

The Impact of Men's
Labor Migration on the Sexual and Reproductive Health
Of Their Left-behind Wives in Tajikistan

by

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ABSTRACT

The aim of the study is to examine the impact of international male labor migration on the sexual and reproductive health of women who stay back home in Tajikistan. The data for this study was gathered as a result of ethnographic field works conducted on several occasions from 2011 to 2013.

The results of the study suggest that male migration does not have an impact on fertility levels of the left-behind women. Although similarly to previous studies this study shows that wives of migrants are less likely to use contraception, it nevertheless demonstrates changes in contraceptive behaviors of wives of migrants such as seasonal removal and insertion of an intrauterine device (IUD) and shift from long-term to short-term contraception use. However, despite the availability of numerous forms of contraception in the country, the pattern of contraceptive use such as the reliance on IUDs dominant during the Soviet period continues to exist among wives of non-migrants. One of the most important findings of this study is women's ability to use condoms for a short term with husbands after their return and asking spouses to have an HIV test. This finding challenges the dominant discourses in HIV and migration literature focusing on the inability, impossibility and failure on the part of the wives to negotiate HIV prevention due to various factors impeding the promotion of HIV prevention skills and measures among women.

Moreover, the study demonstrates that, on the one hand, male migration worsens reproductive health of the left-behind women, but, on the other hand, it improves/increases their access to reproductive health institutions thanks to remittances. Although self-reported symptoms of women show a slight difference in reproductive morbidity, including STIs of wives of migrants and non-migrants, health care providers believe that this difference is

significant and wives of migrants are more likely to have complications during pregnancy, delivery and post-delivery periods.

The study also shows that the majority of HIV prevention and family planning programs target only wives of migrants and non-migrants, however it is crucial that migrant men should also be targets of these programs.

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ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
CIS	Commonwealth of Independent States
DFID	United Kingdom Department for International Development
DHS	Demographic and Health Survey
DVC	Dermato-venereal Disease Center
EU	European Union
FC	Friendly Cabinets
GBAO	Gorno Badakhshan Autonomous Oblast
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
IOM	International Organization for Migration
IUD	Intrauterine Device
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MLSP	Ministry of Labor and Social Protection
NGO	Nongovernmental organization
Ob/Gyn	Obstetrician-Gynecologist
PHC	Primary Health Care
RT	Republic of Tajikistan
STI	Sexually transmitted infection

SU	Soviet Union
TB	Tuberculosis
TFR	Total Fertility Rate
TLSMS	Tajikistan Living Standards Measurement Survey
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USSR	Union of Soviet Socialist Republics
WB	World Bank
WHO	World Health Organization

INTRODUCTION

This study aims to understand how male labor migration influences the sexual and reproductive health of the wives who stay behind in the sending communities in Tajikistan. Narratives of Tajik women who stay behind while their migrant husbands leave to work in Russia will help to produce valuable accounts of their unique sexual and reproductive health experiences, and how they deal with health issues in a transitional country with dramatic changes in political, social and economic areas.

In order to understand the impact of migration of men on the sexual and reproductive health of the left-behind spouses, I first provide information about historical, physical and social background of the country which will help to understand current problems of its health system¹ and poor reproductive health status in Tajikistan. Next I explore some of the key issues that this study examines and explain the significance of the study in terms of its focus on migration, its impact on women, its influence on access of left-behind women to reproductive health care, family planning, and protection skills from Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS). I conclude

¹According to the World Health Organization (WHO) “health system” includes all the organizations, institutions and resources that have the aim to improve health. In order to operate and provide people with responsive and economically fair services based on decent treatment, a health system requires staff, finances, information, supplies, communications and general management and direction (WHO, 2005). A good operation of health system provides a balanced response to needs and expectations of people in the following ways: 1) improves health status of individuals, families and communities; 2) protects people from factors that threaten their health; 3) defends population from economic impact of ill-health; 4) provides people with access to people-centered care; and 5) ensures participation of population in decision makings that impact their health and the functioning of the health system (WHO, 2010).

the introduction by describing the organization of the dissertation and summarizing the main findings of each chapter.

Migration and health

Migration has always been one of the most important ways for people to search for better opportunities and peaceful lives (ILO, 2012). There are different reasons/causes behind migration. Among these the most common are: political instability, government resettlement policies, discrimination, and economic factors or unemployment. Labor migration makes up the biggest part of all migration processes in the world. Economic theorists as well as practitioners even label labor migration as one of the forms of investment in the economic growth of developing and poor countries. It is, therefore, not surprising that most labor migrants come from the developing world. In particular, the remittances of labor migrants and their skills are considered the ‘magic bullet’ for development in their home countries. The International Organization for Migration (IOM) defines **labor migration** as a ‘movement of persons from one State to another, or within their own country of residence, for the purpose of employment’ (ILO, 2012, p. 3).

Migration and population mobility has become a permanent facet of a rapidly globalizing world, and the Asia-Pacific region is no exception (Marin, 2013). Labor migration has become “a way of life” (Dladla, Hiner, Qwana, & Lurie, 2001, p. 79) for a large number of young men in Tajikistan. Previous studies showed that the majority of Tajik migrants are men and from rural areas (IOM, 2010; Olimova & Bosk, 2003). The IOM survey of 2010 shows that men constitute 88% and women only 12% of migrants in the country (IOM, 2010). There are Tajik families where the wife is a labor migrant or both spouses are migrants and leave their children behind, but in the majority of cases, it is usually

men who are migrants. The situation in Tajikistan is similar to other post-Soviet countries such as Uzbekistan and Kyrgyzstan and in contrast with some Asian countries such as the Philippines, Sri Lanka and Indonesia, where female migrant workers outnumber male migrants. Structural poverty, unemployment, and low wages, which are insufficient to maintain a family, force young men to leave families and communities to join a large and increasing number of migrants to work abroad and support families back home.

For many Tajik families international male migration to Russia, which is a main pattern of migration in the country, is the only survival strategy to fight poverty (Olimova & Bosk, 2003). However, despite improving family lives and decreasing poverty of households, migration is one of many social factors that have contributed to the AIDS epidemic (Lurie et al., 2003a; Lurie, 2006). Migration of men is also related to social disruption, breakdown of partnerships and families, conflicts, increased high-risk sexual behavior, increased numbers of sex partners and higher risk of infections throughout the world (Coffee et al., 2005; Coffee, Lurie, & Garnett, 2007; Hughes, Hoyo, & Puoane, 2006; Hunt, 1989). Mobile people or those who recently changed their place of residence are considered to be at higher risk for sexually transmitted infections (STIs) including HIV in comparison with people with more stable residence arrangements (Lurie et al., 2003a; Lurie, 2006). However, it is important to point out that it is not the migration itself but the structure and circumstances of the migration process that place mobile individuals at risk of STIs, including HIV infection (Lurie et al., 2003a; Lurie, 2006).

While male migration with its disruptive impact and marital separation contribute to vulnerability, the social situations associated with male migration pose a further risk (Coffee et al., 2005; Hughes et al., 2006; Lurie et al., 2003b). Often men separated from their families and permanent sex partners may engage in sex with commercial sex workers (CSWs) without

using condoms, and alcohol consumption and drug abuse that can expose them to STIs (Hong, Qin, Li, Ji, & Ye, 2009; Hunt, 1989; Liu et al., 2005). Migrant workers often serve as a “bridge population” who can then transmit HIV infection from high-risk groups such as CSWs to the general population (Liu et al., 2005). Studies agree that migrant men while away from their female spouses or sexual partners are more likely to have additional sex partners and become infected with STIs including HIV (Collinson, Wolff, Tollman, & Kahn, 2006; Lurie et al., 2003a; Lurie, 2006; Zuma et al., 2005). Some migrants not only have casual sexual partners but also create “parallel families” in the destination (Zuma et al., 2005). Exposure of labor migrants to HIV results in transmitting the infection to their female partners when they come back from migration (Lurie et al., 2003a; Lurie, 2006; Coffee et al., 2005, 2007; Hunt, 1989; Mundandi, Vissers, Voeten, Habbema & Gregson, 2006; Zuma et al., 2005).

Several studies examined the reasons behind involvement of migrant men in risky behaviors and found that living in a state of insecurity, isolation and depression without family contributed to such behaviors (Hunt, 1989). Removal of social control then further exacerbates the risks (Brockerhoff & Biddlecom, 1999). It has also been noted that emotional uncertainty as a result of exposure to urban settings can result in finding short-term solutions to migrants problems in the form of engaging in multiple and possible high-risk sexual contacts (Collinson et al., 2006). In addition, an increase of economic resources of migrant workers is also associated with an increase of high-risk sexual behaviors and higher rates of STIs among them (Liu et al., 2005; Sevoyan & Agadjanian, 2010). At the same time, low use of condoms among migrant workers (Brockerhoff & Biddlecom, 1999; Hunt, 1989) and practice of unsafe sex result in transmission of HIV from infected labor migrant men to left-behind wives, especially in rural areas (Brockerhoff & Biddlecom, 1999). Previous works

not only illustrate transmission of the infection from migrant men to their female partners, but also the other way round (Hughes et al., 2006; Lurie et al., 2003b). These studies demonstrate that male mobility also contributes to the spread of STIs when left-behind women in order to survive may engage in transactional sex (Lurie et al., 2003b; Zuma et al., 2005).

However, a study by Mundandi et al. (2006) in Zimbabwe reports no difference in risk behavior and HIV incidence between migrant and non-migrant men. They attribute the lack of difference between two groups to the following factors: mature stage of HIV/AIDS epidemic in Zimbabwe and greater awareness of people about HIV infection at this stage of the epidemic; strong cultural attachment of migrants to their home and family; the practice of staying with relatives during migration which allows migrant workers to avoid a number of problems, including financial and social ones, and remaining under social control of relatives resulting in decrease of their risk behaviors (Mundandi et al., 2006).

Most studies are conducted among male migrant workers rather than among their partners who are left behind back home (Hughes et al., 2006). In addition, previous works are also undertaken among migrant men at the destination areas and even fewer studies examine both areas involved in the migration process (Lurie, 2006). Few studies are conducted among female partners with the focus on the transmission of HIV/AIDS (Dladla et al., 2001).

Moreover, there is still lack of research on various aspects of reproductive health in post-Soviet countries that go through a transitional period with significant recent changes in social, political and economic environments. The majority of existing studies on the left-behind women have been carried out in Latin America and African countries, which have different socio-political and economic backgrounds. Therefore, research of the influence of

male international migration on sexual and reproductive health of women left behind in post-Soviet Tajikistan can fill important gaps in the literature.

Reproductive health care providers are important actors in the protection and promotion of reproductive health of women (Harries, Cooper, Myer, Bracken, Zweigenthal & Orner, 2007). In addition, health care providers play a crucial role in determining access to and quality of health services (Harries et al., 2007). It is, therefore, crucial to understand the perspectives and actions of providers in order to have a clear picture of the situation in Tajikistan, because they decide the care that women receive and shape the outcome of that care (Hayford & Agadjanian, 2010). To date, little is known in the migration and health literature about perspectives and attitudes of reproductive health providers and representatives of local and international organizations working among migrant families towards a range of reproductive health aspects of the left-behind women, including STIs, reproductive morbidity, access to reproductive health care, fertility, contraception use and decision making power in the migration and health literature. To my knowledge, prior work in this area does not exist. Therefore, gaining a better understanding of these aspects from the standpoint of not only the left-behind women and wives of non-migrants, but also from the viewpoint of the providers can certainly help to understand the entire context better and to develop strategies to improve provision of these services in the future (Same, Bell, Rosenthal & Marcell, 2014).

More researchers have gone beyond individual behavior approach to examine health problems. An example of this approach is a study of Hunt (1989) who uses “historical materialist epidemiology” where the author argues that the economic structures determine health and sicknesses in the society (p. 353). He argues that this approach helps to understand how political, economic and social structures define patterns of disease and mortality. He also

uses the social, economic, political and historical environment to study “the biological cause” of HIV infection (Hunt, 1989, p. 355). Hunt (1989) argues that while it is necessary to understand the biological aspect of HIV that alone is not enough because HIV should also be examined within a socially and historically context. Hunt’s argument (1989) is important for my research because sexual and reproductive health issues of women left behind in Tajikistan should be examined not only from the biological point of view, but also from social and historical points of view. Therefore, extensive information on Tajikistan in Chapter 1 and 2 helps to understand the background of the country; its political, social and economic changes have caused social and economic disruption in the lives of the society and population with adverse impact on the health care system and health status of its residents. It also shows that the Soviet system did not develop the nation’s industrial sector but instead used the country as a source of raw materials such as cotton and other agricultural products (Jawad & Tadjbakhsh, 1995). As a result, the country now cannot provide its increasing young unemployed population with jobs (GoRT, 2004) and is experiencing a high outflow of migrant laborers. This background information helps readers to understand how these factors contributed to migration, particularly to negative changes in the health care system that was previously able to provide the entire population with egalitarian access to health services but now fails to do so. The chapters also show the reasons behind deterioration of reproductive health status of women in Tajikistan.

In this study I also tried to go beyond a behavioral approach that considers individual reproductive health issues as the results of individual behaviors blaming poor health caused on unhealthy behavior and noncompliance with medical advice. Instead, I tried to examine how migration, and in particular the larger social determinants, have an influence on the health of the left-behind spouses. Although the main focus of the research was on the effect

of male migration on the sexual and reproductive health of women, the study found that other characteristics impact on health status. In addition to migration, other aspects such as income, education, employment, health care system operation, culture, tradition and place of residence also have complex and interconnected influences on women's experiences and health outcomes.

Following Mohanty's (2003) approach, I also tried to avoid constructing a universal, singular, homogenized and systematized image of a "left-behind woman" but instead tried to understand "complexities which characterize the lives of women" (Mohanty, 2003, p. 22) and take into account the heterogeneous reproductive health care experiences of the left-behind spouses. Avoiding homogenization allowed me to see that although some left-behind women are poor, with low education, traditional and family oriented, they are nevertheless able to negotiate HIV prevention measures to protect themselves and are able to make reproductive decisions. Although the study cannot explain all the complexity behind these findings, it certainly opens up an important avenue for its better understanding.

The organization of the dissertation

With these considerations in mind, I have organized the dissertation in the following way. Chapter 1 presents key information about the geography, people, culture, economy, history and social and political changes in Tajikistan. Most importantly for this study, it also provides the background on the history of migration in general, and labor migration in particular to understand the roots of the current situation in the country. This background is also important for understanding and contextualizing the findings of the study. It is followed by Chapter 2 which focuses on the reproductive health status and the health care system in Tajikistan.

Chapter 3, “Theoretical Background” analyses the existing literature on various perspectives of migration and fertility, contraception use, knowledge and concerns about STIs/HIV, ability to use HIV prevention measures and skills as well as access of women to reproductive health care. It also shows how previous studies have shaped and changed our knowledge of health, access to health, reproductive health, and HIV/AIDS and their relation to migration.

Chapter 4, “Research Questions and Methodology” formulates the research questions and describes the data collection methods and procedures as well as processes of analysis of the data for this research. I also address the ethical issues of my study.

Chapter 5, “Migration, Fertility and Family Planning” shows that temporary migration of a husband does not affect fertility of left-behind women in Tajikistan. Migration contributes to low fertility in those communities where more women are involved in migration than men (Lindstrom & Saucedo, 2002). Because in Tajikistan male migration significantly outnumbers female migration its effect on fertility is much lower (Lindstrom & Saucedo, 2002). The undocumented status of Tajik migrants is a serious barrier for social interaction and integration of the migrants in the destination area that restricts their exposure to low fertility norms (Lindstrom & Saucedo, 2002).

Chapter 5 also shows that while male migration does not affect fertility, it does influence contraceptive use of the left-behind women. It results in practice of seasonal removal and insertion of the IUD among some women and in shift from long- to short-term contraception use. This suggests that it is possible that over time there will be an increase in the use of short-term contraception due to migration and further reduction in long-term contraception use. This chapter also provides perspectives of reproductive health care

providers on fertility and contraceptive behaviors of wives of migrants and non-migrants and their decision-making power.

Chapter 6, “Knowledge and Awareness of HIV Risks and Prevention Practice” discusses the importance of conducting health promotion activities such as awareness raising campaigns among wives of migrants, because the interviews demonstrate that those women who were exposed to them were able to protect themselves. One of the most important findings of this research is short-term use of condoms with husbands after return and women asking their husbands to have an HIV test. This challenges the dominant discourses in HIV and migration literature about the inability, impossibility and failure on the part of the wives to negotiate HIV prevention measures due to various socio-economic, cultural, and traditional factors.

Chapter 7, “Migration and Access to Reproductive Health Care Services, and Antenatal and Delivery Care” argues that, on the one hand, male labor migration worsens reproductive health of the left-behind women, but, on the other hand, it improves their access to reproductive health care institutions through remittances. It therefore argues that although, as a whole, migration improves access of women to health care services, access also depends not only on remittances but also on place of residence, education attainment, employment and the quality of the operation of the health care system.

Finally, Chapter 8, “Conclusion and Implications of the Findings” provides recommendations to improve the reproductive health of the left-behind women in Tajikistan. It also restates the key arguments and findings of the study highlighting the main ways in which this particular study contributes to the existing literature on migration and reproductive health.

CHAPTER 1

TAJIKISTAN: COUNTRY PROFILE

General Information

Geography and population

Tajikistan is the smallest Central Asian country with a total area of 143,000 km² (Nozar, 2001). It has borders with China to the east, Afghanistan to the south, Uzbekistan to the west and Kyrgyzstan to the north (Map 1) (Nozar, 2001). About 93% of its territory is covered by mountainous terrain and only 6-7% is arable land (Centlivres & Centlivres-Demont, 1997). Administratively, Tajikistan is divided into 4 regions: Sughd and Khatlon regions, Regions under the Republican Subordination (RRS), and the Gorno - Badakhshan Autonomous Region (GBAO)² (Map 1).

Tajikistan is home to over 80 ethnic groups (Jawad & Tadjbakhsh, 1995). The major ethnic groups are the Tajiks, Uzbeks and Russians (Jawad & Tadjbakhsh, 1995). The distribution of the population over the country is as diverse as the country's geography: the population density is 0.4 persons per km² in Murgab district of GBAO and 288 per km² in industrial northern Sughd region (Olimova & Bosk, 2003). Seventy five percent of the population lives in rural settings (Mirzoev, Green, & Newell, 2007).

² Although the English acronym is GBAR, the region is famous as GBAO within the country and even in foreign literature. GBAO stands for Gorno-Badakhshan Autonomous Oblast (Russian for region). In this study I will, therefore, use the acronym GBAO.

Map 1: Map of Tajikistan



Source: <http://geology.com/world/tajikistan-satellite-image.shtml>

History

The history of Tajikistan is intricately connected with that of Central Asia as a whole. The original dwellers of most of the Central Asia were Iranian-speakers (i.e. the present-day Tajiks), while the Turkic and Mongol peoples, who entered Central Asia later, are now the dominant ethnic group in Central Asia (Jawad & Tadjbakhsh, 1995). The Samanid Empire (819-999), which is considered the first Tajik state, was founded in the 9th century (Jonson, 2006). The Samanids ruled the largest part of Central Asia and parts of present-day Afghanistan, Iran, Pakistan and India for more than 100 years (Jonson, 2006).

Between 1865 and 1884 the Russian Empire conquered Central Asia. This brought an end to the “Great Game” - the 19th century struggle between the Russian Empire and the British Empire for dominance in Central Asia (Hopkirk, 1994; Jawad & Tadjbakhsh, 1995; Johnson, 2006). After that, the borders were established between the Emirate of Bukhara, then a protectorate of Russia, and Afghanistan, which was under the control of the British Empire (Centlivres & Centlivres-Demont, 1997).

The republic, which is known today as Tajikistan, was established as a separate entity on 14 October 1924 as an Autonomous Republic and was part of the Uzbek Soviet Socialist Republic (Centlivres & Centlivres-Demont, 1997). It was not until 5 October 1929 that the separate Tajik Soviet Socialist Republic was created with the backwater town of Dushanbe³ as its capital as part of the Union of Soviet Socialist Republics (USSR) (Centlivres & Centlivres-Demont, 1997). However, the centers of the Persian language and civilization, the cities of Samarkand and Bukhara which thrived under the Samanids, were left within the territory of Uzbekistan, and to this day remain an area of contention for both the Uzbeks and the Tajiks (Centlivres & Centlivres-Demont, 1997; Jawad & Tadjbakhsh, 1995).

The country benefited from the economic system of SU that contributed to the development of infrastructure providing people socially and economically (Khakimov & Mahmadbekov, 2009). Main benefits were gender equality, job training and job placement and provision of citizens with the right to universal education (Khakimov & Mahmadbekov, 2009). Movement outside the USSR was limited and it was crucial to be loyal to the state and the Communist party. Similarly to other Soviet republics of

³ Literally means “Monday”, a day on which a major bazaar was held in the city in the past (Jawad & Tadjbakhsh, 1995).

Central Asia, Tajikistan benefited from the infrastructure built since the beginning of 1920s (Khakimov & Mahmadbekov, 2009). Under the SU, Tajikistan had comparatively high human development indicators (HDI) reflecting the legacy of social development achieved during the Soviet period (Falkingham, 2003). It had almost universal adult literacy and life expectancy at birth of about 70 years (Falkingham, 2003). In 1991, Tajikistan had about 2,308 industries, gross domestic product (GDP) constituted 400 United States Dollar (USD) per capita income, high literacy rate (96.7%) and high employment rate (78% of the employable-age population) (Khakimov & Mahmadbekov, 2009). However, at the same time, it had the lowest indicators among former Soviet republics. In comparison with the other republics it was not well developed mainly due to the underdevelopment of the industrial sector. Along with Uzbekistan, it served as the main producer of cotton for the SU (Jawad & Tadjbakhsh, 1995), but it was also not equipped to exploit its rich minerals and water resources (Khakimov & Mahmadbekov, 2009). Therefore, Tajikistan was supported by subsidies from the Soviet government at about 40% of its GDP in the 1980s to maintain economic and social structure.

In September 1991 Tajikistan gained its independence from the SU (Falkingham, 2003). At the end of that year following the collapse of the SU it was recognized internationally as an independent state. However, after the proclamation of independence it rapidly became apparent that Tajikistan as a state had neither national harmony nor a secure economic base (Falkingham, 2003). After gaining its independence the country went through significant economic and social crises along with transition from a socialist planned to a market-driven/capitalist economy, disintegration of traditional cooperation and trade with former partners as well as the

withdrawal of subsidies from Moscow (Falkingham, 2003, 2004; Habibov & Fan, 2008). As a result, the GDP sharply decreased as did expenditures of the central government. Furthermore, outbreaks of fighting occurred in June 1992 due to a political conflict between opposition and government supporters and these conflicts resulted in a bloody civil war that started at the end of 1992 (Falkingham, 2000; Jawad & Tadjbakhsh, 1995).

The civil unrest continued until 1997 when a peace agreement between the government and the opposition groups was secured (Falkingham, 2000). According to various sources between 25,000 and 100,000 people were killed and many more became refugees in Afghanistan, Iran and Russia as result of the Civil War. There were scores of internally displaced persons as well (Centlivres & Centlivres-Demont, 1997). The Civil War brought about severe economic and social issues for the country. In 2001 the population was at 5.4 million but as a result of the Civil War 600,000 were internally displaced, and another 80,000 left for other countries, mainly Afghanistan (Hohmann, Roche, & Garenne, 2010). According to the official data, about 280,000 people fled Tajikistan over the period of 1992-1996 (Clifford, 2009). Although a peace agreement was achieved, many donors, such as United Kingdom's (UK) Department for International Development (DFID), were not involved in Tajikistan until 2000 due to security concerns (Mirzoev et al., 2007). Thus, in the early stages of the transition, the economy of the country received less donor support than other Central Asian countries (Mirzoev et al., 2007).

As a result, between 1989 and 2003 many indicators of health deteriorated and Tajikistan experienced a decline in its HDI and it is currently ranked 133rd - the

lowest of the former Soviet republics (Table 1) (UNDP, 2014). The reasons for such a sharp deterioration was the worsening of the economy situation and, to a lesser degree, the worsening of the quality of life, including life expectancy, and the steep downfall of the level and quality of education (Walker, 2008).

Table 1: Selected human development indicators

HDI rank	Country	Life expectancy at birth (years)	Mean years of schooling (years)	Gross national income (GNI) per capita (US\$)
1	Norway	81.5	12.6	63,909
57	Russian Federation	68.0	11.7	22,617
70	Kazakhstan	66.5	10.4	19,441
116	Uzbekistan	68.2	10.0	5,227
132	Nicaragua	74.8	5.8	4,266
133	Tajikistan	67.2	9.9	2,424
135	India	68.4	4.4	5,150

Source: Human Development Report 2014 (UNDP, 2014)

The 11 September 2001 attacks on the World Trade Center, New York and the Pentagon, Washington had major repercussions for Central Asia as a region (Johnson, 2006). The United States started its military campaign in Afghanistan in October 2001. Tajik and Kyrgyz airbases were used for raids into Afghanistan and for delivering supplies to the US army in that country (Johnson, 2006). Therefore, the interests of the US and its allies in Central Asian countries, including Tajikistan,

increased. This created a completely new situation for all parties involved. Tajikistan's foreign policy and the amount of aid it received from the US, European Union (EU), various United Nations (UN) agencies and the World Bank (WB) and International Monetary Fund (IMF), led to the expansion of its relations with Western and Asian states and the diversification of its foreign policy (Jonson, 2006). Funds provided to the Tajik government in return for its support and using its military basis had an impact on many aspects of life as well as on its health sector.

Culture

The Tajiks are the only national group of Iranian descendants in an otherwise Turkic-speaking environment in Central Asia (Centlivres and Centlivres-Demont, 1997). The four other Central Asian states are predominantly of Turkic descent (Katzman, 2002). Tajikistan is a Muslim country where a religious revival is in progress (Jonson, 2006). Despite the fact that Soviet authorities put significant efforts into suppressing religion during their 70-year rule, Islam remains central to people's lives in Tajikistan. The majority of Tajiks belong to the Sunni⁴ form of Islam, with the exception of some 200,000 Pamiris who are Shi'a Ismailis⁵ with the major

⁴ Sunni Islam is one of the branches of Islam and its followers constitute 80% of Muslim population. The word Sunni is Arabic and means one who follows the traditions of the Prophet Muhammad (d. 632). The difference between Sunni and Shi'a trace back to the 7th century and the division was a result of the disagreement after death of Prophet Muhammad on who will be his successor. The Sunnis consider that the successor of the Prophet should be chosen by the Prophet's companions and, as a result, his friend and companion Abu Bakr (d. 634) became the first caliph.

⁵ Shi'a Islam is the second biggest branch of Islam. The Shi'a believe that the Prophet appointed his cousin and son-in-law 'Ali ibn Abi-Talib (d. 661) as his successor and the spiritual leadership (Imamat) should stay within the family of the Prophet. The word *Shi'a* is

concentration in the GBAO. The majority of Europeans in Tajikistan belong to the Russian Orthodox Church (Jawad & Tadjbakhsh, 1995).

Tajik, which is a form of Persian, is an official language in Tajikistan. The alphabet of the language was changed from Persian-Arabic to Latin in 1929, and subsequently to Cyrillic in 1939. In 1989, about two years prior to the final dismantling of the SU, Tajik was introduced as the official state language by the government of Tajikistan. Russian remained as the language of interethnic communication (Jawad & Tadjbakhsh, 1995). However, Russian was widely spoken by most of the urban residents, government officials, bureaucrats, and business people up until the late 1990s (Atkin, 1997). It continues to be widely used even today

Economy

As mentioned earlier, the Republic of Tajikistan, even before the dissolution of the USSR, was the poorest (Falkingham, 2003, 2004) and the least developed (Mirzoev et al., 2007) republic with the lowest economic output (Fan & Habibov, 2008) among other post-Soviet countries of the former SU. Tajikistan was a republic with a low per capita GDP, a high demographic growth (3.3% per year in 1988) and a low rate of urbanization (Centlivres & Centlivres-Demont, 1997). Tajikistan does not have large-scale resources of oil or gas, but it is rich in minerals (Jawad & Tadjbakhsh, 1995; Jonson, 2006). However, most of the riches lie unexploited

also an Arabic in origin and has a meaning of “a group of people” or “a party” as in the commonly used term “the Party of Ali”. The Ismailis are the only Shi‘i branch who have a present and living Imam (spiritual leader). Their current Imam is His Highness Karim Aga Khan IV (b. 1936).

because the dangerous mountain passes are closed between November and April. In addition, economic difficulties have prevented the country from investing in excavations (Centlivres & Centlivres-Demont, 1997). The country also lacks efficient policies, institutions and resources to exploit these riches fully.

Tajikistan is also home to two major factories: a uranium processing plant in Chkalovsk in the Sughd region and an aluminum plant in Regar in the Hissor valley (Jawad & Tadjbakhsh, 1995). They are the world's largest producers of uranium and aluminum, although they are currently producing below their capacity (Katzman, 2002). Despite a dramatic decrease in production since the Civil War, the aluminum processing plant is the main source of foreign currency income for the country.

Tajikistan has the second largest hydro-electric power reserves in the former SU and has 65% of Central Asia's water resources (Jawad & Tadjbakhsh, 1995). The potential for building more hydro-electric power stations is immense in the country. However, this remains a contentious issue due to the sensitive political situation in Central Asia and the opposition of countries such as Uzbekistan to the building of some of these stations, which in turn hinders the efforts of Tajikistan in securing financial support for its intended projects (Jawad & Tadjbakhsh, 1995).

The majority of the population lives in rural areas and earns their living through agriculture (Jawad & Tadjbakhsh, 1995). Agricultural products include cotton, vegetables, fruits, and some grains, with animal husbandry practiced in the mountainous areas (Jawad & Tadjbakhsh, 1995). The total area of land in Tajikistan which is used for cotton production is 303,000 hectares, which produced some 850,000 tons of cotton annually before the Civil War. Small industries generate

approximately two-thirds of Tajikistan's industrial productions (Jawad & Tadjbakhsh, 1995).

Following independence in 1991, the Republic of Tajikistan (RT) proceeded to implement its economic reform program (Mirzoev et al., 2007). However, due to the Civil War the implementation of this reform program faced considerable set-backs (Olimova & Bosk, 2003). After signing the peace agreement in 1997, the economic restructuring programs by the government were rekindled, but the pace of the implementation was slow. The IMF began to support the reforms after signing an agreement in 1998 on Enhanced Structural Adjustment Facility (Olimova & Bosk, 2003). This agreement was renamed in 1999 as Poverty Reduction and Growth Facility Arrangement (Olimova & Bosk, 2003). The support for the reforms was also provided by a structural adjustment credit from the WB. Quite rapidly a free market environment was created and also the legal framework for it to function was developed, while the process of privatization was going on (Olimova & Bosk, 2003). Land reform resulted in transformation of collective and state farms (*kolkhoz* and *sovkhos*)⁶ into private farms or joint-stock companies (Olimova & Bosk, 2003) which resulted in the increase of unemployment among the rural population. In 1999, the restructuring of large enterprises began in the country. In particular, extensive reforms of agriculture took place as a result of which 70% of croplands passed from state-ownership to private hands by early 2001 (GoRT, 2004).

The main four commercial banks also went through structural reorganization (GoRT, 2004). In April 2001 the monetary reform was completed. However, the level

⁶ From Russian '*kollektivnoe khoziaĭstvo*' (collective farm) and '*sovetskoe khoziaĭstvo*' (Soviet farm, a state-owned farm).

of the economic development continues to be low due to slow administrative reforms (Olimova & Bosk, 2003). The private sector is not well developed due to various barriers. In addition, the country's economy is characterized by deindustrialization, de-urbanization and divestment of many sectors of the economy (Olimova & Bosk, 2003). This has a significant social influence leading to a widening gap between the wealthy and the poor. As a result, the majority of the population has not benefited from national economic development over the years (Niyozov, 2001; Olimova & Bosk, 2003). The growing income gap along with the population growth stimulate migration (Olimova & Bosk, 2003).

As a result of the dissolution of the SU and the transition to market economy, unemployment is the most acute problem. Although the official rate was 2.5% in 2008, according to WB data, the rate exceeds 30% (Atkin, 1997). The significant reduction of employment was seen in the public sector due to privatization (Olimova & Bosk, 2003). Jobs in the industries, construction, transport and communication reduced after 1992 (Olimova & Bosk, 2003). At the same time, private farming and housekeeping work was on the rise. The percentage of unemployed and underemployed increased as well as the size of the economically active population in Tajikistan (Olimova & Bosk, 2003). As a result, thousands of people have gone to Russia and Kazakhstan in search of jobs. These are among the few countries where Tajik citizens can go without visas and where they can find employment.

Some sources report that by the early 2000s the political situation in the country and its economy was slowly improving (GoRT, 2004). The implementation of structural reforms of various sectors and political stability contributed somewhat

stable success of macroeconomy and finance (GoRT, 2004). As a result, since 1997 some signs of economic movement upwards became visible; for instance, the official statistics indicate that the GDP increased from 1.7% in 1997 to 10.2% in 2002 and by 2001 it was 47.3% higher than the 1991 level (GoRT, 2004). The GDP increase was a result of exports of cotton and aluminum as well as remittances from migrant workers (Walker, 2008). Due to some progress of socio-economic reforms leading to macroeconomic stabilization, the government was able to implement the poverty reduction strategy with financial support of international donors. Despite this, the living standard of the majority of the population in the country remained low (Niyozov, 2001; Walker, 2008).

Labor Migration

Labor migration is important for the economic system and in the development process of low-income countries that have more potential workers than jobs (Khakimov & Mahmadbekov, 2009). In Tajikistan, lack of jobs meant that migration became a crucial part of modern life. This migration has affected all aspects of the society (Khakimov & Mahmadbekov, 2009). Every year a significant number of Tajik men leave to work abroad (Walker, 2008).

At present, there are different and at times contradictory assessments of the total volume of labor migration from Tajikistan. According to the Federal Migration Service of Russia, currently about 1.15 million Tajik migrants reside in the Russian Federation (IOM, 2014). However, the Statistical Agency under the President of RT mentions only 793,447 labor migrants in Russia in 2013 (STA, 2014). Walker (2008) argues that the official statistics on migration often do not reflect the real number of

labor migrants in the country (Walker, 2008). This is explained by the fact that many labor migrants migrate on a temporary basis and, as a result, it is difficult to trace or control their actual number (Walker, 2008). This issue also exists because the registration system of the country does not function properly due to weak government statistical systems. As a result, the official statistics are often inconsistent and incomplete (Walker, 2008). Official government documents also state this problem pointing out that total migration from Tajikistan is slightly higher than the official estimates because labor migration is very hard to track (SA, 2003).

Importance of remittances

Many studies show that the flow of remittances along with economic progress contributed to a decrease of poverty in Tajikistan (SA, 2007). A survey conducted by the WB showed that the poverty level decreased from 83% in 1999 to 64% in 2003 (SA, 2007). Remittances are important for all sectors of the society, but particularly, for the well-being of poor families (Walker, 2008). The amount of remittances was US\$ 550 million in 2004 constituting 26% of the GDP of the country. This number reached US\$ 735 million, constituting 31% of GDP in 2005 (Walker, 2008). Remittances are the highest contributor to GDP in Tajikistan. It is estimated that remittances constitute 13% of the total income of families and 20% of the total private spending of families in some settings, although they are predominantly used to cover consumption needs of the households and debt repayment (Walker, 2008, SA, 2003).

The history of labor migration in Tajikistan

Although some sources call labor migration a new and recent phenomenon in Tajikistan (Clifford, 2009; Weine, Bahromov, & Mirzoev, 2008), others argue that during SU and long before that Tajiks were involved in labor migration (Abdulhaev, 2012; Khakimov & Mahmadbekov, 2009; Olimova & Bosk, 2003). But in the majority of cases it was forced migration and was connected with foreign interventions and wars. After the dissolution of the Samanid Empire in 9th-10th century, considered at least by the Tajiks to be the first Tajik state, Tajiks were forced under the pressure from nomad Turkic - speakers to move from area to area over a thousand years (Abdulhaev, 2012). Under the attacks of nomads they had to leave the valleys and move to safe mountainous places where they became involved in agriculture and handcrafts (Abdulhaev, 2012). In addition, migration of traders was dominant among valley Tajiks especially in the north of Tajikistan (SA, 2003).

Historically, inhabitants of the current territory of Tajikistan were very mobile (Olimova & Bosk, 2003). Trade migration has a long history and is a part of Tajik culture (SA, 2003, Olimova & Bosk, 2003). Educational migration was also common among the Tajik people who went to Bukhara to study in madrasas or religious schools along with *haji* (pilgrimage) to Mecca and *ziyarat* (visitation of other religious holy places) (Olimova & Bosk, 2003). Along with these types of migration, labor migration was the main migration trend when residents of mountain places such as Karategin and Maschoh, Baldjuvan, Kulob and Hissor travelled to valleys, particularly to the Fergana valley, in search of work (Olimova & Bosk, 2003). They usually worked in construction, cotton fields and as porters (Olimova & Bosk, 2003).

At the beginning of the 20th century about 25-70% of men moved from villages of the Zeravshan River area to search for work (Olimova & Bosk, 2003).

During the Soviet period, Tajiks were also involved in labor migration. The first waves of migration under the Soviets began in 1920s with migration of a large number of migrants, mainly of European descents, to Tajikistan either voluntarily or by force from other parts of the SU (Abdulhaev, 2012). The external migrants were sent to develop the country due to shortages of highly skilled specialists at the beginning of the Soviet period (Khakimov & Mahmadbekov, 2009). Thus, high external migration and high birth rates contributed to urbanization of the country (Khakimov & Mahmadbekov, 2009) and improved its socioeconomic conditions (Abdulhaev, 2012).

De-urbanization started in 1970s and increased in 1980s and 1990s. In the 1990s it was one of the direct results of the Civil War that resulted in emigration of non-indigenous people outside Tajikistan also leading to external and internal migration of highly skilled indigenous urban residents (Khakimov & Mahmadbekov, 2009).

However, there is a considerable difference between the nature and form of current migration and the migration during the Soviet period. During the Soviet period, migration occurred within the borders of the country, that is USSR and it was the Soviet government which assisted and controlled it. Part of the migration policy of the government of the USSR was also connected to the state development project (Khakimov & Mahmadbekov, 2009), sometimes voluntarily, but in the majority of cases by force. In 1970s and 1980s many Tajik families were resettled to populate and

develop some parts of Russia, such as Nechernozemye, Siberia and the Far East (Khakimov & Mahmadbekov, 2009; Olimova & Bosk, 2003). In addition, many young people took part in big construction projects across the USSR (Olimova & Bosk, 2003). Tajik households were also resettled to populate some of the “virgin lands” of Kazakhstan and were involved in construction of new cities and railroads, in particular, the Baikal-Amur railroad and various infrastructure and oil and gas production sites of East Siberia according to scheduled work placements (Khakimov & Mahmadbekov, 2009; Olimova & Bosk, 2003). Moreover, during the Soviet period young people attended schools to improve their professional and technical skills, mainly in Ukraine and Russia (Khakimov & Mahmadbekov, 2009).

Mandatory service in the army was another source of migration in SU. Many did not come back to Tajikistan and stayed in Russia after completing their military service (Olimova & Bosk, 2003). The Soviet period in Tajikistan was also characterized by a large-scale internal migration. In order to stop importing cotton from overseas and to provide military and weaving and textile industries with raw material, and to prevent unemployment of workers of weaving industry in the USSR, especially Russia, the government tried to develop unused agricultural lands of Central Asia, including Tajikistan, by turning them into cotton fields (Abdulhaev, 2012). They also moved farmers (pl. *dehqonho*, sing. *dehqon*) with their families and, in some cases, entire villages, from mountainous areas, where there was a lack of agricultural land and overpopulation, to valleys with shortage of population and plenty of unused land (Abdulhaev, 2012). Also, Tajiks refugees who fled overseas in the 1920s and 1930s from the Red Army returned to Tajikistan. These families were also sent by the state to work in cotton fields in the valleys (Abdulhaev, 2012).

Current migrants in comparison with previous ones may choose where to migrate and work whereas before these decisions were made by the state (Khakimov & Mahmadbekov, 2009). In addition, labor migrants now move to other countries rather than internally, and issues must be addressed at the intergovernmental level (Khakimov & Mahmadbekov, 2009).

Nevertheless, following independence, the social, economic and political situation in Tajikistan significantly changed and as a result the number of migrant laborers increased dramatically. Consequently, labor migration became the key type of migration (Khakimov & Mahmadbekov, 2009; IOM, 2009). After the dissolution of SU, Tajikistan faced mass migration flows which changed the appearance of the country, and had a deep impact on social, economic and political life (SA, 2003). Labor migration first reappeared in those regions where it was dominant in the past in Tajikistan (Olimova & Bosk, 2003). For instance, in the Fergana valley local markets were reestablished and merchant migration, which was traditionally crucial for the North of the country, was revived (SA, 2003).

One of the most important factors causing the flow of mass forced migration was the Civil War of 1992-1997, which was a period of great political instability in Tajikistan. Over 1991-1995 284,600 people emigrated out of Tajikistan (SA, 2003). Gradual decrease of migration exchanges is observed since 1995 with all countries of the CIS, except Russia which became one of the main pulling centers for migrants from Tajikistan (SA, 2003). Most, if not all of this migration, is labor migration.

Labor migration is a significant sphere of activity involving a large number of unemployed people of Tajikistan (SA, 2003). In addition, labor migration results in

creation of jobs for those who otherwise would not have employment opportunity in Tajikistan or would be on a wage that is inadequate for basic living expenses. Labor migration also contributes to the development of various aspects of society. This is clear from the example of small merchants who developed trade infrastructure themselves without support from the government and investment. They stimulate development of transportation, communication means, goods support, institution of intermediaries, marketologists and the creation of catering facilities and etc (SA, 2003). The main flow of migration, that is 84% of Tajik labor migrants, go to Russia (Olimova & Bosk, 2003). There are several reasons for that: 1) the average monthly wage is thirty times higher in Russia than in their own country; 2) structural reforms in Russia lifted control over labor relations and wages resulting in the development of a housing market and many construction jobs; 3) shortage of labor forces in Russia due to low birth rate and high mortality rate leading to increasing demand in foreign labor; 4) increase of labor migration from Russia to other western countries including the European Union who were quickly replaced by Tajik and other labor migrants; 5) the economic development of Russia during the transition period increased investment and booming construction industry creating many jobs; 6) the progress of reforms created favorable conditions for the development of business leading to increase in salaries, decrease of unemployment and creation of new jobs mainly in small and medium businesses; and finally, 7) increase in ageing population which led to need for young workers (Olimova & Bosk, 2003; SA, 2003).

Above 90% of Tajik migrant workers are male, however, the number of women labor workers has been increasing in the last years (ILO, 2008). The dominant

age groups among migrant workers are 20-29 and 40-49 years (Olimova & Bosk, 2003; Walker, 2008).

The educational attainment of labor migrants is lower than that of the general population (Clifford, 2009). Half of labor migrants do not have any degrees. Young people constitute the main part of this segment (Olimova & Bosk, 2003), who have secondary or incomplete secondary school education (SA, 2003). The second group is middle and older age group who are qualified laborers and specialists (SA, 2003). Migrants with degrees are a heterogeneous group, including physicians, engineers, actors, teachers, managers, clerks and so on (Olimova & Bosk, 2003). Many labor migrants are unable to find work that matches their education and so work in other areas which are in need of labor forces (SA, 2007). Main spheres of activities of labor migrants are construction, private enterprises and the public service sector (catering, auto service, loaders, street cleaners, gardeners, personal drivers and staff of private security agencies) (SA, 2007).

Legal issues faced by the migrants

The majority of problems of migrants are due to their legal status and they are connected with their registration in Russia (Olimova & Bosk, 2003). Many construction workers live on construction sites in trailers or other premises around them. If the workers repair or renovate apartments in Russia, they often live there. The registration agencies do not register them in these places. They also do not allow registering them in their place of work (Olimova & Bosk, 2003). In addition, registration is also an expensive and time consuming process and those workers who have it got it through their employers (Olimova & Bosk, 2003). Thus, registration of

labor migrants is a major source of their vulnerability (Olimova & Bosk, 2003). Olimova and Bosk (2003) classify migrants into legal and irregular. Although Tajiks do not need a visa to enter Russia, they need to be registered in the place of residence, which many of them do not do (Olimova & Bosk, 2003). Sixty percent of all migrant workers from Tajikistan reside and work without appropriate documentation in Russia (IOM, 2014).

Many labor migrants also do not have signed employment contracts with their employers and therefore cannot receive work permits (Olimova & Bosk, 2003). Very often Russian employers hire Russian citizens as full time employees on a fictitious basis (only on paper); that is, to use Olimova and Bosk's term (2003) as "dead souls"⁷ but actually hire Tajik constructors do the work (p. 46). During an inspection of the construction sites it is quite hard to reveal illegal labor migrant workers because nobody checks documents of each worker (Olimova & Bosk, 2003). Although employers have to bribe inspectors, it is nevertheless cheaper for them in comparison with the money they save by using labor migrants without registration and work permits (Olimova & Bosk, 2003). Very often labor migrants receive very low payment and often employers cheat them on their wages (Olimova & Bosk, 2003). Tajik migrants often receive less than they had been promised and agreed, or they are paid only half of the agreed sum or not at all. Often if contract was in dollars, employers use lowest or underestimated exchange rate to pay the wages to the migrant workers knowing that they cannot do anything about it (Olimova & Bosk, 2003). Very often these cases are observed among labor migrants that are hired unofficially. In a

⁷ A reference to the sale of dead souls based on the book of Nikolay Vasilievich Gogol (d. 1852) "Miortvye Dushi" (Dead Souls).

study in Moscow half of respondents reported that they had to wait from two to six months to get their salaries. About 20% of migrant workers did not receive the correct amount or did not get paid at all (Olimova & Bosk, 2003). It is better to work for state agencies because they provide more social benefits rather than private enterprises (Olimova & Bosk, 2003).

The survey showed that the average monthly income of Tajik labor migrants is USD \$274. There is a demand for low paid and low qualified work force in Russia and therefore Tajik migrants mainly fill non-prestigious, dirty and difficult working jobs. It is estimated that migrants send 48% of all their income to Tajikistan (SA, 2007).

The nature of the work of labor migrants in Russia does not provide opportunity to live and work legally and bring family and, therefore, they are forced to work on a seasonal basis (SA, 2007). The majority of seasonal workers do not want to bring their families to Russia because they receive very low wages which are insufficient to satisfy the needs of their family in Russia (SA, 2007).

According to the survey data, 97.2% respondents moved from RT to earn money and support the left-behind family members (SA, 2007). They consider their migration as a measure to receive income to support wellbeing of family and relatives. Only 2.3% respondents consider that once they leave they are not obliged to care for their closest relative back home (SA, 2007).

Tajik labor migrants usually are engaged in seasonal work (ILO, 2008). At the beginning of spring they go to work in other countries and return in fall or winter of

the same years (ILO, 2008). About 75-80% of migrants return home every fall or winter. According to data of MLSP only 0.5-1% of migrant workers go and find a job through the Tajik government and other private agencies of employment (ILO, 2008). The rest try to find job through relatives, neighbors, friends and family members.

CHAPTER 2

REPRODUCTIVE HEALTH STATUS AND HEALTH CARE SYSTEM IN TAJIKISTAN

Reproductive health status

The background on the political, social and economic context of Tajikistan provided in the previous chapter has strong repercussions for what is at the heart of my research, namely reproductive health of women. The chaotic, dysfunctional and expensive health system in Tajikistan has had strong effects on the health of women in general, and their reproductive health, in particular. It is therefore important to discuss several important aspects of reproductive health status in more detail in this chapter.

Antenatal care

Dowswell et al. (2010) argue that the concept of antenatal care emerged from the belief that it is possible to prevent maternal death as well as fetal and infant death. Oakley's study (as cited in Dowswell et al., 2010) found that effective care of the health of a pregnant woman during the pregnancy is the main requirement of the maternity service care. Antenatal check-up has to be started at 16 weeks until 28 weeks and then biweekly from 28 to 36 weeks and after 36 weeks on a weekly basis (Dowswell et al., 2010). During each visit height of uterus and fetal heart should be measured and test of urine should be carried out. These recommendations have been basic all over the world since 1929. With the development of technology new

examination, such as screening intervention to define women of high risk groups were added to otherwise routine package of antenatal care (Dowswell et al., 2010).

It is the right of a woman to have access to proper health services in order to “go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant”, as mentioned in the definition of reproductive health (UNPOPIN, 1994, para. 7.2). Paragraph 7.2 of the Report of the International Conference on Population and Development defines it in the following way:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (UNPOPIN, 1994, para. 7.2).

