this research was conducted three and a half years after the immigrants' arrival.

Most women did not perceive any change in health after migration, but more felt that their health had deteriorated. Many related psychological problems not only to violence and trauma prior to their departure but also to settlement problems. Although immigrants with pre-immigration traumatic experiences may benefit from special mental health services, they seem reluctant to access these facilities. According to the authors' findings, women feel that better financial security would improve their physical and mental

health, and they prefer to rely on their own resources and in their own language, given that they had survived during the conflict. In addition, social displacement in a new society, by comparison to their previous socio-economic position, and low status jobs seem to contribute to poor psychological and physical health outcomes.

The authors conclude quoting an earlier paper that states "risk does not end by physically removing women from vulnerable situations", and, they add, resources and programmes need to be available for these populations in the country of resettlement.

Markovic M., L. Manderson, and M. Kelaheer, "The health of immigrant women: Queensland women from the Former Yugoslavia", *J Immig Health*, 4(1):5-15.

INFECTIOUS DISEASES

Tuberculosis among Tibetan Refugees in India

According to the authors, tuberculosis (TB) is a major public health problem among the Tibetan population living in India. In order to determine the incidence and risk factors for TB, the researchers included data on health and diseases in this population, from 1994 to 1996. Over the three-year period, some 1,575 new TB cases were reported in a population of 53,959 persons. However, TB incidence varied substantially between regions (higher incidence in valleys than in the northeast) and by age. In both groups, the Tibetan-born and Indian-born persons, incidence peaked among the 15-29 years age group, and the elderly. The study also showed that incidence rates among unemployed persons consistently were three times higher than average. In addition, farmers, those engaged in animal husbandry,

sweater sellers and their helpers, and students had higher than average TB incidence over the period under consideration. On the other hand, housewives, monks/nuns living in the settlements and the military had lower than average rates.

The authors point out that the striking incidence of TB among this Tibetan population in India was recognised qualitatively many years ago, and has been associated with factors such as overcrowding, population mobility, malnutrition and other factors affecting their immunity. The authors stated that there is little doubt that TB existed in Tibetan population before the 1950s, due to trade and travel. However, TB may have been uncommon in traditional Tibetan society due to the sparse population and high altitude.

The authors conclude that in 2000, the Revised National Tuberculosis Control Programme pilot, carried out according to the WHO-recommended strategy in selected districts, gave successful results. This strategy is being expanded rapidly all over India and should be adopted by the health care system which provides for the Tibetan population living in India.

Bhatia S., and D. Rowley, "Tuberculosis among Tibetan refugees in India", *Soc Sci Med*, 54:423-432.

Please send any information (research work, conferences, publications, etc.) you wish to circulate through the Newsletter to:

The Editor

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BOOK REVIEW

AIDS & MOBILITY: LOOKING TO THE FUTURE

In contrast to tuberculosis surveillance, the authors write that no HIV/AIDS surveillance data on ethnicity have been reported at central European level since 1986. As at December 2000, although no HIV/AIDS data by nationality had been published, it had been noted that HIV rates among heterosexually infected persons were rising and that a large proportion of them was from a country with a generalized HIV/AIDS epidemic.

The European Project AIDS & Mobility (A&M), which was created at the request of the World Health Organization (WHO)/GPA (Global Programme on AIDS), has been operating for almost ten years. The initiative grew from the fact that many of the HIV prevention activities for mobile populations (including travellers and migrants) were not entirely addressed by the national AIDS plans in Europe while international mobility was increasing. The project began in 1990 "to encourage and, wherever necessary, to improve the HIV/AIDS prevention activities aimed at people who travel internationally, or who reside in a culturally and linguistically 'alien' environment" (Hendriks, 1991).

The activities during 1990 to 1994 were focused on two groups: travellers and migrants. The authors state that these groups could not always be distinguished, thus groups such as mobile sex workers, foreign drug users and asylum seekers were sometimes classified as travellers. However, by 1994, the organization stopped using the term "traveller" and the project focused on migrants (particularly marginalized migrant communities in Europe) and ethnic

minorities. By 1998, the activities expanded beyond HIV/AIDS prevention and began to address new issues such as access to treatment, policy development and advocacy.

