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Multilevel HIV Prevention to Address the Impact of Labor Migration on Wives

Prévention multiniveaux du VIH pour appréhender l'impact de la migration de travail sur les femmes

МНОГОУРОВНЕВАЯ РАБОТА ПО ПРОФИЛАКТИКЕ ВИЧ ДЛЯ РЕШЕНИЯ ПРОБЛЕМЫ ВОЗДЕЙСТВИЯ ТРУДОВОЙ МИГРАЦИИ НА ЖЁН МИГРАНТОВ

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Multilevel HIV Prevention to Address the Impact of Labor Migration on Wives

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Background

Globally, women bear a disproportionate burden of HIV disease. Of the 1.7 million women with HIV in Asia, 90% were infected by their husbands or partners (UNAIDS, 2009). HIV/AIDS is spreading in Muslim majority low- and middle-income countries (LMIC) (UNAIDS, 2011), including rapid growth in Central Asia (Donoghoe, Lazarus, & Matic, 2005; Donoghoe *et al.*, 2008; WHO, 2006). In 2009 there were 1,422 registered HIV cases in Tajikistan, which more than quintupled by 2014 to 7,610 (Tajik Republican AIDS Center, 2013). However, the conservative estimate of actual HIV cases in Tajikistan is 17,000 (UNAIDS, 2010). Central Asia has seen an alarming increase in the proportion of new HIV cases among women (UNAIDS, 2012). The proportion of women among HIV positives in Tajikistan has rapidly increased from 9% in 2005 to 29% in 2011, reaching 35% in 2012, 39% in 2013, and 45% in 2014 (Tajik Republican AIDS Centre, 2014).

As the HIV/AIDS epidemic continues to grow, labor migrants are considered a vulnerable population for HIV infection. There are an estimated

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214 million international migrants worldwide sending home around $414 billion in remittances annually (UNFAP, 2013; World Bank, 2013). As a former Soviet republic in Central Asia and the world's second largest migration pipeline, Tajikistan relies on remittances from labor migrants more than any other Central Asian country (Chiovenda, 2013; Marat, 2009). One in four adults from Tajikistan are seasonal labor migrants (International Labor Organization, 2010). Their primary destination is Russia, with almost one million traveling to and from Russia yearly (International Labor Organization, 2010). Most are married, non-drug using, heterosexual males; in Russia, they are legally marginalized and at the bottom of the socioeconomic hierarchy (Eurasianet, 2006). Away from family, the vast majority (92% – based on our study of a representative sample of 400 Tajik labor migrants in the bazaars and construction sites of Moscow) have unprotected contact with Moscow sex workers and most return home without HIV testing (Weine *et al.*, 2012). Tajikistan is highly vulnerable to an HIV epidemic among the general population, primarily via sexual transmission (Godinho, 2005).

Globally, women married to labor migrants have higher rates of HIV infection, principally due to their husbands'increased sexual risk behaviors (Saggurti, Mahapatra, Sabarwal, *et al.*, 2012; Krishnan *et al.*, 2008). Economically dependent upon their husbands, wives must accept marriage with separations and infidelity and are often discouraged from discussing sexual health, AIDS, and HIV prevention (Hong *et al.*, 2009; Salgado, Diaz, & Maldonado, 1996). Studies have documented that these women are subject to: high HIV stigma, low HIV knowledge and awareness, fear of repercussions for involvement in HIV prevention, lack of control of finances, limited geographic mobility, lack of awareness of husband's infidelity, emotional distress, and intimate partner violence (El-Bassel *et al.*, 2011; Gibney *et al.*, 1999; Hasnain, 2005; Kelley & Eberstadt, 2005; Obermeyer, 2006; UNAIDS, 2011). Our studies of Tajik wives documented how male labor migration both increases husband's infidelity and mobility, and diminishes wives' control over finances, sexuality, and health (Golobof *et al.*, 2011; Weine *et al.*, 2012). For example, one women said, "I am sure that if a man is far for a long time he will have sex with other women. My husband strays, so I know he gets involved with other women."

