# Labour Migration and HIV Vulnerability in Tajikistan

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**Abstract**

*Central Asia has experienced a rapid increase in HIV infection over the last decade. The dire life circumstances of labour migrants working in Russia, which are well-known, have increased their HIV risk vulnerability. Low socioeconomic status, lack of access to services, separation from family, and limited risk awareness all contribute to migrants' HIV vulnerability. In a structurally patriarchal society, gender norms limit the wives' abilities to protect themselves and their husbands from HIV/AIDS. This paper examines the factors responsible for the elevated HIV risk behaviours among Tajik labour migrants and which, in turn, infect their left-behind wives in Tajikistan. Having applied Robert Connell's theory of gender and power, it has been manifested that how gender inequality gender and power imbalance has made women vulnerable to HIV. The extended version of the theory of gender and power examines the exposures, social/behavioural risk factors, and biological properties that increase women's vulnerability for getting infected with HIV.*

**Keywords**

Labour Migration, Left-behind Women, Vulnerability, HIV, AIDS, Tajikistan

## Introduction

Migration and population mobility has become an enduring dimension of a rapidly globalised world. The estimated number of international migrants is 272 million and women make up around 47.9% of the total (ILO, 2020). Migration results from the interplay between political, social, economic, cultural, and environmental factors. The interplay stimulated various forms of movement of people characterised by duration, reason, and form. It includes the migration of refugees, displaced persons, economic migrants, environmental migrants, and persons moving for other purposes, including family reunification (United Nations Department of Economic and Social Affairs, 2002). Variations are commonly drawn among migrants according to whether their movement is classified as forced or voluntary, internal or international, temporary or permanent, or economic or non-economic (UNO, 2012). In the Central Asian region, economic migration, or migration for employment, has dominated the movement of people. Although primarily motivated by economic conditions, however, Central Asian migrants are not an exception to Arrow's assessment that movement of people implies the movement of sexual desires, beliefs, expressions, and acts (Marin, 2013). In contract labour arrangements, low-skilled migrants are only accepted as 'single' and reduced to asexual beings while as, on the contrary, high-skilled workers are given opportunities to

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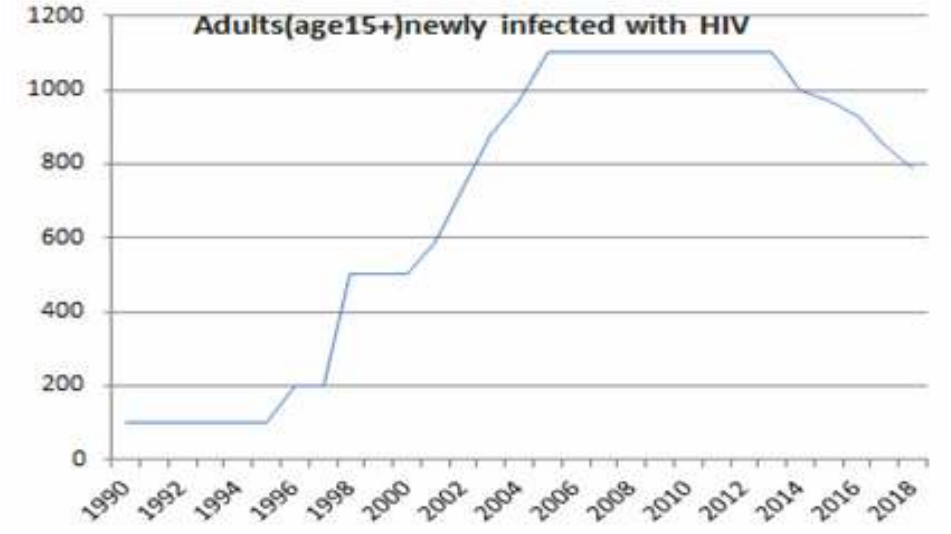
settle with their families (Sciortino, 2013). To regulate the low-skilled migrant's employment and stay in the host country, migration policies are also concerned with migrants' sexuality and reproduction. Specifically, migrants' bodies and their sexual and reproductive behaviours have become the 'point of interest of regional, bilateral and national policies centralising on three issues: (i) management of contract migration, (ii) HIV and AIDS prevention, and (iii) human trafficking.

