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Health experiences of child migrants in the Western Pacific Region

Abstract

Migration is a key social determinant of health affecting children's life chances and health outcomes. Yet, relatively little is known about young migrants' own health experiences. This paper reports findings from a systematic review examining the health experiences of children who migrated in the Western Pacific region. A systematic search of the peer-reviewed literature from 2007-2017 was conducted using MEDLINE, EMBASE, PsycINFO, CINAHL, Cochrane Database of Systematic Reviews, Web of Science, ASSIA and IBSS. Included articles reported data generated with children up to 18 years and who had migrated across international borders to the Western Pacific region (predominantly Australasia). The Mixed Methods Appraisal Tool was used to assess study quality. Eleven of 499 articles identified were included in the review and focused on three areas: diet and body size; mental health; and social integration. The review exposes the paucity of research on the health experiences of child migrants in the Western Pacific region. More child-centred research that examines the health-related impacts of migration on young people, and from their own perspectives, is urgently needed.

Introduction

Increases in international migration have spurred growing interest in its health and social impacts. The importance of migration to health is widely acknowledged throughout the Sustainable Development Goals (SDGs) (United Nations [UN], 2016) and recent studies have strengthened the evidence-base demonstrating migration as being an important social determinant of health (Hijern, 2012; Castanenda *et al.*, 2015). A growing body of research demonstrates the range of adverse physical and mental health outcomes associated with migration, including changes to health lifestyle behaviours as part of acculturation processes and resettlement, along with the negative effects of trauma and displacement for migrants. Evidence from Europe, for example, suggests deterioration in health outcomes over time, including poorer mental health, lower quality diet, and a lower uptake of health care amongst migrant groups (Dias *et al.*, 2012; Hjern 2012; Jayaweera, 2014, 2018). Yet widespread variation exists across differing migration trajectories and population sub-groups (e.g. refugees, asylum seekers, economic migrants), with some research reporting positive influences and health protective factors associated with migration, including lower rates of health risk behaviours such as smoking and alcohol consumption (Prado *et al.*, 2009; Correa-Velez *et al.*, 2010; Weishaar, 2010; DiCosmo *et al.*, 2011; Hjern, 2012).

Such disparities in the research present challenges for the development of relevant health and social care programmes, including how host countries such as New Zealand can best respond to the diverse and complex needs of migrants. Advancing understanding of the relationship between migration and health is thus a much-needed first step towards the identification of effective interventions and policy responses that better address the health-related and social care needs of migrant groups considered especially vulnerable, such as children and young people. In Aotearoa New Zealand (NZ), for example, whilst policies such as the Refugee Resettlement Strategy (Immigration NZ, n.d.) and Migrant Resettlement and Integration Strategy (Immigration NZ, n.d.) aim to support the wellbeing of migrant groups, these strategies do not detail child specific needs and instead focus on broad resettlement factors (e.g. access to education, housing, health services).

The absence of child-specific approaches is noted in the broader international literature. Indeed, the health of child migrants has received little attention in research, with many existing migration studies taking an adult-centred approach and drawing on parents' migration status and health to assess children's own experiences (Carballo and Mboup, 2005; Ingleby, 2009; Sime, 2016; Curtis *et al.*, 2018; Spencer *et al.*, 2018). Some exceptions include Chase *et al.* (2008) and Liabo *et al.* (2017). Because of this, very little is known about children's own perspectives on health and their migration experiences (Carballo and Mboup, 2005; Ingleby, 2009; Sime, 2016; Curtis *et al.*, 2018; Spencer *et al.*, 2018) – despite acknowledgement of the importance of ascertaining children's views on matters affecting them, and as enshrined in the Convention on the Rights of the Child (UN, 1989). A recent systematic review from Europe has examined the available evidence on child migrants' health (Curtis *et al.*, 2018). This review exposed important omissions in the European research to date, including the limited availability of research that takes children's experiences as its prime focus. Although parents (and other adults) may determine children's access to and consent for health care treatment, the absence of children's own perspectives on their health and migration experiences limits the understanding of the potentially different priorities and needs children may have for their health, including best ways to support and promote their health during migration and their acculturation in a new country (Spencer et al. 2018).