Scientists and advocates have called for women to more actively protect themselves against the HIV risk posed by their partner's behaviors. (White, 2005). Public health leaders have called for integrating gender issues into HIV/AIDS programs, promoting gender awareness, transforming gender relations, and empowering women (Loue & Mendez, 2006; Pequegnat & Szapocznik, 2000; UNAIDS, 2002; Weiss, Whelan, & Gupta, 2000; Wingood & DiClemente, 2000; WHO, 2003). Others have called for a new wave of structural approaches to confront the social drivers of women's HIV risks (Cornman, 2010). Several approaches have been attempted with Muslim women, including: working with religious leaders (Kegeles, Hays, & Coates, 1996), reducing intimate partner violence (Silverman *et al.*, 2008), and microfinance (Cornman, 2010). HIV prevention programs have been developed for other types of wives at risk from their partner's behavior, e.g., wives whose husbands are MSM, substance users, or seafarers (Asian Development Bank, 2011; Panda *et al.*, 2000; Solomon *et al.*, 2010). Despite the evidence of migrants' wives rapidly increasing risk of HIV, existing prevention strategies have not focused on them (Weine, Bahromov, Loue *et al.*, 2012). Our 10 years' work in Tajikistan extensively documented how women rely on the support of peers, *bibiotuns* (female religious practitioners of Islam) and nurses to manage HIV concerns, but presently none of these supporters have access to evidence-based interventions for HIV prevention.

Only a few evidence-based HIV preventive interventions focus on labor migration, and none address at-risk wives (Golobof *et al.*, 2011). When addressing HIV risk due to labor migration, it is necessary to focus not only on individuals' knowledge, attitudes, and behaviors, but also on socio-structural dimensions contributing to risk, which can include socio-structural conditions, individual behaviors, and access to biomedical care (Blankenship *et al.*, 2006; Gupta *et al.*, 2008).

Multilevel interventions are well suited to addressing the complexity of HIV prevention amongst wives of labor migrants, but there is a need to build adequate evidence on what levels should be addressed, with what interventions, and by whom. A multilevel intervention works on two or more levels which are intended to work synergistically to facilitate changes in HIV risk reduction (Wingood & DiClemente, 2000; WHO, 2003). For example, Mpowerment, a National Institutes of Health funded commu-

nity-level intervention developed for young US gay/bisexual men, involves community mobilization and individual and community empowerment, and has been shown to be efficacious (Kegeles, Hays, & Coates, 1996).

Our prior studies (discussed below) demonstrated how HIV risk and protection were embedded in gender relations and norms, which has been discussed elsewhere (Golobof *et al*., 2011; Weine *et al*., 2012). Specifically, we documented the key role of women's circles. These are casual, social gatherings of wives in Tajikistan over tea with an average of 6 women and a clearly identified leader. The circles are a valued source of support and information sharing and a maintainer of gender norms, especially for migrant's wives. A woman explained, "very often we gather together and talk about our husbands and their work and life in Moscow…I like very much meeting with the women. I need them sometimes. We share out thoughts." (Golobof *et al*., 2011). We also demonstrated the key role of *bibiotuns* (female clerics) in shaping norms for women including health issues. This led us to take a gender-specific approach to addressing HIV risk and gender disparities through using female peer leaders, nurses and female religious clerics.

Preliminary Work

To prepare for and develop Healthy Homes, several formative and pilot studies of migrant's wives were conducted by researchers from the University of Illinois at Chicago in the United States in collaboration with the Prisma Research Center in Tajikistan. These are summarized below.

Formative Studies. We conducted an ethnography that included interviews and observations with 30 Tajik wives (average age =31.3; range19-48) living in Dushanbe married to Tajik male migrant workers currently working in either bazaars or construction sites in Moscow (Golobof *et al*, 2011). The results documented the wives' concerns over their husbands' safety in Moscow and the difficulties of living without husbands. Gender norms limited the wives' abilities to protect themselves and their husbands from HIV/AIDS. They had some awareness of HIV/AIDS, but limited abilities to speak about sexual activity, HIV/AIDS, condoms, and HIV testing. Wives did not use condoms with their husbands and depended upon their husband as their protector. Wives turned to their "circle of friends" or a primary care nurse or *bibiotun* for support, but these relationships rarely focused

on preventing HIV. The *bibiotuns* were based in neighborhoods and played a key role in counseling local wives about everyday struggles, including health and HIV. We also described how the *bibiotuns*' understanding of Muslim religious norms and gender norms impacted Tajik migrants' wives HIV protective and risk behavior. We identified five gender norms (faithfulness to husbands, trusting husbands, patience, modesty in your needs, and modesty in communication about sexuality) and called for preventive interventions that selectively modify these norms so as to protect women's and family health (Bahromov & Weine, under review).

