



Pregnancy, childbirth and health of female labour migrants from Central Asia in Russia

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Abstract

The research note contains an analysis of data on health, pregnancy, and childbirth experience among female labour migrants arriving in Russia from Central Asia. Empirically, the study bases on the data of three surveys conducted in 2015, 2017, and 2020. In total, the surveys contain information on 2,028 migrants from Tajikistan, Kyrgyzstan, and Uzbekistan living in Russia. The analysis proves that with gradual feminization of labour migration from Central Asia, pregnancy and childbirth in a significant part of labour migrants take place in risky living conditions; the existing system of maternal health protection for migrants in Russia needs modernization. Compared to earlier studies on this topic, the survey data showed a higher proportion of female migrants who had got pregnant and gave birth in Russia along with a lower proportion of migrants who terminated pregnancy. These differences may indicate a change in the reproductive behaviour of women who come to work in Russia from the countries of Central Asia. The presented note shows the need for in-depth studies of the reproductive behaviour of labour migrants in Russia, as well as the development of national migration statistics, which should become gender sensitive.

Keywords

health of migrants, female migration, labour migration, Central Asia, Russia, reproductive behaviour

JEL codes: I12, I18, J13, J61, J68

Introduction

Intensive migration flows in the Eurasian migration system (Ivakhnyuk 2008) justify the need for medical services and healthcare programmes for foreign workers. However, many issues in this field remain unresolved and are not listed among the priorities, even within the framework

of the Eurasian Economic Union (EAEU) (Aliev 2016; Poletaev and Florinskaya 2015; Poletaev 2018; Poletaev and Zayonchkovskaya 2019). At the same time, just a few academic studies consider the health of labour migrants, in particular, the health of female labour migrants in Russia (Ivakhnenko 2013; Kislitsyna 2013; Nafeev et al. 2013; Trudovaya migratsiya...2010).

One of the trends in labour migration from Central Asia to Russia is its gradual feminization (Zhenshchiny-migranty... 2011; Poletaev 2016; Nasritdinov et al. 2016; Poletaev 2019); for example, the share of women in the total migration flow from Kyrgyzstan reaches 40%. Moreover, we observe changes in the marital structure of female migration; in 2000–2010, female migrants mostly entered Russia together with their husbands, but then the data showed an increase in proportion of single and divorced women. Some of them come from families that had broken up as a result of labour migration, since husbands who had been away for a long time started new families and/or divorced their wives in their homeland (Zhenshchiny-migranty... 2011).

At the same time, the reproductive behaviour of labour migrants is studied poorly (Zhenshchiny-migranty... 2011; Agadzhanian and Zotova, 2011; Peshkova and Rocheva, 2013; Protection, 2014). The purpose of this work is to present the data collected by the author within special surveys on health, pregnancy, and childbirth experience among labour migrants conducted in 2015, 2017, and 2020. Existing estimates of the composition of labour migrants arriving in Russia, over 75% of the total flow falls on immigrants from Central Asia (Selected indicators... 2020), which is why the author focuses on the behaviour of migrants from Tajikistan, Kyrgyzstan, and Uzbekistan.

Empirical base of research

The study uses data from three surveys conducted by the author in 2015, 2017, and 2020 (Poletaev 2016, 2021; Poletaev and Zlobina 2018) among female labour migrants from Kyrgyzstan, Tajikistan, and Uzbekistan living in Russia. A total of 2,028 women were surveyed in three rounds. The surveys of 2017 and 2020 focus on three Russian cities that are highly attractive to migrants from Central Asia (Moscow, St. Petersburg, and Yekaterinburg). The 2015 survey was conducted in five cities (Moscow, St. Petersburg, Yekaterinburg, Kazan, and Nizhny Novgorod). The key sample characteristics for each year are shown in Table 1.

Moscow is the main migration center in Russia and the richest Russian city with the most developed economy, attracting the largest number of migrants. Migrants arriving in Moscow are characterized by high differentiation by age, gender, and professional status, they differ in the level of earnings and experience of living in Russia. St. Petersburg is the second most important and attractive Russian city for migrants with a rich migration history. Yekaterinburg is the main center of attraction for migrants in the Ural region, a large industrial and administrative center with a constant demand for foreign labour. Kazan is the capital of Tatarstan, a city where migrants from Tajikistan, Kyrgyzstan, and Uzbekistan — countries with a predominantly Muslim population — have the opportunity to live next to the Muslim population of Russia. Nizhny Novgorod is an important economic, industrial, scientific, educational, and cultural center of Russia, the largest transport hub and administrative center of the Volga Federal Okrug, the center of the Nizhny Novgorod agglomeration (the sixth largest in the country and the second in the Middle Volga region); therefore, it also turns out to be attractive to migrants. These factors determined the choice of survey geography and the structure of respondents by cities of their residence.