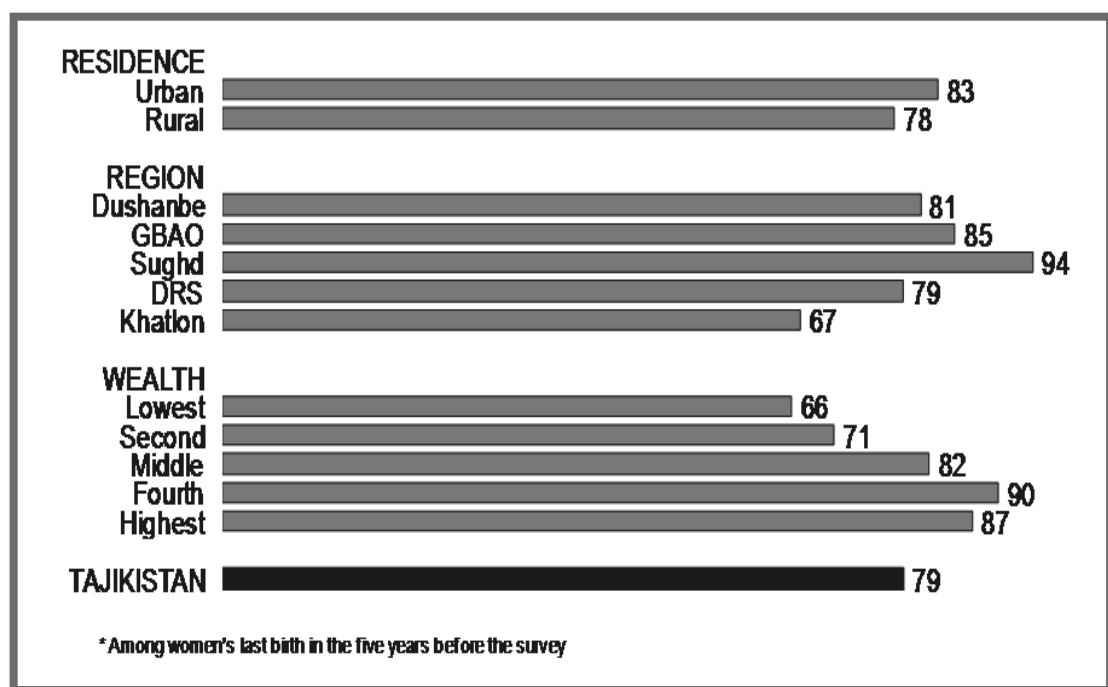
It is important to receive health care during pregnancy, at birth and soon after the birth for a woman and a child to survive and remain healthy (STA, MoH, & ICF, 2013). Health care provided by medically-trained providers to observe the pregnancy,

to recognize complications connected with the pregnancy and prevent adverse outcomes of pregnancy is crucial. Antenatal care is effective only if it is provided on a regular basis over the pregnancy (STA, MoH, & ICF, 2013). The MoH of Tajikistan recommends for a pregnant woman to have 7 antenatal care visits (STA, MoH, & ICF, 2013) according to the recent regulation. During the Soviet period the recommended number of visits was 15 for a woman without complications during pregnancy. The WHO recommends at least four antenatal care visits for low-risk pregnancy according to the new approach of the WHO which promotes fewer clinical visits but is more goal oriented in comparison with the standard antenatal care model requiring a higher number of visits (WHO, 2003). The Demographic and Health Survey (DHS) conducted in Tajikistan in 2012 showed that 79% of women sought antenatal care from a skilled health professional at least one time during the last delivery within five years before the survey (STA, MoH, & ICF, 2013). The survey shows that 64% consulted a doctor for antenatal care and about 15% of women saw a nurse or a midwife. However, one out of five of women did not receive antenatal care at all during their most recent pregnancy (STA, MoH, & ICF, 2013).

Coverage of antenatal care depends on certain characteristics of the mother. Women with higher parity and age receive less antenatal care (STA, MoH, & ICF, 2013). For instance, women who were younger than 20 year old more often seek antenatal care rather than those older than 35. Eighty four percent (84%) of women with first pregnancy compared to 61% of those with sixth or higher delivery received antenatal care. Insignificant difference was observed among urban women (83%) compared to rural women (78%) (STA, MoH, & ICF, 2013). Women in Sughd region (94%) were most likely to be covered by antenatal care followed by GBAO (85%)

and those living in Khatlon region were least likely to be covered (67%). Education improves access to antenatal care because 69% of women with no or primary education received antenatal care in comparison with 92% of women with secondary and higher education background. In addition, women from lower income households (66%) are less likely to seek antenatal care in comparison with women from wealthy households (90%). The 2005 Multiple Indicator Cluster Survey (MICS) showed 77% coverage of women by antenatal care compared with 79% of DHS in 2012, indicating a very small change between 2005 and 2012 (STA, MoH, & ICF, 2013).

Figure 1: Percent of women who received at least one antenatal visit



Source: STA, MoH, & ICF, 2013

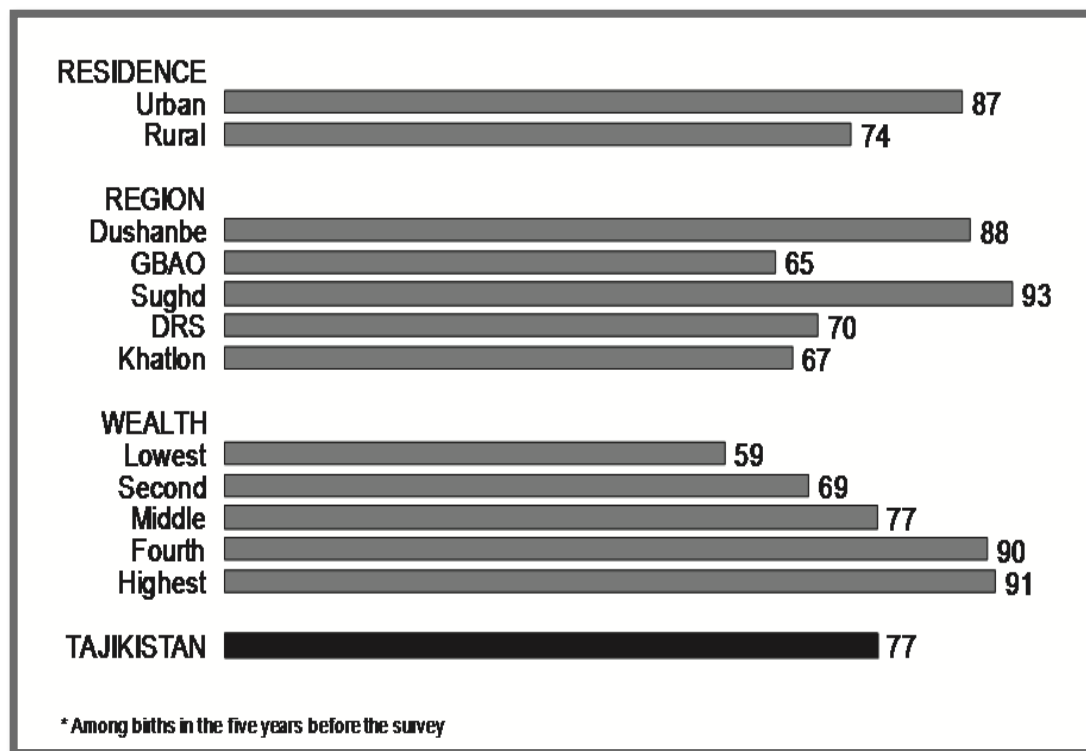
Delivery care

It is important to provide adequate medical care and hygienic environment during birth to decrease the risk of complications and infections that can result in death or severe diseases of a woman and a child (STA, MoH, & ICF, 2013). It is also crucial that the deliveries occur in a safe and clean condition, and with attendance of medical workers (STA, MoH, & ICF, 2013). The DHS, conducted in 2012, revealed that 77% (three-third) of women delivered their babies at a medical institution and 23% at home (STA, MoH, & ICF, 2013).

The latest survey in Tajikistan shows that younger mothers and also women giving birth to their first child more often deliver in a medical institution as opposed to older mothers and also women with higher birth rates (STA, MoH, & ICF, 2013). For instance, 80% of mothers younger than 20 years old and 61% of mothers older than 35 delivered their babies at a health facility. Eighty six percent (86%) of first births in comparison with 51% of women with higher parity have a delivery in a health facility (STA, MoH, & ICF, 2013). In addition, women who received antenatal care are more likely to deliver at the health institution compared to those who did not receive it. Only 53% of women who did not consult a health professional for antenatal care had delivery in a medical facility and 91% of those with four and higher antenatal visits had institutional births. It is clear that institutional delivery is higher among women who received antenatal care during pregnancy. Urban women (87%) in comparison with rural ones (74%) had higher rate of delivery in a medical facility (STA, MoH, & ICF, 2013). In addition, 93% of mothers in Dushanbe, 88% in Sughd,

67% in Khatlon and 65% in GBAO had their babies at the health care facility (STA, MoH, & ICF, 2013).

Figure 2: Percentage of births occurring in health care facilities



Source: STA, MoH, & ICF, 2013

Education has an impact on where the women decide to give birth: 69% of women with no or only primary education attainment compared with 94% of those with higher than secondary education had their babies in a medical institution (STA, MoH, & ICF, 2013). Wealth of the household has also a strong impact on delivery experience. Every 9 out of 10 women from higher income households and less than 6 out of 10 from lower income households had institutional delivery (STA, MoH, & ICF, 2013). Institutional delivery has increased over time in the country, because the

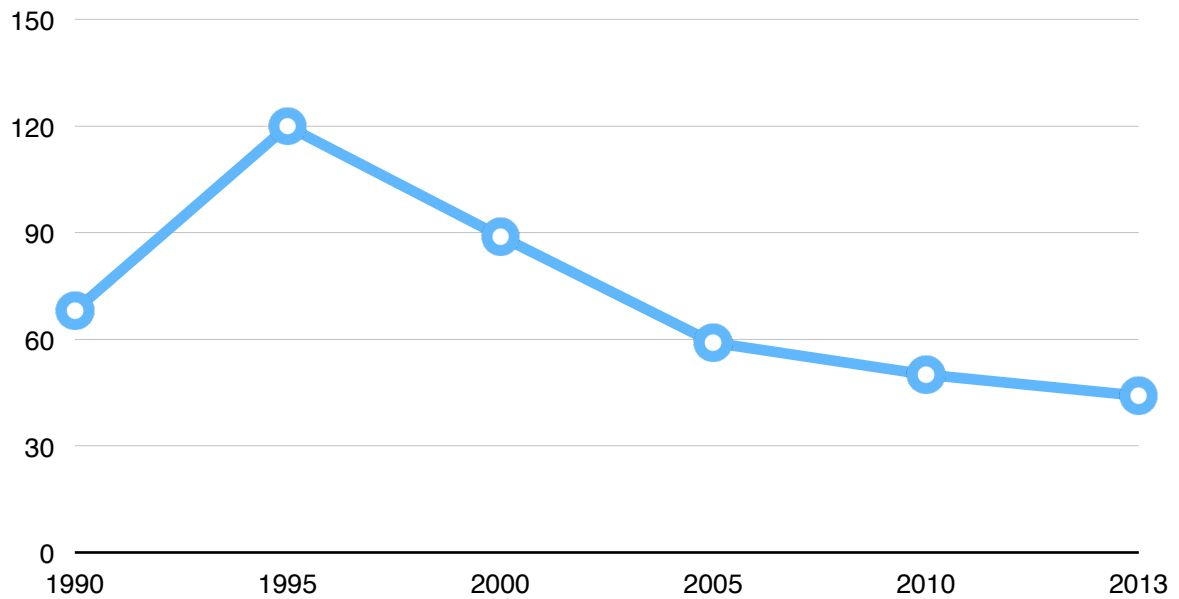
2005 MICS showed that 62% of women had delivery in a medical institution in 2005 compared to 78% in the DHS conducted in 2012. However, the rates are lower than they were in 1985. This is due to the fact that during the Soviet period almost everybody gave birth in the hospital. Unfortunately, statistics prior to 1992 is either not available or cannot be accessed. Even the Medical Statistical Center under the Research Institute of Obstetric, Gynecology and Neonatology in Dushanbe could not provide me with any statistics prior 1992.

Maternal mortality

In 1990, the official maternal mortality ratio⁸ was at 68 deaths per 100,000 live births, which then sharply increased to 120 in 1995 and then significantly decreased to 85 in 2000 and further to 59 in 2005 and approached 44 deaths per 100,00 live births in 2013 (WHO, 2014b). This data show that maternal mortality ratio worsened dramatically following the collapse of the SU and the Civil War and then stabilized by 2005 when the government with donor support managed to implement some positive changes in the health care sector

⁸ Maternal mortality ratio - number of maternal deaths during a given time period per 100,000 live births during the same period (WHO, 2014b).

Figure 3: Trends in maternal mortality ratio from 1990 to 2013 in Tajikistan



Source: WHO (2014b)

However, many sources argue that data on maternal mortality in Tajikistan does not reflect the real situation (Falkingham, 2003; Habibov & Fan, 2008). Habibov & Fan (2008) suggest that numbers from vital registration are incomplete and show considerably lower numbers because of underreporting (Habibov & Fan, 2008). Walker (2008) also states that the official figures do not show the real magnitude of maternal mortality in the country because they do not cover adequately the true situation and they are not reliable. Rakhimova (2010) also states that “reliability and relevance” of health and demographic statistics is a serious concern and the official indicators are not reliable because of out-of-date definitions, collection methods, underreporting and lack of full registration of important statistics (p. 1). It also happens because of weak data collection and registration systems as well as because local health officials conceal maternal deaths from the MoH (Rakhimova, 2010).

In addition, because 71% of deliveries in Tajikistan, according to Rakhimova's study, occur at home, and maternal deaths during home deliveries are often not registered (Rakhimova, 2010), this certainly has an effect on the quality of the collected data. If these cases were registered, the rate would have been even higher. Despite that, the existing data shows that in some regions and towns the rate of maternal death is higher and that it is also higher in urban than in rural areas (GoRT, 2004).

Fertility

From 1959 to 1989 Tajikistan had the highest fertility rate in the SU, with a peak in the total fertility rate (TFR)⁹ at 6.3 children per woman in the mid-1970s followed by a decrease paralleling trends in other Soviet republics, with the TFR declining to 5.04 children per woman in 1991 (Clifford, 2009). After independence, fertility kept declining and the TFR reached 3.96 in 2000-2002, but continued to remain the highest among the post-Soviet countries (Clifford, 2009). Some sources connect the decrease of TFR with measures implemented by the government in collaboration with the United Nations Population Fund (UNFPA) (GoRT, 2004) after independence. Despite decrease in TFR after independence, the country's population increased from 5,108,600 in 1989 to 7,565,00 in 2000 (Olimova & Olimov, 2012).

According to 2012 DHS, TFR was 3.8 children per woman (STA, MoH, & ICF, 2013). It is higher at 3.9 births per woman in rural areas and 3.3 births per woman in urban settings (STA, MoH, & ICF, 2013). Age-specific fertility rates are

⁹ Total Fertility Rate is the number of births that a woman can have by the end of her reproductive years (Bongaarts, 1978).

low in women between 15-18 years old, which is 54 per 1,000 nationally, and then rise with peak at 20-24 years at 253 per 1,000 and are still higher among women between 25-29 years at 216 per 1,000 and then sharply decreases among women of older ages (STA, MoH, & ICF, 2013). Fertility rates are higher in rural settings with a particularly significant difference among women younger than 30 years old.

Fertility not only differs by place of residence but also by region (STA, MoH, & ICF, 2013). For instance, it is lowest at 3.3 births per woman in GBAO and Sughd regions followed by Dushanbe with 3.4 births, RRS with 3.9 and it is the highest with 4.2 in Khatlon region (STA, MoH, & ICF, 2013).

Education is also one of the strong determinants of fertility (STA, MoH, & ICF, 2013). The TFR declines from 4.2 among women with no or primary education to 2.7 births per woman among women with higher education (STA, MoH, & ICF, 2013). Finally, women from wealthy households have fewer children.

Forty-four percent (44%) of women in Tajikistan state in surveys that they do not want any more children (STA, MoH, & ICF, 2013). About 1% of women are sterilized (SA, MoH, & ICF, 2013). Forty-five percent (45%) of women consider that four children is the ideal size of a family. According to DHS, women's preferred average family size is 3.6 children (STA, MoH, & ICF, 2013). However, women usually had half a child more than they wanted to have. Thus, the rate of complete fertility would be 3.3 if women could avoid unwanted pregnancies (STA, MoH, & ICF, 2013).

Figure 4: Total fertility rate among women by residence, region and wealth



Sources: STA, MoH, & ICF, 2013

Tajikistan is predominantly a rural society where 75% of the population lives in rural areas (Walker, 2008). Despite the overall increase of population, the number of urban residents slightly decreased because of emigration of ethnic Russians after independence and because of lower fertility among urban residents in general (Walker, 2008). The proportion of the urban population decreased from 30.8% in 1991 to 21.9% in 2004 (GoRT, 2004). While the urban population decreased, the rural population increased by 31% from 1989 to 2000 (Walker, 2008). This urban trend is also connected with “stagnation and collapse of the city-forming industrial and production potential” in addition to outmigration of the ethnic Russian population who predominantly lived in urban areas in the country (Walker, 2008, p. 99). In

addition, many Tajiks who had also lived in urban places for a long time left Tajikistan because of lack of job opportunities (GoRT, 2004).

Contraception

Success of reproductive health planning programs is usually measured by levels of utilization of contraceptives among women and by decrease in fertility resulting from contraceptive use (STA, MoH, & ICF, 2013).

About 28% of women use some form of contraceptives in Tajikistan according to the latest findings of DHS (STA, MoH, & ICF, 2013). Most women (26%) use modern methods of contraception such as the IUD, pills and condoms and 2% use traditional method such as withdrawal and rhythm method (STA, MoH, & ICF, 2013). The latest survey shows that the IUD is the most widespread and popular method among Tajik women. About 19% of currently married females use it. Six out of ten women who use family planning use IUDs (STA, MoH, & ICF, 2013). Two percent of women reported using the pill, male condoms, injections and withdrawal (STA, MoH, & ICF, 2013). One percent of women also reported having had sterilization.

According to DHS 2012, contraception use is low among young married women because they want to start building a family. Low contraception use is also seen among those who are older in comparison with those who are middle aged (STA, MoH, & ICF, 2013). The survey found that the utilization of contraceptive methods is low among women younger than 25 years old but rises to 47% among those between 35-39 years and then decreases to 19% among women of 45-49 years old (STA, MoH, & ICF, 2013). Very few women start using contraception before at least one child

(STA, MoH, & ICF, 2013). Contraception use remains low until married women have more than two children. Forty-two percent of women who have 3-4 children use birth control methods, whereas only about 20% of those who have 1-2 children use birth control methods (STA, MoH, & ICF, 2013).

The residency of husband (i.e. the time when the husband actually lives with his family and is not in migration) is also one of the main factors impacting contraceptive use (STA, MoH, & ICF, 2013). Women who mentioned that their husbands live away from them do not often use contraception (17%). Women whose husbands live with them (29%) reported higher use of contraception. They also had higher rates of modern contraceptive method use (27%).

The 2012 DHS shows that there is a difference in use of contraception between urban women (3 in 10) and rural women (one-quarter) (STA, MoH, & ICF, 2013). There is a significant variation in contraceptive use by regions. The highest use of contraception is observed among married women in GBAO and Sughd (35% in each region) (STA, MoH, & ICF, 2013). Married women in RRS and Khatlon had the lowest use of contraception at 22% and 24% respectively. Women who have higher education were twice as likely to use contraception as those with primary or no education (41% versus 21%) (STA, MoH, & ICF, 2013).

The IUD is prevalent among all groups of women irrespective of their background. Two - thirds of women use the IUD. Injectable contraception is often used by those who have higher parity (5-6 children), those living in GBAO and those from lower income households (STA, MoH, & ICF, 2013). Women in the capital city,

women with higher education and those from wealthy households often report use of male condoms (STA, MoH, & ICF, 2013).

The use of contraception among married women increased from 34% to 38% in the middle of the last decade and then significantly declined to 28% in 2012 (STA, MoH, & ICF, 2013). This decline is mainly due to the reduction in the use of IUDs (STA, MoH, & ICF, 2013). In addition, a decline in contraceptive use is observed in both urban and rural settings (STA, MoH, & ICF, 2013). Its use dropped from 42% in 2005 to 32% in 2012 in urban areas and from 36% to 27% in rural areas. DHS does not provide clear reasons for this difference, but one of the possible explanations is migration of men for work in Russia (STA, MoH, & ICF, 2013). Because of the long absence of their husbands, women with migrant husbands are less likely to use methods of contraception or even to stop using them as they do not see themselves at risk of pregnancy with their husbands being away (STA, MoH, & ICF, 2013). The survey shows that 17% of women who report that their husbands live elsewhere use contraception, whereas 29% of those who live with their husbands use contraception.

Abortion

Abortion continues to be used as a method of birth control (GoRT, 2004). Since 1955 abortion has been legal in the country (Walker, 2008). The legislation on abortion was updated in 1997. Significant decrease in abortion rate is observed during the independent period from 223 per 1,000 live births in 1996 to 94 per 1,000 live births in 2006 (Walker, 2008). High utilization of abortion is explained by limited access to contraception (Walker, 2008). Most abortions (56%) occur among women from 30 to 39 years old and many abortions are motivated by socio-economic

conditions (Walker, 2008). It was reported that the abortion rate among adolescents increased from 4% in 1998 to 20% in 2002 because more Tajik adolescents are sexually active and less likely to use contraceptives (Walker, 2008). Almost all abortions are carried out in government health institutions. About 70.6% of abortions are performed in the first trimester of pregnancy.

The proportion of abortion increases significantly with the age of a woman (SA, MoH, & ICF, 2013). The proportion of pregnancies ending in abortion is 1% among teenagers and 26% among women between the ages of 35 and 44, and it also increases with parity from 1% of women with one child to 25% among women with 5 or more children (STA, MoH, & ICF, 2013).

The proportion of pregnancies ending in abortion is 12% among urban and 8% among rural women. It is highest in Dushanbe (14%), RRS (8%) and is lowest in Khatlon region (7%). Education is connected with an increase of abortion: the share of abortions is 3% among women with no or primary education, and 14% among those with higher education (STA, MoH, & ICF, 2013). It also increases with wealth and is highest among women in the 4th and 5th wealth quintiles with 11 and 13 % respectively (STA, MoH, & ICF, 2013).

Surgical methods¹⁰ of abortion were dominant for decades in Tajikistan, whereas medical methods¹¹ of abortion were introduced only couple a few years ago.

¹⁰ Surgical abortion is a method of abortion that involves several different surgical techniques for early termination of pregnancy, that is, in the first three months of pregnancy (Say et al., 2010).

¹¹ Medical abortion is a method of abortion that involves the use of medicines (e.g. prostaglandins, mifepristone alone, mifepristone with prostaglandins and methotrexate with

Several complications that can occur during surgical abortion are infection, cervical laceration, incomplete evacuation, uterine perforation, hemorrhage and complications due to anesthesia (Say, Brahmī, Kulier, Campana, & Gülmezoglu, 2010). Unsafe and harmful procedures during surgical abortions often lead to infertility, miscarriages and even low birth weight in future pregnancies (Say et al., 2010) and other complications such as sepsis, genital trauma, death, emotional feeling including depression, guilt and grief (WHO, 2008). Uterine perforation is rare but does happen during surgical abortions. Therefore, medical methods were developed as safer alternatives to surgical abortion (Say et al., 2010). However, the majority of studies to examine the efficacy of the medical methods of abortion were conducted in settings with good operation of emergency care institutions (Say et al., 2010).

STIs and HIV

STIs are infections mainly transmitted through sexual intercourse (WHO, 2007). However, they can also be transmitted from mother to child during pregnancy or labor and during transfer of blood products or tissue, and very rarely through non-sexual modes (WHO, 2007). There are more than thirty bacteria, viruses and parasites that are transmitted through sexual intercourse. The most common conditions they cause are gonorrhoea, chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, HIV infection and hepatitis B infection (WHO, 2015).

Walker (2008) in his study refers to a significant increase of STIs in Tajikistan since 1990s, but it is believed that the real number is even higher than the one

prostaglandins hormones prostaglandins and/or mifepristone - often known as RU 486- and/or methotrexate) which can be used to terminate early pregnancy either on their own or in combination (Say et al., 2010).

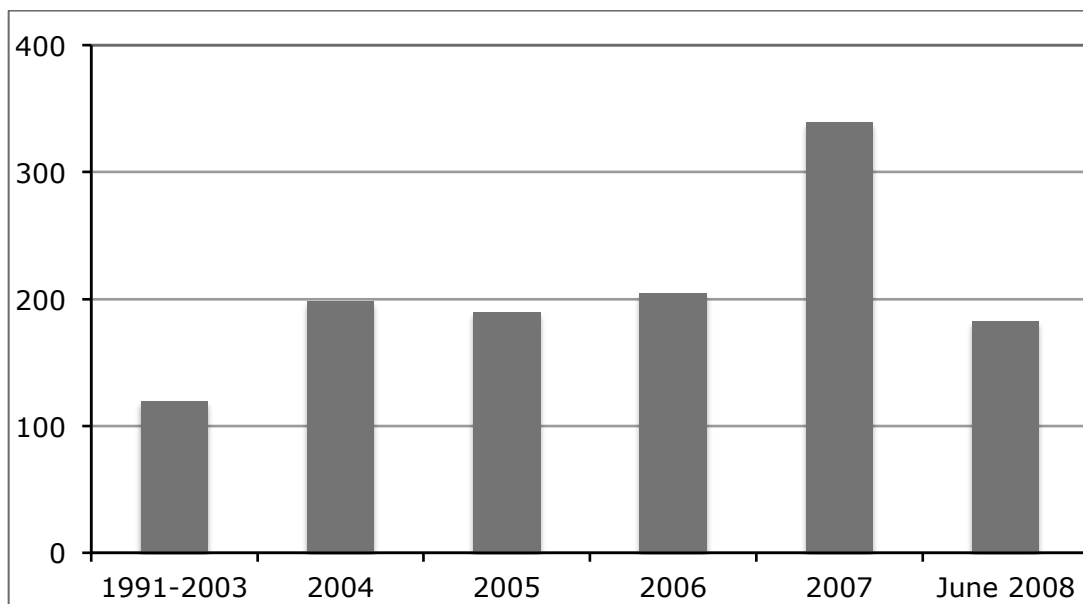
officially reported (Walker, 2008). The incidence of reported cases of syphilis increased from 1.6 cases per 100,000 population in 1990 to 12.9 in 2000 and decreased to 3.6 in 2005 (Walker, 2008). The same trend was observed with gonorrhea and other STIs when the incidence of these infections increased in 2000 and then dropped (Walker, 2008). It is suggested that reduction in these numbers is not real and is only due to decreased coverage of reported cases (Walker, 2008).

Prior to 1990, congenital syphilis was reported extremely rarely; in 2000, eight cases of the infection were registered (Walker, 2008). A small study conducted by the Republican Reproductive Center (RRC) among 1,034 women in a community in Khatlon region revealed that 25% of them had trichomoniasis, 18% had candidiasis, 15% chlamydia, 6% syphilis and 2% had gonorrhea (Walker, 2008). Some women may have had more than one infection, however, the study carried out by RRC does not report the percentage of women who had multiple infections. Also, younger women tended to have an infection more often. It is vital to recognize the importance of the high incidence of STIs in the country. High incidence of ulcerative general STIs is of particularly serious concern because they contribute to transmission of HIV infection (Walker, 2008).

In 2008 the prevalence of HIV was low at less than 1% of total population and, according to official statistics, 1,049 HIV cases were registered in Tajikistan (Walker, 2008). However, Joint United Nations Programme on HIV/AIDS (UNAIDS) argues that the actual number of the infection is ten times higher than the registered cases (Walker, 2008). About 84% of HIV infection is registered among people ages 15-29 years and 81% of them are male. The most common way of transmission is injecting

drug use (IDU) (Walker, 2008). However, with the spread of HIV epidemic in the country, this mode of transmission is decreasing, while the heterosexual mode is on the rise (Walker, 2008).

Figure 5: Number of people diagnosed with HIV infection in Tajikistan by year of diagnosis from 1991 to June 2008



Source: *The Nation at the Crossroad* (Miskinzod, 2009)

In 2005 the first case of HIV was diagnosed in a pregnant woman and by January 2008, 28 pregnant women were reported to have been infected (Walker, 2008). Those who tested positive received antiretroviral therapy (Walker, 2008).

Health care system

The health system of Tajikistan should be analyzed against the background of a country which recently acquired its independence, experienced a civil war and which faces important economic and social challenges. The health sector of the

country is one of the worst among other post-Soviet countries in the Central Asia (Habibov, 2010). The country's health care system was strongly affected by the transition period and further deteriorated by the long and violent Civil War (Habibov, 2010). The political and economic conditions had a dramatic and negative impact on the health care facilities (Habibov, 2010).

Similarly to other post-Soviet countries following independence, Tajikistan inherited the 'Semashko model'¹² of health care system from the SU (Hohmann et al., 2010). This model had a universal comprehensive free but inefficient health-care system with an enormous quantity of human resources employed and a huge infrastructure (Fan & Habibov, 2009; Habibov & Fan, 2008). It was also characterized by high volume of health care usage with an insignificant difference in terms of access to health care among various groups of population (Falkingham, 2003). During the Soviet period, the priority of the health care system was to provide population with access to health services, which made it possible to cover the entire population of the country with universal primary health care (PHC) (Mirzoev et al., 2007).

After the transition and economic crisis many of the health facilities were closed due to shortage of financial resources, equipment, medicines and

¹² Nikolaï Aleksandrovich Semashko (1874–1949), an academician of the Academy of Medical Sciences, was a Russian statesman who served as the first People's Commissar of Public Health from 1918 to 1930. He was one of the founders of the health system in the newly emerged SU, overseeing the essential work of combating epidemics, laying the foundations of Soviet public health system, and a system of protecting of mother and child and protecting the health of children and adolescents. It was also under his leadership that the network of medical research institutes in the SU was created. For more on him and the emergence of the Soviet health system, see Anna J. Haines, *Dr N.K. Semashko: The Commissar of Health*, New York: Vanguard Press, 1928.

pharmaceuticals, and lack of qualified medical professionals (Habibov & Fan, 2008; Mirzoev et al., 2007). A large number of health care facilities were significantly damaged by the Civil War (Mirzoev et al., 2007; Fan & Habibov, 2009). Others existed only on paper or are in inoperable condition due to shortage or absence of water, sanitation and electricity (Habibov & Fan, 2008). Health facilities in rural areas have particularly suffered from the impact of various socio-economic and political factors.

Due to economic difficulties in the health sector, rural facilities of PHC continue to suffer from shortage of staff, equipment and supplies (Mirzoev et al., 2007). As a result, large numbers of these facilities stopped their operation due to the lack of resources and basic working conditions (Mirzoev et al., 2007). In comparison with PHC facilities, hospitals have been able to continue functioning thanks to the introduction of fees for some of health services and were not, therefore, severely affected (Mirzoev et al., 2007).

Similarly to other post-Soviet states, Tajikistan was not able to maintain its health system properly, because of financial constraints which were the result of significant reduction in economic output and a related decrease in government revenues and funding allocated for health (Hohmann, et al., 2010). Lack of financial resources in transitional countries often result in worsening of the quality of health care services, reduction of existing ineffective public health measures and rise in informal payments¹³ (Bonilla-Chacin, 2005). The same is the case in Tajikistan. The share of spending on the health care system within the overall GDP decreased from

¹³ More detailed information on informal payments will be provided later in the chapter.

6.4 percent in 1994 to 1.5 percent in 1999 and continues to be less than a tenth of its pre-independence rate (Falkingham, 2004). With the reduction of government spending, beds and the number of health professionals were also reduced. The official data also show a sharp reduction in the use of health care services by the population. For instance, hospitalization decreased from 21.5 to 9.6 per 100 population between 1990 and 1999. Outpatient referral also decreased from 7.5 per person per year in 1990 to 3.4 in 1999 (Falkingham, 2004).

The health care system of pre-independence Tajikistan was very hierarchal (Habibov, 2010), centralized and hospital oriented (Mirzoev et al., 2007). Health care institutions functioned at different levels, starting from small rural hospitals to dispensaries and reaching republican hospitals (Habibov, 2010). The higher the levels of health care system, the better the quality of services it provided (Habibov, 2010). PHC was not developed well and experienced shortages of modern medical equipment. For this reason, patients did not refer to primary health care specialists but instead tried to see medical personnel in the hospitals because they were considered to be more professional and also because those health facilities were often better equipped with diagnostic equipment and pharmaceuticals (Habibov, 2010).

The country has a large number of doctors, but their geographic distribution varies considerably. They are mainly concentrated in the cities, while there is a deficit of doctors in remote areas (Mirzoev et al., 2007; Parfitt & Cornish, 2007). The number of doctors is much larger in Dushanbe, at 71 per 10,000, than in the country as a whole (Fan & Habibov, 2009; Mirzoev et al., 2007).

In 2001, expenditure on health sector constituted US\$ 39 million (US\$ 6.3 per capita), out of which only 26% was covered by the government, while 43% was covered by donors and 31 % by patients or users (Mirzoev et al., 2007). Nevertheless, informal payments are thought to be even higher by many researchers. As a result of decreases in state spending, the capacity of the health care system to effectively provide the public with accessible medical care deteriorated (Falkingham, 2003). Government expenditure for health care covered salaries of human resources and some parts of catering in the hospitals, drugs or maintenance and reconstruction. The gap between the government budget and the real care costs is increasing, which puts the financial burden of keeping the system running on the shoulders of the population who have to pay official costs and often “under-the-counter or informal payments” (Falkingham, 2003, p. 33).

It is argued that Tajikistan’s health sector is one of the most corrupt sectors in the country (Fan & Habibov, 2009). Therefore, corruption is one of the major problems for the health sector (Mirzoev et al., 2007). As mentioned earlier, the transition period from socialist to capitalist economy resulted in cutting government expenditures on health care and, first of all, the reduction of salaries of health care workers, which were already quite low (Habibov & Fan, 2008). The formal wage of a health care worker dropped significantly from US\$ 288 to 2.87 which is almost 99% decrease in real terms over the period 1990-1999 (Mirzoev et al., 2007; Fan & Habibov, 2009). In addition, for a very long time salaries of workers of public sector, including health care, were often paid late (sometimes up to 5 months later). Due to these reasons informal payments for health services have become one of the main sources of income for those who work in the health sector (Habibov & Fan, 2008).

The situation continues to be the same today. The salary of the health care workers remains very low. Therefore, fees that are charged for consultation of patients help to subsidize low salaries of health care workers despite the fact that the consultations of health professionals remain officially free (Falkingham, 2004). Vast majority of doctors and nurses receive out-of-pocket payments and in-kind gifts as survival mechanism in this protracted transitional period (Falkingham, 2004). One can even argue that it serves as a survival mechanism for those working in the sector because otherwise they cannot live on the salary paid by the state.

In addition, despite the fact that many health care services remain free according to the Constitution of the country, a small number of health care institutions were given 'self-financing status' allowing them to charge fees for their services (Falkingham, 2004, p. 250). Many hospitals and clinics were also granted the right to charge fees for their services according to a price list developed and approved by the MoH. Moreover, the government is also actively considering the extension of user charges for other services (Falkingham, 2004). Officially services of prenatal care are free-of-charge, but unofficially out-of-pocket fees in forms of cash or in-kind exchanges are common (Falkingham, 2004; Habibov & Fan, 2008). The burden of informal payments has become a major determinant for seeking health care services among women from poor households. As a result half of women in 1999 did not access prenatal care because they could not afford it (Habibov & Fan, 2008) and the situation remains the same even now.

The amount of out-of-pocket payments increases with the rise of the level of health care specialization (Falkingham, 2004). Hospitals and surgeons charge more

money for their services than feldshers (physician assistants)¹⁴ and staff of SVA (rural physician clinics) where the staff only get gifts or can charge nominal fees. The poor usually utilize only primary care facilities and providers, such as feldshers, or medical assistants while better-off people refer to polyclinics and hospitals (Falkingham, 2004). In addition, the poorest people often receive treatment at home (e.g. a nurse or a feldspar comes to see them) or in FAP (physician assistant/midwife posts) or SVA while the richest sections of the population receive treatment from a doctor in a polyclinic or a hospital.

Moreover, recent government health care expenditures favor tertiary care whereby four-fifths of health care expenditure (78%) are spent on hospitals. Taking into account the various patterns of hospital use by different groups of population in Tajikistan, it seems that such state expenditures are not effective in targeting the poor and most vulnerable (Falkingham, 2004). Physicians often charge patients informally based on their “subjective assessment of patients’ ability to pay” (Falkingham, 2004, p. 257). The author states that poor people pay less than those who are rich. However, it must be said that the costs of medicines and pharmaceuticals are higher than the costs of out-of-pocket payments for medical workers in Tajikistan (Habibov, 2010).

Another shortcoming of the health care system in Tajikistan as identified in previous studies was long hospital stays, which is commonly connected with the funding system that encouraged utilization of treatment protocols with long inpatient care, including invasive procedures (Habibov, 2010). However, the new protocols of treatment require fewer days of hospital stay with minimum invasive procedures

¹⁴ The term is commonly used in Russia and other countries of the former USSR.

(Habibov, 2010). A rigid financial system which is not under the control of hospitals causes the continuous utilization of the old-style protocols of treatment and does not allow cutting long hospitalization effectively. Outdated protocols of treatment are another reason for lengthy hospital stays.

According to old protocols, the length of stay is set as a performance target and punishment is applied to hospitals that do not reach the targets (Habibov, 2010). Treatment protocols utilize ineffective treatment not based on evidence, such as low power laser therapy. In addition, these protocols do not use cost-saving procedures. As a result, hospitalized patients often receive long-term treatment. For example, they would receive intra-muscular injection which could have been easily replaced by the intake of tablets for a short time as outpatient with the similar treatment effect (Habibov, 2010). The prolonged and ineffective hospitalization, as mentioned earlier, is a result of old treatment guidelines that are not based on clinical evidence and which contain lots of invasive treatment (Habibov, 2010). Hospital care spending should be used for high risk interventions; however, it was common to admit patients into hospital without regard to the severity of their illness in the Soviet period.

There are deficiencies not only in the low amount of available funding, but also in the budgeting process itself (Mirzoev et al., 2007). The MoH is in charge only of the state budget for national tertiary hospitals and activities of the MoH. However, it is the regional administrations (*hukumats/governments*), which control budgets for primary- and secondary-level health institutions (Mirzoev et al., 2007). Local administrations usually allocate the quarter of their funding on health care, so it is clear that health care spending depends on local designs. Local administrations are

free to distribute resources across sectors, but they usually do not give priority to the health sector (Mirzoev et al., 2007). This results in significant gaps between projected and disbursed budgets, and differences between regions (Mirzoev et al., 2007).

Reforms

In 1996-1997, the Government and the MoH declared their desire to introduce health reforms (Mirzoev et al., 2007). The Concept of Health Reforms was developed in the beginning of the 2000s (Mirzoev et al., 2007) in line with what was happening in other post-Soviet countries of the region. The key difference is the failure to successfully implement health reform initiatives in Tajikistan (Mirzoev et al., 2007). The process of implementing the health reforms is slow in Tajikistan in comparison with other central Asian countries, such as Kazakhstan and Kyrgyzstan. Mirzoev et al., (2007) associate it with the impact of the Civil War and emigration of a large number of qualified medical professionals. In addition, the government's inability to adapt to transitional processes is also seen as another important reason for the slow speed of the health reforms in Tajikistan (Habibov, 2010).

The main focus of health reforms in Tajikistan is on strengthened PHC and the decentralization of the health sector (Mirzoev et al., 2010). With the aim to redirect health funding to PHC, the MoH decreased the number of hospital beds from 104.8 per 100,000 population in 1990 to 70.1 in 1997 and then to 62.7 in 2002 (Mirzoev et al., 2007). However, it was not allowed by the government at the time to reinvest the saved money into PHC and instead the MoH completely lost the budget allocated for those beds. At present, the MoH is careful about the possibility of reforms with similar results in the sector (Mirzoev, 2007).

In the early days of the reforms, various donors supported the health sector with fragmented initiatives. However, despite the help of the donors, the health reforms remained slow and “often un-coordinated” in Tajikistan and the country continued to significantly depend on external support (Mirzoev et al., 2007; Mirzoev, Green, & Newell, 2010). Mirzoev et al. (2007) characterize the reforms of PHC as one of “the most radical experiments” (p. 498). They were conducted in a way that some donors began rehabilitating the existing PHC, while others tried to create mechanisms to rationalize the PHC network. The MoH changed the name of various types of facilities on several occasions to review their responsibilities, but no tangible differences were achieved in practice (Mirzoev et al., 2007).

Several key donors, such as WB, the Islamic Development Bank and the Asian Development Bank (ADB) and dozens of other international organizations have been working in Tajikistan since the beginning of the relief stage. They implemented or helped to implement more than 480 health programs in the country between 1999 and 2003 with US\$ 51 million contribution of donors into the health system (Mirzoev et al., 2010). Implementation of these health projects by various international agencies caused fragmentation and application of initiatives resulted in decrease of efficacy of the MoH. Limited resources and fragmentation of donor help to the health sector in Tajikistan were among the main reasons why the entire process was not successful. The traditional project-based donor attitude to providing aid to the health sector often causes “confusion, dissipation, wasting of scarce resources and lack of sustainability” (Mirzoev et al., 2010, p. 271). As a result, now “the health system has evolved and is made up of a jigsaw composed from models advocated or imposed by donor agencies” (Mirzoev et al., 2007, p. 498). Therefore, the result of all these years of

reforms is a health system which is more disjointed and cumbersome than it used to be. For example, the use of maternity health care facilities diminished after the dissolution of the USSR, the economic crisis, and the Civil War (Falkingham, 2004) and continues to deteriorate (Habibov & Fan, 2008). There is, therefore, no or very little progress in the health care reform. Finally, one of the important repercussions of donor dependency in general and, in terms of the implementation of the reforms, for Tajikistan, is the development of a health system heavily depended on external aid. Similar situation exists in other republics of the former SU (Mirzoev et al., 2010). Following the transition period, a necessity of large-scale reforms of the public sector emerged, which was influenced by limited financial resources including 25% of the state health budget and about 50% of external aid (Mirzoev et al., 2010). Aid is mainly given in form of project funds, which are largely implemented through uncoordinated initiatives (Mirzoev et al., 2010). Donors have a considerable impact on policy-making. Their involvement can sometimes aid the capacity building of MoH, but its sustainability is questionable (Mirzoev et al., 2007).

CHAPTER 3

THEORETICAL BACKGROUND

This chapter examines some of the key concepts in the understanding of the impact of labor migration of men on the health of their left-behind wives. It also examines some of the key literature on topics related to issues, approaches and methodologies relevant for this study.

Fertility

“Fertility” is the quality of being fertile and the ability to produce offspring. Bongaarts (1978) uses the definition of “natural fertility” proposed by Louis Henry when couples purposefully do not use fertility control subject to the number of children they have. Bongaarts (1978) also discusses “proximate determinants of fertility” impacting fertility, such as 1) proportions of married (i.e. marriage is identified as one of the main determinants of fertility); 2) contraception - a purposeful use of method of birth control to decrease the risk of conception; 3) induced abortion-utilization of practice with the purpose to interrupt the normal gestational process; 4) lactational infecundability¹⁵ – infecundability of a woman after pregnancy until the pattern of normal ovulation and mensis is re-established which depend often on lactation’s intensity; 5) frequency of intercourse - changes in the frequency of sexual intercourse because of temporary separation or illness; 6) sterility- females who are sterile before menarche¹⁶ and after menopause¹⁷; 7) spontaneous intrauterine

¹⁵ Infecundability - inability to conceive.

¹⁶ Menarche refers the first menstruation of a woman.

mortality- conceptions that do not end in a live birth but in a spontaneous abortion or stillbirth; and 8) duration of the fertile period - when a female can conceive for a very short time in the middle of the menstrual cycle (Bongaarts, 1978, p. 107).

All the above-mentioned factors impact fertility of women, but this study will focus on the impact of migration of a spouse on fertility of the left-behind women. Nevertheless, it is important to be aware of all these factors because they help to understand that fertility depends on a number of cross-sectional factors and migration is only one of such factors.

Because fertility is a very important aspect of women's reproductive health, it is quite natural that if labor migration impacts the overall health of the left-behind women, it will undoubtedly have an impact on their fertility as well. It is, therefore, important to look into the issue of the impact of labor migration on the fertility of the left-behind women.

Early fertility studies showed that there were extensive seasonal fluctuations in the rate of monthly conception among women who would have otherwise had the possibility of becoming pregnant (e.g. because they were married), were not pregnant and did not experience postpartum anovulation (Menken, 1979). F. van de Walle (1975) (as cited in Menken, 1979) in a study on Ticino, a canton of Switzerland revealed that the 19th century low fertility rate and the significant seasonal swings in birth rates were the results of a regular annual male migration. Every year men of the

¹⁷ Menopause is the cessation of menstruation at the time of woman's life when the production of estrogen declines and menstruation ceases. It usually occurs sometime between the mid-forties and early fifties (Mastroianni, Faden, & Federman, 1994).

canton worked for several months in other regions of the country causing these changes in fertility and birth rates (F. van de Walle (1975) as cited in Menken, 1979). The fertility of married couples was twenty five percent lower than in other cantons because this particular canton had high levels of periodic occupational mobility resulting in separation of spouses (Potter & Kobrin, 1982). Chen et al. (1975) (as cited in Menken, 1979) during the two-year of observation in Bangladesh also found that monthly conception rates significantly varies from month to month annually due partly to spouse separation and male absence (Potter & Kobrin, 1974; Menken, 1979). The monthly conception rate varies from more than .15 (15 conceptions per 100 married, menstruating women) in three successive months of the year to less than .08 per month in six successive months (Menken, 1979). Thus, spousal separation decreases fertility by lowering coital frequency, fecundability and conception rate.

Menken (1979) used a mathematical model of reproduction (the reproductive process) to study the impact of changes in seasonal swings in monthly conception rates on the overall fertility rates. Her study showed that seasonal migration and seasonal changes in conception rates significantly decrease annual birth rates due to changes in coital frequency, short temporary absences and other factors. Although the seasonal character of conception rates widely distributes conceptions by month of the year, its overall impact is close to a new level, which is constant and is the result of lowering fecundability (Menken, 1979). Bongaarts and Potter (1979) used a simulation reproductive model - REPMOD that permitted to make changes in the reproductive parameters according to age and other variables, to confirm that the asymptotic annual birth rate in population with seasonal fecundability fluctuations is

similar to the annual birth rate of population where due to the seasonally varying values fecundability is kept constant.

A large number of studies examine the effects of migration on fertility of permanent migrants at the destination areas. The concern around different fertility rates among migrants and non-migrants increased interest in studying the association between migration and fertility and its effect on population growth rates in urban settings (Bach, 1981).

According to Bach (1981), the influence of mobility on fertility remains a popular research area, although it often suggests ambiguous and conflicting results. Currently, various hypotheses exist to explain the influence of a new setting on fertility of migrants and their behaviors (Kulu, 2005). Partially complimentary and partially contradictory views about how migration influences fertility of migrants are suggested (Kulu, 2005). One of the hypotheses explaining the impact of mobility on fertility of migrants is the *socialization hypothesis*. It argues that fertility patterns, values and behaviors prevailing in the childhood environment of migrants determine their fertility behavior (Kulu, 2005; Clifford, 2009). For that reason, migrant couples have the same fertility rates as other couples in their place of origin. Only the next generation of migrants has a similar level of fertility as that of the residents at the destination environment (Kulu, 2005).

The next hypothesis is the *adaptation hypothesis* which suggests that migrants adopt the norms and values of fertility prevailing among native residents at the destination (Chattopadhyay, White & Debpuur, 2006; Lindstrom & Saucedo, 2002). This hypothesis relies on sociological as well as economic theories behind fertility

determinants. The sociological theory suggests that social and cultural norms dominant in the destination define fertility of migrant couples (Chattopadhyay et al., 2006). The economic theory proposes that the adaptation is a result of impact of income of migrant family and the expense of childbearing at the place of destination (Chattopadhyay et al., 2006; Clifford, 2009). Thus, different wages for females, males and children, and the financial restriction connected with costs and income in the destination setting as well as educational and job prospects and expenses of childbearing result in changes in fertility behavior (Chattopadhyay et al., 2006). Overall, according to these theories, socio-cultural norms and childrearing expenses alter fertility behavior of migrants. As a result, fertility of migrants eventually becomes the same as that of the residents at the place of destination (Chattopadhyay et al., 2006).

The adaptation hypothesis relies on the arguments which purport that with time the fertility behaviors of migrants become similar to that of the population at the destination. Therefore, it suggests that re-socialization is possible (Kulu, 2005). Lindstrom and Saucedo (2002) state that some studies use the adaptation hypothesis to explain the impact of economic factors on fertility, while others utilize the assimilation hypothesis within the cultural framework to explain the adjustment of migrant fertility to the fertility norms of population at the destination. The authors state that it is hard to separate the influences of assimilation from those of adaptation since these processes happen concurrently. Therefore, they are used in many studies in combination either under the umbrella of adaptation or that of assimilation (Lindstrom & Saucedo, 2002).

Another hypothesis useful for this study is the *selection hypothesis* which suggests that migrants have fertility values similar to those characterized for native non-migrant residents at the destination, but not to those common among the population at the origin setting (Kulu, 2005). Chattopadhyay et al. (2006) argue that the selection hypothesis shows the tendency among the migrants to be self-selected depending on their individual characteristics (e.g. educational attainment, age at marriage and occupation) which is commonly connected with a lower or higher than the average level of fertility of people in the origin setting. For instance, Chattopadhyay et al. (2006) argue that females who move to urban settings may have higher level of education than rural residents who stay behind, because they have the tendency of having fewer children than women with a lower level of education and thus contribute to the reduction of urban fertility rate. Selection can also be related to unobserved characteristics like the tendency to postpone having children, openness to change and innovation, fertility aspirations (Chattopadhyay et al., 2006) and mobility aspirations (Lindstrom & Saucedo, 2002). Jensen and Ahlburg (2004) also argue that the selection hypothesis suggests that migrants differ from non-migrants due to observable characteristics, such as education and age and also unobservable characteristics, including motivation, which result in comparatively lower fertility rates among migrants than non-migrants.

According to the *disruption hypothesis*, shortly after migration because of the influences of the disruptive factors brought about by migration, the level of fertility of migrants reduces (Chattopadhyay et al., 2005; Kulu, 2005). Disruption hypothesis implies that migration which causes disruption leads to lower fertility due to physical separation of married couples (Jensen & Ahlburg, 2004). Chattopadhyay et al. (2006)

suggest that the disruption in childbearing occurs as a result of separation of married couples or as a result of a desire to postpone having a child after the migration. The disruption influence is often examined in terms of temporary migration that shows that it is lower among migrants than non-migrants. Nevertheless, the disruption in childbearing due to migration may be followed by its increase amongst the same migrant couples (Chattopadhyay et al., 2006). The period of disruption in the fertility rate of a woman, therefore, may last only for a short period (Chattopadhyay et al., 2006; Lindstrom & Saucedo, 2002).

