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Abstract

Research on migration and health is gaining significant ground, with a focus on the adverse physical and mental health outcomes experienced by migrants. The health-related experiences of children and young people who migrate, however, are relatively absent, with children's migration and health status often conflated with that of their parents. The omission of children's own perspectives limits knowledge about how health is understood and experienced by child migrants, including the identification of best ways to support their health. Drawing on the empirical literature on child migrants and health from the World Health Organization's (WHO) Western Pacific Region, we adopt a critical perspective to examine how the research to date supports a particular way of understanding and investigating the health of children and young people who migrate. Specifically, we highlight how a dominant focus on parents' migration status, (negative) health outcomes and patterns of risk behaviours limits, rather than aids, the understanding of migrant children's health. In doing so, we illustrate how much of the evidence base upholds Westernised biomedical notions of health and privileges the use of particular methodologies to assess health outcomes and reduce health risks. These preferences, in turn, shape the subsequent range of 'appropriate' forms of health education for, rather than *with*, children. We conclude by drawing on some exceptions and consider the opportunities these provide for developing health education in line with children's own understandings of health – crucially underscoring the importance migrant children and young people attach to the more social aspects of their health and migration experiences.

Keywords

Agency, children, health experiences, migration, social belonging

Introduction

International migration has increased rapidly in recent times (Czaika and De Haas, 2015). Globally, an estimated 31 million children live outside their country of birth, including 11 million child refugees and asylum seekers (Garin et al., 2016). Establishing the precision of such estimates is, however, complicated by inadequate collection and disaggregation of data (International Organization for Migration [IOM], 2013) – including differential identification of migrants and migration status (Jayaweera, 2010, 2014; World Health Organization [WHO], 2017), in addition to variations in the reporting and classification of the ages of children and young people (Gushulak et al., 2009).

Global migration patterns have triggered concern about the impacts of migration on health, including the challenges presented to global health systems as the consequence of escalating health care demand. Indeed, migration is increasingly recognised as a key social determinant of health (Castaneda et al., 2015) with international evidence mounting about its adverse impacts on morbidity and mortality (Hjern, 2012; McKay et al., 2003). Likewise, the Sustainable Development Goals (SDGs) signpost the particular health-related challenges faced by migrants and the critical role of host countries in supporting effective health care responses (United Nations [UN], 2015) – including how local socio-economic conditions can shape health experiences and access to health care for migrants (Dias et al., 2012; Hjern, 2012; Jayaweera, 2010, 2014).

Despite increasing attention towards migrant health, the experiences of children and young people who migrate have been relatively overlooked in research to date (Carballo and Mboup, 2005; Ingleby, 2009; Sime, 2016). Moreover, very little is said about the development of relevant forms of health education and promotion with migrant children. A significant proportion of the existing literature suggests that migrant children may experience poorer health status and are exposed to multiple health risk factors as a consequence of migration and resettlement processes (Lau et al., 2012; Lee et al., 2012; Mellor et al., 2012; Posselt et al., 2015; Wood et al., 2015).

Other research draws important attention to access to health care services, including how organisational and cultural differences in health care provision can result in lower uptake of relevant services by both adult and youth migrants (Dias et al., 2012; Sime, 2014).

Evidence of this kind serves to strengthen dominant risk-based discourses to position migrant children as being especially vulnerable and thus in need of protection. Yet, some research suggests a contrary perspective and points to the 'immigration paradox' whereby migrant children fare better than their non-migrant counterparts, despite facing significant socio-economic challenges (Di Cosmo et al., 2011; Prado et al., 2009). Similarly, research with adult migrants highlights the positive coping and adaptation strategies employed by European migrants to 'successfully' navigate new country contexts (Weishaar, 2010). Such findings signal some of the unique strengths and capacities migrant young people demonstrate and which they 'bring to their new country' (CorreaVelez et al., 2010: 1399). This area of the literature seeks to identify protective factors (see CorreaVelez et al., 2015, for example) and examine the (negative) effects of the acculturation process (see Di Cosmo et al., 2011; Prado et al., 2009) in an effort to help explain inconsistencies in the evidence to date. Yet, other research reports deterioration in health and well-being over time and as part of acculturation experiences and related stresses (Hjern, 2012; Rechel et al., 2013).

