



USAID
FROM THE AMERICAN PEOPLE



ASU THE MELIKIAN CENTER:
Russian, Eurasian & East European Studies
ARIZONA STATE UNIVERSITY



The impact of male labor migration on contraception and abortion dynamics among women married to migrants in rural Armenia

Ani Jilozian

✉ *Ani Jilozian*
✉ *Center for Gender and Leadership Studies*

This study/report is made possible by the generous support of the American People through the United States Agency for International Development (USAID). The contents of this study/report are the sole responsibility of the authors (or CGLS) and do not necessarily reflect the views of USAID or the United States Government

Yerevan 2015

TABLE OF CONTENTS

Introduction.....	3
Rationale.....	6
Research questions.....	7
Study design & methods.....	8
Results.....	12
Discussion.....	22
Policy Recommendations.....	23
Acknowledgements.....	25
References.....	26

LIST OF GRAPHS

Graph 1. Age of participants.....	10
Graph 2. Number of children.....	11
Graph 3. Number of household members.....	11
Graph 4. Educational background.....	11
Graph 5. Period of time that husband spends abroad	11
Graph 6. Type of contraceptive ever used.....	12
Graph 7. Number of induced abortions.....	13

INTRODUCTION

Male Seasonal Labor Migration in Armenia

There exists a well-developed pattern of seasonal migration in Armenia, primarily to Russia as well as other parts of the former Soviet Union (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).

Prevalence of contraception and abortion in Armenia

More than half of married women of reproductive age in Armenia are using a method of contraception. The most widely used method among currently married women is withdrawal (25%), 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).

Among countries with reliable information on abortion trends, the Caucasus region has the highest legal abortion rates in the world (Sedgh et al, 2011). Almost half of 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).

Consequences of husbands' labor migrant status on contraception/abortion dynamics

Despite the extensive research on the consequences of migration, little is known about the effects of seasonal migration on contraception/abortion dynamics, especially in the context of the former Soviet Union, a low fertility setting where there has been vast social, political, and economic changes over the last couple of decades.

It has been found that, though long-term separation of spouses decreases the chances of conception, changes in one's socio-economic situation; cultural values and preferences; knowledge, availability, and use of contraception; and frequency of sexual intercourse may change as a result of migration (Sevoyan, 2011).

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).

RATIONALE

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 Armenia. 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 factors that lead to abortion seeking behavior in regions of high migration; thus, more exploratory qualitative research in particular is needed to uncover the role of abortion and contraception in reproductive strategies that shape the reliance on abortion among women married to seasonal migrants.

This study investigates the perceptions and experiences with contraception and abortion among women with husbands who seasonally migrate; seeks to elucidate the multifaceted and interconnected factors that influence decision-making about contraception and abortion among this population; and examines how health providers' perceptions and experiences with contraceptive methods and abortion practices translate to counseling and treatment of women with migrant husbands.

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.

RESEARCH QUESTIONS

The study poses two main research questions:

- 1) How have women's beliefs, perceptions, attitudes, and experiences with various methods of contraception and abortion practices been influenced by spousal separation and the socio-cultural milieu in which the women live?

2) How do pharmacists' and health providers' perceptions and experiences of the various contraceptive methods and abortion practices translate to counseling/treatment of women with migrant husbands?

STUDY DESIGNS & METHODS

Study design

The analysis uses data from a longitudinal qualitative research study that was conducted in the Gegharkunik province of Armenia, an area of particularly large male labor out-migration primarily directed to Russia. The interviewer employed individual, in-depth interviews due to the sensitivity of the subject matter. Content analysis was used to identify and interpret recurrent themes in the data.

Population/Sample

The interviewer carried out in-depth interviews 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. Interviews were also carried out with 9 health providers (5 gynecologists and 4 pharmacists) in the three cities in closest proximity to the target villages, named Gavar, Marduni, and Vardenis. 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.