Labour migration is a high trend in Central Asia. Conditions such as economic breakdown and low wages push young men to work away from their homes and families where they are likely to have unprotected sexual contact with commercial sex workers. According to United Nations Programme on HIV and AIDS, " The region also reports the fastest rates of HIV/AIDS growth in the world" (UNAIDS, 2006). According to the World Health Organization, "In 2018, 26,000 people were living with HIV in Kazakhstan, 8500 in Kyrgyzstan, and 13000 in Tajikistan" (Deryabina, 2019). The slumping of the Soviet Union produced an economic collapse and a failing healthcare system that bisected with changes in moral and social norms in Central Asia (Smolak, 2010). In the years following the collapse, all health indicators declined dramatically in the former Soviet republics, and HIV prevalence rates increased (Atlani et al., 2000). The overall decline of the health care system produced a catastrophic impact on the health of the population, particularly on the health of women and children. In the post-Soviet period, the rise in sex work and drug use, risk factors associated with HIV infection, has contributed significantly to the rise of HIV in Central Asia. Young men from all Central Asian countries, unable to find employment in their places of origin, go to Moscow in search of good-paid work. The economic and socio-political crises affecting Russia and the surrounding region have created a "risk priming environment" for the spread of STI, including HIV infection (Aral, et al., 2003). Also, Russia is documented as a major country of origin and a major country of destination in human trafficking of young women for sex work. Sex work in Moscow presents a unique situation as this city is a major economic and social magnet for both men and women. The Moscow sex market appears to be an adjusted response of the social system to the economic pressures in Russia and the surrounding countries of the former Soviet Union. The male migrant population creates a great demand for sex work. Similarly, young women who cannot find employment in their hometowns move to Moscow, often temporarily, to find work. In the absence of other employment, sex work presents a rather attractive alternative for these women. These migration patterns have led to the emergence of a burgeoning industry that specializes in recruiting young women into Moscow to become sex workers (Aral et al. 2003). The WHO, and World Bank have identified migrant workers as a major source of the HIV epidemic in Central Asia (Godinho et al., 2005).

Labour Migration and HIV Vulnerability is associated with various factors: prolonged or frequent absence from home; precarious financial status; difficult working and housing conditions; change in cultural norms; separation from family; low social support; substance abuse; mental health problems; lack of HIV testing; needle sharing; limited condom use; concurrent multiple partners; sex work; low HIV knowledge, and low perceived HIV risk (ILO, 2017) and the patriarchal structure regulating the sexual sphere where men's interests are of absolute priority (Japan International Cooperation

Agency, 2008). Tajik people learned about HIV/AIDS at the time when their country was part of the Soviet Union and AIDS was not a serious problem either for the society or for the Ministry of Health of the USSR (Zhores, 1990). Although, as few as 112 people out of 285 million Soviet citizens were officially known to be infected by that date, it was only in 1987 when the first HIV case was officially reported in a Soviet medical publication and described as "a homosexual who got infected in East Africa in 1982" (Latypov, 2008). This man remained the index case until October 1988 when a woman named Olga was posthumously diagnosed with AIDS. This particular case has been widely believed by many Tajiks to come from Khujand, the second-largest city in Tajikistan located in the northern part of the country. According to the Tajik media reports, in 1985 Olga went to Leningrad where she engaged in prostitution, died of AIDS, and was then buried in Khujand (Latypov, 2008). Independent Tajikistan reported its first case in 1991. These cases were two persons who returned to Tajikistan from their business trips to African countries (Latypov, 2008). Although by 1993 some 1,200,000 people were tested for HIV (ILO, 2008) in Tajikistan. In 2000, there were 11 registered cases. Heterosexual HIV transmission is increasing and is mostly "exported to the country from the outside" (Thorne, et al., 2010; Weine, Bahromov, & Mirzoev, 2008). In 2001, thirty-four new cases were reported and it was three times as much as all previously known cases. In 2004, Tajik authorities reported 198 new HIV cases, almost a five-fold increase compared to the previous year. Meanwhile, there were an estimated 10,000 [5,000– 23,000] people living with HIV (PLWH) in Tajikistan (United Nations Programme on HIV and AIDS (UNAIDS, 2008). In 2013 4,581 people were living with HIV in Tajikistan and 69.8% are male and 30.2% are female (ADB, 2016). The most common transmission route for women is through sexual contact (80% of cases) while men are equally likely to become infected through sexual contact (43% of cases) and injecting drugs (42%) of cases (Japan International Cooperation Agency, 2008). In 2016 United Nations estimated that 14,000 Tajiks were HIV positive (Sharifzoda, 2019). According to the country fact sheets of Tajikistan 2019 adults and children living with HIV are 14000 [12000-18000] (WHO, 2019).

Source: World Bank 2019



The above graph depicts, the number of adults who are HIV infected, from 2014 it shows a downward trend may be it is due to various measures which are taken by the government of Tajikistan to curb this epidemic. Testing capacity is increased and the government made it compulsory to submit a medical certificate before getting married. In 2018 approximately 134,000 people received medical check-ups before marriage and 58 of them were identified as HIV positive (Sharifzoda, 2019). Free medical examinations are conducted at airports, railway stations, and border checkpoints to regulate the spread of infections that labour migrants bring back from abroad.

