

Article

# Children's Health in Migrant Families: Gender and Care Dynamics

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**Abstract:** The feminization of labor migration is one of the most apparent Socio-demographic processes in Uzbekistan, which has to varying extent affected family structure, childcare arrangements and child health. Even though female migration is a source of household income generated from remittances, it carries complicated public health consequences for left-behind children. It explores the effects of gendered migration on child health in relation to changes in caregiving and exposure to risk in migrant families in Uzbekistan. Employing a mixed methods approach, the study combines quantitative household survey data with qualitative findings from migrant families. The results suggest that maternal migration restructures primary care arrangements, and that responsibility for daily childcare is frequently assumed by grandparents or other relatives. They study substitute care that leads to variations in nutrition, hygiene supervision and utilization of preventive health services. There is additional evidence of increased risk for respiratory infection, malnutrition, delayed immunization and psychosocial stress in children from migrant families. The study also identifies environmental health pathways linking maternal absence to household sanitation practices and health-seeking behavior. Overall, the results highlight that while remittance inflows improve material well-being, gendered care deficits generate unintended child health vulnerabilities. The findings underscore the need for integrated social protection and community-based child health interventions within migration-affected regions of Uzbekistan.

**Citation:** Bahadirovich R. B. Children's Health in Migrant Families: Gender and Care Dynamics. Central Asian Journal of Medical and Natural Science 2026, 7(2), 184-189.

Received: 14<sup>th</sup> Jan 2025  
Revised: 30<sup>th</sup> Jan 2025  
Accepted: 13<sup>th</sup> Feb 2026  
Published: 24<sup>th</sup> Feb 2026



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**Keywords:** Female Migration, Child Health, Care Dynamics, Gender Roles, Left-Behind Children, Public Health, Care Deficit, Household Environment, Social Determinants of Health

## 1. Introduction

In recent decades, the feminization of migration has emerged as a defining feature of global labor mobility, significantly reshaping family structures, caregiving arrangements, and child well-being across sending societies. As increasing numbers of women migrate for employment particularly into domestic and care sectors the traditional gendered division of caregiving responsibilities is undergoing substantial transformation. While female migration often improves household income through remittances, it simultaneously generates complex social and health implications for children left behind [1].

Migrant family children commonly undergo changes of primary caregiving over to grandparents, kin or elder siblings. These care substitution mechanisms may be devoid of the emotional, nutritional and wellness surveillance that mothers would normally offer. There is new evidence that these disruptions are leading to increased risk of child

morbidities such as respiratory infections, malnutrition, late vaccinations and psychosocial stress-related disorders [2].

In both cases, child health status and healthcare utilization are affected by a lack of maternal care caused by either household-level or temporary community level migration and 19 Women occupy central positions in their children's lives with respect to maintenance of health, hygiene behaviour and use of preventive healthcare. It is thus the case that maternal absence might affect overall environmental health conditions in household such as sanitation facility, food quality and healthcare utilization [3].

Despite growing scholarly attention to migration–development linkages, the intersection of gendered migration, caregiving restructuring, and child health outcomes remains underexplored, particularly in low- and middle-income contexts. This study therefore seeks to examine how gendered migration dynamics shape children's health conditions within migrant households, with specific attention to caregiving transitions and environmental risk exposure [4].

The study calls for targeted policy measures in Uzbekistan aimed at supporting migrant families through local childcare systems, health monitoring programs, and reintegration-oriented social services [5].

The relationship between female migration, caregiving restructuring, and child health has received increasing scholarly attention within migration and public health research. Existing literature demonstrates that the feminization of labor migration produces both developmental gains and social vulnerabilities within migrant-sending households [6].

## 2. Materials and Methods

**Research Design:** Employed a mixed-methods research design integrating quantitative and qualitative approaches to examine the relationship between female labor migration, caregiving restructuring, and child health outcomes in migrant families. The mixed design enabled a multidimensional assessment by combining measurable health indicators with lived caregiving experiences.

**Study Population and Sampling:** Since migration-affected households are informal and partly unregistered, probability sampling could not be adopted. Thus, a non-probability snowball sampling method was used to recruit respondents via migrant networks, community of neighborhood referral, and local social service contacts. The quantitative study was conducted among households with migrant mothers whose children aged 0–14 years were living in the migration affected regions of Uzbekistan.

Child health “outcomes” comprised of respiratory infections and diarrhea, nutritional status, immunization coverage, and neonatal health conditions. The quality of caregiving, observations on hygiene practices and preventive medical care were measured with Likert-scale items.

**Analytical Methods:** Quantitative analysis of the data was performed through statistical description and comparison, for which a prevalence estimation technique and cross-tabulation of disease exposure by type of caregiver were used. Thematic coding was used to analyze qualitative data and extract common patterns of care-giving and health risk. The use of data triangulation increased the analytical and interpretive validity.

