Social Science & Medicine 152 (2016) 50–60

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

A scoping review of female disadvantage in health care use among very young children of immigrant families

Ariel Pulver [a, b, *], Chantel Ramraj [a], Joel G. Ray [b, c, d], Patricia O'Campo [a, b, c], Marcelo L. Urquia [a, b, c]

[a] Dalla Lana School of Public Health, Department of Epidemiology, University of Toronto, 155 College Street, Toronto, ON M5T 3M7, Canada
[b] Centre for Research on Inner City Health, Li Ka Shing Knowledge Institute, St. Michael's Hospital, 209 Victoria Street, Toronto, ON M5B 1W8, Canada
[c] Institute for Clinical Evaluative Sciences, Sunnybrook Hospital, 2075 Bayview Avenue, Veterans Hill Trail, Toronto, ON M4N 3M5, Canada
[d] Departments of Medicine and Obstetrics and Gynaecology, St Michael's Hospital, University of Toronto, 30 Bond Street, Toronto, ON M5B 1W8, Canada

ARTICLE INFO

Article history:
Received 18 August 2015
Received in revised form
5 December 2015
Accepted 18 January 2016
Available online 19 January 2016

Keywords:
Gender
Children
Immigration
Health inequities
Pediatrics
Ethnicity

ABSTRACT

Preference for sons culminates in higher mortality and inadequate immunizations and health care visits for girls compared to boys in several countries. It is unknown if the negative consequences of son-preference persist among those who immigrate to Western, high-income countries. To review the literature regarding gender inequities in health care use among children of parents who migrate to Western, high-income countries, we completed a scoping literature review using Medline, Embase, PsycINFO and Scopus databases. We identified studies reporting gender-specific health care use by children aged 5 years and younger whose parents had migrated to a Western country. Two independent reviewers conducted data extraction and a quality assessment tool was applied to each included study. We retrieved 1547 titles, of which 103 were reviewed in detail and 12 met our inclusion criteria. Studies originated from the United States and Europe, using cross-sectional or registry-based designs. Five studies examined gender differences in health care use within immigrant groups, and only one study explored the female health disadvantage hypothesis. No consistent gender differences were observed for routine primary care visits however immunizations and prescriptions were elevated for boys. Greater use of acute health services, namely emergency department visits and hospitalizations, was observed for boys over girls in several studies. Studies did not formally complete gender-based analyses or assess for acculturation factors. Health care use among children in immigrant families may differ between boys and girls, but the reasons for why this is so are largely unexplored. Further gender-based research with attention paid to the diversity of immigrant populations may help health care providers identify children with unmet health care needs.

1. Introduction

Gender inequity in health continues to be a deep-rooted worldwide problem. Efforts to reduce sexism over the last century have achieved much success in several Western, high-income countries, while inequities in other world regions continue, including, but not limited to, low and middle-income settings (Inglehart and Norris, 2003). In many societies, having a son is believed to be more beneficial to a family, both financially and socially. Explanations have included a perceived lack of economic utility of daughters, marginalization of females in the workforce, expensive dowry systems in some cultures, and unintended consequences of strict one-child policies (Donato et al., 2003; Ebenstein, 2010; Puri et al., 2011).

1.1. Gender inequity in children's health around the world

Following the introduction of prenatal sex determination through ultrasound access in various regions of India and China, higher male to female ratios at birth have been repeatedly identified (Arnold et al., 2002; Bhalotra and Cochrane, 2010; Ebenstein et al., 2010), most likely due to selectively terminating female fetuses. Male to female birth ratios even increase at higher birth

* Corresponding author. Dalla Lana School of Public Health, Department of Epidemiology, University of Toronto, 155 College Street, Toronto, ON M5T 3M7, Canada.
E-mail address: ariel.pulver@mail.utoronto.ca (A. Pulver).

http://dx.doi.org/10.1016/j.socscimed.2016.01.027
0277-9536/

orders due to mounting pressure to give birth to a boy (Arnold et al., 2002; Barcellos et al., 2012). One study from India found a male to female birth ratio of 1.88 for last born children compared to the country average of 1.07 (Arnold et al., 2002). Other explanations have included the non-reporting of female births, female infanticide occurring the day after birth, and excess unexplained female deaths in the first year of life (Khanna et al., 2003; Sudha and Rajan, 1999).