The labour migration in Tajikistan had to be viewed as a "step-wise construction", whereby the migration of workers may occur in four steps: source, transit, destination, and return, each having certain HIV-related implications (UNAIDS, 2001). This construct emphasized one crucial point that to control the rapid spread of the disease, HIV prevention activities need to cross the national boundaries of individual states. It is estimated that around1.5 million migrants went to Moscow from Tajikistan between 2004 and 2008 (Karimov and Maksudov, 2010) and most of these migrants were men, between 18 to 45 years old, who worked as seasonal labour migrants, staying in Moscow from early spring until late autumn (Zabrocki et al. 2015). Russia is one of the fastest-growing HIV epidemics in the world, with the HIV infection rate increasing 7% in 2013. The average infection rate by the end of 2013 was 35.7 cases per 100,000 people (Novosti, 2013). Studies show that labour migrants to Russia may be at risk for HIV infection due to their risky sexual behaviour, including unprotected sex with sex workers (Amirkhanian et al. 2011; Weine, Bahromov, and Mirzoev; 2008). Tajik migrants who become infected in Russia may act as a bridge for HIV transmission between Russia and Tajikistan, infecting their wives when they return home (Golobof et al. 2011; Kramer et al. 2008; United Nations Programme on HIV and AIDS (UNAIDS, 2008). In this way, migrant workers may sow the seeds for a new regional HIV epidemic. Migrant workers are to be more likely to utilize the services of sex workers and have multiple partners (Mayer and Beyrer, 2007; Magis-Rodriguez et al. 2009). Recent studies reveal HIV prevalence is high and heterosexual transmission rates are escalating and is a major transmission route (Smolak, 2010). Paradoxically, 1700,000 Tajik citizens are working abroad and 80 percent of Tajikistan's financial resources stem from migrant workers (ILO, 2006) hitherto the majority of HIV cases in Tajikistan were among migrant workers. Labour migrants have been included in the risk group in terms of the proliferation of multiple infectious diseases, including diseases of the reproductive system and sexual diseases (Olimova & Bosc, 2003).

**Theoretical Perspective**

According to the theory of gender and power, three major social structures characterize the gendered relationships between men and women: the sexual division of labour, the sexual division of power, and the structure of cathexis (Connell, 1987; Wingood & DiClemente, 2000). This paper aims to apply an extended version of the theory of gender and power to examine the exposures, social/behavioural risk factors, and biological properties that increase women's vulnerability for acquiring HIV. These exposures, risk factors, and biological properties all interact to increase women's

vulnerability to diseases, including HIV. We have tried to put the arguments in the paradigm of Connell's theory of power and gender and how the exposures, risk factors, and biological properties all interact to increase women's vulnerability to diseases, including HIV. The social mechanisms produce gender-based inequalities and disparities (e.g., in women's economic potential, women's control of resources, and gender-based expectations of women's role in society). Let us first discuss the three structures (labour, power, and cathexis) and define potential exposures and risk factors generated by each structure, and see how each structure, exposure, and risk factors that increases women's HIV risk.

**Working Conditions**

Migrants working in Moscow are mostly undocumented young males (80%), married (70%), and between 18 to 40 years of age (Olimova & Bosc, 2003). Usually concentrated in the so-called "3-D" jobs – dirty, dangerous and difficult — with little or no occupational and safety protection in the construction sector, as migrants are hired to do the hardest job, in very poor working and living conditions, demanding endurance, physical power and good health condition (Akramov, 2006). Significant numbers of migrant workers live and work in geographically isolated areas, such as construction sites, mining facilities, or in rural agricultural areas, where healthcare facilities and services are limited, inaccessible, or non-existent (ILO, 2016). Many migrants who work in the mining and construction sectors have high rates of occupational accidents, injuries, and deaths. The mining sector in certain countries is a particularly risky environment in terms of HIV exposure and infection (ILO, 2013). Most of the Tajiks who worked in construction reported that they lived in a Barak or wagon. There have been many cases of fires in the wagons where Tajik migrants were burned and killed. They were also subject to workplace accidents at the construction sites for which they could not get medically treated in Moscow. Migrants working in the *bazaars* lived in overcrowded, unsanitary, and poorly heated dormitories or apartments. Ten people live in one room to save money and they felt safer when in large numbers as it is difficult to find rooms for rent because migrants are not trusted. Also, it is expensive for one or two people to rent a place in Moscow (Luo, Weine, Bahromov, & Golobof, 2012). Migrants feel unprotected as they experience: discrimination; beatings; imprisonment; poverty; inhumane and unsafe housing; lack of access to general medical care and health education; lack of access to HIV information, HIV testing, and HIV treatment ( ILO, 2016).

> "*If Russians want, they can kill you, beat you and say whatever they want. A Tajik does not have the right to say a simple word. Tajiks are unprotected". "I saw myself in the skin of a slave in Moscow. We are unprotected."*(Weine, Bahromov, & Mirzoev, 2008).