**Ethical Considerations:** Ethical principles were well observed. Voluntary participation was requested and informed consent obtained from all respondents to ensure the privacy of household and child health information following social research ethics procedures.

### 3. Results and Discussion

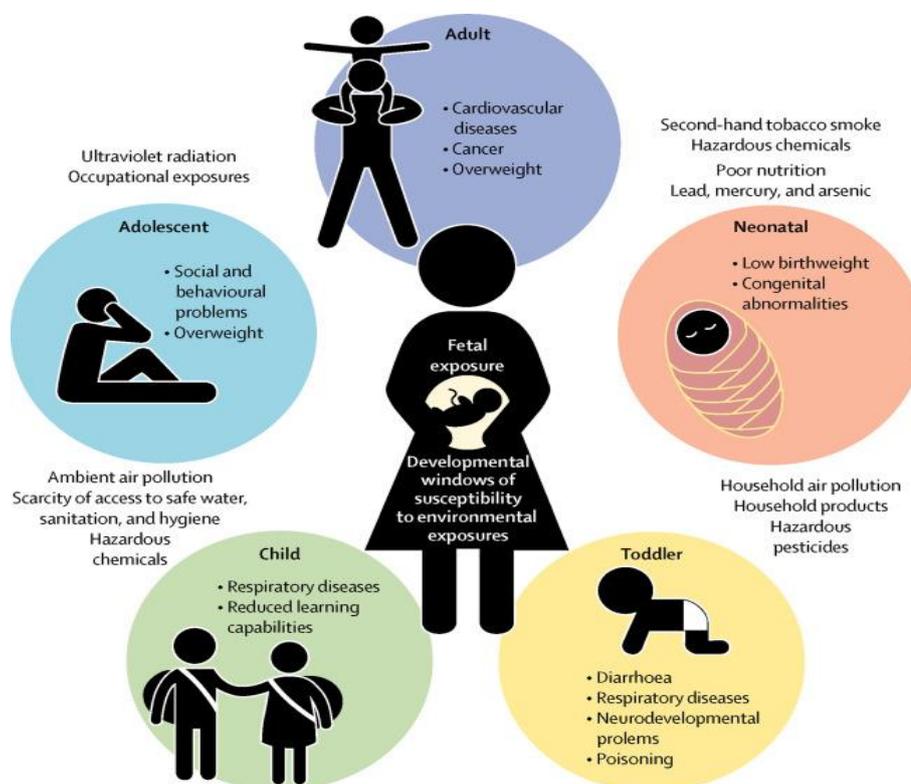
The statistical results demonstrate that maternal labor migration is associated with poor child health among children in migrant families. The left-behind children in transnational families were heavily exposed to various health risks including communicable disease and non-communicable diseases, significant causes involved care giving substitution and environmental health conditions.

Respiratory disorders were found to be the most common category of morbidities among 38-44% children in migrant households. The most common types were recurrent acute respiratory infections, bronchitis, followed by seasonal pneumonia and bronchiolitis. These results are consistent with worldwide childhood health surveillance systems, noting that respiratory infections are the most common cause of morbidity among infants and young children under 5 years of age, and particularly in low- and middle-income countries [13].

Nutritional disorders are the second most common and mentioned in approximately 27–33% of the population, malnutrition, micronutrient deficiency and anemia being some of them. This micro-level pattern reflects a more regional trend as well, given that disruptions to caregiving and household food insecurity sharply increase malnutrition risks for children in families affected by migration according to UNICEF (UNICEF).

There were also indications of change in preventive healthcare. The unrecovered immunization rate among left-behind children was 21.26%, leading to increased susceptibility to vaccine-preventable diseases such as measles and pertussis. The World Health Organization reports that parental absence and instability in caregiving are linked to delays in vaccination commencement among at-risk children (WHO).

Gastrointestinal and parasitic diseases account for an estimated 19–24% of illnesses in children, including diarrhoeal infections and helminthic parasites. According to UNICEF child sanitation reports, poor hygiene monitoring and unsafe water contact that persist are critical factors in childhood infectious disease burden among children not retained under continuous maternal care (UNICEF).



