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## **Chapter 22: Migrant children and young people's 'voice' in healthcare**

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### **Introduction**

Across the UK and internationally there is a fast-growing commitment to listening to young people in decisions that affect their lives, including in public decision-making. The case for the importance of taking young people's views into account and facilitating their participation has been made on grounds of both principle and pragmatism. In the past, researchers have been criticised for considering them as 'objects of study' rather than seeking their experiences and their views on what is important to them and their lives. Prout (2001: 193) argued that children's voices should be listened to because they have their own consciousness as 'persons in their own right' and arguably experience the world in their own ways. Adopting adults' perspectives on matters that concern children and young people reflects historic approaches of power and regulation, and young people's generational positioning as less knowledgeable and in need of being controlled.

Children's distinct life experiences and competencies, including their ability to share their views if appropriate ways of involving them are identified, have been increasingly recognised by research and policymakers alike (Punch 2002). The 1989 United Nations Convention on the Rights of the Child (UNCRC) clearly affirms children and young people's rights to an adequate standard of living, the highest attainable standard of health and the right to be consulted and participate in decisions that have a direct impact on their lives. This means that including children and young people and taking into account their views is not only good practice, but also a matter of rights and entitlements, and public services have a duty to ensure that these rights are respected.

In a healthcare context, it is important to acknowledge that children and young people may experience health, illness and healthcare provision in significantly distinct ways to adults. The UNCRC states that rights should be ensured for all children and young people, irrespective of their various statuses, including nationality, ethnicity, language, social class or race. In today's globalised world, these statuses overlap and intersect for most, not always in

positive ways, as children's health outcomes and wellbeing differ across diverse nations, ethnic and socioeconomic groups. The extent to which their rights to participation are ensured also depends on the ways in which they are thought of by others in the societies in which they live.

Children and young people's health and wellbeing is significant not only for their everyday lives, but also for the futures of the societies in which they live. In this context, listening to young people's views on provision of healthcare is key, to ensure that their needs are met and also to identify the challenges for services in meeting these needs. It is also important to ensure that all voices are heard, as certain groups are often more likely to be included in debates. Young people traditionally excluded are often on the periphery of society, for example, those living in extreme poverty, migrants, those affected by disabilities or mental health issues, or young people not in education. In many countries, certain groups also fall outside existing services, as rights to access public services might be restricted, as in the case of asylum-seekers, refugees or illegal migrants (Jayaweera 2010).

This chapter draws on research with Eastern European migrant children newly arrived in the UK in relation to experiences of healthcare provision post-migration. Although understanding users' views of healthcare provision is key to informing policy on health-related measures, the views of migrant groups, and in particular those of children and young people, are rarely explored. In order to address this gap, this chapter examines first the wider context of the physical and mental health status of migrant children and adults, the social determinants that influence migrant children's health outcomes and issues in their access to and use of healthcare services post-migration. The main focus is on children and young people's views of health service provision, the barriers they face in relation to health service use and the strategies migrant families adopt to overcome perceived shortcomings in provision, including adopting a transnational use of health services.

In the context of migration, young people's experiences of healthcare are significant because provision might need to adapt to meet their specific needs, as they may experience distinct barriers in terms of access and the quality of their experience. As already mentioned, children and young people are also entitled to healthcare rights, and effective policies need to be developed to ensure these rights are met. The chapter highlights the important role of migrants' active participation as users of health services, with a significant role for children and young people as cultural brokers for adults, and concludes that appropriate health policy and care delivery should take into account the needs and expectations of diverse populations.

## **Seeking the views of children and young people**

In this chapter, I refer to migrant children and young people as those who were born in one country and then relocated to another country with their family, through planned rather than forced migration. I do not include refugee and asylum-seeking children, as their needs are acknowledged as more complex, due to the likely more traumatic nature of their migratory situations and legal status (Kohli 2006). Over the past two decades, research with children and young people has seen a significant shift in terms of how researchers perceive children and their ability to contribute to the research process, not only as research participants, but also as research partners and co-researchers (Kellett 2005). This has included an emphasis on the 'competent child' (or young person), and change in attitudes in relation to children and young people's ability to contribute as experts in their lives, often attributed to the rise of constructivist and interpretive theoretical perspectives in sociology (James and Prout 1997; James et al. 1998; 1998; Prout 2005). This 'new sociology of childhood' aims to reframe views of childhood as experienced, debated and defined in processes of social action that have children and young people as central actors.

