

Maintaining pre-school children's health and wellbeing in the UK: a qualitative study of the views of migrant parents

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ABSTRACT

Background There is evidence that key health behaviours of people who migrate deteriorate over time, which has a consequent impact upon the health of dependent children. As health in the early years sets the course for lifelong health, it is important to explore parents' views on maintaining children's health following migration.

Methods Five focus groups were held with parents of preschool children who had migrated to the UK within the last 10 years ($n = 28$). Parents originated from Romania, Poland, Somalia and Pakistan, with one group of Roma Gypsy parents. Data collection took place in January to March 2015.

Results All groups, apart from the Roma, perceived barriers to maintaining optimal health and well-being for their preschool children following migration to the UK. Eastern European parents experienced difficulties in ensuring family financial security, while parents from more established communities focused on barriers to children's exercise, play and nutrition.

Conclusions This study highlights aspects of public health where migrants and their children can experience adverse effects in the UK. These findings have implications for policymakers, commissioners and providers of health services who aim to promote good health among preschool children.

Keywords children, ethnicity, health promotion

Introduction

Migration is increasing globally as people seek better economic and social conditions abroad or flee crises within their countries of origin.¹ Migrants are defined as people who are born abroad and intend to stay in the country of settlement for at least one year.² Recent migration to the United Kingdom (UK) includes people from European Union (EU) accession countries.^{3,4} The most common reason for people to migrate to the UK is for work or study.¹ Almost half of the migrants are women of reproductive age¹ and in 2011 25% of children born in the UK were to a mother born abroad.⁵ While migrants make up a small proportion of the UK population (13%)³ there are a growing number of children born to migrant parents.

Research into the health of migrants is limited and has tended to focus on ethnicity and ethnic variations in health, rather than on migrant status.⁶ There are significant gaps in

available knowledge about the health of migrants, particularly as the UK, like many EU countries does not collect routine registry or survey data on migrants. Most existing research is concerned with asylum seekers and refugees and focuses on specific health issues such as mental health, infectious disease and chronic disease⁷ rather than exploring the maintenance of good health. Migrants are known to be more vulnerable to diabetes, specific communicable diseases, maternal and child health problems, occupational health hazards, injuries and poorer mental health.⁸ Some migrants experience greater health inequalities, such as Roma Gypsies who are recognized internationally as a marginalized community with high health needs.⁹

A number of studies suggest migrants enjoy good health at the time of migration but that health status deteriorates over

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time.^{10–14} There is debate over the extent to which this deterioration in health status is attributable to ‘acculturation’ (adoption of norms, values, and lifestyles prevalent in the host society), or to structural barriers to good health (socio-economic deprivation and poor access to health services).^{6,12,15} Critics of acculturation as an explanatory theory state that insufficient attention is paid to evidence about the health conditions pre- and post-migration, with widespread stereotyping of ethnic groups.¹⁵ Known lifestyle changes among migrant groups once settled include higher levels of smoking and eating diets high in fat and lower levels of breastfeeding and physical activity, all of which impact upon the health of children.^{6,16} For every 5 years spent in the UK a migrant mother is 5% less likely to breast feed to four months.¹⁶

Children, particularly in the early years, are dependent upon the health behaviours of their parents to set the context of their daily lives, and lay the foundations for lifelong health.^{17–19} High-energy dense food and sedentary behaviours are known to contribute to obesity in pre-school children, both of which are modifiable health behaviours under parental control.²⁰ For this reason developed countries offer universal child health promotion programmes.^{21,22} In the UK population the most socio-economically advantaged lead the healthiest lives²³, but new migrants are also more likely to practise key healthy behaviours, irrespective of socio-economic status.⁶ It is therefore important to explore the barriers and facilitators to maintaining pre-school children’s health in the UK.