Developing Healthy Homes. Based upon the results of an extensive mixed methods study of Tajik migrants, their wives, sex workers, regular partners, and service providers (Weine, 2008), we formed an Intervention Design Collaborative (of migrants, wives, community leaders and providers) which developed the Healthy Homes HIV preventive intervention (Weine, 2010). This utilized a community-based participatory research approach where community persons were asked to work with the researchers to help make the intervention better in terms of its feasibility, acceptability, and effectiveness. The collaborative endorsed addressing the issue of HIV risk to wives posed by their husband's infidelity through educating wives but also involving husbands. Healthy Homes was designed as a multilevel HIV prevention to reduce HIV risk among wives of migrants by: 1) enhancing wives' HIV risk awareness, knowledge, and prevention skills; 2) improving wives' access to HIV/STI care, and; 3) promoting cultural norms and attitudes that enable wives to be more active in protecting themselves and their families from HIV.

Healthy Homes Pilot Study. In Dushanbe in 2013, the Healthy Homes pilot study was conducted. The pilot study focused on peer-delivered dissemination in the women's circles. First, nurses selected 10 women peer leaders from each of two primary care health clinics and those peer leaders recruited an additional three women from each of their circles. All were married to migrants. The nurses then trained the peer leaders from one of the primary care clinics in five sessions across 3 weeks. Next, the peer leaders disseminated the information among the women in their circles and the nurses were available to facilitate access to care. All participants completed all assessments. Compared with the controls, the Healthy Homes group (n=40) compared with the control group (n=40) reported statisti-

cally significant increases in HIV knowledge and worry, communication with spouse and health worker, HIV and STI testing, condom attitudes and use with husband (see Table 1). No increases in family conflict or violence were reported. In conclusion, multilevel HIV prevention centered on wives of seasonal labor migrants is feasible, acceptable, and potentially efficacious.

Preparing for the Healthy Homes Prevention Trial. In May 2014, the Intervention Design Collaborative re-convened in Dushanbe to review the pilot results and to further develop Healthy Homes, including plans for an evaluation. Encouraged by the results, the IDC further strengthened Healthy Homes as a multilevel HIV prevention package of three integrated levels: 1) structural: community mobilization through *bibiotuns*; 2) biomedical: facilitating access to HIV & STI testing and care; 3) behavioral: peer-delivered dissemination in women's circles. Other evaluation issues discussed included selecting endpoints, biomarkers, assessment times, and a comparison condition.

Healthy Homes

The Healthy Homes Framework

Healthy Homes is built on a conceptual framework derived from Roger's diffusion of innovations theory, which explains how new innovations start and become normative (Rogers, 1995). Based on this theory, a substantial body of evidence supports the effectiveness of peers for the delivery of preventive interventions, especially in high risk and difficulty to reach populations (Broadhead *et al*., 2006; Ford *et al*., 2000). The framework claims that peer leaders can communicate HIV prevention messages among their social networks, thus reducing individual risk levels in the community (NIMH, 2007a). A peer leader model based on diffusion of innovations theory has been used by multiple HIV prevention researchers in the US and has been found to be effective including with diverse populations (Kelly *et al*., 1997; Kelly *et al*., 1991; Sikkema *et al*., 2000; Sikkema, 2005; St. Lawrence *et al*., 1994). However, peer leaders vary across sociocultural contexts, especially with diverse populations in low-income countries (NIMH, 2007b).