While children's rights to participate have been enshrined in the United Nations Convention on the Rights of the Child (UNCRC) since 1989, it is only recently that children's and young people's views have been acknowledged as valid in their own right. There is now an expectation that research will consider children's rights to participate in investigating issues that affect them, including family legal procedures or initiatives to do with public places and the services they access. Prout (2001: 193) argued that taking notice of children's voices should be a matter of priority because 'it speaks to questions of flexibility and responsiveness in welfare and service provision and to debates about young people's engagement with key institutions such as schools'.

Articles 12 and 13 of the UNCRC explicitly address the right of children to be informed, involved and consulted in decisions that affect their lives, although the rights are expressed with several caveats, which have been criticised for the difficulties they pose for implementation (Bell 2008; Spyrou 2011). For example, Article 12 limits the right of participation to children who are 'capable of forming their own view', putting the responsibility on adults to decide on individual children's capability. This logically leads to questions around how capability should be established and by what measures and again puts adults in a position of power, as they make the judgement. Although Article 12 places the onus on adults to take responsibility for including children's views, it gives very little guidance on how this might be achieved. Similarly, Article 3, which discusses the best

interests of the child as a key priority in any matters involving children, implies that adults need to prioritise children's protection and wellbeing. Nevertheless, these statements are not straightforward in their application, as adults need clear mechanisms to identify children who might be vulnerable and consider the ways in which ideas such as right to participation, protection and vulnerability are constructed across times, social groups and cultures (Rogoff 2003). Despite these caveats, the Convention provides a critical framework and a mechanism for empowering children in research and the shift in childhood studies has also been matched by a shift in wider policies on the inclusion of children's voice in governance at various levels. In the UK, for example, recent policies such as the Children and Families Bill 2013 in England (DfE 2013), and the Children and Young People (Scotland) Bill 2013 (Scottish Parliament 2013) emphasise the importance of giving children and young people an active role in decisions that concern their lives – for example, through contributing to improvement of local services – and place responsibility on services to create opportunities for consultation.

### **The impact of migration on the health of Eastern European migrants**

Migratory patterns to the UK have seen a significant change over the past two decades, in terms of migrants' country of origin, reasons for migration and settlement patterns (Castles and Miller 2013). Data from the last UK population census indicate that more than 7.5 million people, or 12 per cent of the UK population, were born abroad (ONS 2013), with the most common countries of birth being Poland, India and Pakistan. With the expansion of the European Union (EU) in the past decade, an increasing number of labour migrants to the UK now come from Central and Eastern Europe. Unlike in the past, when many adults migrated alone, a significant number of recently arrived European migrants have migrated together with their families, many of which include children and young people. Unlike people arriving from the non-EU countries, EU migrants have full entitlement to healthcare in the UK, as all 28 EU member states have either publicly sponsored or regulated universal healthcare. Since 2011, a directive on healthcare promotes cooperation between member states and access to safe and high-quality cross-border healthcare for European citizens (European Union 2011). However, despite free access to healthcare, comparatively little is known about EU migrants' health and wellbeing overall and their experiences of accessing healthcare provision post-migration.

The increase in the number of recently arrived migrants has led to debates about migrants' impact on the economy, the likely increase in demand for public services and, more broadly,