Methods

This research was conducted from a social constructionist and interpretivist paradigm, which serves to highlight the influence of constructed identities upon experiences, actions and behaviours.²⁴ Focus groups were held with parents of pre-school children from recent EU accession countries (Romania and Poland), and from longer established migrant communities (Somalia and Pakistan), who had migrated within the last 10 years. One group consisted of Roma Gypsy parents originating from Romania. These nationalities and ethnicities were selected to provide a spectrum of migrant experiences, and allow similarities and differences between groups to be observed.²⁵ Ritchie *et al.*²⁶ emphasize the need for small samples in qualitative research in order to ensure in depth analysis of the data, while recognizing that where more than one national or ethnic group are included within a study for reasons of comparison, this will increase the sample size overall. Ethical approval was obtained from a University ethics committee.

Recruitment was carried out in inner-city areas of high socio-economic deprivation, ranking in the most deprived

10% in England,²⁷ by gatekeepers who were interpreters and link workers familiar to local communities. Gatekeepers gave verbal information to potential participants, accompanied by translated written information. Information was given 1 week prior to the focus group to allow parents time to consider whether they wished to participate. Researchers were described in written information and verbally as being from the University; LC was known to some of the Roma community from a previous study.²⁸ Groups were held in a community setting familiar to local mothers. Somali and Pakistani groups attracted solely mothers; all other groups were mixed. Participants received a supermarket voucher as a ‘thank you’.

Focus groups were conducted in the first language of participants apart from Polish participants who chose to speak English, and the Roma group which was conducted in Romanian (in the absence of Roma interpreters). LC and SM led the groups, and interpreters provided contemporaneous translation. A topic guide focused on parents’ experiences of keeping children healthy in the UK. Questions were open, asking generally about the experience of bringing up children in the UK. The topics of exercise, diet, infant feeding, safety, alcohol and smoking were included as prompts, but group members were free to discuss topics to the extent and depth which arose.

Focus groups lasted between 60 and 90 min and were digitally recorded and the English content transcribed verbatim. Data were imported into NVivo10 and analysed using a thematic content analysis approach, where transcripts were coded to identify themes and categories using constant comparison²⁹ and to identify patterns and search for ‘deviant cases’.³⁰ Both researchers (LC and SM) coded transcripts independently and discussed emerging themes in each group and across groups, reaching an agreement about dominant themes.

Findings

Findings are presented according to two themes; socio-economic wellbeing and maintaining a healthy lifestyle. Table 1 gives the demographic details of participants; disparities in education and number of children are of note. For each direct quotation the participant number, nationality, sex and age are given.

Socio-economic wellbeing

All groups took a broad view of the factors influencing their abilities to keep their children healthy in the UK, seeing financial stability as the cornerstone of their children’s health. Accessing better life chances for children was a major factor

Table 1 Demographic details of participants

	Sex	Age	Educational qualifications	Employment	Number of children	Length of residency in UK
Romanian (n = 7)	5 × F 2 × M	Range 18–35 years (mean 30 years)	7 × A level equivalent	1 × employed 1 × student 1 × seeking work 4 × not known	Range 1–2 children (mean 1)	Range ≤1 year – 4 years (mean 2 years)
Roma (n = 6)	4 × F 2 × M	Range 17–47 years (mean 30 years)	6 × no qualifications	2 × employed 1 × seeking work 3 × mothers at home	Range 1–8 children (mean 3)	Range ≤1 year – 5 years (mean 3 years)
Polish (n = 6)	4 × F 2 × M	Range 28–36 years (mean 33 years)	2 × Master's degree 2 × Bachelor's degree 2 × A level equivalent 1 × not known	4 × employed 1 × student 1 × seeking work 1 × mother at home	Range 1–2 children (mean 1)	Range 2–9 years (mean 7 years)
Somali (n = 5)	5 × F	Range 27–43 years (mean 35 years)	2 × A level equivalent 3 × vocational qualifications	2 × employed 3 × mothers at home	Range 1–4 children (mean 2)	Range 5–9 years (mean 6 years)
Pakistani (n = 4)	4 × F	Range 29–35 years (mean 31 years)	2 × A level equivalent 2 × GCSE equivalent	4 × mothers at home	Range 2–4 children (mean 2)	Range 1–10 years (mean 5 years)
Total (n = 28)	22 × F 6 × M					

in deciding to live in the UK, notwithstanding the difficulties experienced by parents in living apart from home and family.

