Health and well-being among child immigrants in Europe

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Summary: This study examines health, well being and involvement in risk behaviours of immigrant children across twelve European countries, using data collected in the 2006 Health Behaviour in School-Aged Children study. Findings suggest that immigrant children are significantly more likely to live in less affluent families, but no other cross-national patterns are evident. The lack of clear patterns suggests that no one-size-fits-all programmes are suitable for working with immigrant children. There is a need for more specific research to increase our understanding of the needs and experiences of migrant children in Europe.

Keywords: Migrant Children, Health Behaviour, Europe

Introduction

The process of immigration has proved stressful for voluntary migrants,[1] and for migrant children the stress may be even greater as immigration is imposed on them. Here, we examine the experiences of child immigrants across a number of European countries.

Previous studies on the health of child-immigrants were carried out primarily in the USA, with fewer studies carried out in Europe.[2,3] Findings from these studies were equivocal. Some studies found that immigrant children fare worse compared to their native peers in relation to mental health, risk behaviour, academic achievements, health and well being,[4,5] some reported that immigrant children fare better,[6] while others found no differences,[7,8] or that differences disappear when controlling for socioeconomic circumstances.[9] However, what is missing is a comparison of the experience of immigrant children across nations which makes use of comparable data with a large number of participants and countries.

This paper uses data that were collected in the 2006 Health Behaviour in School-Aged Children (HBSC) survey, a WHO collaborative cross-national study that is conducted at four-year intervals in a growing number of countries. In 2006, the survey was carried out in 41 countries, from Europe and North America, all following the same research protocol.[10] The HBSC survey provides a unique opportunity to examine health, life satisfaction and involvement in risk behaviours of immigrant children across the participating countries. For these purposes, immigrants are defined as children who were born outside of the country of residence.

As part of the cross-national HBSC study, national research teams surveyed students from schools and school-classes to produce nationally representative samples of eleven-, thirteen-, and fifteen-year-old children. All participating countries obtained approval to undertake the survey from the appropriate regulatory bodies. In 2006, twelve of the participating countries collected information on participants' country of birth. These include: Flemish-speaking Belgium, Germany, Denmark, Spain, Greece, Ireland, Iceland, Italy, Scotland, Sweden, Wales and Portugal. To explore whether there are general patterns across countries, we have compared immigrant children to their native peers on questions relating to self-reported health, life satisfaction and involvement in risk taking behaviours. We have also looked at family affluence, as differences between immigrant and native children could be attributed to differences in socioeconomic circumstances rather than the immigrant status per se.

Health and life satisfaction

Self-rated health was measured as: "Would you say your health is…?" Response categories were dichotomised to 'excellent' vs. 'good', 'fair' and 'poor'. Children were also

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asked about their perceived life satisfaction: "Here is a picture of a ladder, the top of the ladder '10' is the best possible life for you and the bottom, '0' is the worst possible life. In general, where on the ladder do you feel you stand at the moment?" Answers were dichotomised to 9–10 as high level of life satisfaction vs. 0–8.

Risk behaviours

Five areas of risk behaviour are also considered here. Participation in fights was measured using the question: "During the past twelve months, how many times were you in a physical fight?" This question was dichotomised into 'never' vs. '1 time or more'. Bullying was measured using two questions: "How often have you been bullied at school in the last couple of months?" and "How often have you taken part in bullying another student(s) at school in the last couple of months?" Both questions were dichotomised to 'more than twice' vs. 'twice or less'. Smoking was measured using the question: "How often do you smoke tobacco at present?" This question was dichotomised to 'weekly or more' vs. 'less than weekly'. Students were also asked about their history of drunkenness; "Have you ever had so much alcohol that you were really drunk?" with responses dichotomised to 'twice or more' vs. 'never or once'.

Family affluence

Young people's socioeconomic status was measured using the Family Affluence Scale (FAS).[11] This scale is based on four material conditions of the households in which young people live, including: family vehicle ownership, having their own bedroom, number of family holidays and number of family computers. The scale was used to create three variables: low, middle and high family affluence.