the influence of migration on cultural values and national identity in receiving countries (Yuval-Davis 2011). Current debates on immigration often centre on the provision of public services (Spencer 2011). While some claim that increased migration has led to pressure on public services in the UK context (Institute of Community Cohesion 2007), others have raised concerns about migrants' low uptake of healthcare (Rolfe and Metcalf 2009; Collis et al. 2010), with some recent data suggesting that areas with increased rates of immigration have seen reduced waiting times for hospital outpatient referrals across England (Giuntella et al. 2015). It is generally perceived that European migrants are mostly young and healthy, which may explain their low service use. The 'healthy migrant effect' may also be due to self-selection, as migrants are likely to consider their health before deciding to move abroad. However, international research shows that in contrast with the 'healthy migrant effect' in the early stages of a migratory wave, migrants have a higher risk of deteriorating health over time through the so-called 'health acculturation' (Ronellenfitch and Razum 2004), which occurs independently of improvements in their socioeconomic condition. Collis et al. (2010) also highlighted that many of the Eastern European countries that migrants leave from continue to focus on treatment rather than prevention in relation to key public health concerns, such as alcohol and tobacco use, obesity and low levels of physical activity, and mental health concerns. Increased stress and anxiety often triggered by the experience of migrating have also been linked to higher risks of developing somatic complaints and illnesses, such as heart disease, depression and anxiety (Robila 2010). Cultural differences might also affect health outcomes; for example, through perpetuating stigma around mental health issues, which can adversely impact on psychological and emotional health and attitudes to asking for professional help. One major factor in researching the effect of migration on individuals' health outcomes is the fact that data on migrants' health are scarce, mainly because migrants are not a homogenous group and country of birth and immigration status are not recorded consistently when health services are accessed.

While studies on the health of adult migrants are limited overall, studies on the health of migrant children in the UK are almost non-existent. Elsewhere, studies of migrant children have reported on the unique situations that contribute to their increased risk of poorer physical and mental health. The age at which they make the transition from one country to another has been highlighted as significant in how they adapt to the new country, with younger children faring better in terms of health and education outcomes (Chuang and Moreno 2013). Research with immigrant adolescents in Europe has reported on their difficulties concerning physical and mental health, and social isolation, with significantly

higher scores on all scales of psychological distress and psychological problems (Sandhu and Mooza 2013). Like their parents, young Eastern European migrants may perceive mental health difficulties as taboo and worry about the stigma of accessing support, despite evidence that they present an increased risk of somatic complaints and illnesses such as depression, anxiety and suicide ideation in relation to non-migrant groups (Robila 2010). Beisser et al. (1998) have identified several unique situations that may contribute to the mental health issues of migrant youth. These include: adapting to family separation; disruption to education and language issues; and pressure to adapt to new customs while also conforming to their parents' expectations in relation to values from their homeland. Some migrant children also experience racism in schools and neighbourhoods (Devine 2009), which may result in poor self-esteem and self-worth and feelings of marginalisation.

Social determinants of health from individual characteristics (such as age, sex and constitutional factors), to social and community networks and socioeconomic and environmental conditions (such as education, housing, working conditions) play a key role in explaining the health practices and outcomes for migrant groups (Dahlgren and Whitehead 1991). Migrants' experiences are often polarised and aspects such as social class, types of jobs migrants engage in and the social capital available to them intersect in a multitude of ways in shaping their health outcomes (Ryan 2011). For migrants in low-skilled jobs, government measurements that restrict access to work and public services for certain groups and negative public perceptions of migrants can also significantly increase their disadvantage and contribute structurally and institutionally to poor health outcomes. Factors such as different expectations and cultural beliefs in relation to health have been shown to influence the health-related decision-making and behaviours of migrants from a wide range of socioeconomic backgrounds (Spencer et al. 2007; Son 2013; Thomas 2010). Migrants' health is thus influenced by a range of political, social and economic forces and one's status as recent migrant can be seen as an additional layer to those already identified by existing models of social determinants of health (Sime 2014).

### **Conducting research with young migrants**

The impact of migration on children and young people's health and wellbeing, as well as their views on their access to healthcare provision and experiences of health services constitute a relatively new research area in a European context. Consideration of the most appropriate research approaches and techniques is therefore important in ensuring that participation is facilitated and does not become adult-led, restrictive or too burdensome for

some young people. Thomson (2008) has outlined the advantages of doing participatory and visual research with children, as it allows them the means to take some control of the research process. By encouraging children's lead in the process of generating the data and in directing the discussion within interviews, children gain a voice and can influence the outcome of the research and its impact. Participatory and visual forms of research can also be effective methods for use with newly arrived young migrants, particularly where fluency in the language of the host population may be an issue. Researchers also need to consider their structural position, in terms of age, ethnicity and class, and how this can influence power relationships in the process and affect issues of access, consent, data collection, analysis and dissemination (Sime 2008).