'I feel the life is much better here especially for the children; there are a lot of facilities for the children, there is more care here than back home.' (P1, Pakistani mother, age 38)

Parents described the UK as a nation which prioritized the health and wellbeing of children, by providing free education and health care, and maintaining quality standards for housing and childcare. However, financial security for individual families varied, with some struggling to find work, affordable housing and childcare. Those who brought most capital in the form of education and qualifications found work more easily, though this could be lower status work than anticipated (see Box 1). Roma and Somali women described finding employment as difficult; for Roma women low literacy levels were an additional barrier. Discrimination was mentioned by Romanian and Roma participants, with a Roma father perceiving greater prejudice against his Romanian nationality than Roma ethnicity (see Box 1).

Higher wages were offset by increased costs of housing and childcare. Romanian, but not Roma participants, described entitlement in Romania to 2 years of full maternity pay plus low-cost nursery places. This provision was seen as superior to benefits in the UK, and as allowing mothers to be with their children in the crucial early years. Parents from all nationalities described the loss of informal childcare by extended family.

Pakistani and Somali women spoke of a communal child rearing ethic 'back home,' not just within the family, but extending to neighbours and the wider community. Without this, much childcare and household work fell to the mother alone, leading to increased stress and isolation.

Precarious employment coupled with high housing costs led to two families (Polish and Romanian) experiencing temporary homelessness. Both families had been helped by social workers to find new accommodation, a single mother after two days living on the street. They attributed this speedy help to having children, evidencing better treatment of families with children than they would anticipate in their departure countries.

Living a healthy lifestyle in UK

Parents' views on maintaining a healthy lifestyle were strongly related to the quality of life to which participants were accustomed. Roma participants described living in a dangerous environment in Romania, with poor infrastructure and a risk of children dying 'three days after they were born' (P3, father, age 47). By contrast life in the UK offered an opportunity for children to thrive:

'To be honest we are scared to say which things are better in this country, and do you know why, because we are afraid for someone to take these things from our children.' (P4, Roma mother, age 26)

Box 1: Migrant parents' work in the UKBarriers to finding work

Somali group: 'Men is a bit easier than women to find a job. As a woman you have the kids mainly with you and a man can do like a heavy duty job like warehouse, they can do taxi driver...bus driver.' (P3, mother, age 43).

Polish group: 'I was finish a Master's degree in administration and in England I am a cleaner.' (P2, mother, age 35)

Roma group: 'The country doesn't stay put to wait for us, technology advances...and the technology here is too high up for us, and you know the applications are done online, and we don't really know how to write, you understand?' (P2, mother, age 34).

Discrimination

Roma group: 'When you tell [the agency] you are from Romania, then sparks, they feel like sparks come out...the agency send the people to the employers and then it makes it difficult to, much more difficult to receive work...I went to a job and said I am a Gypsy, no problem I worked there for 7 months.' (P3, father, age 47)

Romanian group: 'Everybody can think that we can go back and we can work there, but it is not true...I was put in a situation to be asked to go back to my country, and I did say I have nowhere else to go.' (P5, mother, age 34).

Childcare and work

Polish group: '[We] share the child care...we don't have any family here. So actually we choose to work part-time both of us, so he stays with her half of the time and I stay with her instead of working both of us full time, because the nursery is really expensive. It's so expensive.' (P6, mother, age 31)

Roma group: 'When you are two in a couple and you don't have children you can both go to work, but when you have a child then one needs to stay at home, and you don't have a big income and the benefits are low.' (P5, mother, age 17)

Romanian group: 'I find it harder at the moment because I am the only one working and we pay the rent and it seems to me quite hard.' (P2, father, age 28)

Parents described aspects of healthy living which were challenging to maintain in the UK (see Box 2). Views on healthy food were mixed, with all groups except the Polish and Roma considering that food was healthier in their country of origin. Somali and Pakistani women considered that the tradition of communal outdoor play in their countries of origin led to children being fitter, and also gave them independence. In the UK mothers took children to parks, but poor weather meant that children spent more time in sedentary indoor activities, such as watching TV. In addition, it was not seen as normal to allow children to play outside in the UK without parental supervision due to fear of accidents (Polish and Pakistani groups), and also paedophiles (Somali group).