Table 1. Sample characteristics: surveys of migrant women in 2015, 2017, and 2020

		2015	2017	2020
Sample size, persons		1,239	349	440
Subsamples by country of origin, persons	Tajikistan	634	-	152
	Kyrgyzstan	605	349	151
	Uzbekistan	-	-	137
Subsamples by city of residence, persons	Moscow	390	150	195
	Saint Petersburg	250	100	127
	Yekaterinburg	209	99	118
	Kazan	190	-	-
	Nizhny Novgorod	200	-	-
Age composition, % of the sample	18–25 years old	34	37	28
	26–35 years old	33	31	39
	36–60 years old	33	32	33
Composition by work experience in Russia, % of the sample	1–2 years	50	55	50
	3 years or more	50	45	50

The samples of all three surveys consist of working female migrants from Central Asia and do not include other groups of migrants (foreign students, underage migrants, migrants of retirement age, unemployed, etc.), since they all have different living conditions and strategies for integration and adaptation. This distinction makes it necessary to study their reproductive behaviour separately. For the same reason, labour migrants who, in addition to the citizenship of their country, have Russian citizenship or a residence permit in Russia, were not included in the survey samples. Due to the fact that the study in all five cities involved employees of Russian non-governmental organizations providing direct assistance to migrants and speaking Kyrgyz, Tajik or Uzbek languages, it was possible to reach respondents who do not speak Russian and therefore belong to the group of most vulnerable migrant women who are less integrated into Russian society than others.

The surveys were conducted based on structured questionnaires using face-to-face interview techniques; individual unsupervised self-reporting was not allowed. The survey was carried out by experienced interviewers at the place of work or residence of the respondents. The primary survey points were set in the city districts, and these districts were allocated in advance among the interviewers. Various infrastructural objects within these districts served as secondary points of the survey; no more than two respondents were selected at one point; surveying women living in one household was restricted. Previously, this approach was tested in a study by the Center for Migration Research (Zhenshchiny-migranty... 2011), where it proved its effectiveness.

The sample in all three surveys was quoted based on three parameters: age, experience of living in Russia, and citizenship. Quotas for other characteristics were not introduced, but the interviewers followed the approach of the greatest possible diversity in terms of the respondents' employment. This approach was first tested in 2015, and as a result of its im-

plementation, it was possible to identify four main areas of employment for migrant women from Central Asia: (1) wholesale and retail trade, (2) services in hotels, catering, and restaurants, (3) other services, including laundry (dry cleaning), hairdressing, and beauty services, and (4) services in private households. The last sphere of employment for female migrants is typical for Russian cities. The same approach was applied in 2017 and 2020.

To ensure the possibility of comparisons when dealing with a small sample size, the author works with three age groups: young women (18–25 years old), women of middle working age (26–35 years old), and women of an older working age (36–60 years). The composition of these groups was controlled by the work experience of migrants in Russia (50% with experience of 1–2 years, 50% with experience of 3 years or more). The sampling technique chosen by the author differs from that used in previous studies among migrant women from Central Asia (Agadzhanian and Zotova 2011) by a wider age interval, which became possible due to the increase in the total sample size.

The described approach does not ensure representativeness of the data, but it enables comparisons between groups of migrant women.

Main research findings

General health

The health status of migrant women before pregnancy, as will be shown later, is closely related to the pregnancy outcome. Despite the fact that most female migrants at the time of entry into Russia do not declare health problems, working and living conditions worsen their general health (Poletaev 2020), which has negative consequences during pregnancy.

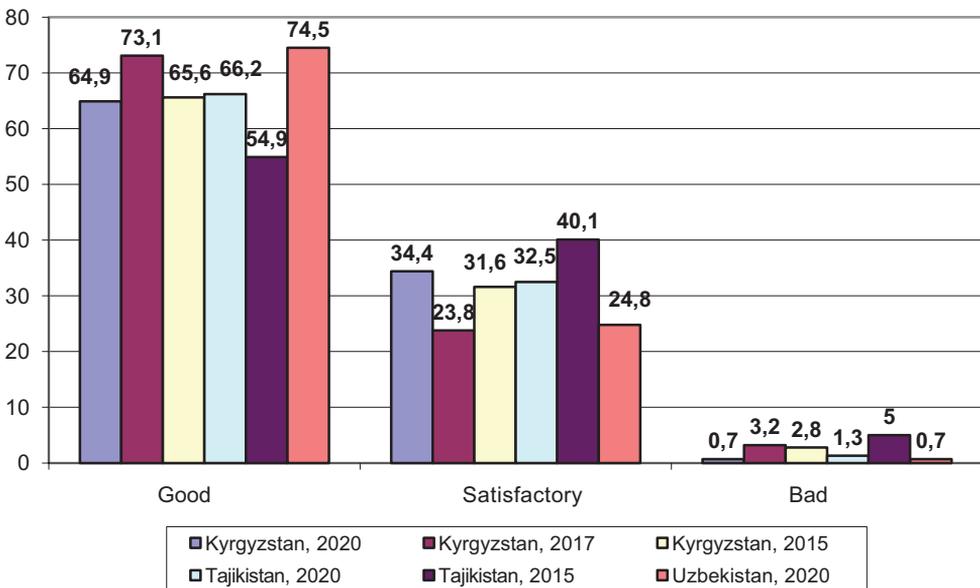


Fig. 1. Distribution of respondents by health status, % of respondents. *Source:* author’s calculations based on survey data from 2015–2020.