Child-centred, qualitative research has clear advantages in giving migrant children a voice to inform current policy, practice and debates on global migration and social justice. However, researchers need to be mindful of migrant children's position within their families and society overall. Their participation is often hedged by constraints and controls (Sime 2015). In families, adults may want to ensure that children's participation is restricted to topics that families are comfortable with and non-intrusive in relation to family relationships, roles and rules, or adults may want to speak on behalf of their children.

In this chapter, I draw on data collected with 57 Eastern European children, aged seven to 16, who had lived in Scotland for less than three years at the time of the study. They were of both genders (31 girls and 26 boys) and from a range of socioeconomic backgrounds and the majority (48) were Polish, the main migratory group to the UK since 2004. Given children and young people's diverse competencies and preferences, a range of research methods and techniques were used to ensure that all involved were able to find the best tools to express their views. Fieldwork combined focus groups, individual interviews, diaries and photography. Focus groups have been shown to work well with children (Hennesy and Heary 2005), as they allow them to stimulate each other's ideas, and also allow the researcher to assess the extent to which the group shares beliefs and experiences. They were conducted in the children's own language (eight groups) and with interpreters present for multilingual groups (three groups), and covered children's access and views in relation to a range of services, including healthcare. Participants were encouraged to discuss first the experiences of a 'typical migrant family', a technique adopted in order to reduce the pressure of having to share personal stories, but still drawing on their knowledge and beliefs about migrants' lives in the UK. They could thus talk indirectly about what a migrant child 'would' experience, but also relate to their own experiences if they wished to. Child-centred activities were used,



based on images of services children were likely to access – such as schools, medical centres, leisure centres, parks, etc. – and hands-on activities, to stimulate children’s enthusiasm and engagement (Christensen and James 2000).

Following on from the focus groups, 23 in-depth family case studies were completed, including 29 children (six pairs of siblings were involved) and at least one parent in each family. The case studies included a majority of Polish children (n = 13), and five Lithuanian, four Slovak, two Bulgarian and two Romanian children, as well as one Hungarian, one Russian and one Czech family. In total, 15 girls and 14 boys were involved, with an average age of 11 (age range was 8–16 years old). All case studies consisted of visits to children’s homes, as homes were seen as a more relaxed environment than public spaces. However, domestic spaces are not always under children and young people’s control, as these are often shared spaces with other family members (Sime 2008). To increase children’s sense of control over the process, we gave them the opportunity to take photographs of services they used and to complete a weekly diary. While some children and young people enjoyed these activities, others were more reluctant and preferred to just talk about their experiences. This highlights the importance of having a flexible set of tools and techniques that young people can choose from and the necessity of ensuring, on an ongoing basis, that young people are still in agreement to take part.

### **Young migrants’ health behaviours and engagement with health services post-migration**

Adult European migrants have been found to engage with health services less regularly than the majority population (Spencer et al. 2007; Collis et al. 2010). Despite public speculation that migrants add pressure on services (Delanti et al. 2011), there is very little systematic evidence in the UK on services accessed by migrants, patterns of use and views of services available. There is also limited evidence on how migrants’ health behaviours alter as a result of family migration and changes to their family income and cultural influences in the new society. Children are strongly influenced by their families’ ideas about health and healthy behaviours (Sime 2014). Shared values among individuals have a key role in the creation of social capital (Bassani 2007) and, in the case of migrant families, cultural values and knowledge shape their beliefs about health and health practices (Migge and Gillmartin, 2011).