Lindstrom and Saucedo (2002) also mention the *diffusion hypothesis* to explain the effect of migration on fertility at the origin. Clifford (2009) argues that the diffusion hypothesis shows that adopted fertility norms have an impact not only on the fertility of individual migrant couples, but also on the fertility of people who live in the place of origin. Lindstrom and Saucedo (2002) state that the assimilation/cultural adaptation/adaptation hypothesis uses cultural theories of fertility to emphasize how norms and ideas impact fertility behaviors and preferred size of family. The cultural framework regarding fertility tries to include the impact of the sociocultural factors of fertility practices and focuses on aspects which play a crucial role in shaping and communicating norms (Lindstrom & Saucedo, 2002). The cultural approach suggests that temporary migration is a powerful mechanism to reduce fertility significantly. Because once migrants return to their place of origin, they bring the newly learned innovative ideas and new behaviors with them. These ideas and behaviors brought by permanent and temporary migrants from migration then become common among residents of origin areas, especially those with a long history of

mobility, and, define gradually standards for fertility both among migrants and non-migrants (Lindstrom & Saucedo, 2002).

Previous studies also examine other important aspects of the impact of migration on fertility. For example, Potter and Kobrin (1982) state that in a situation of so-called natural fertility, fecundability is predominantly connected with frequency of coitus, which decreases when spouses are often separated for months for different reasons. The authors suggest that spouse separation has a significant impact on marital fertility. They argue that according to migration theory, fertility is lower among young migrant couples in origin as well as destination places because separation of spouses decreases the rate of childbearing (Potter & Kobrin, 1982). Potter and Kobrin's (1982) study showed that spousal separation had a remarkable impact on marital fertility. They were also able to show that while short and irregular separation has little influence, single separations of two or more years and regular separation of spouses had significant impact on births among population with natural fertility. The influence of separation is stronger among the fecund healthy population/couples with short-term post-delivery anovulation (Potter & Kobrin, 1982). It increases among the couples who separate early in their reproductive lives. This combination often occurs among migrants who moved from rural to urban setting and whose migration is relatively permanent (Potter & Kobrin, 1982).

When separations happen later in marriage, the effect of migration on fertility might be comparatively little, even if the separation is quite regular and long-lasting (Potter & Kobrin, 1982). The authors cite results of Van de Walle's data for Ticino that discuss such situation where the absent male spouses were much older. It implies

that if absences occurred among younger couples, the extreme fluctuation documented in the study in Ticino would have had even more noticeable influence on fertility (Potter & Kobrin, 1982).

Chattopadhyay et al. (2006) state that migrants have the same rates of childbearing as the native residents at destination and suggest that as a result the rate of growth of the cities will slow down, while the residents in rural areas will continue to have higher fertility. The authors suggest that in order to decrease the level of fertility nationwide, family planning measures should be directed towards rural settings, which could be useful in the case of Tajikistan.

Lindstrom and Saucedo (2002) state that “the role of migrant-based diffusion in fertility decline will depend on the prevalence and gender composition of migration in the community” (p. 1346). It is believed that the experience of migration of a wife plays a more significant role in shaping marital fertility than that of a husband (Lindstrom & Saucedo, 2002). Thus the migration of women has a stronger effect on fertility in comparison with the migration of men. This argument is consistent with studies of the role of diffusion in contraceptive use and fertility decline where the focus is placed on the social networks of women (Lindstrom & Saucedo, 2002). The interesting point that Lindstrom and Saucedo (2002) bring up is that men migrants are aware of low-fertility norms and values including small size of family as well as gender roles dominant in the United States such as more autonomy of a woman and equal relations between married couples, but they refused them and preferred traditional patriarchal family norms with focus on husband and father’s dominant role in the family. In fact, migrant men did not settle in the U.S. by marrying local or

locally born Mexican women because of these values and norms. Instead, they preferred spouses born in Mexico rather than those born in the U.S (Lindstrom & Saucedo, 2002). In comparison, women with migration experience in the U.S. upon returning to their native country have births with longer time lags between them and a slightly lower TFR.

Chattopadhyay et al. (2006) and others argue that most of the research on the subject is dedicated to the examination of migration of rural people to urban settings, whereas the influence of this mobility on rural fertility has not been researched well. But for a country such as Ghana, where rural settings are usually either the final destination of return of migrants or as parts of circulatory movements of migration, undertaking research on these issues is crucial. The authors also argue that examining only rural-urban mobility is not sufficient to understand the impact of migration on the national fertility trends (Chattopadhyay et al., 2006).

Lindstrom and Saucedo (2002) also make the same argument, namely that the bulk of the research on migration and fertility is devoted to the influence of long-term migration from settings with high fertility to those with lower ones. They are also concerned with the effect of in-migration on the overall fertility and growth of population in destination areas.

However, little focus is put on the influence of temporary migration on fertility in place of origin, even though the number of temporary migrants is higher than that of long-term migrants. Lindstrom and Saucedo (2002) also suggest the use of the diffusion hypothesis for this kind of analysis in origin settings. They explain it in the following way: “Return migrants may facilitate fertility decline in their communities

of origin through the diffusion of low-fertility norms and values acquired while working and living in the U.S. (Lindstrom & Saucedo, 2002, p. 1344).”

These studies are very useful and trigger many important questions about the connection between migration and fertility, but they do not look at the impact of short-term and temporary migration on the fertility of the left-behind wives. The number of studies that examine the impact of spousal separation as a result of seasonal or temporary migration of one of the partners (i.e. the husband) on fertility of the left-behind woman at origin is limited. Sevoyan (2011), for example, shows that although seasonal labor migration did not disrupt the pregnancy rates and lifetime fertility among left-behind women in low-fertility areas, it has an impact on fertility in high-fertility settings. She argues that pregnancy rates are similar among both migrant and non-migrant couples because in the absence of migration contraception use controls fertility.

While examining the effect of seasonal labor migration on fertility in the origin settings, Sevoyan (2011) found that seasonal migration does not lead to additional disruption in the fertility levels in a short or long-run. This finding goes against those from high-fertility settings. Clifford’s (2009) study on Tajikistan revealed a short-run disruptive influence of separation of married couples due to temporary migration. At the same time, although Clifford (2009) did not find the effect of unobserved selectivity, he nevertheless shows the impact of the circumstances and patterns of community migration on fertility.

Another study, directly examining fertility among wives of migrant men in Mozambique, showed that lifetime fertility of these women decreases during

migration of their husbands but then it increases after cessation of migration of their spouses (Agadjanian, Yabiku and Cau, 2011b). In addition, the study also indicates that wives of migrants, irrespective of children number, want to have another baby after the return of their husbands. However, this is more prevalent among the wives of successful migrant workers. Spouses of economically successful migrant workers use contraception more often in comparison with other women due to the growing impact of migration (Agadjanian et al., 2011b). This leads me to the examination of the nature of contraception use among wives of labor migrants.

Contraception

Contraception is the utilization of different devices, drugs, agents, sexual practices, or surgical procedures to avoid pregnancy (MNT, 2009). Contraception allows women to plan if and when they desire to have a child. There are various types of contraception (MNT, 2009).¹⁸

¹⁸ There are traditional and modern types of contraception methods. Traditional methods include abstinence, when sexual intercourse is avoided to prevent pregnancy, and withdrawal or coitus interruptus when a male approaching an orgasm pulls his penis out of the vagina and ejaculates outside of it (MNT, 2009). There are other types of traditional (herbal) contraceptives (rue, parsley, acacia, lemon, pennyroyal, savin, tansy, golden groundsel, blue cohosh, assafoetida, slippery elm, calamus/sweet flag, and cotton root) (Koblitz, 2014). Women used the herbs mainly as teas alone or in combination with each other. They also rarely used them in vaginal or even rectal areas (Koblitz, 2014). The use of herbal contraceptives were not reported by the respondents. Modern contraception methods include **male condom** when a polyurethane or latex device is used to serve as a mechanical barrier for sperms to enter the vagina to prevent pregnancy (MNT, 2009). It is put on the penis before having sexual intercourse. Condom is the only contraception that prevents both pregnancy and STIs. **Female condom** is polyurethane device that has a ring on both ends and one is

located behind the pubic bone to keep the condom in place (MNT, 2009). The second ring is usually outside the vagina. **Spermicides** are also type of modern contraception that are used before sexual intercourse in the vagina that serves as a chemical barrier (MNT, 2009). **Contraceptive sponge** has a depression to keep it above the cervix. With the help of applicator foam is put into the vagina. Contraceptive sponge spermicides kill the sperms and the sponge itself serves as a barrier for the sperm (MNT, 2009). **Diaphragm** is a rubber device that is placed behind pubic bone of a female above the cervix which rings helps to press it against the vagina walls. It becomes particularly effective when it is combined with spermicides (MNT, 2009). **Cervical cap** is placed on the cervix to act as a barrier and block sperms from entering the uterus. One third of the cap should be filled with spermicides. **The Pill** is a widely used contraception in the developed world. Many combined pills contain two hormones - an estrogen and progestin. The pills prevent the release of the egg (ovulation), and they also contribute to thinning of the uterine's lining (MNT, 2009). **Contraceptive patch** is a transdermal patch applied to the skin. It releases synthetic estrogen and progestin hormones. They act as combined contraceptive pills. It is used for three weeks and applied on the lower abdomen or buttocks. *The fourth week is patch-free* (MNT, 2009). **Contraceptive vaginal ring (NuvaRing)** – is a vaginal ring releasing a low dose of hormones of an estrogen and a progestin throughout three weeks. It is inserted for three weeks into the vagina of a woman and will be removed for one week when she has menses (MNT, 2009). **Contraceptive injection (The Shot)** - Depot medroxyprogesterone acetate (DMPA) contains only progestin which has long acting effect but reversible. *DMPA is injected every 3 months*. DMPA blocks the egg's release and it also has other effects of contraception (MNT, 2009). **Implants** - Implanon is a rod made of progestin. *It is inserted under the skin of the upper arm of a woman*. The hormone's release is slow and effective for three years (MNT, 2009). **Intrauterine devices** – is a device placed in the uterus by a medical professional. It can be used both as a primary contraception and occasionally as emergency contraception (to prevent implantation of egg or if egg is already fertilized as abortifacient (induce abortion). It is widely used in developing countries. IUD is effective from 5 to 10 years and effectiveness depends on type of IUD (MNT, 2009). **Sterilization** is two types female and male sterilization. Female sterilization involves **tubal ligation** when fallopian tubes are sealed to prevent fertilization. **Vasectomy** is a surgical procedure aiming to cut the right and left vas deferens-the tubes through which sperm pass into the ejaculate. **Emergency contraception (emergency postcoital contraception)** – are measures that are used after sexual intercourse to prevent pregnancy. Pills and IUD are used for this purpose (MNT, 2009).

The impact of migration on contraception use has not been researched well. Previous studies are focused on migration and fertility, only some studies briefly discuss the association between contraception use and fertility because contraception is one of the key determinants of fertility. In addition, the majority of studies were conducted among permanent migrants at the destination. Studies at the destination areas found that urban residents are more likely to use contraception than rural ones. Existing studies also show that migrants moving from rural to urban settings have better knowledge of contraception and use them more than non-migrants (Lindstrom & Hernandez, 2006; Lindstrom & Munoz-Franco, 2005).

Millman and Potter (1984) discuss additive constraints on fertility as a result of the separation of spouses and contraception practice. They suggest that women using IUDs are relatively less likely to remove it during separation. If that is the case, it means that women use double protection from conception both by using contraception and by being separated from their spouses (Millman & Potter, 1984).

Lindstrom and Hernandez (2006) suggest that the limited awareness of migrants about contraception may serve as a cause of their unmet need for birth control and their limited choices of contraception methods during the initial time of their residency in urban settings. They also state that when migrants arrive at the place of destination, they have limited knowledge of contraceptive methods but it gradually increases over time. In cases when the demand for contraception increases faster than the awareness of the methods of contraception, the level of unmet need for contraception tends to be higher during first years after migration. Lindstrom and Saucedo (2002) state that temporary mobility and spousal separation decrease fertility

in the short run but not in the long run. They also demonstrate the impact of gender of migrants on fertility rates. In particular, they show that women with migration experience in the U.S. have greater contraceptive experience and lower birth rates, including total birth rates after they return to the origin destination. However, men with the U.S. migration history are associated with higher marital fertility rates in Mexico. Lindstrom and Saucedo (2002) suggest that because of temporary migration and separation of spouses, birth probabilities decrease in the short run, but marital fertility is not decreased in the long run. This tendency suggests that temporary migrants are selected for higher fertility (Lindstrom & Saucedo, 2002).

Moreover, evidence from a traditional migrant-sending community in Mexico reveals that Mexican migrants who live at least one year as a young person in the U.S. or Mexicans born in the U.S. currently practice contraception more often (Kessler, Goldenberg, & Quezada, 2010). Especially, exposure to contraceptive practice dominant at the destination place during youth, that is time of their formative years, results in significantly higher use of modern contraception among migrants. This is a result of exposure and adoption of contraception practice in the U.S. Thus, migrants moving from rural to urban areas become better aware of contraception and are more likely to use them. However, despite higher use of contraception, Mexican migrants have higher rates of unmet need of contraception and unintended pregnancies (Kessler et al., 2010).

Several recent studies have started examining the influence of mobility on the use of contraception among migrants at the place of origin. The role of social networks in increasing the knowledge and use of contraception was studied in rural

Guatemala (Lindstrom & Munoz-Franco, 2005). This study demonstrates considerable influences of diffusion on fertility reduction through social interaction. The findings show that as a result of internal and international migration, migrants, as a group, are isolated in terms of different identities such as language or geography of residency and are exposed to new reproductive norms and behaviors. Since migrants keep ties with their kin in the place of origin through their social networks, they transfer contraceptive knowledge and contribute to adoption of methods of birth control among members of their rural communities. Thus, history of migration in urban settings, having kin in urban and international settings, and living in a community with high levels of migration, are all associated with greater knowledge of contraception (Lindstrom & Munoz-Franco, 2005).

More research is conducted on migrant men rather than their female partners or spouses who stay behind. A study researching the impact of contraception use as a result of spousal separation of one of the partners, especially males, in post-Soviet Armenia, was quite important for this research. This study supports findings from previous research which shows that the use of contraception is lower among wives of migrants than those of non-migrants (Sevoyan, 2011). However, unlike studies in settings with high fertility rates, this study does not show disruption influences of seasonal mobility on fertility in the short- or long- run. Sevoyan and Agadjanian (2013) explain the absence of a considerable difference between annual pregnancy rates of wives of migrant and non-migrants by limiting conception and pregnancies' number as a result of spousal separation due to seasonal migration among wives of migrant men and modern contraceptive use among wives of non-migrants. Because in many post-Soviet countries abortion is widely used as a method of birth control, a

study from Armenia provides a very important finding. Sevoyan and Agadjanian (2013) illustrated that abortion rates are higher among wives of migrants than among women married to non-migrants in households with lower income. Nevertheless, with the increase of wealth, rates of abortion are higher among wives of non-migrants than wives of migrants. Agadjanian et al. (2011b) found that wives of successful migrant workers were more likely to use more contraception in comparison with other women. Hong et al. (2009) states that there was no difference in condom use between wives of migrant workers and those of non-migrant men in China. The only difference was that wives of migrants know the source of a free supply of condoms.

Evidence from rural Zambia demonstrates that migrant men and women negotiate condom use only in some short-term relationships and later its use becomes inconsistent (Bond & Dover, 1997). Condom use is not popular among men and women, but women due to financial and ideological dependence on males have less power to negotiate utilization of condom. The use of condoms is also complicated by ideas and views of people about sex as a procreative act with focus on the potency of men and fertility of both a male and a female that often overrides concerns over HIV and other STIs (Bond & Dover, 1997).

Other problems that migrant workers face with condoms' use are the idea of successful sex, the practice of dry sex, and the acceptance of men's lack of control over their sexual drive. Bond and Dover (1997) also state that there are factors such as poverty and alcohol use, certain patterns of labor migration, failure to discuss sexual decisions between men and women, and the negative associations with condoms make the use of condoms among migrants more problematic (Bond & Dover, 1997). A

study in South Africa by Hughes et al. (2006) shows that the fear of rural partners of migrant workers to acquire an STI is not associated with the use of condoms or other protective measures. Rural women with long-term migrant partners had greater fear of contracting STIs than those with short-term partners. Women with long-term migrant partners are also more likely to have poor communication with their partners about sexuality, condom use or STIs including HIV (Hughes et al., 2006). Eighty-eight percent of rural women reported that they did not use any type of contraception.

Despite that, more than 30% of partners were fearful of contracting STIs from their migrant partners, but many did not discuss sexuality with partners and only 8% used condoms to prevent pregnancy (Hughes et al., 2006). Behavioral theory arguing that perception of possible risk leads to risk-avoidance behavior was not supported in this study (Hughes et al., 2006). Although many rural women were aware that they could be exposed to STIs through possible risk behaviors of their migrant partners, none of them used condoms or other preventive measures to prevent STIs (8% of women used condoms for contraception purpose only). Hughes et al. (2006) explain that the fear of risk does not lead to risk-avoidance behaviors due to the predominant discourses about sex with a permanent partner as safe, while sex outside of the primary relationships is risky. Many rural women think because they are in a monogamous relationship they are not at risk due to absence of their own risky sexual behavior. Usually, they are concerned only about the sexual behavior of their partners (Hughes et al., 2006).

Lastly, Moreno (1994) studied the effect of migration on contraception use in Brazil through its various mechanisms such as selectivity, disruption and adaptation.

Although he revealed the existence of a relation between migration and contraception use, it was not strong.

Knowledge and awareness of HIV/AIDS and HIV prevention measures

A large body of migration literature suggests that wives of migrant workers are especially at risk of becoming infected with HIV and STIs by their migrant husbands (Bahromov & Weine, 2011; Brockerhoff & Biddlecom, 1999; Collinson et al., 2006; Lurie et al., 2003b; Liu et al., 2005; Mundandi et al., 2006; Nguyen, Yeoh, & Toyota, 2006; Parrado, McQuiston, & Flippen, 2005; Sevoyan & Agadjanian, 2010; Smith-Estelle & Gruskin, 2003; Zuma et al., 2005). These studies argue that while in migration, migrant workers sometimes engaged in risky sexual behaviors, such as having multiple partners or using sex workers without condom (Agadjanian, Arnaldo, & Cau, 2011a; Brockerhoff & Biddlecom, 1999; Coffee et al., 2007; Collinson et al., 2006; Herrera & Campero, 2002; Lee, 2008; Lurie et al., 2003a; Liu et al., 2005; Mundandi et al., 2006; Sevoyan & Agadjanian, 2010; Weine et al., 2008; Williams & Campbell, 1996). As a result, while men migrant workers are engaged in unsafe sex without condoms with multiple partners or sex workers, they contract STIs including HIV and transmit them to their wives when they return home.

At the same time, some studies indicate that wives of migrant workers may also be involved in sexual relationships when their husbands are away (Lurie et al., 2003a; Lurie et al., 2003b). These studies show that in discordant couples with a male migrant partner, it is usually the female partner who was HIV positive, while the male migrant partner was HIV negative (Lurie et al., 2003a; Lurie et al., 2003b). These studies from Africa clearly show that the left-behind partners themselves can contract

HIV infection from their sexual partners in the village while their migrant partners have been away. The results can help to rethink HIV/STIS prevention measures and policies to cover both migrant workers in the host countries and their wives in the sending countries.

Previous studies also suggest that migrant men have negative attitudes towards condoms and are not willing to use them. Their left-behind wives, because of their economic and social dependence on their migrant husbands, do not negotiate condom use; as a result, they do not use condoms with their migrant husbands (Buckley, 2007). In particular, Golobof, Weine and Bahromov (2011) in their study on Tajikistan state that a patriarchal society with its male-dominated gender norms compromises abilities of left-behind women to protect themselves from HIV/AIDS. Wives of migrant workers have some information about HIV/AIDS, but they have limited abilities to discuss sexuality, HIV/AIDS/STIs, prevention measures, condoms or HIV testing with their migrant husbands. In addition, the authors argue that women have never used condoms with their husbands and were scared to raise the topic of condom use due to fear of violence and abandonment (Golobof et al., 2011). Moreover, according to the same study, none of the left-behind wives reported that they had an HIV test and only a few were aware of its existence. The majority of the left-behind wives did not speak with their migrant husbands about testing for HIV. Some wanted to ask their husbands to have the test, but only two of them would ask the husbands to get tested in the future (Golobof et al., 2011).

Roy and Nangia (2005) in their study on India show that the left-behind wives do not discuss their STIs or Reproductive Tract Infections (RTIs) with their husbands

or with anyone else and suffer silently due to stigma, the culture of silence and the fear of rejection by their husbands even when their husbands are their only sexual partners and source of STIs (Roy & Nangia, 2005). Thus, Indian women hide and neglect their health condition. Hughes et al. (2006) argue that 36% of rural partners of migrant workers were fearful of contracting STIs from their migrant partners. Women whose migrant partners were absent for prolonged periods of time and irregularly visited them were more afraid of contracting STIs and were also less likely to have sexual communication (Hughes et al., 2006). Not even one woman took prevention measures to protect themselves and only 8% of women used condoms to prevent pregnancy.

Agadjanian et al. (2011a) in their study on Mozambique argue that women married to migrants are more likely to worry about contracting HIV infection from their husbands than women married to non-migrants. It has been noted that particularly women married to successful migrants were more concerned about getting infected from their husbands, because of their higher income and more opportunities to pay for extramarital sex (Agadjanian et al., 2011a). However, there was no difference between wives married to migrants and those married to non-migrants in terms of condom acceptance by husbands. Both groups think that their husbands would reject the use of condoms. But especially women married to successful migrants are more likely to believe that their husbands would be against using condom with them than those married to non-migrants (Agadjanian et al., 2011a).

In another study on Mozambique, Agadjanian, Menjivar and Cau (2013) also argue that wives of migrants worried about being at risk of getting infected with HIV by their husbands and the consequences of that for their families. Moreover, the authors state that women have limited communication with their migrant husbands even at home about HIV/AIDS, which is usually initiated by the husbands. If women initiate such a discussion they can be suspected of having extramarital relations. Despite that, a small number of women reported having conversations with their husbands about risks and prevention of HIV/AIDS. In addition, the study also mentions that women found it especially difficult to talk about condoms with their migrant husbands. The majority of women do not have the courage to ask their husbands to use condoms, however, only a few women would not have unsafe sex without condoms if they knew that their husbands are infected.

Dladla et al. (2001) in their study on South Africa suggest that female partners of migrant workers were aware that they are at risk of contracting HIV infection from their returning migrant partners, because women believe that their partners are involved with infected CSWs when they are away. The female partners also say that “men bring HIV/AIDS to them and there is nothing they can do” (Dladla et al., 2001, p. 79). This study shows that women were able to discuss love, sex and their fears and concerns regarding HIV/AIDS with their regular partners. Some women in regular relationships also talk about STIs and inform their partners when they have an infection. However, other women do not discuss HIV or STIs and do not inform their regular partners about STIs, if they have them even when they know the regular partner is the only person who infected them with the infection. Women talk with their casual partners only about financial assistance and they usually do not inform

their casual partners about STIs if they have them (Dladla et al., 2001). The majority of women did not use condoms because men do not like condoms and they think it can build mistrust between them and their partners.

Migration and access to reproductive health care services, and antenatal and delivery care

There are virtually no studies addressing the access of the left behind wives to reproductive health care institutions or general health care facilities in sending communities. However, several scholars such as Roy and Nangia (2005) investigating the reproductive health status of the left-behind wives of migrant workers in Bihar state in India suggest that reproductive morbidity¹⁹ is higher among the left-behind wives of migrant men than among the wives of non-migrant men. They argue that Indian left-behind women frequently do not report their reproductive health problems due to the stigmatization of reproductive morbidity. In addition, due to “the culture of silence” women suffer silently from STIs that make them vulnerable to HIV infection (Roy & Nangia, 2005, p. 226).

Another reason for the lack of women’s access to reproductive health care services in India is that many women hide or neglect their condition even if they know that the only source of infection is their husbands because of the fear of ostracization and rejection (Roy & Nangia, 2005). The same study also states that out of those women who reported having health problems, the majority of them did not receive

¹⁹ The WHO working group defines reproductive morbidity as any morbidity or any dysfunction of reproductive system, or any morbidity which is the result of reproductive behavior, such as pregnancy, abortion, childbirth or sexual behavior (WHO, 1989).

treatment for their reproductive tract infections mainly due to non-affordability of the cost of treatment. Some women who tried to seek treatment usually did not refer to state health care workers due to inadequate functioning of the government system that forces low-income people to pay for subsidized and free health care services. In addition, several women referred to traditional healers. Some women did not receive treatment because they did not feel comfortable to discuss “shameful and dirty” issues with a male physician (Roy & Nangia, 2005, p. 228). Some women did not consider that they have a serious health problem because they thought it was a normal condition. Most of the women used home remedies to treat their reproductive health problems. In general, the authors argue that when the husbands are away the left-behind women do not discuss their reproductive health issues with anyone, even doctors.

Gulati (1993) does not focus on general or reproductive health problems, but she studies the impact of migration on the wives of migrant men in her study in Kerala state in India. The author states that every wife of a migrant man wanted to deliver her babies in the hospital. Out of ten children in her sample born to wives of migrant men, only two were delivered at home (Gulati, 1993). In addition, out of the six deliveries, four were in private and more expensive health care facilities. One can assume that migration improves access to reproductive services because women can afford to deliver in private hospitals, where probably the services are better than in public hospitals let alone at home. Gulati (1993) states that “access of the migrant households to improved medical care has distinctly improved (p. 129).”

In addition, the author highlights that private medical facilities continue to be built in the migrant households' areas that show that the family of migrant workers want and use them. In addition, areas where large numbers of migrant households reside attract the construction of new private medical facilities indicating that migration accelerates the establishment of medical institutions (Gulati, 1993). However, it is also necessary to mention that the Indian government promotes construction of health care facilities nationwide. Gulati (1993) also highlights the fact that women usually, when they are in their parents' house, visit the doctor even when they have very minor health issues. However, the left-behind women residing with their in-laws cannot decide when and where to visit the doctor if they have any health problems, because the husbands usually send money to their mothers who regulate the visits outside the house, including even visits to the physician (Gulati, 1993). Her study allows concluding that several factors impact access of left-behind women. First of all, economic factors, such as receiving remittances, improve access. This in turn also attracts companies to build health facilities in residence areas of households with migrant members along with state policy to improve health care access.

Moreover, cultural factors, such as the influence of the in-laws and their attitudes towards health issues, also play an important role in the level of access of women to health care services. A study from Nepal suggests that as a result of migration of husbands not only the economic condition, housing, child education, but also access to food and water as well as access to health care institutions have been improved (Gartaula, Visser, & Niehof, 2011). The study argues that migrant households are better able to afford utilization of health services. In addition, the authors suggest that the left-behind wife's access to health care institutions is

restricted by the in-laws, as in the case of Gulati's (1993) study, because when the woman was sick she did not receive adequate attention from the in-laws who did not give her the money for treatment. She usually asks for money from her parents or her husband (Gartaula et al., 2011). However, the situation of this particular woman improved when her sons grew up. Again, on the one hand, migration improves many aspects of the migrant households' lives through remittances, including access to health care, but, on the other hand, cultural factors such as restrictions placed on access to remittances placed by the in-laws or neglect of the in-laws have a negative impact on access to reproductive health care services.

CHAPTER 4

RESEARCH QUESTIONS AND METHODOLOGY

Research questions and conceptualization

As noted earlier, only recently there has been a shift from focusing on the migrants in the destination to paying attention to the left-behind wives in the origin country (Sevoyan & Agadjanian, 2010). Therefore, the aim of this study is to examine the difference between the reproductive health of wives of migrants and non-migrants. It argues that migration improves the access of the left-behind women to reproductive health care services. However, it also emphasizes that, if in general the data show improvement in the access of women to health care, at the same time, it also demonstrates the complexity of the situation and how other factors can have an equally important impact on the access of women to health care. It also demonstrates that access of women does not only depend on migration of the husband, but also on other aspects of their identities, such as education, income and place of residence. The existing literature shows that only isolated aspects of reproductive health are studied separately without looking at these issues in a more comprehensive manner taking various aspects into account. As the literature suggests, it is impossible to study the impact of migration on the health of the left behind wives without looking at the social, economic and cultural and traditional issues involved.

This study argues that it is the sum of the various aspects of a woman's life that has impact on her health and the quality of her life, among which reproductive and sexual health are most important and, therefore, they should all be studied

together. These research questions take into account the complexity and composite nature of the issue of migration and its impact on the reproductive health, well-being and status of left-behind wives.

Central Research Questions

This study will be guided by the following research questions:

- How does male labor migration impact the sexual and reproductive health of their left-behind wives?
- How do factors such as education, employment, ethnicity, culture, religiosity and socio-economic situation affect the relationship between male labor migration and sexual and reproductive health of women left behind?

Subsidiary Research Questions

In order to address the above questions in a comprehensive manner, the following subsidiary research questions have been identified:

- How does labor migration of husbands impact the fertility and contraceptive behaviors of their left-behind wives?
- What is the nature of the knowledge of the left-behind wives about STIs/HIV risks and what prevention practices and skills are they aware of?
- What is the status of the reproductive and sexual health of the left-behind women and what kind of provisions/constraints exist for their access to reproductive care services and antenatal and delivery care?

- How do health care workers and staff of state agencies and local and international non-government organizations perceive/stereotype sexual and reproductive health issues among left-behind wives?

Approach and Methodology

Researchers, policy-makers, and practitioners recognize that women's health and experiences are shaped not only by sex and gender, but also by other factors such as race, class, culture, income, education, age, ability, sexual orientation, immigration status, ethnicity, and geography (Hankivsky, 2012). I add migration of their husbands to this list.

It is important to acknowledge multiple realities, and not to “essentialize any group, that is, not to treat any group as if all its members are exactly the same and have the same experiences, view and priorities” (Morris & Bunjun, 2007, p. 23). There are many linguistic, cultural, ethnic, religious, income, health, educational, age and political differences within the wider group (Morris & Bunjun, 2007). I therefore, tried to sample different groups of left-behind women in various communities and regions of the country to bring out different experiences and perspectives.

Methods

Data collection

For the purpose of this research, I used qualitative method because it is one of “the most gender sensitive” research methods (McCall, 2005). It is also considered “the perfect window through which to access women's wisdom and experience”

(McNamara, 2009, p. 171). Qualitative method helps to examine “complexities of social life to find diversity, variation, and heterogeneity” (McCall, 2005, p. 1779). In his support for qualitative research, McCall (2005) also argued that qualitative research as a whole is more suitable for an in-depth examination of the complexities of the social lives of individuals.

The data for this study was gathered through ethnographic field work conducted on several occasions from 2011 to 2013 in Tajikistan. This study endeavored to listen to voices of women, take into consideration their experiences and obtain women’s own interpretations of their social situations (Ackerly & True, 2010; Harding, 1987). I used face-to-face in-depth-interviews with open-ended questions as the main data collection method to gather data of a better quality. The interviews were detailed and semi-structured conducted in sensitive, non-judgmental and culturally appropriate manner (Weine et al., 2008). Interviews with wives of migrant and non-migrant men lasted from more than 70 minutes to up to 3 hours. Interviews with health professional lasted from 30-40 minutes to 1.5 hours. I personally conducted all interviews.

A preliminary interview guide was developed according to possible topics to be covered during the interview. It also provided a basic structure for each interview to ensure that the interview is focused and that key interest themes are studied. However, particular attention was given to the aspects that the interviewees found most relevant and are ready to discuss in-depth. The interview was conducted in a way that the participants were given the freedom to tell their story in their own way and according to their own rationale in order to enable a participant-led discussion. It

was quite fulfilling and significantly revealing for me that all my informants were flexible in discussing the topic and that they found it particularly important to discuss the issues at stake with me.

The majority of interviews with women, especially in rural areas, were conducted in a convenient location or at their home with some in urban areas, as they chose it. However, I made sure that there was sufficient privacy for the interviews and that the conversation could not be overheard by other people. Interviews with staff of organizations were conducted at their offices.

I gave out an information letter and recruitment script with the outline and details of the study (see Appendix I and II) to make sure that they are fully aware of and understand the aims and objectives of the research. Information letter and recruitment script were translated into three languages (Shughni, Tajik and Russian) and an interviewee chose which one she preferred. The interviewees had opportunities to ask all necessary questions about the study in advance. Those who wanted to arrange for a different and more convenient time to meet were given the choice to do so. Interviewees who agreed to be interviewed did it by giving a verbal consent. No additional information irrelevant to the study was asked for by the researcher.

Each participant who gave consent was interviewed by the researcher and had the opportunity to ask questions about the study before starting the interview. In 2011, I conducted 3 pilot interviews with spouses of migrant laborers and volunteers from the capital city Dushanbe to examine whether the wording, length and relevancy of the interview guide was appropriate for the respondents (Hughes et al., 2006). Since one of my informants was pregnant at the time of the interview, I realized that I did

not include experience of antenatal and delivery care. As a result, I added questions on these aspects to the interview guide.

The interview format was revised before the main part of the interviewing process. I also continued to update questions throughout the study. As a result, the following were included in the interview guide: socio-demographic situation, the general and reproductive health history, family planning, STIs including HIV, migration history of husband, life before and after migration, communication and relationship with relatives, friends and neighbors (see Appendix III).

Interviews were conducted in one of the three languages spoken in the region (Shughni, Tajik or Russian). I speak all three languages and used whichever language the interviewees chose. As mentioned earlier, the letter outlining the study and its objectives and the consent form were also prepared in three languages. Interviews were recorded on two digital recorders. Although I thought that due to cultural particularities and tradition as well as sensitivity of the research problem, some people might refuse to be recorded, none of my informants refused. There were a few cases when women told me more about very sensitive issues, such as sexual life, after I finished recording the interview.

Although none of the women refused to be recorded, one representative of an international organization refused to be recorded. Also, I could not record a staff member of another international organization because I was not allowed to take any recording equipment into their office due to their security rules. In order to make up for this, I took detailed notes during the interview. I transcribed all digital recordings from my field trips. Digital recording and notes were fully transcribed by me. The

recording allowed me continuous and comprehensive examination of the interaction between myself and the interviewees (Silverman, 1993). All transcripts were coded through pattern coding and memoing. As a result of using a grounded theory approach, a model emerged.

In-depth interview participants received an equivalent about of \$5 (20-23 Tajik *somoni*) depending on exchange rate at that time, whether or not they completed the interview. The amount of compensation was similar to the amount given to respondents of other studies conducted in the region. It was a way of showing my appreciation for spending their time with me and discussing the research topic.

The second data collection method I used is textual analysis to examine policies, legislation, official statistics, surveys, and other relevant documents in the realm of male labor migration and reproductive health. The documents provided me with a rich vein of analytic topics and are an important source of information (Silverman, 1993). Textual analysis of the documents provided me with the background and context of the research issue. They also complement data obtained from interviews (Marshall & Rossman, 1999). The documents I examined as part of this study pertaining to the role and response of the state institutions regarding the research issues are annual reports, publication materials, government strategic plans on reproductive health in general, and HIV/AIDS in particular, policy documents on migration and migrant workers, state official statistics' documents on various reproductive health issues and migration flow, survey reports, and reports of local and international organizations. Relevant documents on reproductive health were obtained from the Republican Reproductive Health Center, the MoH, and policy and statistics

documents on migration and migrant workers were obtained from the MLSP, Agency on Statistics under the President of RT, Strategic Agency under the President of RT, health international organizations, state agencies and various other organizations. Textual analysis also allows seeing the strengths, limitations and ways of improving the state and international organizations' documents to make them more effective to eliminate health inequality (Marshall & Rossman, 1999).

I also tried to use the self-reflexivity method to avoid reproduction of inequality in the research (Naples, 2000). Reflexivity was used as a tool to address the power differences between me, as an investigator, and the subjects of the study, particularly because in some cases we were of different ethnicity, class (income), education and other differences of identities (Hunter, 2002). It is crucial to determine social positions and to reflect on power between the researcher and the research participant, because power has an impact on how to define problems, how to interpret the interaction during the research, and how to construct narratives (Naples, 2000). Critical reflexivity allowed me as a researcher to be aware of my own assumptions that affect knowledge production, to see the limitations of my perspectives and thus to decrease bias (Naples, 2000). It is also hoped that this would decrease the possibility of unintended harm of the research subjects with certain adverse effects for them. In my case, it is very important to be aware of the fact that I belong to the society and culture that I am studying. On the one hand, belonging to the same society and culture gives me incredible comfort and privileges of understanding the environment, knowing the languages and having access to people. On the other hand, this poses the danger of missing some of the points that an alien researcher would pick up more

quickly, of the women not opening up completely, and of coming to the field work with my preconceived ideas.

Sampling and recruitment

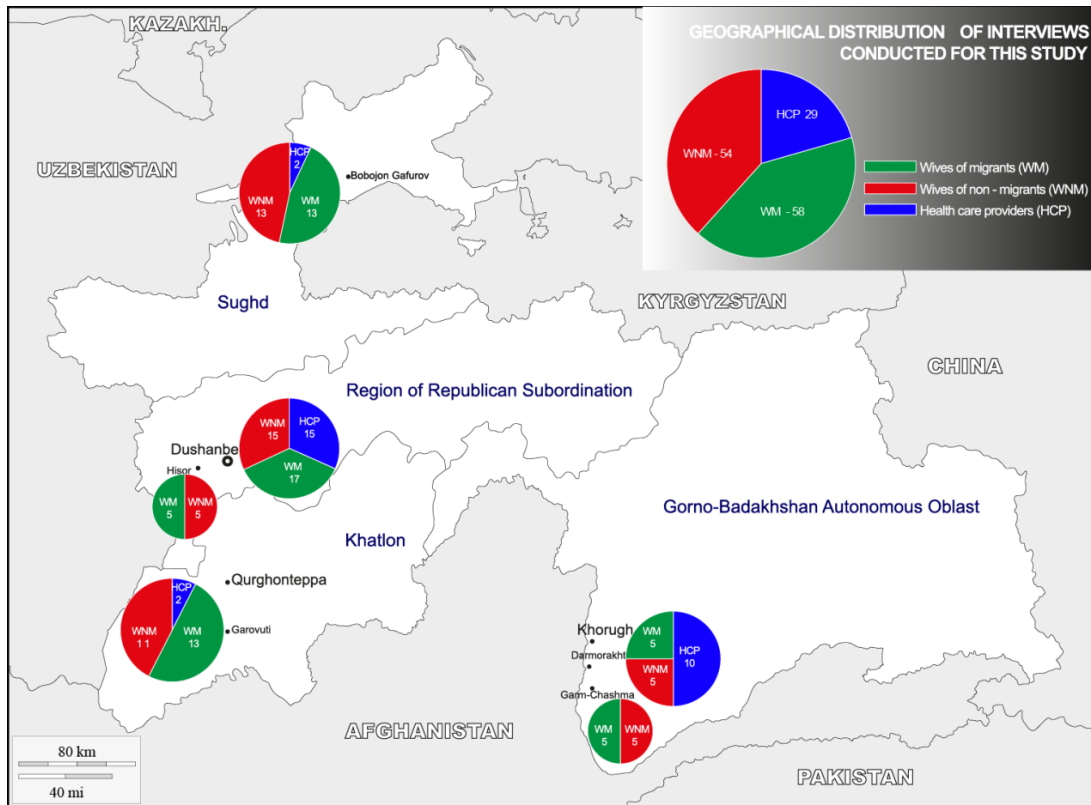
I conducted interviews with a purposive sample of 58 wives of migrant men, and 54 wives of non-migrant men. Within the scope of this study, the following criteria were used to recruit the wives of migrant men: 1) having husband with more than 1 year of international migration experience and 2) age between 18-49 years old. For comparison purposes, wives 1) whose husbands never migrated and 2) age between 18 and 49 were selected. Women of this particular age group have reached reproductive maturity, are sexually active and also have the highest potential risk for STIs/HIV. In addition, the sample covered women from both urban and rural areas, various regions which have different socio-economic characteristics (Dushanbe city, GBAO, RRS, Khatlon and Sughd regions) and cultural and religious beliefs (Sunnis and Shi'a Ismailis) as well as reproductive health outcomes.

Despite this, the study does not aim to generalize its findings to all population of the country or to speak on behalf of all women in Tajikistan. It was done in order to better understand the impact of migration on reproductive health of women left behind in Tajikistan.

Golobof et al. (2011) state that previous studies on Tajik migrant workers (Weine et al., 2008) showed that 30 wives of migrant men were sufficient in order to reach theoretical saturation. Taking into account previous studies in Tajikistan, I am confident that the purposive sample is adequate to understand main “patterns,

concepts and dimensions” (Weine et al., 2008, p. 92) regarding reproductive health experience of wives of migrant and non-migrant men and perspective of health professionals and staff of organizations regarding their reproductive health.

Map 2: Geographical distribution of interviews conducted for this study



Source: Conceptualized by Dilofarid Miskinzod, designed by Zamira Rakhmatova

I also conducted interviews among 29 doctors and staff of local and international organizations. The only criterion for recruiting the medical personnel and staff of state, local and international organizations was work experience with migrant families or wives of migrant men. I also talked to about 14 staff of state agencies and international organizations which did not cover questions from a guide

for my interviews, but these discussions were important for better understanding of many aspects of migration.

The purposive sampling technique was chosen because the research has specific theoretical concerns. It leads the researcher to choose also specific individuals. I started with a purposive sampling technique to approach informants; that is, I started with individuals I knew personally and then at the end of the interviews asked whether they knew other respondents who could be interviewed for the purpose of this study. In this way, the snowball sampling technique, which is based on personal referrals from the key informants, allowed me to expand my network of samples. My research showed that this approach works best to recruit participants due to cultural particularities of the population of the country. It is important for the first interviewees to know the researcher well and trust to talk about their experiences, especially when matters of sexual health and life, STIs including HIV and also contraception or abortion use are concerned.

In 2011, I was in Garm-Chahsma village²⁰ of GBAO for a month to conduct the field work. I asked a nurse who worked in the sanatorium, where I was based, to help me find participants for the research. She introduced me to several women whom I asked to be participants, but none of them actually were ready to talk to me until I met one of my former patients from when I was working as a doctor obstetrician-gynecologist (Ob/Gyn) in Khorog (a small town in GBAO, which serves as its administrative center). We discussed her myoma and how she was feeling and I told her about my research. She agreed to participate in my study and to be interviewed and

²⁰A remote village in GBAO located about 50 km from the administrative center, Khorog.

after that she referred me to numerous women whom I could not recruit before. She was a gatekeeper for me in this particular village. So later in other regions, I tried to find a gatekeeper who could open the door to other women in those settings.

Another problem that I encountered during the interviews in almost all regions was to find wives of non-migrant men. I was astonished to find out during the research process that migration was so widespread in the country that it was harder to find women whose husbands never migrated rather than those whose husbands migrated. It seems that at some point of time in their lives, many men in these regions travelled to work in Russia or other countries.

Table 2 presents the demographic characteristics of women by husband's migration status for urban and rural areas. The table illustrates that 22 wives of migrants were between 30 and 39 and 40 and 49 years old, 17 wives of non-migrants were between 30-39 years old and 23 between 40-49 years old. Age of left-behind wives was slightly higher than that of wives of men who never migrated. None were younger than 20 years old.

Approximately 28 left-behind women reported having complete school education (11 years) in comparison with 25 wives of non-migrants. About 17 rural left-behind women stated that they had incomplete school education (9 years). The number of wives of migrant men with early drop out of school at 3rd and 4th grades was considerably higher in rural areas than in urban ones. In addition, 2 rural women married to labour migrants stated no education at all. Only 7 wives of non-migrants stated that they had incomplete school education and the majority of women with incomplete education have 9 grade school educational attainment and only one

dropped out of school at 3rd grade. In addition, 10 left-behind wives and 8 wives married to non-migrants state that they have college education (medical or technical college). About 3 wives of migrants had higher education, while 14 wives of non-migrants, the majority of whom live in urban areas.

Table 2: The distribution of demographic characteristics of women by husband's migration status in urban and rural areas

<i>Demographic characteristic</i>	Urban Wives of migrants	Rural Wives of migrants	Total (58)	Urban Wives of non-migrants	Rural Wives of non-migrants	Total (54)
	Number (17)	Number (41)	Number (58)	Number (15)	Number (39)	Number (54)
<i>Age</i>						
20-29	5	9	14	8	6	14
30-39	8	14	22	6	11	17
40-49	4	18	22	1	22	23
<i>Education</i>						
School (incomplete)	2	15	17	1	6	7
School (complete)	11	17	28	4	21	25
College	3	7	10	1	7	8
Higher	1	2	3	9	5	14
<i>Religion</i>						
Muslim (Sunni)	15	31	46	9	27	36
Muslim (Shi'a)	2	10	12	4	12	16
Christian	0	0	0	2	0	2

More than three-fourths of wives of migrants (49) identified themselves as Sunni Muslim, with 12 identifying as Shi'i Muslim (belonging to the Ismaili branch).

About 36 wives of non-migrants identified as Sunni Muslim, 16 as Shi‘i Muslim (mainly Ismaili) and 2 as Christian (Table 2).

Out of 112 respondents, 58 were wives of migrants and 54 were wives of non-migrants. Among 58 left-behind women 17 were urban and 41 were rural residents. Thus, 41 wives of migrants were from rural regions: 13 from Khatlon region, 13 from Sughd region, 5 from RRS, 10 from GBAO. In addition, 17 were from urban area of Dushanbe (Tabel 3). Out of 54 women married to men who never migrated 15 were urban and 39 rural residents. Eleven wives of non-migrants were from Khatlon region, 13 from Sughd, 5 from RRS, 10 from GBAO and 15 from Dushanbe.

It is important to examine the situation in all the regions, because they are quite different from each other. The regions differ in their geographical setting, economic situation, connectivity, culture and religion, and social attitudes. I, therefore, hope to show whether these differences contribute to the impact of the migration of the husbands on the health of the left-behind wives or not.

Table 3: Regional distribution of sample by husband’s migration status

<i>Region</i>	Wives of migrants	Wives of non-migrants	Total
Khatlon	13	11	24
Sughd	13	13	26
RRP	5	5	10
GBAO	10	10	20
Dushanbe	17	15	32
Total	58	54	112

Although the sample includes women from all regions of the country, various religious backgrounds and affiliations, ethnicity and age, it does not attempt or argue to be representative of the population of the country or tries to generalize its finding from this particular group of population to the whole population of Tajikistan. These different identities were used only with the purpose of determining how common or not are the experiences of wives of migrants and non-migrants among women from different regions, religion, education and age groups. All information provided regarding demographic characteristics of the participants are based on self-identification.

Data analysis

The grounded theory inductive approach was used to analyze interview transcripts. This method allows the systematic identification, categorization and organization of key themes and sub-themes of the texts and transcript. The themes and sub-themes gleaned from the texts provide the foundation for the development of a theoretical model for the study of the impact of male labor migration on reproductive health of wives of migrant workers.

All in all, the difficulties that I anticipated in the research proposal at the beginning of my research in terms of collection of very sensitive and personal information regarding HIV, STIs, contraception use, abortion, reproductive health issues and so on, did not materialize. I was afraid that some women would perhaps refuse to participate in the research and would be very reluctant to answer my questions. Certainly, using the purposive sampling technique to recruit participants, who knew me and probably trusted me to talk about their experiences, minimized this risk. I think there

are two major reasons why I was quite successful in my interviews. First, I could talk to them in their native language and therefore they felt comfortable. Secondly, they were very open with me about their experiences, including sexual and health issues, because of my background as an Ob/Gyn physician.

Ethical considerations

It was clear that this study posed some challenges of ethical nature and risks for my informants, since there are levels of sensitive and personal issues involved, such as safety, dignity, cultural respect, privacy and consent (Thomas, 2007). Therefore, I applied for ethical approval from the Institutional Review Board of the Arizona State University in 2011 (see Appendix IV). Only after obtaining the approval, I went ahead with my research.

To make the purpose and nature of the research as clear as possible for the participants, all participants were provided with an information sheet and recruitment script in their own language with plain and clear expression of the goals, objectives, participant's involvement, methodology and the intended use of the research results (consent to use and details of use). The participants were informed that they had the option to withdraw from this research at any time they want.

Any documents connected with the study, such as transcripts, letters and documents, are stored in a safe place. I did not gather personal information from interviewees participating in the study not relevant for the study and the interview. Any information disclosed by the informants was kept in strict confidentiality. All information gathered as a result of the research has been and will continue to be

released in the future via journal articles, reports and conference papers only in a way that the identities of participating interviewees cannot be determined.

Limitations and Future Studies

This current study is conducted only among left-behind women, while it would be useful to undertake a similar study among migrant men. It would be particularly beneficial to carry it out among their migrant husbands of the participants to understand their perspective on the same issues discussed with their wives as well as examine how these issues can be addressed in a multi-input way. It is clear that working in one direction only by concentrating on the left-behind population in Tajikistan cannot lead to desired results without also working among the migrant men.

Despite the fact that the study has been conducted in the capital city and all four regions of the country, the results cannot be generalized to the all population because the study shows that experience of women can be different in two villages within even the same region. Therefore, including more study settings from the same region, especially remote rural areas, and also increasing the number of respondents on each site would reduce this limitation.

In addition, because the interviewees were asked to recall a lot of information from the past, there is a high chance of a recall bias. Although the data had been collected over three years, every time it was done in a different setting with different women. Therefore, it would be very useful to conduct a longitudinal research among the left-behind women to examine changes in fertility and contraception behaviors,

and sexual and reproductive health to enhance our understanding of the impact of migration on these issues in the long run.