Because Healthy Homes uses multilevel approaches (structural, biomedical, and behavioral) and aims for multiple HIV risk reduction goals (e.g. increasing testing and condom use, reducing stigma and STIs) (Pequegnat *et al*., 2000), we went beyond the peer leader model and drew from several additional theories. First is Connell's socio-structural theory of gender and power, which focuses on women's exposure to gender and power factors that produce gender inequalities which can increase HIV risk for women, such as women's financial dependency or fear of interpersonal violence; Connell's theory calls for empowerment of women to improve health (Connel, 1987; Wingood & DiCelemente, 2000). Second are structural models and theories (Blankenship *et al*., 2006) and migration theory (Brettell & Hollilfield, 2007; Porters & DeWind, 2008). Together, these explain the social determinants of HIV risk, especially those related to the multilevel processes of labor migration (e.g. social policies, sociocultural practices) which can amplify HIV risk and gender inequalities. This calls for changes to the risk environment. Third are social cognitive theory (Bandura, 1985) and the theory of reasoned action (Fishbein & Ajzen, 1975), which explain how individuals' adoption of changes in AIDS risk behaviors are predicted by knowledge, attitudes, beliefs, intentions, and perceived self-efficacy.

By drawing on these theories, and also upon evidence from the study results described earlier, the Healthy Homes Framework was derived. Overall, it claims that a gender-specific multilevel HIV prevention involving structural, biomedical, and behavioral components can lead to multilevel changes that reduce HIV and STI infections. This framework emphasizes three components: 1) Peer-delivered dissemination in women's circles that enhance wives' HIV risk awareness, knowledge, and prevention skills, access to HIV/STI care, and pro-active role in protecting themselves and their families from HIV and STIs; 2) Nurses facilitating wives' and husbands' access to HIV & STI assessment and care that enhances HIV testing and other services through one-on-one assistance; 3) Community mobilization through *bibiotuns* that changes community norms and practices around women's role in HIV prevention. The framework also provided a basis for designing the evaluation of Healthy Homes.

Healthy Homes' Multilevel Components.

More Healthy Homes consists of three components designed to synergistically reduce HIV risk among women married to migrant workers by targeting changes at behavioral, biomedical, and structural levels. These are:

1. Behavioral: Peer-delivered dissemination in the women's circles.

This component is designed to enhance wives' HIV risk awareness, knowledge, and prevention skills, access to HIV/STI care, and pro-active role in protecting themselves and their families from HIV/AIDS and STDs. This will be achieved by having nurses train the peer leaders who then disseminate their knowledge to their women's circle. For example, women learn about marriage, migration, family coping, protecting family health, and reproductive health risks and are told, "because you are all trusted within your circles, we want you to be comfortable talking about these same issues with your friends and women in your community." They are asked to keep their conversations with their women's circles to a minimum until after the training is complete so that they are the most knowledgeable and prepared for having these conversations.

2. Biomedical: Nurses facilitating access to HIV & STI assessment and care.

This component is focused on increasing wives' and husbands' access to HIV and STI testing and care. The nurses will meet with those wives who might benefit from one-on-one (one nurse and one wife per meeting) assistance and provide individualized risk reduction counseling, information about where to get testing, facilitate referrals, and help wives overcome obstacles, meet with family, or escort wife to testing. Wives will be referred to the nurses by the peer leaders and *bibiotuns*. Additionally, the nurses will also organize 2-hour group information and support sessions in the clinics for both wives and husbands where they will advocate for wives and husbands to get HIV testing together (Chomba *et al*., 2008; Farquhar *et al*,. 2004; Guthrie, de Bruyan, & Farquhar, 2007; Painter, 2001). For example, the session discusses providing mutual disclosure in a safe place, easing tension and reducing accusations or blame to deal with these difficult issues together, and establishing sexual agreements in their relationships. The nurses emphasize, "After this group information and support session,

we would life to request that wives and husbands get HIV tested together. If you would like, we can assist your in getting tested together."

3. Structural: Community mobilization through bibiotuns.

This component is designed to change community norms and practices around women's role in HIV prevention through collaborating with key women religious leaders in communities. Through training by the nurses, *bibiotuns* will learn how to promote wives' capacities to protect themselves and their family from HIV/AIDS, based on reframing of women's roles. They will also learn how to challenge prevailing stigma and myths about HIV/AIDs, as well as to increase awareness and build knowledge regarding HIV protection. For example, following their training the *bibiotuns* will be asked to discuss in further detail how they can integrate the new information they learned into their work and what they plan to do. The *bibiotuns* will be told to regularly share this knowledge through direct engagement with community members, disseminating information in existing forums (e.g. after Friday prayer meeting), and conducting new activities for promoting community awareness (e.g. organizing a meeting with women service providers).