In response to this gap, in this paper we report findings from a systematic review examining the extant evidence on the health experiences of children who migrate across the World Health Organisation's (WHO's) Western Pacific region. The Western Pacific region is the largest of the six WHO global regions comprising 37 Member states (including countries stretching from China to NZ and the Pacific Islands) and is home to approximately 1.8 billion people (WHO, n.d.). This politically

and economically diverse region has witnessed rapid changes to migration in recent years. Of note are the significant increases in migration to Australia and NZ. In Australia, there was an estimated increase of one million people born overseas between the 2011 and 2016 Censuses (Australian Bureau of Statistics [ABS], n.d.). NZ has witnessed similar increases, with the highest annual gain in net overseas migration in 2015-2016 (68,400 people) (NZ Government, 2017). Rapid shifts across the region has enhanced the ethnic diversity of host countries, with rising numbers of peoples across the Western Pacific region, including from China and the Pacific Islands but also from the Middle East and Africa now living in Australia and NZ. Data on the number of child migrants is limited and the data available limits sensible interpretation as migrant children are counted either with all children, or with migrant adults, families or households. Such absence of reliable data on child migrants contributes to the broader tendency to discount, or render less visible, the experiences of young migrants – again setting limits to identifying appropriate, child-centred approaches.

Given the significance of migration as an important social determinant of health, there is a critical and timely need to examine the extant evidence-base on the health of child migrants and particularly children's own views on their health. Without such knowledge synthesis, significant gaps remain in our understanding about the impacts migration may hold for health and social care policies and practice related to the health and wellbeing of child migrants in NZ and Western Pacific region more broadly. The aim of this paper is to report findings from a systematic review examining the extant evidence-base on the health experiences of child migrants in the WHO's Western Pacific region. In doing so, the paper exposes the fragmented nature of research to date, including the critical gaps in knowledge about these children.

Materials and Methods

To ensure consistency, this review followed the procedures reported in the European systematic review (Curtis *et al.*, 2018) and to enable comparisons in the evidence-base across global regions. English language articles published between 2007 – 2017 were reviewed in February 2017. This time period was deemed most appropriate as 2007 reflected the date at which Bulgaria and Romania joined the European Union. Articles were sourced from the following databases: MEDLINE, EMBASE, PSychINFO (via OVID), CINAHL, Cochrane Database of Systematic Reviews, Web of Science, ASSIA (Applied Social Science Index and Abstracts), and International Bibliography of the Social Sciences (via ProQuest). The search strategy covered all main terms associated with definitions of child migrants (child*, young, adolescent, teenage, migra*, emigra*, immigra*, transient, refugee, asylum seek*); and health (health care, quality of life, health promotion, mental health, sexual

health, tobacco, drug and alcohol use, dental health, diet and nutrition). Articles were included only when they: 1) reported data generated directly with children, up to 18 years of age, 2) included children who had migrated across international borders during their own lifetimes, and 3) focused on migration across the Western Pacific region. Our inclusion criteria meant that all reviewed studies must report on children who themselves who have migrated during their own lifetime. This included children who migrated with or without families and where reported (see table one). To ensure studies data generated directly with children, our inclusion criteria meant that children must have been specifically involved in providing responses to the research questions through either completing surveys, being interview respondents, or research participants of participatory research for example (see table one for study methods used). While these inclusion criteria may seem narrow, our goal was to examine children's *own* health experiences as part of their migration trajectories rather than proxy measures of children's health. We consider the limitations of this approach in our concluding discussion. Bibliographies of literature reviews were assessed to ensure identification of all potentially relevant empirical studies. All authors assessed and discussed full text papers to confirm eligibility.

Data extraction

The initial search identified 499 papers. However, following review of the titles and abstracts, 433 papers were excluded either because, 1) the papers conflated children's migration status with their parents' migration status; or 2) it was not possible to differentiate findings relating to children who had migrated in their own lifetimes from children who were born to parents who were migrants. Eleven articles met the inclusion criteria and were included in the review.