Opinions about children's play among Romanian parents were divergent. In Romania some families owned houses in rural areas where children could freely play in the garden or courtyard, while others lived in an inner-city apartment block. A few considered that norms had changed and Romanian children now played outside less. A similar picture of change emerged in the Polish group, where personal experience of play ('when I was a child and playing in Poland, it was like all construction, like steel, it wasn't safe' (P5, father, age 35)) was considered outdated. Those who had revisited home towns in Poland described provision of children's playgrounds and green spaces for outdoor leisure activities, often supported by investment from the European Union. However, there was agreement that fitness was promoted more widely in the UK; an example was a project to encourage family cycling (see Box 2).

The type of leisure pursuits available in the UK had an impact on relationships between parents and children. Greater societal involvement of men in parenting was observed; 'If I go outside on a Saturday morning I just see dads with their strollers down the street' (P6, Polish mother, age 31). This was fostered by activities specifically for fathers of young children, such as Dads' groups. In contrast, Somali and Pakistani women described an increase in maternal responsibility for their children due to no longer having a wide circle of relatives and neighbours who could contribute to informal childcare. Mixed feelings were expressed about this as mothers described increased mother/child closeness resulting from sole care, but also additional stress and a curtailment of children's freedom (see Box 2).

Exercise and nutrition were readily discussed as impacting on child health and wellbeing, but parents' use of alcohol and tobacco provoked less discussion. Most agreed there was no change in these activities, but Pakistani women claimed they were less hidden post-migration. No group spontaneously discussed infant feeding, but Roma, Pakistani and Somali women described decreased duration of breastfeeding in the UK when questioned. Reasons for this varied (see Box 2), including changed cultural practices, lack of privacy in crowded houses, and choosing bottle-feeding to facilitate work. No group appeared aware of implications for child health of reducing breastfeeding. Table 2 gives an overview of identified barriers to children's wellbeing.

Box 2: Changes to nutrition and exercise post-migrationFamily foods

Roma group: 'In Romania, pigs, cows, they're all ill and you get illness when you eat them...here the shops are clean, the food is clean and you do not get ill.' (P5, mother, age 17)

Polish group: 'I notice I eat healthier food in the UK, definitely yes, more vegetables more fruit...we don't eat so much vegetables in Poland.' (P3, father, aged 33)

Somali group: '[In Somalia] vegetables it's just like fresh and organic, the meat is fresh, not like meat from the freezer. You go to the market and buy it fresh, taste different, just like completely different.' (P4, mother, age 27)

Romanian group: 'In Romania you have more natural products, more organic food than here...regarding food I think we eat much healthier in Romania than here.' (P7, mother, age 30)

Polish group: '[At Easter] we did have a tradition with a basket that you take for food to the church to be blessed and the next morning you eat it together with your family...[here] I won't take my little ones because I think that's the only time we go into the church.' (P4, mother, age 28)

Exercise

Pakistani group: 'They have more activities back home...there are a lot of opportunities, big houses and the streets are quite safe because the children play outside, and you know they have an open environment... football, cricket bat, climbing trees, all that back home.' (P3, mother, age 35)

Somali group: 'In the country the children have more freedom there, they play a lot and learn with the others...it's more the child...it's good to learn by themselves... here the mother have to be careful do everything by herself, and teach him alone.' (P5 mother, age 28)

Roma group: '[Here] I have time to go in the park with the children, swimming, whatever I want.' (P2, mother, age 34)