Data collection

The investigator used a semi-structured interview guide 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 investigator personally conducted all interviews with women and health providers in private rooms at their residences and health institutions, respectively. When privacy was compromised, the topic was changed. All interviews were recorded after obtaining oral consent. Notes were also taken during interviews.

Data analysis

The investigator transcribed all interviews and employed inductive content analysis to analyze the data. This approach was considered the most appropriate given the scant existing theory and literature on this research topic, as well as the ability to gain direct information from participants without imposing preconceived notions. The investigator initially used open coding to begin creating categories and abstraction and subsequently developed themes corresponding to the codes.

Timeline

The project started in 2009 and the fieldwork for the latest wave of data collection took place from December 2014 to February 2015.

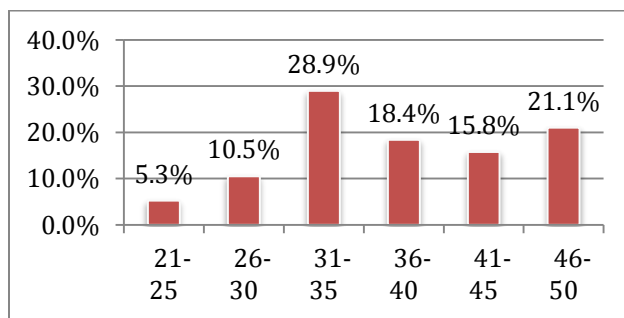
Ethical Considerations

The proposal was reviewed by the Institutional Review Board at the Arizona State University. Before conducting each interview, the investigator explained the research and asked participants to provide oral consent, requiring no signature from participants in order to support anonymity. Furthermore, the investigator made participants aware that they could stop their participation at any point in time and could choose not to answer specific questions. Confidentiality was protected in all

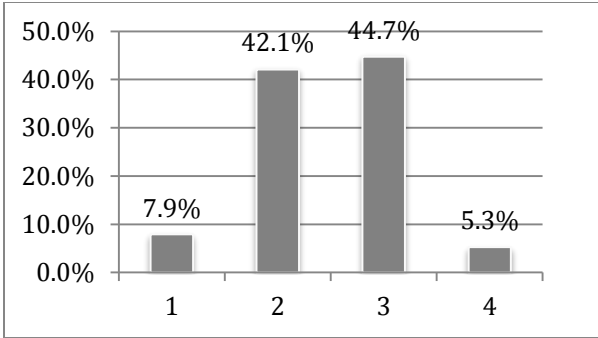
instances during the course of the study. Participants' names, contact information, and other personal qualifiers were not recorded and were not included in transcriptions. All verbatim quotes used in reporting the findings were edited to delete personal identifiers. Additionally, given that each village had a small number of residents, the investigator chose to record only the region and not the specific names of each village. After all interviews were transcribed and translated, recordings were deleted.

Demographics

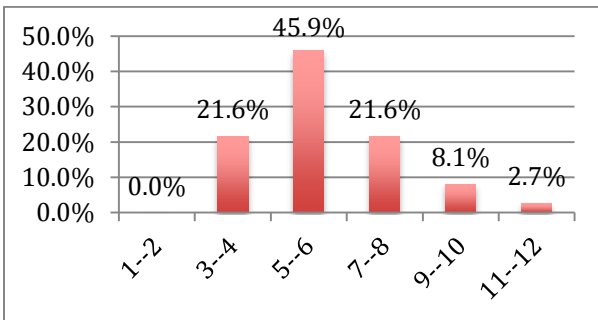
The age of the women interviewed ranged from 21-49, with an average age of 37. The women had 2.5 children on average. The majority of participants (73%) lived in traditional family households with extended family members (an average of 6 family members per household), whereas 27% lived with only their immediate families. The majority of women (65%) had a high school education; 14% did not graduate high school and 21% received higher education. Seasonal migrants married to the participants lived outside of Armenia for an average of 6 months/year. See Graphs 1-5 below for more details:



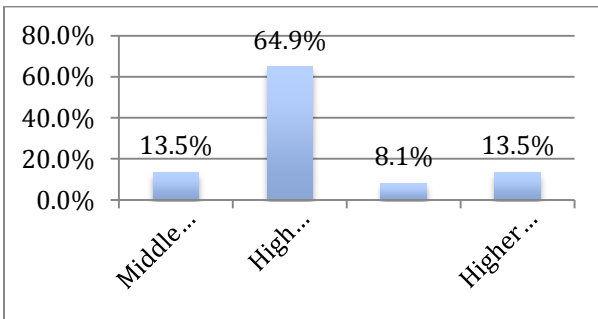
Graph 1. Age of Participants



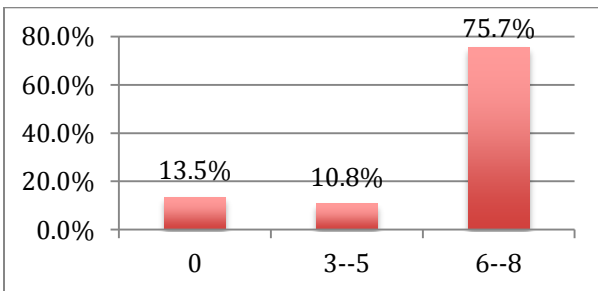
Graph 2. Number of Children



Graph 3. Number of household members



Graph 4. Educational background



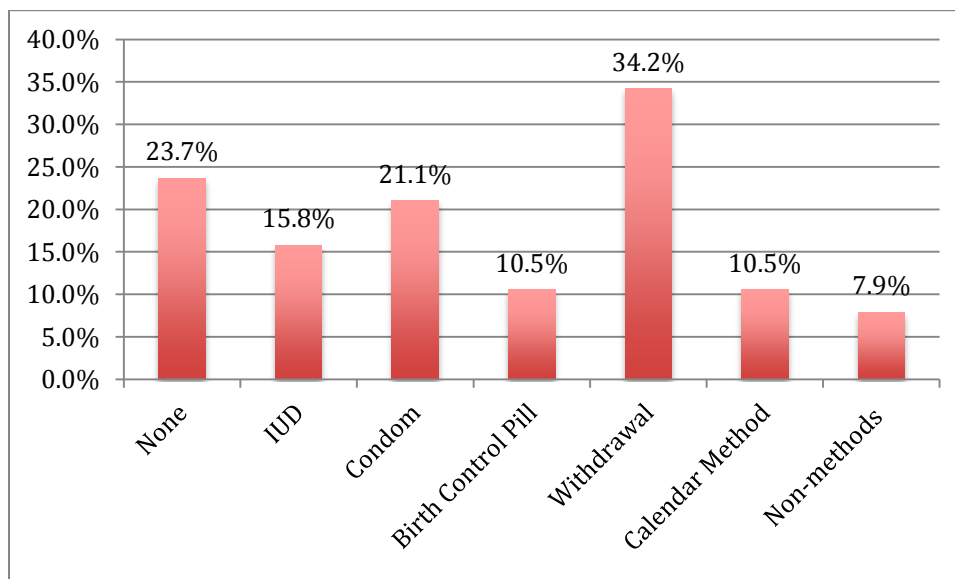
Graph 5. Period of time that husband spends abroad