Healthy Homes*' Training*

Healthy Homes uses a train the trainer approach, whereby: #1 subject matter experts train the nurses; #2 nurses train the peer leaders, and #3 nurses train the *bibiotuns*. For all these trainees, Healthy Homes emphasizes one overall and four sub-themes (see Table 2) that were derived from the prior mixed methods study and refined through the Intervention Design Collaborative. The overall theme is "Protect yourself, your family, and your nation from HIV/AIDS" and the sub-themes address the needs to "be informed", "act safely", "let your spouse know you care", and "tell your friends and family." The training steps are summarized below:

1. Training the nurses.

The nurses training will be focused on building their capacities as both trainers of the peer leaders and *bibiotuns* and as service navigators who facilitate wives' and husbands' access to HIV and STI assessments and care. Training consists of 20 hours of Healthy Homes' seminars conducted by international and local subject matter experts on HIV prevention that focus

on the development of the following knowledge and skills: 1) findings from research about sexual practices and HIV risk and protection among migrants and their families; 2) stigma associated with HIV & STI; 3) HIV testing and treatment; 4) multilevel HIV prevention strategies with migrants and their families; 5) roles of peer leaders and *bibiotuns* in influencing norms and behaviors; 6) conducting group training sessions; 7) gender, cultural, family, social, and violence issues concerning migration, women, and HIV; 8) networking and collaborating; 9) community mobilization; 10) service navigation.[2] The seminars are supported by the Healthy Homes manual, directed readings, practical exercises, and reviewing intervention sessions through weekly supervision to discuss the trainings and to develop strategies to address adherence challenges. These may include recruiting participants, promoting interest in the topics, following the manual accurately or departing from the manual, or women reporting family conflict or violence.

2. Nurses training the peer leaders

This training by the nurses will both give the peer leaders new knowledge and also train the peer leaders on how to initiate conversations on these topics with their peers in the women's circles. As with other behavioral and social skills training, these goals are best achieved by: 1) bringing peer leaders together over multiple group sessions; 2) using interaction, discussion, and role playing techniques to help participants practice and feel comfortable delivering HIV prevention messages; and 3) guiding peer leaders in having real-life conversations with their peers (NIMH, 2007c). Trainings will consist of five sessions (see Table 3). Each meeting will begin with casual conversation over tea for 15 minutes, then has 90 minutes of didactic presentation, role-playing, and group discussions, and then concludes with a 15-minute wrap-up. The training will include standard HIV education and awareness components with a focus on Islamic cultural norms and marriage, migration and the family, health risks of migration, and protecting wives and husbands from sexual health risks. Standard HIV knowledge and prevention are incorporated appropriately throughout each session. Each training session will also include a focus on talking with

[2] Service navigation refers to navigating the health care system, including removing barriers and facilitating access to care and services, interacting with medical providers and staff, understanding health information, and self-care.

peers (other women married to migrants) about HIV prevention, which includes role-playing and discussion.

In session one, peer leaders will be provided with: 1) an outline of the training session content; 2) a "Know Your Risk" HIV factsheet focused on the epidemic in Tajikistan and Russia; 3) a list of organizations that provide health and social services in Tajikistan and Moscow; and 4) conversational statements for peer leaders that target modifiable multilevel determinants of risk behavior. Rather than traditional HIV education programs that are based on only providing factual messages, peer leaders will be trained to introduce HIV prevention messages through everyday conversations that target the wives' HIV/AIDS-related knowledge, skills, norms, attitudes, intentions, and self-efficacy, and that address pertinent wives' and family concerns (NIMH, 2007d). After the training, peer leaders will be asked to disseminate their knowledge to their circle. For example, the nurses explain to the women the purpose of the intervention and remind them throughout their training that they have an important role to remember the key points of what they are taught so they can pass on information to other women to improve their personal and family health. At the last session they are reminded to share what they learned in a clear and convincing way to make Tajik families healthier. Nurses will check in monthly to support peer leaders' continued dissemination.