In addition, the research is based on self-reported information and symptoms of women of both study groups and it was likely that some interviewees provided socially acceptable responses and did not report diagnosis of HIV/STIs and reproductive morbidity as well as extramarital relationships. All efforts were made to ensure that the study participants understand about the confidentiality of their responses and the interviews were conducted in the absence of the husbands. Therefore, it would be also very beneficial to conduct study using tests for HIV/STIs and clinical examination for other reproductive health problems to base one's findings on laboratory confirmed cases of HIV/STIs and reproductive morbidity to make more strong arguments. This would also solve problems with recall bias and untold cases of STIs and reproductive morbidity.

CHAPTER 5

MIGRATION, FERTILITY AND FAMILY PLANNING

This chapter focuses on fertility and contraception behaviors of the left-behind wives in post-Soviet Tajikistan, an area of high fertility and low contraceptive use (Clifford, 2009). Specifically, I examine the impact of labor migration of husbands on fertility and contraceptive behaviors of the left-behind wives; challenges associated with access to contraception and their use; similarities or differences in fertility and contraception behaviors among wives of migrants and non-migrants at the origin communities; and the socio-demographic, economic, and cultural factors influencing fertility preferences and contraception use.

Fertility

Several important studies examine the association between migration and fertility of long-term migrants who migrate from high to low fertility areas. These studies mainly examine the effect of migration on aggregated fertility and increase of population in the receiving settings (Lindstrom & Saucedo, 2002). In comparison, the influence of temporary migration on fertility in sending settings has not been well examined despite the fact that the number of temporary migrants is higher than the number of long-term migrants in many parts of the world (Lindstrom & Saucedo, 2002). Thus, much of the research has focused on movements of rural populations to cities (Chattopadhyay et al., 2006). Other streams of migration as well as the impact of migration on rural fertility have been largely ignored (Chattopadhyay et al., 2006).

Many studies show that the disruptive impact of both temporary and seasonal migration decreases the conception and birth rates in the short term (Agadjanian et al., 2011b; Clifford, 2009; Goldstein & Goldstein, 1981; Lindstrom & Saucedo, 2002; Millman & Potter, 1984). Millman and Potter (1984), in particular, suggest that due to an increase in the frequency of intercourse after separation, the conception rates of migrant couples offset the impact of migration separation. Lindstrom and Saucedo (2002) also argue that migrant couples in Mexico make up for the lost reproductive period after separation. However, Goldstein and Goldstein (1981) believe that the level of fertility, once disrupted, is not the same again.

Particularly important for my purpose are studies on Tajikistan and other post-Soviet countries, such as Estonia and Armenia. In his study on Tajikistan, Clifford (2009) demonstrates that migration causing separation of spouses has a clear disruptive influence on fertility in the short-run, but its impact on total number of births is not clear because migration is a recent phenomenon in the country according to him. Kulu (2005) suggests that Estonian migrants, irrespective of their origin areas, have the same level of fertility as non-migrants who live at the destination. In addition, fertility increases when people move due to formation of a union. A study on Armenia demonstrates that migration does not disrupt fertility further in a setting with low fertility because of the older age of migrant spouses (Sevoyan, 2011).

Migration and fertility

Fertility and family planning are the main aspects of health of women. They are very important for women in Tajikistan. If a woman is not fertile, it does affect her overall health, and her family and social life. Being infertile or having even one child

leads to broken families and lives. It often leads to the end of a marriage. Mushtari, a 25-year old wife of a migrant man in Garovuti village of Khatlon region, said that she could not get pregnant for about five years. She visited various Ob-Gyns many times and received treatment, but she could not get pregnant. She believed it was because her husband had a problem with his health. Finally, after three years, they adopted a baby and she looked after the baby. She thought that with the adoption of the baby the tension brought about by infertility would ease. The left-behind woman said that she worked very hard for her husband's family "like a slave". She was busy with work on the field, which is very hard taking into account hot summers in this particular part of the country.

Despite all her efforts and hard work, one day she found out that her mother-in-law, without her knowledge and without even telling her, married her husband to her niece and sent them both to Russia. She found out about her husband's second marriage after he and his new wife were already in Russia. She was devastated and had to return the child to his biological parents, who were relatives of her husband. She was not able to keep the baby since she had to go back to her own family where she had several sisters-in-law. This heartbreaking story is not a unique case of how infertility leads to breaking down marriages and families, usually with devastating consequences for a woman.

Thus, fertility is very important for women in Tajikistan. A wife of a migrant man with HIV infection, who lost her long-term migrant husband to AIDS, said that she got married again to a HIV negative man and did not want to infect him and therefore uses condoms. But both of them plan to have a baby. Obviously she cannot

get pregnant while using condom. She consulted an Ob/Gyn who advised them to place the sperm of her husband with syringe in her vagina to get pregnant.

They have now been trying it for two months, but she is not able to get pregnant so far. She was advised to take medicines for three months (probably antiretroviral therapy (ARV) for the prevention of mother to child transmission of HIV) if she gets pregnant. She will also have to deliver the baby by cesarean section, a method advised by the instructions on prevention of transmission of HIV from infected pregnant mother to a child approved by the MoH of the RT. She was also told that the baby will also be given ARV therapy for about 20 days and she should not breastfeed the baby. This woman is planning to have five children: two girls and three boys. She is, therefore, doing everything possible to get pregnant.

Although the sample used in this study is very small and not statistically representative, the analysis of the data shows that the fertility of wives of migrant men is similar to that of women married to non-migrant men. This is in contrast with previous findings which argue that temporary migration decreases fertility because of the disruptive effect of the long or repeated separation of spouses and the likelihood that migrants would come back to the origin areas with attitudes and behaviors adopted recently at destination, which contribute to lower fertility (Lindstrom & Saucedo, 2002).

The interviews with wives of migrants help to understand why migration does not impact fertility among women who stay in Tajikistan and never accompany their husbands in Russia. Mumtoz, a 46-year old urban left-behind woman who always stayed behind in Tajikistan, said that migration did not impact her fertility in any way.

Her husband's migration did not discourage her from having the desired number of children. Mumtoz said:

I got married in 1986 and after 6 years in 1992 my husband went to work in Russia. By that time I already had three sons. After my second and third child, I had an IUD, but then after my husband left, I had it removed it because he was not in Tajikistan. I had it removed after my third child and did not use it again. After that, every time when my husband came back, I got pregnant and when he left I had a baby (every time I got pregnant) until I stopped getting pregnant altogether.

The reason for having many children in her case was that she wanted to have at least one daughter and, therefore, she kept on getting pregnant. However, every time she gave birth to a boy. She also stated that if she had had a girl earlier, she would not have had so many children. Therefore, the desire for a certain gender of a child was the main driving force of high fertility in her family, not migration. Many other wives of migrants also responded that migration did not have any impact on their fertility.

Similarly, the current study supports Clifford's (2009) findings that migrant men who learn to favor small families often cannot make changes in fertility attitudes of their spouses. For instance, Shafika, a 38-year old urban wife of a migrant man in Dushanbe, said that she wanted to have her fourth baby because she had two boys and wanted one more baby sister for her daughter. Her migrant husband discouraged her from having the fourth child. However, despite his opposition, Shafika had her fourth baby girl. She said: When I had two boys and a girl, I said to my husband: 'Let's have

another girl.’ ...He told me: ‘There is no need. These are enough for me’. Then anyway I had another daughter after 11 years.”

Although migration of the husband does not have any impact on births among the women who always stayed back home, it does affect fertility of some women who accompanied their husbands in Russia for various periods. Only a few left-behind women, who visited their husbands because of different reasons, said that when they were in Russia it had an influence on their fertility. For instance, Sadokat, a 41-year old urban wife of a migrant man, said that when she was with her husband in Russia for two years, she got pregnant there and had an abortion, because she already had a small baby, her husband lost his job and she was forced to work to support her family. Sadokat is from the capital city and had very good Russian language skills so she easily found a job, worked and later she found a job for her husband as a night security guard in the same shop. Sadokat said that, if she were in Tajikistan during her second pregnancy, she would have certainly had the baby and would not have had an abortion. Although it is common to use abortion as a method of birth control in Tajikistan, it is not common to have an abortion until one has 2 or 3 children. However, because she was in a difficult financial situation, she decided to have an abortion.

In addition, Salomat, a 41-year old urban left-behind woman, said that her husband did not come for years and she went with her two daughters to find him in Russia. She found him and then started working in a shop. When she became pregnant, she had an abortion because she had to continue working to support her family. She said:

We did not have the right condition in Russia to have more children. I called a doctor and she prescribed me a medicine, and I miscarried the baby. I worked as a cashier in a shop during the day and I packed stuff at the company at nights.

It is not surprising that working almost all day and living in a difficult economic situation did not allow her to have another child. It seems that hard economic conditions of migrant families in Russia discouraged and did not allow migrant families to have a baby while they were in Russia. Both women had more children after their return to Tajikistan. This finding is in line with the results of studies showing that financial opportunity and restrictions in the United States discourage Mexican-born women from having large families (Bach, 1981; Chattopadhyay et al., 2006; Lindstrom & Saucedo, 2002).

Similarly, the data also show that male labor migration does not postpone the first pregnancy. Many young left-behind women stated that their migrant husbands were usually already working in Russia even before their marriage. Then, they would come back to get married and after a while go back to Russia again. Many young left-behind women reported that after the marriage, their husbands usually stayed for about 2-4 months and only after confirming pregnancy of their wives, husbands would leave again to work in Russia. Then after each return of the husband, they got pregnant until they reached the desired number of children or the desired balance of both genders.

It is clear from the interviews that wives of migrants would first get pregnant and only then their husbands would go to work in Russia. Many women also

mentioned that the birth of a child, taking care of the baby and the joy of motherhood helped them to forget their loneliness and other problems connected with the absence of their husbands as well as reduced the stress connected with adaptation to new family life.

Many young women, who in the majority cases had arranged marriages, said that at the beginning of their family life, it was very hard for them because they had to adapt to a new family and home after moving to their husband's house after the wedding. In addition to that, they had to cope with the fact that their husbands had to go back to Russia shortly. Mohbegim, a 39-year old rural woman married to a migrant, told me during the interview that she suffered from loneliness, lack of husband's support during pregnancy and stress connected with having especially her first child. She also suffered during subsequent pregnancies, because she did not have the support of her husband who was away. In fact, it is a very common situation that many migrant husbands are absent during the pregnancy of their wives, and women do not see their husbands and do not have their support during pregnancy as well as during delivery. Migrant husbands usually return when their children are about 4 to 7 months or even older depending on the duration of their stay in migration. Therefore, despite the fact that most of these women do not have the support of their husbands during pregnancy and delivery, the arrival of children keeps them busy. The interviews also show that for rural young women the arrival of children often means that they are relieved from hard work in the field. For example, many women in Khatlon region said that they had to stop working in the cotton fields because they were either pregnant or had a small baby to look after.

It is, of course, not surprising that wives of non-migrant men did not report such situations. This group of women did not have similar experience. Neither did they mention stress with adaptation to new family circumstances in the same way. Probably because they have the support of their husbands, it makes the transition and adaptation period to the family life smoother for them. Many wives of migrant men have an additional pressure, because their husbands wait until they become pregnant to go back to their work in Russia, and thus put additional pressure on their wives to get pregnant as soon as possible, whereas wives of non-migrant men do not experience such a pressure to get pregnant.

Several tentative explanations are proposed for the lack of migration's impact on fertility among wives of migrants in this study. First, short and infrequent migration has insignificant influence on fertility, while migration of longer duration of two or more years, for instance, has considerable effect on fertility. This tendency has been also demonstrated by Potter & Kobrin (1982). Therefore, the lack of the impact of migration on fertility could be attributed to the seasonal character of migration in Tajikistan (Clifford, 2009). However, the recent tendency towards longer stays in Russia may change the influence of migration on fertility in the future (Clifford, 2009). In addition, despite the fact that migration also was common in the past in the country, the pattern of current migration differs significantly from previous trends.

Another possible explanation is the illegal status of Tajik migrants. Previous studies also suggest that undocumented status of migrants is a serious barrier for social interaction and integration of the migrants in the receiving communities which otherwise would expose them to low fertility ideas and norms reducing their fertility

(Lindstrom & Saucedo, 2002). As mentioned earlier, according to Weine, Bahromov and Mirzoev (2008), many Tajik migrants are undocumented in Russia, which decreases their social interaction with residents and impede their integration in the destination communities.²¹ Therefore, the exposure of migrants to fertility norms of the residents is limited, which might have otherwise contribute to lower fertility rate among them.

Table 4: Average number of children of wives of migrants and non-migrants in urban and rural areas

Urban Wives of migrants (17)	Rural Wives of migrants (41)	Total (58)	Urban Wives of non-migrants (15)	Rural Wives of non-migrants (39)	Total (54)
2.8	3.2	3.1	2.7	3.6	3.3

Although there is a slight difference in fertility status between wives of migrants and non-migrants, there is a significant difference between fertility of urban and rural women among women of both study groups especially women married to non-migrants. Similar to earlier studies, the data show that fertility of urban women of both study groups is lower than that of rural females (Jensen & Alhburg, 2004). Urban women desire to have fewer children than rural women (Chattopadhyay et al., 2006). In addition, lower fertility among the urban population is due to dominant values and

²¹ See section on labor migration in Chapter 1 above, pp. 12-22.

norms regarding small family size in urban areas and better knowledge of contraceptive methods and higher level of contraception use, especially the most modern contraception (Kessler et al., 2010; Lindstrom & Munoz-Franco, 2005; Lindstrom & Hernandez, 2006). Other studies state that women living in rural areas have higher fertility than those with urban background due to their lower socio-economic, income and education differences (Kulu, 2005).

Previous studies also connect fertility with prevalence of poverty in rural settings and various socio-economic and demographic characteristics of the settings (Jensen & Alhburg, 2004; Moreno, 1994). Rural women also marry earlier and have a higher prevalence of remarriage than urban women (Chattopadhyay et al., 2006). In his study, Bach (1981) argued that rural women marry about three years earlier, but those who get married late have lower fertility. Moreover, the current analysis shows that high volume of work is another possible reason for larger family size in rural areas according to Mehrangez, a 38-year old rural left-behind woman from Garm-Chashma village of GBAO. She said: “People in the village have lots of work to do, lots of hard work; therefore, it is better to have more children in the village to help out”. Zebo, a 45-year old rural wife of a migrant man from the same village, also said that she wanted to have four children, because:

In a village, it is better to have lots of children, since there is a lot of work such as collecting wood and mowing the grass. Children can help to ease the burden for me when they grow up. When you live in a city, two or three children are enough.

Decision-making power regarding fertility

The data show that before marriage, only half of the women in both study groups thought about family planning in general, and about the number of children they would like to have in particular. Most women in both groups wanted to have two boys and two girls. The majority of wives of migrant men communicate with their migrant husbands about family planning and discuss the number of children they want or can afford after marriage. Those wives of migrant men who had conversations with their husbands about family planning also state that they make the decision about the number of children they would like or can afford to have together. However, there are a number of women who never thought about children before their marriage. They also said that they did not plan the size of their family with their husbands after marriage. As Kamila, a 37-year old rural left-behind woman in RRS said: “It happened by itself. Because I never talked to my husband about how many children, I want or he wants. We never talked about this.”

Sumbula, a 35-year old left-behind woman in Garm-Chashma village of GBAO, also said that they never thought about or discussed family planning or the number of children to have. She said that they never discussed whether they wanted a boy or a girl; whatever God gave them was enough.

The data also shows that the decision making power of the left-behind women changes slightly across the various regions. Women in Garm-Chashma and Pish villages of GBAO reported that mostly the couples make the decision about the number of children together in the majority of cases or the wife has the decision making power. The interviews show that rarely mothers-in-law or husbands were the

ones who were the main decision maker about family size in this regard. Interestingly, the migration success of husband does not change decision-making power of a wife regarding fertility within the family. For instance, Zaragul, a 40-year old rural left-behind woman in Garm-Chashma village of GBAO, said: “I told him that four children are sufficient in life. [What did your husband say?].²² He agreed with me and did not say anything.” The husband in this married couple has higher education, worked as a teacher before migration, was successful in migration and invested his remittances in a business which provides the family with very solid income now, while the wife is a housewife with secondary school education. It might be also the case that the husband agreed with his wife because she wanted four children, but if she had wanted fewer children or she had only girls, he might have not supported her decision.

Even in a family with a less successful migrant man, in my sample the wife actually decided how many children to have. For example, Lolazor, a 45-year old left-behind woman from Garm-Chasma of GBAO said:

My husband did not say anything. I myself said that, if we would live in the village, we should have four children. But now these two children have been given to us (i.e. given to us by God) and they are enough... In our case, my husband is satisfied with these two children.

Fotimazuhro, a 41-year old left-behind woman from Pish village, said her periods were delayed and she thought she might be pregnant. Her husband told her to

²²The questions in square brackets are my questions used to direct the interviewee or to clarify a certain point further. I am including them here to clarify the flow of the conversation.

have the baby, but she refused to have the baby because she had to do lots of work inside and outside the house, in the field and the garden. In addition, she teaches at school. These responsibilities do not allow her to have a baby now. Therefore, if the pregnancy is confirmed, she will have an abortion even if her husband wants her to have this fourth baby. Not only the left-behind women, but also wives of non-migrants in this region have the decision-making power. Sevinch, a 37-year old rural woman with a non-migrant spouse from Pish village, also said that her husband wants her to have another baby, a boy, because they already have three daughters. However, she told him that she would have a baby only in her 40s in order for her youngest daughter to be older and go to school. In her case, it is also she who decides when to have a baby. Despite her husband's strong wish to have a baby now, she postpones it to raise her daughters first. Overall, mothers-in-law have less impact on decision-making power of women in GBAO and women have more power to make decisions.

In Khatlon region, decision-making power changes. Some left-behind women state that they do not communicate with their husbands about family planning and about the number of children they want to have. Some wives of migrant men mentioned that it is only the husband who decides how many children the family should have. Zubaida, a 25-year old rural left-behind woman from Garovuti village of Khatlon region, said that it was her husband who decided how many children to have in their family. It is common in RRS and Khatlon region that the mothers-in-law and husbands have more impact on the decision regarding family planning and usually encourage the women to have more children or to have another boy or girl to have pairs for the existing daughter or son.

A surprisingly different situation is observed in Sughd region, where some women mentioned that their mothers-in-law do not allow them to have more than two children which is contrary to situation in RRS and Khatlon region. On many occasions, women in Sughd region said that although they wanted to have four children, their mothers-in-law believe that with the difficult economic situation in the country, two children were sufficient. This was an unexpected finding because it is usually believed that mothers-in-law have more pronatalist attitudes and support larger families. It is, therefore, recommended that this aspect should be further investigated in future studies. Interestingly, despite this, very few women in Sughd region are under the strong influence of their mothers-in-law in terms of other aspects of their family life.

It has to be mentioned that there were also left-behind women in RRS and Khatlon region who make decisions themselves and do not depend on their mothers-in-law. However, the data show that having only one child is not an issue in Sughd region, while in RRS and Khatlon region having only one child places a woman under pressure from relatives to have more children. It was interesting to learn that many wives of non-migrant men in Sughd suffered from secondary infertility and received treatment, but they wanted to have only one more child because many already had one child. Two-child families seem to have become a much more acceptable option in Sughd region.

In general, it seems that women in Sughd, Dushanbe and GBAO have more decision-making power regarding family planning in comparison with women in RRS and Khatlon region. The study suggests that there are several possible explanations for

that. First, women in RRS and Khatlon region of the study sample have only primary and incomplete secondary school education and fewer women in these regions had complete secondary school education. Many women dropped school due to the Civil War, because these two regions were most affected by the Civil War. At the same time, almost all women in Sughd and GBAO, and the capital city of Dushanbe have complete secondary school education. Secondly, it seems that the impact of religion is stronger in RRS, where the majority of women are veiled and have quite conservative views. Relatively fewer women are veiled in Khatlon region, only one was veiled in Sughd region and none in GBAO.

As far as the wives of non-migrant men are concerned, they are also able to communicate with their husbands about family planning. However, the data show that it happens less often than among married couples with non-migrant husbands. In addition, husbands have more decision making power in these families especially in rural areas, which is unlike the families with migrant husbands where the decision is made together or depends mainly on the wife. It also seems that women in Sughd are not so concerned about the gender of the baby and are fine with having a child of any gender.

In Dushanbe, comparatively more wives of non-migrants had higher or college education and were more independent in making decisions or they also mentioned that they made decision about family size together with their husbands. They were also more likely to have fewer children. Although Table 3 shows that wives of non-migrant men have higher average fertility, but it is lower especially among wives of non-migrants in urban areas because the majority of urban women married to non-

migrants had college and higher educational background and more decision-making power. This supports Bach's (1981) argument that women who have high educational levels are more likely to have fewer births. In Dushanbe, women were more likely to have fewer children, especially those who have higher education and who were born and raised in the city. Some had two or three children. Those urban women, who have grown up in Dushanbe, even when without higher education, had more decision-making power and wanted fewer children. The data show that some urban women who moved from rural areas to Dushanbe after purchase of apartments as a result of the migration of their husbands and who also do not have higher education, usually prefer a higher number of children. In most cases, they have four to five children.

In most cases when migrant husbands are away women inevitably become independent which is an unintended consequence of the migration of their husbands even in rather conservative and religious families.

Other determinants of fertility

Although the study was more focused on examining the impact of migration on fertility of wives of migrants and its comparison with wives of non-migrants, during the research, it became clear that other aspects had stronger impact on fertility than migration.

The analysis of the data gathered during the interviews shows that the ideal number of children for many wives of migrant and non-migrant men was four: two boys and two girls. Nevertheless, it does not mean that wives of migrants and non-

migrants had this desired number of children. Different factors affected their decision regarding the number of children.

One of the main determinants of fertility among left-behind women is the financial situation of the family, which restricts the number of children in the family with a migrant husband. Nazokat, a 39-year old rural left-behind wife in Ukteppa village of Sughd region, said that she wanted to have four children before her marriage, but because the financial condition of the family was difficult, the married couple decided to have only two children. She also stated that if their financial situation were good, they would probably have had more children.

Conversations regarding the impact of financial situation on family planning were also common among wives of non-migrants. Some women married to non-migrants also said that financial situation influenced their decision about the number of children. Sevara, a 49-year old rural wife of a non-migrant man from Pish village of GBAO, said:

At that time [i.e. following the Civil War], it was the time of poverty and shortage of everything. We had to ask other people for everything all the time. However, you can ask once or twice, but cannot beg all the time. Somehow, we survived. That is why we decided together to have only four children and they are enough for us.

However, the data suggests that the left-behind women complained slightly more often about financial problems restricting their decision to have children. This is not surprising, because, according to the interviews with women and doctors, the

majority of married couples with a migrant husband come from poor families with lower educational background. Clifford (2009) argues that it is mainly the poor and those with lower education who migrate to work overseas in Tajikistan. Therefore, this can explain why the impact of financial restrictions is felt much more strongly on the fertility of the wives of migrant men.

Another determinant of fertility predominantly among wives of migrant men is the housing issue, which is also connected with financial situation of the family. Benazir, a 49-year old rural left-behind wife from Ukteppa village of Sughd region, wanted to have more children, but it is her housing condition that restricted her:

I wanted to have more children, but our house is too small. Those who give birth to a son, they need another house. Taking into consideration our family situation, we stopped having children. My mother-in-law has 9 children. Five of her sons now live in one house, 5 sisters-in-law live together. Why there is a need for more boys? God gives our lives to our children ... I always thought that I would have two boys and two girls, but I came here (i.e. she moved into her husband's house) and there is no condition here to have more children. The condition is not good. My husband also did not want more children. He said: "Let's raise these two properly. They are enough. Let's feed and clothe them properly ..." Now, one of my brothers-in-law has four kids, another three. However, my husband is not like them.

In general, many wives of migrants from all study settings reported that the main reason that their husbands went to Russia is either to buy a flat or a house or to build one. For instance, Jasmin, a 33-year old rural left-behind woman in Garovuti

village of Khatlon region, Halima, a 32-year old wife of a migrant man from the same village and Tohira, a 35-year old left-behind woman from Garm-Chashma village of GBAO, mentioned that it was the lack of a house that forced their husbands to go to work in Russia. There were no wives of non-migrants in the study that said that housing was the reason behind their desire to reduce the number of children in their families.

Another important determinant influencing fertility of wives of migrant and non-migrant men is gender of the children. Those families that have many children, five or seven, had them because of the desire to have a baby of a particular gender. Rangila, a 48-year old rural left-behind woman from Garm-Chashma of GBAO said, that she wanted three children, but now she has five because:

Since I had three daughters first, I wanted a boy. You know that it is very hard to live without a boy in a village. I wanted a boy. I also thought about my old age. A neighbor in my village had only two girls and did not have a boy. When he was young and was told that he needed to have a boy, he used to say that the two girls were sufficient. Later, when his wife passed away (and his daughters were married and moved to live with their husbands and in-laws), he was forced to live with his brother-in-law. Do you know how hard it is to live with your brother-in-law? He did not think about this when he was young. Therefore, we thought that we needed to have a boy.

It is clear from the conversation that if the woman had had a boy earlier, she would have had fewer children. There are also many cases when families who had only boys had to have more children until they finally had a girl. Mumtoz, a 46-year

old urban wife of a migrant man, said that she had seven sons, because she kept on getting pregnant with the hope of having a daughter, but “every time it was a boy again and again”. Her wish to have a girl resulted in her having seven sons. Three out of seven sons are now in Russia with her husband.

The gender of the children is also a determinant of fertility among the wives of non-migrant men. Robiya, a 40-year old urban wife of a non-migrant man, only had one girl and she wanted to have another girl for her daughter to have a sister and that is why she ended up having seven children, six boys and one girl. She stated:

When I gave birth to a daughter, I wanted to have another one. But I had boys. [Which child was she?] She was my fourth child. Then I waited for 8-9 years and tried one more time to have a daughter, but I had a boy again.

Very often, the reason why wives of both migrant and non-migrant men had a large number of children was that they wanted to have a gender balance. It is commonly observed that those families who have a larger number of children (for Tajikistan a large number is more than four children) are those who did not have either boys or girls at the beginning, or even now, and they tried or still attempt to have a child of the desired gender.

Contraceptive behavior and migration of a husband

Studies among migrants in urban and international destinations have shown that due to exposure to new reproductive norms, values and behaviors, access to contraception and the knowledge of migrants about contraception have improved (Kaufman, 1998; Kessler et al., 2010; Lindstrom & Munoz-Fernando, 2006). Migrants

in urban and international areas are also more likely to use modern contraceptive methods and adopt the ideas about small family size (Kaufman, 1998; Kessler et al., 2010; Lindstrom & Munoz-Fernando, 2006). These factors result in a reduction in fertility rates among migrants.

To date, very few studies have examined the use of contraception among partners of migrant workers at the origin (Lindstrom & Hernandez, 2006). Studies on contraception and spousal separation because of seasonal migration of one partner that is a male, show that female partners of migrant men are less likely to use contraception than women married to non-migrant men (Hughes et al., 2006; Kaufman, 1998; Lindstrom & Hernandez, 2006; Sevoyan, 2011; Sevoyan & Agadjanian, 2013). Thus, male labor migration is negatively related to utilization of contraception due to less coital frequency and a reduction in a risk to become pregnant (Kaufman, 1998). The absence of males may increase the demand for children due to demand for labor force in the future. Children can also provide protection and support for women, who may be in insecure financial and social relationships (Kaufman, 1998).

The finding of this study is in line with the results of previous research showing that wives of migrant men are less likely to use contraception than those married to non-migrant men. Similar to previous studies, the analysis shows that absence of a male spouse or partner for prolonged time has a negative impact on likelihood of use of contraception by a woman (Hughes et al., 2006; Kaufman, 1998; Lindstrom & Hernandez, 2006; Sevoyan, 2011; Sevoyan & Agadjanian, 2013). However, little is known about the actual mechanisms that cause low use of

contraception among left-behind women which this study tries to examine thanks to detailed information collected about the reason behind the women's choice to use contraception or not, changes occurring in contraceptive behavior after migration, duration of contraception use and reasons for its discontinuation.

Many previous studies were conducted in countries of Latin America and Africa, which differ from post-Soviet Tajikistan in terms of socio-economic and political characteristics. However, a study on Armenia, a post-Soviet country where migration is also widespread, adds very important findings for understanding the influence of migration on contraception and abortion use, but it has been carried out in a setting with low fertility (Sevoyan & Agadjanian, 2013). In contrast, Tajikistan is characterized as a country with a high fertility rate and low utilization of contraception. Even during the Soviet period, it had the highest fertility rate among other Soviet republics in the USSR (Clifford, 2009).²³ Although the fertility rate declined after the dissolution of the Soviet system, it still remains the highest among other post-Soviet countries (Clifford, 2009). Contraception use, however, is low. According to the existing data only 30% of women used contraception in 1999 (Clifford, 2009; Falkingham, 2000), which further decreased to 28% according to the latest DHS in 2012 (STA, MoH, & ICF, 2013).

Dominant methods of contraception

The data show that out of all methods of contraception, long-term birth control methods, such as IUD, are most widely used among wives of migrants as well as non-migrants in Tajikistan. This is similar to many other post-Soviet countries, including

²³ See above Chapter 2, pp. 23-50.

Armenia, Russia, Ukraine, Moldova, Georgia as well as Vietnam (Goldberg & Serbanescu, 2001; Knudsen, 2006; Sevoyan & Agadjanian, 2013). Goldberg and Serbanescu (2001) connect this fact with a vestige of the Soviet health system, which limited the availability of other permanent or long-term contraceptive methods and did not encourage the use of hormonal methods, which were thought to carry with them negative health consequences and serious side effects. No other modern method was in widespread use across the country (Goldberg & Serbanescu, 2001).

Thus, IUD is the most widely used among left-behind women, while utilization of other short-term contraception is low. However, the data show that there is a tendency towards decreasing use of IUD and increasing use of short-term contraception among this particular group of women. The discussion about the experience of the left-behind women with long-term methods of contraception could probably help to understand why contraception use is low among the left-behind women and, how migration influences contraception behavior in Tajikistan.

The majority of wives of migrant men, who reported using contraception, state that they use an IUD. The second mode widely used, although not at the same level as IUD, is Depo-Provera injection. IUD is, however, also the most popular method among women married to non-migrants according to the data. The interviews show that IUD is similarly popular among women living in rural as well as urban areas. The majority of women use Copper TCu IUD. They usually start using it after their second child or third child, very rarely after their first one.

How do changes in contraceptive behavior occur?

Although IUD is widely used both by wives of migrants and non-migrants, experience of the left-behind women with IUD is different. While wives of non-migrants do not mention seasonal/temporary removal and insertion of IUD, some left-behind women in various regions of the country went to reproductive health care providers and had their IUDs removed after the migration of their husbands to Russia. Thus, as the interviews show, during spousal separation these women did not use IUD, but before or soon after their husbands' return they visited the medical professional and inserted a new IUD. The period of not using an IUD varies from 4-6 months to 1- 2 years depending on duration of their husbands' migration. This is in contrast with the findings of Millman and Potter (1984) that IUD acceptors are relatively unlikely to have their IUDs removed during separations. This, however, would mean that there will be some degree of redundancy between the protection from conception afforded by contraception and separation for these women. However, in the case of Tajikistan, additive constraints on fertility by using contraception and separation cannot be observed among this particular group of women who remove their IUDs during separation from their husbands. The redundancy between the protection from conception by IUD and separation could probably be observed among left-behind women who keep their IUD when their husbands are away. Shakarmo, a 44-year old rural left-behind woman in Ukteppa village of Sughd region, said: "When my husband went to Russia I removed my IUD because I wanted my body to rest from it while he is away and when he returned I had another IUD".

Sinjid, a 33-year old urban left-behind woman in Dushanbe, also said:

Over four years I did like this. When my husband went to Russia, I removed it [i.e. IUD]. When he came back, I had it inserted as soon as he arrived. I put and removed it two times over four years when my husband was in migration.

The interviews with medical professionals also support findings from discussions with the left-behind women about their experience of seasonal removal and insertion of IUD. The interview with Farzona, an Ob/Gyn from the reproductive health center of GBAO, demonstrates that wives of migrants often asked doctors to remove their IUD when their husbands are in migration in order “for their uterus to rest from it while their husbands are away”. It is not only the case in GBAO, but it is a common practice among wives of migrants across the country. Oftoba, an Ob-Gyn from the reproductive health center in Dushanbe also reported:

When women’s husbands migrate, they come and ask to remove their IUDs. They stop using Depo-Provera and use condoms instead. But this process has “seasonal character”. When their husbands return, they visit us and have the IUD re-inserted, or ask for Depo-Provera injection and condoms. It has, as I already mentioned, a “seasonal character”.

Oftoba also said: “When their husbands are not here [i.e. in Tajikistan], they rarely come to see us. But when their husbands return, they visit us more often”. Zamira, a nurse from the reproductive health center in Garovuti village of Khatlon region, also reported:

When they (i.e. migrant husbands) come from Russia towards the beginning of winter, starting from November we have a line in the clinic for contraception

(condoms and pills). The demand usually increases in November. More women visit us then. Before their (i.e. migrant husbands) return, they (i.e. left-behind women) start coming saying that “he is coming on the 20th or he is coming on the 10th or the 25th, I need to be prepared. I need to do something.” Women are becoming very smart about these things. Husbands usually call and tell them “we are coming and you need to be prepared.” They are so smart. They come and ask either for IUD, and until he arrives in 10 days the IUD will already be in its place, or they will take pills.

The above interviews with the reproductive health care providers in various regions of Tajikistan certainly support findings from the left-behind women about removal and insertion of IUD during spousal separation due to migration. The interviews with women and doctors also demonstrate that this trend is common both in urban and rural areas among wives of migrants. In addition, they also show that access of wives of migrants to contraception has a seasonal character. Thus, the wives of migrants visit doctors more often after the return of their husbands. This is not surprising because with the return of the husbands they are in need of birth control to prevent unplanned pregnancy. However, it is possible that only left-behind wives who had better economic conditions may afford seasonal removal and insertion of IUD, because a visit to a doctor, procedures of removal and insertion of IUD and the price of the contraception itself all cost money. Women in rural areas in addition to the above-mentioned costs also need to pay for transportation to get to a reproductive health facility for removal or insertion, so the travel cost may also increase the expense of this practice. Therefore, mainly left-behind women from households with

higher income or women with successful migrant husbands are more likely to practice the removal and insertion of IUD than those from lower income households.

At the same time, the data shows another trend in contraceptive behavior among some left-behind women. These women used IUD for many years before the migration of their husbands to Russia and then stopped using this long-term contraception and shifted to short-term methods of birth control when their husbands visit them. For example, some urban left-behind women in Dushanbe stated that they had been using short-term contraception such as the spermicide “Pharmatex”²⁴ for many years during the visits of their husbands. Sometimes they use films,²⁵ if they are not able to find Pharmatex. Thus, these women shifted from IUD to Pharmatex or films and have been using them successfully for a long period. No unintended pregnancies or induced abortions were reported among these women.

The in-depth interviews with these women show that social networks among urban left-behind women contributed to the increased use of Pharmatex and films among them. Shafika, a 38-year old urban wife of a migrant man, said she first learned about Pharmatex from her doctor and then recommended it to her neighbors who were also her close friends. Most of the women in her neighborhood have migrant husbands, which makes them close to each other and, therefore, share their experiences with each other.

²⁴ Pharmatex is a vaginal contraception that acts locally in the vagina by destroying the cell of sperm. It acts as a disinfectant and decreases the risk of STIs as well. Pharmatex is manufactured in forms of capsule, ovules, tablet and creams.

²⁵ Film is a vaginal contraception, which after insertion dissolves and creates a gel coating. It has a very effective spermicide that destroys sperm in close contact over three hours. But it is especially effective in 15 minutes and remains active over three hours.

The case of this group of left-behind women demonstrates that social learning is an important process through which information about the range of alternative behaviors and their consequences is acquired from others (Lindstrom & Munoz-Franco, 2005). This is crucial for promoting contraception use. Lindstrom and Munoz-Franco (2005) suggest that social networks can influence fertility goals by means of several mechanisms. First, they can increase awareness of alternative reproductive choices. Second, the members of an individual's social network, who adopt new reproductive practices, provide examples of the consequences of innovative behavior (Lindstrom & Munoz-Franco, 2005). Third, network partners can apply social pressure to conform to normative expectations regarding family size. As evident from the interviews, all three mechanisms worked in this social network of the left-behind women in the way that Lindstrom and Munoz-Franco (2005) suggest.

Social networks not only impact fertility goals, but also influence the adoption of modern methods of birth control by: 1) spreading knowledge about available types of birth control methods and the place to obtain them; 2) giving information about the effectiveness of alternative contraception methods, their possible side-effects and safety; and 3) impacting views of persons in terms of the moral and social acceptance of using modern methods of birth control (Lindstrom & Munoz-Franco, 2005).

The concept of social networks used by Lindstrom and Munoz-Franco (2005) to explain the effect of migration on contraception awareness and its use in rural communities in Guatemala can also explain the impact of social ties in promoting information about and the use of Pharmatex and films through interpersonal communication among urban left-behind women living in the same neighborhood in

Dushanbe. Shafika, who first learned about spermicide, shared information not only about spermicide, but also its availability and the place to obtain it with her friends. She also provided the members of her social networks with information about its efficacy, safety and potential side effects. In addition, her own experience of effective and safe use also contributed to practice of this contraception among other women within her network as suggested by Lindstrom and Munoz-Franco (2005). Favziya, a 33-year old left-behind wife in Durbad village, also stated that her sister in-law experience with IUD was a reason why she decided to choose pills instead.

Interviews with the reproductive health care providers also support this trend in the contraceptive behavior of the left-behind wives. In particular, the interviews with Ob/Gyns show that the majority of wives of migrants who had been using IUDs for years, stopped using it. They use short-term contraception which is tailored to the duration of their husband's visit. According to the doctors, women whose husbands visit them for a month are more likely to use condoms or pills; if it is for 3 or more months, then they would use longer term contraception, such as Depo-Provera. For instance, Farzona, the doctor of reproductive health center in GBAO, said that:

The majority of women whose husbands are migrants do not use IUDs, because it is not cost-effective and beneficial for them. They might have to insert IUD today and her husband would leave tomorrow. Therefore, they mainly use Depo-Provera, Rigevidon (the oral method of contraception) and condoms.

Thus, the interviews with women and providers show that there is a clear shift from using the IUD, which traditionally was the dominant method of birth control, to short-term contraception among wives of migrants. Farzona also said that the

reproductive center has Implanon²⁶, but the left-behind women do not use it because their husbands leave after a very short period, whereas the expiration date for this contraception is three years. This means that by the time their husbands come back next time, it might be expired and wasted. She said:

As I said, they mainly use Depo-Provera. For instance, a woman comes and says: 'I need to take condoms because my husband is coming for a month'. Or she would say: 'I will take Rigevidon and use it for a month, because he will leave in a month so why should I use an IUD?' Even those women who have IUDs come and ask us to remove it because their husbands have left. Almost all of them remove it. In general, they do not use IUDs so much now.

Finally, there were also some left-behind women who said that when their husbands left for Russia they wanted to go and remove their IUDs, but they did not have time to do so. These were usually women living in rural areas who have lots of work to do outside the house and are overburdened by work. Therefore, they have less opportunity or time to visit a doctor. In general, it seems probable that the use of IUDs among wives of migrant men will further decrease in future. Because the majority of wives of migrants use IUDs, probably the use of contraception will be even lower among wives of migrants taking into accounts these trends. Couples will be using more coitus-dependent contraception such as condoms, spermicides, films or traditional method of birth control including withdrawal.

²⁶ Implanon - a hormone-releasing sub-dermal long-term contraception for the prevention of pregnancy for up to three years.

The interviews with wives of non-migrant men demonstrate that practice of removal and insertion was not observed among this study group. Among women whose husbands never migrated some women state that they are satisfied with the IUD. Others state that after using it, they developed side effects such as prolonged bleeding or back pain and as a result they asked medical providers to remove it. Heavy menstrual bleeding and pain are the most common reasons for the discontinuation of the IUD (Grimes, Hubacher, Lopez, & Schulz, 2011) among Tajik women. Wives of non-migrants who do not have these side effects usually use it for the entire life, which was predominantly observed among women married to non-migrants who had long and uninterrupted use of this method. Certainly wives of non-migrants had removed their IUD to have a child or by the end of their expiration date and replaced it by a new IUD if they desired to continue contraceptive protection. Wives of non-migrant men who had removed their IUD due to side effects often used other contraception methods such as Depo-Provera injection, pills and condoms but only for short time. In many cases they also stopped using Depo-Provera and pills due to bleeding and amenorrhea and often referred to abortion to control their births. The study also shows easy access of women to abortion and abortion often used as a method of birth control not only by wives of non-migrants but also the left-behind women. Sevara, a 49-year old wife of a non-migrant man from Pish village of GBAO, said that she used different types of IUD starting with the so-called “Soviet one” which did not suit her because she was bleeding then she used the so-called “Finland IUD” which was self-expulsed and she had ectopic pregnancy and after that she stopped using IUD at all. Then she had about seven or eight abortions; actually the

number of abortion was so many that she does not even exactly remember how many abortions she had. All her abortions were surgical ones.

Depo-Provera is the second most common contraception among non-migrants' wives but the number of women using this method is significantly lower than the number of those who use the IUD. In addition, women also use it for a shorter period. Many women both in urban and rural areas also complained about different side effects of Depo-Provera such as bleeding and pain. Some women thought that they developed myoma after using Depo-Provera. Rangina, a 49-year old rural wife of a non-migrant man from Garm-Chashma, said: "I had IUD for 5-6 years, then I removed and had Depo injections and after that I became ill [literary: my uterus became sick]. I used Depo-Provera every three months, sometimes 6 months, for about 2-3 years". She connects her myoma with injections of Depo-Provera. It was interesting that many other women, both wives of migrants and non-migrants, in different regions also connected their myoma with Depo-Provera injections.

In addition, the providers also mentioned that women married to non-migrants often use them for a long period of time, which also supports finding from wives of non-migrants about the use of birth control methods among them. They did not find any other particularities in terms of contraceptive use in this study group while they very clearly described changes in the use of contraception among wives of migrants. The doctors also state that wives of non-migrants use contraception, while the left-behind wives often refuse to utilize methods of birth control when they offer them. The interviews with Ob/Gyns show that the IUD is still the dominant method of

contraception among women married to non-migrants. For example, Farida, a physician in a maternity home in Dushanbe, stated that:

Wives of non-migrants are happy to take them (i.e. contraceptives) and they often use IUDs or Mikroginon. Wives of migrants mainly refuse them (i.e. contraceptives) saying that their husbands came and they got pregnant and now they (i.e. migrant husbands) left. They tell us that why would they need contraception if they do not have sex [while their husbands are away].

Decision-making power regarding contraception

Another important aspect of contraception use is the decision-making power of the women. Therefore, the study tried to understand whether decisions regarding the family size or choice and use of contraception in general, or a certain type of birth control, in particular, is made by the women themselves or under pressure from doctors, relatives or husbands. It is clear from the data that the majority of women, irrespective of the migration status of their husbands, were in charge of making the decision to use certain methods of contraception, and nobody else including husbands, relatives or medical staff was pushing them to use contraception in general or certain methods, in particular. This was also true regarding seasonal use (removal and insertion) of the IUD during spousal separation due to the migration of husbands. Only 5% of women said that husbands or mothers-in-law asked them to use contraception. Although both wives of migrants and non-migrants state that they themselves decide on the kind of contraception they wanted to use without pressure from anybody, it seems that often good or bad experience of relatives, neighbors and friends had an impact on their choice of contraception method.

Lindstrom and Munoz-Franco (2006) in a study on contraceptive knowledge and use in Guatemala state that relatives, friends and neighbors were more important sources of information about family planning than were health service providers and the mass media. Data gathered during the field work also shows that women who had a relative or a friend with good experience of a particular method of contraception were more likely to use the same contraception as their friends, relatives and neighbors. For example, Silsila, a 36-year old left-behind wife from RRS, said that because her sister-in-law had many problems with her uterus after the insertion of an IUD, she and her husband were afraid to use it and, as a result, she was keeping on having either abortion or a baby. At the same time, good experience of relatives, friends and neighbors, on the other hand, encouraged the use of certain contraceptives among women as it was observed among urban left-behind women in Dushanbe with Pharmatex or IUD among other women. What was interesting to learn is that doctors had the least impact on women's decision regarding family planning because women during the interviews said that they went to the doctor and said that they want to have an IUD and they had it inserted unless they had any infections or health issues preventing them from using an IUD. In most cases, the decision on which method of contraception to use had been made before they went to see the doctor. The women in both study groups were asked who made the decision to use current contraception, or whether someone helped her to make the decision and so on. The study also found out that despite active population control programs financed by the UNFPA providing various methods of contraception in reproductive health centers throughout the country for free, misuse and forced imposition of contraception and sterilization on women, which was reported in Bangladesh (Hartmann, 1995), was not observed in

Tajikistan. However, similarly to the findings in Bangladesh “most of the programs only targeted women, ignoring male responsibility for birth control” (Hartmann, 1995, p. xvi).

The doctors in GBAO also support the finding that in many cases the social networks of women irrespective the migration status of husbands such as neighbors had an impact on the decision making powers regarding contraception or health related issues. Neighbors have a significant influence on health related issues. For example, Gulshod, a doctor of the maternity hospital in this region, reported that often when referring to doctors women say that “My neighbor uses the pills and, therefore, I also want to use it”. Certainly, the Ob/Gyns made sure that there is no health problem that serves as a reason why a certain method of contraception cannot be used. The doctors also offered information about other methods of birth control, but if women did not have contraindications they insisted on the desired contraception method. Nilufar, a doctor of a reproductive health center in GBAO, said “information that they receive on the street has impact on their use of contraception”. Gulshod also said that after we began using Implanon, which is placed inside the hand, I now often hear from women saying: “apparently there is a new thing out there, which people call “hand IUD”. Nilufar stated that women, irrespective of the migration status of their husband, usually hear from other women and come and ask for the same contraception. This finding must be explored further in future studies.

The opinion of reproductive health care providers regarding the decision-making power of wives of migrants and non-migrants is different. Some wives of migrants, as Oftoba, an Ob-Gyn in Dushanbe stated, are more independent in

comparison to wives of non-migrants, because their husbands are absent and they decide themselves on all issues. According to her, they “are very independent and decide on contraception and other issues themselves”. Zamira, a nurse in Garovuti village of Khatlon region, had similar thoughts:

Wives of migrants are more independent. Probably, because their husbands go and work very hard in Russia, therefore, they advise their wives to prevent pregnancy to use IUD or something else. Also, many left-behind women also go to Russia; they receive knowledge there and they are better aware as a result.

However, others, such as Farida, a doctor of a maternity hospital and Zarina, a doctor at a reproductive health center in Dushanbe, stated that wives of migrants depend on their husbands, but wives of non-migrants do not. According to these providers, in many cases husbands and in-laws make decision on their behalf. Zarina also believes that often women, irrespective of their migrant husband’s status, depend on their parents, their in-laws and their husband. The majority among them do not work and do not have higher education, because those who marry migrant men usually get married after grade 9 or 11. That is why they are completely depend on their husbands and his parents, especially on issues such as where to go, whom they can visit. Nevertheless, they have more decision-making power in terms of their own health. They, of course, discuss health issues with their husbands, who also send them money for treatment, but in general, they mainly make decisions on their own. Thus, Zarina believes that more often than not women come and get tested and make their

decision regarding their health independently. However, all providers agree that if women have higher education and work, they are more independent.

All providers including medical personnel, staff of state agencies, local and international organizations believe that education attainment is important in the decision making process. Many staff of organizations and state agencies said that they do not see clear impact of migration on decision making power of the left-behind women or difference in terms of decision making power between the two study groups. However, they emphasize that women who have higher education have the power to make many health-related decisions on their own, including contraception and condom use. They also state that although there are some women who say that they need to discuss the matter with their husbands, most make decisions themselves. They would say that their health situation was not very good and that they could not have more children. However, in Dushanbe, doctors often state that women have the voice to make decisions, but many would still need to discuss the issues with their in-laws in order to go for examination. According to Munavar, a doctor of DVC in Dushanbe, there are also women who are independent; they come and have examination on their own. However, at the same time, there are women whose husbands and relatives are against their visit to the doctor. These women, in particular, completely depend on their in-laws and it is the in-laws who make the final decision in terms of their health.

The lack of use of contraception during absence of husbands also suggests that extramarital relations are not common among the left-behind women. In addition, even if they exist, they are very rare. When the doctors were asked about abortion or

the possibility of getting pregnant during the absence of husbands, the majority of them said that something like that would be absolutely rare in Tajikistan. Instead, women with migrant husbands usually come and ask to remove their IUDs after their husbands had left and stop using birth control. According to the respondents, the left-behind women might give birth, and in fact, most of them do give birth while their husbands are away, but they never get pregnant while their husbands are away. Overall, all of the doctors said that they never had a woman who had had an abortion or got pregnant and gave birth to a child conceived when her husband was away, which indicates absence of extramarital affairs among the left-behind wives during the migration of their husbands.

Socio-economic and geographical factors and contraception

The data gathered as a result of this study show that out-of-pocket expenses are not only a serious barrier for access to health care in Tajikistan (Falkingham, 2003), but also for access to and use of contraception. It seems for some left-behind women expenses do not restrict their use of contraception, because some women had removed their IUDs after their husbands leave and inserted them upon the return of their husbands. For others, the affordability of doing so was an issue and even a single time insertion of IUD is beyond their means, such as in the case of Afzuna, a 29-year old wife of a migrant man from Garm-Chashma village. Afzuna cannot afford to cover the cost of travel to the health facility in Khorog. For a few left-behind, it was a considerable financial burden even to make one journey to have an IUD inserted. Therefore, they end up having many children which, according to them, they would otherwise not have.

