Forced Migration, Fertility and Reproductive Health: A Review

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Abstract

The paper reviews research on forced migration and fertility, identifies problems and challenges in this research and present suggestions for future research avenues and priorities. It starts with a critical examination of the definitional ambiguities that hamper and constrain research on forced migration and fertility, then outlines the current state of the field, and offers suggestions on how the field could be advanced by critically incorporating theoretical paradigms and models applied in studies of the association between voluntary migration and childbearing and accounting for both the changing nature of forced migration and the changing global fertility landscape. It concludes with a discussion of possible directions for research in the area of forced migrants’ reproductive health.
Defining the field of study
As in other aspects of the demography of forced migration, definitional ambiguities complicate research on fertility and reproductive health. The most common of these definitional challenges is to clearly distinguish between forced migration and voluntary migration. In fact, both types of migration can be thought of as part of a spectrum rather than a dichotomy; whereas differentiating the two extremes of that spectrum is relatively straightforward, the differences become increasingly blurred toward the spectrum’s middle. Thus, it can be argued that any migrant is at least to some extent “forced” into migration by his or her economic and social circumstances or those of their households. The sudden and often violent circumstances of exit, which typically characterize exit from areas of overt ethnic or political conflict or of natural disasters, may not be present to the same degree in migratory moves resulting from simmering, low-intensity guerilla-type warfare or socio-political and ethno-religious tensions. True, voluntary migration typically involves some planning and preparation, but even so most migrants-to-be are faced with considerable uncertainties and their knowledge about the destination settings is often incomplete and inaccurate.

These definitional challenges are further complicated by an often arbitrary attribution of the refugee status or internally displaced person (IDP) status by international agencies as well as by national and local agencies in the receiving settings. It is not uncommon that this formal recognition is granted only to a small part of migrants who are forced to abandon their permanent places of residence due to conflict of disaster, while leaving many members of these same communities who migrate for largely the same reasons and often to the same destinations outside the purview of refugee-focused activities and resources. The system of refugee and IDP camps, while greatly facilitating the management and protection of camp residents, further reifies the exclusion of those who by choice or by fluke find themselves outside the camps’ wall.

The current state of knowledge
There is a considerable cross-national literature that humanitarian crises produced by war or natural disasters, affect fertility behavior (e.g., Agadjanian and Prata 2002; Khlat et al., 1997; Lindstrom and Berhanu 1999; Winter 1992). However, within that literature, studies focused specifically on crisis-triggered forced migration and fertility are relatively few. As in other aspects of the demography of forced migration, analyses of forced migrants’ fertility and reproductive health are greatly constrained by the availability of adequate data. Because assessments of fertility and reproductive health of forced migrants are often commissioned by the agencies work with forced migrants’ needs, such assessments focus uniquely on forced migrant groups and rarely involve comparisons with non-migrants and voluntary migrants (e.g., Hynes et al., 2002; Okalawon 2010; Von Roenne et al., 2010). Moreover, many of these assessments typically deal with the time of crisis and flight and of their immediate aftermath; the economic and health conditions prevailing in communities before the onset of the crisis and the forced exit that this crisis triggers, are rarely considered even though some evidence points that post-flight fertility is strongly influenced by pre-flight nutritional status and related health characteristics (e.g., Holck and Cates 1982).

The forced migration cycle typically involves a relatively short stage of flight, a stage of varied length spent in refugee camps or other temporary safe havens, and a stage of repatriation or resettlement; the effect of forced migration on fertility may vary across these different stages
as well as within the second and third stages if they is sufficiently long. In his review of the evidence on the effects of humanitarian crises, which typically involve forced population dislocations, on fertility Hill (2004) distinguished among short-, medium-, and long-term effects and related these effects to different proximate determinant mechanisms. He concluded that fertility among forced migrants often declines in the immediate aftermath of the crisis and related dislocations. However, his review did not find support for increased involuntary fetal loss during forced migrants’ flight to safety, and he attributed the decline mainly to spousal separation and stress that reduce coital frequency and consequently the probability of conception. Yet, even if fertility registers a decline in the immediate aftermath of the crisis and flight, it usually rebounds to pre-crisis level in the post-emergency stage so that lifetime fertility of forced migrants is typically comparable to that of the rest of the population (Hill 2004).