Findings

The proportion of immigrant children in the sample varies from 4% in Wales to 11% in Ireland (see Table 1). In all countries, except for Ireland and Scotland, the level of family affluence reported by immigrant children is lower than that of their native peers (Table 2), and immigrant children are found to be over-represented in less affluent households and under-represented in more affluent households. This finding stands out as the strongest, most consistent difference between child immigrants and their native peers and is similar to findings previously reported.[7,12] This suggests that further analyses must control for these differences in family affluence when comparing immigrant children with their native peers on aspects of health, life satisfaction and risk behaviour.

Table 1: Distribution of foreign-born children by country, gender and age group; percentage (number of children)

Country	All	Boys	Girls	11 y	13 y	15 y
Belgium (Flemish)	4.8 (206)	5.1 (111)	4.5 (95)	3.2 (41)	5.6 (78)	5.4 (87)
Denmark	5.5 (313)	5.6 (153)	5.4 (160)	4.1 (85)	5.4 (110)	7.2 (112)
Germany	6.5 (468)	6.5 (237)	6.4 (231)	5.1 (114)	6.6 (160)	7.3 (187)
Greece	7.2 (265)	6.0 (106)	8.1 (159)	4.3 (47)	7.9 (93)	8.8 (124)
Iceland*	6.5 (122)	6.1 (58)	6.9 (64)			6.5 (121)
Ireland	11.0 (536)	10.5 (260)	11.5 (276)	10.1 (138)	10.5 (187)	12.2 (206)
Italy	4.8 (190)	5.0 (100)	4.6 (90)	3.6 (45)	4.7 (63)	5.8 (77)
Portugal	5.8 (235)	4.8 (103)	5.8 (132)	5.3 (68)	5.5 (82)	5.2 (85)
Scotland	8.3 (515)	8.3 (253)	8.4 (262)	6.6 (111)	8.6 (194)	9.4 (205)
Spain	8.6 (737)	8.2 (358)	8.4 (379)	9.8 (292)	7.9 (223)	7.3 (222)
Sweden	4.7 (207)	5.1 (111)	4.3 (96)	3.9 (58)	4.2 (57)	5.8 (88)
Wales	4.0 (177)	3.9 (84)	4.2 (93)	4.7 (70)	3.9 (59)	3.3 (45)

* data available for 15 year olds only

Once we take the differences in gender, age and family affluence into account, immigrant children do not significantly differ from their peers in their health and life satisfaction in most countries, with the notable exception of Ireland and Wales. In Wales immigrant children are 1.5 times more likely to report excellent health ($p<0.05$) and in Ireland they were also significantly more likely to report high life satisfaction compared to their native peers. These findings suggest that despite generally reporting lower levels of family affluence, in most countries immigrant children did not report poorer health or lower life satisfaction. This finding could be viewed as counterintuitive, if we consider that many studies have shown the negative influence of socioeconomic hardships on adolescent development.[13] This phenomenon has previously been labeled as ''the immigrant paradox''.[14]

Another important aspect of immigrant children's life that is often addressed is involvement in risk behaviours. Here too no clear and consistent cross-national patterns emerged. In some countries immigrant children were more likely to report alcohol use and in others they were less likely to report drunkenness or smoking behaviour (see Table 3). Bullying victimisation and bullying perpetration were more prevalent among immigrant children in Ireland, Scotland, Spain and Italy, but bullying was less prevalent among immigrant children in Greece, with no differences in the other countries. Similarly, physical fighting was more prevalent among immigrant children in Germany, Greece, Italy, Spain and Sweden, but not in the remaining seven countries (Table 3). These different patterns in different coun-

Table 2: Distribution of Family Affluence Scale (FAS) by foreign-born status: percentage