Most of the interviewed migrant women assessed their health as good (from 55% to 75% depending on the country and year of the survey; Fig. 1). This could be explained by the selection — migrant cohorts are mostly formed of healthy women who are ready for difficult working conditions. Between 24% and 40% of the respondents considered their health to be satisfactory, and from 1% to 5% of migrating women assessed it as bad. In 2020 (the year of the development of the coronavirus pandemic), on average, about two-thirds (68%) of labour migrants from Central Asia assessed their health as good.

Among women from Kyrgyzstan, we do not observe any significant changes in the assessment of health dynamics during their stay in Russia: about 16–17% of the women surveyed in 2015, 2017, and 2020 say that their health has deteriorated over the past year (Fig. 2). 14% of migrant women from Tajikistan indicate a deterioration in their health in 2020 compared to the previous year, while in 2015 this indicator was higher, it reached 23%. Among migrant women from Uzbekistan, the share of those who noted deterioration in their health over the past year was the lowest — it amounted to 8% (2020). An improvement in their health was reported by 2% to 7% of migrant women. On average, one out of six migrants included in the observation for all the years of the survey reported a deterioration in health.

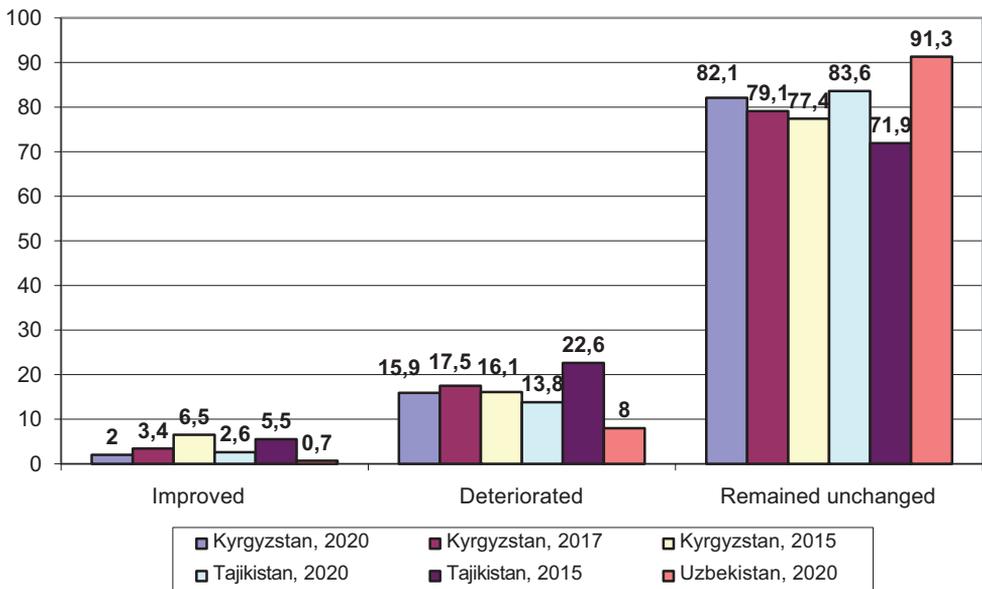


Fig. 2. Distribution of respondents by the dynamics of their health status in Russia, % of respondents. Source: author's calculations based on survey data from 2015–2020.

Surveys show that most of the migrants included in the observation do not pay enough attention to preventive health supervision and visit doctors only when there is an urgent need for it; this was stated by 40% to 50% of respondents, depending on the year of the study and the country of origin of migrants (Fig. 3).

In the presence of a legal labour contract, migrating women from EAEU countries are entitled to a free mandatory medical insurance (MMI) in Russia. Among female migrants from Kyrgyzstan surveyed in 2020, 23% had a mandatory medical insurance (in Fig. 3 they are included in the “other” category). Together with 17% of female Kyrgyz migrants who