Due to the above mentioned data limitations, few studies have systematically examined the effects of forced migration on fertility while also drawing comparisons with fertility and other reproductive health outcomes among forced migrants with those among non-migrants and voluntary migrants of similar backgrounds and looking at the trends over time. Several such attempts are worthy of note. Thus Randall (2004) examined fertility of Tamasheq (Tuareg) repatriated refugees in Mali. Despite minor fluctuations in fertility at the time of flight, which were mainly due to temporary changes in nuptiality, the group’s fertility indicators barely changed throughout a prolonged period of residence in refugee camps. However, fertility again dropped slightly and reproductive health indicators worsened after repatriation. A study by Avogo and Agadjanian (2008) used retrospective fertility histories collected through a survey in Angola’s capital Luanda to reconstruct and compare fertility dynamics among forced migrants (i.e., those who left their places of origin primarily because of war), voluntary migrants (those who left for war-unrelated reasons), and non-migrants (Luanda natives). They found that war migrants had higher yearly probabilities of birth that either non-war migrants or urban natives, illustrating the more selective nature of war-unrelated migration. At the same time, the authors also detected evidence of adaptation to the urban environment among both war-related and war-unrelated migrants manifested in declining probabilities of birth after arrival in the city; yet such adaptation proceeded more quickly among non-war migrants than among war migrants. Verwimp and Van Bavel (2005) compared lifetime fertility of former refugee and non-refugee women in Rwanda and found it to be higher among refugees. The authors explained this difference through the difference in child survival between the two groups: the higher fertility of former refugees was compensatory to a higher probability of child death in that group. Such comparative studies are generally more informative than those focused uniquely on forced migrants. However, they also have limitations, especially in their reliance on retrospective data that are fraught with inaccuracies and omissions, and in their constrained choice of comparison groups.

Moving the field forward

Applying general theories on migration and fertility to forced migration cases

The general models for the analysis of the association between migration and fertility can usefully inform research on the effects of forced migration on fertility, but they need to be tailored to the specific characteristics and circumstances of forced migrants. These models typically entertain the mechanisms of selection, disruption, and adaptation, which are said to affect both the distal and proximate determinants of fertility. The selection argument posits that
migrants tend to be self-selected on individual characteristics, such as age, gender, health, marital status, education, and occupation, which set them apart from the rest of the population in the origin area and make them more similar to people in the destination areas or at least more receptive to demographic (including fertility) preferences and behaviors prevalent there. For example, migrants may have higher than average educational level and other socioeconomic characteristics that are conducive to lower fertility (e.g., Chattopadhayay, White, and Debpuur 2006; Farber and Lee 1984; Kahn 1988; Zarate and Unger de Zarate 1975). Thus selection may be manifested in the tendency to postpone the onset of childbearing and to have a lower ideal/desired family size, and more generally, in greater openness to change, flexible aspirations and access to information about family and fertility norms in destination areas (Ribe and Schultz 1980). Although, forced migration is unquestionably less selective than voluntary migration, the selection mechanisms, may still be at play in most situations, except for extreme cases of unanticipated, sudden, and violent exit.

While the selection argument may be least applicable to the analysis of forced migrants’ fertility behavior, the disruption perspective, on the contrary, seems to fit their experience perfectly. In the general literature on migration and fertility, migration is thought to disrupt migrants’ life through spousal separation, and where no such separation takes place (e.g., family migration) through deliberate postponement of childbearing in the time preceding and following the move. The fertility of migrants is therefore expected to be lower than that of non-migrants, although the disruptive effect of migration is thought to be of short duration, unless it is perpetuated through continuous spousal separation (Goldstein 1973; Goldstein and Goldstein 1981; Hervitz 1985; Jensen and Ahlburn 2004; Kulu 2005; Lindstrom and Saucedo 2002). It is important to note, however, that in the case of voluntary migration, the disruption of life is typically anticipated and even planned for; in fact, in settings where migration is common, the disruption associated with it is normative and is built into the fertility regime (Agadjanian, Yabiku, and Cau, 2011). The unanticipated and violent nature of the disruption of normality caused by forced migration sets it apart from voluntary types of migration. The disruptive effects of forced migration on fertility therefore operate primarily through disruption of coital activity because of partners’ separation, or mental and physical stress resulting from the flight, as well as, possibly, from elevated risks of fetal loss (although evidence on such elevated risks is inconsistent). Importantly, however, as was pointed out earlier, the conditions that may adversely affect fertility may form and accumulate prior to the flight (e.g., Holck and Cates 1982). These conditions may linger in the post-flight circumstances as well. Deliberate postponement of fertility at that stage is also quite plausible and may, in fact, last longer than among voluntary migrants due to continuing hardship and uncertainty about the future. Yet, one can also argue that because such a disruption was not planned, forced migrant couples may be less prepared than voluntary migrants for controlling their post-migration childbearing and therefore more exposure to the risk of unwanted pregnancy. Likewise, fetal or child loss during the flight may trigger compensatory desires among forced migrants.