3. Nurses training the bibiotuns.

The nurses will conduct a separate five-session training with the *bibiotuns* who are linked to the Healthy Homes clinics. On the basis of prior studies and direct consultation with *bibiotuns*, the peer leader training was adapted to best fit the *bibiotuns*' formal roles. The modifications include: 1) more detailed discussion of Islam, gender norms, and women's rights; 2) discussion of the *bibiotuns*' existing beliefs and practices regarding women, health, and AIDS; 3) discussion of how the *bibiotuns* should integrate the new knowledge into their work so as to change wives' norms and practices; 4) provision of practice-ready materials for distribution with individual wives and in community settings. For example, in each session the nurses achieve a consensus understanding from the bibotuns of how the *bibiotuns* can emphazise expanding women's role in health protection, such as what practices can they tell women to follow to prevent being

infected, while being good Muslims. Nurses will check in with *bibiotuns* monthly to support their community mobilization activities.

Involving Husbands

To give the husband's the same information as the wives regarding HIV risk and protection, the nurses will organize monthly group information and support sessions in the clinics for couples. These groups will be co-led by male nurses because husbands are likely to be more receptive to session content delivered by a male. To make HIV testing a shared activity, the female and male nurses will request that wives and husbands get HIV tests together and will offer to accompany them. At each of the information/support sessions we will provide pre-test counseling followed by the opportunity to go immediately for joint testing. To reduce the potential for intimate partner violence (IPV), the female and male nurses will raise the issue of IPV in the information sessions with husbands, and the male nurses will address important male roles such as protection of family, taking responsibility for their actions and protecting themselves and their families while away at work, and the effectiveness of non-violent communication within the marital relationship. For example, the nurses state, "we do not want husbands to feel they are being blamed and become angry, which could result in violence against his wife. Instead, discussing these issues openly is a way to respect your marriage and keep one another safe and protected from HIV." Additionally, the session content for the wives will address (and reduce) the potential for IPV by emphasizing the importance of respectful communication within the marital relationship and offering strategies to: a) negotiate for condom use and HIV testing that avoid accusations and appeal to husbands' role as protector; b) defuse angry responses when a discussion seems to be escalating, and; c) frame condom use as a way to protect the health of all family members.

Evaluating Healthy Homes

This program can be evaluated using a randomized controlled trial and an effectiveness-implementation hybrid design. Hybrid designs simultaneously investigate both effectiveness and implementation (Hoagwood, Atkins, & Lalongo, 2013). As described by Curran (Curran *et al.*, 2012), a type 1 hybrid design combines a major effectiveness component with a

minor implementation one. The first aim of the evaluation will be to examine the impact of the Healthy Homes multilevel HIV prevention program, through comparing women exposed to the program versus a comparison condition for healthy lifestyles, on HIV protective behaviors and potential mediating variables from baseline to post-intervention assessments. The second aim of the evaluation will be to assess implementation processes, community mobilization, facilitators and barriers to implementation, and the sustainability potential of the Healthy Homes program. It can do so through observations of program implementation and qualitative interviews with a purposive sample of the Healthy Homes cohort, peer leaders, *bibiotuns*, nurses, and other key informants.

Conclusion

Impacting billions globally, labor migration supports many families but also adds to their burdens and instability, changes the social landscape, and is associated with increased HIV risk behaviors and infection. Although wives of labor migrants are known to be at significantly elevated risk for HIV, there are no evidence-based programs focusing on HIV prevention with wives of labor migrants. To build HIV prevention services for wives of migrants calls for understanding how to intervene among the complex circumstances of labor migration and gender disparities in partnership with local communities, organizations, and investigators.

Globally and locally, many call for women-focused HIV prevention that addresses gender disparities. Our Tajik-US team developed a multilevel intervention through extensive prior research and community collaboration. We documented that it increases women's protection from HIV without putting them at higher risk of domestic violence, because it focuses on changing particular health behaviors and not the overall power balance in families. The intervention mobilizes peers, nurses, and female clerics to change select cultural norms, individual knowledge and behaviors, and access to biomedical care. It engages women in HIV prevention and gives them new capacities focused on helping their husbands to reframe the male role of family protector to include getting HIV tests and using condoms outside of marriage.

Though Tajikistan is low prevalence, it is not low risk. Tajik male migrants' HIV risks are well documented. In many low-and middle-income

countries, being married is the #1 HIV risk factor for women, and being married to a migrant greatly inflates a woman's HIV risk (Krishnan *et al*, 2008). Given these risks, Healthy Homes is needed to keep Tajikistan low prevalence. If effective, this program could halt the current and future growth in HIV among high-risk populations of labor migrants, their wives and children.