**Figure 1.** Developmental windows of susceptibility to environmental health risks across the life course

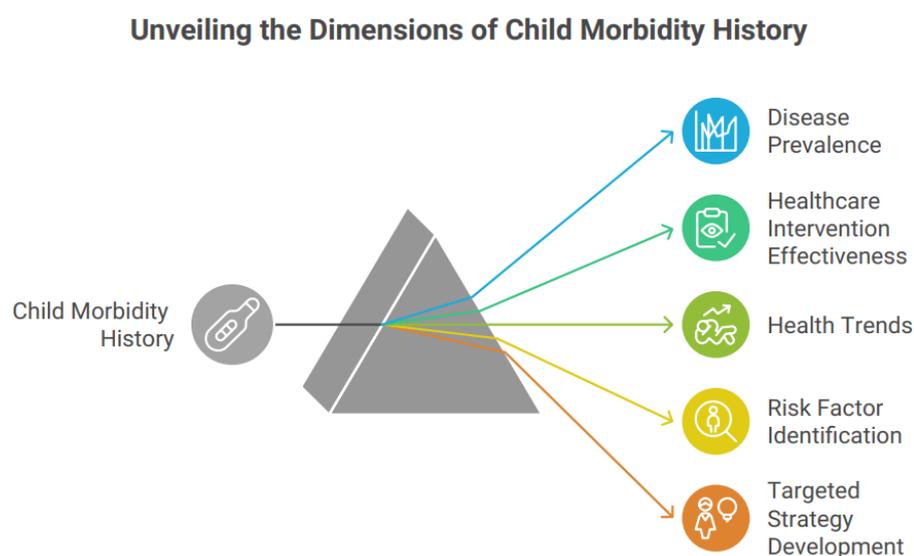
The visual model introduces a life-course approach to environmental health vulnerability, demonstrating how the risks and outcomes of exposure evolve at different developmental periods. From the prenatal period to the neonatal and early childhood stages, biological vulnerability is exacerbated by environmental factors such as air pollution, noxious agents, lack of sanitation and nutritional inadequacy. In the context of migrant families, gendered caregiving transitions -in particular maternal absence- can intensify exposure to such risks through compromised child hygiene surveillance, disrupted feeding practices and lowered levels of preventive health care use. Therefore, environmental exposure pathways become important mechanisms that connect migration-induced care deficiencies to disease patterns in children [7].

Neonatal health outcomes also reflected vulnerability. Low birth weight (8–10%), neonatal jaundice (11–13%), and neonatal infections (6–7%) were observed in migration-affected households. WHO maternal and newborn health assessments similarly identify postnatal care discontinuity as a risk factor for early-life morbidity (WHO, 2022) [8].

Psychosocial disturbances affect 29–34% of children, manifesting as anxiety, sleep disorders, and developmental stress responses. UNICEF child well-being frameworks note that prolonged maternal separation increases psychosocial vulnerability and indirectly affects physical health resilience (UNICEF, 2020) [9], [10].

Overall, integrating global child health evidence with empirical findings underscores that caregiving substitution and feminized migration patterns constitute significant public health determinants shaping childhood morbidity in migrant families [11], [12].

Discussion emphasizes that female labor migration produces a complex and multifaceted effect on children's health in migrant-sending families. Though remittances result in improved material living conditions, the gendered re-structuring of care roles has unintended health externalities [13]. Lack of continuity in the care provided to mothers also undermines preventive health supervision, controlled feeding, hygiene surveillance and the early detection of illness during vulnerable developmental periods. When interpreted through a life-course environmental susceptibility framework, these disruptions reveal cumulative exposure pathways linking caregiving substitution to elevated risks of respiratory illness, nutritional disorders, infectious diseases, and psychosocial stress among children left behind. Therefore, the health consequences of feminized migration must be understood not solely as household-level adjustments but as broader public health concerns shaped by gender, environment, and developmental vulnerability [14], [15]. Addressing these risks requires integrated, child-centered, and gender-responsive social and health policy interventions in migration-affected communities.



**Figure 2.** Multidimensional Analytical Framework of Child Morbidity History

*This figure presents a multidimensional analytical model illustrating how child morbidity history serves as a central evidence base for assessing disease prevalence, evaluating healthcare intervention effectiveness, identifying health risk factors, monitoring epidemiological trends, and informing targeted public health strategies.*

#### 4. Conclusion

We explored the nexus of female labour migration, restructuring of care provision and child health outcomes in migrant families. The results show that the feminization of migration has intricate public health implications which go beyond economic benefits from remittances. Although higher household income leads to better material conditions of life, it does not fully mitigate the caregiving deficits resulting from maternal absence. The findings suggest that left behind children in migrant households are at higher risks to develop respiratory diseases, nutrition-related disorders and infectious diseases and to have incomplete immunization and psychosocial stress. Neonatal and early childhood vulnerabilities, such as complications of low birth weight, breastfeeding cessation, and neonatal infections, illustrate again the key role of maternal availability in protecting early life health. These potential harms are conveyed via caregiving displacement, environmental health exposure and decreased preventive healthcare utilization. In terms of gender migration, maternal compared to paternal migration results in the largest disruptions to child health, emphasising the role of women for household health dominion and hygiene norms and developmental activities. As such, the study locates feminized migration within a larger life course and social determinants of health perspective. The study concludes that female migration is both an economic survival strategy and a structural public health determinant of children's morbidity experiences. A response to these complex vulnerabilities necessitates gender-responsive migration governance, strong community childcare systems, and directed public health interventions focused on children in migration-affected families.

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