RESULTS

Contraception and Abortion Dynamics

Use of contraception

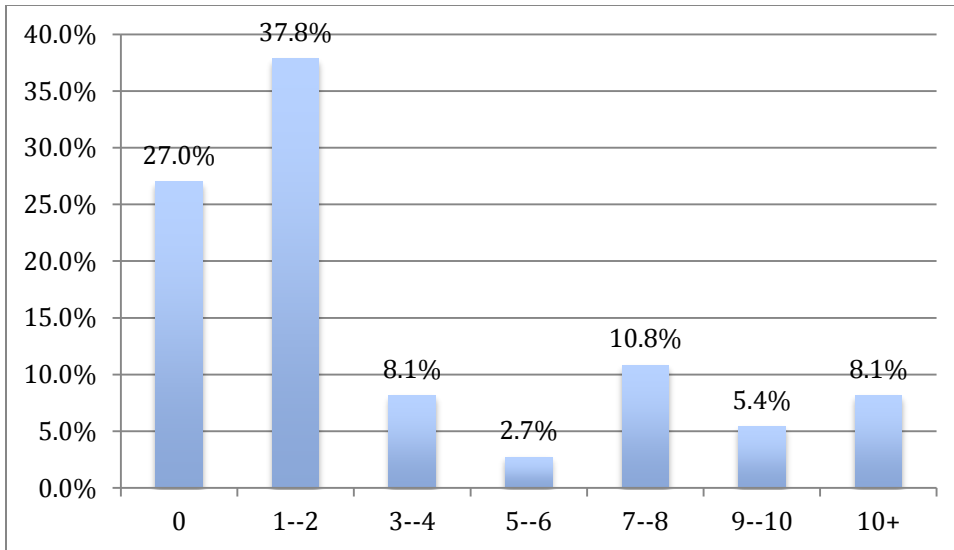
Nearly half of the participants had used a form of modern contraception at least one point in time, whereas nearly one quarter had never used any type of contraception. See graph 6 for more detailed information regarding the type of contraception ever used by this population.



Graph 6. Type of contraceptive ever used (note that participants may have used more than one method)

Recourse to abortion

The participants in the study experienced 3.5 induced abortions on average since the beginning of their reproductive periods. See graph 7 for a breakdown of the number of abortions experienced by this population.



Graph 7. Number of induced abortions

Barriers to the use of modern contraception among women married to migrants

Modern contraception avoided due to perceived low risk of pregnancy

The participants in this study primarily used natural contraceptive methods of contraception over modern ones due to a variety of reasons. Some of their reasons were similar to women married to non-migrants, namely socio-economic barriers, familial and peer influences, and negative perceptions. However, women married to migrants also had a perceived low risk of unintended pregnancy.

Though many of the participants 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.

“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.” – Gynecologist practicing in Martuni

Modern contraception perceived as encouraging unnecessary sexual behavior

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.

“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 also completely against it.” – Mother of 2 in her mid-30s

Modern contraception perceived as posing health risks to sexually inactive women

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.

“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.’” – Mother of 2 children in her late 40s

“To be honest, I decided once to use the IUD, but then I changed my mind. I thought, ‘What’s the need?’ since [my husband’s] not here. Why should I put stress on my body by inserting something foreign? If we were together – if I’d go to be with him or if he’d stay – then I’d use it.” - Mother of 3 children

Lack of sexual assertion and condom use

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.

“I trust my husband... There was no need [to have a conversation]... We’ve never used condoms, I’ve never been sick, and I’ve never gone to the doctor after my husband came back.” – Mother of 3 in her early 40s

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.

“[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.” – 40 year-old mother of 3 children

Despite the fact that the majority of couples did not converse about the topic of condom use, some women did understand that they were at greater risk and did assert themselves more. Generally these women were nearing the end of their reproductive age, though more research would need to be conducted on this topic to understand whether age has an impact on asserting condom use among migrant couples in Armenia.

“It would be safer to use condoms, right? He’s a man, isn’t it? All men are the same. You’re not safe. You can’t say... Of course I talked to him about it. All men are the same. However you like it, men go out, meet others, and you worry. Isn’t it safer with condoms than with another method?” – Mother of two children in her late 40s

Influence of husbands’ migrant status on fertility decisions

Lack of advanced planning regarding desired number of children and pregnancy spacing

In general, participants tended not to plan pregnancies and communicate with their husbands about their desired number of children or birth spacing. Women either noted that they and their husbands played an equal role in fertility decisions or that their husbands ultimately decided on the number and timing of children. Few noted that they were the sole decision makers regarding their fertility.