This research uses a hybrid design. Hybrid designs are a new approach that can shorten the time for moving an intervention from clinical trials to public health impact (Hagedorn, Boorbaloochi, & Rimmele, 2010). This is called for regarding Healthy Homes, where the need is both to demonstrate its effectiveness and to prepare for broader implementation to combat widespread HIV risk among migrant's wives (Hoagwood, Atkins, & Lalongo, 2013).

Table 1

Variable	Healthy Homes (n=40)	Control (n=40)	Test
	Pre-Post 2	Pre-Post 2	
Wife knows husband HIV result	50%	8%	p<.0008
Wife has been tested for HIV	50%	13%	p<.0002
Wife has been tested for STI	12%	7%	NS
Condom with husband	28%	0	p<.0028
HIV/AIDS knowledge scale	2.4	0.5	p<.0001
Worry about HIV/AIDS	1.0	0	p<.0001
Likelihood of HIV/AIDS	0.1	0	NS
Talk with husband about sex	35%	0%	p<.002
Talk with husband about AIDS	67%	0%	p<.0001
Talk with health prof. re AIDS	80%	0%	p<.0006
Know where to get HIV test	32%	5%	p<.006
Condom use attitudes scale	7.8	0	p<.0001

Table 2

Overall: "Protect yourself, your family, and your nation from HIV/AIDS."
Be Informed: "Gain new knowledge and awareness about HIV/AIDS. Learn about your health and how you and your loved ones can stay healthy."
Act Safely: "Get tested for HIV yearly and use condoms with all partners not HIV tested and outside of marriage."
Let Your Spouse Know you Care: "Spouses should talk openly about sexuality and HIV/AIDS risk and protection."
Tell Your Friends and Family: "Help your friends and family to know how to stay healthy by sharing with them what you have learned."

Table 3

	Content
1. Islam, Marriage, and Women's and Family Health	1) Introducing Healthy Homes; 2) Islam, Marriage and Women's Roles; 3) Violence from Husbands; 4) Peer Education and Seminar Schedule; 5) Take Away Messages
2. Migration and Family Coping with Migration	1) Welcome and Review; 2) Migration's Impact on Families; 3) Family Coping and Strengthening; 4) Practice Supportive Conversations; 5) Take Away Messages
3. Protecting Family Health Amidst Migration	1) Welcome and Review; 2) Challenges of Migration for Families; 3) Strengthening Women's Role in Family Health Protection; 4) Take Away Messages
4. Protecting Wives and Husbands from Reproductive Health Risks (I)	1) Welcome and Review; 2) Reproductive Health; 3) Sexually Transmitted Infections; 4) Hand-Shaking Exercise; 5) Understanding HIV/AIDS; 6) Understanding Migration and HIV/AIDS; 7) Take Away Messages
5. Protecting Wives and Husbands from Reproductive Health Risks (II)	1) Welcome and Review; 2) Preventing HIV Transmission; 3) HIV Testing; 4) HIV-Related Stigma and Care-Seeking Behavior; 5) Take Away Messages; 6) Review of Healthy Homes

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Abstract

In this paper, studies of Tajik wives documented how male labor migration both increased husband's mobility and infidelity, and diminished wives' control over finances, sexuality, and health. Based upon these results, authors have formed an Intervention Design Collaborative (IDC) of migrants, wives, community leaders and providers which developed a new HIV prevention model called Healthy Homes. It was designed as a multilevel HIV prevention to reduce HIV risk among wives of migrants by: 1) enhancing wives' HIV risk awareness, knowledge, and prevention skills; 2) improving wives' access to HIV/STI care, and; 3) promoting cultural norms and attitudes that enable wives to be more active in protecting themselves and their families from HIV. A pilot study of Healthy Homes was conducted in two Dushanbe primary care clinics. Compared with the controls, the Healthy Homes group reported statistically significant increases in HIV knowledge and worry, communication with spouse and health worker, HIV and STI testing, condom attitudes and use with husband. No increases in family conflict or violence were reported. In conclusion, multilevel HIV prevention centered on wives of seasonal labor migrants is feasible, acceptable, and if effective, could help to halt the current and future growth in HIV among high-risk populations of labor migrants and their families.

