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POLICY BRIEF

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Women Left Behind Get Left Out:
Addressing the Intermittent Contraceptive Needs in Migrant-Sending Regions of India

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Background

India's demographic landscape is undergoing rapid transformation, marked by declining fertility and rising internal and international migration. In states like Kerala, Bihar, and Uttar Pradesh, millions of men migrate for work, often returning home only once or twice a year. While this pattern has been extensively examined through economic and labour lenses, its significant impact on the reproductive health of the women left-behind by these male migrants remains largely overlooked. These "left-behind" wives, who are temporarily separated from their husbands, have a specific contraceptive need shaped by the irregular and often unpredictable presence of their spouses, highlighting a critical gap in our understanding of reproductive risk associated with this form of migration.

Data from the National Family Health Survey (NFHS-5) reveal heightened reproductive vulnerability in terms of unmet need for contraception and unintended pregnancies (Box 1). The centre of this issue can be described as the intermittent contraceptive gap-a cyclic pattern of unmet need for contraception that arises during the short, infrequent visits of migrant husbands. These visits, while brief, often involve renewed physical intimacy that calls for a timely demand for contraceptive protection. However, women are often unprepared during these windows due to a combination of factors: inconsistent access to family planning services, limited availability of appropriate contraceptive methods, lack of anticipatory counselling, and prevailing social stigma around contraceptive use during rare presence of husband. This lack of preparedness may increase the risk of unintended pregnancies, which may lead to unsafe abortions and poor reproductive health outcomes.

Box1:

NFHS-5 data reveal that among currently married women aged 18–49 with over one year of marital duration,

- Those women whose husbands lived away for more than six months showed a substantially higher **unmet need for contraception** compared to their counterparts living with their husbands (17.2% vs. 9.1%).
- In addition, the prevalence of **unintended pregnancies** was also higher among women with absent husbands (8.7% vs. 7.9%).

Current family planning programs, such as the National Family Planning Program and Mission Parivar Vikas, are imagined on the assumption of continuous marital cohabitation and regular

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contraceptive needs. These assumptions fail in high-migration prone regions, where contraceptive demand is intermittent but urgent. This policy brief urges policymakers, health planners, and key stakeholders to recognise and address the contraceptive gap among temporarily separated couples due to migration. It needs tailor-made interventions to ensure that women left behind by migrant spouses can exercise their reproductive rights safely and effectively.

Study Area and Data Source

This policy brief examines two migrant-sending pockets: the Middle Ganga Plain (MGP) region (comprising Bihar and Eastern Uttar Pradesh), and the state of Kerala. According to NFHS 5, these regions report a higher percentage of women whose husbands live away for more than six months (Figure 1A). Despite similar migration patterns, these regions exhibit stark differences in reproductive health indicators. The MGP region records high fertility (TFR, the average number of children born per woman, stands at 3.0 in Bihar and 2.4 in Uttar Pradesh), and low use of modern contraceptives (Figure 1B). In contrast, Kerala reports a low fertility (TFR 1.8), moderate contraceptive prevalence[1]. This analysis is grounded on data from the Middle Ganga Plain Migration Survey (2018 &19) and the Kerala Migration Survey (2018). The focus is on rural, currently married women aged 18–49 with at least one year of marital duration. The sample includes- 1180 wives of non-migrants (WNM), i.e., women who are co-residing with their husbands, and 1059 wives left behind (WLB), i.e., women whose husbands have migrated for employment, in the MGP region (Total 2,239 women), and 719 WNM and 726 WLB in Kerala (Total 1,445 women).

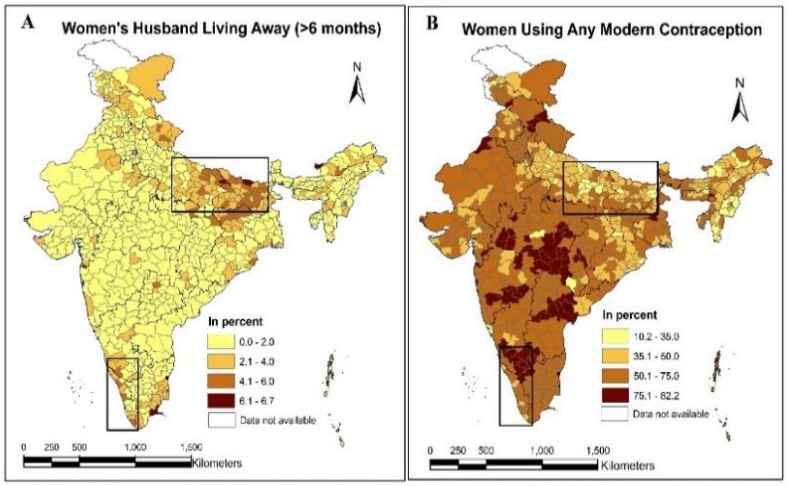

Figure 1: figure 1(A) shows the percentage of currently married women (aged 18–49 years and married for more than one year) whose husbands were living away for more than six months in India, based on NFHS-5 data
figure 1(B) shows the percentage of currently married women (aged 18–49 years and married for more than one year) in India using any modern method of contraception, based on NFHS-5 data
Note: Boxes on the map indicate the study areas. The upper box refers to Eastern Uttar Pradesh and Bihar, while the lower box refers to Kerala