[Insert figure one]

Quality assessment

The following data were extracted from the 11 papers: children's country of origin, children's country of settlement, methods, and key findings. Methodological quality assessment was conducted using the Mixed Methods Appraisal Tool (MMAT) (Pluye *et al.*, 2011), which enables appraisal of complex systematic reviews involving multiple methods (e.g. quantitative, qualitative, mixed methods) and by including methods-specific questions for each study design. MMAT scores range from 1 (weak) to 4 (strong). Two researchers independently assessed the included papers using the MMAT tool and questions. Methodological quality was ranked highly for eight articles (Correa-Velez *et al.*, 2010; DiCosmo *et al.*, 2011; DeAnstiss and Ziaian, 2010; McMichael and Gifford,

2010; Sampson and Gifford, 2010; Fernandes *et al.*, 2014; Griffith *et al.*, 2014; Posselt *et al.*, 2015) (MMAT score of 4); two articles had a MMAT score of 3 (Mellor *et al.*, 2012; Wood *et al.*, 2015), and the remaining article had a MMAT score of 2 (Lee *et al.*, 2012). Final MMAT scores were discussed amongst the study team to confirm rankings and reach consensus. The main methodological shortcomings arose from the failure to report response rates. Other limitations were associated with underreporting of study contexts.

Data analysis and synthesis

Study findings were reviewed individually and then combined using a thematic approach. Given the diverse focus of studies and their related results, in this paper we highlight the following three common areas reported in the included studies: (1) diet and body size; (2) mental health; and (3) social integration. Where appropriate, the analysis drew links across these areas to identify possible synergies in the evidence-base, and to identify points of departure with respect to the investigation of child migrants' health experiences.

[Insert table one]

Results

Study designs

Despite the extensive size of the Western Pacific region, much of the research included in this review came from Australia (n=9), with one paper each from NZ and North Korea. Five studies (DeAnstiss and Ziaian, 2010; McMichael and Gifford, 2010; Sampson and Gifford, 2010; Fernandes *et al.*, 2014; Posselt *et al.*, 2015) utilised a qualitative descriptive design, with three of these five reporting on qualitative data from a mixed methods study. Six articles (Correa-Velez *et al.*, 2010; DiCosmo *et al.*, 2011; Lee *et al.*, 2012; Mellor *et al.*, 2012; Griffith *et al.*, 2014; Wood *et al.*, 2015) reported quantitative data, with two studies reporting survey data that used mixed methods.

The health experiences of child migrants

Included articles focused on different health priority areas, presenting methodological difficulties when synthesising findings. Despite the disparate evidence-base, included studies did appear to centre around three important themes: diet and body size, mental health, and social integration. The social wellbeing of child migrants featured strongly across five studies but this was not reported as being the primary area of study. Overall, reported findings suggest the importance of social influences on the health and wellbeing of child migrants.

Diet and body size

Three studies focused on the diet and nutrition of migrants, including an assessment of post-migration changes to diet on adolescent body mass index (BMI) and the development of obesity (Mellor *et al.*, 2012; Griffith *et al.*, 2014) and asthma symptoms (Wood *et al.*, 2015). Broadly, these three studies examined the impacts of acculturation and specifically, how changes to diet following migration correlate with the aforementioned health outcomes. Specifically, two studies focused on adolescents' BMI and examined socio-economic influences (Griffith *et al.*, 2014) and parenting functioning and style (Mellor *et al.*, 2012). While findings from these studies indicated that acculturation patterns and parenting style/functioning were not predictors of adolescents' BMI or risk factors for obesity, the authors did highlight the importance of developing 'culturally sensitive' obesity prevention programmes for young migrants.

The study by Wood *et al.* (2015) investigated the relationship between increasing length of stay in Australia and dietary changes and the effects on asthma, in particular the experience of respiratory wheeze. Similarly, this study reported no significant effects on asthma wheeze following migration despite reporting evidence of dietary changes overtime, including increased intake of saturated fats and decreased consumption of dietary fibre. Saturated fats are known risk factors for longer-term negative health outcomes, including the development of cardiovascular disease. These findings are significant for future health outcomes of migrants and potentially increased costs to public health services of destination countries. However, two of these studies (Mellor *et al.*, 2012; Wood *et al.*, 2015) had an MMAT score of three and thus some caution is needed when interpreting the significance of these studies. Further research investigating the impacts of acculturation and changes to the health practices of migrants is thus warranted.