Health behaviours and practices may appear to be private matters for individuals and families, but they are configured by a range of social contexts, which for children and young people consist of schools, family, peer group and neighbourhoods (Morrow 2010). While

some authors claim that unchanged dietary habits, health beliefs and practices in migrant adults may be indicative of an emotional attachment to their home culture (Son 2013), others have emphasised the socioeconomic factors and inequalities that make positive health practices more affordable to the better-off (McKendrick et al. 2014; Nazroo 2014). Parents and children may also wish to adopt healthy behaviours and eating habits, but may be limited by the local availability and affordability of healthy foods or sports activities.

In our research, most of the children and young people gave largely positive accounts of their health overall and were confident in terms of accessing services available, such as GPs, pharmacies, hospitals and dentists. Most children were able to discuss particular aspects of the health system and health practices that they encountered in Scotland, often making comparisons with provision that they had encountered in their country of origin. Although sometimes they would differ in their assessment of quality of provision – for example, their perceptions of the competence of medical staff – they regularly commented on the better quality of the resources and equipment and the free prescriptions or services such as dental checks and eye tests available to all in Scotland:

Zuzanna (12): Maybe the dentist and medication for kids is free here, so that's better. But maybe in Poland you get to see better doctors, not only GPs.

Esther (13): I think that Polish doctors are better.

Dzulieta (14): I think that it is the same here and there.

Wioleta (14): I think that they have better equipment here. (Polish focus group)

While most children were registered with family doctors (or GPs), some were not, and were reliant on emergency services in case of illness. Some also said that they had kept registration with doctors and dentists in their country of origin. This reflected families' confidence in services they were familiar with, but also their precarious work conditions, which meant that return was also a possibility and families wanted to keep their registration with services in their own country:

*We haven't been here [in Scotland] long, so we didn't register yet with a doctor, but mum said we can go to the hospital in case of anything. But we are usually quite healthy. (Marta, Polish, 12)*

My mum says we might not stay here [in Scotland] long if she cannot find work, so we kept our doctor back in Poland, just in case. (Marek, Polish, 10)

Many children and young people commented on the child-centred approach to healthcare from the medical staff. This gave them a sense of empowerment and involvement in decisions on their care and was seen as good practice:

I feel they talk to you more here [in the UK] and they ask you what you want, [they do] not just [ask] your mother. (Ana, 13, Bulgarian)

Children with chronic conditions commented on cross-cultural differences relating to the management of their conditions, and how they had to adapt to new views on suitable medication, practices and routines of engaging with medical staff. These included differences in medication that was prescribed for the same condition in different countries, the frequency of check-ups and the medical staff young people would interact with. One key aspect children and young people commented on was access to specialists, which seemed to be more routine in Eastern European countries even for minor conditions, while in the UK, their conditions were managed by GPs or local practice nurses. In addition to more immediate access, the issue of trust and reassurance that familiar doctors offered and the benefit of a shared language were other considerations when families decided to travel abroad to access healthcare. Ana, a Bulgarian teenager who had a chronic eye condition, explained how she perceived the long waiting times to see a specialist as frustrating and unhelpful, which in her case led to her mother's decision to travel to Bulgaria and see a specialist straight away:

Well, here, you wait like months to get to a doctor ... which is annoying ... boring ... *you know you have an appointment, but it's so far away that you forget about it and just live your life and by the time your appointment comes, you are OK. So we went to see the Bulgarian doctor, the one that operated on me. And she said it's OK if we wait and see how it goes, because it might get worse if they operate again. And I trust her more, I feel safer with her.*

(Ana, 13, Bulgarian)

### **Barriers for young migrants' access to health**

It is clear from many studies that migrant families encounter a range of barriers that prevent them from accessing healthcare (Sime 2014; Robila 2010; Thomas 2010; Son 2013). In the UK context, with constant changes to rules around entitlements to access to healthcare,

especially for non-EU migrants, young people and their families can face a constant struggle to understand the health system in their new country and the rules of engagement with service providers. In addition, the uncertainty over their families' entitlement to healthcare and treatment, especially immediately after their arrival, cultural differences in provision and approaches to treatment and language barriers can make the experiences of accessing health provision more difficult. In this section, we emphasise three types of barriers that research has identified as significant in relation to migrant groups, including lack of adequate information, cultural differences in the provision of care and the language barrier. I reflect on these from children and young people's perspective, as their experiences are often distinct from adults' own views and young people are often in the position of facilitating service access for their families, due to their access to information through schools and their competence in the majority language (Sime and Pietka-Nykaza 2015).