Key Findings

- **Nearly half of women in both the MGP region and Kerala are left-behind** due to spousal migration. Migration is mostly internal in MGP (43.4%) and international in Kerala (49.3%).
- **Intermittent visits and shorter duration of stay** of Left-Behind Husbands in the main features of migration in the region. Over 80% of the migrant husbands visit their left-behind families only once or twice a year, and nearly 60% stay for less than a month.
- **Lower Contraceptive Use Among Left-Behind Women by** 6% compared to WNM in both regions. In MGP, 70% of WLB use no method, compared to 63.3% of WNM.
- **Use of spacing methods like condoms and pills is less common** in the MGP region and among left-behind women. In Kerala, more than one-fourth of the wives are aged below 35 years (28.4%), compared to nearly 4% in the MGP used condom. Traditional methods and IUD use are more common among Kerala women aged 25–35. Female sterilisation rises with age, reaching 32% among women 35+ in both WLB and WNM groups.

[1] International Institute for Population Sciences (IIPS) and ICF. (2021). National family health survey (NFHS-5), 2019–21: India. *National Family Health Survey, India*.

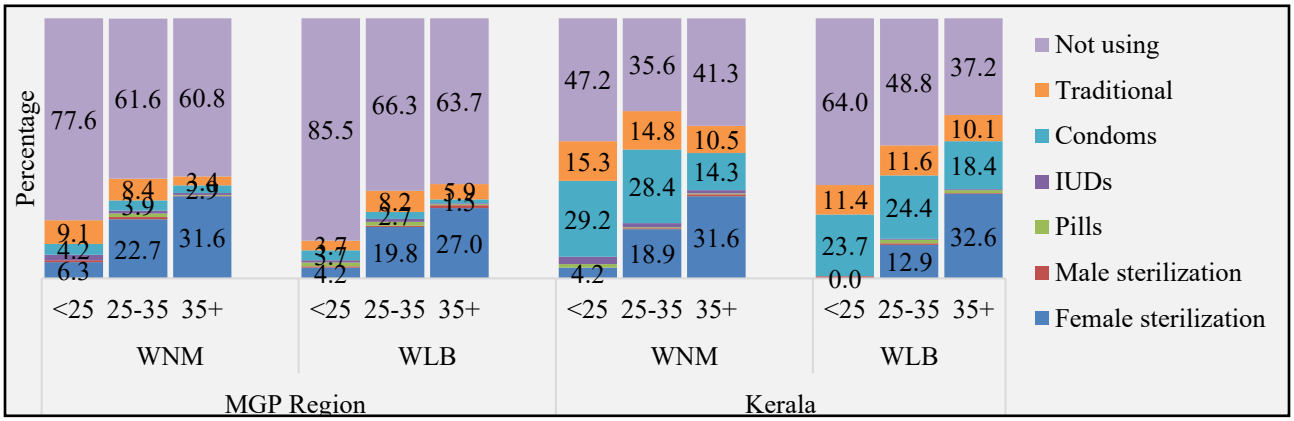

***Figure 2**: Percentage distribution of women by use of contraceptive method and non-use across the age group and husband's migration status in the MGP region and Kerala*

- Young left-behind women, especially those under 25, show alarmingly low contraceptive use (MGP-85.5% and Kerala-64.0%), often due to limited awareness, prevailing social stigma, and weak health system engagement.
- **In MGP, the major reason for non-use of contraception** among left-behind women was cited as 'Husband is away'(56.4%), followed by a desire for children (21.8%).
- **There is a weak role of grassroots health workers** in motivating contraceptive use. Only 3–4% of WLB cite ASHA/ANMs as motivators. Most women are self-motivated or influenced by husbands, especially in MGP.