These conditions are widely regarded as human rights violations and likely increase the risk of acquiring HIV as is described in human rights theory (Weine, Bahromov, & Mirzoev, 2008). Human rights approaches concerning HIV/AIDS are based on the premise that "human rights abuses contribute to the spread of HIV and undermine attempts to protect people from becoming infected". Migrants' behaviour and attitudes regarding HIV risk and protection were being framed by the harsh conditions of labour

migration. To comfort themselves from these harsh conditions migrants used to have parties occasionally on birthdays or during national holidays. They sit together and drink different alcoholic drinks, have fun and later dance with girls who they bring in from the street (Luo, Weine, Bahromov, & Golobof, 2012). STI rates are high among the lower strata of sex workers, who are often impoverished non-Muscovites, with limited access to or utilization of health care (Aral et al., 2003). As 85 percent of labour migrants, aged 20 to 49 years old, are married concomitantly their lives are at risk of being exposed to any illnesses that the migrants carry, including sexually transmitted infections such as HIV thus contribute to the acceleration of an epidemic in Tajikistan that has risen dramatically since 2000 (Godinho, et al. 2005; Hamers & Downs, 2003). In May 2011, 3051 HIV cases were registered in Tajikistan, of which 145 (10%) were migrant workers (Tajikistan HIV/AIDS Prevention Center, 2011), and concomitantly increased number of HIV cases have been observed among wives of male Tajik migrants following their return to home (Hegland, 2010). From the above literature, it has been manifested that temporary migrants to whom Piore (1979) used the phrase 'birds of passage" tolerate most abysmal working conditions to accumulate wealth for their investment back home as they have a goal to return their home country (Pedraza,1991). The rupture, separation, and loss that are a part of any migration affect the mental health of all immigrants. Migration induces deep and continuous strain that comes from the difficulties encountered in entering a new economic system and culture, changing people's personalities (Pedraza, 1991). These strains are reflected in the immigrants' physical and psychological health distress, and depression (Vega, Kolody, & Valle, 1987). Migrant workers from Tajikistan who have very poor working and living conditions and being out of Tajikistan in Moscow, they also find themselves drawn to activities involving alcohol and women (Akramov, 2006). They believe that being in a new and difficult social environment is leading them to try new behaviours (Weine, Bahromov, & Mirzoev, 2008). Consequently, being far from their families, most Tajik male migrants have sex with multiple partners, including Moscow-based sex workers, who are known to have rates of HIV-1 that are 30 to 120 times higher than that of Moscow's general population (Shakarishvili, Dubovskaya, Zohrabyan, St Lawrence, Aral, Dugasheva, & Ryan, 2005).

**Division of Power**

Paradoxically, labour migration flows and trends are influenced by gender dynamics and can provide new opportunities to improve women's lives and change oppressive gender relations. It can also expose women to new vulnerabilities as the result of precarious legal status, exclusion, and isolation (Marin, 2013). Lack of viable economic opportunities, migrant workers and cultural barriers, gender inequality, and poverty (Smolak, 2010) all place the region at risk for a surge in HIV infection rates albeit which is true in the case of Tajikistan. Gender norms are largely shaped by tradition. Female sexuality is the central point of moral respectability and honour; moreover, it is nested in the woman's family, reflecting both her character and that of her husband and family as well. Along the same lines, the only morally acceptable expression of female sexuality is limited to the context of marriage. Society in Central Asian countries is collectivistic and families are expected to defer to the greater good of the community.

Moreover, the collectivist ideals of the majority trump the individualist inclinations of the few (Harris, 2006). Family structure is extended and individuals are expected to place more weight and value on the needs of the family than their own needs. This standard is particularly expected of women. Along such lines, a significant number of marriages in Central Asia are arranged, sometimes with little input from the woman. The collectivist culture of Central Asia is responsible for structuring and guiding virtually all aspects of family life, including marriage (Harris, 2004). Collectivist traditions also dictate that a great deal of importance be placed on reputation within the community. Such emphasis on reputation can be devastating and yield significant implications about HIV (Smolak, 2010). As the social network is the lifeline of the collectivistic society, the people with positive HIV status keep it secret so that it may not interfere with the pursuit of their life goals and to avoid ostracism which may otherwise limit their life goals (Williams, 2007).