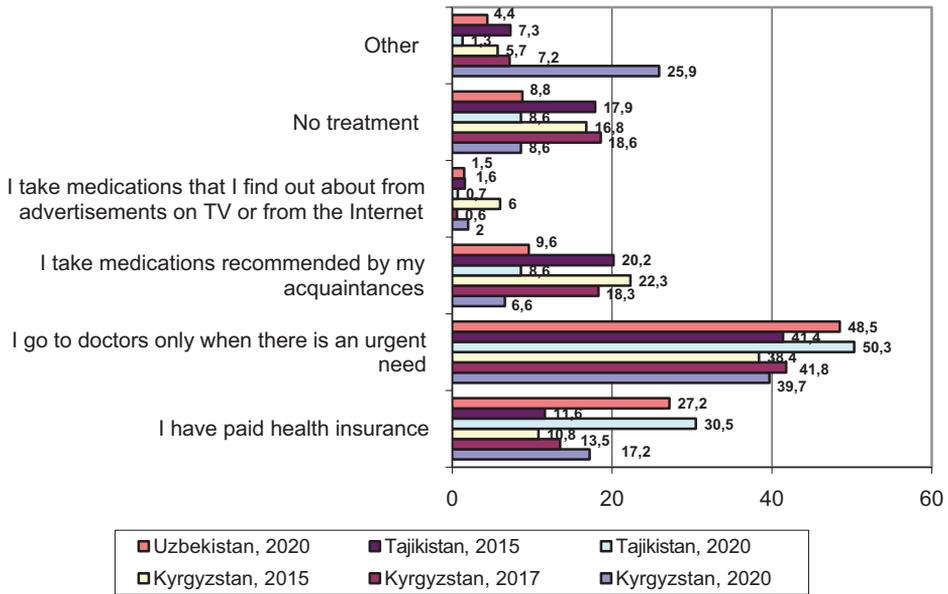


Fig. 3. Distribution of respondents by method of treatment and prevention of diseases, % of respondents. *Source:* author’s calculations based on survey data from 2015–2020.

have paid health insurance, these respondents formally had the best access to healthcare services. At the same time, 95% of respondents from Kyrgyzstan, who indicated that they had purchased a paid health insurance policy, reported that its cost does not exceed 6,000 rubles, which means access to only a minimal set of services.

Similar results were obtained in 2020 in a survey of female migrants from Tajikistan and Uzbekistan who have paid health insurance (31% and 27% of the respondents from these countries, respectively): an overwhelming majority of them (100% and 94%, respectively) buy health insurance policy at a cost up to 6,000 rubles; usually, they purchase the policy to obtain a working patent, but not to get full-fledged medical care.

On average, 7% to 22% of migrant women from different countries in different years of the survey indicated that they were taking medications advised by their acquaintances, and from 9% to 19% said that they had not been getting any treatment at all.

Pregnancy and childbirth among labour migrant women

In three rounds of the survey, 19% to 27% of female migrants indicated that during their stay in Russia they had got pregnant (Fig. 4), and 3% to 9% — more than once, which is higher than estimates obtained in the 2010 study (approximately 2–3 times higher for a single pregnancy and 3–9 times higher for several pregnancies; see (Zhenshchiny-migranty... 2011)).

A comparison of estimates for 2015, 2017, and 2020 for female migrants from Kyrgyzstan shows that, despite a slight increase from the 2015 survey to the 2020 survey, on average, the proportion of such women remains quite stable. The noted increase in indicators occurs both in the group of those who had one pregnancy (from 16.7% in 2015 to 21.8% in 2020) and in the group with several pregnancies (from 2.5% in 2015 to 5.4% in 2020).

Among women who came from Tajikistan, we observe a decrease in the proportion of those who had more than one pregnancy (from 8.7% in 2015 to 4.0% in 2020) and stable indicators in the group of those who had one pregnancy (16.7% in 2015 and 17.0% in 2020).

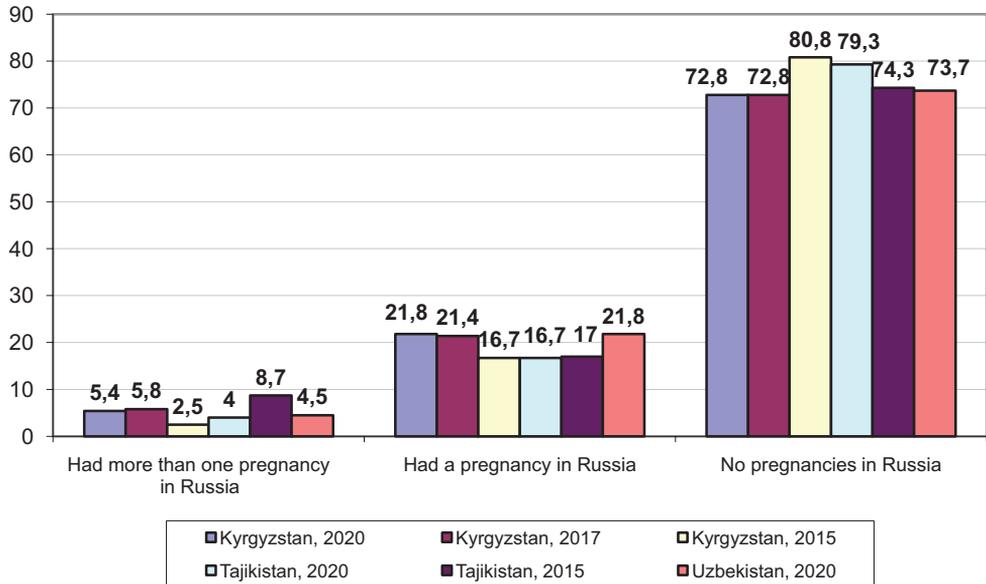


Fig. 4. Distribution of respondents by pregnancy experience during their stay in Russia, % of respondents. *Source:* author's calculations based on survey data from 2015–2020.