Polish group: 'I wasn't really active in Poland but here I think it's more natural to go jogging outside on the street, you see people on their bikes...there is a project...about getting young children on a bike with the parents... it's for parents twice a month, you go with your child, you can hire a bike ... [with] a seat or a trailer...and go on a trip...there's one specialist person who is the leader, sometimes there are 20 people with children.' (P6, mother, age 31)

Breastfeeding

Roma group: 'In Romania even if you want to bottle feed your child you don't have money to buy it, so you have to breast feed even if you want to or not, but here you do have two options. You can breast feed, and you can bottle feed as well because you can afford this, you have more money.' (P1, mother, age 35)

Somali group: 'Mother when she have baby there, because she was having a lot of rest...getting support from the family, she was producing much more milk, but here you know, you have a baby two days ago but you have to do all the chores again, taking children to school, walking to the clinic, so you might not produce much milk, so that's why maybe they bottle feed as well.' (P2, mother, age 34)

Somali group: '[It's] something cultural, if you have a baby it's not good for a woman to go out and the baby as well, so you have to keep inside and after 40 days end they have a party...[here] you have to go out.' (P1, mother, age 38)

Pakistani group: 'Everybody breastfeeds back home...a lot of mums want to breast feed here... [but] because we are living in a joint family...they get embarrassed, they can't breast feed because in front of their father-in-law [or] brother-in-law you know...my religion does say that you do not reveal yourself.' (P4, mother, age 29)

Discussion**Main findings of the study**

This study has highlighted the magnitude of change in all areas of life post-migration, which influences parents' health behaviours and care of children in the early years. It provides a contextual understanding of the challenges parents face in maintaining a healthy lifestyle for their pre-school children. Commonalities between the experiences of migrant parents were observed. Parents sought to improve the health of children by migration, but encountered difficulties in maintaining health and wellbeing. For Eastern European parents difficulties arose primarily in maintaining family

financial security post-migration, while parents from the more established Somali and Pakistani communities focused on barriers to children's outside play and activity. Despite the long-term health consequences of decreased breastfeeding, this was not identified by participants as having an impact on optimal child health. Parents described the tangible benefits which motivated migration as being weighed against the loss of family and community support, which offered a safety net in times of crisis.

The diversity of participants demonstrated how change is experienced by those of different nationalities and ethnicities, and a variety of socio-economic backgrounds. Ease of integration into UK society was facilitated by parents' resources,

Table 2 Post-migration barriers to the health and wellbeing of pre-school children identified by participants in focus group discussions

	<i>Romanian parents' focus group</i>	<i>Roma parents' focus group (Romanian speaking)</i>	<i>Polish parents' focus group</i>	<i>Somali parents' focus group</i>	<i>Pakistani parents' focus group</i>
Theme 1: Socio-economic well being					
Women experience difficulty in finding work		✓		✓	
Difficulty in finding work commensurate with qualifications			✓		
Difficulty in affording childcare and/or housing	✓		✓		
Parents experience discrimination	✓	✓			
Family experience of homelessness	✓		✓		
Theme 2: Living a healthy lifestyle in the UK					
Decreased duration of breastfeeding post-migration		✓		✓	✓
Reduced access to affordable fresh food	✓			✓	✓
Loss of community traditions related to nutrition			✓	✓	
Loss of support from extended family and/or community	✓			✓	✓
Mother isolated due to language barriers					✓
Reduced active play for children	✓			✓	✓

such as education, professional qualifications and language skills, which could mitigate the impact of migration. The Roma stood apart from all other groups in describing severe hardship and social exclusion in their country of origin, and were the most appreciative of new opportunities offered to children. Given that this study focused on parents who had come to the UK for work or study it was striking that precarious employment and housing were commonly experienced, and even homelessness, as this has been perceived as a more common concern with asylum seekers and refugees.^{31–33} This highlights the fragile economic stability of some migrant families and the potential risks for children.