Patriarchal rules dictate the institution of marriage in Tajikistan. Labour migration impacted the families in Tajikistan especially women. Marriage remains a central part of Tajik culture, with most Tajik women marrying before reaching age 22 and the majority of men marrying by age 30. Tajik girls are primarily raised to be homemakers and caretakers of the family affairs, future mothers, wives, and "performers of the husband's will", while the boys are raised to be "future breadwinners and family mainstays" (UNO, 2005). Furthermore, in the Central Asian context, economic pressures and religious regulations largely drive polygamy. Infidelity is common in Tajikistan (Ryazantsev, et al., 2014) as Uehling has put it like that in Tajikistan “marital infidelity was reframed as a Muslim tradition called polygyny, lending it an aura of respectability” (Uehling, 2007) and it is a major source of inequality between husband and wife (Charrad, 2001). Polygyny has a strong impact on women's self-esteem it is a way to “humiliate women as a sexual being: not being able to satisfy her husband” (Mernissi, 1987). In most parts of Tajikistan especially rural areas where the younger generation moves to Russia as migrants the women outnumber men, they have only two options left either to practice celibacy or to prefer *defacto* polygynous marriage (Lemon & Thibault, 2018). Since celibacy inevitably leads to the questioning of a woman's reputation and morals, so it is motivated by a desire to shield oneself against gossip − a form of local punishment for transgressing social norms (Kikuta, 2016). Being single often rhymes with the suspicion of prostitution (Cleziou, 2015). The changing nature of marriage and the rise of polygynous unions are both social and economic in nature of which labour migration is an important factor. According to a survey conducted in 2001, eight percent of Tajik migrant labourers in Russia married a second time and lived with their Russian wives (Kasymova, 2006). In 2013, Al-Jazeera reported that every year, 14,000 migrants establish new families in Russia. Of these migrants, it is estimated that 1/3 already have families in Tajikistan (Thibault, 2018). Yet, recently, the difficult negotiation of these family ties seems to increase the number of divorces (Dodarkhujaev, 2015), as well as an increase in polygynous unions in Tajikistan.

Albeit, Tajik society is generally conservative, however, divorce is common. In the context of labour migration, many migrants even end up divorcing over the phone or via text message while in Russia (Najibullah, 2009; 2011). Divorces typically, and quite understandably, often precipitate the interruption of money transfers to the first wife as

culturally women are expected to attain financial support from their husbands (Harris, 2006). Migrant divorces thus reinforce the financial precariousness of families left behind, and the reliance on in-laws (Reeves 2011). In the year 2011, 6,797 divorces were officially registered in Tajikistan and 7,608 in 2012 which represents an increase of 11 percent in the divorce rate. In 2013, the number of divorces increased again by 7 percent in comparison to the previous year, totalizing 8,194 divorces. In 2013, the number of marriages registered was slightly lower than the number of divorces (Rasulzade, 2014). In the past, divorcees used to be stigmatized, because they signalled that the wives had "failed in a woman's most important profession – that of marriage" (Harris, 2005). It is a well-known fact that the survival capabilities of these women are narrow in Tajikistan because of the limited employment or support opportunities available. Concomitantly, these women are vulnerable to trafficking especially, "after they are informally divorced from their absent migrant husbands and they need to provide for their families" (ADB, 2016).

Another facet of labour migration is that of abandoned wives. In 2009, it was estimated that there were between 230,000 and 288,000 economically abandoned households in Tajikistan (ILO, 2009; Khitarishvili, 2016). Consequently, these women are living at or below the poverty level. The condition of these abandoned wives is deteriorating as the husbands stop remittances which is the only source and blood-line of several households living in poverty. These migrants settle in the host country as permanent migrants and in the vast majority of the cases, start a new family there and forget the family back home, leaving their wives to fend for themselves (Berninghaus & Seifert-Vogt, 1989). In often cases, such women are not supported by their in-laws and in some cases, they are even expelled from their homes without any reason (UNO, 2008). Already suffering from traumatic conditions, they easily become vulnerable to depression, suicide, poor physical health, famine, prostitution, or enter polygamous marriages as a coping strategy. Even if these women enter into a polygynous union, which is permeating in the traditional Tajik society, they don't have any financial security as their designation always remains as that of "second wives" and they don't have any inheritance rights and only entertain small share from their husband's economic gains (Cleuziou, 2016). The second wives live in more precarious conditions as they do not have any right on husbands property or they cannot claim any alimony as their marriage are not officially registered rather they are done in simple ceremonies (Lemon & Thibault, 2018). As a result, in search of survival and shelter, these women have higher chances of engaging in prostitution (ILO, 2009). Other factors that push women to fall victim to human trafficking include inequalities in the labour market, experiences of domestic violence and isolation, lack of social protection, and low educational qualifications (ADB, 2016). Unofficial information acquired through International Labour Organization and HIV/AIDS expert in Tajikistan indicates that some women who are abandoned by their husbands may engage in prostitution in the *bazaars* through exchanging sexual services for economic subsistence. This is a matter of basic survival and this type of sex work is termed as sexual' survival strategies (Schoepf, 1988 ). As mentioned, these abandoned women also fall prey to traffickers who lure them with fake promises of getting the job in the host country. Human trafficking increases vulnerability to HIV infection (ILO, 2013).

Although there is not necessarily a direct causal correlation between trafficking, HIV, and AIDS, once a person is trafficked they are often in an alien environment in which they have little power or agency which increases their vulnerability to HIV. The susceptibility of a trafficked woman to HIV is higher than that of a person who engages in sex work out of choice. Most victims of human trafficking are poorly educated. Their knowledge of HIV risk factors is therefore likely to be low, meaning they have inadequate knowledge of how HIV is transmitted or what they can do to prevent transmission. They may therefore inadvertently transmit the virus to others if they are not aware of their HIV status.

