Power, preference, and prejudice: male labor migration and fertility regulation in rural Armenia

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Abstract

Despite extensive research on the consequences of migration for non-migrating household members, little is known about the effects of seasonal migration on contraception and abortion dynamics, especially in many parts of the former Soviet Union, low fertility settings with high levels of migration, that have seen vast social, political, and economic changes over the last couple of decades. Previous research on migration and fertility regulation in this region has found that women married to seasonal migrants are less likely than those with non-migrant husbands to be using the hormonal pill or an IUD; however, they have an unwanted pregnancy rate similar to that of women married to non-migrants and are equally likely to abort a pregnancy. This paper uses longitudinal qualitative data to examine the impact of husbands’ migrant status on women’s perceptions and experiences with contraception and abortion and documents the barriers to modern contraceptive use faced by this population.
INTRODUCTION

This paper investigates the perceptions of and experiences with contraception and abortion among rural women whose husbands are seasonal migrants and seeks to elucidate the multifaceted and interconnected processes of decision-making about contraception and abortion within the circumstances created by spousal separation as well as a broader socio-cultural milieu in which the women live. In parallel, it examines how health providers’ views on and experiences with contraceptive methods and abortion practices translate to counseling and treatment of migrants’ wives.

As in other parts of the former Soviet Union, there exists a well-developed pattern of seasonal migration in Armenia, primarily to the Russian Federation (NSS RA, 2010). Armenian males typically leave the country in the early spring to work in construction and agriculture and return in late autumn (ILO, 2009). The duration of their annual work abroad is often 5-11 months, with a mean duration of 9 months (ILO, 2009).

According to the 2010 Armenia Demographic and Health Survey (ADHS), 22% of currently married women and 28% of formerly married women reported that their spouses had worked abroad during the 3 years preceding the survey for at least 3 months at a time (NSS RA 2012). In general, urban women, those with higher education, and those from the wealthiest households were less likely to report that a husband was employed away from home compared with rural, less educated, and less wealthy women (NSS RA 2012).

In the Gegharkunik province, one of the poorest provinces in Armenia where the data in this study were collected, men work as seasonal labor migrants in high
numbers due to poor conditions unfavorable for agriculture and a shortage of non-agricultural employment (Asatryan, 2007). Regional variations are great. Nearly half of ever-married women in Gegharkunik (44%) report that their husbands work abroad compared with 1% of ever-married women in the Syunik province (NSS RA 2012).

Among countries with reliable information on abortion incidence, Armenia has one of the highest legal abortion rates in the world (Sedgh et al, 2011). Almost half of Armenian women who report having an induced abortion state contraceptive failure as the reason, and, among those, over a third report that traditional methods lead to such contraceptive failures (NSS RA 2012). The rest of pregnancies that result in induced abortion occur among women who do not use any contraceptive method (NSS RA 2012).

More than half of married women of reproductive age in Armenia are using a method of contraception. However, the most widely used method among currently married women is withdrawal (25% of all women), followed by the male condom (15%), and the IUD (10%) (NSS RA 2012). National survey data show that modern contraceptive methods have increased from 22% in 2000 to 27% in 2010, and use of traditional methods has decreased over the from 38% in 2000 to 28% in 2010 (NSS RA 2001; NSS RA 2012). Despite improvements, Armenian women still face barriers to using modern contraceptive methods. Critical barriers include direct and indirect costs, a lack of awareness of available options, misperception on side effects, and public distrust (Sacci et al, 2008).
An analysis of migration and current contraceptive use based on the 2005 ADHS supports the notion that seasonal migration negatively affects modern contraceptive use in Armenia. The odds of migrants’ wives using an IUD, birth control pill, or injections to control fertility are 61% lower among non-migrants’ wives. Interestingly, the effect of migration was even more pronounced in terms of condom use, with 67% lower odds that migrant couples would use condoms than non-migrant couples (Sevoyan, 2011).

It is possible that migrants’ wives are less likely to negotiate protected sexual intercourse with their husbands, either because they lack agency and/or need to prove their trust and fidelity to their husbands (Hughes et al, 2007). The socio-cultural environments in which women live often intensify their vulnerabilities. In setting where traditional norms are more pervasive and women lack greater agency, they are stigmatized for seeking or discussing information about sexual risks (Weiss et al, 2000). Thus, women may be unable or unwilling to converse with their spouses about contraception and, in particular, assert condom use if they are economically or socially dependent on them or physically or emotionally abused by them (Weiss et al, 2000). Interestingly, even though spousal separation due to seasonal male migration was found to be negatively associated with contraceptive use, and women in Armenia with migrant husbands were less likely than those with non-migrant husbands to be using the hormonal pill or IUD, they had an unwanted pregnancy rate similar to that of women married to non-migrants (Sevoyan, 2011). This is consistent with regional variation in the ADHS 2010 showing that women in Gegharkunik have among the highest unmet need for family planning, with 4 in 10
women expressing a need for family planning (NSS RA 2012).

Seasonal male migration has profound and multifaceted effects on household wellbeing in rural Armenia (Agadjanian and Sevoyan 2014). However, there is a dearth of scholarly literature on gender relations, sexual partnerships, and seasonal migration, particularly as they pertain to contraception and abortion dynamics among women married to seasonal labor migrants in the former Soviet Union in general, and in Armenia in particular. Little is known about the role of male seasonal labor migration, a massive phenomenon in rural Armenia, in decision-making regarding the use of contraception and abortion as well as choice of contraceptive method and type of abortion. Especially little is known about the socio-cultural and institutional factors that lead to abortion seeking behavior in regions of high migration; thus, qualitative research in particular is needed to better understand the strategies of fertility regulation that shape the reliance on abortion among women married to seasonal migrants.