Key-words: HIV/AIDS, Tajik wives, labor migration, L-Healthy Homes, prevention, risks reduction, primary care.

Prévention multiniveaux du HIV pour appréhender l'impact de la migration de travail sur les femmes

Résumé

Nos recherches sur les épouses tadjikes ont documenté comment la migration de la main-d'œuvre masculine augmentait la mobilité et l'infidélité du mari et diminuait le contrôle des femmes sur les finances, la sexualité et la santé. Sur la base de ces résultats, des chercheurs de l'Université de l'Illinois à Chicago en collaboration avec le Prisma Research Center au Tadjikistan ont formé un groupe de migrants, d'épouses, de leaders communautaires et de fournisseurs appelé Intervention Design Collaborative (IDC) qui a développé un nouveau modèle de prévention du VIH. Appelé Healthy Homes. Il a été conçu comme un outil de prévention multiscalaire du VIH pour réduire le risque de VIH chez les épouses de migrants en: 1) améliorant leurs connaissances des risques, leurs compétences en matière de prévention du risque de VIH chez les femmes; 2) en améliorant l'accès des femmes aux soins du VIH et des IST; 3) en faisant la promotion des normes et des attitudes culturelles qui permettent aux femmes d'être plus actives pour se protéger et protéger leur famille contre le VIH. Une étude pilote de Healthy Homes a été menée dans deux cliniques de soins primaires de Douchanbe. Comparé au groupe témoin, le groupe Healthy Homes a signalé une augmentation statistiquement significative

des connaissances et des inquiétudes liées au VIH, une communication avec le conjoint et le personnel de santé, des tests de dépistage du VIH et des IST, l'usage de préservatifs et leur utilisation avec le mari. Aucune augmentation des conflits familiaux ou de la violence n'a été signalée. En conclusion, une prévention multiniveau centrée sur les épouses de travailleurs saisonniers est faisable, acceptable et, si elle est efficace, pourrait aider à stopper la croissance actuelle et future du VIH parmi les populations à haut risque de travailleurs migrants et leurs familles.

Mots-clés : VIH/SIDA, femmes tadjikes, migration de travail, L-Maisons saines, prévention, réduction des risques, soins primaires.

Многоуровневая работа по профилактике ВИЧ для решения проблемы воздействия трудовой миграции на жён мигрантов

Аннотация

На основе исследования, проведённых среди таджикских жён, в статье показано, как мужская трудовая миграция повышает мобильность и неверность супруг и снижает контроль жён за финансами, сексуальностью и здоровьем. Основываясь на этих результатах, авторы разработали комплекс мероприятий под названием сотрудничество по выработке мер (IDC) по мигрантам, жёнам, лидерам общин и кормильцам семей, которая предлагает новую модель профилактики ВИЧ, называемую «здоровые семьи». IDC была разработана как многоуровневая профилактика ВИЧ-инфекции для снижения риска ВИЧ среди жён мигрантов путём: 1) повышения их осведомлённости, знаний и профилактики ВИЧ-инфицирования; 2) улучшения их доступа к медицинскому обслуживанию при ВИЧ/ИППП и; 3) поощрения культурных норм и подходов, которые позволяют жёнам проявлять большую активность в защите себя и своих семей от ВИЧ. Пилотное исследование «здоровые семьи» было проведено в двух клиниках первичной медико-санитарной помощи в Душанбе. По сравнению с контрольной группой, группа «здоровые семьи» показала статистически значимое повышения уровня знаний и беспокойства, связанных с ВИЧ, поддержанием коммуникации с супругом и работниками здравоохранения, тестированием на ВИЧ и ИППП, и использованием презервативов с супругами. В течение рассматриваемого периода, каких-либо семейных конфликтов и насилий не отмечалось. В заключение можно предположить, что многоуровневая профилактика ВИЧ, ориентированная на жён сезонных трудовых мигрантов, является осуществимым, приемлемым и эффективным методом, что может помочь остановить нынешний и будущий рост ВИЧ-инфекции среди населения повышенного риска трудовых мигрантов и их семей.

Ключевые слова: ВИЧ/СПИД, таджикские жены, трудовая миграция, L-здоровые дома, профилактика, снижение рисков, первичная медико-санитарная помощь.