**Unequal Status**

Central Asian societies still believe in controlling the sexuality of women. The lower status of women is reflected in many dimensions such as the historically disadvantaged legal status, inequities in compensation for women's work outside the home, lack of recognition and compensation of women's work in the home, and generally lower status to equitable employment opportunities and positions of power in social institutions (Amaro, 1995). Women are raised to be homebound, obedient, dependent, modest, and concerned about their reputations (Harris, 2004; 2006). Tajik society adheres to the traditional practices such as restricting girls' education and women's rights, confining girls and women to the home, arranging early marriages of young girls, and using violence to chastise wives and sisters (Haarr, 2007). The risk of HIV infection in women cannot be separated from the unequal status of women and the resulting differences in power between men and women (Amaro, 1995). The impact of women's unequal status on their risk of becoming infected with HIV has been noted by many experts worldwide. The unequal status of women puts them at a severe disadvantage in negotiating sexual encounters in seeking and utilising educational and health services (Chen, Amor, & Segal, 2012). Women's ascribed roles as unequal and sex are something that women give to men in which there is little room for women's acceptance of their sexuality. From this perspective stepping out of traditional roles, as required by safer sex negotiation, places women in direct conflict and challenge with men (Miller, 1986). This presents women with a very difficult situation because *"since women have had to live trying to please men they have been conditioned to prevent men from feeling even uncomfortable. Moreover, when women suspect that they have caused men to feel unhappy or angry they have a strong tendency to assume that they are wrong"* (Miller, 1986).

Women in Tajikistan are expected to behave by cultural norms and prescribed gender identities. Concomitantly, when a girl marries, she leaves her family and joins her husband in the house of her in-laws as the *kelin* (bride). Traditionally, the *kelin* was considered the lowest in importance in the family hierarchy, even lower than children (Poliakov, 1992). Still today, some families consider that the role of the *kelin* is to be at the service of both her husband and her in-laws (Harris 2005), as in the connotation of Walby "*a system of social structures, and practices in which men dominate, oppress and exploit women*" (Walby, 1989). Albeit, patriarchal rules dictate the institution of marriage in Tajikistan it condemns the expression of sexual desires of women while men have more opportunities and leverages to make choices in life. Their sexual desires are socially and

religiously endorsed and are at liberty to have multiple partners (Lemon & Thibault, 2018). Although husbands are expected to control and discipline their wives for behaviours that transgress expectations, and they make this control explicit and visible to protect the reputation of the family (Haarr, 2007). Men are at the privilege to define the nature of the sexual practices and the social arrangements in which they are embedded (Walby, 1989). Gender stereotypes are so strong that the Tajik men don't discuss their sexuality with their wives fearing it might encourage their wives to become more independent or worse to become sexually active in their absence (Harris, 2005). These gender differences even add to the dissatisfaction between relations and are the root cause of the unequal status in society. These conservative views on sexuality also affect marital dissatisfaction (Harris, 2005; Temkina, 2005). A small study of migrants' wives (30 women) in Tajikistan revealed the complex gender dynamics behind the HIV epidemic. Migrants' wives were aware that their husbands were engaged in extramarital affairs, but "believed they had no choice but to accept it" (ADB, 2016). Because of commonly accepted stereotypes about men as leaders and providers, the wives trusted their spouses to take precautions and protect themselves against HIV and generally did not ask their husbands to use condoms (Golobof, et al., 2011). Migration provided opportunities for Tajik migrants for greater sexual encounters than are available or acceptable in communities of origin, which may be small and tightly knit, as well as subject to more restrictive behavioural codes. Having multiple concurrent partners is a behaviour that can be facilitated by mobility and it plays a role in increased HIV risk when it includes limited or no use of condoms. Outside of the norms and constraints of their original social environment, migrants can be more likely to engage in sex with multiple partners (Zabrocki, et al., 2015). It has also been seen that partners who are left behind tend to engage more in sexual relations outside the primary relationship than those with non-migrant partners (Corono and Walque, 2012). Such practices, furthermore, make them also vulnerable to venereal diseases and HIV/AIDS (ILO, 2009) as they face increased risk of exposure to HIV due to migrant or mobile worker partners who engage in unprotected extramarital sexual relations (ILO, 2016).