Among female migrants from Uzbekistan in 2020, the proportion of those who had a pregnancy during their stay in Russia (26.3%), including once (21.8%) and more than once (4.5%) is close to the estimates for women from Kyrgyzstan and Tajikistan (Fig. 4).

The main pregnancy outcome of the interviewed migrant women is the birth of a child, which usually occurs while they are still residing in Russia (Fig. 5): this happens in 39% to 61% cases, depending on the country and year of the study and stands for 8% to 18% of the total number of women included in the sample. The 2020 survey showed that 20% of the surveyed female migrants from Kyrgyzstan, 13% from Tajikistan and 18% from Uzbekistan went back to their country of origin to give the birth.

It should be noted that the proportion of women who lost a child due to miscarriage or stillbirth in 2020 among respondents from Kyrgyzstan and Tajikistan was very high (28% and 29% of those who had a pregnancy, respectively). These indicators were many times higher than the proportion of those who terminated a pregnancy (8% and 14% of those who had a pregnancy, respectively). This may indicate poor living, nutrition, and working conditions during pregnancy, as well as the poor health status of migrant women. The survey showed that the majority of women are not supervised in the maternal clinics before childbirth. As a result, in the absence of medical supervision during pregnancy, pathologies of the mother and the unborn child are not diagnosed, the necessary treatment is not prescribed, and the hospitalization of female migrants during childbirth takes place in the infectious wards of maternity hospitals, which significantly increases the risks of both infant and maternal mortality.

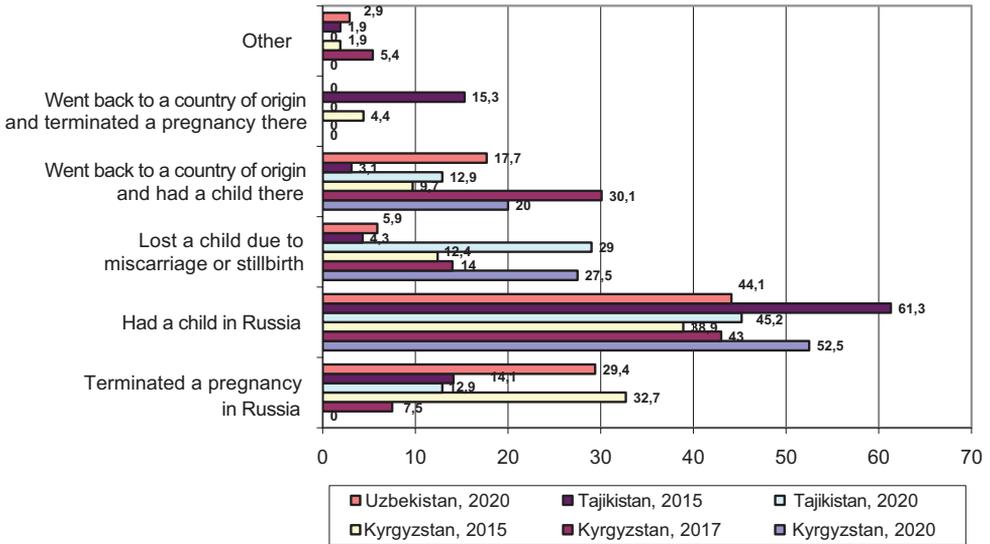


Fig. 5. Distribution of respondents by pregnancy outcome during their stay in Russia, % of respondents who had a pregnancy. *Source:* author’s calculations based on survey data from 2015–2020.

Answers to the question about the pregnancy outcome, especially in case of a terminated pregnancy, should be interpreted with caution: the question is sensitive, and this can be especially pronounced in the group of migrant women from Central Asia. Nevertheless, the conducted surveys showed that among the Kyrgyz women included in the sample, the proportion of those who had an abortion in Russia varied from 33% of those who had a pregnancy in 2015 to 8% in 2017 and 0% in 2020. Among respondents from Tajikistan who had a pregnancy, the proportion of those who terminated it in Russia was 13% in 2020 and 14% in 2017. In 2020, the highest share of respondents who terminated a pregnancy in Russia was recorded among migrants from Uzbekistan (29% of those who had a pregnancy). At the same time, in the same year, none of the interviewed women indicated leaving for their homeland to terminate a pregnancy, which may be due to restrictions on travel due to the pandemic. In 2015, 15% of the respondents from Tajikistan who had a pregnancy went back home to do so, and among the respondents from Kyrgyzstan this proportion was 4%. Taking into account the ongoing increase in the share of single and unmarried women in the structure of arriving migrants, we can assume that, unlike married women, they actively try to use contraception and, in any case, do not consider it possible to have an abortion at home in order to avoid gossip. Unfortunately, the respondents were not asked about their age and marital status at the time of pregnancy, therefore, it is not possible to make any suggestions about the circumstances under which migrants decide to terminate pregnancy and perform a procedure associated with a health risk. However, generally, the data show that the proportion of those respondents who terminated pregnancy in Russia is 2–3 times higher than of those who returned to their homeland to do so.