In part, reported anomalies in the research to date may be explained by the differential identification and classifications of children and young people, their migration status and understandings of health across the research literature. As we proceed to illustrate, the investigation of the healthrelated experiences of children and young people who migrate is disparate and complicated by a range of conceptual and methodological challenges. Such inconsistencies result in fundamental gaps in knowledge about how best to address the health-related needs of migrants (Tulloch et al., 2016) – including the development of relevant and effective health education responses. Furthermore, there is a distinct paucity of research that takes children's perspectives as its starting point (Sime, 2016) and the health of child migrants is often attached to, or conflated with, parents' and adults' migration and health status (Curtis et al., 2018; Vathi and Duci, 2016). This relative absence of children's own perspectives on health, and how these are shaped by their migration experiences, provides limited clues about their health education needs while simultaneously contributing to the broader tendency to position (child) migrants as being largely devoid of health and personal agency.

Drawing on a review of the empirical literature on child migrants and their health experiences from the WHO's Western Pacific Region, we critically examine how the research to date supports a particular way of knowing and investigating the health of children and young people who migrate. Where relevant, we draw on and compare this regional evidence base with the wider international to highlight possible synergies and disparities in research to date. Our main aim, however, is to unpack how dominant constructions of the health and well-being of child migrants shape particular forms of health education while silencing other approaches.

Our work is informed by a series of systematic reviews conducted across four global regions (Western Pacific, Europe, Africa and the Americas) as part of an international collaboration that sought to identify current knowledge about the health experiences of child migrants (Curtis et al., 2018) – from children's own perspectives. Details of the review methodology and outcomes for the Western Pacific Region are forthcoming (Spencer et al., submitted). Here, we critically examine how existing research from the Western Pacific Region identifies and positions (1) migration status, (2) children and (3) health experiences. In the discussion that follows, we consider how these positionings encourage and promote particular forms of health education for, rather than *with*, children and young people.

We conclude by drawing attention to some exceptions within the research that take children and young people's perspectives as their starting point and consider how these perspectives might

effectively be harnessed in the development of health education to support the well-being of these children.

Migration experiences

In response to changing global migration patterns, research investigating processes and effects of (forced, unforced) migration and resettlement is gaining increasing ground across a range of disciplines, including health (see Hjern, 2012). Yet, a significant proportion of studies examining the health and well-being of migrants use different definitions of migration – often focusing on diverse population sub-groups from a range of countries and cultural contexts (Gushulak et al., 2009; Jayaweera, 2010, 2014). Other studies provide even less clarity and simply limit their focus to particular geographical or ethnic groups, rather than offering a distinct definition of their selected migrant populations (e.g. Griffith et al., 2014; Wood et al., 2015). Lack of consistency regarding the definition, identification and classification of migration status across the literature (Jayaweera, 2014; WHO, 2017) presents particular challenges when seeking to identify commonalities in health and migration experiences to support the development of relevant health education responses. This differential identification of migrants further tells us something about how particular sub-groups may be prioritised (or not), while others are effectively marginalised or relatively overlooked in the research.