“The decision is mainly made by the husband as the head of the household. The wife cooperates with him.” – Mother of 2 children in her late 40s

Family size not perceived to be influenced by husbands' migrant status

The majority of participants noted that they would have had the same number of children regardless of whether or not their husbands worked as seasonal migrants. A few women, however, believed that they might have had more children due to difficulties in getting pregnant or the fact that their husbands' absence created challenges for them.

“I think we may have had more [children had he been around]. Four wouldn't have been bad. Everyone has their challenges. You have to be able to provide for your children. He wasn't around during every step of the way, sometimes even for the whole year. When the child started walking, he didn't even realize that it was his child. When that's how you're living, why have another child?” – Mother of 3 children in her late 30s

Recourse to abortion not perceived to be influenced by husband's absence

According to participants, use of abortion was primarily driven by socio-economic conditions, a desire for birth spacing, son preference, and a desire to limit family size. Women typically did not attribute their husband's status as a migrant worker and, thus

their absence, as influencing their decision to have an abortion. Several of the participants noted that their husbands began working as migrants after their children were born and that their husbands' migrant status did not effect decision-making regarding abortion.

It was the norm for women to consult their husbands regularly about family matters when they were abroad; thus, they noted that decisions regarding abortion would have been the same regardless of their husbands' presence or absence.

“It’s true that he goes to Russia. Anything that involves the family, any issue, I have to call him and tell him that there’s this problem and together we have to make a decision about how to solve it. It’s like that. Without him, I can’t make decisions regardless of the issue.” – Mother of 4 children in her mid-40s

Abortion characterized differently by women with varied pregnancy experiences

Participants who had complications during pregnancy and/or experienced miscarriages were typically more likely to use language suggesting that they were psychologically affected by having to have an abortion. Others generally perceived it as an unfortunate reality of being a woman and spoke about it casually.

“It was so painful for me to have those two taken out. I was sick, so that’s why I had to have an abortion. But it was so painful for me to have those two taken out. It’s like cutting off two of your fingers and tossing them away. I took it very hard. I don’t accept doing it.” – Mother of 2 children in her late 40s

“I had abortions. All women go through this... If I were to say that I regret it, that would be a lie. No, what would I do if I had another child? How would I provide for it? The living conditions are hard. Things are really hard for us.” –
Mother of 4 children in her mid-40s

Son preference primarily linked to social norms among women with migrant husbands

The participants used language to suggest that having son preference and using sex selection was a normal phenomenon and part of the struggle of everyday life. In general, the notion that a son was necessary for the family went unchallenged, and often women had trouble answering the question of why they or their husbands desire to have a son. One woman in her mid-thirties with three daughters and one son said of her husband, “What kind of man wouldn’t want to have a boy?”

Sex-selective abortion was typically seen as necessary in instances where families did not have a son to continue the family lineage. Most women in the study stated that the reason for son preference and sex-selective abortion was to continue the family lineage or simply had to do with personal preferences. One mother of 3 children in her early 30s firmly stated, “It just has to do with your desire... Girls today are especially disorderly. I don’t like girls.” Another participant similar in age and number of children exclaimed, “Of course [you need a son]. The daughter marries and leaves. The son is the heir; he continues the race/family.”

In other regions where this type of research is carried out, the reasons stated by women are often more varied and have more to do in part with socio-economic conditions. In this study, which focused on the perceptions of women married to migrants, few noted socio-economic reasons, such as the dependence on male children to care for elderly parents and keeping inheritance within the family. This phenomenon may be due to stronger ties to traditional norms and may also have to do with remittances and the husband's migrant status, although no direct correlation can be made based on this research.