Mental health

Acculturation influences were studied in four papers in relation to the mental health of child migrants. Two papers examined the relationship between substance use (smoking, alcohol consumption and use of marijuana) on migrant children's mental health (DiCosmo *et al.*, 2010; Posselt *et al.*, 2015). DiCosmo *et al.* (2011) examined smoking rates, alcohol and marijuana use in first- and second-generation secondary school migrants in NZ. Immigrants showed significantly lower risk of engaging in these practices compared to their non-immigrant peers. The authors of these studies suggest such findings may provide evidence of the protective effects of their migration status and positive health practices. This study further underscored the importance of participation with the host community as part of a positive, health-enhancing acculturation process. Likewise, the

study by Possett *et al.* (2015) highlighted the significance of the host community to the mental health of young migrants. With a focus on alcohol use, this qualitative interview study reported the negative effects of limited education and employment opportunities on the mental health of first generation refugees in Australia. Interviews further revealed the harmful impacts of social disconnection, including the experience of racism and discrimination on these young people's mental health and their decision to use alcohol as a means of coping with their new circumstances.

Drawing on focus groups with 44 male and 41 female refugees aged 13 – 17 years from Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia, and Sudan, De Anstiss and Ziaian (2010) reported further evidence of the socio-cultural barriers to mental-health seeking practices. Participants in this study reported friends as being the primary source of support for mental health issues, including depression and described their reluctance to seek help from family or health care-professionals.

Social integration

Three studies took a specific focus on social wellbeing and integration of child migrants (Correa-Velez *et al.*, 2010; McMichael and Gifford, 2010; Sampson and Gifford, 2010). As reported above, a further three papers highlighted evidence of the importance of social influences (including social context and social relationships) to the physical and mental health of young migrants (DeAnstiss and Ziaian, 2010; Posselt *et al.*, 2015).

The social wellbeing and integration of child migrants was explored by Correa-Velez *et al.* (2010) and Sampson and Gifford (2010). These studies emphasised the importance of establishing a sense of belonging to child migrants' social health, including the importance of the physical environment and place of settlement. Closely tied to social wellbeing was the importance of participation and integration with the host community and as reported above, how social disconnection can have negative effects on the mental health of child migrants (Posselt *et al.*, 2015). The potentially negative and harmful impacts of experiencing stigma, discrimination and social exclusion was reported in five papers (Correa-Velez *et al.*, 2010; DeAnstiss and Ziaian, 2010; McMichael and Gifford, 2010; Sampson and Gifford, 2010; Posselt *et al.*, 2015). Importantly, findings also demonstrated the significant role the host community can play in developing migrant children's social wellbeing.

The importance of strong social bonds and relationships was identified in five studies. Friends and family were reported to be especially relevant to the wellbeing of young migrants (Correa-Velez *et*

al., 2010; DeAnstiss and Ziaian, 2010; McMichael and Gifford, 2010). Further, relationships with health and social care professionals was reported as a barrier to the uptake of mental health-related services (DeAnstiss and Ziaian, 2010; McMichael and Gifford, 2010; Posselt *et al.*, 2015), with two studies indicating that children would first seek support from friends and/or family when managing health concerns and issues. Gaps in health-related knowledge (McMichael and Gifford 2010; Fernandes *et al.* 2014) and knowledge of health service provision (DeAnstiss and Ziaian, 2010; Posselt *et al.*, 2015) were identified in four papers and these studies draw attention to differences in the pre- and post-migration contexts and how these shape health-seeking practices (DeAnstiss and Ziaian, 2010; McMichael and Gifford, 2010; Posselt *et al.*, 2015). These findings echo the importance of socially inclusive environments and relationship to the host community.

Discussion

This systematic review aimed to examine the evidence-base generated directly with child migrants about their health and wellbeing. Similar to a recent review from Europe (Curtis *et al.*, 2018), our synthesis of the evidence from the Western Pacific region demonstrates significant gaps in the scope and quality of the research on the health experiences of child migrants. A notable finding from this review is the relative paucity of research reporting children's own perspectives and experiences – a sentiment increasingly echoed across the children's literature (Sime, 2016). Moreover, research that has sought to access and illustrate migrant children's perspectives has largely focused upon a restricted number of biomedical health issues and, in some cases, has been highly localised (e.g. Australia, NZ). Because of this, synergies in the research to date are less readily identifiable with differences in foci, methodological approach, and findings evident. Furthermore, by taking a focus on dominant health outcome measures, the importance of the social aspects of young migrants' health and wellbeing is less well investigated. Synthesising the evidence is further problematic given the varying migration trajectories and home countries of migrants. Differences in the socio-cultural and political contexts of country of origin may have different influences on, and implications for, health, with some papers not reporting country of origin (e.g. DiCosmo et al., 2011). The latter creates further difficulties for teasing out how differing country contexts may influence health and social integration for migrants. Studies did not always report whether children migrated with/without families, which may again have implications for their health and wellbeing.