Children as a distinct group are notably less visible in published research (Sime, 2014, 2016). Migration studies that do include children often collate (and sometimes conflate) categories such as economic migrants with documented and undocumented refugees and asylum seekers, along with unaccompanied asylum-seeking and refugee children. Sampson and Gifford (2010) and McMichael and Gifford (2010), for example, described young people in their studies as having 'refugee backgrounds', while De Anstiss and Ziaian (2010) referred to their sample as refugees or children of refugees according to the definition provided by the United Nations Convention relating to the Status of Refugees (United Nations High Commissioner for Refugees [UNHCR], 1951). This latter study also included young people who initially arrived (in Australia) as asylum seekers and/or family sponsored arrivals – thus potentially reflecting quite different types of migrants and migration experiences. Such blurring of statuses downplays the crucial importance of children's own identities, including the differential contexts and consequences, of migration for different groups of children and young people (e.g. forced or unforced, accompanied/unaccompanied refugees, asylum seekers). Detailed exploration of such differences may prove crucial in advancing knowledge of how children's migration experiences come to shape their uptake of, and engagement with, health education.

An unpacking of children's migration status in the existing research is further complicated by the inclusion of both first- and second-generation migrants (and the different classifications of these statuses; see Di Cosmo et al., 2011), as well as the inclusion of samples that comprise a diverse range of cultures and/or countries of origin (see Posselt et al., 2015; Wood et al., 2015). Widespread variations in terms of sampling (which are not often accounted for in the analysis) often mean that crucial details about the importance of differing socio-cultural and political contexts are omitted, including how the country of origin may shape perspectives on, and experiences of, health. For example, some research highlights the significant effects factors such as education and language can have on acculturation – including access to health care and relevant support (Earnest et al., 2015; Henderson and Kendall, 2011; see also Kearns et al., 2017, for European example). Yet, through the tendency to homogenise samples, these important contextual nuances (and their effects) are overlooked. Personal, social and cultural identities and their significance to health, thus become diluted through the conflation and construction of a uniform migrant status (Sampson and Gifford, 2010).

Homogenisation is again evident when seeking to tease out the specific experiences of migrant children research. It is often tricky to disentangle the experiences of children from those of younger adults (and adults) as studies draw on different age classifications and frames. The significance of age may prove key to understanding children's perspectives since the experience of migration reflects a greater proportion of their younger lives. Furthermore, the migration experiences of children and young people are often hidden within the available evidence and 'children have been considered as just an appendage to (the migration of) adults' (Vathi and Duci, 2016: 55). Across much of the research, children's particular migration status is often unclear and/or conflated with that of their parents or carers (for example, see Cyril et al., 2016; Earnest et al., 2015; Gao et al., 2015; Ge, 2014; Jordan and Graham, 2012; Kiss et al., 2015; Lau et al., 2012; Mu and Jia, 2016; Pang et al., 2015; Wong, 2008). In many ways, this tendency to conflate children's status with that of adults reflects a broader propensity to de-centre children (and their perspectives) in health and social research. The consistent prioritisation of adult frames of reference inevitably sets limits to the types of health education responses made possible, as the subsequent discussion highlights.

Children's perspectives

Through a privileging of adult migration status, crucial opportunities may be missed to advance knowledge of how different groups of children understand and respond to their migration experiences – including the impacts on their health and well-being. Many studies to date reflect traditional notions of children as objects rather than subjects of research, which are often premised on developmental and deficit understandings of childhood (Christensen, 2004; Mayall, 1998). Indeed, childhood as a social category is often viewed as being synonymous with concerns about vulnerability and risk, and children are readily depicted as a (developing) group in need of (adult) protection (James and Prout, 1997). Such perspectives help account for the somewhat cursory acknowledgement of children as agents and experts on their own lives – despite broader recognition of the value of ascertaining children's perspectives in recent years in response to the United Nations Convention on the Rights of the Child (CRC) (UN, 1989).

