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Forced migration in childhood: Are there long-term health effects?

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ABSTRACT

Studies on the health of migrants have increased considerably in number in recent years, but little is still known about the long-term health effects associated with forced migration, and particularly for people who were forced to migrate as children. Data shortcomings together with the methodological challenges of studying migrant populations limit the ability to disentangle the roles of various factors that influence migrant health outcomes. Finland provides an unusual opportunity to study long-term health consequences associated with forced migration. During World War II, twelve per cent of the Finnish population was forced to leave the region nowadays referred to as Ceded Karelia. After the war, these Karelians could not return home because the area was relinquished to the Soviet Union. Using high quality, linked register-based data for the period 1988–2012, we investigate whether this forced migration had long-term health consequences for those who were forced to migrate as children. Comparison groups are non-displaced persons born on the adjacent side of the new border, and people born elsewhere in Finland. Health at ages 43–65 years is measured by receipt of sickness benefit, which is an indicator of short-term illness, and receipt of disability pension, which reflects long-term illness or permanent disability. All-cause and cause-specific mortality is analysed at ages 43–84 years. We find no support for the hypothesis that the traumatic event of being forced to migrate during childhood has long-term negative health consequences. The forced child migrants have lower odds for receipt of sickness benefit, and women also have lower odds for receipt of disability pension. The mortality results are largely driven by patterns specific for eastern-born populations of Finland. A likely reason behind the absence of negative health consequences is that these migrants seem to have integrated well into post-war Finnish society.

1. Introduction

Population mobility is one of the leading policy issues of the 21st century. An estimated one billion persons are on the move either internally or internationally (UNDP, 2009). About one fifth of the world's population today, or more than 1.5 billion people, live in countries affected by conflict. Political instability has a large human cost. By the end of 2012, about 45 million people were displaced due to conflict or persecution, and more than 15 million of them were refugees (UNDP, 2014). Since then the numbers have grown. In 2014, more than 800,000 asylum applications were recorded, whereof more than 600,000 in Europe (OECD, 2015). In 2015, the number of irregular entries into the European Union was over one million (BBC, 2016). Thus the OECD countries face an unprecedented refugee crisis.

There is an extensive body of research on the health of immigrants in a variety of countries, but a dearth of quantitative studies on the subject of the health of forced child migrants. Most of these studies are concerned with populations who originate in severe conflict zones in

developing countries. The typical outcome studied is under-five mortality, or other aspects related to health below age five, such as child immunizations (Kristensen, Aaby, & Jensen, 2000; Senessie, Gage, & Von Elm, 2007). Studies of the immediate effects of forced migration demonstrate a mortality disadvantage for children of displaced populations compared to the children of the host population (Guha-Sapir and Gijsbert, 2004; O'Hare and Southhall, 2007). Research concerned with longer-term consequences are less conclusive (Avogo and Agadjanian, 2010; Verwimp and Van Bavel, 2005). Migration itself may pose significant hazards with psycho-social impacts (Hicks, Lalonde, & Pepler, 1993; James, 1997), but it may also increase access to health care and improved environmental conditions (McKenzie, Gibson, & Stillman, 2009; Popkin and Udry, 1998).

To the best of our knowledge, there are no follow-up studies that extend to adulthood in which forced child migrants are observed with respect to health several decades after the move, and for a context outside less developed world regions. Finland provides an unusual

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opportunity to undertake such analyses, and to overcome some of the problems commonly related to the study of the interrelations between migration and later life health outcomes. During World War II, twelve per cent of the country's population was forced to leave the region that is nowadays referred to as Ceded Karelia when it was occupied by the Soviet Union. After the war, these Karelians could not return home because Finland relinquished this region to the Soviet Union. These forced migrants, who primarily were farmers, were relocated elsewhere in Finland and had to prepare for permanent existence in new surroundings. The Finnish population register makes it possible to undertake longitudinal analyses of the health of these migrants several decades after they were forced to move. These data are of high quality with no loss to follow-up, and they avoid methodological challenges present in many data sources.

Migration can in many respects be conceptualised as a process of change (Hertz, 1993). Learning to cope with numerous hardships and anxieties created by settling into a new environment can create psychological distress with long-term consequences also for physical health and mortality. Migration is often viewed as a U-shaped process, in which the migrant's initial elation on arriving in the new society is replaced by feelings of distress and dissatisfaction when difficulties are encountered, while these feelings gradually fade when the person adapts to the new environment (Ritsner and Ponizovsky, 1999). Despite a large body of literature, it is not clear what course distress will take and how long a distress period will last. In this paper, we are particularly concerned with the issue of whether there are any health consequences of forced migration in the very long term.

There is only one previous large-scale study of the long-term health consequences of the forced Finnish migrants (Saarela and Finnäs, 2009a). It analysed mortality at ages 55–79 years of people who were forced to migrate at any age between 0–50 years. Apart from a peak in male mortality around the collapse of the Soviet Union, interpreted as induced by stress, no other mortality differences between migrants and non-migrants were found, and there were no differences by migration status among women. Here, we focus on the children who were forced to migrate, which they did together with their parents at ages 0–17 years, and compare their health and mortality at ages 43–84 years to those of individuals who were born in other parts of Finland, and particularly to those born on the Finnish side of the new border.