#### Lack of adequate information on entitlements and services available

Children and young people's life experiences post-migration are configured by a range of factors, which include their parents' values, aspirations and employment opportunities. In our sample, most parents were in jobs below their level of qualification, often working in catering, food processing, agriculture or construction jobs. Many women were homemakers, due to their limited English language skills. This meant that many families relied on one income, often precarious and dependant on availability of work. Family income influences access to good-quality housing (Rolfe and Metcalf 2009) or the type of neighbourhoods in which migrants live (McGhee et al. 2013), meaning that migrant children and young people may become marginalised due to the complex interactions that result at the juncture of age, ethnicity, social class and place. Low income and poverty may lead to poor nutrition and substandard living conditions. By being forced to access low-cost accommodation in areas of high deprivation, migrants' access to services is affected by their status as new arrivals. Services are often of poorer quality in deprived areas and migrants may feel at risk in terms of personal safety when trying to access these (Spencer et al. 2007). In addition, the novelty of the new system and lack of direct experience of interacting with services in their new country may put them at a disadvantage in terms of access to information about services available.

In my research, I asked newly arrived migrant children if they accessed healthcare services available in the community, such as specialist or wellbeing clinics, pharmacies or spaces for leisure that could help promote better health. I report elsewhere the overall limited knowledge

among new migrants of services available locally (Sime and Fox 2014; Sime 2015). Many families, newly arrived, were not certain of their entitlement to access health services, although all are free at point of use. They also relied on accident and emergency (A&E) care ‘if something happened’ and were not always registered with a doctor or dentist. Children from countries that had limited rights in terms of access to the employment market and welfare benefits at the time of the study (Romania and Bulgaria were not at the time EU members) were affected by their families’ restricted access to healthcare. This meant that in some cases, families made deliberate decisions not to access care for fear of deportation and limited information on what health practitioners would and would not do in relation to their immigration status.

Information on access to health services is often mediated by schools, who send home information, bring interpreters into school to explain to parents what other services are available locally or actively mediate access for the families and, in some cases, help them register with doctors or dentists or fill in registration forms for families. In this process, children become important ‘cultural brokers’ for their families, translating information or exercising pressure on families to access provision, for example, to leisure facilities. As I show elsewhere (Sime and Pietka-Nykaza 2015), children’s enhanced linguistic competence in English and regular contact with services through school positions them as ‘experts’ in the family and confers them a certain advantage over their parents, especially if the parents’ linguistic competence is still developing. This reversal of social norms means that children can often have the main role in mediating their families’ access to opportunities, which can also lead to increased ambivalence in children towards their parents’ homeland language, culture and identity, as well as increasing pressure on children given the responsibility. Children and young people are also more likely to interact with other children through play and leisure time, and in so doing, enable the realisation of important social capital benefits (Putnam 2000). Participation in the community is also an opportunity for children to develop networks with other ethnic groups, and use these as sources of information and as a route to better access to community resources. However, networks of access to resources may be built in ways that privilege some ‘insiders’ (i.e., the established communities) over newcomers. For example, local children and young people may know of ongoing clubs, activities or have their own informal networks of getting together with friends to engage in leisure activities. In some cases, migrant children relied on information from their friends and their limited experience of services to assist with parents’ decisions and actions. The roles young migrants have to take on to facilitate their families’ engagement with local services therefore require

complex skills and confidence and involve activities usually reserved for adults. These new roles may also pose increased pressure on them, including a risk to their mental health and wellbeing.

#### Cultural differences in provision and rules of engagement with services

Previous experiences of the health system in the homeland will influence migrants' behaviours in relation to how the health system in the new country is accessed, expectations about how accessible services are and perceptions of the medical staff. I reported elsewhere (Sime 2014) on health practitioners' views that differences in provision led to disappointment among migrants, who often complained about waiting lists, restricted access to specialists and different approaches to treatment. A common complaint is on the perceived 'paracetamol culture', where practitioners prescribe mild painkillers for conditions commonly treated with antibiotics in other countries.