Differential health investments towards sons and daughters seem to continue through early childhood. For example, girls in India are not breastfed for as long as boys (Barcellos et al., 2012; Jayachandran and Kuziemko, 2009), are less likely to be immunized adequately (Pande, 2003; Pande and Yazbeck, 2003), and receive proper nutrition (Barcellos et al., 2012; Choudhury et al., 2000; Pande, 2003). Moreover, in regions of India and Pakistan, girls are less likely to obtain health care when illness does occur compared to boys of the same age (Hasan and Khanum, 2000; Pandey et al., 2002). A study in Delhi, India demonstrated that female infants were 2 times more likely to die from preventable illnesses (e.g. diarrheal illness) whereas no gender differences were observed for less preventable illness (e.g., congenital anomalies, septicemia, birth asphyxia) (Khanna et al., 2003). Such drastic levels of the subordination of girl children in several countries have created extremely imbalanced population sex ratios including in China (0.94), India (0.93), and Pakistan (0.90) relative to the sex ratios seen in developed countries (1.05) (Sen, 1992, 2003).

1.2. Gender inequity in immigrant children's health

The gender inequalities in infant and early child health care mentioned above occur in many of the top source countries of immigrants to Western, high-income countries (UNICEF, 2009; World Bank, 2012). Recent analyses have revealed higher male to female birth ratios among immigrants from India, South Korea and Pakistan to the United States (US), Canada, and Norway, implying that sex-selective terminations and gender discrimination in parenting decisions endure following immigration (Almond et al., 2009; Puri et al., 2011; Ray et al., 2012; Singh et al., 2010).

Parent held gender-biases are especially important when one considers the presiding role parents hold over their children's health care at very young ages. Gender inequities may indeed continue into infancy and early childhood in Western countries, the extent to which remains largely unexplored. From age 0 to 5, a child's health care use depends virtually solely on the decisions of their caregivers. Doctor visits, vaccinations, or the decision to go to the emergency department rely on parents' actions for the benefit of their child. If the parental-held gender biases affecting very young girls' health care persists following migration to immigrant receiving, Western countries from immigrant sending countries, we hypothesize that female children in such families would be at a disadvantage compared to their male counterparts.

The health of children in immigrant families is a growing priority for health care providers and policy-makers (Mendoza and Festa, 2013; Canadian Pediatric Society, 2012; Takanishi, 2004). There have been calls for research on the health of immigrant children that focus on the child's social context and social position, including the child's gender (Takanishi, 2004). It is important to understand how girls' health care experience may differ from boys in both immigrant sending and immigrant receiving setting (Bharadwaj et al., 2014). Therefore, the objective of this study was to review the literature regarding gender inequities in health care use among very young children, 0–5 years in immigrant families in Western high-income countries.

1.3. Theoretical framework

This research paper follows a gender-based analytic approach. Gender-based analysis helps to recognize and clarify the differences between males and females. It enables us to uncover inequities in health and interactions with health care systems (Health Canada, 2003; Clow et al., 2009). Gender-based analytic approaches are critical in advancing our understanding of how social factors including race, ethnicity, and immigration status intersect with gender to shape health (Greyson et al., 2010). The reporting of outcomes by gender is central to gender-based analysis. It is important to collect up to date information on what is known about gender differences in the field of study through systematic searches of the literature and highlight the gender differences in the determinants of the given health issue (Moerman and van Mens-Verhulst, 2004). In this review, we therefore aimed to map the literature of gender-specific reporting of health care outcomes for very young children in immigrant families to identify 1) patterns of health care service use for immigrant boys and girls, 2) the use of gender-based analysis in immigrant children's health care research, and 3) gaps and challenges in researching health care inequities for immigrant children.

2. Methods

We conducted a scoping literature review of studies from Western high-income countries describing gender differences in the health care use of very young children, 0–5 years, in immigrant families. Arksey and O'Malley's methodological framework for conducting scoping reviews (Arksey and O'Malley, 2005), and relevant items from the MOOSE reporting guidelines for systematic reviews of observational studies guided our methodology (Stroup et al., 2000). Common reasons for undertaking scoping reviews include summarizing and disseminating research findings and identifying research gaps in the existing literature (Arksey and O'Malley, 2005). Rather than being guided by a strict research question with narrow inclusion and exclusion criteria such as is the case for a systematic review, the purpose of this scoping review was to identify all relevant literature, utilizing wide definitions of terms to ensure broad coverage.

3. Search strategy

3.1. Peer reviewed electronic sources

This review was conducted through systematic searches of electronic library databases including Medline, Embase, and PsycINFO. The electronic search was limited to sources published from 1980 to November 2014 and those published in English. The search strategy was developed in collaboration between author AP and a medical librarian.

Three central concepts were used in combination and guided the search:

3.1.1. Immigration

MeSH terms included: “Emigrants and Immigrants”, “Emigration and Immigration”, “Refugees” and “Transients and Migrants”; keywords included “immigra*”, “refugee*”, “newcomer*”.

3.1.2. Children

MeSH terms included: “Infant”, “Infant, Newborn”, “Child”, “Pediatrics”, “Child, Preschool”; keywords included: “infan*”, “child”, “neonat*”, “newborn*”, “pediatric*”, “paediatric*”.