The third mechanism through which migrants’ fertility may change is adaptation to the fertility regimes in areas of migration destination. Migrant streams are usually directed from rural to toward urban areas, where fertility levels are lower and fertility regulation is more widespread than in typically less urbanized origin communities. The new environment presents migrants with new opportunities such as education and labor force participation, which raise the costs of childbearing, and offer them better access to family planning. As a result, migrants’
reproductive behavior increasingly aligns with that of urban natives and migrant long-term fertility is lower than that of non-migrants in origin communities (e.g., Lee and Pol 1993). Adaptation mechanisms are likely to be at work among forced migrants as well, especially as their experiences in places of destination grow similar to those of voluntary migrants. However, several factors may delay or even derail the adaptation process. First, forced migrants’ socioeconomic exclusion may be more pervasive than that of voluntary migrants. Their socioeconomic exclusion may be further reinforced by their spatial insulation in camps or other designated areas, which hampers their interactions with local residents and the reproductive information and services available to them. Both socioeconomic exclusion and spatial separation can heighten the sense of temporariness of current status and circumstances among forced migrants thus discouraging them from adjusting their reproductive aspirations and preferences. In extreme cases, prolonged spatial, social, and political insulation may work to encourage and sustain high fertility in refugee camps despite gloomy economic conditions that otherwise would be expected to depress fertility. High fertility in Palestinian refugee camps (Fargues 2000) is a frequently cited example of this apparent anomaly.

It is important to note that although the three perspectives on the association between migration and fertility can usefully inform the analysis of reproductive implications of forced migration as well, the three perspectives are not mutually exclusive and therefore should be entertained simultaneously in conceptualizing and analyzing the effects of forced migration on childbearing.

Responding to changing nature of forced migration

Whereas political violence that occasionally erupts in different parts of the world and, increasingly, environmental catastrophes continue to push people to seek refuge outside their communities, the composition and direction of forced migration flows become increasingly diversified. This diversification further blurs the boundaries between forced and voluntary migration. Instant communication technologies, increasingly available even in most remote and impoverished parts of the world, help spread information about impending threats and allow time for individuals and households to prepare their responses, including the responses that involve moving. Such responses are increasingly part of family strategies: the decisions on which family members should leave and where they should head are increasingly made on the basis of perceived threats to individual family members and benefits of them migrating or staying for the family interests. And even though forced migratory moves often remain sudden and traumatic, forced migrants are no just fleeing from but also fleeing to. Family material and social resources increasingly guide the trajectories and destinations of forced migrants: thus an Uzbek woman, who flees anti-Uzbek pogroms in Kyrgyzstan, ends up not among her co-ethnics in neighboring Uzbekistan but in faraway Russia’s capital Moscow, where her husband has been working as a seasonal migrant for several years.

The diversification of forced migrants’ destinations also means that they may increasingly find themselves in contexts that are legally, socioeconomically and culturally very dissimilar from those where they originated. Legal regimes of the receiving context crucially shape forced migrants’ opportunities, including their access to reproductive and sexual health care: more liberal and inclusive rules help improve this access while more restrictive and exclusionary policies produce an opposite effect. The structure and size of employment niches available to forced migrants are critical for their incorporation in the host society as is their cultural
(dis)similarity to (from) the host population also critically affect also matters. Common or similar language, religion or other aspects of culture may reduce anti-migrant stigma and facilitate their incorporation in the host society and access to reproductive health information and services. On the contrary, wide cultural gaps may slow down this process. A particularly important sociocultural aspect of a receiving context is the system of gender norms and relations that predominates there. Specifically, settings with more egalitarian gender systems where women’s opportunities autonomy are greater may be conducive to migrant women’s better access to reproductive care, including access to contraceptive and abortion services, which in turn may affect their ability to regulate fertility. More gender egalitarian settings, by offering women greater employment and educational opportunities may also discourage continuing childbearing within marriage or lead to postponement of marriage and onset of childbearing. These increasingly complex dynamics of legal, economic, and cultural, incorporation must be taken into account in the analyses of forced migrants’ reproductive preferences and behavior.