Despite these short-comings, the research that does exist from the Western Pacific region reflects evidence from Europe that suggests the importance of social integration for the physical and mental health and well-being of young migrants (Hollins *et al.*, 2007; Briones *et al.*, 2012; Vervliet *et al.*,

2014) – including the development of their resilience (VanGeel and Vedder, 2015). Assimilation (or lack of) into the host community, including experience of stigma and discrimination, have been reported as key risk factors affecting a range of health practices and outcomes for migrants (Hollins *et al.*, 2007; Kalverboer *at al.*, 2009; Groark *et al.*, 2010). In NZ, the tendency to prioritise English language attainment in resettlement strategies may be especially relevant to children's assimilation – including the potential 'loss' of their cultural ties associated with their first languages. Moreover, the research with children has a tendency to focus on health outcomes and often privileges biomedical understandings of health, rather than unpacking how social contexts shape their health and migration experiences (Spencer *et al.*, 2018). This is reflected in the NZ Refugee and Migrant strategies, for example, where explicit child-specific indicators focus on immunisation targets. Foregrounding the factors children identify as important to their health is a crucial step towards the advancement of knowledge of the social influences on their wellbeing.

Although migration opens up possibilities for improved wellbeing, the complex process of re-settlement can trigger health concerns for young migrants. Of importance to their wellbeing is the need to maintain connections with family and friends from their country of origin, while simultaneously integrating themselves into new social environments, contexts and relationships. Worrying about family and friends in their home country can trigger significant stress for young migrants (Mares and Zwi, 2015) and may contribute to adverse outcomes for children. Indeed, feeling a sense of belonging has been found to be instrumental to successful adaptation and positive health outcomes (Gifford and Wilding, 2013) and further supports the importance of enacting Article 12 of the Convention on the Rights of the Child and children's rights to participation (UN, 1989). Tied to the importance of ascertaining children's perspectives is the acknowledgement of the possible lack of relevance of dominant public health concepts to child migrants. Western concepts of mental ill health, such as post-traumatic stress disorder and depression, were not recognised by young refugees from countries such as Democratic Republic of the Congo and Afghanistan (Earnest *et al.*, 2015). Future research with child migrants must thus demonstrate cultural sensitivity to the diverse backgrounds and migration experiences of children and young people – including how country of origin may impact on children's capabilities and assets to navigate and manage their health and migration experiences.

Despite these insights, caution is needed with regards to the evidence-base detailed in this review. Definitions of migrant status and health varied substantially across the research and identifying consistent themes was challenging, as described. The papers included in the review also illustrated a

geographical bias with the majority of papers originating in Australia. This latter issue may reflect the decision to include only those papers published in English, which may have inadvertently excluded evidence published across the broader Asia-Pacific region. However, these shortcomings do signal the urgent need to establish a firmer evidence-base on the health experiences of child migrants – a point echoed in the European review of child migrants' health experiences. Without such knowledge, health and social care responses may be more focussed towards traditional or biomedical public health priority areas (e.g. risk factors for obesity, mental health) and largely reflecting Western adult notions of health. Developing knowledge about culturally and socially diverse health experiences may demand new ways of investigating migrant children's health experiences, including recognition of the social aspects of their wellbeing.

Conclusions

The impacts of migration on health are increasingly recognised (Zimmerman *et al.*, 2011). Despite such international recognition, findings from this review highlight the distinct gap in knowledge about children's migration and health experiences. Evidence to date demonstrates inconsistencies in the range of health issues and outcomes examined with clear implications for health and social care research to develop a more robust evidence-base. In the NZ context, Refugee and Migrant strategies can play a fundamental role in improving outcomes for migrant children's health and wellbeing. Yet findings from this review suggest more work is required to integrate child-specific and informed goals and indicators in support of their wellbeing and resettlement. In line with the SDGs (UN, 2016), this review underscores the importance of the social factors related to migration and children's wellbeing. In particular, the experiences of exclusion and discrimination have been found to negatively affect children's health and their engagement in health and social care services. Furthermore, the impacts of acculturation, including assimilation of risky health practices, suggests the need to engage migrant families in health promotion efforts, including access to affordable housing, education and employment opportunities. As international migration continues, advancing understanding of the differing health and social care impacts and opportunities migration brings for children is imperative to ensure their health and well-being are supported.

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