Country	Foreign-born			Natives			Significance level
	High FAS	Mid FAS	Low FAS	High FAS	Mid FAS	Low FAS	
Belgium (Flemish)	44.5	37.7	17.8	47.2	42.7	10.0	P<0.01
Denmark	42.9	39.2	17.9	51.4	41.4	7.3	P<0.001
Germany	22.1	47.0	30.9	48.5	39.5	12.0	P<0.001
Greece	11.4	41.4	47.1	28.6	47.7	23.6	P<0.001
Iceland	62.9	28.4	8.6	70.7	27.5	1.8	P<0.001
Ireland	21.5	54.9	21.5	20.0	56.4	23.6	N.S.
Italy	27.0	37.4	35.3	32.2	46.1	20.4	P<0.001
Portugal	22.6	40.1	32.9	32.0	43.4	24.4	P<0.005
Scotland	48.0	38.2	13.8	42.8	40.8	16.3	N.S.
Spain	22.3	42.7	35.0	40.9	46.1	13.1	P<0.001
Sweden	33.5	43.8	22.7	57.0	37.3	5.7	P<0.001
Wales	31.6	41.8	26.6	45.6	41.4	13.0	P<0.001

Table 3: Models of logistic regression: odds ratios of involvement in risk behaviours predicted by foreign-born status, by country

Country	Was in a fight	Been bullied	Bullied others	Weekly smoking	Been drunk
Belgium (Flemish)	1.24	0.89	1.54	1.10	0.93
Denmark	1.20	0.87	1.36	0.88	0.37***
Germany	1.93***	0.79	0.93	0.90	1.27
Greece	1.56**	0.89	0.69*	0.87	1.60*
Iceland	0.78	0.70	0.44	0.64	0.88
Ireland	1.00	1.39*	1.24	1.13	0.85
Italy	1.59**	1.12	1.89**	0.83	1.07
Portugal	1.13	1.33	1.38	1.08	1.10
Scotland	1.02	1.44*	1.05	1.24	0.92
Spain	1.27**	1.98***	1.67***	0.65*	1.08
Sweden	1.50*	1.23	2.53***	1.31	1.05
Wales	0.79	1.30	1.03	0.60	0.54**

*p<0.05; ** p<0.01; ***p<0.001
All analyses are controlled for gender, age and family affluence

tries mean that, despite the similarities in the samples and the way that things have been measured, there is no one story that can be told about the health of immigrant children across Europe.

Limitations

The HBSC study provides a unique opportunity to gain further cross-national understanding of child immigrants, using similar methods and a standardised questionnaire across a range of countries in different regions of Europe. Nevertheless, there are some limitations to these data. First and foremost, the overall study is aimed at the general population and not at immigrants, resulting in relatively low absolute numbers of immigrant children in the study, but also in lack of specific information about the immigrant population. The relatively low number of immigrant children in the sample does not allow stratification by country of origin. Similarly we cannot undertake a more thorough analysis of cultural differences and potential conflicts or interactions between different groups of immigrants and between the country of origin and country of destination, thus preventing us from making recommendations regarding specific minorities. Unfortunately, we also cannot differ between immigrants and returning citizens whose children were born while away from their native country. There is a clear need for specific studies to be conducted to facilitate these more nuanced views to be explored.

Conclusions

Given the absence of general patterns, this study highlights the complexity of the immigration phenomenon. Of all the variables examined, the only consistent finding is the low affluence of immigrant children across countries. This is in itself an important finding, given the widespread influence of socioeconomic factors on the lives of children and families. These findings suggest that there is a need for more focused studies on immigrants, looking at different groups and at country of origin and of residence, but also the need to engage in participatory studies allowing the voice of immigrants to be heard. It is clear that we need to promote tolerance towards diversities in societies and to create mechanisms that allow for better integration of immigrant children in society.

The article also provides insights into issues that could have implications for research, policy and practice. Primarily the

need to use the social determinants of health approach to immigrant child well-being. Two examples are noted:

- Noting that immigrant children are found to be over-represented in less affluent households, it is important that (a) migration policy provide migrant families with equitable access to social protection services, and that (b) social protection policies foster and encourage equitable access to public services and opportunities. Such support and social protection needs to begin in childhood and be provided across the life course.
- Given the complexities of the migration phenomena, international comparison of data on migrant health is challenging and can lead to disparate results. While it is important nevertheless to continue these efforts at international level, it is first and foremost essential to scale up investment in information systems at national and sub-national level that look at health inequities, including by migrant status. Such information can then be taken into consideration in the design of policies and programmes, in the health sector and beyond, with particular usefulness for primary health care level in areas serving migrant communities and other populations that may face higher levels of social exclusion.

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