The impact of forced migration on those who migrated as children might differ from that of their parents. The children have not been in combat or participated in war-related civilian activities. Also, the early life experiences of child migrants differ from those of their parents in that they have been exposed to the environment in the new destination from a young age. Acculturation to the habits of new surroundings can be assumed particularly strong for the child migrants, although these experiences might differ depending of the specific age at which they migrated. It needs to be emphasised as well that the child migrants grew up under highly similar environmental, economic and social circumstances as the non-displaced children. Thus it is plausible that the child migrants have similar health profiles later in life as people in the comparison group born on the adjacent side of the new border in eastern Finland. If the move was a highly critical life event, however, we would expect to observe worse health and higher mortality later in life of the forced child migrants. The overall aim with this paper is to investigate whether this might be the case.

2. The association between migration and health

The event of migration is known to be associated with stress and processes that may influence health, such as increased stress levels, disrupted social ties, diminished social support and social isolation (Deri, 2005; Jasso, Massey, Rosenzweig, & Smith, 2004). Conventional theory on migrants' adaption to stress suggests that moving imposes stress on the individual because it disturbs the equilibrium between the migrant and the environment (Ben-Sira,

1997). This compels the migrant to readjust, which may negatively affect health and raise subsequent mortality. Although these negative health consequences of migration are likely to become weaker over time (Cornia, 2000), a fundamental issue is whether they are discernible in the longer term.

One of the main challenges in identifying the impact of migration on health lies in the fact that the event of migration itself is likely to be correlated with unobserved characteristics of the migrants, such as biological endowments, personality traits, and random health shocks (Stillman, Gibson, & McKenzie, 2012). Furthermore, migrants often differ from the native population with regard to socioeconomic status, exposure to discrimination that stems from xenophobia or racism, and they may experience poorer working conditions if sorted into more dangerous and strenuous occupations (Orrenius and Zavodny, 2009). In addition, health profiles and epidemiological regimes may differ between origin and destination areas (Cunningham, Ruben, & Narayan, 2008; Rivera et al., 2002).

Numerous studies, particularly those from the United States, nevertheless document better health among most immigrant sub-groups than among native-born residents as measured by various indicators such as mortality, morbidity, or self-rated health (Elo, Mehta, & Huang, 2011; Elo, Vang, & Culhane, 2014). These migrant health advantages have been attributed to selective migration, referring to the fact that migration, and long-distance migration in particular, is dominated by people whose health is better than that of the origin country population (Lu and Qin, 2014; Riosmena, Wong, & Palloni, 2013; Wallace and Kulu, 2014). This positive health selection can be reinforced by host country screening of prospective immigrants (Chiswick, Lee, & Miller, 2008; Gushulak, 2007). Whether children of migrants who move with their parents are subject to same selection mechanisms as their parents is less well known. In the case of the present study, selective migration is unlikely to play a role, because all families were forced to move. Similarly, selective return migration, which postulates that unhealthy migrants or migrants who experience deteriorating health have a greater tendency to return to their origin communities than healthier migrants (Abraído-Lanza, Armbrister, Flórez, & Aguirre, 2006; Andersson and Drefahl, 2016), is absent in our case study. None of the families who were forced to migrate could return to Ceded Karelia after World War II.

Sociocultural protective factors, such as close family ties, have been hypothesized to enable migrants to cope with stress and promote better health-related behaviours, e.g., good dietary habits (Landale, Oropesa, & Gorman, 2000). At the same time, most studies document that the health of immigrants often decline with time spent in the host country, and the health status may converge or even fall below that of the native born. The acculturation is consequently a temporal process by which individuals adopt the behaviours and attitudes of the host society. The adoption can be associated with both negative health behaviours, such as uptake of drinking and smoking, and reduced physical activity, and positive health behaviours, such as increased use of preventive health services (Anson, 2004; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005). If the immigrant group remains culturally distinct, the importance of sociocultural protective factors may remain important over time (Franzini, Ribble, & Keddie, 2001). In our study, the forced migrants were culturally similar to the Finnish population prior to their move, especially to those who were living on the Finnish side of the new border in Eastern Finland. Thus, cultural differences are unlikely to play a substantial role in the present study.

Due to potential reporting differences by nativity status, data artifacts have also been cited as potential source of bias in comparing health status of the foreign-born and the native-born populations based on survey data (Riosmena et al., 2013). Loss to follow-up in prospective mortality studies and in longitudinal studies more generally can lead to biased estimates when the foreign born return to their country of origin (Abraído-Lanza, Dohrenwend, Ng-Mak, & Blake-Turner, 1999; Constant, García-Muñoz, Neuman, & Neuman, 2015; Turra and Elo,

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