Kaufman (1998) suggests that in those districts that are relatively well off women residing there are more likely to use contraceptives. This association is due, at least in part, to the greater availability of services in these areas. Moreover, it is likely that opportunities associated with economic development, especially education, contribute to the increase in contraception use (Kaufman, 1998). The experience of the women I interviewed also shows that for some left-behind women in urban areas, where the health care system is developed well, access to contraception was less visible than for those living in rural areas, where access to health care was limited. For others, living in rural areas with better access to pharmacies and reproductive health care, expenses were not a significant burden. For example, Xurama, a 39-year old wife of a non-migrant man in Durbad village of RRS, said that she had bought her IUD in a pharmacy then the village midwife inserted it for her and charged her an insignificant amount for the insertion of IUD. Anisa, a 43-year old wife of a non-migrant man in Durbad village, said that she bought oral contraceptive pills for 1,5-2 *somoni* (50 cents) from the medical facility. She also mentioned that the medical facility received the pills as humanitarian aid (which usually means that they were meant to be distributed free of charge). The woman also stated that the medical facility had more expensive pills costing 12-15 *somoni* (\$3-4), but she could not afford those and bought only pills for 1,5-2 *somoni* (50 cents). Sojida, a 26-year old wife of a migrant man from a rural remote village of Garm-Chashma, said that she could not afford the cost of the IUD itself, but most importantly, she could not afford the cost of travelling to the city to have it inserted. And that is why she kept on having babies. Life became even harder for her with the arrival of each baby.

Thus, access to contraception is a particularly significant issue for women in remote rural areas, a fact which substantiates the findings of other studies stating that access to methods of contraception is a problem in more remote rural settings (Lindstrom & Hernandez, 2006). However, it is also clear that the cost of contraception is an issue for wives of both migrant and non-migrant men. Unaffordable costs have reduced contraceptive utilization, especially among the wives of non-migrant men who need constant use of contraception in contrast with the left-behind women, who, at least, do not need them for a certain period of time when their spouses are absent. Therefore, the major cause restricting access of some wives of non-migrants to contraception is the cost related to its use.

The issue of the cost of contraception is a very sensitive one among the women as well as the medical personnel. If in the majority of cases women cannot afford it, doctors also find themselves faced with a difficult dilemma. According to the representatives of international organizations and health officials, they provide reproductive health centers with contraceptive methods free of charge. However, all women in all regions of the country mention that they paid for their contraception. At the same time, medical personnel state that they do not charge money for contraception itself, because they receive them free of charge and when they give it to the women they mention that is humanitarian aid and it is free of charge. However, the medical personnel charge them for miscellaneous supplies, for example for iodine, gloves and cotton, which they use during the medical procedure to insert the IUD. However, it has to be mentioned that the medical personnel themselves buy these supplies since many health facilities do not receive them from the government. Even if they receive the supplies, they are usually in very small quantities and, therefore, do

not last for a month as they are supposed to. Health workers have to buy them again with their own money and then charge patients for the cost of their services. It is of course impossible for the medical personnel to cover the cost of all supplies they have to buy with their meager salaries. The health care workers also said that when women pay, they inform them that they were paying for the service (e.g. cost of materials and cost of medical personnel's work), but not for contraception, which is free because it is humanitarian aid. However, this still does not explain why women are charged for pills or spermicides that are supposed to be free, because no supplies are used for their distribution. It is most probable that the medical personnel have to charge patients for the services they provide in the latter cases, because it is the only way for them to top up their meager salaries. Medical workers have to complement their salaries, which are so low that otherwise there is no point for them to even work. However, the burden of most of the expenses for the functioning of the health system in Tajikistan is on the shoulders of the patients.

As mentioned earlier, abortion is often used as a method of birth control in Tajikistan, similar to many other post-Soviet countries (Goldberg & Serbanescu, 2001).²⁷ The interviews show that the number of abortions is likely less among wives of migrant than non-migrant men, which is probably not surprising due to long-term absence of their husband due to migration and lower frequency of coitus. Therefore, fewer left-behind women mentioned having abortions in comparison with women married to non-migrants.

²⁷ See above Chapter 2, pp. 36-38.

There is a possibility that if the women are asked the same questions during winter periods, the responses could be different because the migrant husbands are at home. However, field work in Tajikistan especially in GBAO is very difficult during winter time but it does not mean that it should not be undertaken in future studies.

Summary

In sum, the study shows that migration does not have a significant impact on the fertility of the left-behind women who stay back in Tajikistan. It also suggests several possible explanations as to why temporary migration of male partners does not have an impact on the fertility of the left-behind women. However, the data show that other factors such as financial problems and gender balance of the children had similar effect on fertility of both study groups, while housing was a more common factor among wives of migrant men. The study shows that rural wives of migrant and non-migrant men have slightly higher fertility rates in comparison with their urban counterparts due to differing reproductive norms and values, knowledge and use of contraception, socio-economic and demographic situations, early remarriage and prevalence of poverty in rural settings (Chattopadhyay et al., 2006; Jensen & Alhburg, 2004; Kessler et al., 2010; Kulu, 2005; Lindstrom & Munoz-Franco, 2005, Lindstrom & Hernandez, 2006; Moreno, 1994). Attitude of people regarding number of children also differs depending on regions of the country. If in RRS and Khatlon region women tend to have more children, in Dushanbe, Sughd region and GBAO this is not the case. In addition, decision-making power regarding family size slightly changes across regions as well.

The study also shows that migration of men has an impact on contraception use of the left-behind women. It usually results in the practice of seasonal removal and insertion of IUD among some women and in shift from long-term contraception use, such as IUD and Depo-Provera, to short-term methods of birth control including spermicides, films, vaginal suppositories and condoms as well as traditional methods. In addition, the study shows that while some left-behind women can afford seasonal insertion of IUD, others cannot afford even one-time insertion of IUD.

The interviews with Ob/Gyns were particularly helpful in understanding the changes in contraceptive behaviors of the left-behind women, because every one of them was talking about the same changes as mentioned by women themselves in various study settings. First, they also mentioned the practice of removal and insertion of IUD among the left-behind wives. Second, the doctors also support the findings from the left-behind women in terms of a shift from using long-term contraception to short-term ones. The findings on contraception use among the left-behind women also suggest that over time, there is a possibility of increase in the use of short-term methods of birth control or coitus-dependent contraceptives due to migration.

Moreover, the interviews with the doctors showed that access to contraception and removal and insertion of IUD both have seasonal character. These particularities could not have been brought to light without the inclusion of the reproductive health care providers in the study. Interviews with the health care providers also helped to better understand the changes in contraception behaviors among the left-behind women.

Moreover, the study shows that while the majority of the Ob/Gyns think that both wives of migrants and non-migrants have the power to make decision in terms of contraception and fertility, the representatives of state agencies and international and local organizations think that women do not have the power to make decision in terms of family planning or any other reproductive health issue. Yet, they make exception only for women, who have higher education and those, who are originally from urban areas. That is, they seem to be more biased towards women with lower educational attainment and those coming from rural areas. At the same time, the majority of women reported that they make decision regarding fertility and contraception themselves or make them together with their husbands and without being under pressure of a male spouse, relatives or medical personnel.

Finally, the interviews show that paying for contraception is one of the most serious barriers discouraging their use in the country. In addition, although various modes of contraception are supposed to be provided free of charge in all reproductive health care facilities, in reality patients have to pay for them or associated services.

CHAPTER 6

KNOWLEDGE AND AWARENESS OF HIV RISKS AND PREVENTION

PRACTICE

Wives of migrant men are one of the major groups considered at higher risk for HIV infection (Herrera & Campero, 2002). For a long period of time, the prevalent view was that HIV was transmitted from migrant men, who had sexual contact with other women while working abroad, to their partners upon their return home (Brockhoff & Biddlecom, 1999; Lurie et al., 2003b). However, Lurie et al. (2003b) showed that it is the woman who had HIV infection in a third of discordant couples²⁸ that included a migrant man who had worked in South Africa (Lurie et al., 2003b).

However, without regard to the gender of the infected half of a couple, it is evident that migration is a major risk factor of HIV infection for both genders (Lurie et al., 2003b). As mentioned, not only migrant men who are away from their sexual partners have sex with other women and may contract STIs including HIV (Brockhoff & Biddlecom, 1999; Lurie et al., 2003), but also their female partners have sex outside the primary relationship when their male partners are away. This subsequently increases the risk of both partners for HIV infection (Lurie et al., 2003b).

The analysis of the literature on the topic shows that the majority of studies on the role of migration in HIV infection and its spread have been conducted in African countries. Little is known about HIV prevention and transmission in transitional

²⁸ A long-term sexual couple where only one member has a sexually transmitted infection.

countries, such as post-Soviet Tajikistan, which differ greatly from Africa.

This chapter begins with the discussion of knowledge, awareness, and concerns of the left-behind wives of migrant men about HIV in Tajikistan. It shows that there are different levels of knowledge of wives of migrant and non-migrant men about HIV. The chapter also shows that knowledge of women depends on education background and place of residence. It also demonstrates that knowledge about HIV and prevention modes differ between urban and rural settings and often depend on the exposure to educational intervention. In particular, I aim to examine the nature of the knowledge of the left-behind wives about HIV risks and their familiarity with prevention measures and skills.

The chapter, therefore, addresses the following research questions in order to contribute to the overall aim of the study: 1) What are the main sources of information about health issues among the left-behind wives? 2) How do they learn about STIs/HIV prevention measures and skills? 3) What are the options used by the left-behind wives to protect their sexual and reproductive health? 4) How do the left-behind wives exercise their personal agency in terms of negotiation of condom use and other prevention measures to protect themselves, such as asking their migrant husbands to have an HIV test?

Although the initial purpose of the study was to examine knowledge of women about STIs including HIV/AIDS, the interviews with both study groups showed that women have some level of awareness about HIV/AIDS, but have extremely limited knowledge about other STIs. Even those women who had extensive information about HIV/AIDS knew little about other STIs. This is a public health concern of immense

importance. Because of the women's lack of knowledge about other STIs, however, this chapter will focus on HIV/AIDS.

In order to define the level of knowledge of HIV/AIDS among women, I used the following criteria to determine what I consider good, poor or moderate knowledge within the context of Tajikistan. Good knowledge is when a woman knows what HIV is (what kind of a virus it is; that it is incurable), how it is transmitted, and how it can be prevented. Moderate knowledge is when a woman can answer what HIV is, some modes of transmission, or at least one means of protection. Poor knowledge is when a woman knows one mode of transmission or only knows what HIV is.

Knowledge and awareness about HIV/AIDS

Impact of education

The narratives of the left-behind women show that the level of their HIV/AIDS knowledge depends not so much on the migration status of their husband as on their educational attainment and residence background as well as on exposure to educational interventions. The analysis of the data demonstrates that some left-behind women have good knowledge about HIV, how the infection is transmitted and means of protection. The in-depth interviews with left-behind wives revealed that good knowledge and awareness was strongly associated with college or medical education among them. Likewise, higher education was also directly associated with better knowledge of HIV/AIDS among wives of migrants and non-migrants. This shows that having higher education, college and medical education is directly connected with

better knowledge and awareness about the infection between both wives of migrant and non-migrant men living in both urban and rural areas.

This finding is consistent with results of Golobof et al. study on Tajikistan which argues that the knowledge of wives of labor migrants is dependent on the level of their educational attainment. Similar to their study, data gathered for the current study also demonstrates that wives of migrants with higher education have a relatively better knowledge about HIV/AIDS in Tajikistan. This situation is not unique for Tajikistan. However, the current study also shows that wives of non-migrants with higher education are also better aware of HIV than those with lower education attainment. And there is no difference among wives of migrants and non-migrants with higher education in terms of awareness of HIV/AIDS in various areas of residence. Yet, despite this, the overall number of wives of migrant and non-migrant men with good knowledge of HIV/AIDS is still very low.

Doctors and representatives of local and international organizations participating in the study also stated that women with higher education are better aware of HIV/AIDS than those with lower education attainment. However, they also stated that women living in urban areas have better knowledge on the issue than those living in rural areas. At the same time, they also mentioned that they did not notice or were not aware about the mechanism of the impact of migration on the knowledge of the left-behind wives. Neither did they know about possible similarities or differences in the awareness of these two study groups.

Moreover, the study demonstrates another interesting nuance: that good knowledge of HIV/AIDS does not always lead to use of HIV protection skills or

measures. Despite the fact that women were well aware of the means of HIV protection and had good overall information about HIV and modes of its transmission, the left-behind wives did not use condoms with their migrant husbands or did not ask their returning spouses to have an HIV test before having sexual intercourse with them. There were exceptions for one rural woman with higher education and good knowledge in Khatlon region and an urban left-behind in Dushanbe. At the same time, the majority of wives of non-migrants with higher education and good awareness use condoms only to avoid pregnancy but not to protect from HIV infection. It can be concluded that wives of migrant and non-migrant men with higher, college and even medical background in the majority of cases had very good knowledge of HIV/AIDS but did not use safe sex or ask spouses to have a test for HIV. Golobof et al. (2011) also argue that wives of labor migrants have some knowledge of HIV prevention measures and the majority of them knew that condom use prevents HIV/AIDS. However, they hesitate to discussing condom use with their spouses. Although wives of migrants were interested in prevention, they did know “how to take a more active role” in protecting themselves (Golobof et al., 2011).

Impact of residence

In general, while there are no differences between the knowledge of women with higher education in both study groups as well as in urban and rural areas, the awareness of women with secondary education is better in rural than in urban areas. Surprisingly, among wives of migrants and non-migrants with only secondary education, those who live in rural areas were better aware of HIV/AIDS than those residing in urban settings due to their exposure to educational campaigns, which

focused on rural areas. The majority of the rural left-behind women with secondary education had moderate knowledge of HIV infection thanks to exposure to educational intervention such as trainings and seminars or to having personal conversations on this issue. For example, Sabrina, a 48-year old left-behind woman from Ukteppa village of Sughd region, was aware of HIV. She said: “It [i.e. HIV] is transmitted through sexual intercourse, injection, blood, and from an infected mother to child”. She was also aware about how this infection is not transmitted saying that: “It is not transmitted through washing hands, eating, *salom* (traditional hand-shake when people greet each other), conversation and kissing”. The rural left-behind woman also named some methods of protection from HIV infection such as: “Not to have sex with unknown people, using condoms, having tests for STIs, seeing doctors during pregnancy”.

In contrast, rural wives of migrants who did not attend such educational programs had poor awareness of the infection. This shows that exposure to educational interventions makes a significant difference in knowledge acquisition and changes in behaviors of these women. These findings are in line with the findings of a comparative study of women with and without formal education in migrant communities in Nepal (Smith-Estelle & Gruskin, 2003). It also showed that from among women with no formal education exposed to HIV education intervention programs, 76% stated that they knew about AIDS, while only 22% of women with no formal education and who never participated in such programs reported to have heard about AIDS (Smith-Estelle & Gruskin, 2003). Three times more women in Nepalese migrant communities became aware of AIDS due to educational intervention. Thus, the current as well as previous study demonstrate that educational campaigns make a

tangible difference in the acquisition of knowledge and awareness of women about HIV/AIDS even within the same study group.

Similarly, left-behind wives with only secondary school education residing in urban settings with few education campaigns have poor knowledge of HIV/AIDS. In general, women with secondary education living in urban settings had limited information about HIV infection. However, it was interesting to find that doctors and staff of organizations, interviewed as part of the study, still believe that in comparison with rural women, urban women have better knowledge of HIV/AIDS.

As mentioned above, the good knowledge about HIV/AIDS among the rural women is the result of information and education campaigns conducted by different agencies in these areas. The interviews with women show that the main reason why the rural left-behind wives with primary or secondary school education were better aware of HIV/AIDS than their urban counterparts was due to attending seminars and training or having visits and conversations with medical personnel, staff and volunteers of local and international organizations. For example, Zainab, a 44-year old left-behind woman from Ukteppa village of Sughd region, said:

Salima gave us a booklet about HIV; how it is transmitted through sex, blood; how it is transmitted from a pregnant woman to her baby. I read all this in that booklet. I was also told that when my husband came, I needed to ask him to have his blood test to know his condition and only then I should have sex. They also talked about it on TV, didn't they? Then if you want to have sex, you need to use condoms. They (i.e. nurses/volunteers) also gave us condoms. They gave us condoms as aid (*pomosh'* meaning for free) from the gynecological center.

In our further discussion Zainab added: “Doctors (*“dukhturho”* in Tajikistan often refers to all medical professionals, including nurses, midwives and doctors) – Salima - and others walk the street by street and gather all women and tell them about these kinds of diseases and how they are contracted. They explain everything”. Shabnam, a 49-year old wife of a migrant man from the same village, said:

These nurses come and explain everything, give us booklets which we read... These nurses are from the Health Center... Sometimes they come to the house and talk to us personally. For example, if there are 2-3 persons on the street, women who came for fetching water, they gather them and talk to them and explain everything to them.... Sometimes when we come to the Women’s center, we also receive information and explanation there.

Although the women think that the educational information among them is done by physicians, the interviews with staff of local non-governmental organizations (NGOs) and health workers in Sughd region revealed that these nurses are actually volunteers of a local NGO “Chashma-i Hayot” which works as partners of the IOM for the project “HIV Prevention among migrant workers and their families in Tajikistan”. This program is financed by the United Nations Development Program (UNDP) with donor support from the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM).²⁹ Often local NGOs or international organizations hire nurses from reproductive or health centers due to their medical background as volunteers to conduct their HIV prevention activities in the region. Nurses get paid for their work and receive small presents as incentives to do the job. Often nurses along with doing

²⁹ More details about sources of information will be provided later in the dissertation.

their HIV prevention activities as volunteers also while walking through the village do their direct medical responsibilities asking pregnant women to come for antenatal care and to bring their kids for immunization or provide advice on birth and so on.

As far as wives of non-migrants with secondary education is concerned, the rural wives of non-migrants with secondary education who attended awareness-raising campaigns also have some knowledge about HIV infection. Many of them reported that they learned about it during the seminars. However, urban wives of non-migrants and rural women married to non-migrants have poor knowledge most of which comes from TV ads on HIV or posters in health care facilities during visits to the doctor. Moreover, the study shows that there is no difference in knowledge of urban wives of migrant and non-migrant men with secondary education. One interesting aspect of the conversation with wives of non-migrant men, which should be discussed in more details, is that when they were asked about HIV/AIDS, they associate them mainly with migrant men. It seems that, according to some women whose husbands never migrated, migrant men are the source of these infections and only their wives are at risk of contracting them. At the same time, the majority of them do not see themselves at risk of HIV infection. Even if you ask them about HIV/AIDS, they start talking and refer only to wives of migrant men. There is also the danger of the common narrative that if you are married, then you are protected from being infected. In other words, women married to non-migrant do not protect themselves because they think that they are protected from HIV/AIDS and STIs. For instance, the narrative of Jandiya, a 46-year old wife of a non-migrant man from Durbad village of RRS, shows this tendency. When she was asked about what she knew about HIV/AIDS, she replied:

I heard about this AIDS from people. When you sit to chat with women they say... these boys who go to Russia and come back, they had sexual contact and became like this [i.e. infected] and that they are under doctor's supervision...When they get the disease, then they take their wives to the doctor and they found out that their wives had that disease too. ...They (i.e. their wives) contracted it from their husbands. Then the poor girls get very upset. They talk very often about it. It is very bad. I learned about it from them (i.e. neighbors). Thanks God my husband did not have affairs. He does not go to Russia.

Mubina, a 42-year old wife of a non-migrant man, said: "It is necessary always to use condoms with those who come from there (i.e. migration)". Overall, some wives of non-migrants say "it is necessary to use condoms or ask husbands to have doctor's examination when husbands of the left-behind women come back from migration". Since many wives of non-migrant men have their own spouses around them, they think that these measures do not relate to them and they are not at risk of contracting HIV/AIDS.

Only a few women married to non-migrants said that they think that their husbands have extramarital relations and they were concerned about contracting STIs or asked their spouses to have an HIV test. A study in Zambia and Rwanda countries show that the majority of HIV transmission occur among men and women within marriage (Kristin et al., 2008). It is due to culture supporting extramarital sexual relationships and preventing women from use of HIV prevention in the marital relationships (Kristin et al., 2008). Glynn, Carael, Buve, Musonda, & Kahindo (2003)

also state that 50% of HIV infection was a result of extramarital sexual intercourse. Although the referenced studies are from settings with high prevalence of HIV, it is possible that some non-migrant men have extramarital relationships in Tajikistan as well.

Providers' views

Although recently a lot of educational work has been done in rural areas among migrant families, the knowledge and awareness about HIV/AIDS and prevention skills is still assumed by providers to be lower among the rural population, which is the opposite of the results of interviews with women.

For example, Sitora, a doctor of the AIDS center in Dushanbe, shares the opinion of her colleagues that “the level of knowledge is the same among wives of migrants and non-migrants. But there is a difference between rural and urban women. In urban areas women have at least some information”. The interviews with Rudoba, another doctor of the AIDS center in Dushanbe, explains her view on the differences in awareness between urban and rural areas:

Knowledge is very low or extremely low regarding not only HIV infection, but also other reproductive health issues, because many of them are from remote rural areas with lack of access to information. For example, in the city access to information is better. There is the Internet; people are more educated and many have higher education. The majority of NGO and organizations work in urban areas, but rural areas and remote areas are almost not covered. For example, if

we take into account Shurobod and Murghob, people have lower awareness there, but most migrants are from there and they have next to no information.

Health care workers also believe that religion affects HIV knowledge. Some providers mentioned religion as a reason for lower knowledge on HIV among women. Farida, a doctor of maternity hospital in Dushanbe, reported:

Now it is very common that parents marry girls very early and they are not informed or educated... Probably because now staunchly religious people are increasing among the population, they have a huge impact in the society. As a result, people do not even register their children in schools. For example, a girl who has just finished school, or is only in grade 8 is married off. She does not know; she is not informed; she does not even read. She ends up delivering with severe vaginal tears and fever.

At the same time, the women themselves do not mention negative impact of the Islamic fundamentalist resurgence on their health or lives. However, as mentioned above, some doctors believe that it has a negative impact not only on the knowledge of the women, but also on their health and access to reproductive health care services.

The majority of doctors, nurses, staff of state agencies and local and international organizations working with migrant families reported that various educational/awareness-raising campaigns are organized to increase information of left-behind women, in particular, and, women in general in various regions of the country. Named among organizations conducting the prevention seminars were: The Committee on Women under the President of the Republic of Tajikistan, the MLSP,

NGO “Kalam”, NGO “Chashmai Hayet”, NGO “Volunter”, the EU, the Aga Khan Foundation, reproductive health system doctors and nurses, IOM, GFATM, UNDP, and so on. All of them conducted their activities on HIV/AIDS, and probably due to activities of these organizations women are more aware of HIV/AIDS.

HIV/AIDS prevention skills and measures

One of the essential prevention measures against HIV/AIDS infection and its spread is HIV testing which is also the first step to HIV treatment and care (Bateganya, Abdulwadud, & Kiene, 2010). However, a large number of people both in developed and developing countries remain unaware of their HIV positive serostatus (Tudor Car, Gentry, van-Velthoven, Mihelle, & Car, 2013). Awareness of one’s own HIV serostatus is important to accessing HIV treatment, care and support, preventing further transmission of HIV infection (Tudor Car et al., 2013) and to improving the course of the disease (Bateganya et al., 2010). In addition, post-test counseling increases HIV knowledge. The test also helps to determine how many people are infected with HIV to assess how much health care support is necessary in certain areas.

HIV testing is a medical procedure that involves a pre-test counseling session conducted by a trained counselor, an HIV antibody test, and a post-test counseling session when a person receives results and consultation to decrease HIV risk behavior to remain uninfected (if a person is HIV negative) or prevent transmission of infection to others (if a person is HIV positive) (Bateganya et al., 2010). In addition, people with an HIV positive test will be referred to HIV treatment and care programs,

provided with emotional support and encouraged to disclose their status to their partners (Bateganya et al., 2010).

As was mentioned earlier, similar to the findings of studies in other settings, condoms were not popular and their use was low among the left-behind women in Tajikistan (Bond & Dover, 1997; Hong et al., 2009; Hughes et al., 2006; Sevoyan, 2011). The low use of condoms is perhaps one of the important factors in the transmission of STIs, including HIV, from labor migrants to their female spouses (Hong et al., 2009). Promoting the use of condoms is one of the key strategies of fighting STIs (Bond & Dover, 1997), and it is the only mode of contraception that prevents not only pregnancy, but also the transmission of STIs, including HIV (Hong et al., 2009). However, even all these advantages of condoms do not make its use widespread among both wives of migrants and wives of non-migrants. Many women said that it is because either they or their husbands do not like it. Many previous studies state that male migration is associated with higher rates of STI, including HIV among migrant men due to high-risk sexual behaviors, such as having a high number of sexual partners (Coffee et al., 2005; Coffee et al., 2007; Hong et al., 2009; Kessler et al., 2010). Findings of previous studies also show that there is a strong negative relationship between temporary migration and condom use (Bond & Dover, 1997; Hughes et al., 2006; Hong et al., 2009; Sevoyan, 2011).

The current study also shows that condom use is low among wives of migrants despite the fact that condoms are easily accessible. Condoms are free of charge in many urban and rural health facilities as well as through volunteers and peer educators of many non-governmental local and international organizations' projects in

Tajikistan, according to the interviews with women, doctors and staff of organizations. Many urban women, both wives of migrants and non-migrants, reported that every time they visit reproductive health institutions they receive condoms free of charge. Rural women also mention that medical personnel on a regular basis provide them with condoms even at their homes. However, even free-distribution does not contribute to wider use of condoms among women in Tajikistan. These findings echo those of a study in China which also found that only 3.7% of wives of migrants always used condoms (Hong et al., 2009).

Our findings are in agreement with results of the previous studies in terms of low use of condoms among left-behind women in particular and in women in general. Unlike those studies, this study adds a very important finding to migration and contraception/STIs/HIV literature. That is, despite the low general or regular long-term use of condom among wives of migrant men, which was found in previous studies as well (Bond & Dover, 1997; Hughes et al., 2006; Sevoyan, 2011), this study also revealed that many rural left-behind women were able to negotiate condom use successfully for a very short period (usually 1-3 days) until their recently returned husbands had an HIV test. Insisting on condoms use and asking husbands to have an HIV test were surprisingly common among the rural left-behind women in Garm-Chashma village of GBAO, Hissor village of RRS and Ukteppa village of Sughd region as opposed to in urban areas (Table 4). Only one wife of a migrant man in Garovuti village also asked her husband to have condoms and have an HIV test. Left-behind women in these three regions used condoms with their returned migrant husbands and as soon as it was confirmed that the husband is HIV negative, they stopped using them. The interviews show that women obtained and improved the

protection skills through training and individual counseling with the health workers or staff of local and international organizations. The providers urged the women to protect themselves by negotiating condom use with their returning migrant husbands and asking husbands to have an HIV test soon after arrival. An increase in short-term condom use after the return of a migrant spouse among Tajik left-behind women is a very important aspect of HIV prevention in the country. It helped women to protect themselves from HIV and gave male spouses time to take an HIV test. All of them after confirming negative results stopped using condoms. Although women do not use condoms long-term, this short-term use of condoms pending an HIV test among husbands plays a significant role in protecting left-behind women from HIV.

Table 5. Use of HIV prevention measures by wives of migrants and non-migrants

HIV prevention measures	Wives of migrants (58)		Wives of non-migrants (54)	
	Urban (17)	Rural (41)	Urban (15)	Rural (39)
Used condoms until husbands had an HIV test	0	5	0	0
Refused sex until husbands had an HIV test	0	7	0	0
Asked husbands to have an HIV test, but did not refuse sex or demand condom use	1	0	0	1

Thus, the analysis of the data shows that rural left-behind women with secondary education and moderate knowledge of HIV/AIDS were able to negotiate HIV prevention measures with their spouses. However, many of them were

participants of HIV awareness raising campaigns. In particular, the left-behind women asked their migrant husbands to use condoms or refused to have sex at all until their spouses had HIV tests (Table 4). Thus, this study reveals that educational intervention not only increased the awareness of participants about HIV/AIDS, but also improved their HIV prevention skills; an extremely important finding which has not been observed in previous studies (several cases of wives of migrants that are provided below). Urban left-behind women also did not mention using HIV prevention measures, including short-term condom use, refuse of sex or asking a spouse to have an HIV test. Only one urban wife of migrants used HIV prevention measures.

It should be mentioned that only about 13 left-behind women and one wife of a non-migrant in the study sample in different regions of Tajikistan used condoms or refused sex and asked husbands to have an HIV test. However, even if the number is still small, it is a very crucial step towards prevention of HIV and there is hope that this practice will be more widely spread and used by other left-behind women. Women should also be encouraged to ask their husbands to have tests not only for HIV but also for other STIs as well.

As was mentioned earlier, one of the unexpected findings of this study is that some left-behind women who participated in the study offered or suggested their returning migrant husbands to have an HIV test and use of condoms. In 2011, I interviewed one of the first left-behind wives named Rehna, a 37-year old wife of a migrant man from Garm-Chashma village of GBAO. The woman said that she heard

about STIs from the staff of Aga-Khan Foundation³⁰ who came to her house, particularly “a woman named Latofat from Dasht village showed us videos about women’s diseases and about AIDS and how they are transmitted. We watched them”. Rehna also said that the staff of this international organization told them:

Your husbands will go to migration and can get these kinds of diseases. When they return, you need to ask them first to have test and only after that you can have sexual intercourse with them. Mine came and himself went to the doctor and he did not have anything. Nothing was there. [Did you ask him to see a doctor?] No, he came from migration, I was in Khorog and we went together. He was tested and everything was fine with him. He was examined in Khorog. [Was that his idea or yours?] No, it was not his idea. When he came, I told him that the seminar was organized for us and I also showed him those pictures.

But what was more remarkable about Rehna’s story was that she used condoms until her husband had his HIV test: “When my husband just arrived from Moscow, until going to the doctor, we used condoms. We were told during that seminar that we need to use condoms with our husbands until they have tests.” When I asked her where she got the condoms from, she answered that they had also been

³⁰ The Aga Khan Foundation (AKF) is a private, not-for-profit international development agency. Founded in 1967 by the Aga Khan, the 49th Imam (spiritual leader) of the Shia Imami Ismaili Muslims, it is one of the first agencies created as part of the Aga Khan Development Network (AKDN). AKF endeavors to provide long-term solutions to problems in the areas of health, education, rural development, the environment and the strengthening of civil society. Its work is concentrated in the poorest areas of South and Central Asia, Eastern and Western Africa, and the Middle East.

given to them during the seminars. The use of condoms for short-term was needed to give her husband time to have his test. Rehna went on to say:

They gave us the condoms during the seminar and explained how to use them. When my husband came, I explained to him and he said: “If you do not believe me, let’s go to the doctor.” [Was that the first time you used condoms?] Yes. [How was your husband’s reaction?] It was the same, good. [Did he fight or had a quarrel with you?]. No, he understood me. He did not say anything. I only explained to him and he understood. [Do you still use condoms?] No. [Why?] I did not need it anymore after that. When he comes back again from Moscow, first we will use condoms and then we will take him to the doctor. If we do not protect ourselves, we do not have much money to go for treatment.

However, what was also important is that she stated that when he comes back again she will use condoms with him and ask him to have the test again. In addition, the reaction of the migrant husband to her offer to use condom and to have a test was important to examine. This finding is quite important because Weine et al. (2008) in a study in Russia found that most labor migrants from Tajikistan have unsafe sex with sex workers whose HIV infection rates are 30-120 times higher than among the general population in Moscow (Weine et al., 2008). In that study, all male respondents reported having unsafe sexual intercourse with sex workers every week. Some Tajik male migrants stated that they usually use services of “cheap sex workers” who only want “vodka and food” (Weine et. al., 2008, p. 464). Labor migrants usually bring one or two prostitutes for 10 or 15 men at one night in order to avoid being caught by

police and other dangers and because it is cheaper. This study shows how Tajik migrant workers put not only themselves in danger of contracting STIs including HIV but also their wives back home by transmitting it to them. Hunt (1998) states that when migrant workers return home they also carry with them HIV infection which they then pass on to their partners. Therefore, the ability of the left-behind women to protect themselves from HIV is a crucial step towards prevention of HIV and its spread among the country's general population.

However, what was also interesting is that women not only in GBAO but also in other regions of the country reported asking their husbands to use condoms or refusing to have sex until they have an HIV test. In Durbad village of RRS, Kamila, a 46-year old left-behind wife of a migrant man, said:

I am very strict about the health of my husband. For example, when he comes, I tell him he needs to receive his treatment. I tell him: "You are a man". For instance, I tell him to have his blood test to make sure he is clean and only then I have sex with him. [How did you learn about it?] I watch TV; I read books. In general, I know [about these matters]. Also doctors tell us. [What do the doctors tell you?] For instance, women's doctors (i.e. Ob-Gyns) tell us. When I go to any health facility, it is written there, I read. [When your husband comes back, do you tell him first to go and to have his test or do you have sexual relations until he has his test?] No, my health is important for me. Although he swears that he did not have sex with anyone, I tell him that he is a man at the end of the day and that I need to find out first, because my health is important for me.

The woman continued that her husband said: “I am well, I am clean. But I know a doctor is a doctor, medicine is a medicine”. She added: “For instance, he says this, but I insist and then he agrees to see the doctor”. As can be seen from this interview in comparison with previous one, Kamila does not use condom with her husband but refused to have a sex with him at all until he had an HIV test.

Lojvar, a 45-year old wife of a migrant man from Durbad village of RRS, also said that doctors gave them brochures and books about HIV. These doctors also told them that when men return from Russia first they need to go to the doctor to get examined and to have tests. She said:

Doctors go house to house; nurses also go. They gave us brochures. They also come and say that when your husbands return, you should not have sexual intercourse with them, but first they need to have a test, otherwise infectious disease will harm you. Doctors tell us this and send nurses. They are good in this regard. They go around the village.

Then I asked her whether she asked her husband when he returned from migration to see a doctor or whether she had sexual relations first. Lojvar answered: “First he goes to see a doctor to find out whether he is well in order not to infect me. Then he comes and tells me that this is a paper that the doctor gave me”. When I clarified what kind of paper that was, she responded that she did not trust him until she saw a document/letter from the doctor (*spravka*) confirming that he is HIV negative. I also wanted to make sure that she did not have sexual intercourse without the HIV test. She said: “How can it be without this (i.e. the test). My own health is more important for me”.

Not only in these two regions, but also in Ukteppa village of Sughd region, some left-behind women said that they did not have sex until their husbands had an HIV test. However, what was remarkable in the story of Sumbul, a 44-year old left-behind woman from Sughd region, is that after the return of her husband from migration, she asked him not only to have an HIV test, but herself had an HIV test as well. This was not reported in other cases in other regions. Her case was especially interesting because both partners had their tests for HIV. It is important because some previous studies in other countries showed the bi-directionality of the spread of HIV infection not only from a returning migrant man to his partner but also the other way around (Lurie et al., 2003b). As Lurie et al. (2003b) suggested, some women with migrant partners had sex outside the relationship while their partners were in seasonal migration. Only one rural left-behind in this study admitted having sex while her migrant husband was away; the majority of the left-behind women did not have sex outside the marriage. Yet, the prevention programs should work both with the left-behind women and their husbands and encourage both partners to have tests for STIs including HIV to prevent the bi-directional transmission of the HIV infection.

As was mentioned, in this sample except for one rural left-behind woman, the majority of left-behind women and of wives of non-migrants did not admit that they had sexual intercourse outside their marriage. Moreover, respondents reported only a few cases of someone else in their communities who had a sexual affair. Therefore, it seems that outside of marriage sexual relationship is not common in Tajikistan. In another post-Soviet country, Sevoyan and Agadjanian (2010) also found that extramarital affairs were uncommon in Armenia. Women in this study also connect their higher risk for STIs to the risky behavior of their migrant husbands rather than

their own sexual behavior. But it is also important to remember that women are likely to underreport their sexual affairs in previous studies (Lurie et. al., 2003a, b). The underreporting maybe connected with values/norms of society regarding sexual relationships, which do not accept or acknowledge the existence of extramarital affairs among women and men (Zuma et. al., 2005). Zuma et al. (2005) state that females usually underreport their sexual relationships while males over-report it. But even then, reporting that both partners in a migrant couple had an HIV test is very crucial in HIV prevention, which should be promoted in other regions in addition to asking only the husband to have a test upon his return. Thus, Sumbul a 44-year old rural left-behind woman in Ukteppa village, reported an interesting case:

First time when he (i.e. her husband) went to Russia, we both went to the regional AIDS center and he had a test and then he left for Russia. Now, when he comes back, we will go there and he will have an HIV test. Maybe he had sexual intercourse with someone over there. First time when I saw him after return, I told him that we had to have an HIV test before having sex. He said he didn't mind. We went both and had our tests and the results were normal. [Both of you?] Yes, both of us. The results were normal. Now I trust him. He was quite mischievous even here. I thought he had a sexual intercourse there. I bought condoms and sent him. Then he came back and we had our tests and they were fine. He has been 5 years there. [Who told you to do so?] No one, I saw it on TV, if a man comes from Russia he needs to have his tests. I heard that and we had the test. [Did you have a sexual intercourse before that test?] No, I did not have. The first night after he arrived it was Tuesday, I told him: "Man (*mardak*), let's go and have your blood test". He only asked: "Where

should we go to have the test?” I said: “Where you went before going to migration, in the AIDS center.” Then we went and had our tests...the results were normal and we had sex.

This case is important in light of the findings of previous studies on the bi-directionality of the spread of HIV infection and increased vulnerability of both partners in migrant couples to HIV infection (Lurie et al., 2003b; Mundandi et al., 2006). In addition, this example supports the conclusion of a systematic review of mass media interventions for promoting HIV testing, stating that mass media promotes the uptake of Voluntary Counseling and Testing (VCT) (Vidanapathirana, Abramson, Forbes, & Fairley, 2009). The example also supports the finding of the systematic review that the utilization of mass media is one of the most effective strategies in communicating behavioral change messages in regards to prevention of HIV/AIDS (Vidanapathirana et al., 2009). Thus, mass media should be used to promote voluntary HIV counseling and testing and to sustain test-seeking behavior. However, it should also be mentioned that there were some wives of migrant men who were exposed to advertisements about HIV and HIV test on TV but did not use HIV prevention measures. The educational interventions should be conducted as they are now in different directions such as through media, personal conversations and through seminars, training and other types of educational campaigns.

However, only two doctors reported about how wives of migrants managed to force their husbands to use condoms and then have an HIV test. Sabina, an Ob-Gyn in GBAO, said that one patient in a remote rural village told her: “I told my husband: ‘Let’s use condom today and then after you have your test, we will not use it

anymore”. However, this is a rare example of negotiation of condom use and an HIV test according to Sabina. As a whole, although condoms are widely available everywhere they are rarely used. Sitora, a doctor from the AIDS center in Dushanbe, also reported: “It does not matter whether a woman has a migrant husband or not, or whether she is working or not. If they have information or if they have higher education, they use condoms”. Then Sitora shared a story of a woman who brought her migrant husband with her for an HIV test:

My husband returned from migration a week ago. I asked him to come for the test, but he refused. Finally, I managed to bring him. The husband then said: “I did not do anything, but she argues with me every day; refuses to have sex and asks me to come to have a test for HIV”.

The doctor continued that the wife after that test asked the doctor again whether it was really true that he did not have the infection. After Sitora confirmed that he does not have the infection, the left-behind woman relaxed. The doctor of the AIDS center was surprised and asked the woman how she learned about the necessity to ask her husband to have an HIV test. The woman told her: “I saw an ad on TV emphasizing that when our migrant husbands return, they must have a test for HIV and that is why I brought him for the test”. Her husband also told the doctor that:

‘I came back from migration and it has been almost one week already, but she refuses to have sex with me. She told me that maybe I lived with someone else there; therefore she does not want to have sex without condom with me. Then she told me to have sex with condoms or not at all. I did not want it and then she made me come to the AIDS center’.

As can be seen, the interviews with both the left-behind women and doctors show that many wives of migrant men insist on condom use or refusing sex as well as asking husbands to have an HIV test. The reasons behind the increase are usually said to be the following: the ad campaigns urging women to ask the migrant husbands to have an HIV test and use of condoms; the work of volunteers of various state agencies, local and international organizations during educational sessions about STIs and HIV and a test for HIV. The volunteers explain to women that their returning husbands have to have the test upon their return.

The profile of the left-behind wives who successfully negotiated condom use and HIV test showed that they were between 30 and 40 years old. These women may have been better aware of prevention measures such as condom and HIV test. They also had more information and knowledge of HIV prevention and had more control over their marital sexual relationship. There are several possible explanations for this. First, women of this age group have longer marriage and as a result they are more comfortable to discuss sexuality, condom use and an HIV test with their husbands. All women mention exposure to HIV prevention measures such as education campaigns and HIV ads on TV. The majority of women who were able to negotiate condom use and HIV test with their migrant husbands were rural women with secondary education, housewives and those economically-dependent on their migrant husbands in terms of remittances which were the only income in their family. This finding contradicts previous studies that showed that due to social and economic dependence of the left-behind women on their migrant husbands, they are not able to negotiate or refuse sex with their spouses; migrant husbands were absent for a long time, worked hard and provided the left-behind family with money to survive (Bond & Dover,

1997; Hughes et al., 2006; Salgado de Snyder, 1993). One possible explanation for this phenomenon is that concerns over HIV infection and their own health may be stronger than economic and social factors for these women. In the case of these women, surprisingly, the classic prevention messages strongly encouraging females to take the initiative and protect against STIs (Hughes et al., 2006), which have been questioned in other settings, may actually work.

Thus, my findings were quite surprising and unexpected, because the existing literature did not have similar findings. For example, Hughes et al. (2006) state in their study that no women used prevention measures to protect themselves, and only eight percent of women used condoms to avoid pregnancy. Agadjanian et al. (2011a) in their study in Mozambique also found that both wives of migrant and non-migrant men think that their husbands would reject use of condoms; particularly women with successful migrant husbands believed that their husbands will strongly object to the use of condoms. Another study in Mozambique conducted by Agadjanian et al. (2011b) argues that women found it especially difficult to talk about condoms with their migrant husbands.

The majority of women do not have the courage to ask their husbands to use a condom. Only a few women would not have unsafe sex without condoms if they were aware that their husbands had contracted infection. Dladla et al. (2001) in their study of partners of migrant men in South Africa found that the majority of women did not use condoms because men do not like condoms and they think use can build mistrust between them and their partners. In addition, the above-referenced studies did not mention the use of HIV tests. Thus, these studies do not report successful applications

of HIV prevention methods among the wives of migrant men, who purposefully insisted on using condoms or refused to have sex altogether with their returning migrant husbands and also asked them to have an HIV test. This current study on Tajikistan, therefore, adds important findings to the existing literature on the left-behind wives by showing that some wives of migrants were successful in using HIV prevention measures to protect themselves.

In many cases during my conversations with wives of non-migrant men it seemed that the reaction of some of them was different when they were asked about whether their husbands had STIs/HIV tests or not or how would their husbands react if they suggested to have these tests. Some wives of non-migrant men said that there was no necessity for their husbands to have a test because they are not migrant workers and did not go to Russia. Zulola, a 46-year old rural wife of a non-migrant man from Durbad village of RRS, said: “How and why is it related to my husband? Why should I ask him? He would not like it, because he is a clean man. He does not like these kinds of things and he is not a migrant”. Although some wives of non-migrant men think that it is mainly migrant men who have HIV, there were also wives of non-migrants who asked their husbands to have tests for HIV or STIs and they refused. Others said that their husbands while responding negatively to the request to have tests also highlighted that they do not migrate. However, by arguing so they underestimate their risk of contracting HIV infection at home. Mumina, a 48-year old wife of a non-migrant man from Ukteppa village of Sughd region said that:

When I offered him he asked why he should have it. ‘Do not worry’, he said, ‘I do not have anything’. I told him that those who come from Russia become

infected and he said: 'But, I do not go to Russia, do I?' I told him one can never be sure.

Some wives of non-migrants said they and their husbands were fine with having an HIV test. The reaction of husbands was normal. However, only one rural wife of non-migrant man was able successfully to negotiate an HIV test with her husband. Lalbegim, a 24-year old rural woman with higher education from Pish village of GBAO, asked her non-migrant husband to have an HIV test. She said:

There were conversations that the number of people with HIV is increasing in Pamir. Then I told my husband: "Let's go and have an HIV test". He said: "Why?" When I was pregnant they asked me to have this test. When they took my blood for the test I also asked him to have a test. He agreed and had the test. All the results were fine. A person should have his tests once a year. I had a cavity in my teeth and I went to the dentist and after the dentist's visit I was worrying about it, because I heard that sometimes the instruments are not cleaned properly and then one can contract HIV this way as well. But after this test I do not worry anymore.

Lola, a 35-year old urban wife of a non-migrant, said that her husband has an HIV test every six months because he works as a doctor in the medical facility. However, there are also women married to non-migrants who cannot insist that their husbands have an HIV test. Uldus, a 24-year urban wife of a non-migrant man, is aware that her husband is cheating on her and has extramarital relationships with another woman. She even caught him with her. She said that she was concerned about the possibility of contracting STIs from her husband, and asked him to use a condom

and to have tests for HIV and STIs, but he completely ignores her suggestion. Dladla et al. (2001) stated that women are aware of condoms but do not use them in any relationship because men oppose them.

The data, however, also show that some left-behind women had a problem when the returning migrant husbands saw that she had condoms. Farangis, a staff person in a state agency, also reported that they faced many problems particularly at the beginning of their project implementation. Farangis shared an experience of a woman who took condoms from the seminar and went home, but when her husband returned and saw condoms, he thought she probably had extramarital sexual intercourse when he was away. They started arguing and her mother-in-law woke up. Fortunately, the mother-in-law was aware about seminars and condom distribution. She explained to her son that they had attended the seminar where they were told about the disease and were given condoms. However, by the time her mother-in-law explained the situation to her husband, they had already had huge arguments. Farangis stated that these kinds of stories happen a lot, especially in rural places where the role of religion is very strong or the mentality is different. Farangis added:

We, of course, have many families like this. However, those women whose understanding is high and those with higher education certainly do not have these issues. But those who are scared of their husbands or even the medical personnel experience these issues.

Thus, if even the short-term use of condoms, when many wives of migrants ask their husbands to have their test, is problematic, then constant use of condoms is even more problematic for Tajik men. Rudoba, a doctor of the AIDS center in

Dushanbe, said that she had a very unusual couple with the wife being HIV positive and the man being HIV negative. They were happily married, they love each other, and are both highly educated. They have been married for 13 years and never had any conflicts in the family. It is not clear how the woman contracted HIV infection, but they think that it is most probably through tattooing of her lips in the hairdresser's. When Rudoba told them to use condoms in order not to infect the husband, "he held his head and said that now he had to use condoms for the rest of his life". Rudoba added: "It was like a catastrophe for him to use condoms. Imagine if a highly educated man reacts like this to using condoms, I can imagine the reaction of an uneducated man?!"

Nevertheless, previous findings can certainly be used to explain the inability of negotiation of short term use of condoms among the rest of the wives of migrant men who still cannot negotiate safe sex or refuse unsafe sex. About 44 out of 58 (76%) left-behind women in this study did not or were not able to negotiate condom use when their spouses came back. Also, the number of those women who cannot do it is three times higher than those who were able to negotiate its use - 14 versus 44 respectively. Unfortunately, many left-behind women were still not able to negotiate and insist on condom use, let alone ask their husbands to have an HIV test. This could also be explained, as mentioned earlier, by women's lack of power and inability to negotiate condom use due to financial and ideological dependence on husbands (Bond & Dover, 1997; Hughes et al., 2006), failure to discuss sexuality, condom use, HIV/STIs or poor sexual communication (Golobof et al., 2011; Bond & Dover, 1997; Hughes et al., 2006). Finally, one of the reasons for the lack of condom use is the total refusal to use condoms by the husbands. A 37-year old urban left-behind woman

Shafolat, told me that her husband did not like using condoms to the point that he would tell her that he would rather not touch her at all. She says:

With condom he says: "I will not even touch you. I will bother neither you nor myself. Let's just sleep. Leave it." He basically said that he does not need it (i.e. sex). Me too. He says: "With condom a person is suffering. Why should I bother you and myself?" He does not agree.

My findings support those of Dladla et al. (1997) that condoms are not popular, especially among men. The most commonly cited reason by the women during interviews for not using a condom was men's objection to its use. The negative attitude toward condoms among both men and women in Tajikistan is similar to those reflected in the study on Zambia, which discusses issues such as reduced sensitivity while using condom, painful and less pleasurable sex with condoms and more satisfaction while practicing sex without condoms (Bond & Dover, 1997). According to Bond and Dover (1997), partners of migrants mention that while some men agree to use condoms, others refuse to practice sex with them and women cannot force them to use condoms and even asking about it may expose them to violence. However, what was surprising in my findings is that rural left-behind women who were able to refuse sex and force spouses to use condoms and also have an HIV test did not experience violence because of that. During the interviews, I specifically asked about the reaction of the women's spouses to their suggestions and whether they were verbally or physically abusive. Women responded that they were neither physically violent nor verbally abusive in response to their requests.

Thus, the data show the complexity of the problem discussed by demonstrating that although the majority of women still face issues constraining condom use, similar to those discussed in earlier studies, other left-behind women may successfully overcome problems restricting use of condom thanks to effective HIV/AIDS educational programs. Although only 14 out of 58 left-behind women were able to insist on either condom use or refused having sex with their husbands and then asked their husbands to have an HIV test, it is nevertheless very encouraging and suggests some useful ways forward for the future of education and prevention programs on HIV/AIDS and STIs. Therefore, communication about condoms, sex and STIs is one of the important aspects of changing behavior among women in Tajikistan.