Much of the migration research that does take a particular focus on children can be seen to align with, rather than challenge, prevailing deficit and risk-based orientations to childhood (some exceptions are discussed shortly). For example, a number of studies aim to identify and report on the effects of multiple exposures to risks, harms and vulnerabilities that arise during migration and resettlement (see Lau et al., 2012; Lee et al., 2012; Mellor et al., 2012; Posselt et al., 2015; Wood et al., 2015). While not downplaying the significant effects of experiencing civil unrest, trauma and persecution on these children, the tendency to focus on adverse outcomes perpetuates popular understandings of the migrant child as especially 'vulnerable and voiceless' (Pope Francis, 2017). While some research suggests a more positive focus on resilience or aims to identify protective (rather than risk) factors (e.g. Earnest et al., 2015; Leung and Karnilowicz, 2009; Mitchelson et al., 2010), these examples arguably support a deficit orientation by drawing attention to children's (lack of) knowledge, self-esteem or aptitudes to 'successfully' adapt to adversity and new country and cultural contexts, such as fluency in English language (Earnest et al., 2015). In doing so, possibilities for, and examples of, children's own capacities to identify and shape their health and migration experiences are overlooked or rendered less important in the forms of health education that typically follow. For example, 'appropriate' health education responses are often premised on the building of children's knowledge, confidence and skills to adapt to their new circumstances. Enhancing children's strengths is, of course, crucial to enabling opportunities for their personal and health agency, but such approaches often fail to recognise (and harness) the existing assets and capabilities children bring to their new situations and circumstances (Correa-Velez et al., 2010).

A further issue in the research to date is the tendency to ascertain parents' perspectives on children's experiences and their health-related needs. Numerous studies purporting to explore children's health experiences rely primarily on data generated from parents rather than from children themselves (e.g. Quach et al., 2015; Riggs et al., 2015; Stillman et al., 2012). By way of example, Abu-Rayya (2014) collected survey responses from parents to examine psychological and sociocultural problems among young migrants aged 11–15 years. Likewise, Ziaian et al. (2012) relied on parental reports of depressive symptomatology among children to explore behavioural problems among refugee children and young people. Other research focuses on parenting styles, knowledge and practices and considers the resultant impacts on children's health and resettlement experiences (Cyril et al., 2016; Mellor et al., 2012; Pang et al., 2015). While these studies provide useful insights into parenting, such research seldom acknowledges or interrogates the limits to the primary focus on parents for understanding children's own experiences – with concomitant effects for the shaping of health education. Arguably, the tendency to consult parents, rather than children themselves, provides only a partial account of children's health experiences (and assumed priorities for health education); crucially, one which is filtered through an adult lens.

Health experiences

Accessing migrant children's own health experiences is crucial for understanding the potentially differing frames of reference and priorities for health these children may have. The broader health promotion literature signals some alternative perspectives young people hold and how these inform their engagement (or not) with dominant health education approaches (Spencer, 2013, 2014). Advances in health research in recent times have seen a shift away from health as being the absence of disease, towards an understanding of well-being that reflects a multifactorial, holistic state (WHO, 1946). Yet, health frameworks and discourses in relation to child migrants and refugees continue to adhere primarily to biomedical, Western orientations to health and maintain a dominant focus on the objective assessment of predefined public health priority areas.

Recent examples from research conducted in the Western Pacific Region include a focus on asthma symptoms (Wood et al., 2015), obesity and diet (Griffith et al., 2014; Mellor et al., 2012), mental health (De Anstiss and Ziaian, 2010; Lee et al., 2012; Posselt et al., 2015), sexual health (McMichael and Gifford, 2010), oral health (Quach et al., 2015) and substance use (Di Cosmo et al., 2011; Posselt et al., 2015). In line with a biomedical orientation, a considerable part of the literature utilises large-scale epidemiological studies to establish the prevalence of (ill) health and/or identify health risk factors (e.g. Cyril et al., 2016; Griffith et al., 2014; Mutch et al., 2012; Quach et al., 2015; Zwi et al., 2017). Studies of this kind provide important data about the health status of migrants, including acknowledgement and the assessment of harmful exposures to significant life events. However, by privileging (and limiting) the investigation of health to the assessment of risks and associated outcomes, this style of research downplays the relevance of socio-cultural understandings of health and how these understandings may offer different starting points for health education. Furthermore, the use of quantitative methodologies and methods inevitably limits possibilities to generate a deeper and more nuanced understanding to advance the knowledge base on children's own migration journeys and health-related experiences.