I was very sick last year, and they give me only paracetamol, and I was ill for two months. It *was something with my neck, I couldn't speak. I was in the hospital and they just give me that.* (Agnieska, 15, Polish)

Perceived differences in approaches to treating conditions also led some families to adopt more informal approaches towards solving health problems, such as relying on family and friends for advice and treatment. These approaches included: emergency visits to the homeland to access doctors and dentists and to avoid 'waiting lists' in the UK or high charges for private care; or asking family members to post medicines or check a diagnosis with known medical staff in the homeland.

Romek [son] got an allergy after the swimming pool, so I went to emergency. The woman looked at photos on the internet and then she gave me a prescription for some cream. But then I read the instructions and realised it was for scabies, so I called Agata, my friend, because her son had a similar problem, and I borrowed from her the cream that she got in Poland and it helped. (Dagmara, Polish mother)

*We couldn't get antibiotics here, and my mum was sure the doctor was wrong, so we called my auntie back home and she went to our local doctor [in Poland], told them what I have and then they posted me the medicine.* (Marek, 14, Poland)

A key finding reported in the literature is that as migrants access better work and become more familiar with the system, they are able to build networks of support and become better-informed on existing services and how these operate. Research with Eastern European families (Sime and Fox 2014; McGhee et al. 2013), for example, has reported on families' narratives around temporary, transitional housing arrangements, such as residing in poorer areas, with a view of moving on to better opportunities once their work opportunities improve. As migrants strive to improve their work and living circumstances, their understanding and expectations of health services also change (Migge and Gilmartin 2011). In the case of children and young people, the influence of education, friendship groups and other members of the local community means that their health behaviours, attitudes to health and wellbeing and expectations of health services are also likely to change over time. In this context, practitioners need to be aware of the changing nature of migrants' expectations and health-related behaviours and values over time, to ensure provision is addressing their needs and takes into account their changing values and expectations.

#### The language barrier

Language is a key barrier to many migrants' access to health services. Migrants have different levels of competence in the language of their destination country and their developing competence in the majority language affects their ability to access information on services and entitlements, and their experience of interacting with medical practitioners and understanding treatment options. In our study, as children often developed their competence in English much more rapidly than their parents due to their school attendance, they were often asked by their parents to translate information materials or act as interpreters in medical appointments:

*When you don't understand, it's hard to know [what is available], like my mum when the nurses were visiting her, she said that she doesn't understand and they try to translate it, point it out until she will understand. Or if I am home, then I do it for her, tell her what they said, read the paperwork for her. (Klaudia, 13, Polish)*

As discussed above, children and young people may feel under pressure to act as interpreters, and they may often give the impression of full competence in the new language, while lacking the full vocabulary to translate accurately. For practitioners, using children as interpreters is to be discouraged, for concerns over confidentiality and unreasonable pressure

on children as well as their developing competence to interpret complex terminology and convey medical conversations accurately, and good practice would require professional interpreters to be booked for medical appointments. Working with families through an interpreter poses several challenges in terms of establishing rapport, collecting information, explaining treatment and time pressures, as appointments are usually time-limited. In addition, the cost of involving an interpreter or the limited availability of interpreters for less common minority languages may delay appointments and deter families from engaging with services. Research has also highlighted how migrants' feelings of unease about local care provision due to perceived social, cultural, religious and linguistic differences and lack of trust prompt people to seek care in more familiar contexts, such as from health providers in their country of origin (Glinos et al. 2010; Migge and Gilmartin 2011).