Communication about condom, sex and STIs

This study shows that communication and conversations about condoms, sex and STIs take place not only among urban or educated left-behind women, but also among rural residents and women with lower educational attainment who economically dependent on their migrant husbands. What is also interesting is that there are actually a lot of conversations and communication going on among couples with a migrant husband. This finding is also in contrast with studies suggesting that women have limited conversations about sexuality, condom use or STIs with their migrant partners (Bond & Pover, 1997; Golobof et al., 2011; Hughes et al., 2006). The data show that many women of different social, economic and educational backgrounds have conversations about extramarital sex, condoms, HIV and STIs (“bad diseases”) with their husbands not only before migration, but they also continue to have them by phone when their spouses are in Russia.

It is possible to propose tentative explanations for their ability to have communications and conversation in contrast with previous studies. Currently, there is quite an active discourse in Tajik society about migration and extramarital relationships of migrant men in Russia. Many have heard about extramarital relations of migrant relatives, friends or neighbors in Russia. There are also many programs on TV and articles in local newspapers and magazines about migration and extramarital affairs, which probably encourage some wives of migrant men not only to discuss condom use with their husbands before migration at home, but to talk about it by phone when they are away. In addition, health workers and staff of local and international organizations conduct awareness-raising campaigns on migration and STIs among women in rural areas, which also encourage these discussions among them. As a result, some left-behind wives not only talk but they also provide their migrant husbands with condoms before they leave for Russia. Sayora, a 43-year old urban left-behind wife, said that before her husband left for Russia, she informed him that she had put many condoms in his bag and he should use them when necessary over one year while there:

I thought that he will do something there during this one year. Whether he wants or not, he will have sex with someone. When I talked to him by phone, I told him: “You will do everything, but be careful not to harm me [as a result]. Do not bring any diseases for me.” But I knew that he would do something there (i.e. he will have sex)... Every time when I called him, I told that he should be careful. He said: ‘Do you think that I am stupid and do not understand anything. When I was in my village, my cousin gave me a lot of condoms knowing that my husband was leaving for Russia. I brought all of

them home and put them in his suitcase and said that all of them are for you for one year.” I gave them all to him and he left. I put them in his pocket and his suitcase, closed it and let him go.

This case and other cases illustrate how women talk about sex and condom use and their fear of contracting STIs with their migrant husbands both at home and by phone when they are away. They are able to discuss condom use with partners and even provide them with condoms to protect themselves. Sumbul, a left-behind woman from Sughd region on page 166 said that she also bought and sent condoms to her husband in Russia. Moreover, Ruhafzo, a wife of migrant man from Pish village, also reported the same. Some women even accept that their husbands have extra-marital relationships as long as they protect themselves and, thus, protect them from getting infected. In this case, the fear of getting infected overcomes the fear and disgust about their husbands having extramarital affairs or even having random sexual intercourse. This attitude has not been discussed in previous studies. In the Tajik case, women who took such a drastic measure to the problem of protecting themselves from being infected had different educational backgrounds. Some women were urban residents; others rural; some worked outside the home, others did not. So it is safe to state that women with various educational and socio-economic backgrounds were able to speak out and protect themselves.

One of the main reasons why women were able to force their husbands to use condom for short-term and have an HIV test was because they had information which they had acquired from medical personnel and staff of organizations with strong messages to protect themselves. Many women who had communication and

conversations with their husbands about various sexual matters and STIs had attended meetings with staff or health workers. Previous studies show that even limited discussion of sexual and reproductive health between spouses significantly constrains the adoption of risk-taking behaviors (Hughes et al., 2006).

However, condom use was less likely reported among wives of non-migrant men than among the left-behind women. Women married to non-migrants usually use them only while undergoing treatment with Ob-Gyns. When treating patients with gynecological problems many doctors ask them to avoid sex during treatment, or to use condoms. Some wives of non-migrant men used condoms for a short time to prevent pregnancy, but as the interviews show after some time they stop using them. Again as in the case of wives of migrant men, one of the main reasons for discontinuation of condom use was dislike of condoms by women and more often by husbands among this study group.

The data show that only a small number of women were satisfied with use of condoms. Samira, a 49-year old rural left-behind wife in Garovuti village of Khatlon region, told me she had learned that condom was the best method of contraception because it prevents both pregnancy and STIs. This she learned during training sessions and she has been using them with her husband for a long time. Also Shamshod, a 27-year old urban wife of a non-migrant man, says that she used condoms for contraception purpose about two years after her first child. Both she and her husband were satisfied with it and did not complain as many others did about inconvenience of its use. Bejoda, a 28-year old wife of an urban non-migrant man, said:

My husband and I read lots of literature on contraception and we found out that the only contraception that does not have any side effect for me is a condom. Therefore, we decided to use condom all the time as a method of birth control.

Thus, the main reason that they choose and use it is the lack of side-effects. She also said that when they realized that other contraceptives were causing side-effects, they decided not to use them. The profile of women who successfully use condoms with their husbands for a long time is that of a woman between the age of 23-45 years and with higher education.

Despite these positive findings, unfortunately, some wives of migrants and non-migrants do not talk about condom use, sexual life and STIs at all because they do not feel comfortable to discuss these topics with their husbands. Golobof et al. (2011) also state in their study in Tajikistan that although few wives of migrant men have some knowledge about HIV/AIDS, their ability to communicate about sex, HIV/AIDS, condoms and HIV test is limited. Golobof et al. (2011) also suggest that women do not use condoms with their husbands, because they believe that their husbands are aware how to protect themselves.

Sources of information on HIV prevention

Another purpose of the research was to examine how the left-behind women learn about HIV/AIDS prevention measures and skills. During the research women who were aware of HIV prevention measures or who were able to practice HIV prevention skills were also asked where they received the information and how they

learned about the measures and obtained skills. The data show that sources of information for the wives of migrant men differ depending on the region of the country.

Despite the fact that many left-behind women are not able to use HIV prevention skills and do not insist on applying HIV prevention measures such as condom use and an HIV test by their returning migrant husbands, there are nevertheless many women in different regions of the country who were able to negotiate condom use with their migrant husbands and also managed to ask them to have an HIV test when they returned. As mentioned, this was not observed in previous studies among the left-behind wives and partners in other settings.

However, it has to be mentioned that this tendency was predominant among the left-behind wives who had conversation about the consequences of their husbands' migration for their health with medical personnel and also among those who attended meetings/awareness-raising campaigns/seminars on migration and its impact on health organized by local health care professionals, local non-government or international health organizations in Tajikistan.

As Table 5 shows, 10 out of 14 left-behind women who reported using HIV prevention were exposed to these types of interventions in GBAO, RRS, Sughd and Khatlon regions. This suggests that the impact of conversation and discussion of migration and STIs with health care workers and organizations' staff had a more significant influence on knowledge of left-behind wives than did media or distribution of educational materials. Because out of those women who mentioned only media, such as advertisement on TV, as a source of information on HIV, only two women

managed to ask their husbands to have an HIV test in Sughd region as shown in Table 5. Only two of the women with only media as a source of information and who did not attend the seminars or did not have conversations with health professionals mentioned insistence on condom use or on having an HIV test. Therefore, it suggests that the education campaigns factor has a stronger impact than the media.

Media is certainly a useful source of information in addition to seminars and training in promoting HIV prevention measures but it cannot make substantial changes in the behavior of the women on its own as do the effective educational campaigns. Just distributing educational materials has the minimal impact on the application of HIV prevention measures: women who received only booklets and brochures with HIV information have some knowledge. No women who reported only distribution of education materials as a source of their knowledge in Pish village used HIV prevention measures (Table 5). The involvement of volunteers who only distributed educational materials without providing further information or without having conversation with the women fails to increase the use of prevention measures.

Khadicha, a left-behind woman in Garm-Chashma village of GBAO, said that she and other women had been informed about the risk of contracting HIV or STIs, to which they often referred as “bad diseases”, from a nurse conducting seminars organized by the Aga-Khan Foundation.³¹ They also received brochures, booklets and information papers and free condoms from that nurse.

The left-behind wives of migrant workers from Durbad village of RRS also mentioned that they were asked to use condoms until their husbands have tests for

³¹ More details were provided earlier in Chapter 6, p. 157.

HIV/STIs by the health care personnel (probably midwives or Ob-Gyns because they call them “*dukhturoni zanona* (lit. women’s doctors)” from Hissor Regional Hospital) and they were provided with awareness raising information materials and free condoms. The left-behind wives in Sughd region mentioned volunteers from the local NGO “Chashma-i Hayot”³² working as partners of the IOM within the project "HIV Prevention among migrant workers and their families in Tajikistan”. As mentioned earlier, this project is implemented by UNDP with donor funding from GFATM.

Table 6. Sources of information on HIV by regions

Source of information	Name of regions					
	GBAO		RRS	Sughd region	Khatlon region	Dushanbe
	Pish village (Darmorak ht)	Garm-Chashma village	Durbad village	Ukteppa village	Garovuti village	
Agha-Khan Foundation (awareness-raising campaigns)		3 wives of migrants				
Ob-Gyns of Hisar			3 wives of migrants			
International Organization for Migration				3 wives of migrants		
TV (advertisement)				2 wives of migrants		
Seminars on HIV/STIs					1 wife of a migrant	
Unknown	1 wife of a non-migrant					1 wife of a migrant
Distribution of booklets and brochures with HIV information	No woman					

³² For more information, please refer to p. 147.

The data show that another positive aspect of the work of the international organizations or medical personnel in these regions is that they not only invite wives of migrant men, but also wives of non-migrant men. The interviews with women show that the seminars focus on prevention measures for wives of migrant men and on the importance of protecting themselves after the return of husbands. However, it would be also useful to pay more attention during the seminars to the risk factors for wives of non-migrant men and protection measures for them also, as they do not have access to information on HIV/AIDS.

Another aspect of the education and information campaign that should be discussed is that meetings are often organized with women who are younger; but those who are older, especially those above reproductive age (49 years old), are not invited. Probably it is due to, as Herrera and Campero (2002) state, “shared misunderstanding” produced by social standards of sexuality which suggest that only younger people have sex. However, it is crucial to cover not only younger women who are sexually and reproductively active but also older women as well as mothers-in-law to improve their knowledge and to teach them new protection skills. It also would be good to include women of broader age groups in the study to receive more different perspectives of women especially those who are older than 50 years. Moreover, the data show that mothers and mothers-in-law usually take younger women to obstetricians when they get pregnant or have any other health problems. In addition, the data show that often it is mothers-in-law who make health related decisions in some families and in some cases, especially in rural areas, young daughters-in-law or daughters are totally under the influence of older women in their families. For example, the interview with Favziya, a 33-year old wife of migrant man

in Durbad village of RRS, shows that she could not go to a meeting on HIV and other STIs because “there was a senior person in charge” who decides where you can or cannot go. Therefore, it is important to invite women of both generations to awareness-raising campaigns and meetings.

It is also important to pay attention to the language of the information and educational materials and where to distribute certain materials in a particular language. Most women in rural areas know only Tajik. For example, Zarifamo, a 49-year old left-behind woman in Pish village of GBAO, said: “I read those booklets which are in Tajik, but those which are not (i.e. they are in Russian) I only look at pictures”. Booklets in Russian should be distributed in urban areas among those who know Russian better. It should be noted that although distribution of educational and information material improves awareness of rural women regarding HIV/AIDS to some extent, it does not lead to application of HIV prevention measures and skills. No single woman from Pish village who had received materials, mentioned that they used condoms with their returning migrant husbands or asked them to have an HIV test as can be seen from Table 5.

It seems the reason for low uptake of HIV testing by wives of migrants in the capital city Dushanbe, Garovuti village of Khatlon region and Pish village of GBAO is connected with the fact that none of the left-behind women in these localities had any discussion or conversation with nurses or staff of local non-government or international organizations about the impact of migration on their health, the spread of HIV or any other STIs. Nor did they mention participating in any seminars, training, awareness raising campaigns or meetings organized in their villages or visits of health

professionals at their home, and having personal conversations with them at home. Some left-behind women in Pish village of GBAO mentioned that volunteers distributed condoms and information and educational materials about HIV among them. However, this has not been very effective in promoting HIV prevention skills, even though it slightly improved their knowledge. It can be assumed that the impact of the work and the type of activities organized by medical personnel and local non-government and international organizations explain these regional patterns with predominant influence of the left-behind women. Moreover, the analysis shows that educational campaigns are more effective in promoting HIV preventions measures rather than media or distribution of information and educational materials on their own.

Barriers in HIV prevention

The research shows that the majority of the left-behind women in all regions and the capital city did not ask their husbands to have a test for HIV infection or other STIs, or to use condoms with them when they returned from Russia. Therefore, the study also wanted to examine why the left-behind women do not practice safe sex; why they do not ask their husbands to have an HIV test and what the barriers for the application of HIV prevention measures are.

One of the reasons hindering the application of HIV prevention measures is the trust that the left-behind women put in their migrant husbands and their belief that their husbands do not have any sort of extramarital relationships when they are away. For instance, Sharmina, a 46-year old urban woman with a husband with 17 years of migrant history and rare visits from her husband during his migration period, said that

she did not believe that her husband had affairs while he was away in Russia. Kabutar, a 48-year old woman from Ukteppa village of Sughd region, said: “I *can* ask him to have a test, but why should I do that? Because he does not have sexual relations with anyone else. My heart does not allow me to ask him”. Marina, a 29-year old wife of a migrant in Dushanbe, said that she thinks that her spouse does not have extramarital relationships. Herrera and Campero (2002) suggest that the lack of perception of the risk is common among women who are in monogamous relationships and believe in the life with a stable sexual partner based on trust and fidelity. Therefore, such women do not feel the necessity to use condoms with their partners. Most women find themselves at increased risk due to their trust in their partners and lack of awareness about their own vulnerability, because they are assured that “family is a safe space and that risk rises only outside of it” (Herrera & Campero, 2002, p. 559).

Another barrier is that migrant men deny the possibility that they engaged in risky sexual behavior. Some women did ask their returning migrant husbands to have HIV test, but the men refused to have it saying that they did not have sexual intercourse with women in migration. For instance, Favziya, a 33-year old woman from Durbad village of RRS, said:

Once I told that there was an advertisement on TV showing a man returning from Russia who missed his wife and children and who passed a test. Why don't you also go and get tested? He said: “That man in the ad might have not been sure or confident about himself. If I did not do anything, why should I have a test? This man probably had money and found someone, and he is

confident that he did this kind of a thing, and he needs to have a test in order not to destroy his family's health. I, on the other hand, who did not do this, why should go there?'

This goes against the findings of Weine's et al. (2008) study among Tajik labor migrant men in Moscow, which found that all respondents of the study had unprotected sex with CSWs on a weekly basis. The same study also mentions that many migrants return home without having done an HIV test.

Tohira, a 35-year old left-behind wife in Garm-Chashma village of GBAO, also reported a similar situation: "I tell him let's go to see a doctor, but he does not agree. ...I tell him, but he says that he goes there [i.e. to Russia] to work not to engage in such kind of activities. He says: 'I am clean'". Similar situations exist in the capital city. When wives of migrant men ask their husbands to have an HIV test, they usually refuse to have it. Mashuka, a 43-year old urban left-behind woman, said:

I asked him to have a test once, but he said he was not sick and he would not go for the test. He totally refused and said that he did not want to do it. I do not know what he will say now, when he comes back this time.

These examples show that wives of migrant men are concerned about and are aware of the possibility of contracting STIs, including HIV, from their migrant husbands. It is also common that women who were aware of risk and were told by providers to ask their returning husbands to have an HIV test tried to do so. However, they faced problems when trying to make their husbands agree to have a test. It is a challenge that women have to deal with. These cases also show that migrant men

often refuse to have a test for HIV infection insisting that they did not have sexual relations with women in migration. As many previous works on HIV and STIs among migrant men suggest, it is crucial to conduct prevention interventions among both migrant men and their partners. The above-mentioned cases make it clear that migrant men need prevention measures and education; otherwise the situation of the left-behind wives will not change.

There is also another barrier. The left-behind women believe that their husbands are aware of HIV infection and that they would take care of themselves. When I asked Sinjid, a 43-year old urban left-behind woman, about HIV protection and whether she has asked her husband to have an HIV test, she replied:

He himself knows. He is a teacher (referring to the fact that her husband was a teacher before he migrated); he knows about it. My husband is educated and he knows everything. He does not even go to the hairdresser to shave his mustaches and beard. When I take my children there, he warns me not to let them use their [i.e. of the hairdresser] razors, because there are so many infections, such as hepatitis *etc.*”

Also Marina, a 29-year old urban wife of a migrant man, believes that her husband is educated and is aware of these infections and knows how to protect himself. This finding is in line with the study of Golobof et al. (2011) on Tajikistan. It similarly revealed that wives of labor migrant men trusted their spouses and believed that they were aware about how to protect themselves from HIV/AIDS.

Finally, some women completely lacked knowledge about HIV/AIDS. Thus, there are also wives of migrant men who did not even know about prevention skills and measures. Therefore, lack of knowledge and awareness is another important obstacle. Hong et al. (2009) also discuss the poor knowledge of the left-behind women in terms of condom use, which in addition to other factors, increases the risk of contracting STIs/HIV. Revealing barriers in HIV prevention is important, hence prevention programs to fight HIV must take them into consideration when designing STIs/HIV prevention measures in Tajikistan to improve the health of this particular vulnerable social group in the country.

Cost of failure of negotiating HIV prevention measures

Failure to negotiate safe sex with condoms or asking a migrant husband to have STIs/HIV test may lead to contracting HIV infection. Unfortunately, many women participating in this study fail to negotiate HIV prevention measures, even if they know about them. In this section, I will look at what the reasons behind this alarming situation.

Gulbarg, a 27-year old urban wife of a migrant man, with medical background (she is a nurse) revealed that she was HIV positive. She contracted her infection from her deceased migrant husband with a long term migration history (about 15 years) and a history of drug use. When she just married her husband and saw him after the wedding for the first time, Gulbarg asked him to have an HIV test, but he refused and she could not insist. Gulbarg could not persuade her husband to have an HIV test although she was concerned about his health. She told me the following:

When I was under *chodar*³³ and we met each other for the first time under the *chodar*, his condition was that I had to respect his parents in a way that they were happy with me and that in return he would respect my parents. I said: “I will fulfill all your conditions, but you also need to fulfill my condition.” I told him: “Let’s go together to have our tests. If I fulfill all your conditions, then you also need to fulfill my conditions. Let’s go the two of us together to have a test.” He said he did not have anything and that only I should go and have a test. I said no, both of us needed to have it for the sake of our own health. He refused and said that everything was 100 percent [alright with him]. I then said that I did not go here and there. Let’s go and have the examination. He refused. Then I made it simple and explained that I am a nurse, maybe I cut my hand somewhere. I explained it to him in this way to calm him down. I went on insisting that we should go and have the test together. No, no everything is 100 percent, he continued to insist.

She was diagnosed with HIV during an antenatal care visit. This left-behind wife is confident that it is her migrant husband, who also had a history of drug use, who infected her. As a nurse she had to have her HIV test every six months according to rules and legal regulations for medical personnel working in health care facilities in Tajikistan, and until her marriage all her HIV tests were negative. In addition, when she found out about her condition, her husband also had an HIV test and it came out positive, but his CD4 cell counts was much lower than hers and he died after several

³³ In some parts of Tajikistan, newly married couples will stay in the corner of the home covered by fabric which separates them from the rest of the people in the house for a certain period of time.

months. However, her CD4 cell count is not low to the point where she needs to have antiretroviral therapy. This also supports her claim that her migrant husband was the one who infected her. This example of an HIV positive woman also shows that even an educated woman with medical background failed to negotiate safe sex and apply HIV prevention measures, although she was very well aware of them. If she had been able to exercise her personal agency and insist on her newly married husband having an HIV test, she could have prevented the HIV infection. It seems that this particular woman was in a very difficult situation. She had just married her husband, whom she had not even known before because it was an arranged marriage. Despite that, she had the courage to ask him to do the test. Perhaps if they had known each other better or were married for several years then she could have insisted on condom use or an HIV test before having sexual intercourse with him, as did women whose cases I described earlier.

Many women like her find themselves constrained by the context in which they live and there is nothing that they can do to change the situation. Therefore, as mentioned earlier, unless the attitude of migrant men is changed in Tajikistan, a significant shift in attitude towards sexual health and prevention of STIs/HIV spread will not happen.

Summary

The study shows several important aspects regarding knowledge and awareness of HIV/AIDS and other STIs. First of all, it shows that knowledge of both wives of migrants and non-migrants is very limited in terms of other STIs. This is a huge concern for public health, which has significant implications for the women who

remain vulnerable to STIs. The findings of this study also show that, unfortunately, the majority of the left-behind women both in urban and rural areas do not use HIV/AIDS prevention measures and skills.

The analysis also shows that the majority of wives of migrants and non-migrants with higher, college and medical education living both in urban and rural areas have better knowledge about HIV infection than those who have only secondary education. This finding is similar to the results of the study by Golobof et al. (2011, p. 94) in Tajikistan, which mentions that the left-behind wives' "knowledge about HIV/AIDS varied with their level of education. More highly educated wives had more detailed knowledge about HIV/AIDS". The interviews with providers also confirm that women with higher education were better aware of HIV/AIDS than those with lower education. However, the majority of women with higher, college and even medical education do not use HIV prevention measures.

It also shows that wives of migrants with secondary education residing in rural areas had better awareness of HIV/AIDS than those living in urban settings due to exposure to education intervention. This is in contrast with the opinion of doctors and staff of organizations who believe that urban women have better knowledge of HIV/AIDS than rural women. Probably, providers' belief in lower knowledge of rural women resulted in conducting more educational campaigns in rural areas. As a result, rural women are better aware of HIV, while urban women remain uncovered by educational programs and consequently have no or little awareness of HIV/AIDS. It is therefore recommended that urban women with lower educational attainment should

also be covered by HIV/AIDS programs. The attention of policymakers and prevention programs must be redirected to this group of women as well.

In addition, the study reveals that rural left-behind women with secondary education and moderate knowledge of HIV/AIDS were the ones who successfully negotiated the use of condoms with their returning migrant husbands and then asked them to have an HIV test. This finding adds important information to the existing literature on migration and HIV. In particular, it demonstrates that despite having only secondary education and being economically dependent on their migrant husbands, some Tajik women were able to negotiate safe sex with condoms and ask their husbands to have an HIV test in a patriarchal Muslim society. Noting the ability of these women to protect themselves is important, because previous studies did not report similar findings (Hong et al., 2009; Lurie et al., 2003a; Lurie et al., 2003b). Although the number of wives of migrant men who were successful in practicing HIV prevention is low (13 out of 58 left-behind women), it is nevertheless encouraging. Hopefully more women will be able to protect themselves if providers continue effectively to conduct their prevention work in the country in the future. This is because the findings of this study show that many women who succeeded in practicing preventive measures were participants of such programs. Moreover, the necessity of using HIV prevention should also be promoted among the left-behind women with higher, college or medical education. It was surprising to find out that they neither used condoms nor asked their returning from migration husbands to have an HIV test.

However, the data also highlight some of the shortcomings of the awareness raising campaigns, which should be taken into consideration for the future. For example, seminars should cover both younger and older women left behind. They also should cover not only rural left-behind wives, but also their urban counterparts. They should also be conducted among women with secondary education, who do not have any information about HIV/AIDS. During the campaigns, prevention measures and their importance for wives of non-migrant women should also be particularly highlighted. In addition, the study shows that despite the fact that distribution of education materials on HIV slightly increases the knowledge of HIV among women, it does not lead to increase in the use of HIV prevention measures among the left-behind wives.

At the same time, the interviews show that some wives of non-migrant men believe HIV/AIDS is a problem of migrant men and their wives only. They do not see themselves at risk of this infection. When they were asked about their knowledge of HIV infection or their experience of asking a husband to have an HIV test, the majority of them refer to the wives of migrant men as being at risk and do not consider themselves to be at risk of this infection. The study shows that only one rural wife of a non-migrant man asked her husband to have an HIV test due to her concerns about increasing numbers of HIV-positive people among the population.

The data also show the importance of media campaigns on the subject and distribution of information and education materials in increasing the awareness of women in terms of HIV/AIDS. However, the evidence suggests that such campaigns

are more effective when combined with personal consultation or conversation with a trained specialist or exposure to other awareness raising campaigns.

CHAPTER 7

MIGRATION AND ACCESS TO REPRODUCTIVE HEALTH CARE SERVICES, AND ANTENATAL AND DELIVERY CARE

Access to health care contributes to the improvement of health and the relief of sickness (Gulliford, Figueroa-Munoz & Morgan, 2003). It has also been justified in economic terms due to its benefits in improving the health of entire communities, leading to conditions that favor economic growth (Gulliford et al., 2003). However, in low-income countries, problems of access concern the availability of basic health services, such as the ability to visit a doctor or to receive health care during pregnancy and delivery (Gulliford et al., 2003).

The aim of this chapter is to examine the influence of labor migration on the access of their left-behind wives to reproductive health care services, antenatal and delivery care. In particular, it examines major sexual and reproductive health issues faced by the wives of migrant men; the conditions and difficulties associated with accessing reproductive health services and maternity homes; the mechanisms used by the left-behind wives to protect their sexual and reproductive health and to access health services; and the perception of health care workers and staff of state agencies, local and international organizations about the reproductive health issues of the left-behind wives.

Building on the framework for the study of access to medical care by Lu Ann Aday and Ronald Anderson (1975), Gulliford et al. (2003) argue that it is important to examine access in terms of the ability of individuals who need care to get into the

system. Aday and Anderson (1975) (as cited in Gulliford et al., 2003) state that access means either the possibility or actual entry of a person or a group of people into the health care system. Thus, having access means a possible use of service that is needed (availability of service), while obtaining access means the commencement into the utilization process of health care services.

Therefore, it is important to explore the sexual and reproductive health status of the left-behind women and various provisions/constraints with respect to access to reproductive care services, antenatal and delivery care taking into account the impact of international male labor migration. The chapter argues that the relationship between labor migration and the left-behind wives use of reproductive health care services has been poorly examined. The chapter, therefore, explores the extent of the changes in the left-behind wives' access to reproductive health care institutions as a result of the migration of husbands with focus on the ability of these women to visit a doctor for their reproductive health problems and to receive antenatal and delivery care. It tries to demonstrate possible pathways of the impact, which are not clearly known and examined yet. In particular, it will explore the impact of the flow of remittances and other factors related to migration, along with the role of cultural variations in the understanding of reproductive health, health beliefs, customs and practices, and socio-economic issues in the experience of the left-behind wives and changes in their health seeking behaviors.

Understanding possible pathways of migration's influence on the reproductive health of women left back home and their use of reproductive health care

institutions is crucial to improving reproductive health of wives of migrants. This will also benefit families, societies and the nation as a whole (Gulliford et al., 2003).

Reproductive morbidity

First, in this chapter a comparison of reproductive morbidity among wives of migrant and non-migrant men will be presented. Table 6 shows a small difference between reproductive morbidity of wives of migrant and non-migrant men. In particular, it shows that the number of women without reproductive health issues in both groups is the same.

Thus, eleven women in each group said that they did not have any problems with their reproductive health throughout their life. Out of 18 reproductive health issues reported in Table 6, a higher number of left-behind women mentioned reproductive problems than wives of non-migrant men. Out of 18 reproductive health problems, only three, such as myoma, cytomegalovirus and itch were named more among wives of non-migrants than among the left-behind women. The number of left-behind women (4) with confirmed HIV cases was twice as large as the number of women whose husbands never migrated (2). But two wives of non-migrant men mentioned experiencing of cytomegalovirus, while no left-behind women had this particular infection.

In addition, more left-behind women mentioned reproductive health issues, such as inflammation (this includes inflammation of uterus, tube and ovarium), cystitis, erosion of the cervix and cyst, in comparison with wives of non-migrant men. Some women, especially those living in rural areas, complained about abnormal

vaginal discharge or reported receiving treatment because of a discharge, but they could not recall the exact name of the infection causing this symptom even if they had a test for it. They also could not recall the names of medicines they took which could have allowed me, at least, to identify the infection based on the medicines they took. The number of left-behind women who reported having had abnormal vaginal discharge was 11 compared to 8 wives of non-migrant men. At the same time, more wives of non-migrant men (5) complained about itch in comparison to three of the left-behind women. Very often women who complained about discharge also had itching.

However, all of these differences are minor. Given the non-random sample and the small difference, the data do not show whether any specific illness is more common among wives of migrants or not. However, it should be noted that wives of migrants reported a total of 70 illnesses, compared to 53 among wives of non-migrants (Table 6).

Although the interviews with wives of migrants and non-migrants indicate a slight difference in reproductive morbidity, Ob-Gyns of reproductive health centers, maternity homes and gynecological departments in different parts of the country, interviewed as part of this study, said that there is a higher rate of reproductive morbidity among the wives of migrants than among the wives of non-migrants. This argument is also supported by doctors working in AIDS centers, dermato-venereal centers and the staff of local and international organizations (who are often also doctors and work as part of health projects providing migrant workers and their

families with different services). They also think that there is a significant difference between reproductive health problems among these two groups of women.

Table 7: Reproductive health issues among wives of migrant and non- migrant men

Name of illnesses	Wives of migrants	Wives of non-migrants
Myoma	3	6
Cyst (of tube or ovarian)	2	1
Cystitis	5	4
Erosion of the cervix	6	4
Bleeding, hormonal dysfunctional bleeding, irregular periods	6	2
Endometritis, inflammation, inflammation of uterus	18	14
Vaginal discharge	11	8
Itches	3	5
Infertility	4	2
HIV	4	2
Hepatitis C	1	1
Cytomegalovirus	0	2
Candidiasis	1	0
Polyp	1	0
Climacteric syndrome	1	1
Lower abdominal pain	1	0
Pain during sex	1	0
Prolapse of uterus	2	1
Total	70	53

Similarly, in their study on India, Roy and Nangia (2005) also found that the left-behind women were more likely to have higher levels of reproductive morbidity than women married to non-migrants. However, Roy and Nangia's conclusions are based only on the evidence from wives of migrants and non-migrants without taking into account the views of health care providers.

In addition, all the doctors interviewed as part of this study believe that male international migration has a negative impact on the reproductive health of the left-behind women. None of the respondents mentioned any positive effect of migration on the reproductive health of their left-behind wives. Sabina, a reproductive health official in GBAO, argues that "the health of wives of non-migrants is better. Those women who are married to non-migrants have fewer problems with their reproductive health and come to see a doctor less often".

Farida, a doctor from the maternity home in Dushanbe, also states that although wives of non-migrants are more likely to be under reproductive health center supervision on a regular basis, they visit the centers less often than the wives of migrants. She believes the wives of non-migrants are also less likely to be diagnosed with STIs. In comparison, wives of migrants have more reproductive morbidity.

An Ob-Gyn in GBAO said: "If you compare the frequency of the same reproductive health issues among these two groups of women, it is clear that they are more common among the left-behind wives." All health care providers, including doctors working in the reproductive health system, dermato-venereal and AIDS centers believe that the level of STIs is higher among the left-behind women than among those married to non-migrants. This finding is consistent with the results of a

study conducted in Armenia, which revealed that wives of migrants experienced symptoms of STIs more often and were more likely to be diagnosed with STIs than wives of non-migrants (Sevoyan & Agadjanian, 2010).

Similarly, Munavar, a doctor of a dermato-venereal center (DVC) in Dushanbe, states: “Our experience and the statistics we have show that migration of men has a negative impact on the health of their wives”. He also said that the majority of migrant men are infected in Russia. They receive treatment, but sometimes because of incomplete treatment, they return without fully recovering and, inevitably, infect their wives. This is similar to Roy and Nangia’s (2005) study, which also states that migrants become carriers of STIs and make their wives vulnerable when they come back to their own country.

According to Munavar, those men who receive complete treatment do not represent a risk for health of their wives, but those who receive incomplete treatment and have no evident symptoms of infections, still infect their wives because of the hidden infections in their bodies. He also reported that the analysis of data from the “friendly cabinets” (FCs),³⁴ established throughout the country by the Republican Center of Dermato-Venereal Diseases with the support of UNDP and GFATM, showed that these health facilities determined 29% of patients with gonorrhea and

³⁴ In 2009 the GFATM, as part of its HIV competence linked with labor migration, and in collaboration with the UNDP and the MLSP, established 45 FCs throughout Tajikistan in regions with highest migration. The aim of these cabinets is to provide anonymous consultations and treatment for STIs as well as diagnosis, treatment and/or referral for other infectious diseases. The Global Fund provides medications as well as salary supplements and special training for medical personnel who work as staff members of these clinics; the Tajik government provides space and basic salaries (Cook, 2014).

49% with syphilis out of the total migrant families that refer to FCs in a year. He said: “In those cases when we identify gonorrhea, chlamydia, ureaplasma, mycoplasma, cytomegalovirus and other viruses, further conversations with the women reveal that most of them have migrant husbands in Russia”. He added that during the Soviet period gonorrhea and syphilis were the most common infections, whereas now infections such as chlamydia, mycoplasma, ureaplasma, gardenias, cytomegalovirus and herpes are more common, while syphilis and gonorrhea have become less frequent.

Oftoba, an Ob-Gyn in Dushanbe, also says: “In the past, infections, such as trichomoniasis, virus of herpes, cytomegalovirus, chlamydia and mycoplasma, were rare and, or, I can even say, were not even seen at all in the country, but after the increasing volume of migration they became common. Now women come to us with these problems quite often.”

Thus, according to the providers, the most common STIs among Tajik left-behind women are trichomoniasis, herpes, mycoplasma, chlamydia, cytomegalovirus, ureaplasma, toxoplasmosis, gonorrhea and syphilis. Although the majority of doctors believe that the reason behind such a widespread level and increasing number of STIs in Tajikistan is migration, the doctor from the DVC thinks that it is also due to better development of diagnostic equipment after the independence. Munavar is the only provider who thinks that not only migration, but also improvements of diagnosis of STIs are the reasons behind the increase in the rate of STIs in the country. However, similar to other health care providers, he believes that they are more likely to be diagnosed among wives of migrants rather than the wives of non-migrants.

Having stated that left-behind women have more infections and viruses, many doctors in the regions, especially in the remote ones, note problems with diagnosis of these infections. Ob-Gyns from regional reproductive health centers, regional maternity hospitals as well as regional health officials focusing on reproductive health, talked about their inability to diagnose these infections. As Sabina, an Ob-Gyn of GBAO, said:

We cannot determine infections and viruses here, so we have to send them to Dushanbe. However, when they come back to see us, they have been diagnosed with a basket full of these infections. When I started working, we never had a woman with toxoplasmosis, for example. We did not have this kind of diseases at all. Now we cannot find a patient who does not have some kind of infections. When we see that a woman had two miscarriages either both of them were here or one here and another in Moscow, then we send them to Dushanbe to determine what infections they have. The number of infections and viruses has been increasing constantly. When we sent patients for diagnosis, they came back with infections such as toxoplasmosis, cytomegalovirus, chlamydia, and ureaplasma infection. The majority of these cases were among women whose husbands were in Moscow. There is no laboratory for testing infections here in the region. Therefore, when a woman has two miscarriages we check her blood group to see whether she is Rhesus positive and also exclude hormonal reasons. The next step is always to ask her to have tests for infections and, therefore, we send her to Dushanbe to have these tests. In most cases, our assumptions about infections prove to be right.

From the interviews with doctors it becomes clear that many regions lack laboratories that have modern equipment to diagnose infections and viruses among women. The lack of laboratories and equipment is a great concern, because as we will see later, the data show that undiagnosed or untreated infections have a significant impact on the reproductive health of women and on the health of their children and family in general. According to the reproductive health care providers, the left-behind women have more complications during pregnancies and deliveries in comparison with wives of non-migrants. In addition, the left-behind wives' newborns also have worse health outcomes, which will also be discussed later.

Doctors noted that many women, whether married to migrant or non-migrant men cannot afford to travel to the capital city Dushanbe. Neither can they afford the high cost of tests. For example, the cost of a test for only one virus is 40 *somoni* (\$10) according to an Ob-Gyn in GBAO, but often doctors require tests for several infections. Moreover, their stay in Dushanbe and food costs will also add to travel expenses. Usually young women, who do not have children, can afford to go to Dushanbe to have the tests, because the family is interested in having children and supports them financially. However, according to the doctors, many women who already have children or who do not have sufficient income remain undiagnosed and cannot receive appropriate treatment.

The most striking finding was that doctors in various regions and Dushanbe mention the same health problems during pregnancy among wives of migrant men in different regions and the capital city of Tajikistan. Doctors often say that half of their patients, if not more, are wives of migrant men. Sabina, an Ob-Gyn in GBAO, said:

when we wrote our report we noticed that complications most often occur among those women whose husbands are in migration or among the women who are themselves migrants. Last year our report showed that 30% of pathologies were reported among wives of migrant men and female migrants. In comparison with the left-behind women reproductive health outcomes are even worse among migrant women, namely those who migrate to work or stay with their husbands in Russia.

Migration and access to reproductive health institutions: mechanisms of its impact

The study also endeavors to examine the access of the left-behind women to reproductive health institutions comparing it with the level of access of the wives of non-migrant men. This is another aspect of the health status of the left-behind women which has not been investigated before.

Webber, Spitzer, Somrongthong, Dat and Kounnavongsa (2012) in their study on migrant women state that: “Gaining access to primary health care services, including sexual and reproductive health care, is complex (p. 21).” They cite the work of Wellstood et al. (2012) arguing that many factors such as individual characteristics including income, age, gender, and level of need along with system characteristics and the policy environment as well as economic factors, geography, availability of services, and socio-cultural issues affect access of migrant women to health care. Therefore, this study focuses on examining the impact of migration of husbands and other determinants on the access of their wives to health care.

As part of this study, the left-behind women were asked about whether their access to reproductive health care services improved or worsened in any way because of the migration of their husbands. They were also asked about the reason behind why it improved or worsened. Also, they were asked to give examples of these changes. In particular, I was looking at several aspects of access of left-behind women. First, I examined whether left-behind women visit/refer to a doctor or use reproductive health care services when they have any problems with their reproductive health, such as endometritis (an inflammation of the endometrial lining of the uterus) or vaginitis (an inflammation of the vagina). I also asked whether they received antenatal care during pregnancy and health care during delivery.

The data show that migration impact has different degrees of positive influence on the use of reproductive health services for many left-behind women. It varies from a significant improvement in their access to only being able to see a doctor and receiving part of the treatment. The majority of the left-behind women reported that in comparison with their life before migration of their husbands, they are now more able to see doctors for their reproductive health issues. Improvement was reported by some left-behind women across all study settings. Some left-behind women, such as Zainab and Mehrinisso in Sughd region; Zarifamo, Farishta and Nektbaxt in GBAO; and Samira and Umrik in Khatlon region, state significant improvement in their access to reproductive health institutions. For instance, Zainab, a 44-year old left-behind wife from Ukteppa village of Sughd region, said:

My husband sends me money from there (i.e. migration) and I go to see doctors. However, I did not visit doctors as often before as I do now. Recently

when I was sick and did not feel well, my husband called me and told me to go to doctors and to get treatment. He always tells me to go to see doctors.... My husband sends me money on a regular basis, but when I tell him that I am sick, he sends me more money than he usually does. Now, whenever I need, I can go to doctors.

Zarifamo, a 49-year old rural left-behind woman from Pish village of GBAO, also states that migration did improve her access to doctors, because she said:

After my husband started working in Russia I went to the hospital for treatment several times. I can also buy all medicines that I need. If I did not have money, how could I go to the doctor? He tells me from Russia to buy whatever I need. I was able to go and see doctors even before his migration, but I think after he went to work in Moscow it is much better now. I have money and I can go to doctors both in the rural hospital in the neighboring village or to the Regional Hospital in Khorog.

It is important to mention that left-behind women not only have good access to reproductive health services, but also to health care institutions in general. For example, Zarifamo was able to visit the doctors when she was unwell due to her climacteric syndrome. But she was also able to go and stay in the regional hospital on several occasions, because of high blood pressure and headaches accompanied with unconsciousness. Unlike Zainab and Zarifamo, however, several other left-behind wives mentioned only little improvement. Some women state, for example, that although before migration of their husbands they could not see a doctor at all, now they see doctors but still cannot receive the full course of treatment prescribed to

them. Accordingly, these women believe that after migration, their access improved and it is now better than it was before. Although this group of women did not receive treatment to the same extent as those whose access improved considerably, at least they can now be diagnosed and have partial treatment instead of having none.

The data demonstrates that improvement in the access of the left-behind women can be explained by several pathways/mechanisms. Regular flow of remittances from migrant husbands to left-behind wives is one of the most important factors in the improvement of their access. The constant flow of remittances improves the economic and financial situation of women, which in turn improves their health seeking behavior. The interviews with the wives of migrant men show that if the migrant man provides the family with regular remittances, the woman is able to visit a doctor whenever she needs and she is able to pay for expenses connected with travelling to a health facility, visiting a doctor and obtaining medicines required for treatment.

Moreover, it seems that migration has a positive impact on health seeking behavior of migrant men in Russia too. Migrant men are probably exposed to information about the necessity of frequent visits to the doctors and other public health promotion campaigns, and as a result, they become better aware of various health issues and prevention measures. In short, a significant improvement was observed among those left-behind wives whose husbands often urged them to visit doctors both when they are away in Russia and when they are back at home in Tajikistan. Improvement in awareness and health seeking behaviors of migrant men positively affected health seeking behaviors of their left-behind wives at home. It is

clear from the above-mentioned conversation with Zainab and Zarifamo, as well as from the interviews with Sinjid and Shaftolu in Dushanbe, that when migrant husbands are told on the phone about any health issues by their wives, they urge them to visit a doctor. Shafika, a 38-year old urban left-behind woman, said that when she told her husband that her menses had become irregular recently, he urged her to see a doctor in order to avoid it turning into a chronic illness. Shaftolu, a 38-year old urban left-behind woman, also said that when she does not feel well, her husband tells her to go to the doctor and not to stay at home. This suggests that the husbands are also strong pushing factors for increasing the access of the left-behind women to health care. Specifically, it is clear from the interviews that if the migrant men did not urge their wives to go and see a doctor, they might have postponed their visit to the doctor even further.

Another possible pathway/mechanism for improving access to health care is an improvement of living standard of the left-behind women, especially after purchasing an apartment or constructing a house of their own. Urban and rural left-behind women said that when they lived as part of extended families with their in-laws, they did not receive remittances since the husbands usually sent money to their parents who were in charge of spending it. This is similar to a study by Gartaula et al. (2011) in Nepal. In other words, they did not have access to money and freedom of how to spend it. Moreover, some women stated that mothers-in-law made decisions regarding whether a left-behind woman can visit a doctor or not. As a result, many left-behind women did not have the decision making power. At the same time, many left-behind women say that their mother-in-law was the one who took them for the antenatal care and who went with them to see a doctor for the first time if they had any problem with

reproductive health. Despite that, many wives of migrants still believe that after separation from the extended family and living in a nuclear family, they were better able to use health services and gained more decision making power in the latter situation.

In sum, lack of money due to large family sizes while living as part of extended families, lack of decision making power and dependence on in-laws' decision making power regarding access to health care institutions often impede some left-behind women's use of the reproductive or general health care services.

Thus, urban as well as rural left-behind women believe that after they started living separately from their in-laws their access became better. First, because now husbands send remittances directly to their wives, who live separately in their own apartments/houses, although many husbands also keep helping their parents. In addition, wives become more independent and make decision themselves whether they can visit a doctor or not, and when and how often such visits should occur. For instance, Latifa, a 32-year old urban left-behind woman, said that with her previous three pregnancies she had never seen any medical personnel in Rasht valley, a region which was severely hit by the Civil War. Neither did she have any tests during her three previous pregnancies. She delivered only her first baby at the regional maternity hospital. She delivered her second and third child at home with the help of a traditional birth attendant without special training.

However, after she moved to Dushanbe after the purchase of a new two-bedroom apartment, she received antenatal care during her last pregnancy and delivered her last baby in the city maternity hospital. This demonstrates that purchase

of a new apartment with remittances from migration and living in a nuclear family as well as better health seeking behavior common in urban areas contributed to the improvement of access to reproductive health services for this left-behind wife. Her case confirms the suggestion of Webber et al. (2012) that obtaining access to health care is complex, because so many factors such as remittances and improvement of economic and living condition, financial situation and direct access to money, social factors including improvement of decision-making power, as well as urban norms of health seeking behaviors, contributed to improvement of her access.

Having said that, I strongly believe that the main determinant of the improvement is migration, because it is the work of the husband in Russia which allowed him to save a sufficient amount of money to buy an apartment leading to the independence of his immediate family and, thus, the independence of his wife's health choices and behavior. Thus, it is migration and the possibility of earning income that can serve as a catalyst for positive changes in the health behaviors of women. Other factors are very important too, but they strongly depend on this main determinant. Thus, migration's positive effect on the use of reproductive health institutions operates through: 1) a regular flow of remittances with an increase during their illness; 2) migrant husbands' insistence that their wives visit doctors and receive treatment; and 3) improvement in their quality of lives, especially their living conditions; and 4) gaining more decision making power. Although, on the one hand migration worsens the health status of the left-behind women, on the other hand migration and regular flow of remittances is the major determinant for improving access to reproductive health care services. Without migration, the left-behind women would have had even less opportunity to access reproductive health care services.

The interviews with the reproductive health care providers add important details of left-behind women's improved access to reproductive health care. It was interesting, however, that some doctors do not classify it as *improvement*, but rather as *increase* because wives of migrants have more reproductive morbidity which increases their visits to the doctor as a result. The evidence from reproductive health providers show that wives of migrants use reproductive health services more often and they also explain very important aspects of the access of this particular group of women to these services. Several possible explanations for more access of the left-behind women emerge from the interviews with the medical professionals. First, because wives of migrant men have more reproductive health issues, it is not surprising that they refer to the doctors more often. Second, financial opportunity, highlighted by many doctors, is another reason for better access. For example, Obida, an Ob-Gyn of a reproductive health center in Sughd region, said: "Migrants send their wives money and ask them to go and receive treatment", or Farzona, an Ob-Gyn of a reproductive health in GBAO, said: "Wives of migrants would call their husbands and ask to send them money for visiting a doctor". The wives of non-migrants, according to the same respondent, sometimes cannot even afford to receive "complete treatment and receive only half of the prescribed medicines." Zamira, a medical worker in Garovuti village of Khatlon region, also said:

Women married to non-migrants cannot find money for long treatments. Even if the doctor prescribes medicines, they receive part of the treatment, but do not complete the treatment. Whereas those who have their husbands in Russia are confident that if the husband calls and she tells him that she is

sick, he will find money from wherever he can and will send it to her so that she can receive her treatment.

This suggests that wives of migrant men can often rely on their husbands when they get sick. They can ask their husbands to send them money for treatment and, even if he does not have the money, he borrows it from somebody and sends it to them so that they can receive the treatment needed.

Third, several respondents reported that exposure of migrant men to health information overseas resulted in improvement of their knowledge regarding health issues and health seeking behavior. For instance, as Oftoba, an Ob-Gyn of reproductive center in Dushanbe, said:

I want to say that in recent years we observe cases when husbands, who work in other countries, are more concerned about the health of their families. They bring their wives for checkups and hospital appointments. This is perhaps because they work in other countries where they receive information [about health issues], they learn something, they feel responsibility; responsibility for wives, children. There is just something going on. Often we observe among wives of migrant men that they come and tell us that their husband just came back and that he works somewhere there, and that he wants her to be examined and get treatment.

During the Soviet period, health care was universal and free of charge. Everybody had access to health care because even transport cost for getting to the health care institutions was much cheaper. Moreover, there were certain stages in life,

when people had to go through comprehensive health-checks. After the collapse of SU, the health care system and, therefore, health awareness, decreased rapidly due to the Civil War and the economic and social stagnation. Currently, the situation is improving in comparison with the early post-Soviet decades, because although the health care is only theoretically free, people have more opportunities to access health care services, medicines and information about healthy life-style. One of the main reasons for this is migration and flow of remittances and the overall improvement of the economic situation in the country.

Fourth, Farida, a doctor from the maternity hospital in Dushanbe, provides another explanation: because left-behind wives are more courageous and forthcoming in terms of their health issues, they visit doctors more often. If any infection is diagnosed, they blame their migrant husbands for the infection. She stated that the wives of non-migrants are more likely to be under reproductive health center supervision on a regular basis, but they rarely visit doctors. The wives of non-migrants are usually more confident about their health and do not even consider the possibility of having any kind of STIs. This is because they believe that since they live together with their husbands and neither of them has extramarital relationships, there is very small or no chance of them being infected. They have a different profile. They also think that since their husband is near them, they do not have to visit the doctor often. However, it has to be mentioned that they are rarely diagnosed with STIs. Overall, it seems that they are shyer than wives of migrants when talking about their sexual life and health. Wives of migrants are more open; as stated above, if they are diagnosed with STIs they blame their husbands for their health and go everywhere and have examination, as well as receive treatment. However, as far as the wives of

non-migrants are concerned, they are relatively shy and, if diagnosed with STIs, they receive their treatment confidentially.

Fifth, according to many doctors the access of the left-behind wives to health care is better but it often reflects the seasonality of migration. It was interesting to learn that many doctors/Ob-Gyns mentioned that the visits of wives of migrants had a “seasonal character”, i.e. when their husbands are away they do not come, but when their husbands come they bring them to the doctor in some regions. Some doctors reported that the majority of the left-behind women come for examination upon the return of their husbands from migration. They tell doctors that their husbands work overseas and that there is hepatitis, HIV and many other infections, they need to have medical examination. They ask to be tested. That is why they are more likely to refer to doctors than wives of non-migrant men. In addition, when their husbands send them money, wives of migrant men immediately go for medical examination. Oftoba, an Ob-Gyn in Dushanbe, said the following:

When their husbands return, the first thing they do they go to see a doctor. They do not go for shopping in the market, but first of all they go to the doctor to be examined. They do not know when the next time their husbands will come and whether they would have enough money again for the examination, so before anything else they come for medical checkups.