Health provider counseling for women married to migrants

Lack of individualized counseling on contraception

Contraceptive counseling, including counseling on condom use for STI prevention, by health providers 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. In instances where providers know of the women's status, they will recommend condoms to avoid contracting an STI. However, issues of confidentiality and lack of trust in the medical system may make women uncomfortable with disclosing this information and/or seeking testing and treatment from their physicians.

“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." – Gynecologist based in Vartenis

Health providers generally noted that they see fewer patients who are interested in contraceptive counseling, which they attribute to the growing outmigration and high rate of seasonal migration in the region.

"I think there are fewer people using [modern contraceptives] than 5-10 years ago. When I used to have a family planning cabinet at the hospital, I had a lot of patients, many. And they would take a large amount of condoms and we would do many IUD insertions. Now I feel like that number has dwindled. Maybe it's because all the youth are leaving this place. Now older the older people remain. I think that's why."

– Gynecologist based in Vartenis

Lack of individualized counseling on abortion and dismissal of the phenomenon of sex-selective abortion

Given their aversion to the procedure, health providers generally counseled women about abortions in the same manner using shaming and scare tactics. They did not take into consideration a husband's status as a migrant worker when counseling and tended to dismiss the widespread problem of sex-selective abortions.

“When they’re still unborn, we kill them. That has always been painful for me. I’ve carried it out, I won’t say that I don’t, but it’s painful every time... I have a picture taped to the wall in the room where we do abortions that shows how a child [fetus] flinches when you come close to it with a surgical tool.” – Gynecologist based in Vardenis

“The issue of sex selection isn’t that bad now. For instance, now we had one woman give birth to her third girl. She could have aborted the pregnancy at 14 weeks after learning the sex, but she didn’t... It’s always been like this. It’s kind of blown out of proportion when they say that especially in Gegharkunik they keep boys and not girls... It’s exaggerated. It’s true that our community likes boys, but the numbers are not that catastrophic.” – Gynecologist based in Martuni

DISCUSSION

The findings suggest that, given the inconsistent and/or incorrect use of contraception, women with migrant husbands are highly vulnerable to unwanted pregnancies and sexually transmitted infections and are in need of greater counseling on contraception that is specifically tailored to their needs.

Women in Armenia who are married to migrants face the same barriers to modern contraceptive use as women married to non-migrants in addition to other barriers, including a perceived low risk of pregnancy, husband’s desire to control their wives’

sexuality in their absence, the perception that modern contraceptives are risky for non-sexually active women to use, and a lack of agency to assert condom use.

Participants rarely spoke to their husbands about issues concerning family planning and fertility decisions, and most stated that childbearing and use of abortion were not related to their husband's migrant status. For the most part, recourse to abortion was primarily driven by other factors. Participants used language to suggest that son preference was influenced not by socio-economic concerns but rather a deep-seated preference for sons due to the Armenian mentality regarding relative value of gender.

Though this study illustrates the importance of exploring the connection between seasonal male migration and contraception/abortion dynamics of non-migrating partners in Armenia, more qualitative and quantitative research with a larger sample is needed to fully examine the multifaceted issues that arise from this arrangement. Of particular importance is shedding greater light on regional differences in son preference given that rates of sex selection in Gegharkunik are among the highest known in the world.

POLICY RECOMMENDATIONS

Targeted contraceptive counseling at the community level

Increased provision of targeted contraceptive counseling is necessary to more effectively promote improvements in sexual and reproductive health of women married to labor migrants in rural Armenia, especially as this relates to condom use

and long-acting methods of contraception. Educational programs should take into account the barriers women with migrant husbands face with regards to utilizing modern contraception with a particular emphasis on promoting women's empowerment to raise their decision-making capacity with the ultimate goal of reducing the unmet need for family planning among this population. Trainings with women will help educate them about the various methods of contraception in order to make better contraceptive choices; debunk long-held myths; and dispel fear and distrust of certain modern contraceptives. Health education should also include men in the communities in order to encourage them to take a more active role in their partners' reproductive health.