Gaining insight into migrant wives’ attitudes, behaviors, values, concerns, and motivations related to abortion-seeking as well as counseling and treatment of health providers enables us to develop focused intervention strategies that would reduce the unmet need for family planning and the number of unsafe/illegal abortions in regions of high male migration in Armenia.

DATA AND METHODS

The analysis uses data from a longitudinal qualitative study that was conducted in the Gegharkunik province of Armenia, an area of particularly large male labor out-
migration primarily directed to Russia. The project started in 2009 and the fieldwork for the latest wave of data collection took place from December 2014 to February 2015.

In-depth interviews were carried out with 38 women of reproductive age married to migrant workers in 6 villages in the Gegharkunik province who had been previously enrolled in the study. Eligible participants included sexually active women between the ages of 18-49 who had migrant husbands, were able to comprehend oral consent to participate, and were fluent in Armenian. A semi-structured interview guide was used to collect data, which included an opening introductory narrative, questions that addressed different dimensions of the research questions, and probes in addition to main questions.

The analysis of women’s interviews is complemented by that of interviews with health providers carried out by the first author in 2014. In total, 9 health providers (5 gynecologists and 4 pharmacists) in the three towns in closest proximity to the target villages—Gavar, Martuni, and Vardenis—were interviewed. The providers’ interviews focused on their perceptions, and experiences with various contraceptive methods and abortion practices. Questions addressing counseling and treatment were used to elucidate how their perceptions and experiences may translate to care offered to patients, specifically women married to migrant husbands.

All interviews were digitally recorded and transcribed. Inductive content analysis was employed to identify recurrent themes and schemas in the data and to connect these themes and schema across time and across the two blocks of data (women and providers). This approach was considered the most appropriate given the
scant existing theory and literature on the topic as well as the ability to gain direct information from participants without imposing preconceived notions.

PRELIMINARY RESULTS

In this extended abstract, we present some initial insights on the complex processes of contraceptive and abortion decision-making among migrants’ wives. The completed paper will make full use of our longitudinal data to discuss in-depth various types of barriers to modern contraceptive use among women married to male seasonal migrants, the women’s strategies and choices in navigating these barriers, and the role of health providers in facilitating and obstructing these strategies and choices.

The migrants’ wives in the study had a perceived low risk of unintended pregnancy. Though many noted that they would still not have chosen a modern contraceptive even in the event that their husbands did not migrate for work, several others noted that they would have chosen to use a method, in particular long-acting methods like an IUD, if their husbands stayed in Armenia all year. Several of the participants simply wrote off the idea of using modern contraceptives given that they were sexually active for only a few months of the year. A 30 year-old mother of one remarked, “[My husband] comes back for a little while and says, ‘Let’s just protect ourselves like this [withdrawal] for a few months”.

Interestingly, health providers supported the notion that a women married to migrant workers should use short-acting contraceptives instead of long-acting ones, which may have been reflected in their contraceptive counseling. One gynecologist based in Martuni noted, “We insert the IUD for years, 3-5 years, 7 years. What do they
need it for? Why should they have an IUD inserted to use it for 3 months and then have it stay in for the rest of the year? It’s better if they use birth control pills for 3 months than an IUD.”

The women showed low motivation to use contraception, especially long-acting methods like the IUD, not only due to low perceived risk of pregnancy but also due to the perception that a woman should not be on birth control in her husband’s absence. This may be linked to the need to control women’s sexuality and ensure that women are faithful to them in their absence. A mother of two in her mid-30s reported, “It’s just that my husband isn’t here. I can’t use an IUD. I’ve thought about it, but since he’s more often not here, for 2-3 months, I don’t know... My husband is completely against it.”

Interestingly, a few participants believed that leaving in an IUD while not sexually active posed as a health risk, which created an additional barrier for women married to migrants to use this form of long-acting and effective contraception. One mother of two in her late 40s reflected, “I took [the IUD] out because my husband went to Greece. They told me, ‘Take it out, take it out, it’ll have an effect on you. Since your husband’s not here, it’ll be bad for your body.’”

Though nearly all the women interviewed understood that their status as wives of seasonal migrants posed as a greater risk of contracting STIs, few spoke to their husbands about condoms and either showed lack of agency in asserting condom use or a lack of motivation, desire, or forethought. In many cases, women noted that having a conversation about condoms was unnecessary because they trusted their partners and never experienced any health complications. Others outwardly spoke about the realities they face and used language to suggest that they considered cheating a normal
phenomenon for male seasonal migrants; however, many of the same women lacked the agency to have these discussions. A 40-year old mother of three stated, “[Men working as migrants] understand [the need for condoms]; we don’t have to explain it to them. We’ve been married for a long time, so we don’t allow ourselves to have those sorts of conversations.”

Posing as an additional barrier to modern contraceptive use was a lack of counseling and proper treatment by health providers. Contraceptive counseling, including counseling on condom use for STI prevention, did not include probing to identify whether a woman was married to a migrant or non-migrant; thus, counseling was often not tailored to the needs of migrants’ wives. Furthermore, issues of confidentiality and lack of trust in the medical system make women uncomfortable with disclosing this information and/or seeking testing and treatment from their physicians. One gynecologist based in Vardenis noted, “I always try to explain to them that they should use condoms. I don’t know how much of that gets through to them, because we’ve had cases where they come to us infected, but if I know that my patient’s husband does that kind of work [migrant work], I always tell them to use condoms. I don’t know how effective this is, because even if they do get infected, naturally a lot of the time they don’t come here because most of the community members know them, so they’ll go to Yerevan or Martuni, a nearby region. Most of the time they go somewhere else so that no one finds out.”
REFERENCES