Finally, in Tajikistan many doctors state that it is usually the husbands and mothers-in-law who accompany them on their visits to the doctor. It is, therefore, natural to expect that when a husband is absent, the woman cannot visit the doctor and starts to do so when he returns. Moreover, when their husbands are away, the women

often cannot have a baby-sitter to look after their children to be able to visit doctors. They also said that wives of non-migrants only came for examination when specifically requested by the doctor, when some kind of pathology is determined.

Despite the more frequent referrals of the left-behind women, it was noted that wives of migrants in comparison with wives of non-migrants tend to have more severe problems. Zarina, a doctor of a reproductive health center in Dushanbe, said:

They have small children and they do not have anyone to leave their children with. The main reason is, however, the low self-consciousness of the women. They keep on postponing their visit from one day to another and, when they finally refer to us; they have exacerbated forms of illnesses.

In addition, later referral and “seasonal character” can be also connected with social problems, because the majority of these women are from rural areas. All domestic work beginning with bringing up kids to household chores, to work on the land and looking after the animals is on the shoulders of the women. Farzona, a doctor of the reproductive health center in GBAO, said “there are some villages in the Shokhdara district where no young men are left; all have left for Russia, and there are only women and old men left”. Under these circumstances, it is the women who carry all responsibilities and do not have time to go and check their reproductive health. Fotimazuhro, a left-behind woman in Pish village of GBAO who works as a school teacher, said:

I know I have an inflammation, a discharge and erosion, but I do not go, for example as others, and receive treatment. I do not have time for this. On the

one hand, I have to take care of the house, my work at school, household's work, my children's homework, in summer there is also work in the field and the garden... My husband provides me with money and I have a good life, but I cannot go to doctors... not because of lack of money, but due to the work in the field and garden and many other household chores.

Many rural left-behind women said that they could not leave their children and stay in the hospital to receive treatment, because there was no-one to look after their children or with whom they could leave their children. In addition, these women work in the field growing vegetables, work in the garden growing fruits and mowing the grass. Even watering fields and gardens becomes the responsibilities of the left-behind women after the migration of their husbands, as mentioned by Ruhafzo, the 41-year old rural left-behind women from Pish village of GBAO. In addition, women also look after the cattle. Almost all rural women have either a cow, sheep, goats or other type of animals, because according to Simo, a rural family cannot live without cattle in the village. In many cases, rural left-behind wives also need to take the cattle of all villagers to the pasture and look after them for a whole day.³⁵ Zebo said that if before her husband did it, now she and her daughter had to take the responsibility for it every month when their turn comes. In sum, all the left-behind wives were responsible for both male and female household tasks and therefore have less time to look and care after themselves. As a result, they do not receive required medical care/attention.

³⁵ This is usually organized on a rota basis in villages and usually the men of the households take the turn, but because the husbands of the left-behind wives are in migration, they have to step in themselves.

Migration and its impact in urban and rural areas

Falkingham (2003) states that there is a considerable difference between urban and rural settings, since urban women have better opportunities to receive antenatal care and deliver their babies in health institutions in Tajikistan. This study also confirms the findings of previous research stating that women in Dushanbe are more likely to use antenatal care and delivery services. But what this study also tries to achieve is to discern any differences between the use of reproductive health care facilities during illness between wives of migrant and non-migrant men. Overall, the data shows that left-behind women have slightly better access to reproductive health services than wives of non-migrant men in the sample. They are more likely to refer to doctors and receive treatment when they have a problem with their reproductive health. But the opportunity to visit doctors among the left-behind women and wives of non-migrant men is different between rural and urban areas. The current study reveals that there is a difference among wives of migrant and non-migrant men in urban and rural areas in terms of their ability to visit a doctor.

In Dushanbe, the only urban setting in the study, it seems access of wives of non-migrant men to reproductive health care services is better than that of the left-behind women. In this study, seven wives of non-migrant men said that they have very good access to reproductive health services. In addition to these seven, two wives of non-migrant men also said that before divorce with their non-migrant husbands due to HIV, their access to reproductive health services was very good as well. Only two women state that sometimes they have issues with lack of money, which hinders their access to health care. Guljamol, a 37-year old wife of a non-migrant man who had a

high position in the army, said that she had her own doctor, a professor of obstetrics-gynecology who was invited to her home and examined her at her house where she also received full treatment. Mexmona, a 43-year old urban wife of a non-migrant man, whose husband has several private companies, states that she went to Moscow to have an examination and treatment for her reproductive as well as general health issues in a private clinic. Her trip to Russia as well as her treatment there was paid for by her non-migrant husband. All women with non-migrant husbands in Dushanbe interviewed as part of this study had higher education and had a job with a sufficient salary that allows covering not only expenses of the households but also their wives' visit to the doctors and treatment. Six wives of non-migrant men also have higher education and two have a college education, which is also an important factor for better health seeking behavior and better access among this group of women in Dushanbe.

These findings show that in the urban area, wives of non-migrant men were more likely to use reproductive health services due to the impact of education and having financial means to do so. This is not surprising because previous studies show that the education of women has a positive impact on good health status and utilization of health care institutions (Falkingham, 2003). Having a higher level of educational attainment does not cause individuals to be sick more than others (Habibov & Fan, 2008), but people with higher education are likely to use health care more often than those who have low educational attainments (Habibov & Fan, 2008; Habibov, 2010). Studies suggest that people with higher educational background have better access to information and are better aware about how healthcare services are

organized and how they operate and are, therefore, better positioned to utilize them (Habibov & Fan, 2008; Habibov, 2010).

It is, thus, possible to conclude that access of wives of non-migrant men to reproductive health care is good in Dushanbe due to 1) higher education and relatively well paid jobs of their husbands; 2) higher education of wives of non-migrants; as well as 3) women's own income because some of them also work and receive good salary. In general, many urban wives of non-migrant men such as Uldus, Shukufa and Pevasta said that their life in general improved especially after they also started working. It is quite evident that having their own income among wives of non-migrant men also contributed to their better access to health care. At the same time, regular receipt of remittances of migrant husbands is the main reason behind the improvement of the access of left-behind women to reproductive health institutions in Dushanbe, because only one left-behind women had higher education and worked for a local newspaper. The rest had complete or incomplete secondary education and were housewives, and remittances were the only income in their households.

However, the situation is different in rural areas. The study shows that along with the migration of a husband, many other factors influence access for women to health care in rural areas. For instance, previous studies show the availability and location of health care institutions is a crucial factor for the utilization of health care in the developing (Falkingham, 1999; Habibov & Fan, 2008) and developed world (Gulliford et al., 2003). Living in a residential area without a polyclinic and living at greater distance from a health facility reduce the frequency of utilization (Habibov & Fan, 2008). As far as Tajikistan is concerned, in her study Falkingham (2003) states

that there is also a difference in the use of health care services between urban and rural women.

This current study similarly shows that rural women are more likely to complain about problems with accessing reproductive health services than urban women. Wives of non-migrant men in rural areas of several regions reported lack of financial resources as a major reason for not receiving treatment. As mentioned earlier, although prenatal care and many other health care services are theoretically free of charge in the country, cash and in-kind exchange is a common form of unofficial out of pocket payment for services (Habibov & Fan, 2008). The unofficial payment serves to compensate the low salaries of health care professionals, which have long been quite low due to economic issues (Falkingham, 2003; Habibov & Fan, 2010) after the dissolution of the SU. As a result, the unofficial payment becomes the main determinant of access to health care for women, especially from poor families.

This study, therefore, supports previous studies in identifying lack of financial means and inability to pay unofficial payment as one of the major barriers for accessing health care services (Falkingham, 2003; 2004; Fan & Habibov, 2009; Habibov, 2010; Habibov & Fan, 2008). For example, Marodsylton, a 43-year old rural wife of a non-migrant man in Sughd region, reported that she would visit a doctor very rarely, because her husband could not provide her with sufficient income. His salary is 90 *somoni* per month (equivalent of approximately \$18) and it is not even enough to cover food and other household expenses. Shamima, a 43-year old wife of a non-migrant man from Durbad village, said that she had been bleeding for more than a year after her Depo-Provera injection, but she could not see doctors because her

husband was sick and his pension was very small. Although her husband asks her to see a doctor, she tells him that she would rather spend the money on her kids. Thus, the limited use of reproductive health care services among wives of non-migrant husbands predominantly depends on the financial situation of the household. However, in contrast with the left-behind women, they do not complain about being overburdened by work in the village. In contrast, the first group, namely rural left-behind wives who remain in charge of both female and male housework in the family, found it harder to find time to see a doctor or receive treatment because of the level of their workload, although they complain less about the lack of money.

The interviews show that the left-behind women's access to reproductive health care in rural areas is slightly better than that of the women whose husbands never migrated. First, some rural wives of non-migrant men, despite not having a migrant husband, depend on remittances sent by their sons, who work in Russia, and brothers, who work in Tajikistan in order to have access to health care services. For instance, Tutinisso, a 46-year old rural wife of a non-migrant man in Garovuti village of Khatlon region, said that when she has any problem with her health she waits until her sons send her remittances from Russia so she can go to see a doctor. In addition, wives of non-migrant men in rural areas often have good access to local rural health care facilities (so-called *medpunkt*, lit., "medical point"). The medical points are usually served by nurses and do not have laboratories or even equipment for simple tests, such as blood or urine tests. Although the wives of non-migrant men have good access to local rural health facilities, they rarely refer to regional hospitals which are served by doctors, equipped with better medical equipment and have laboratories. For instance, Sevara, a rural wife of a non-migrant man from Pish village of GBAO, said:

If I do not feel well, I go to see our nurses in the medical point in the village and they prescribe me medicines which I then buy from a pharmacy in Khorog. But if the nurses have these medicines as humanitarian aid, then they give them to me for free... I go to the hospital in Khorog³⁶ very rarely.

Sevinch, a 37-year old rural wife of a non-migrant man from the same village, also said:

I go to the local medical point if I have any health issue. The service is free of charge. Nurses often give me free medicines. They help me and they are very nice. The nurses do not charge me and do not take money from me even if I offer. But when I go to a hospital, I have to pay at each step, whereas when I go to the rural medical point, whenever or for whatever reason, I do not pay anything.

The interviews show that in comparison with rural wives of non-migrant men, the left-behind women, such as Zarifamo and Mushkilmo from the same village, do not mention referral to local medical facility, where health services are free and medicines are sometimes free, but immediately refer to the neighboring rural hospital and mainly to the Regional hospital or polyclinic in Khorog where the services are certainly expensive.

In addition, in Garm-Chashma only two left-behind women with migrant husbands were able to refer to the Khorog Regional hospital for their reproductive and general health problems, while wives of non-migrant men and left-behind women

³⁶ It is served by doctors and has laboratories to carry out various tests.

with less successful husbands could not afford it.

Falkingham (2004) in her study also states that the poor usually use primary health care facilities and providers, such as nurses or physician assistants (feldshers) in comparison with people who have better income allowing them to use polyclinics and hospitals. The poor people often receive treatment at home or at FAPs (physician assistant/midwife posts) and SVA (rural physician clinics) while wealthier people receive treatment in polyclinics and hospitals (Falkingham, 2004). Taking into account the pattern of health facilities usage by women in rural areas, it is clear that while the left-behind women are more likely to use polyclinics and hospitals, wives of non-migrant men usually refer to primary health care facilities such as rural medical points rather than secondary health care facilities such as hospitals or polyclinics.

On the whole, women in rural areas whose husbands never migrated are less likely to access reproductive health care institutions in some rural areas. For instance, the majority of wives of non-migrant men in Durbad village of RRS, Garovuti village of Khatlon region and Garm-Chashma village of GBAO mention that they do not see a doctor and do not receive treatment when they have any reproductive health issue. The main reason for restricted access is lack of money. The majority of women mention that their non-migrant men do not earn sufficient money to cover all their required expenses including food, clothes, and school supplies for their children. If they find money, they usually spend it mainly on food similar to the left-behind wives who do not receive regular remittances from their migrant husbands. In addition, the wives of non-migrant men in these villages usually mention that they hardly ever see a doctor. If they have any health issue and it is not severe, they wait until the body

heals itself or they refer only when they cannot bear the pain any more or the condition gets so bad that they are forced finally to refer to the doctor.

In general, rural population faces more problems than urban population with access to health care even in developed countries such as UK (Haynes, 2003). Haynes (2003), for example, emphasizes that rural residents experience higher than average costs to access health care services even in a developed country like the UK. People using health care pay not only for the travel expenses, but also bear costs of the time spent, which can include paid and unpaid job, child care and leisure activities. All these expenses are directly related to the distance between home and services, and have a disproportionate effect on the poor (Haynes, 2003).

Migration and worsening access

Worsening access was rarely mentioned during the interviews. The majority of left-behind women stated that their access to reproductive health services had improved, and only few left-behind wives reported decrease in frequency of consultation with the doctor or use of health care services. The reason why it is, nevertheless, useful to discuss is that it helps to compare the experiences of women who mentioned improvement of access to reproductive health care services and those who noted a worsening of their access to better understand the impact of migration. The analysis of data shows that access of fewer left-behind wives was better before migration and worsened after when their husbands migrated to Russia. For example, when asked about the ability to visit a doctor after migration of her husband, Mubina, a 46-year old left-behind woman in Durbad village of RRS, said that her situation was

difficult, because when she had been sick, her husband could not send her money. This is because he works, but does not get paid by his employers.

When my husband was here, he went to work somewhere and was able to find money for our daily expenses. At least, a man was near me; life was not so hard for me. Even if his income was meager, we were able to manage to top it up somehow and were able to go to a doctor. Now if I ask him to send me money, for example, he says: "I am working. If they pay me, I will send but if they do not pay me, I cannot send". For example, he has called in the last 2-3 days and said that his employers had not paid him yet and he did not know what to do. It is hard. Then you think about it and you have blood pressure, and you will have all other problems. But at the same time, it is Tajikistan; there is no job available for him here. But it is also dangerous for a man in migration.... This year the winter was severe, there was so much rain and snow that all my walls were falling down. We used money only for food. This is how our life is. Kids are without father. It is very difficult to provide school supplies, clothes.

There were also other left-behind women who similarly to her mentioned that they were in a better position to see doctors before rather than after their husbands' migration. Mohbegim, a 40-year old rural left behind wife from Pish village of GBAO, also said:

When he (i.e. her husband) was here, I was in a better position to go and see doctors. When he left, I went to see a doctor, but I could not buy medicines. When he was here, I was able to see a doctor and receive treatment. However,

if he does not have a job here [and does not go there for work], again I cannot go to a doctor.

The experience of these women is in contrast to that of women who reported improvement of their access after migration of their husbands and who also mentioned that their husbands send them remittances on a regular basis. Some even mentioned that when they get sick, the husbands send more money for the treatment. In addition, these women also reported improvement in their living condition such as construction of a house or purchase of an apartment, cars and other households' equipment. The above examples show that the condition of some left-behind wives got even worse and consequently affected their ability to access health care services. They did not mention that their husbands asked them to see a doctor.

The reason why these two and other left-behind women report worsening access to reproductive health institutions is rare and irregular receipt of remittances from their migrant husbands. Some receive it after two months and some after several months. The detailed analysis of their interviews shows that in these two cases their migrant husbands told them that they work, but do not get paid for their work. In addition, in both cases the quality of their lives went down or got worse in comparison to those left-behind women who reported improvement of their access to the reproductive health services. These women also struggle with numerous other social and economic problems like feeding their children, and supplying them with clothes and school material.

The lack of remittances sent by their husbands can be explained in two ways. First, not only these two, but very often other left-behind wives in different regions of

the country, who do not receive remittances from their migrant husbands on a regular basis and who also mentioned the lack of money as a cause of their limited access to health care, reported that it is because their migrant husbands were cheated in their work-place. Many migrant workers who go to Russia and work for construction companies or other people are often hired illegally. They are promised verbally to be paid upon the completion of the work or after a certain period of time. However they do not get paid for months, or in many cases, they do not get paid at all. Moreover, because they work illegally, they have nowhere to go to complain. Very often they wait for several months hoping that they will get paid. Sometimes, they do get paid eventually, sometimes they get paid much less than what had been promised and, sometimes they do not get paid at all. Unfortunately, very often there is nothing that they can do about it, because they have no access to social or legal protection.³⁷

Olimova and Bosk (2003) in their work show that labor migrants are often cheated and are paid only half of what they were promised or not at all. Moreover, sometimes, if the contract was in dollars, they get paid in Russian rubles with lowest or underestimated exchange rate (Olimova & Bosk, 2003). In some cases, they wait for their wages for two to six months. Because many migrant workers are illegal or irregular, as Olimova and Bosk call them, in Russia, they do not have written contracts with employers and, therefore, they cannot do anything about the situation in which they find themselves when they are not getting paid.

Another explanation for the decrease of remittances sent or irregular flow of remittances to the left-behind families is the creation of a second family or having a

³⁷ For more information on the illegal status of the Tajik labor migrants in Russia and the difficulties they face as a result of that, see above Chapter 1, pp. 19-21.

girlfriend/partner in Russia (IOM, 2009). Some labor migrants, especially those with a longer history of migration, try to find a more or less stable girlfriend or partner (Olimova & Bosk, 2003). These are often Russian women or sometimes other women from Central Asian countries. In many cases, they even marry them and create second parallel families and as a result they decrease significantly the amount of remittances they send to their families back home. However, even after the second marriage, many migrant husbands usually do not abandon their left-behind families in Tajikistan, but they rarely visit them or rarely send them money. Typically, they would tell their left-behind wives that they had a problem with finding a job in Russia or that they worked but they did not get paid without telling them the truth about the second families or girlfriends in Russia. Support of the second family in migration leaves a very small amount of money that they could send to their left-behind families in Tajikistan.

This situation was particularly highlighted during the interview with Dilrabo, a 27-year old urban left-behind woman, who said that at the beginning when her husband left for Russia he sent her money separately from the money he sent to his parents. Also, her husband sent her money and asked her to receive antenatal care and give birth to her baby in the maternity hospital in Dushanbe rather than in Hissor where she is originally from. However, after about two years when he married another woman in Russia, he stopped sending her money and her financial situation worsened considerably.

Having a girlfriend or a second wife not only leaves their wives with less remittances, it also increases the risks of contracting STIs. Thus, on the one hand, an

extramarital relationship of migrant husbands increases the risk of contracting STIs and, as a consequence, problems with their reproductive health. On the other hand, it leads to low flow of remittances and as a result of which the left-behind women do not have the financial means for seeing doctors and receiving treatment for their reproductive tract problems. This issue is not unique to migrant men and their families in Tajikistan. Existing studies on the left-behind partners in Africa also discuss the fear of the partners of migrant men findings partners and second wives in migration and the negative effect of that on the flow of much needed remittances to their families back home (Dladla et al., 2001).

Before moving to the discussion of the impact of migration on antenatal and delivery care of the left-behind women, it is important to talk about the “culture of hospitalization”. In general, irrespective of their husband’s migration status many women do not receive treatment because of the “culture of hospitalization” dominant during the Soviet period. They believe that treatment is only effective when they are hospitalized where they receive injections for their reproductive health issues. Some women do not think that it is effective to receive treatment on an outpatient basis. One of the possible explanations can be the treatment protocols requiring ineffective treatment not based on evidence (Habibov, 2010). These protocols do not use cost-saving procedures and hospitalize patients who end up receiving long-term treatment. Patients often receive intra-muscular injection, which could be effectively replaced by tablets for a short period of time as outpatient with similar treatment effect (Habibov, 2010). The prolonged and ineffective hospitalization is a result of the old treatment guidelines that are not based on clinical evidence involving numerous invasive treatments (Habibov, 2010). Hospital care spending should be used for high-risk

interventions; however, it was common to admit patients into the hospital without regard to the severity of their illness during the Soviet period (Habibov, 2010). It is perhaps the culture of hospitalization prevalent then, which continues to influence women even now. That is why they do not consider tablets and outpatient treatment as effective as hospital treatment. Many women think that treatment is only effective if they are admitted into the hospital. They argue that receiving outpatient treatment is of no use and very often they wait for an opportunity (financial and time-wise) when they can be admitted and treated in the hospital. Very often, that never happens because of many financial, family and social pressures.

Antenatal care and delivery experience of the left-behind women

In this section I will discuss the opportunities for women to receive antenatal and delivery care. Prenatal health care plays an important role in attaining positive birth outcomes, because there is a strong association between the use of prenatal services and low child mortality (Habibov & Fan, 2008). This is also supported by Holtz and Grisdale (2008) who emphasize that “prenatal care reduces maternal and newborn complications through regular check-ups by a trained nurse, midwife or physician” (p, 451). A low level of using prenatal care is a significant factor in maternal and child mortality (Habibov & Fan, 2008).

The data show that the migration of husbands does not impact the antenatal and delivery experiences of the left-behind women. The findings of this study demonstrate that antenatal and delivery experiences largely depend on the quality of the operation of the reproductive health care system. There is no difference in the experiences of wives of migrants and non-migrants in those settings where the

reproductive health care system operates well. However, the experience of women can differ in various villages even within the same region. For instance, wives of migrant and non-migrant men reported that they receive antenatal care during pregnancy and delivered their babies at the maternity hospitals in Ukteppa village of Sughd region and Garovuti village of Khatlon region. The rural women in these two villages were even surprised at my question of whether they preferred to deliver their baby at home or in the maternity hospital. In general, women in these villages, without regard to their level of education, could not imagine having a baby outside of the medical facility. Many women in both groups asked: “Is it possible to have a baby at home?” whereas, in villages of some of the other regions, giving birth to a baby at home is considered as a social norm, which will be discussed later. One of the reasons for having similar antenatal and delivery experience among the two groups is good operation of the antenatal and delivery care system as well as the reproductive health care system in these two particular regions.

In particular, access to antenatal and delivery care services is good in Sughd region. First, because, the nurses in this region call women and ask them to come for regular check-ups two times per year in this region. Therefore, if a woman is pregnant, she is identified during these check-ups, registered and taken under doctor’s supervision. In addition, the medical professionals interviewed in this region state that they identify pregnant women during home visits and ask them to come for registration and antenatal care.

Another significant contributing factor is that women can simply walk without the need for taking public transportation because of the close distance to the health

facilities in the villages. These two factors of impact on the access to health care services have also been mentioned by Fan & Habibov (2009), who see a positive relation between the availability of health care facilities and the use of maternal health care services. The good coverage of women with antenatal care and delivery by health facilities in Sughd region is in line with TLSMS conducted in 2007, which showed that 97% of pregnant women were covered with antenatal care and 92% of women delivered their babies at a health care facility in Sughd (State Committee on Statistics & UNICEF, 2009). Although the current research also found good antenatal coverage and delivery in the hospital among women in Garovuti village of Khatlon region, this finding is in contrast with the TLSMS 2007 showing that only 83% of women are covered by antenatal care and just 59% of them give birth in the maternity hospitals in Khatlon region (State Committee on Statistics & UNICEF, 2009). A possible explanation for this discrepancy is the varied quality of antenatal and delivery care in villages of Khatlon region.

Nevertheless, the overall data shows that presently the reproductive health care system operates well in Sughd region. Women in this region have good access to reproductive health services during pregnancy and delivery and also refer to doctors when they have problems with their reproductive health. However, when women have other health issues, some of them do not visit doctors and do not receive treatment. The data also show a very good antenatal coverage and hospital delivery in Garovuti village, but wives of both migrant and non-migrant men state that they usually do not see a doctor or receive treatment for their reproductive health issues and considerably fewer women receive treatment for general health problems.

A good situation in terms of antenatal and delivery care is also seen in the capital city of Dushanbe, although not as universally good as in the two previously mentioned villages. The data show that both urban wives of migrant men and non-migrant men receive standard antenatal care and the majority of them deliver their babies in the maternity hospitals.

Many wives of non-migrants interviewed in Dushanbe had higher education. Higher education, in particular, has a significant impact on health-seeking behavior. Both urban wives of migrant and non-migrant men with higher education think it is safer to have babies at the hospital and it is absolutely necessary to see a doctor during the pregnancy. Similar observation is made by Holtz and Grisdale (2008, p. 451) arguing that “women with more education had a higher rate of a skilled birth attendants at delivery and better rates of survival (p. 451)”.

In addition, women with higher education also express concerns regarding safety and possibility of contracting infections, such as HIV or hepatitis C, in health care facilities during their regular visits and therefore they carry disposable instruments or sterile syringes with them during their visits. Almost all women in both study groups (wives of migrants as well as wives of non-migrants) with higher education had great concerns about safety during their visits to various doctors, especially if they needed to have any invasive medical procedures, such as taking blood for tests during pregnancy or vaginal examination due to possibility of contracting infections in the hospital. Urban women with only secondary school education did not express concerns over safety during visits to doctors or medical

facilities, and they felt that it is safer to have babies at the hospital rather than at home.

It was surprising to hear numerous concerns of urban women with higher education about the possibility of contracting infections, such as HIV or hepatitis C, in health care facilities during regular visits. Also mentioned were dental and gynecologist visits as a mode of HIV or STIs transmission. Several respondents said that they or their children contracted infections during such visits. They also bring example of relatives who contracted infections in a health care facility. This raises concerns about the hygienic situation in the health care facilities in Tajikistan, which is another important aspect highlighted by this research and which should be properly examined and addressed in future studies. However, one might also think that perhaps this is a narrative that women use to render their husband's innocence vis-a-vis infections.

In comparison with the two villages in Sughd and Khatlon regions and Dushanbe city, the situation in terms of antenatal and delivery care is different in other regions. The majority of pregnant rural wives of migrant and non-migrant men in Durbad village of RRS and Garm-Chashma village of GBAO, for example, did not receive antenatal care. In Durbad village of RRS some pregnant women only registered with medical personnel in the middle of pregnancy, because they were afraid that if they did not register, they would not be accepted in the maternity hospital in case of complications during delivery. In Garm-Chashma, a few women said that the nurse registered them and came to their home and checked how their pregnancy was going, and measured their blood pressure. However, many others do

not mention this fact. However, out of all wives of migrant men from this remote village only two left-behind wives with successful migrant men, such as Zaragul and Mehrangez, were able to visit a doctor in the city during their pregnancies and when they had a reproductive tract problem on a regular basis. They were able to go and visit an Ob-Gyn in Khorog town when they are pregnant and have all required examination by the Ob-Gyn from the city maternity hospital and have their blood and urine tests in the city laboratory as well as ultrasound examination during their pregnancies.

The rest of the left-behind women as well as wives of non-migrant men residing in this remote village do not see any health care providers during the entire pregnancy. Very few women said that they only went to have ultrasound examination in the middle of their pregnancy to check how the baby is and how the pregnancy is going, but apart from that they did not see any other medical professionals.

This is perhaps connected with the fact that the wives of successful migrant men were able to afford the transportation cost³⁸ in the town and tests and examination in the city laboratories (some of them are quite expensive). The total amount is quite considerable, because wives of non-migrant men had only small family income in this village, such as a pension of the mothers-in-law, which is 80 *somoni* per month (\$18) or their own or husband's wages of about 120 *somoni* per month (\$30). In addition, many left-behind women receive small amounts of remittances. Health related expenses for one visit to the doctor, without even taking into consideration the cost of treatment itself, is considerably higher than the total

³⁸ The return transportation cost from the village to the town and back is about 30-40 *somoni* (\$10) plus also cost of visit to the doctor 5-10 *somoni* (\$1-2).

income of the entire family. But if the woman needs to be hospitalized, then the cost will triple because then she needs to pay for the ward, tests and so on. When asked about their ability to see doctors, many women in this village mentioned the cost of transportation as the main problem.

The main reason for not using antenatal care services in these two villages for the rest of women is un-affordability of the cost of a doctor's visit during antenatal care and tests, which are required before registering as a pregnant woman. An earlier study also indicates that women cannot meet expenses connected with health care services in the country (Falkingham, 2003). Although officially maternal health care services are free, to augment their low salaries medical personnel impose out-of-pocket fees on women (Falkingham, 2003; Fan & Habibov, 2009). The increase of unofficial informal payments is one of the reasons for reducing utilization of reproductive health care services among women in Tajikistan.³⁹ The current study also states that due to the inability to pay and the poor economic situation women in these two villages do not consult a doctor during pregnancy despite the fact that midwives regularly visit them at home and ask them to come and receive antenatal care. As Favziya, a 33-year old rural left-behind woman from Durbad village of RRS, said: "I need to pay 5 *somoni* for each antenatal visit to the doctor. Instead, I will buy two pieces of soap to wash my children's clothes". In addition, rural women from remote villages, such as Garm- Chashma of GBAO, also complained about the high cost of transportation and unreliable public transportation. This is also supported by the finding of an earlier study, which showed that high cost of transportation in rural as well as urban settings, reduces the visit frequency considerably and may be the

³⁹ On informal payments, see above Chapter 2, pp. 44-46.

cause of delays in using prenatal care facilities even if they provide free comprehensive services. Holtz and Grisdale (2008) reported a similar situation in Zaachila village of Mexico where the majority of indigenous Indian females never received antenatal care, despite free universal health care, due to lack of local health care institutions and acute poverty. A long and costly trip to healthcare facilities to receive antenatal care also discourages many pregnant women, particularly those with small children, from receiving antenatal care. For women in villages located far away from health care facilities, giving birth only with a traditional birth attendant without special medical training is not a matter of preference but a necessity due to limited access to health care facilities (Holtz & Grisdale, 2008).

It is interesting that many reproductive health care providers present a different picture of the state of antenatal and delivery care. They state that they do not even need the money given by the patients and only want them to be registered with the doctor and receive antenatal care. According to the medical personnel, doctors do not charge them, however they need to pay for tests before registration which are not free. Zamira, a nurse in Garovuti village of Khatlon region, said that the left-behind women in the rural areas do not come for antenatal check-ups on time and then the medical personnel try various ways to encourage them to come. She says:

We then tell them that they need to come; we do not need their money, just come and have a check-up by the Ob-Gyn. Our tests cost money and the women would say that they have not received money from their husbands yet. And this is the kind of problem we have. There is a difference between those whose husbands are away and those whose husbands are here. We even ask

them to come and pay for the tests only after their husband sends them the money. We explain this to them and only then they come.

In addition, women have to be examined by the doctor-therapist (a western term for which would probably be General Practitioner), an ophthalmologist and a dentist (all of whom they need to pay for their consultation) before their registration with an Ob-Gyn. Before registration with the Ob-Gyns they also need to have blood and urine tests as well as ultrasound examination depending on their pregnancy period. In some cases, the doctors and facilities where women need to have tests are in completely different locations. According to Sadokat, a 41-year old left-behind woman from Dushanbe, it is very inconvenient, discouraging and frustrating because they have to go to different places to see doctors and have their tests as well as pay for all of them.

At the same time, a rural women in Durbad village stated that nurses from the reproductive health care services come and ask them to visit a doctor in the health care facility, be registered and be under doctor supervision during pregnancy. Despite the visits of nurses urging them to come to see a doctor, both rural wives of migrant and non-migrant men in Durbad village do not refer to a doctor or visit a health care facility during their pregnancy. The main reason again is the lack of money. Falkingham (2004) believes that a possible reason for this is the remoteness of places of residence of the patients from reproductive health care facilities. As a result, women in these settings are less likely to receive antenatal care during their pregnancies in comparison with those settings that have these facilities. This may explain why women in both villages, where there is no reproductive health care

facility within a walking or at least close distance, do not consult a doctor during their pregnancy.

Although the majority of wives of migrant men do not go for antenatal care during pregnancy in Durbad village of RRS, all of them deliver their babies in the hospital. However, all rural women from the remote village Garm-Chashma have their babies at home unless they develop complications during pregnancy or delivery and only then they go to the maternity hospitals. It was observed that with increasing distance of location from the city, the referral of wives of migrant workers to health care facilities decreases. This is connected with the increase of transportation cost in addition to cost of health care services in the maternity hospital. In this situation, only wives with successful migrant husbands can afford antenatal care during pregnancy. Moreover, interviews with Latifa and Salomat, urban left-behind women who lived in Rasht valley before they moved to Dushanbe, showed that when they lived in villages in the valley they did not see any medical personnel during their pregnancies, nor did they have any tests or ultrasound examinations. In addition, since the village of Latifa's husband was far away from the administrative center of Rasht valley, she only had her first baby in the regional maternity hospital and the rest she had at home with the help of traditional birth attendants. In addition, left-behind women who used to live in Rasht valley, said that their children born and grown up in the valley did not receive any vaccinations.

Some women in both villages even said that they had their babies at home completely alone and without anyone around them - no relatives and no friends, let alone medical personnel. When I asked whether they were scared of giving birth to a

baby completely alone, one of them responded: “I believed in myself and knew that everything would be fine”.

A number of rural women from Garm-Chashma village of GBAO said that they feel safer to have a baby in the hospital:

It is better to deliver the baby in the hospital, because if something goes wrong it is safer to be there. Otherwise, when things go wrong, it is difficult to arrange for a car and find gas to reach the hospital on time.

However, lack of money does not allow them to deliver their babies in the hospital and they risk complications and deliver their babies at home. Falkingham (2003) states that antenatal care is a crucial factor for improving outcomes of health in infants, while attendance of well-trained and equipped medical personal during delivery is the main determinant in decreasing maternal mortality. Therefore, the lack of access to antenatal care in both these villages and home deliveries without trained attendants or delivery with the help of unskilled birth attendants (and, in some rare cases, completely alone) in these two villages are issues of great concern that need to be addressed. It seems that giving birth at home becomes a norm for both groups of women in Garm-Chashma and Pish villages of GBAO, whereas not receiving antenatal care is common in Durbad village of RRS and Garm-Chashma village of GBAO.

The experience of women in various villages within the same region can be completely different. Only two wives of migrants received antenatal care during pregnancy, but even they delivered their babies at home. Similarly to the rest of the

women in their village, the majority of both groups of women in Garm-Chashma village of GBAO did not receive antenatal care and delivered their babies at home.

The women in Pish village of GBAO have different experiences. All wives of migrant men said that when they get pregnant, the nurses from the local medical point register and take them under their supervision and send them to Khorog, located about 7.8 miles (13 km) from the village, with the return travel costing 6 *somoni* (less than \$1.5). On the request of the nurses, they have their blood and urine tests, and ultrasound examination in the city laboratories and medical facilities. However, the majority of wives of migrant men said that they also have their babies at home. Only those wives of migrant and non-migrant men who have been advised by the nurses due to complications, have delivery at the hospital from this particular village. If the nurses see that women do not have any complications during pregnancy or it is not their first pregnancy, the nurses usually assist with the delivery of their babies at home. However, other women were advised to deliver at the hospital because the nurses were not confident to help them with delivery at home. The data show that there is no difference in antenatal and delivery care between wives of migrants and non-migrants in Pish, but the left-behind women with successful migrant husbands in Garm-Chashma village were able to receive antenatal care. Therefore, migration does improve access to antenatal care for a very small number of left-behind women.

It must be mentioned that there has not been any maternal death in Pish village so far according to the interviews with women, although the majority of wives of both migrant and non-migrant men delivered their babies at home. One of the possible explanations for why wives of migrant men in Pish village receive good antenatal care

is that the nurses work very well and do their job by making sure that women receive antenatal care which is free. However, the nurses do not encourage or send women to the maternity hospital for delivery because many cannot afford it and also because when they assist delivery they get paid or have some small income. If women go to the hospital for delivery, the nurses lose their income. Therefore, while the nurses in the village make sure that all pregnant women have all tests and ultrasound examination and regular antenatal care check-ups during pregnancy, when it comes to delivery they attend the deliveries at home and do not send them to the hospital so as not to lose their income. Many women from Pish village highlighted that they have a very knowledgeable and experienced midwife and they trust her a lot. If a birth is without complications, delivery at home is a good option. However, if there are any complications, there is very little chance that there are any health facilities in the village or access to emergency services, especially during winter time when the roads are often blocked due to snow, landslides and rockfalls.

They also mentioned that if the midwife is not confident about a particular pregnant woman, she does not take the responsibility to attend her delivery and sends her to the hospital for delivery. In these cases, they go and have their babies in the Khorog maternity hospital. The midwife is also able to recognize any complication promptly and immediately refers them to the maternity hospital. It is perhaps due to timely recognition of complications in pregnancies and referral of pregnant women with complication by the “knowledgeable specialist” midwife in this village, who has been successfully attending many deliveries over the last 20 years after the dissolution of SU, that there have not been any complications and maternal deaths in Pish village so far according to wives of migrants and non-migrants. However, many women in

Garm-Chashma reported that some women died during their deliveries due to different complications in this village.

All reproductive health care providers, in relation to the question on the antenatal and delivery experiences of the left-behind wives and women married to non-migrants, agreed that since the wives of migrants are more likely to have STIs, they also have more complications during pregnancies and deliveries in comparison with wives of non-migrants. In addition, the left-behind wives' newborns also have worse health outcomes. Ob-Gyns working in reproductive health centers, gynecological departments and maternity hospitals in various regions state that the left-behind wives have high levels of miscarriages, non-developing pregnancy, stillbirths and infertility. In comparison with the left-behind women reproductive health outcomes are even worse among migrant women, namely those who migrate to work or stay with their husbands in Russia. The doctors connect it with the negative effects of migration, because they noticed that the same complications during pregnancies occur, but very rarely among women whose husbands never migrated. Sabina, an Ob-Gyn in GBAO, said:

There are so many cases of non-developing pregnancies, miscarriages and stillbirths, and anomaly of development of the fetus. If the fetus is not miscarried, then it definitely has some kind of anomaly. There are so many viruses among women now. Anomalies are mainly among those women whose husbands migrate.

Doctors working in maternity hospitals in rural regions as well as Dushanbe also state that in comparison with those married to non-migrants, wives of migrant

men are similarly more likely to have complications during deliveries and their newborns also have worse health outcomes. Farida, a doctor at the maternity hospital in Dushanbe, said:

Wives of migrants often do not have breast milk, and they have more complications during pregnancies, including fever. They have more somatic diseases such as problems with kidneys, thyroid gland (goiter) and endocrinological illness. Often, they do not have any examination or tests.... Because many of them do not have breast milk, the baby begins to suffer and loses weight. Then their newborns are transferred to the second stage of care because of weight loss, hyperthermia and other problems.

The opinions of the reproductive health care providers were divided with regard to possible differences between the antenatal and delivery experiences of wives of migrants and non-migrants. One group of providers agreed that the wives of non-migrants receive more support and care of their husbands, while the wives of migrants do not have it. The wives of non-migrants also receive more support from the extended family and relatives during delivery and post-delivery period. Farida, a doctor of the maternity hospital in Dushanbe, said:

They (i.e. left-behind wives of migrant men) do not pay even attention to their babies. They constantly think: “why my husband does not call; where is my husband? How is he?” As soon as they give birth to the baby, they start looking at their phone. Usually, only the mothers-in-law call to ask who was born. Nobody worries about them or asks about their condition. Rarely someone visits them or brings them something. It also depends on what kind

of relationship they have. It seems that the baby of wives of non-migrants is wanted. The non-migrant husbands come with their wives to the maternity home, they come as a partner during the delivery, help their wives, massage their back, and help them in every way. They are with their wives during delivery. They also visit them often after delivery. They support them morally and psychically and, therefore, their wives are happy and content. They pay more attention to their kids, their kids' nutrition is better. As a result, their wives are psychologically calm, sleep better and have breast milk. Wives of migrants are always restless, nervous, they are very slim and their nutrition is poor... The maternity home provides patients with food, but it is not sufficient and is usually topped up with the food brought by family members. However, very often this is not the case with the wives of migrants. Some wives of non-migrant men also have social problems, but I think, the intensity and complexity of these are usually less among wives of non-migrants.

On the other hand, another group of reproductive health care providers such as Oftoba, an Ob-Gyn in the reproductive health center in Dushanbe, states that although the migrant husbands are away:

They are very concerned about their wives' pregnancy. Women discuss the issues with their migrant husbands on the phone and, if they have any problems, their husbands send medicines for them from abroad. There were also cases when husbands called us and asked about the condition of their wives and their babies.

Therefore, it is clear that although husbands of the left-behind women are away and cannot be present and support them during pregnancy and delivery, many are genuinely concerned about their wives, care for them and attempt to support them from abroad in the best way they can.

Although the reproductive health care providers believe that the left-behind wives use reproductive health services more often when they experience reproductive health issues, however, they do not think the same about their access to antenatal and delivery care.

Summary

This chapter shows that, on the one hand, male labor migration may worsen reproductive health of the left-behind women, but, on the other hand, improves their access to reproductive health care institutions through remittances. The research also demonstrates that while the interviews with the wives of migrants and non-migrants show only a slight difference between the reproductive health morbidity of these two study groups, the reproductive health care providers believe that wives of migrants have more STIs, which they also consider the main reasons behind more reproductive health morbidity and complications during pregnancy and deliveries. The providers believe that miscarriages, non-development of pregnancies, stillbirths, anomaly of development of the fetus, infertility and delivery with complications as well as worse outcomes of newborns are more common among the left-behind women. They also believe that the same complications occur but very rarely among wives of non-migrants.

The research also shows that migration improves access of the left-behind women to the reproductive health care services both in urban as well as rural areas. The majority of wives of migrants reported improvement of their access to health care facilities after migration of their husbands. In addition, it seems that while women describe their access after the migration of their husbands as *improved*, some providers describe their access as *increased* because of more STIs and reproductive morbidity.

In addition, although both women and providers list some of the common reasons behind the improvement of left-behind women's access to reproductive health care system, they also mention some differences. The women mention such reasons as: steady flow of remittances, husbands' encouragement to see a doctor, access to money, improvement of the living situation along with living in a nuclear family and gaining more decision-making power. The reproductive health care providers believe that emergence of more reproductive health issues among the left-behind women leads to more referrals to reproductive health institutions. However, they also mention remittances, improvement of knowledge of migrant husbands and their health-seeking behaviors and encouragement to refer to a doctor when health issues occur. However, the health care providers think that this increase has a seasonal character. In addition, some doctors also connect the increased referral with the individual characteristics of the left-behind women, their open and courageous attitude in seeking help. This is seen comparatively rarely among the wives of non-migrants.

Finally, cultural particularities, such as the need to be accompanied by a husband or a mother-in-law during the visit to a doctor in some parts of the country,

contributes to delayed referrals and further exacerbated forms of reproductive health issues among the left-behind women compared to wives of non-migrants. If some reasons, such as availability of money through remittances and husbands' insistence on seeing a doctor, were mentioned by both women and providers, other reasons were mentioned only either by women or by providers. It is clear that knowing these reasons is important for developing health care programs to improve reproductive health of this vulnerable social group in the country. According to the health care providers, the left-behind women have more obstetrical complications, which "are the leading cause of death for women of reproductive age in developing countries today" (Holtz & Grisdale, 2008, p. 450). Therefore, it is crucial to improve the reproductive health care of the left-behind women and prevent obstetrical complications and maternal mortality among them.

However, the analysis also shows that migration does not have a significant influence on access to antenatal and delivery care services. There is little difference between experiences of wives of migrants and non-migrants in all regions, because access to antenatal and delivery care depends to a great extent on the functioning of the antenatal and delivery care system (the reproductive health care system). In those regions where the system functions properly, the experience of both groups is largely the same.

CHAPTER 8

CONCLUSION AND IMPLICATIONS

The main purpose of this research is to understand how international labor migration of husbands impacts the sexual and reproductive health of their wives left behind in Tajikistan. A number of important studies have already been undertaken among the wives of labor migrants to understand reproductive morbidity (Roy & Nangia, 2003), STIs including HIV (Coffee et al., 2005; Collinson et al., 2006; Golobof et al., 2011; Hunt, 1989; Mundandi et al., 2006; Sevoyan & Agadjanian, 2010; Sharma et al.; 2012; Zuma et al., 2005), fertility (Agadjanian et al., 2011a; Clifford, 2009; Sevoyan, 2011), contraceptive use and abortion (Lindstrom & Saucedo, 2002; Lindstrom & Munoz-Franco, 2005; Sevoyan, 2011; Sevoyan & Agadjanian, 2013), and condom use (Bond & Dover, 1997; Dladla et al., 2001; Hong et al., 2009; Hughes et al., 2006). However, this study provides a unique opportunity to use qualitative research based on detailed study of the issues involved in examining any changes in the health status of left-behind wives. In this way, I hope to add to the existing literature, most of which was based on quantitative methods.

This study thus examines the relationship between male international migration and some key aspects of reproductive health, including fertility and contraception behaviors, knowledge of HIV and use of HIV prevention measures, reproductive morbidity and access of women to the reproductive health care services including antenatal and delivery care. As part of this study, data has been collected from a sample of left-behind wives and a control group of women whose husbands never migrated to look at similarities and differences of their experiences. In addition,

the study also provides perspectives of medical professionals regarding reproductive health issues of wives of migrants and non-migrants.

In this chapter, I present concluding remarks on the issues discussed in the previous chapters and discuss their implications for future research on the subject as well as for practical steps and programs aimed at improving the health status of the left-behind women.

Fertility and contraception

One of the main objectives of the research was to enhance understanding of how male labor migration impacts fertility and contraception behaviors of the left-behind women in Tajikistan and to demonstrate any similarities or differences in the experiences of women in these study groups. The research shows that migration does not have a significant impact on the fertility of the left-behind women who stay back home, because both wives of migrants and non-migrants had the same average number of children in this sample. These findings are similar to the results of the study in a low fertility origin area – Armenia. Sevoyan (2011) in the study in Armenia also argues that seasonal labor migration did not disrupt the pregnancy rates and lifetime fertility among the left-behind women. She argues that pregnancy rates are similar among wives of migrants and non-migrants due to the seasonal character of migration, older age of migrants and use of contraception in areas below replacement fertility level.

The study suggests several possible explanations for the lack of impact of migration on fertility of the left-behind women. Potter and Kobrin (1982)

demonstrated that short-term and irregular separation has little impact on fertility of migrant couples, but a single long-term separation for two or more years or regular separations of migrant couples had considerable effect on births among population.

Tajikistan is characterized by a seasonal pattern of migration; therefore, migration does not impact fertility of the left-behind women. In addition, disruptive effects on fertility due to new fertility norms, values and behaviors brought by migrants were reported in areas with a long history of migration and a high prevalence of women among migrants (Lindstrom & Saucedo, 2002). Although migration was historically common in Tajikistan, the country did not experience anything similar to the recent pattern of mobility of males. Moreover, the majority of Tajik migrants are men (Clifford, 2009), which may explain the lack of influence on fertility. Earlier studies show that it is the migration experience of a wife which significantly contributed to the decrease of fertility in the origin communities rather than that of a male spouse (Lindstrom & Saucedo, 2002).

Thus, migration of women has a stronger effect on fertility in comparison with the migration of men. Finally, a previous study indicated that illegal status of migrant workers constrains social interaction and integration of migrants in receiving countries (Lindstrom & Saucedo, 2002). Many Tajik migrant workers are without proper documentation in Russia (Weine et al., 2008), which limits social interaction and assimilation constraining the influence of migration on fertility of the women left back home in Tajikistan.

Furthermore, the current study clearly illustrates that migration of men has an impact on contraceptive use of the left-behind women. It supports the findings of

previous works showing that the use of contraception is low among the left-behind women because of low frequency of coitus, reduced risk of pregnancy and increasing demand for children as a source of labor and support in insecure social and financial relationships among migrant partners (Kaufman, 1998; Sevoyan & Agadjanian, 2013). However, unlike previous studies, it shows how these changes occur, which has not been studied hitherto. Thus, the study shows that male migration plays an important role in changing contraceptive use among the left-behind wives. It also shows that analogous changes in contraceptive behavior are not reported among the wives of non-migrants. The dominant change among some left-behind wives is the seasonal removal and insertion of the IUD and a shift from long-term contraception use, such as IUD and Depo-Provera, to short-term contraceptives such as spermicides, films, vaginal suppositories and condoms as well as traditional methods of contraception such as withdrawal.

The practice of seasonal removal and insertion of IUD and a shift from long-term to short-term methods of contraception were reported not only by the left-behind women in both urban and rural areas, but also by reproductive health care providers almost in all settings where they have been interviewed. However, the practice of seasonal removal and insertion of IUD is observed more frequently among left-behind wives from households with higher income or, in other words, among women with successful migrant husbands. The providers also argue that left-behind women refer to them for contraception after the return of their husbands due to an increased demand for contraception. They also reported that the left-behind wives asked them to remove their IUDs or started using short-term contraception. The findings of the study are also in line with Tajikistan DHS 2012, which indicated that the trend towards

reduction of contraceptive use might have been due to migration of men in Tajikistan (STA, MoH, & ICF, 2013).

However, the same changes mentioned above do not occur in contraceptive behaviors of wives of non-migrants who usually use contraception throughout their lives. The study shows that the IUD is a dominant method of birth control among wives of non-migrants. Though many other forms of contraception are provided by reproductive health centers of the country, the pattern of contraceptive use centered on the IUD, dominant during the Soviet period, continues to exist. The second most common contraceptive reported by wives of non-migrants is Depo-Provera. However, many wives of non-migrants associated the use of this contraception with risks of myoma. Several wives of migrants interviewed as part of this study also reported the same health problem after using Depo-Provera. While reproductive care providers describe several important details of contraceptive use and changes after migration of husbands of the left-behind women, they only state that wives of non-migrants use long-term contraceptives among which IUD is the dominant method.

The objective of the study was also to examine the impact of socio-cultural, economic and religious factors on the relationship between migration and fertility and contraceptive use. One of the important findings of this research was the discovery of the significant impact of social networks/social interactions through interpersonal communication and observations on contraceptive use among women in Tajikistan. The interviews with wives of non-migrants indicate that social networks have a significant influence on promoting use of contraception. However, negative experiences of friends, neighbors or relatives with certain types of contraception can

also impede access of women to contraception. Of course, avoiding contraceptives which trigger side effects is a good option, however, the women then have more abortions leading to further health issues and enforced pregnancies. Thus, the social networks play both positive and negative roles in contraceptive use. Surprisingly, many reproductive health providers also suggest that social networks have more impact on choice of contraceptive methods among women, irrespective of their husbands' migration status. This was contrary to my expectation, because I thought that it would be the medical personnel who encourage and advise women on contraception use. Therefore, the suggestion of Lindstrom and Munoz-Franco (2005) to attract non-professional members of the community to the promotion of contraceptive use among Tajik women could possibly increase use of contraceptive in the communities where social networks have influence on contraception utilization.