The survey data indicate that being in migration has an impact on the reproductive plans of women (Fig. 6). Thus, among the interviewed female migrants from Kyrgyzstan, the proportion of those who postponed the birth of a child due to labour migration in 2015–2020 reached 12–18%, among respondents from Tajikistan it was 6% (2020), and among respondents from Uzbekistan it decreased from 19% in 2015 to 16% in 2020.

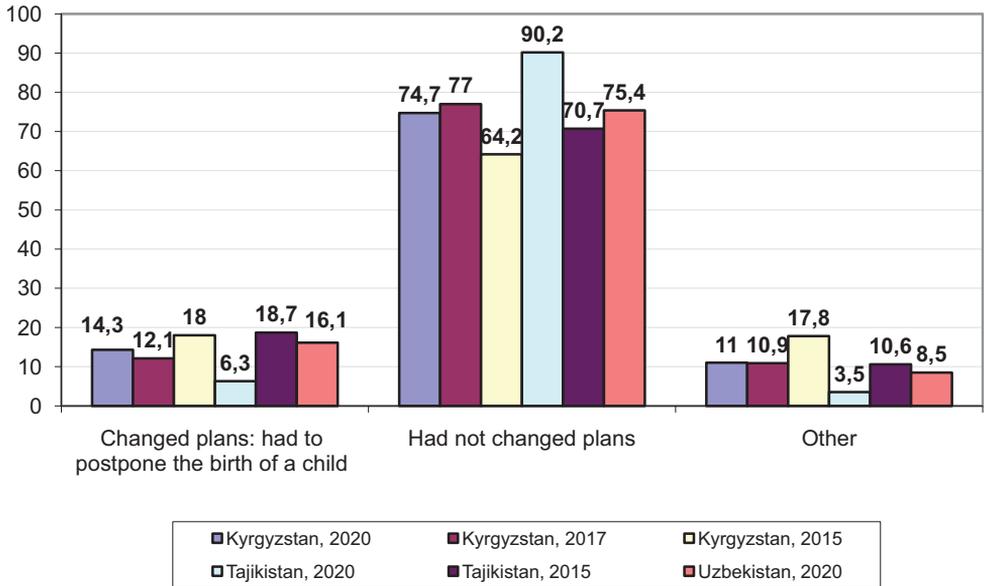


Fig. 6. Distribution of respondents by changes in reproductive plans in connection with leaving home for work, % of respondents. *Source:* author’s calculations based on survey data from 2015–2020.

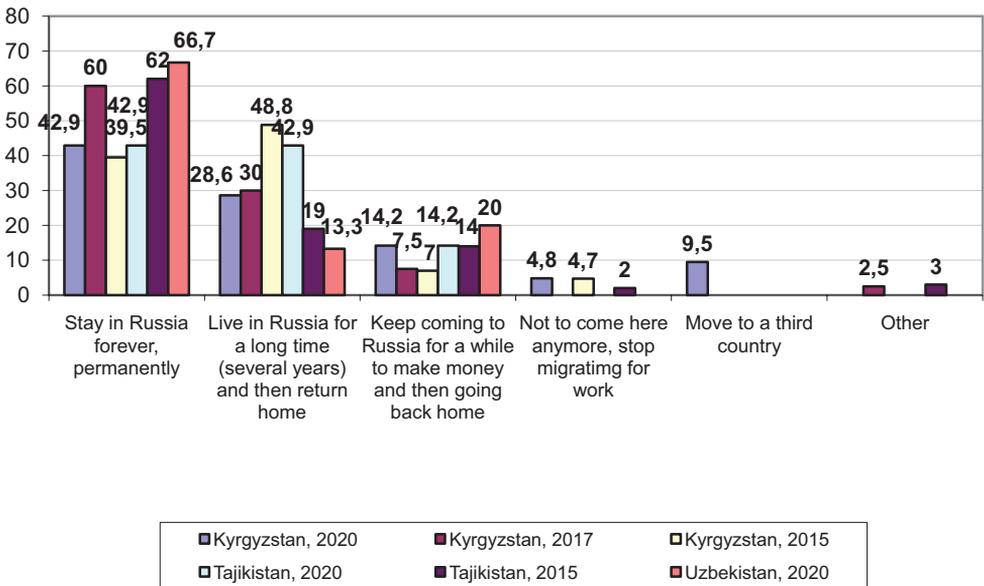


Fig. 7. Distribution of respondents by further plans of stay in Russia, % of respondents. *Source:* author’s calculations based on survey data from 2015–2020.