Some exceptions to this style of research do, however, exist. These provide evidence of children's agency, rather than vulnerability, and help reveal some of the differing priorities children and young people may have for their health and well-being. In contrast to much of the aforementioned research, a study by Correa-Velez et al. (2010) placed the onus of refugee well-being on the host community, and in doing so recognised the role that community social inclusiveness can have for promoting or hindering refugee children's well-being. By foregrounding young people's resources and strengths, the study identified the socially located

conditions for positively supporting young people's well-being, including important relationships with peers and family. Similarly, Sampson and Gifford (2010) drew on a range of participatory and ethnographic research techniques (e.g. drawings and photo-novella) to tap into children's thoughts about their resettlement experiences, attending to the importance of place to young refugees' sense of belonging and wellbeing in a new context (see also Gifford and Wilding, 2013, and Sime, 2014, for European example). These young people's negotiation of new places signalled the more positive aspects of spaces that enabled their learning and playing. Young people in this same study further demonstrated a preference for aesthetically pleasing places and being closer to nature to support a sense of well-being.

The importance children and young people attach to the social environment is further evident in studies that seek to elicit their perspectives on health service utilisation. De Anstiss and Ziaian (2010), for example, illustrated how social factors such as the experience of stigma, distrust and victimisation can hinder young people's support-seeking strategies for dealing with the psychological impacts of exposure to war and conflict. Similarly, in a study of young refugees to Australia from Afghanistan, Africa and Bhutan experiencing mental health and substance misuse, Posselt et al. (2015) highlighted how young migrants' concerns centre on broader social and economic factors, including access to education, employment and housing. Of particular significance to these young people were the disorientating effects of social disconnection to their experiences of well-being (Posselt et al., 2015). Fostering opportunities to maximise opportunities for social inclusion and belonging are thus paramount to young people's health-related experiences. This includes recognition of the unique ways in which these young migrants positively negotiate their resettlement experiences (see Correa-Velez et al., 2010) – often despite (or perhaps because) the significant challenges they have – and may continue to encounter as they navigate their new circumstances.

Discussion

This paper has sought to interrogate the existing literature on the health experiences of children and young people who migrate. In so doing, a number of anomalies and assumptions in the understanding and investigation of migration, children and health experiences have been brought to the fore. Advancing knowledge about the health experiences of children who migrate is complicated by a number of conceptual and methodological inconsistencies within the existing research. These shortcomings limit the types and forms of health education recommended as well suited to the needs and priorities of these young people. Specifically, the silencing of children's own identities and experiences continues to privilege discourses that typically present young migrants as being especially vulnerable and having multiple, unmet and complex health needs (Mutch et al., 2012). By so doing, important opportunities may be lost to identify young migrants' capacities for health and personal agency (Correa-Velez et al., 2010). Of particular importance is children's lack of visibility in many areas of the research, largely due to the tendency to conflate their own migration status with that of their parents (Vathi and Duci, 2016). Indeed, the homogenisation of migrants, their statuses and experiences within the broader literature (regarding both children and adults) legitimates a somewhat narrow, uniformed response to addressing health-related needs (WHO, 2017), thereby aiding the advancement of essentialist frameworks that downplay the importance of unique identities and 'reinforce the marginalisation of refugees as natives outside of their natural place' (Sampson and Gifford, 2010: 117).