It is shown that utilization of methods of contraception is related to education, urban/rural place of residence and wealth/economic situation (Kaufman, 1998), which, as the current research demonstrates, is also true for Tajik women. This study also finds positive association between higher education, urban place of residence and wealth of women, irrespective of the migration status of their husbands, and contraceptive use. The providers believe that irrespective of the migration status of women, all women with higher education and living in urban settings and those from households with higher income are more likely to use methods of birth control in comparison with women who have only primary or secondary education, those from households with limited income and those living in rural areas. Previous study illustrates that women use more contraception in districts that are better developed because of the availability of health care services (Kaufman, 1998). It also shows that

in the settings where women are better educated use of contraceptive is higher (Kaufman, 1998). This research shows that contraceptive use is higher among wives of migrants in GBAO and Sughd region. If economic development can be a possible explanation for the high rate of use of contraception in the latter region, the better contraceptive knowledge of women may explain the high utilization of contraception in the former region, which is otherwise the poorest region of the country. The data show that whereas exposure of the left-behind women to awareness raising campaigns and trainings on contraception in GBAO was instrumental in increasing condom use there, improved economic situation of the latter region is behind the increase of condom use there.

This research also shows that women consider payment for contraception as one of the most significant barriers in the use of contraception. Only a few medical workers say that they charge patients for contraception due to the service or materials used for their insertion. The majority of the medical personnel report that they provide contraception for free, because they receive them as humanitarian aid and distribute them for free. Thus, the providers do not admit charging women for the contraception. However, all women in this study, irrespective of the migration status of their husbands, reported that they had to pay for their contraceptives. In addition, the study shows that cost of contraception is one of the main issues obstructing the use of contraception especially among wives of non-migrants who need to use them on a regular basis.

Although UNFPA provides all reproductive health centers with free contraception, all women in the study reported that they had to pay for all

contraceptive methods they used. Despite the fact that the majority of providers do not report charging women for contraception, it is crucial to guarantee access of women to free or lower contraception cost. It is also important, as this research shows, to make contraception easily accessible for wives of migrant and non-migrant men, especially those in rural remote areas. Comprehensive sex education proved to be extremely effective in preventing teenage pregnancies, unintended pregnancies, whereas promotion of condoms use helped women to be protected from both pregnancy and STIs, as observed in Scandinavian countries (Knudsen, 2006). It would be very useful to implement similar comprehensive sex education programs in Tajikistan. However, educational programs should not be limited to comprehensive sex education at school, but also expand to educational programs for women in communities to improve their knowledge about contraception, types of birth control methods, their side-effects and benefits and also places where they can be obtained with no charges.

It is crucial to carry out measures such as HIV education interventions that contribute to the improvement of knowledge of wives of migrants as well as non-migrants about HIV, HIV tests and use of condoms. Similar to these interventions, education measures on contraceptive use will hopefully result in changes in contraception behaviors to reduce unintended pregnancies, prevent abortions, maternal morbidity and mortality, and improve overall reproductive health. It is important to implement strategies for promoting the advantages of contraception methods to replace abortion as a method of controlling childbearing. Otherwise, availability of modern modes of contraception will not lead to increase in the use of contraception (Sevoyan & Agadjanian, 2013).

Thus, it would be particularly useful to implement interventions to increase knowledge about modern methods of contraception and their use among both urban and rural women (Lindstrom & Hernandez, 2006). It would be more effective to incorporate HIV/STIs awareness raising prevention interventions with programs on contraceptive use (Lindstrom & Hernandez, 2006). This would not be difficult, because as indicated by the data, the medical professionals from reproductive health facilities are hired by local and international organizations to conduct awareness-raising campaigns among left-behind women. Since the main target of these education campaigns are the left-behind women, it does not require any further special approaches.

As this study shows, education for women is one of the best interventions for improving sexual and reproductive health of women in the country. The necessity of improving access of women to education has also been emphasized by previous studies on HIV (Brockerhoff & Biddlecom, 1999; Hartman, 2005; Knudsen, 2006). This study is in agreement with previous works, but the narratives of women and health workers and staff of organizations illustrate that women with higher education have higher use of contraception, lower fertility, better health outcomes, better knowledge about HIV, better access to reproductive health care, more decision making power and they are in control of their sexuality and life. Therefore, the data show that education attainment is one of the most important aspects affecting the reproductive health of the women left behind. Demographers have also been promoting women's education as the main strategy to reduce fertility and to increase contraceptive use for a long period of time. Education for girls would also contribute

to improving gender equality. Unfortunately, education of girls is being prevented by increasing religiosity in many regions of Tajikistan.

Shortage of reproductive health care institutions providing contraception in some remote rural areas is another barrier for the lack of access of left-behind women to contraception and should, therefore, also be addressed. Despite the availability of various contraception methods in many reproductive health centers in urban areas, access of women in rural areas is limited and unmet needs are high. Therefore, more interventions similar to the one in GBAO conducted by Agha Khan Foundation with the collaboration of MoH are needed. This initiative that helped to train midwives on IUD use so that they can provide services in their own villages, should also be conducted in other regions of the country. It could reduce expenses related with contraception for women and decrease unmet needs among rural women. GBAO, where midwives from rural areas were trained in IUD insertion and removal, can serve as an example of how to improve access of rural women in remote villages to methods of contraception and increase its use. This region, according to interviews with providers and DHS 2012, is characterized by high rates of contraceptive use and low fertility. Similar training provided for midwives could serve as an effective intervention in promoting contraceptive use in remote rural areas and make contraception accessible in other villages.

A previous study demonstrated that a highly accessible family-planning program is likely to lower the associated informational and travel costs, and likewise decrease the importance of the socio-economic factors (Kaufman, 1998). These

findings are important for practical implications in Tajikistan with high fertility and low contraceptive use, which according to DHS 2012 is decreasing even further.

The results of the study show changes in contraception behaviors of the left-behind women and particularities of contraceptive use of wives of non-migrants. The study also examined other socio-economic and cultural factors on contraceptive use and fertility behaviors and showed that understanding their impact could benefit policy or interventions and should be taken into account by policymakers. However, the changes in contraception behaviors of the left-behind wives presented in this study should serve as a baseline data and should be researched in more details to broaden and enhance our understanding of the relationship between migration and contraceptive use.

HIV knowledge and prevention measures and skills

Another important aim of the research was to understand the knowledge of HIV among the wives of migrants and non-migrants, the main sources of information about this infection and options they used to protect their health. Moreover, it endeavored to gain information about their ability to negotiate and use HIV prevention measures. Interviews with women as well as with health workers and staff of local and international organizations show that educational attainment (i.e. having higher education) is directly associated with better knowledge of HIV infection among wives of migrants and non-migrants in urban as well as rural areas. Golobof et al. (2011) also revealed that level of knowledge of wives of migrants depends on the level of education, because left-behind women with higher education knew more about HIV/AIDS. Unlike the previous work, however, this study illustrates that the

majority of wives of migrants with higher education, irrespective of their place of residence, do not use HIV prevention measures such as having sex with the use of condoms and asking husbands to have an HIV test despite being aware of these prevention measures.

In addition, the study shows that rural left-behind women with secondary school attainment exposed to education interventions, such as attending seminars on HIV/AIDS and their prevention, are better aware of HIV and used HIV prevention measures more than did women with similar education levels living in urban areas. This research also shows that many left-behind women still cannot protect themselves, which is a great concern and has also been noted in previous studies. Hughes et al. (2006), for example, associate the inability to practice HIV prevention measures with poor communication between sexual partners, while Golobof et al. (2011) relate it with the lack of ability to discuss matters of sexual health out of fear of violence and abandonment. Lack of ability to discuss condoms use was also reported by a study on the same issue in Mozambique (Agadjanian et al., 2011b).

However, the findings of this study show that some rural wives of migrants are able to use HIV prevention skills either by refusing sex altogether or by insisting on condom use with migrant husbands after their return from Russia. They also managed to insist that their husbands have an HIV test. As mentioned earlier, it is important to stress that 22% of the left-behind women were able to protect themselves from HIV infection. The study shows that even in a Muslim society where "most women, especially in rural communities, are socially and economically dependent on their spouses" (Hughes et al., 2006, p. 437), some women successfully applied

prevention measures once they were aware of the dangers of HIV/AIDS. These women received correct information and had face-to-face conversation with health workers. Thus, they became concerned about contracting HIV. These women were in longer marriages and were therefore quite confident to talk to their partners about prevention measures and perhaps still had the confidence inherited from the Soviet period.

Moreover, many Tajik left-behind women who used HIV prevention measures with their returning migrant husbands were predominantly from rural areas of Tajikistan, economically dependent on their migrant husbands, with remittances being their only income in the families. Despite the fact that the number of wives of migrant men who were successful in practicing HIV prevention is low (13 out of 58 wives of migrants in the research sample), it is nevertheless encouraging. It is hoped that more women will be able to protect themselves with the help of medical personnel and staff of local and international organizations. However, for this to happen and to be more effective, they must continue conducting prevention work in the country in a more effective and comprehensive manner. It is also hoped that these women will serve as an example to other wives of migrant men in various parts of the country and also in other settings, such as South Africa. This finding will help to spread the following health promotion message: if women have access to and receive correct information, then even in a patriarchal Muslim society they will be able to protect themselves successfully.

Prevention of HIV and STIs among migrants is crucial because previous works indicate that migrant men, who contracted infections from casual sexual

partners, infect their rural partners after their return from migration (Hong et al., 2009; Lurie et al., 2003a). However, women should be also educated to ask husbands to have tests for other STIs, since awareness and prevention of STIs can reduce reproductive morbidity and complications during pregnancy, deliveries and post-delivery periods among them and their newborn babies.

Findings of this study stand in contrast with the results of many previous studies such as that of Hughes et al. (2006), who argue that standard prevention interventions asking females “to take initiative and protect themselves against STIs and HIV” work mainly among CSWs (p. 437). This study showed that the typical prevention message asking women to protect themselves from HIV actually did work and some left-behind women used condoms with their migrant husbands, while others refused to have sex altogether and asked them to have an HIV test.

The finding of the study is also against the argument of the previous work which suggests that partners have fewer opportunities to communicate about sexual and reproductive health issues in relationships that are stable and long-lasting because they are confident that they know each other and have regular sexual activity (Hughes et al., 2006). This study provides contradictory results that many women who actually were able to refuse sex or used condoms and asked their husbands to have an HIV test for short-term, were married for a fairly long time.

It is crucial to take active steps to challenge the dominant discourses that left-behind women are not able to protect themselves due to social and economic dependence on their husbands. The existing studies focus more on the inability of women to negotiate condom use or ask migrant husbands to have a test for HIV or

other STIs. At the same time, they ignore those women who are able to negotiate condom use and force their husbands to have an HIV test. Thus, I argue that it is important to highlight these cases and the success of these women who are able to protect themselves by using condoms with their returning migrant husbands and asking them to have an HIV test. This process must be presented as a normalizing practice in the literature and media to help the left-behind women to be more confident in using them and developing comfort to discuss prevention measures with their migrant husbands to control their health. It will also help with the awareness raising efforts among the population in Tajikistan and other countries.

Moreover, it is similarly useful to examine modes of sharing information about how the women learned prevention skills, their sources of knowledge, the effectiveness of sources and skills they used to talk to their husbands in future studies. It is crucial to add alternative discourses to the existing literature on migration, health and left-behind women about the ability to use condoms and an HIV test, but the emphasis should also be put on tests for other STIs as well.

In addition, this study suggests that many women struggle even to receive accurate and reliable information from whatever source. It also revealed that some women have access to limited, poor quality and inadequate knowledge which is detrimental for promoting a healthy lifestyle. The findings of this study illustrate the significant impact on the promotion of HIV protection measures through attending awareness raising campaigns and being exposed to ad campaigns on TV. Thus, it is crucial to advocate provision of accurate, reliable and comprehensive information and knowledge from effective and numerous sources. This is because many of the rural

left-behind women do not have access to wider information and education resources due to economic and social isolation and challenges (e.g. lack of electricity even during summer time, lack of access to training on HIV and other STIs, and lack of access to internet and mass media). This information is crucial for prevention programs and policymakers, and for those who develop and implement these programs. It is important to take them into consideration because of high STIs and HIV rates among migrant men reported in other studies from other parts of the world as well as the fact that studies indicate a high rate of sex with CSWs among Tajik migrant men in Russia.

The study also shows the importance and efficacy of conducting health promotion activities such as seminars, trainings and awareness raising campaigns among migrant workers and their families by state agencies, local and international organizations and health workers. This is because the interviews demonstrate that the majority of left-behind women who were able to protect themselves by using condoms and asking male spouses to have an HIV test were participants in these activities. Thus, 11 out of 13 left-behind women who succeeded in negotiation of HIV prevention had participated in such activities (Table 5). However, several shortcomings of the awareness raising campaigns should be taken into consideration in the future while developing and implementing prevention campaigns, such as: 1) covering both young and older women; 2) covering not only rural, but also urban left-behind women, especially those with a lower level of education; 3) covering wives of non-migrant men; and 4) some interventions such as distribution of education and information materials on HIV was not effective in promoting HIV prevention measures.

It was particularly disturbing to learn that some wives of non-migrant men think HIV/AIDS is only a problem that migrant couples can face and they do not see themselves at risk of the infection. Even wives of non-migrant men who attended seminars recommending HIV prevention measures, when asked about their own experience, almost always refer to the wives of migrant men refusing to accept that they themselves might also be at risk.

At the same time, a few wives of non-migrants asked their husbands to have tests for STIs but could not succeed in persuading them to go for a test. Although most of the wives of non-migrants do not belong to vulnerable groups, it would, nevertheless, be useful to promote knowledge of HIV and other STIs among both groups of women during prevention campaigns. The data show that some wives of non-migrants also improved their knowledge of HIV after attending awareness raising campaigns. However, they failed to negotiate HIV prevention measures with their husbands, even though they were aware of the extramarital relations of the husbands. The interviews show that most of the wives of non-migrants who contracted STIs either had husbands that were injecting drug users or had extramarital sexual relations.

This study also indicates that media campaigns are successful in promoting condom use and an HIV test among migrant husbands. However, media campaigns could be more effective when combined with personal consultation or other awareness raising campaigns. The research also demonstrates that although distribution of information and education materials on HIV on their own increased awareness of both wives of migrants and non-migrants, it does not result in the implementation of HIV prevention measures. The study shows that comparatively more wives of migrants

exposed to education intervention were better positioned to use condoms during sex and ask returning migrant husbands to have an HIV test. In general, combining several HIV prevention measures and implementing them in tandem is more effective than implementing only stand-alone programs. Even more effective are personal conversation as well as seminars and training.

In addition, it is evident from the findings that access to HIV tests should be made easier, because women from remote rural areas reported that they have to travel to the administrative center of the region to have an HIV test. An HIV test is the first step to access care and treatment for HIV and other forms of STIs. Therefore, it is important to provide access to other modes of care, treatment and medical and social support for those who are diagnosed with HIV/STIs. Certainly with the increase of access of the left-behind women to an HIV test, the possibility of diagnosis of the infection increases. Access should especially be made easier for women living in rural areas, because some of the rural settings simply do not provide any services. However, the majority of migrant men are from rural areas in Tajikistan. Women from these areas have to travel a long distance to have an HIV test despite the fact that the test itself is free all over the country and no one reported paying for it.

This study supports Hughes et al. (2006) who argue that “there is a need to go beyond interventions that simply seek to modify the behavior of women and men without altering forces that promote risk taking and discourage risk reduction, particularly oscillatory migration” (p. 438). The current study, similarly to previous works (Collinson et al., 2006; Lurie, 2006; Roy & Nangia, 2003), also considers structural strategies with moving labor markets to the rural areas or more frequent

visits of migrants home are possible solutions for the problem, although they are challenging. However, it also takes into consideration the finding of a study by Coffee et al. (2007), which states that more frequent travel between migration and work did not contribute to reduction of HIV infection.

Because structural interventions are very expensive to implement, the current study supports the application of interventions to reduce high-risk-sexual behaviors (Coffee et al., 2007) as a crucial step for fighting the spread of HIV/STIs. For example, Bond and Dover (1997) consider that condoms are an important means of preventing spread of STIs, including HIV, many migrant laborers have sex out of marriage once they leave their home country (p. 389). In addition, health workers and staff of organizations suggest that more migrant workers should take their families along with them to the place of their employment, a tendency which is observed among the younger generation of Tajik migrant workers.

Although structural interventions discussed above are the best measures, taking into account the current economic situation in the country, it is impossible at least in the near future, to consider or rely on those. Therefore, it is important that other prevention strategies should be highly and actively promoted among the population. Lurie et al. (2003a) suggest implementing prevention measures in the place of work for migrant workers. This can indeed be very useful, because it seems that currently the majority of HIV prevention measures are directed at the left-behind women, a concern that has also been voiced by Booth (2004), who argues that although often women live within gender norms and are restricted by male partners, many HIV prevention measures are only directed towards them.

Hughes et al. (2006) suggest that partners of migrant men should not shoulder the responsibility for decreasing STIs including HIV infection, but they need to be provided with skills and tools to deal with this issue. However, without changing the perception and understanding of men, it is almost impossible to change the situation around HIV/AIDS and STIs, as well as reproductive health issues. Therefore, this study supports the arguments of previous studies that interventions should be conducted among migrant couples “as a social unit and not just with one or the other partner” to achieve tangible results (Dladla et al., 2001, p. 2251). Thus, the data shows that even when some left-behind women wanted to protect themselves, their husbands refused to agree to practice safe sex. Moreover, several cases among the left-behind women also showed that infected men did not disclose their HIV positive status to their wives or refused to go for a test. I am confident that when both ends of the migration process are covered with prevention interventions, they will be more beneficial. This is especially important for couples where women do not have power and voice or cannot protect themselves. Therefore, unless, the knowledge, awareness and perception of the men about HIV and other STIs change, prevention measures will not bring about significant positive changes.

Moreover, the findings of this study are in agreement with previous studies which show that women living in rural areas have limited access to reliable prevention measures irrespective of the migration status of their sexual partners (Lurie et al., 2003a). This is an important point because increase in the knowledge was found to be associated with increased use of prevention measures. In other settings, it was shown that transmission of HIV was happening among non-migrant populations in rural areas (Lurie et al., 2003a); therefore scholars suggest that campaigns about prevention

skills should be implemented among all rural young females irrespective of the status of migration of their partners. Although extramarital relationships are uncommon in Tajikistan, it is still crucial to cover with prevention interventions all women in both urban and rural regions.

Reproductive morbidity and access to care

STIs, and particularly HIV, are sexual and reproductive health issues among left-behind women that are very well researched (e.g. Coffee et al., 2007; Collinson et al., 2006; Golobof et al., 2011; Hunt, 1989; Mundandi et al., 2006; Sevoyan & Agadjanian, 2010; Sharma et al., 2012; Zuma et al., 2005). However, other sexual and reproductive health issues among wives of migrants have been less studied. This research demonstrates that, male labor migration improves the access of wives of migrants to reproductive health institutions through remittances. The study also shows that the left-behind wives report a total of 70 illnesses, compared to 53 among women married to non-migrant men. However, comparison of self-reported reproductive health issues of women of the two study groups does not show whether any specific illness is more common among wives of migrants.

Despite a small difference of reproductive morbidity of the two study groups, the reproductive health care providers believe that there is a significant difference between reproductive health of wives of migrants and non-migrants. In addition, the providers also believe that women married to men who never migrated have better reproductive health. All providers emphasize that migration has a negative influence on the reproductive health of the left-behind women. Moreover, providers strongly believe that reproductive morbidity is more common among women left behind than

the wives of non-migrants. Although, it might only serve as a convenient narrative for them.

In general, providers think that the widespread STIs in Tajikistan in recent years are associated with increasing male labor migration. They believe that many STIs now common in Tajikistan were not known or diagnosed in the past. They also consider STIs as the main cause of not only higher rates of reproductive morbidity, but also are one of the major causes of increasing rates of complications during pregnancy, delivery, and post-delivery period among the wives of migrants. STIs are similarly seen as the cause of more complications among newborn babies of the left-behind women. At the same time, providers in rural areas complain about the lack of laboratories to diagnose the STIs. They also state that only a few women are able to afford travel to the capital city to be diagnosed for STIs. Thus, due to geographic disparities many rural women do not have access to proper diagnostics and do not receive adequate treatment. At the same time, many health care providers and representatives of organizations mentioned that friendly cabinets (FCs) are useful in providing wives of migrants with free syndromic management of STIs. However, no single left-behind woman across all study settings mentioned or was aware of these clinics and diagnostic and treatment available therein.

Therefore, the findings of the current research presented in Chapter 6, showing that some left-behind women were able to negotiate condom use and ask husbands to have an HIV test, is an important step in prevention of HIV among them. However, more work should be conducted among wives of migrants to teach them how to ask husbands to have tests for other STIs, such as hepatitis C or

cytomegalovirus. By being able to ask husbands to have tests for STIs, women can protect themselves from both STIs and also prevent reproductive health issues caused by these STIs. Therefore, it is important to establish at least laboratories in the administrative centers of the regions to diagnose STIs. Thus, the left-behind women can be correctly diagnosed and receive adequate treatment.

Although many have assumed that male labor migration has a negative impact on the reproductive health of wives of migrants, the study shows that it improves or, as many providers state increases, access of the left-behind women to the reproductive health care institutions. To my knowledge, the impact of male labor migration on access of the left-behind wives to reproductive health care services has not been studied before. Left-behind wives themselves, as well as health care professionals, believe that migration increases access of the left-behind women to reproductive health care services. The narratives of the left-behind women show that increase in access is the result of: 1) improved financial situation due to regular flow of remittances with an increase during their illness; 2) the positive views of husbands, who push their wives to see doctors and to receive treatment due to improved knowledge of migrants overseas; 3) improvement in their quality of lives such as building houses or buying apartments; and 4) gaining more decision making power. Health workers, however, provide even broader explanations for this increase, such as: 1) increasing reproductive health issues force wives of migrants to refer more often to health services; however, they often refer with chronic form of the illnesses due to their inability to visit a doctor on time; 2) improved financial opportunities because of remittances; 3) exposure of migrant husbands to health information and improvement of their knowledge during migration abroad, which contributes to better

access of their wives; and 4) the profile of left-behind women who are more open about coming and receiving care than wives of non-migrant men.

Health workers also report that access to wives of migrants has “seasonal character”, that is, left-behind women refer more often after the return of their husbands starting in late fall and ending at the beginning of spring, which coincides with the period of the return of the majority of seasonal migrants from Russia in the winter. Some providers also mentioned that the husbands and mothers-in-law bring women to the doctor or accompany them on their visits to the doctor during the medical visits.

This research also helps to demonstrate that the utilization of reproductive health services is often stratified by the multidimensional impact of several factors, such as the migration status of a male spouse (discussed earlier), education (class), place of residence, region, employment (class), and the quality of the operation of the reproductive health care system in a particular locality. Thus, access to reproductive health services improves if: the migrant man is successful in sending money home and his wife is able to use reproductive health service and receive adequate treatment; the family purchases a new accommodation and moves to a better area of residence; the family moves from a rural area with no reproductive health services to an urban area with access to several reproductive health care facilities and institutions; the quality of the operation of the reproductive health care institutions improves; or members of the family are exposed to education and mass media campaigns about health.

Understanding these mechanisms is crucial for improving reproductive health of this social vulnerable group of the population. Gaining and enhancing this

understanding was possible thanks to the qualitative research among women as well as reproductive health providers. These findings show that it is important to promote constant and regular access of left-behind women to the reproductive health care system rather than seasonal access; to educate women to refer as soon as they have symptoms to prevent development of chronic processes riddled with complications which are harder and more expensive to treat; and to discuss the necessity of accompanying women during visits which impede access of women. Therefore, it is important to educate women about early referral.

Although migration of husbands improves access of the left-behind women to reproductive health care services, other factors limit their access. The most important are education and economic situation. Therefore, it is crucial to promote higher level and better quality of education among women, which is decreasing in the country because of an increasing numbers of girls dropping out from schools earlier than ever due to early marriage (Falkingham, 2004). Clifford (2009) stated that the majority of migrant men have only primary or secondary school education. Improvement of their access to education allows them to get an employment with sufficient wages.

It is also important to improve operation of the reproductive health care system, because the study showed that in Ukteppa village of Sughd region, where the reproductive health system operates very well, it makes access of women to reproductive health system universal throughout the village. Because in Sughd, the reproductive health care functions really well, the left behind wives (as well as wives of non-migrants) are properly covered by the service. They are registered for antenatal

care on time. They do not have to travel long distances or pay additional charges for services provided to them. This was supported not only by the findings of this study, but also by the results of the DHS survey in 2012 and the TLSMS in 2007 (STA, MoH & ICF, 2013; State Committee on Statistics & UNICEF, 2009). The improvement of the quality of the reproductive health system should, therefore, be advocated in other regions of the country as well. Although there are many positive aspects in accompanying women to the doctors, however both husbands and mothers-in-law should be educated about the importance of regular access to health care, especially during pregnancy so that women receive more support from their family even if they are not allowed to visit doctors by themselves.

Increasing number of scholars researching migration and HIV see structural interventions as the main strategy to improve the health of migrant families and the quality of their life. Lurie (2006) argues that many social and health issues are the result of complex multiple interacting factors. Lurie (2006) cites Sweat and Denison (1995) that the HIV epidemic has four levels of determinants, namely “superstructural, structural, environmental and individual” (p. 663). Sweat and Denison (1995) also argue that prevention interventions are often directed at causations at individual levels. However, in order for HIV prevention measures, as well as programs on STIs and reproductive health to be successful, they should be directed at various levels of the epidemic, because many causal factors usually contribute to the role of migration in the spread of STIs, including HIV infection (Lurie, 2006).

It is true that health professionals are usually focused on programs directed at individuals and do not concentrate their effort on strategies directed at determinants. Yet structural and environmental measures have “the most far-reaching and sustained impact” though they are harder to implement (Lurie, 2006) and are more expensive (p. 663). Not only in Tajikistan, but also in many other regions of the world, the majority of migrant laborers come from rural areas; therefore one of the most important structural interventions proposed by scholars is the encouragement of development and investment in rural areas (Lurie, 2006, p. 664). The development of rural areas will change situations in the environment, which otherwise forces young people to migrate overseas; it can be the most effective strategy of dealing with HIV (Lurie, 2006). I believe that it can also be an effective solution to fight STIs and other reproductive health issues. Proposed structural interventions for dealing with HIV are similarly useful for the prevention of other STIs, which cause reproductive health issues among the left-behind women in Tajikistan. Consequently, the research also strongly supports the argument that one of the best ways to improve the reproductive health of women is the development of rural areas and creation of jobs so men do not need then to leave families in search of jobs.

Nevertheless, taking into account the social, economic and political situation of the country, it is impossible to implement structural interventions in the nearest future, while the number of migrant workers continues to increase, especially those who migrate for a long-term (Clifford, 2009). Although I also support suggestions regarding structural changes, it is quite obvious that creation of employment opportunities depends on complex economic, social and political issues that will unfortunately not be resolved in the near future in Tajikistan. Therefore, it is

important to continue the implementation of not only HIV but also STIs prevention measures in multiple directions, such as awareness-raising campaigns in person and through media especially TV and radio (in rural areas where there is no electricity in winter). As the study showed, such campaigns and initiatives proved to be effective in promoting HIV prevention measures among the left-behind women; along with the distribution of information and education materials, play scenes, seminars, and trainings. This is very important, because information on prevention of HIV and STIs contributes to safe sex and practice of HIV/STI tests, which helps to reduce STIs and reproductive morbidity among left-behind women.

Syndromic management of symptomatic STIs is considered as a successful prevention intervention for HIV (Lurie et al., 2006) and other STIs. This can be also an important strategy for improving the reproductive health of left-behind wives in Tajikistan. It is important to note that no women in this study reported that they had heard of or known about the existence of the FCs, where this type of medical service is provided for free for migrant families. Yet many medical professionals and representatives of organizations reported that they exist and provide services to migrant families. Thus, their work should, first of all, be evaluated and assessed, and then advertised and promoted more broadly through ads, media and awareness campaigns. Next, it is particularly important that both migrant men and women should be covered by the prevention strategies (Lurie et al., 2006).

Although the main focus of the study was to examine the impact of migration on reproductive health, it also revealed very important determinants of health of the left-behind women. Similar to other post-Soviet countries, Tajikistan inherited a wide

network of medical institutions from the Soviet Union (Habibov & Fan, 2008), but they, as well as antenatal and delivery care, are much dispersed. This study also supports previous studies which consider lack of finances and inability to pay unofficial payment as main barriers for accessing health care (Falkingham, 2003; 2004; Fan & Habibov, 2009; Habibov, 2010; Habibov & Fan, 2008). Wives of non-migrants complain comparatively more often about inability to cover costs of doctors' visit and treatment, while the left-behind women who remain in charge of both the female and male housework in the family, found it harder to find time to see a doctor or receive treatment. Some wives of migrants also struggle with unofficial payment for reproductive health care services, including antenatal and delivery care. Increasing the wages of medical personnel can be another intervention to reduce cost for women and improve their access.

Transportation cost is another barrier for rural women to access reproductive health care services. The government and international organizations made significant positive changes in many aspects of the reproductive health care system, such as promoting breastfeeding, joint stay of mother and the new-born baby, provision of individual rooms for delivery, training for medical workers on the importance of disclosure of maternal mortality and improvement of diagnosis and treatment of STIs, but more work needs to be done to improve the situation.

However, one of the main shortcomings of family planning programs, HIV and STIs prevention programs and strategies as well as programs aimed at improving sexual and reproductive health in the country is that they are targeting only women. It is crucial, as shown in the study, that such programs should equally target men. The

responsibility for contraceptive use, STIs and HIV prevention measures and improvement of health of their wives and partners as well as children, should not only be placed on the shoulders of women, but rather should be shared by both men and women. It is only with the involvement of both partners and changes in their perception about HIV and other STIs that further success can be achieved in this area.

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APPENDIX I

INFORMATION LETTER

INFORMATION LETTER

(In-depth interview with spouses of migrant and non-migrant males, health care providers and staff of organizations)

Dear Madam/Sir,

I am, Dilofarid Miskinzod, a graduate student at Arizona State University in the United States of America, conducting a research study in Dushanbe city and the Badakhshan region of Tajikistan. I am conducting interviews with spouses of migrant and non-migrant males, health care providers and staff of organizations in these two regions. The main goals of my research is to understand the lives and problems of women whose husbands migrate to other countries, including the impact of husbands' migration on marriages and on women's health and health decisions.

I hope that the results of the study will contribute to improvement of women's health in these regions.

I would like to talk with you about your insight on these issues. Our conversation will last about 2-3 hours. Our discussion is confidential, that is, no one except me will know about what we will discuss now. Our conversation is also voluntary, that is, you have the rights not to talk with me at all or if you want to talk with me about these issues, you may not answer some questions if you do not want to answer them or you may interrupt or stop our conversation at any time if you change your mind later on. To show my appreciation for you taking the time to talk with me, I will give you \$5. You will receive this even if you choose not to answer some questions or decide to quit the interview. I am not able to memorize all details of our

conversation and only with this purpose I would like to audio record our conversation if you are comfortable with this. If you are not comfortable with recording, I will take detailed notes of our conversation. I am the only person who will have access to this record and notes, and when I finish the transcription of the interview I will destroy our conversation's recording and notes.

Although my study can be useful and helpful for improvement of health of women in these regions, you will not get from it any personal benefits. At the same time you will not be harmed in any way while participating in this study. Your name will never be mentioned anywhere.

If you have any questions concerning the research study, please contact me at 93 589 2004 or by email: dilofarid@hotmail.com.

APPENDIX II

RECRUITMENT SCRIPT

RECRUITMENT SCRIPT

I am Dilofarid Miskinzod, a graduate student at Arizona State University in the United States of America. I am conducting a research study to learn reproductive and sexual health and sexually transmitted infections and HIV/AIDS in the region as well as to understand the lives and problems of women whose spouses migrate to other countries.

If you accept to participate in my study, you will take part in the interview which will last about 2-3 hours. Your participation is confidential, that is, no one except me will know about our conversation. Your participation is also voluntary, that is, you have the right not to talk with me at all or if you want to talk with me about these issues, you not have to answer some questions if you do not want to answer them. You may interrupt or stop our conversation at any time if you change your mind later on. There are no negative consequences for you if you decide to stop our interview or if you decide not to participate.

If you have any questions concerning the research study, please contact me at 93 589 2004 or by email: dilofarid@hotmail.com.

APPENDIX III

QUESTIONS FOR WIVES OF MIGRANT WORKERS AND NON-MIGRANT
MEN

QUESTIONS FOR WIVES OF MIGRANT WORKERS AND NON-MIGRANT
MEN

I – Gender responsibility and household characteristics

1) *Age*

How old are you?

2) *Education*

What is your education?

Where did you study? How long have you studied for? Did you get your degree? If not, why did not you finish your studies? What was your degree in?

3) *Work*

What do you think about your work at home? How does migration of your husband impact your household responsibilities (e.g. does it increase workload or decrease it, adds new tasks)?

Do you also do work for which you are remunerated in money or things? Where do you work? What do you do? Do you like to work? Why or why not?

How long have you been working (Did you start working after migration of your husband)?

If she does not work but worked before, why did you stop working (if she worked before, whether her current unemployment is connected with migration of her

husband)? In general, how migration of your husband impacted your employment (discouraged as a result of increase of remittances or any other reasons)?

If she works outside of the home: How does your work impact your ability to keep up with your household responsibilities? How can you manage to combine both works and how does it impact you?

How much money do you get in your paid work? Is the income (if she works) sufficient to cover your expenses (e.g. food, clothes, accommodation, health needs, medicines *et*)? If not, why not? Who else helps you financially?

Do you decide yourself how to spend the money (e.g. what to buy or not etc.)? If, the answer is no, then: Who helps you with deciding how to spend the money?

4) *House*

Which part of the city or region do you live in? Do you live in your own house (did you buy it on migration remittances), or do you rent? If you rent, how much do you pay for your accommodation per month?

How many rooms does it have and how long do you live there?

How many people do you live with in this apartment/house? Are they your relatives?

Do you have electricity all year around? Do you have running water?

Do you own a TV? A satellite dish? Do you have a fridge?

5) *Religion*

What is your religion?

How have your religious beliefs and practices (prays, going to mosque, Islamic code of dressing-hijab, fasting during Ramadan, giving zakot etc.) impact your life; the way you cope with your husband's absence? Do your religious leaders play a role in that?

II – Health

6) *General health*

How would you describe your current health situation? Does migration of your husband impact your general health situation?

Do you have any major health problems? In your opinion, are they connected with migration of your husband? Or did you have them before as well?

Do you smoke? How often do you smoke?

Do you drink alcohol? If yes, which and how often?

Do you take drugs? If yes, which and how often do you take them?

If yes, did you smoke, drink alcohol or take drugs before migration of your husband or after he migrated?

7) *Reproductive health*

How many pregnancies did you have? What were their outcomes? In your opinion, did migration impact outcomes of your pregnancies (were outcomes better before

migration or now)? Were any of them terminated? What were the reasons of termination (miscarriages, abortions, family violence etc.)?

How does migration impact your fertility?

Did you go for antenatal care? How often did you see a doctor or a nurse during pregnancy? How does migration affect your antenatal care?

Where do you go for antenatal care? How far away is the antenatal clinic located? How do you get there? If not, why? What were the reasons (financial, social, personal)? Did migration improve or worsen your access to antenatal care services?

Did you have any health problems during your pregnancy (gestational diabetes, AIDS, preeclampsia, pregnancy loss, premature babies, stillbirth, substance abuse, high risk pregnancy, teenage pregnancy)? If yes, did you receive treatment or support for them?

Did you have blood test, urine test, and ultrasound examination as part of your antenatal care? Where did you have your delivery? If it were at home, who attended the delivery? Why did you choose to deliver at home? Why did not you want to have an institutional delivery (if it was home birth)? Did migration of your husband impact your choice of location of delivery?

Did you receive post-natal care? Did you have any health problems in post-natal period (problems with breastfeeding, postpartum depression, postpartum eclampsia etc.)? What did you do about these problems?

Do you have any gynecological problems such as myoma (uterine enlargement), vaginal bleeding, pelvic pain, endometritis (inflammation of uterine), infertility,

pelvic inflammatory diseases, etc? If you had any of these illnesses, did you have relevant treatment for them? If not, why?

How did your reproductive and sexual health change after your husband was gone (returned)? What do you know about diseases such as chlamydia, syphilis, gonorrhea and HIV/AIDS? Did your knowledge improve after migration of your husband? What contributed to this? Do you discuss STIs with him? Did somebody else help to improve your knowledge of STIs (nurses, staff of INGO, government agencies, friends, and neighbors)?

Did you have any sexually transmitted infections such as chlamydia, syphilis, gonorrhea (discharge, pain, ulcer)? Did you receive a treatment for them? If not, why you did not get treatment?

If you had STIs, did your husband know about them? How did you tell him about them? How did he learn about them? In general, how do you communicate with him?

Whom do you discuss your sexual and reproductive health issues with (husband, friends, relatives, in-laws)?

Do you have concerns about other diseases that people can contract through sex?

Did your reproductive health improve in any way because of migration? Why did it improve? Can you give me examples?

Did it worsen in any way? Why did it get worse? Can you give me examples?

8) *Family planning and counseling*

Before you married, how many children did you want to have and how many children did your husband want to have? (Depending on the answer, I will ask them about how they managed to agree on a certain number of children).

Did you or your husband change your mind about the number of children over time? Why?

Who decided how many children to have (you or your spouse or both)? Are you able to decide how many children to have?

Have you ever done anything to prevent a pregnancy? What did you do and why?

Which method of contraception do you use? Did you have any side –effects when you used contraception?

How often do you use condoms with your husband? Who suggested using it (you, your husband, your mother, your mother-in-law, a nurse, a doctor, any other relatives, friends and neighbors)? Why? How did he react, if it was suggested by you? Did someone force you to use contraception? Is yes, what were justifications for that?

Did you receive counseling about contraception before they were prescribed? Who provided counseling and what did it consist of?

If you don't use condoms, what are the reasons for not using them? Did the reason for not using condoms change over time?

Did the decision to migrate affect your decisions and using contraceptives?

9) *Access to health care system*

How often do you go to see a doctor, a nurse, or a traditional healer?

Where do you go for treatment if you have any health problems?

Do you have any problems with accessing of reproductive health care services (financial (lack of money to pay for services, transportation and medicines), bad attitude of medical personnel, fear of lack of confidentiality, personal characteristics of wives of migrant men etc.)?

Did your access to reproductive health care services improve in any way because of migration? Why did it improve? Can you give me examples?

Did it worsen in any way? Why did it get worse? Can you give me examples?

10) *HIV test and knowledge about it*

What do you know about HIV/AIDS? Does migration of your husband impact on your knowledge about HIV/AIDS?

Have you ever had a test for HIV? If yes, how many times? What were the results?

When did you have your first and last HIV tests?

Do you have any concerns about the possibility of contracting HIV infection due to the fact that your husband is migrant?

Can you ask your husband to have a HIV test or test for STIs when he returns from migration? What do you think how can he react to your suggestion?

III – Sexual Behaviors and Risks

Sometimes women don't want to have sex with their husbands for a variety of reasons. Have you ever refused to have sex with your husband and told your husband that you didn't want to have sex? Why? Why not? What happened? What do you think would happen? Are there circumstances in which you could refuse to have sex with your husband?

Are you satisfied while having sex with your husband? If not, why?

Does migration of your husband impact your sexual health? Whether it is improved or worsened?

How often do you have sexual relations with your husband? How often do you use condoms with your husband?

Do you are aware of any STIs which your husband has?

Did your husband use physical or any form of violence to force you to have sex with him?

Did your husband hit you, slap you, injure you, hold you down and force you to have sex or verbally abuse you?

It's not uncommon for men, even if they don't migrate elsewhere, to have sex with another woman or take up with another woman. Have you ever worried that your husband might do so? What made you worry?

It's also not uncommon for the wives of men who migrate to have a boyfriend or to have sometimes sex with other men. What do you think about this? Why do they have a boyfriend?

Do you know other women in your community who have a boyfriend? Why do they have a boyfriend? What are the reasons for having a boyfriend?

Sometimes women have sex with other men in order to receive financial support to survive or because of passion and desire; do you know other women in your community who exchange sex for money or anything else? I don't need to know who those women are.

Do you have a boyfriend in addition to your spouse? What were reasons to have a boyfriend?

How often do you have sexual relations with your boyfriend? How often do you use condoms with him?

Are you aware of any STIs which your boyfriend has?

Did your boyfriend use physical or any form of violence to force you have sex with him?

Does your boyfriend support you with money or in any other way?

Did other men ever give you trouble (use bad words, try to touch you, pressure you sexually, offer you gifts, physically force you to do anything)?

Did you ever choose to have a sexual relationship with another woman?

IV – Marriage and Relationships

11) *Marriage*

How did you meet your husband?

How did you decide to get married?

Is your marriage arranged or did you know each other beforehand?

How are your relations with your migrant husband now? Did migration improve your relations or not? Why?

How do you communicate with each other? What do you usually discuss when you communicate with each other?

How often does he visit you? When was the last time? And before that time?

12) *Family life*

What was your life together like before he migrated?

Did your life improve in any way because of migration? Why did it improve? Can you give me examples?

Did it worsen in any way? Why did it get worse? Can you give me examples?

What do you think, if he did not migrate would you have the same quality of life you have now?

13) *Migration decision*

Who first raised the idea of migrating? What did you think about it? If you did not agree, why? How was the decision made?

Why did he decide to migrate? What were the reasons? Can you give me examples of stories which pushed your husband to migrate?

What kind of work does your husband do? Where does he work? What does he say about his work? Does he like it?

Can you tell me about his migration history?

How often does he come? When did he come last time? What did he bring? If he does not come back, why? How do you communicate with him? If you don't, why not?

Do you know how much he earns and how much of that does he send you? When was the last time your husband sent you money? How much did he send? What about before that? Generally, how often does he send you money? If he did not send money, why he did not send money?

Is the amount earned by yourself (if she works) and sent by your husband are sufficient to cover your expenses (food, clothes, house, health needs, medicines *etc*)?

V – Social Relationships (Kin, In-laws, Non-relatives)

How are your relations with your own relatives? How often do you see/communicate with them? When did you see/contact them last time? If not, why don't you see/contact them? Do they help you (particularly when your husband in migration)?

Do you discuss with them your reproductive health issues? What do you usually discuss? Do you ask them for advice regarding your health issues, contraception or delivery choice?

How are your relations with your in-laws? When did you last time see /contact them? Do they help you in any ways? Are they improved or worsened as a result of your husband's migration? Do you communicate your reproductive health issues to them? Do they provide you with advice in terms of your health issues, contraception or delivery choice?

How is your relationship with your neighbors, friends? When did you last time see /contact them? Are you able see them or visit them without your husband or in-laws' permission? What are you usually talking about when you meet? If you have any questions regarding reproductive health issues do you ask them for advice? Do you share health information with them?

Did the attitudes of you neighbors towards you change after the migration of your spouse? Did it change in a positive or negative way? Why or why not?

Have your kin, in-laws and neighbors tried to help you or pushed you away?

How is your relationship with your children? Do you have any problems with disciplining them? Does anyone help you with raising your children? Can you decide on your own to what school they should go, what to allow them to do or to buy?

Do your children receive neonatal care after they born? Do they receive vaccination?
How often do they see a doctor? How does their access to health care services change
after migration of your husband?

APPENDIX IV

QUESTIONS FOR HEALTH CARE PROVIDERS AND STAFF OF STATE
AGENCIES, LOCAL AND INTERNATIONAL ORGANIZATIONS

QUESTIONS FOR HEALTH CARE PROVIDERS AND STAFF OF STATE
AGENCIES, LOCAL AND INTERNATIONAL ORGANIZATIONS

I – Health and sexual health

How can you describe health status of wives of migrant men in comparison with wives of non-migrant men?

What are their major health issues? Do their health issues differ or not from those of wives of non-migrant men? How?

Where do they usually go if they have any health problems (doctors, nurses, traditional healers etc)?

How can you describe their attitudes to their health? Does their attitude towards their health differ from that of wives of non-migrant men? Are they similar?

Are they concerned about their general health status?

Do they have particular concerns about STIs and HIV/AIDS?

How can you describe their health seeking behaviors? What about wives of non-migrant men?

What is the average age of wives when they start having sexual relation with their husbands?

Do some left behind wives have sexual relations with other men while their migrant husbands are away? What about wives of non-migrant men?

Do they have voice in decision regarding sexual relations with their husbands?

Do they smoke?

Do they consume alcohol?

Do they take drugs?

II – Reproductive health

Compared to women whose husbands stay in Tajikistan, do wives of migrant men seem to have Sexually Transmitted Infections (STIs) more often or less often? What are the most common STIs among them?

What kind of health care do they receive when they have STIs? Do you think they receive adequate treatment? If not, why? Do they have evidence that they have received adequate treatment? How does their situation in this regard differ from women whose husbands stay in Tajikistan?

Do you offer wives of migrant men to have HIV tests? How do they typically react to that? Are they willing to have HIV test if you ask them to have it?

Do they ever suggest getting the test themselves? Can you compare their reaction with that of the wives of non-migrant men?

How often do they have HIV positive results? How about wives of non-migrant men?

Do you think the wives of migrant men are at risk of HIV infection due to their husbands' migrant status?

In your opinion, how good is their knowledge of STIs and, particularly, HIV? How does their knowledge differ from women whose husbands stay in Tajikistan?

Do they use condoms with their spouse? If not, why? Do the wives of non-migrant men use condoms? If yes, what is the main reason for using condoms among the wives of non-migrant men (e.g. to prevent pregnancy, to protect from STIs)? What are reasons for not using condoms by wives of migrant males? How do they explain their refusal to use condoms?

Do you provide condoms or any other methods of contraception to them? Are they free? Are they expensive or cheap? Is the cost of condoms and other contraceptives affordable for them? Who provides contraception for you (e.g. UNFPA, World Bank supported programs, National Ministry of Health *etc.*)? What is the name of the agency/organization providing you with contraception?

Could you tell me about violence among them?

Compared to women whose husbands stay in Tajikistan do they often experience beating or emotional abuse (shouting, “putting-down”) from their migrant husbands? Are there cases of violence among women with husbands who stay in Tajikistan?

Do they tell you about their husbands’ sexual relations with other women?

How can you describe reproductive health of spouses of migrant and non-migrant men in general? Is there any difference? Is there any similarity?

How does the reproductive and sexual health of wives of migrant men change after their husbands’ migration?

How does their health condition change after their husbands returned?

How did their husband's migration (or return) affect their access to health care services?

In your experience, who make decision about children and family planning in families with a migrant and non-migrant man?

What are the reasons for using or not using contraceptive methods in these families?

Tell me about abortion among wives of migrant men? Is the rate of abortion high among them? How does the rate of abortion differ among wives of non-migrant men?

In your experience, did they come for abortion while their migrant husbands were away?

Could you tell me about their antenatal care? How often do they come for regular check-ups? Where do they tend to deliver their babies (hospital and home)?

III – Working with left behind wives of migrant workers

What is your educational background?

Where do you work? Tell me about your work?

Do you work with spouses of migrant workers?

What kind of services do you provide for them?

What do you think are the major problems that these women face while their husbands are gone? What are the major problems that they face after their husbands return? Do their problems differ from those of the women with non-migrant husbands?

Is women's physical health affected when their husbands migrate? Does their husbands' migration worsen it? Or does it improve their physical health?

What kinds of services do you think they need?

Does the physical health of migrants' wives differ from that of other women?

Does the mental health of migrants' wives differ from that of other women? How often do they visit you? Do they visit you more (or less) than wives of non-migrant men?

Do they make decisions themselves or do they depend on someone else?

What do you think doctors/the government/NGOs need to know about these women?

What kinds of activities do you conduct among wives of migrant men?

What was the hardest part of work with wives of migrant men for you? What about your work with other women?

What do you think are the most effective activities/services that your organization has provided to wives of migrant men?

What do you think are the less effective activities/services that your organization has provided to them?

What do you wish you would have done differently in your work with the wives of migrant men to make your work more effective?

What do you think about the abovementioned issues while working with wives of non-migrant men? Are there any differences or similarities?

There is a claim that at present most of the women with HIV positive status are wives of migrant men. Do you agree with this statement or not?

Do you feel that they are being discriminated against because of their status of being a wife of a migrant husband?

APPENDIX V

APPROVAL OF APPROVAL OF THE

INSTITUTIONAL REVIEW BOARD OF THE ARIZONA STATE UNIVERSITY

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INSTITUTIONAL REVIEW BOARD OF THE ARIZONA STATE UNIVERSITY



Office of Research Integrity and Assurance

To: Victor Agadjanian
Social Sci

for **From:** Mark Roosa, Chair *SM*
Soc Beh IRB

Date: 04/18/2011

Committee Action: Exemption Granted

IRB Action Date: 04/18/2011

IRB Protocol #: 1104006280

Study Title: Reproductive and Sexual Behaviors of Spouses of Migrant Laborers in Tajikistan

The above-referenced protocol is considered exempt after review by the Institutional Review Board pursuant to Federal regulations, 45 CFR Part 46.101(b)(2).

This part of the federal regulations requires that the information be recorded by investigators in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. It is necessary that the information obtained not be such that if disclosed outside the research, it could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

You should retain a copy of this letter for your records.