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COMMENTARY

Addressing health-related interventions to immigrants: migrant-specific or diversity-sensitive?

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Addressing immigrants

Immigrants and their offspring are often disadvantaged in terms of health and access to health care including preventive interventions, relative to the majority populations (Smith Nielsen and Krasnik 2010; Spallek et al. 2010; Harris 2012). There is broad agreement by now that this health disadvantage is to a substantial part explained by the same social determinants that also operate on the host populations (Reijneveld 2010; Razum and Stronks 2014). But besides tackling social determinants (Graham and Kelly 2004), we also need to make sure that immigrants receive culturally appropriate health care without discrimination (Reijneveld 2010).

How can this be achieved? Addressing immigrant populations could follow two rather different strategies: implementing services and interventions specifically addressed at this group, a somewhat "exclusive" strategy; or by adapting the existing routine health and preventive services, a more "inclusive" approach. Some people see the exclusive strategy as more appropriate, believing it can be tailored to distinctive needs of immigrants. We argue, however, that immigrants and their offspring should not be treated as a separate, detached group, but be covered by improved routine health services.

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Migrant-specific, "exclusive" approach

Proponents of an exclusive approach argue that there are differences in biology, life course, language, culture, etc., between immigrants and the majority population, so that specific health and preventive interventions are required.

An example is the field of HIV prevention. Among persons from sub-Saharan Africa, women have a higher risk than men, and transmission is mainly via heterosexual contacts. Among persons from Central and Eastern Europe, men have a higher risk, and routes of transmission include intravenous drug use and having sex with other men (von Unger et al. 2011). A strong case could thus be made for an exclusive approach: tailored preventive interventions targeted at sub-subgroups of the immigrant population. The practical limitations are obvious. The number of sub-subgroups increases as more and more additional criteria (such as age group or socioeconomic status) are introduced. Moreover, not even immigrants from one country of origin are a homogeneous group, and there may be cultural conflicts even within families (Garton Ash 2012). Thus, the number of individuals per group becomes so small that it will be impracticable to set up and maintain parallel health structures with appropriate levels of coverage and quality.

In addition, an exclusive perspective carries the risk of multiple stigmas. Demarcating persons with migration history as a subgroup with special needs can be perceived as (albeit well-meant) discrimination. Furthermore, there is a risk of overestimating the importance of cultural differences relative to the *social* determinants of health (Razum and Stronks 2014). This "culturalization" may distract from inadequate or unfair policies and legislation at societal level. Finally, exclusive approaches carry the risk of leading to an under-provision of services because

improvements in health care may not be adopted in specific programs for immigrants at the same speed and quality as in programs addressing the majority population (von Unger 2010).

Migrant-sensitive, inclusive approach

Can preventive (and other) services really address *all* members of society? Evidently, there are differences between population groups, some of them are cultural. But even care providers with experience in immigrant health tend to overlook that many obstacles are related primarily to social determinants, rather than culture. When asked about barriers that Turkish immigrant women in Germany face when accessing mammography screening, experts mentioned "culture- and migration-specific" problems. These included the role of the woman in the family, detailed knowledge of the screening program and other aspects of low health literacy (Berens and Razum 2011)—problems associated mainly with socioeconomic status (Dorgelo et al. 2010), and not necessarily with migration history.

The example demonstrates that there are different needs and expectations within any population; their migration status being just one aspect. Any inclusive approach to prevention needs to acknowledge this heterogeneity. This is possible. Many of the activities in preventive and health services that are being offered today have inclusive elements—sometimes this is made explicit, often it is not. An ongoing HIV prevention poster campaign in Germany promoting condom use ("Mach's mit!", literally "Do it using one!") addresses men and women of different age groups and sexual orientation, as well as with and without migration history. Various subgroups are included, but we rarely even notice it.

An inclusive approach should not lead us to deny the need for action at societal level for the benefit of disadvantaged groups; some crucial determinants of population health clearly lie outside the health field, e.g., non-discrimination, educational attainment, and language skills. Furthermore, it should not ignore those health risks that are due to exposures during migration or in the country of origin (Spallek et al. 2011). Finally, an inclusive view is not about giving up fundamental legal rights by pursuing an ethical relativism (Garton Ash 2012).

Welcoming diversity: the way forward

When conceiving health interventions, we need to shift the balance further towards inclusive approaches. The first step is to appreciate that there are differences between people, and that heterogeneity has become an everyday feature of Europe's societies (Garton Ash 2012). Having a migration history is one among several markers of heterogeneity such as gender, education, religious affiliation, or sexual orientation. Several of the perceived differences between population groups turn out to be gradual rather than fundamental, and related more to socioeconomic status than to, say, a culture that is completely incomprehensible to the (respective) majority. We need to learn accepting heterogeneity as the new "normality in the health system" of Europe's societies (Cattacin and Chimienti 2007). This requires a change in attitudes, towards "a generous, curious, imaginative interest in other cultures, philosophies, and ways of life." (Garton Ash 2012).

One strategy for reflecting on one's attitude towards various forms of heterogeneity is diversity management (Geiger 2008). Diversity management recognizes that needs and expectations of people differ. In health care, it helps providers learning how to accept, and deal with, different needs of *all* members of a society. Providers reflect what they perceive as "cultural differences", and how to consider these in the provision of services. Diversity management will thus benefit both minority groups as well as the majority population.

Open-mindedness and generosity are needed, but not only in the health sector. Immigrants and their offspring are an integral and normal part of our European societies. We should not see them as guests but welcome them as fellow citizens (Garton Ash 2012).

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