What is already known

Migrants are a diverse population in terms of country of origin, ethnicity, socio-economic status, religion and belief, legal status and length of residence, who have a range of health needs.⁶ There is an increase in migration from Eastern Europe with accompanying family settlement.^{3,4,34} Migrants are likely to be negatively affected by social inequities within host societies,³⁵ disadvantaged in terms of employment and housing^{36–38} and with lower levels of health and wellbeing than the host population.³⁹ However, the interrelationship

between ethnicity, migration and health is complex, and inequalities can be in favour of minorities or against.⁴⁰ Jayaweera⁷ suggests that migrants' health issues are obscured by an elision between ethnicity and migration in data collection and research. While some maternal behaviours, such as duration of breastfeeding, appear to decline irrespective of ethnicity or religion,¹⁶ smoking and alcohol consumption remain lower in Muslim women post-migration.⁶ The health of migrant children is underexplored, but higher rates of obesity are of concern.^{41,42} There is a knowledge gap in the UK about the health of migrants' children who comprise a diverse and growing group.

What this study adds

In an increasingly globalized world migrants' health is of growing national and international policy concern.⁴³ This study is innovative in including both parents from Eastern European and established communities who are rarely included in health research.⁷ Conducting bilingual focus groups is a challenging, but powerful means of accessing community attitudes⁴⁴ and by including a ranges of nationalities and ethnicities this study has revealed commonalities in the migrant experience, and areas of specific health need.

Deteriorating health behaviours among migrant parents predisposes both adults and children to 'lifestyle related' diseases such as heart diseases and cancer adding to the burden of ill health.⁴⁵ While childhood obesity is known to be increasing in 0–5 year olds, migrant parents are unique in relinquishing beneficial health behaviours- this offers an exceptional opportunity for early intervention. This study adds to knowledge of the factors which influence health behaviours among migrants from a variety of nationalities and socio-economic backgrounds.

This study offers a nuanced understanding of the context in which parents' keep their children healthy post-migration, supporting the concept of acculturation as a complex, multi-directional process⁴⁶ rather than a linear model focusing on values, norms and beliefs to the exclusion of structural barriers to good health.⁷ This study has reinforced that behaviours, such as breastfeeding or physical activity, are affected by a network of interrelated intra- and inter-personal factors, combined with organizational and institutional influences. When considering children's health, it is apparent that micro-systems and macrosystems pre- and post-migration continue to shape behaviours.⁴⁷

Limitations of this study

Adherence to quality standards for the conduct and presentation of qualitative research gives confidence that findings are indicative (but not representative) of the attitudes and behaviours of these national and ethnic groups.^{48,49} Findings may be influenced by the rapport between the researcher, gatekeeper and community, which may have led to more open responses from the Roma community who are known to LC from previous research. Interpreting for a focus group is a highly skilled activity, requiring an ability to keep pace with discussion and translate verbatim, and experience of this varied between interpreters. While the Eastern European groups were mixed, Pakistani and Somali fathers' views were unrepresented. Focus groups were not well suited to exploring sensitive subjects such as parental smoking and alcohol consumption, though these were discussed more freely in single sex groups.

Conclusion and policy recommendation

This study illuminates the factors which influence health behaviours among migrant parents, which will aid public health practitioners devising interventions to impact upon behaviours contributing to premature morbidity and mortality. Where health professionals deliver health promotion directly to the parents of pre-school children via universal interventions, such as well child programmes, the specific

needs of migrants in relation to breastfeeding, diet and exercise should be addressed. Improved recording and monitoring of migrant status would assist health professionals to target preventive services effectively to the children of migrants, and facilitate further research into supporting migrant parents to continue lifestyle behaviours which optimize child health.

Acknowledgements

We would like to thank all participants and interpreters, and also Professor Debra Salmon who assisted with data collection.

Funding

This work was supported by Avon Primary Care Research Collaborative [BCCG RCF 2014/15/LC] and The University of the West of England, Bristol.

Authors' contributions

L.C. designed the study and wrote the study protocol. L.C. and S.M. conducted the focus groups, analysed the data and contributed to the drafting of the paper. Both authors approve the final submitted version.

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