Violence is a tool used by socially defined dominant groups to control socially defined subservient groups (Miller 1986, Freire 2013). In Tajikistan women treated as subservient has direct ramifications for their exposure to violence especially within relationships with men. A study conducted on a group of women of Latinos by Gomez and Marin (1993) suggests that there is a fear of a partner's anger in response to requests to use condoms. Among women at high risk of HIV infection, the experience of violence and abuse is part and parcel of everyday life. Negotiating condom use in this context is likely to become only another opportunity for conflict and potential abuse. Change in sexual behaviour influences society in general and particularly, sexual relations out of marriage, which hurts wives, who are at the risk of getting sexually transmitted diseases and suffering from psychological stress. The phenomenon of violence against women in families has deep cultural roots. Most Tajiks, both men, and women, do not consider hitting, beating and humiliating behaviours (like constant belittling, calling names, ridicule, non-physical forms of hostility) between the family members to be violence, they view it as a normal part of the family life. The expression of a man's right to 'chastise'

his wife and children, who are considered to be his property, is typically referred to as a family "dispute", "conflict" or "quarrel" and is considered a family's private matter. A woman, who speaks about her family problems in public or complaints about being beaten, is considered to be a "bad wife". Because of the cultural notion that family violence is not openly discussed acknowledged or addressed in Tajik society, women and children typically suffer in silence. The following narrative depicts the extent of violence in Tajik households.

> *"A woman had four children. She lived in a nearby village. She did not cook dinner on time when the husband went to the field to work so the husband beat her…when she was baking bread he stabbed her with a sickle eight times. He came from the back while she was baking and stabbed her…there was blood all over the bread and the oven. She fell to the ground and he was kicking her and trying to get the sickle out…the children went to an orphanage and the villagers paid for the funeral…there were earlier cases where he had beaten her"*. (Japan International Cooperation Agency, 2008)

As referred earlier, HIV vulnerability is associated with various factors like violence, lack of HIV testing; needle sharing; limited condom use; concurrent multiple partners; sex work; low HIV knowledge, and low perceived HIV risk (ILO) 2016). The lack of understanding of HIV often leads to low levels of condom use in migrant communities. Even when they are available, condoms may not be used because there are negative connotations associated with them and because they may be considered by some as an obstacle to sexual pleasure (ILO, 2013). Migrants testing positive for HIV are marginalized both within the country in which they work and in their community of origin. HIV is considered a shameful disease in some cultures, and the HIV-positive individuals' initial reactions to the test results, which may include shock and denial, can be exacerbated by the social ostracism. Due to cultural taboos and the stigma associated with the disease, HIV-positive individuals are often reluctant to disclose their status, even to their spouse or partner, leading to a heightened risk of further transmission of the virus as well as an increased risk that the spouse or other partners will not get tested or treatment, or take preventative measures against additional transmission (ILO, 2016). Similarly, under the influence of drugs and alcohol, judgment can be impaired and HIV transmission prevention measures, such as condom use, can be ignored. A study conducted in the Russian Federation on migrant workers discovered that male migrant workers with higher alcohol and drug use attested to higher engagement in risky sexual practices (Luo, Weine, Bahromov, & Golobof, 2012). One migrant said, "*When I am drunk, I can't tell the difference between A from B. Then how I can use condoms*?" (Luo, Weine, Bahromov, & Golobof, 2012). A study of Tajik male migrants living in Moscow found that they had high rates of unprotected sex with prostituted women, multiple concurrent partners, and low condom use, especially when drinking alcohol. The specific working and living conditions of the labour migrants "tend to amplify some masculine norms that are associated with higher HIV sexual risk" (Weine et al., 2013).

The migrants' wives reported basic knowledge of HIV and AIDS, mainly gained through media programs, but also that they were "discouraged from knowing sexuality and HIV/AIDS", or are reluctant to voice concerns with their husbands because it could be

understood as a sign of infidelity or they fear-provoking (Golobof et al., 2011). Many male migrants and female regular partners had basic HIV knowledge, but many also had significant misunderstandings regarding HIV transmission, symptoms, and prevention. There are still many narratives that suggest that the migrants have meagre knowledge about HIV. One participant reported that "*guys suggest drinking some vodka before and after sex as a prevention means from HIV*" (Zabrocki et al., 2015). One female regular partner even feared HIV transmission through everyday items. She said, "*It can be transmitted from a pan or even when people change their clothes. If a person is infected he must have everything separated: clothes and dishes".*

One can now visualise how traditional Tajik society responds when it comes to gender and sexuality. The females are not allowed to express their concerns about their sexuality. Violations of a woman's body within the institution of marriage frequently are justified through cultural values that socialize Tajik men to believe in their sexual prowess and virility (Harris, 2004). Wives remain under cultural constraints regarding sexuality, they know that their husbands utilise the services of prostitutes in Moscow but they cannot reprimand it and they accept their infidelity without questioning. The wives conform to the traditional behaviours and they fear if they bring up the topic of condom use the husbands can reciprocate with violence or abandonment (Golobof, et al. 2011). As a result, wives become more susceptible to HIV infection. Low knowledge about HIV risk was also been found among Tajik migrants returning home (Olimova & Kurbonova, 2006). The HIV vulnerability of labour migrants working in Russia is a public health concern because of the country's high HIV prevalence rate.