In-depth trainings with health providers

Health providers also need to be better equipped with knowledge regarding modern contraception and the patterns of decision-making in order to counsel women more effectively. Considering that primary care is often underutilized in the Armenian context, especially among women with migrant husbands who often face great challenges, effective post-abortion counseling is extremely important to substantially reduce the unintended pregnancy. More work should be done to educate local providers about proper contraceptive counseling for vulnerable populations, including women with migrant husbands, in an effort to reduce the unmet need for family planning and the number of abortions. An understanding of how one's husband's status as a migrant worker influences decision-making about contraception will help health providers adequately counsel women in their communities. Furthermore,

particular emphasis should be placed on training physicians about the prevalence and consequences of abortions based on the sex of the fetus and ways in which to converse effectively with patients in order to help reduce the reliance on sex selection.

Promoting women's empowerment

Given the persistently high levels of male labor migration in Armenia and the consequences on women's sexual and reproductive health, educational programs should include gender mainstreaming to promote gender equality and challenge harmful traditional notions of gender relations in the region to reduce the rates of STI transmission and induced abortion.

ACKNOWLEDGMENTS

I would like to acknowledge the guidance of Dr. Victor Agadjanian in helping design the research study and providing feedback on an ongoing basis. I would also like to thank the Melikian Center at Arizona State University and the Center for Gender and Leadership Studies at Yerevan State University for their support of this research project.

REFERENCES

1. International Labour Organization (2009). Migration and Development, Armenia Country Study. Retrieved from http://www.un.am/up/library/Migr_Dev_Study_eng.pdf in June 2015.
2. National Statistical Service of the Republic of Armenia (2010). *Statistical Yearbook of Armenia*. Yerevan, Armenia. Retrieved from <http://armstat.am/file/doc/99461548.pdf> in June 2015.
3. National Statistical Service of the Republic of Armenia, Ministry of Health [Armenia], & ORC Macro (2012). *Armenia Demographic and Health Survey 2010*. Calverton, Maryland: National Statistical Service, Ministry of Health, and ORC Macro.
4. Asatryan, A. (2007). Emigration in the South Caucasus Republics. Caucasus Research Resource Centers. Retrieved from http://www.crrc.am/hosting/file/_static_content/fellows/fellowship06/A%20Asatryan/Armen%20Asatryan_report.pdf in June 2015.
5. National Statistical Service of the Republic of Armenia, Ministry of Health [Armenia], & ORC Macro (2001). *Armenia Demographic and Health Survey 2000*. Calverton, Maryland: National Statistical Service, Ministry of Health, and ORC Macro.
6. Sacci I, Mkrtychyan Z, Dolyan N, Armistad A. (2008). Availability and Affordability of Contraceptive Commodities in Pharmacies and Primary Healthcare Facilities in Armenia: Descriptive Study Report. Project NOVA, United States Agency for International Development.
7. Sedgh G, Singh S, Henshaw SK, Bankole A. (2011). Legal Abortion Worldwide in 2008: Levels and Recent Trends. *Perspectives on Sexual and Reproductive Health*, 43(3): 188-198.
8. Sevoyan, A. (2011). The consequences of male seasonal migration for women left behind: the case of rural Armenia. Arizona State University. Retrieved from http://repository.asu.edu/attachments/56768/content/sevoyan_asu_0010e_10596.pdf in June 2015.
9. Hughes, G., Hoyo, C. & Puoane, T. (2006). Fear of Sexually Transmitted Infections among Women with Male Migrant Partners – Relationship to Oscillatory Migration Pattern and Risk- Avoidance Behavior. *South African Medical Journal*, 96(5): 434-438.
10. Weiss, E., Whelan, D. & Gupta, G. R. (2000). Gender, Sexuality and HIV: Making Difference in the Lives of Young Women in Developing Countries. *Sexual and Relationship Therapy*, 15(3): 233-245.