## **Conclusion**

This chapter aimed to summarise the evidence on access to and experiences of formal health services from the perspective of migrant children, young people and their families. Many of the experiences that children and young people have post-migration are likely to have a direct impact on their wellbeing. As their quality of life is directly configured by their families' socioeconomic circumstances, the neighbourhoods in which they live and their friendship networks post-migration, there is an increasing need for local and central government policymakers to ensure a good quality of life and adequate access to health services for newly arrived migrant youth. There has been very little qualitative research or consultation to assess the extent to which newly arrived migrants engage successfully with health services and to elicit their views on experiences of health, access to healthcare and any barriers they encounter in accessing provision. Furthermore, data on migrants' health and use of health services is scarce and patchy, as country of origin, length of stay in the UK or immigration status are not recorded when individuals access healthcare. As mentioned at the beginning of this chapter, including children and young people and taking into account their views is not just good practice, it is a matter of social justice and public services have a duty to ensure that their rights are respected.

Working with young migrants in a health context poses specific challenges for practitioners and requires them to take a holistic approach. One significant challenge is to register young people with services such as GP practices and dentists, especially given the fact that they have little control at times over family decisions. Children and young people can, however, exert influence on their parents, mainly by translating information and finding out from their



friends about services available, but the key issue seems to be around challenges to make adults understand services and trust available provision. Contrary to speculation in the media around practices such as ‘health tourism’ and pressure on health services due to increased migration to the UK, migrants seem to access a limited range of statutory provision and often find alternative routes to state provision, including private and transnational care. Acculturation plays another significant role in how migrant young people adopt or not healthy behaviours and practices – they may be more inclined to adopt new health practices, based on information they get from school, media and other sources in the new language, while still having less control over family decisions. Migrants’ views of health services and expectations are often mapped on their prior experiences and this must be considered by healthcare professionals in the UK. It is clear that differences in provision and expectations about the rules of engagement with services need to be made more explicit to newly arrived migrants in order to better engage them in health-promoting behaviours and gain their trust. Practitioners need to review what prevents children and their families from making efficient use of the full range of health services. This suggests that health services need to be delivered in a culturally sensitive manner, with awareness of children and young people’s position in families and communities.

It is evident that family migration poses significant challenges for children and young people and impacts on their health, health behaviours and wellbeing. For migrant children and young people, factors such as the migration experience (positive or negative), length of residence in the new country, socioeconomic position, age, gender and resilience may help explain different health behaviours and outcomes. Their varied attitudes to healthcare are likely to be influenced by their parents’ social class before migration and socioeconomic situation post-migration, and their prior experiences of healthcare. To this extent, their views of healthcare need full consideration in order to inform policy and practitioners’ behaviours. Healthcare providers must be sensitive and alert to the personal factors that affect migrant children and their families’ decisions to engage with services and work with them to tailor provision whenever possible. Research shows that some families choose to use services transnationally or seek help from informal networks when they lack trust in health services in the new country. Accessing healthcare through multiple routes indicates the active role migrants adopt in making decisions about their use of healthcare provision and children and young people are often key actors within these decisions.

Migrant children are at a crossroads of influences in terms of the health behaviours they should adopt, attitudes about health service utilisation and levels of trust in health

practitioners. While their parents might value more the healthcare system they are familiar with and they understand better, children will be expected to engage in sometimes different health behaviours by their schools and peer groups. Health practitioners working with newly arrived migrant children should be mindful of the multiple influences that impact on their expectations and beliefs and engage them in conversations to dispel any myths and address any concerns they might have. As young people develop their understanding of how healthcare operates in their new country, it is likely that their perceptions and beliefs will change over time. Also, as children's linguistic competence in English is sometimes more advanced than that of their parents due to their schooling, migrant children may in time become mediators of cultural knowledge about services available to their families (Sime and Fox 2014; Sime and Pietka-Nykaza 2015).

Transnational use of health services is a feature of family life for many European migrants, especially in the first few years after migration, and health practitioners need to be aware of children's exposure to possibly distinct cultures of practice. It is also important to highlight that not all children and young people coming from one country will have the same health experiences or outcomes. Existing research shows how different social and economic circumstances are the main contributing factors to children's unequal health outcomes (Morrow 2010; McKendrick et al. 2014). As a result, children and young people's health practices post-migration will take place in a range of new social arenas, while also influenced by their families' cultural values around health. There remains a need for substantial policy and practice development in relation to the health of migrant groups, with a specific focus on engagement of children and young people as an issue of rights and social justice, as well as good practice.

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