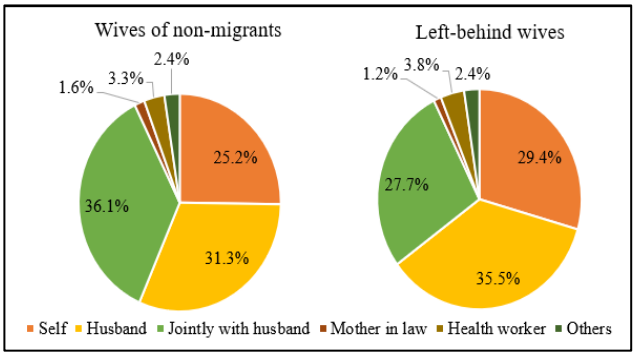

***Figure 4:** Distribution of women reporting of reason for not using contraception in the MGP region*

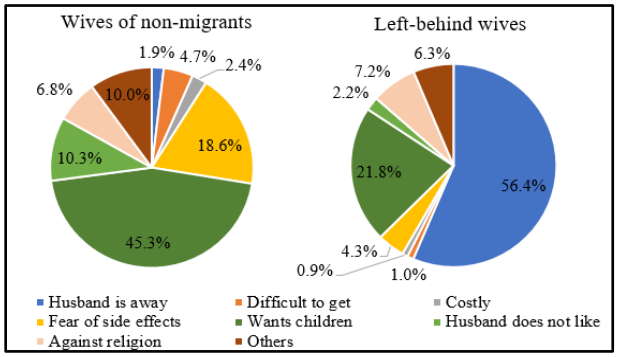

***Figure 4:** Distribution of women reporting of reason for not using contraception in the MGP region*

Policy Gaps

- **Lack of Migration-Sensitive Planning:** National programs like the NFPP and MPV do not recognise left-behind women as a distinct group, overlooking their specific reproductive health needs.
- **Weak Engagement by ASHAs/ANMs:** Frontline workers lack training and mandate to support migration-affected households, limiting outreach, counselling, and follow-up for women at risk of unintended pregnancies due to intermittent spousal visits.
- **Skewed Contraceptive Method Mix:** Current strategies focus heavily on female sterilisation, with insufficient promotion of temporary/spacing methods suited for irregular spousal presence.
- **Neglect of Socio-Economic Vulnerability**: Emotional stress, isolation, and financial dependency among left-behind women are ignored in existing women's programs, indicating a need for integrated, gender-sensitive family planning policies.

Key Recommendations

1. **Integrate left-behind women into regular family planning and economic empowerment programmes in migration-sending areas**

- Develop and implement targeted awareness campaigns within Mission Parivar Vikas (MPV) to address the specific needs of left-behind women.
- To address the intertwined challenges of economic hardship and emotional vulnerability among left-behind women, family planning initiatives should be linked with livelihood programs such as JEEViKA (livelihoods mission of Bihar Rural Livelihoods Promotion Society (BRLPS)) in Bihar and RGMVP (Rajiv Gandhi Mahila Vikas Pariyojana) in Uttar Pradesh to deliver reproductive health education through Self-Help Groups.
- Integrate family planning with mental health counselling and gender support groups within rural health missions. These programs not only offer economic opportunities through SHGs (self-help groups) and microcredit but also provide platforms for social interaction, skill-building, and confidence enhancement. The model of the *Kudumbashree* program running in the state of Kerala may be followed.

2. **Enhance and institutionalise ASHA/ANMs' engagement and training for the intermittent need of contraception among the left-behind women**
   - Develop and mandate special outreach strategies within existing ASHA/ANM programs, specifically for left-behind women and ensure availability of temporary contraceptives at the household level.
   - Incorporate modules on engaging with migration-affected households.
3. **Promote the use of condoms to prevent unwanted pregnancies and STIs/RTIs**
   - Place a stronger focus on promoting spacing methods, particularly condom use among left-behind women. Offer counselling and flexibility around their use to suit the irregular presence of spouses to prevent unwanted pregnancies.
   - As migrants also work as a bridge population in the transmission of STIs/RTIs from high-risk populations to spouses. In this context, promotion of condom use may protect the reproductive health of left-behind women, especially from transmission of STIs/RTIs.
4. **Engage male migrants through coordinated outreach**
   - Integrate male engagement strategies into family planning programs, particularly in migration-affected households. This should include education, counselling, and the promotion of vasectomy as a viable contraceptive option. Normalise vasectomy through localised IEC (Information, Education, and Communication) campaigns and incentivised male peer advocates.
   - Contraception awareness programs should also be implemented at migrants' destinations to increase their awareness and facilitate better spousal communication and planning when they return home.
5. **Strengthen health systems for family planning**
   - Ensure that health facilities in high out-migration regions are equipped to provide comprehensive, confidential, and continuous reproductive health services. This includes expanding access to emergency contraception as well as screening, treatment, and education related to sexually transmitted infections (STIs) and reproductive tract infections (RTIs). Integrating family planning with broader reproductive and maternal health services, such as Antenatal Care (ANC) and Postnatal Care (PNC), will enhance continuity of care and improve overall health outcomes.

Conclusion

The reproductive health, particularly the contraceptive needs of left-behind women in India's migration-affected regions, requires urgent policy attention. Existing family planning programs do not address the unique realities of women affected by spousal migration. However, these women remain largely invisible in national reproductive health and family planning frameworks. Bridging the contraceptive gap among left-behind women in high-migration regions requires a shift toward migration-sensitive, inclusive, and gender-responsive family planning strategies. Recognising the distinct needs of women in Eastern Uttar Pradesh, Bihar, and Kerala, this policy brief underscores the importance of context-specific interventions and stronger health system integration. Ensuring equitable access to contraception for left-behind women is vital for advancing reproductive rights, achieving national population goals, and meeting global commitments under SDGs 3, 5, and 10. Ensuring equitable access to contraception for left-behind women is both a public health imperative and a step toward social justice.