The majority of female migrants from Central Asia surveyed in 2015, 2017, and 2020 (from 72% to 86% depending on the year and country of origin of the respondents) planned to stay in Russia for permanent residence; this is also true for migrant women who had a

pregnancy here. In all years the share of those who planned to come only to earn money and then return home did not exceed 14% among migrants from Kyrgyzstan and Tajikistan and 20% among migrants from Uzbekistan.

Discussion

Survey data indicate a low prevalence of health-preserving behaviour among migrant women. First of all, this, apparently, is associated with their living conditions in Russia and limited financial opportunities. At the same time, this is similar to the attitude to their health among Russians, who are also not inclined to preserve it and prevent diseases (Half of Russians... 2021): about half of Russians (53%) are examined by doctors less than once a year, 48% work irregular hours, eat irregularly or consume unhealthy food, more than a third of Russians are constantly under stress (39%), have bad habits and neglect sports (37% each).

When comparing the health status of migrants from Kyrgyzstan (the country is included in the EAEU) and migrants from Tajikistan and Uzbekistan (countries that are not members of the EAEU), it should be borne in mind that they have different opportunities for access to Russian medicine. The “Treaty on the Eurasian Economic Union» (2014) contains a section on medical benefits provided for migrants and their family members (legal spouse, children, and other close relatives who are dependent on the migrant). Since January 1, 2017, the citizens of EAEU states who work on the basis of a legal employment contract are entitled to the mandatory medical insurance policy, which gives the right to get free treatment and could be provided for a period until the end of the calendar year, but no longer than the term of the employment contract. To obtain it, it is necessary to contact the Mandatory Health Insurance Fund or other insurance institutions at the place of stay. The list of medical services provided under mandatory medical insurance policy includes specialized medical care, preventive diagnostics⁶ and treatment during pregnancy, childbirth, and the postpartum period. At the same time, family members of working citizens from EAEU countries cannot count on free medical care (Moscow City Fund... 2021). Labour migrants that sre citizens of states outside the EAEU, who do not have a mandatory medical insurance policy, receive free emergency medical care only if they have a life-threatening injury as a result of an accident (since 2020, the Russian authorities have included coronavirus in this category).

The results obtained in this work should be interpreted taking into account the fact that the assessment process and the frame of reference used to form judgments about the state of health differ among migrants and the local population. The use of self-assessment of health, of course, could lead to some distortions of real data. There are three reasons for such distortions (Gerry and Baidin 2017). The first one is related to inequalities in access to health care (of varying quality), access to detailed body exams, as well as limited health literacy, which is equally common for both Russians and migrants. The second reason is the so-called «avoidance of diagnosis». This behaviour can be deliberate, associated with limited financial and time resources (which ultimately can lead to late intervention and complications in treatment) or with the treatment of stigmatized diseases (for example, HIV); it also can be unintentional, which refers to avoiding the diagnosis due to cultural differences in seeking health care between migrants and the local population. The third reason for distortions in self-assessment of health is related to the fact that people will give different assessments of their own health, depending on their subjective perception, expectations and hopes related to health, and understanding of the questionnaire question. Despite this, the World Health

Organization recommends the use of self-assessment of health as one of the main indicators for monitoring the health and quality of life of the population (Gerry and Baidin 2017), pointing out the reliability and fairness of this indicator.

An increase in the flow of female labour migrants to Russia has led to a gradual increase in the number of migrant children arriving with them or born in Russia (Zayonchkovskaya et al. 2014; Poletaev et al. 2018). The issue of giving birth by labour migrants from Central Asia in Russia is a sensitive topic (Florinskaya 2014), sometimes overly dramatised in the media (Borodina 2013).

According to a survey conducted by the Center for Migration Research in 2010, among 1,068 female migrants from the CIS (Uzbekistan — 30%, Ukraine — 17%, Kyrgyzstan — 13%, Tajikistan — 10%, Moldova — 9%, Armenia — 7%), pregnancy in Russia occurred at least once in every tenth; only 1% of the respondents had several pregnancies. Most often, pregnancies ended up in their termination in Russia; this answer was given by 42% of women in the reference group (Table 2). Another 7% of the interviewed migrants who had experienced pregnancy went to their homeland to terminate it, 32% gave birth to a child in Russia, 6% — in the country of origin; stillbirth or miscarriage occurred in about every tenth female migrant in this group (11%).

Table 2. Distribution of migrants from CIS countries in Russia by pregnancy outcome, 2010, %

Answers	% of all respondents	% of interviewed women who had a pregnancy in Russia
No answer	0.1	0.9
Terminated a pregnancy in Russia	3.8	41.7
Gave birth to a child in Russia	3.0	32.4
Stillbirth, miscarriage	1.0	11.1
Went home and terminated a pregnancy in the country of origin	0.6	6.5
Went home and gave birth to a child in the country of origin	0.5	5.6
Other	0.2	1.9
Total	9.2	100.0

Source: (Zhenshchiny-migranty... 2011: 132).