The absence of focus on children's own migration status, coupled with a silencing of their perspectives and experiences, is promoted by the use of large-scale epidemiological surveys that aim to (objectively) identify health risks and (negative) health outcomes for migrant groups, including children. These methodologies and methods lend themselves to the development of

particular forms of health education underpinned by dominant biomedical understandings of health. Examples stemming from such biomedical orientations include a focus on health screening approaches within key public health priority areas such as obesity, communicable disease and oral health (see Cyril et al., 2016; Griffith et al., 2014; Mutch et al., 2012; Quach et al., 2015; Zwi et al., 2017). Such approaches further privilege the imparting (and imposition) of 'expert' Western knowledge regarding the causes and consequences of (ill) health and, in doing so, downplay the relevance of differing cultural frames of reference for understanding and promoting health (Benard, 2014; Blaxter, 2010). The relative neglect of cultural nuances in understandings of health may set limits to the effectiveness of, and engagement with, health education approaches that fail to adequately display cultural sensitivity to differing health education needs (WHO, 2017). Indeed, evidence from European studies indicates that cultural differences exert significant influence over access to, and engagement with, health-related services (Dias et al., 2012; Sime, 2014).

While not wanting to downplay the significant challenges many migrant children face, the sustained negative focus on (assessing and screening) health status and level of health risk sidelines possibilities for more positive discourses and counter perspectives to emerge. Opening up such opportunities through the sensitive elicitation of children's perspectives may provide alternative insights into the types of health education deemed important to young migrants themselves. As illustrated, research that engages with more participatory methods of enquiry, including the use of story-making, photo-elicitation and drawings, has enabled opportunities for young people to share their own narratives on their lives and migration experiences (see Due et al., 2016; Gifford and Wilding, 2013; Sampson and Gifford, 2010). Recent research also highlights the importance of maintaining methodological flexibility in research with child migrants, including the use of multiple (creative, participatory) methods to accommodate young migrants' different preferences and varying cultural frames of references (see Sime, 2014, 2016, for example).

Of importance is the recognition of the strengths, capabilities and personal agency children and young people bring to their new environments, along with acknowledgement of the ways in which children's differing home backgrounds come to shape their understanding and experiences of health (Brun, 2001; Sime, 2014) – including possibilities for, and the implications of, transnational and ongoing engagement with health care in other countries. Examples of this kind may provide alternative starting points for health education and offer opportunities to move beyond reductionist disease prevention approaches to engage more fully with children's own perspectives and priorities. Indeed, this area of research reveals the importance young migrants attach to the social environment and context in which health and migration are experienced (Fernandes et al., 2014) – including some of the socially located barriers to optimal health and well-being. Developing a more nuanced understanding of how health and migration are shaped by context, including how differing social and cultural contexts may hold varying opportunities for (and limits to) healthseeking or promoting practices, is thus critical to the advancement of relevant forms of health education. Such insights may help to push forward new theoretical insights in health research with young people, including how children and young people's frames of reference can be drawn on to offer different starting points for understanding their health education preferences and priorities (Spencer, 2014).

At the same time, however, it is important for health education approaches to remain cognisant of the limits to too simple a focus on developing children's capacities and strengths and to recognise and respond to the disabling effects of social context on migrant children's opportunities for health. Forms of health education that acknowledge, and successfully address, the socially located barriers to children's health-enhancing practices (including experiences of stigma, discrimination and social exclusion) may prove helpful in enhancing social integration and well-being of young migrants (Brun, 2001; Due et al., 2016; Fernandes et al., 2014; Posselt et al., 2015; Sampson and Gifford, 2010). Research from Europe highlights the crucial role health care

professionals and providers play in shaping attitudes towards migrants and their engagement with health care services (Dias et al., 2012).

Opportunities therefore exist to develop approaches that work with both local communities and migrant groups to encourage mutual engagement in health-enhancing practices. As Brun (2001) articulates, the negotiation of new social networks and cultural practices helps to define new places and spaces for supporting migrant children's sense of belonging and well-being. Recognising migrant children as the agents, rather than the victims, of their migration and resettlement experiences (Correa-Velez et al., 2010) may offer a necessary first step towards the development of such approaches which aim to engage with young migrants' own health and migration experiences.

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