**Conclusion**

Labour migration is helping the dwindling economy to make a comeback paradoxically; it is also a cause of permeating the sexually infected disease HIV/AIDS. Many factors are responsible which make the migrants vulnerable to such disease. In this study, an attempt has been made to give narratives and facts which are based on the perceptions made by Connell's theory of gender and power which states that the sexual division of power, sexual division of labour, and Cathexis produce those behavioural experiences which affect the physical and psychological health of women which makes them vulnerable to HIV. Gender stereotypes and discrimination make females more vulnerable to exploitation and violence resulting in negative sexual and reproductive health outcomes. This situation requires an immediate response from both sending and receiving countries in addressing potential risks associated with population movement including migrants' vulnerability to HIV and another sexually transmitted diseases. There is a pressing need to develop prevention programmes that are effective in reducing the risky sexual behaviours that increasingly place women especially left-behind women at high risk of infection. To take measures for the effectiveness in HIV prevention, first women should be well educated so that they can change their social surroundings- the root cause of health problems of women. Successful strategies must include the protection of women from abuse and promote their role in society as equals. The higher the levels of women's education, the less they will accept the violence. Gender education should be initiated in Tajikistan but even the intellectuals who are working on gender issues are of

the view that the Tajik tradition should be maintained not destroyed and this gender education has to face a brunt from its own society. The power that males enjoy won't be easy to change and the females have to continue to balance their household chores and the outside work. To prevent HIV infection, it is necessary not only to promote changes that support the active role of women in prevention but also to promote change in attitudes and behaviours of men. Such change will inevitably require that men relinquish the power that they currently hold over sexual behaviour. This will require that prevention efforts address and seek to change the power imbalance in a sexual relationship between men and women. Bringing up morals which are indispensable to local masculinity like familial responsibility may have a significant influence on decreasing HIV risk behaviours (Smith, 2007). Furthermore, integrating HIV risk reduction strategies into the cultural norms that hold the male as the protector and provider of his family may serve as powerful and consonant elements of future arbitration. The future of successful HIV research in Central Asia could be enhanced by focusing on and modulating pre-existing positive characteristics that are deep-seated in the region (Smolak, 2010). Paradoxically, cultural norms surrounding sexuality combined with religious doctrine forbidding sexual relations outside of marriage, have led to HIV being highly stigmatised to some extent but in the case of female sexuality, it has made left behind females more vulnerable to STIs as they cannot enquire about their husbands' sexual behaviour as they spend most of their time away from home and they cannot negotiate with their husbands on condom use as socially this makes them suspicious about their husband's behaviour.

NGOs are working to educate people about the different STI infections and their reproductive rights. The organization named *Guli Surkh*, which means Red Flower in Tajik, founded in March 2004 is providing training, assistance, and support for those living with HIV. Various TV shows are also conducted to aware people about HIV challenges traditional Tajik ways of perceiving issues such as gender rights and reproductive health, while at the same time maintaining respect for customs such as respect for elders and concern for the community. Migrants had elevated depression and poor social supports which makes them vulnerable to HIV/AIDS. Programs that emphasize comprehensive basic HIV education and also address coping with discrimination, improving social supports, reducing depression, and broadening acculturation and assimilation opportunities and HIV risk issues surrounding concurrent sexual partnerships, the importance of protection with different types of partners, and alcohol and drug use should be promoted. Still, it is hard to say whether this will improve the situation with migrants' health in the circumstances of the absence of a well-arranged system of medical services for migrants. Besides, employers are not interested in the medical insurance of their employees and reinforcement of their health. In the circumstances of the absence of medical insurance, migrants have to practice self-treatment, look for medical acquaintances, go to pay hospitals. Many cases have been found where employers themselves arrange parties and avail themselves the services of prostitutes for their employees. The issues of medical servicing of migrants can be admitted as a total failure of the Russian migration legislation. Now, only since 2014 purchasing medical insurance for those obtaining patents for working in Russia has become mandatory but as we know the majority of the migrants working in Russia are

undocumented so it also becomes difficult to assess the real situation of the epidemic in the country and both governments i.e. the host, as well as a destination, has to go a long way to curb this epidemic. The government of Tajikistan is also openly holding events to educate people about HIV prevention programmes. They are encouraging people to come out and know their HIV status. Tajikistan joins "Hands up for #HIVprevention" in November 2016" (WHO, 2016). Tajikistan also amended some of the Lawson HIV/AIDS and has adopted a comprehensive and human rights-based response to the HIV epidemic by lifting all the travel restrictions on entry, stay, and residence for people living with HIV in Tajikistan. It was signed by President Emomalii Rahmon, on 14 March 2014. Technical assistance programmes are launched in collaboration with the Russian government to combat infectious disease. This technical assistance programme is supported by a three-year grant of US$16.5 million from the Russian government which aims to strengthen the health system, ensure better epidemiological surveillance of HIV and promote the scale-up of HIV prevention programmes. These programmes will reach the communities that are at higher risk of HIV infection and will help to break the trajectory of the epidemic to some extent.

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