The surveys of 2015, 2017, and 2020 recorded a fairly high prevalence of pregnancy experience in Russia among migrants from Central Asia who were included in the sample. This may indicate that labour migration is becoming a life strategy, within the framework of which migrants are increasingly solving an entire range of their family issues, including those related to the birth of children. Such an observation is important for further understanding and development of Russia's migration policy, which is not yet gender sensitive, although migrants have already become a permanent component of both the Russian labour market and Russian society. At the same time, it is necessary to emphasize the importance of improving the quality and expanding the number of indicators of gender sensitive migration statistics, without which it is extremely difficult to comprehensively plan the management of external migration flows and the integration of various groups of migrants in Russia.

The prevalence of terminated pregnancies, apparently, can be linked to the level of contraceptive culture at home among migrants from Central Asia. Judging by surveys related to HIV (Poletaev and Florinskaya 2015), education in this area is better established in Kyrgyzstan than in Tajikistan and, especially, in Uzbekistan.

When comparing the prevalence of abortions among migrants from Central Asia and among Russian women, we face methodological difficulties, since the information on migrants included in this paper is based on a specific sample survey and at the same time reflects the number of abortions for their entire period of stay in Russia, while the data for Russia are continuous and show what proportion of pregnancies in a particular year ends in abortion. In 2018, there were 41 terminated pregnancies per 100 births in Russia, that is, the share of abortions reached 29% (Naselenie Rossii... 2020). But for several decades prior to 2007, the annual number of abortions in Russia exceeded the number of births, and in recent years the situation has improved significantly. Thus, according to the roughest estimates, it can be said that the share of terminated pregnancies among migrants from Central Asia probably does not exceed the same indicator for Russian women.

In the samples of three rounds of the survey, the proportion of female labour migrants from Central Asia who had a pregnancy in Russia remains stable (and among migrants from Kyrgyzstan this proportion is growing both in the group of those who have had one pregnancy and in the group of those who have had several pregnancies), with interviewed migrants choosing to have a child in Russia as the main strategy of pregnancy outcome. This probably indicates that the quality of medical care in Russia is at least not lower (and most likely higher) than in their countries of origin, and therefore migrants from Central Asia prefer to give birth to a child without leaving Russia if they have the opportunity. Obviously, special clarifying studies are needed on migrants giving birth to children out of an officially registered marriage; however, our conclusions seem to be applicable to the birth of a child in an official marriage.

Conclusion and prospects of the study

The surveys of 2015, 2017, and 2020 reveal a higher proportion of female migrants who had experienced pregnancy and birth in Russia, and a smaller proportion of migrants who terminated a pregnancy compared to estimates gained in the study of 2010 (Zhenshchiny-migranty... 2011). These differences may indicate a change in the reproductive behaviour of women who come to work from Central Asian countries, a reorientation towards a long-term stay in Russia, the formation of families, and the birth of children in this country.

At the same time, the living conditions of labour migrants from Central Asia in Russia, as well as the mode and nature of their work, on the one hand, can become a reason for some women to postpone the birth of a child, and on the other, lead to higher health risks and increase the proportion of unfavourable pregnancy outcomes. This is evidenced by the results of the 2020 survey: in the formed sample, the share of labour migrants from Kyrgyzstan and Tajikistan who have lost a child due to miscarriage and stillbirth exceeds the share of terminated pregnancies (for migrants from Uzbekistan, the ratio of interruptions and losses is different — 29% versus 6%).

Despite the best opportunities for monitoring pregnancy in maternal clinics for labour migrants from the EAEU, not all of them use such opportunities (among the migrants from Kyrgyzstan who were included in the survey sample in 2020 — 23%). They do not register in

maternal clinics, often due to the fictitious labour contracts, which blocks the possibility of obtaining the mandatory medical insurance policy provided by law.

The analysis proves that despite gradual feminization of labour migration from Central Asia, pregnancy and childbirth in a significant part of labour migrants still take place in risky living conditions; the existing system of maternal health protection for migrants in Russia needs modernization.

The surveys conducted by the author in 2015, 2017, and 2020 were not focused on the reproductive behaviour of female migrants from Central Asia; the questionnaires also included blocks such as “employment in Russia”, “integration”, housing conditions”, “migration plans”, etc. However, the results of the analysis reveal the need for such studies. The focus of future research should be on the reproductive behaviour of not only female migrant workers from Central Asia, but also of the unemployed. In addition, it is necessary to collect detailed information on the order of the pregnancies and births, the motives for having a child in Russia, the possibilities of receiving medical care in different regions of the country, and the local experience of providing foreign women with medical care. The system of migration statistics in Russia also needs to be developed and expanded: it must become gender sensitive.

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