The project has tried to respond to the changes related to HIV and migration in Europe and therefore to the changing needs of migrant populations. Therefore, a small-scale research project was implemented to investigate the situation ten years after the project was initiated, and to formulate recommendations for institutions working with migration and HIV/AIDS.

The present publication, even though it was carried out in a short period of time and with limited resources, provides a good source of information and data on HIV/AIDS and migrants in Europe from various aspects (Chapter I). The other chapters review the project's structure and outputs and illustrate its future challenges and strategies. In the last part, the authors state over the past ten years there has been an increase in the number of migrants; there are different populations migrating; there is a shift in migration laws and increase hostility in governmental and social attitudes toward migrant groups.

In order to respond to these changes, the authors suggest the following priorities: development of culturally and linguistically appropriate services and information; increase the capacity of migrant community-based organizations, and improve access to care for migrants living with HIV/AIDS. Overall, the report is a good and comprehensive illustration of the current situation of certain migrant groups in Europe.

del Amo J., J. Erwin, K. Fenton, and K. Gray, *AIDS & Mobility:*

Looking to the Future. Migration and HIV/AIDS in Europe – Recent Developments and Need for Future Action, Report commissioned by the European Project AIDS & Mobility (NIGZ).

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E-mail: aidsmobility@nigz.nl
web: www.aidsmobility.org,
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Price: 15 Euro/84pp

Loretta Iuri, Migration Health Services,
International Organization for Migration,
Geneva, Switzerland

NEW WEB SITE

A new web site has been published which combines the materials gathered under the programme Psychosocial and Trauma Response implemented in Kosovo by IOM since December 1999. The documents published consist of letters, diaries, drawings, interviews and pictures, which yield different accounts on the experience of wary and forced migration and can therefore facilitate the socio-cultural contextualization of the trauma suffered by Kosovar people.

www.kosovomemory.iom.int

Migration and Health newsletter
is also available online at the
following internet address:

<http://www.iom.int>

MEETINGS

KNOWLEDGE AND COMMITMENT FOR ACTION

The International AIDS Society (IAS), in collaboration with the Fundació Barcelona SIDA 2002, is organizing the XIV International AIDS Conference in Barcelona (Spain) in July. The main goal of this conference is to ensure that knowledge gained from science and experience is translated into action and its theme is "Knowledge and Commitment for Action". In order to integrate science and action, the programme includes:

- Basic sciences
- Clinical sciences and care
- Epidemiology
- Prevention science
- Social sciences
- Advocacy and policy
- Interventions and programme implementation

Contact:
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WORLD CONGRESS OF EPIDEMIOLOGY

The International Epidemiological Association (IEA) is organizing its sixteenth congress in August 2002. The scientific programme features:

- Global health concerns of epidemiology with topics on climate change, water contamination, biodiversity and habitat destruction, population pressures and increases in life expectancy
- International health and international epidemiology on social in-

equality and health, effects of globalization on nations and local communities, theoretical frameworks for epidemiology and models of health, health of indigenous peoples

- Epidemiology as a multi-disciplinary science: methods uses by and messages learned from disciplines which are not part of "traditional" epidemiology, including history, anthropology, humanities, philosophy and the social sciences
- Molecular and genetic epidemiology: contribution of molecular biology and genetics to epidemiology, and vice versa; trends of post-genomic era and its implications for future practice of epidemiology.

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NEW PUBLICATIONS

REPORT OF THE COMMISSION ON MACROECONOMICS AND HEALTH

The World Health Organization (WHO) has published the report of the Commission on Macroeconomics and Health (CMH) which was established by WHO Director-General Gro Harlem Brundtland in January 2000. The aim of the Commission was to assess the place of health in global economic development.

The report proposes a new strategy for investing in health for eco-

nomie development, especially in the poorest countries of the world.

Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health, World Health Organization 2001, ISBN 92 4 154550 X (NLM classification: WA 30)

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Corrigendum

Regarding Book Review of Health, Migration and Return, a Handbook for a Multi-disciplinary Approach of Volume 3, 2001 Newsletter Migration and Health, please note the following:

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