Importantly, modern media and communication technologies play a growing role in the processes of legal, economic, and sociocultural inclusion; the once impenetrable walls of refugee camps and migrant neighborhoods become increasingly porous allowing for ever greater contact of forced migrants with the outside world. Yet, at the same time, these technologies also facilitate migrants’ connections with their communities of origins. Projected onto matters of childbearing, the spread of modern means of communication may therefore both catalyze the adoption of reproductive tastes and practices of the surrounding host society and help retain the traditional fertility preferences and behavior of the place of origin.

Accounting for secular changes in marital and reproductive landscapes
The geographic dispersion of forced migrants poses new challenges for a systematic study of their reproductive behavior and outcomes. Another important challenge stems from the changes in migrants’ reproductive contexts. Most forced migration in the twentieth century involved developing countries with universal and early marriage and high fertility, and even today a large share of forced migrants originate from areas and communities with such characteristics. However, more recent cases of forced migration have involved settings characterized by postponement of and retreat from marriage and declining or low fertility. For example, massive population displacements following the disintegration of Yugoslavia and the Soviet Union have involved populations with already replacement- and below replacement-level fertility. The fertility-disrupting effects of forced migration on fertility in such populations may be muted compared to pre-transitional populations. Moreover, while forced migration in the past often brought refugees and internally displaced persons from higher fertility settings to lower fertility settings, increasingly forced migrants originate from lower-fertility countries or communities and head to settings where fertility is equally lower. As the fertility transition takes hold throughout the developing world, the share of forced migrants who leave low-fertility settings and come also to low-fertility settings will probably further increase. In such cases, while forced migration is likely to cause postponement of marital union formation or postponement of birth within union, it is even less likely than in higher-fertility settings to have a discernible dampening effect on lifetime fertility. In fact, as voluntary migration increasingly shows, migrants’ fertility in places of destination, where both economic opportunities and reproductive health care are typically better than in places of origin, may exceed the levels among their counterparts left behind (e.g., the case of Mexican immigrants in the U.S). It is therefore plausible to expect increases in
fertility among forced migrants in settings of arrival or resettlement not only above the levels predominant in those settings but also above the levels experienced prior to displacement.

Reproductive health: Forced migration and the healthy migrant hypothesis
The assessments of refugee and IDPs’ reproductive health typically paint a dire picture of disadvantage (e.g., Kottegoda, Samuel, and Emmanuel 2008; Okalawon 2010; Von Roenne et al. 2010). Indeed, the hardships immediately before and during forced migrants’ flight may work to worsen their general health and their perinatal and reproductive health outcomes in particular. However, as forced migration becomes increasingly self-selective, these outcomes may improve shortly after migrants find themselves in safe havens. The healthy migrant hypothesis, which posits that migrants, especially those recently arrived, tend to have better health outcomes than non-migrants (especially disadvantaged minorities) due to both positive selection on health and resilience into migration and lack of exposure to health detrimental behavioral and nutritional practices in the host country (Markides and Coreil 1986; Marmot, Adelstein, and Bulusu 1984), may have some relevance to the study of forced migrants’ reproductive health trajectories.

It has been observed that voluntary migrants’ health indicators, including reproductive health outcomes, worsen with increased duration since migration (Ceballos and Palloni 2010; Hawkins et al. 2008; Urquia et al. 2010). A similar trend may be expected among forced migrants. Forced migrants’ socioeconomic disadvantage and social isolation may attenuate and even erase whatever selective health advantage that forced migrants may possess at the time of arrival, even if they are provided access to reproductive health services by host governments and international agencies. Yet, one can also argue that the relative isolation of forced migrants may also help shield them from behavioral and nutritional practices that may be detrimental to their health in general and their reproductive health outcomes in particular.

Finally, as is the case of voluntary migrants (Urquia et al. 2012), duration-dependent differences between forced migrants and their counterparts without an experience of forced migration, may manifest themselves in some reproductive outcomes but not others. Research on forced migrants’ reproductive health should therefore distinguish among specific outcomes, such as morbidity during pregnancy, preterm birth, low birth weight and infant mortality, post-partum depression, etc.) in examining the complex effects of migrants’ economic and social, cultural, and institutional incorporation in the host society.
References