Contraceptive Use Among Women in the Context of Male Out Migration: Unique Patterns and Vulnerabilities

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ABSTRACT

Despite universal contraceptive knowledge and wide facilitation for family planning, 35% of Sri Lankan women are not using a contraceptive method as at 2016 (Department of Census & Statistics, 2017). This study claims that in addition to conventional reasons such as desire for children, unmet need, fear of side effect etc. for non-use, hidden factors could also persist in a country where diverse demographic and socio-economic factors, in this case migration is at play. This paper examines the contraceptive use among left behind women with subsidiary focus on their contraceptive knowledge, reasons for use or non-use and possible implications using a mixed method approach consisting of primary data from a survey and in-depth interviews, conducted in Kandy district of Sri Lanka. Findings indicate that knowledge of contraceptives are high among women, particularly on methods that needs little pre-planning and male involvement – i.e. condoms and withdrawal. Knowledge of emergency methods are also high compared to national figures. Use of contraceptives take a cyclical pattern where it synchronizes with spousal visits. Highest use is reported for male condoms and withdrawal during spousal visits. Emergency contraceptive use is also relatively high. Due to method failures, unintended pregnancies and abortions are reported. Issues on access and poor spousal communication on contraceptive use results in women not using more reliable methods. Left behind women are seen as a group that does not need attention regarding contraceptive use as the spouse is absent. However, family planning programmes should target specific groups such as left behind women that may escape the national focus but needs special attention.

BACKGROUND

Despite universal contraceptive knowledge among women in Sri Lanka, and wide facilitation for family planning, 35 percent of women are still not using a contraceptive method (Department of Census & Statistics - DCS, 2017). Non-use of contraceptives are directly connected to unintended pregnancies (some of which can lead to induced abortions) and transmission of Sexually Transmitted Infections (STIs) etc. that can lead to a wider variety of socio-economic and reproductive health vulnerabilities. Most cited reasons for non-use include desire for children, unmet need, fear of side effects, cultural and family barriers, lack of knowledge etc. (Chaudhury, 2001; Ghule et al., 2015; Sedgh & Hussain, 2014). Yet, in contexts such as Sri Lanka where diverse demographic and socio-economic dynamics are at play, other reasons could prevail, which may be undermined by the more conventional determinants. Unrevealing as many reasons are important when living in heterogenous socio-economic contexts so that different groups with different needs can be specifically targeted and attended to, rather than implementing blanket cover actions. When aggregate figures are improved, for example such as in Sri Lanka, where nearly two thirds (65%) of the women are using contraceptives, in contrast to some South Asian counterparts, the rejoicing of the aggregate figures can distract policy makers from specific needy sub-groups at the micro level. However, when overall aggregate figures improve to a certain level, the targets should be to identify specific groups that escape the national average and needs special attention.

Studies have identified that migration is a significant factor that influences the contraceptive use of women (Ban et al., 2012; Groene & Kristiansen, 2021; Kessler et al., 2010; Mukherjee et al., 2021; Samantha & Munda, 2023). This is less known (Flippen & Schut, 2022) and less studied (Banougnin et al., 2018; Lindstrome & Hernandez, 2006). It is reported that the lack of research on migration and contraceptives results because of the scarcity of larger national surveys that collect data simultaneously on contraceptive use and migration

(Linderstrom & Hernandez, 2006). Migration is known to disrupt already established or existing contraceptive use practices, and are connected to method switch and discontinuation (Kulu, 2005). It can also have positive consequences like exposure to new methods, especially modern, wider choices etc. The connection between migration and contraceptive behaviour has not received much attention in Sri Lanka. Even in international literature, the focus on contraception relates mostly to migrant women (see Flippen et al., 2022; Gele et al., 2020; Zheng et al., 2001). Yet the contraceptive routine and behavioural changes can relate to the left behind also. Studies have indicated that use of contraceptives and reproductive health services is negatively associated with male migration among women in developing countries (Ban et al., 2012). While a logical reason presented is that discontinuation is accepted due to spousal separations, the contraceptive use behaviour changes could call for new knowledge, new methods use and vulnerabilities among these women. These should be explored to provide a quality service based on specific needs.

International contract labour migration, where long spousal separations are a consequence, is now a permanent feature in Sri Lanka. It is mainly seen as a solution to economic hardships, and improving material and social conditions. Consequently, research on migration is more focused on these visible changes, either positive or negative. Migration can also result in many behavioural changes that are most often invisible and not directly connected to migration, but are important in the larger demographic landscape. Therefore, the aim of this paper is to examine contraceptive use among left behind women with subsidiary focus on their contraceptive knowledge, reasons for use or non-use and possible implications.

MIGRATION AND DISRUPTIVE HYPOTHESIS

Scholars have developed several competing theories to explain the relationship between migration, fertility and contraceptive use behaviour (Kulu, 2005). Among them the 'disruption hypothesis' focuses on the disruptive effects of migration on family and marital relationships (Ortensi, 2015). Both internal and international migration is seen as a disruptive event in relation to family relations (Flippen & Schut, 2022). The hypothesis mainly suggests that separation of couples leads to delays in childbearing. The development of this view initially is attributed to the work of Goldstein and co-authors in the 1970s and 1980s (see for example Goldstein & Goldstein, 1983). The disruption hypotheses later become the focus of migration and contraceptives (Kessler et al., 2010; Linderstrom & Hernandez, 2006), mainly in relation to women who migrate; but can also be applicable to women left behind by migrant spouses. According to Linderstrom and Hernandez (2006) migration entails a change in the socio-economic context of family life that affects the contraceptive methods used. With regard to left behind women the disruption to marital life due to migration can act in different ways with regard to their contraceptive use. One obvious factor is the reduced need for contraceptives due to lack of coital relations. Consequently, method discontinuation and then resumption is in accordance with return visits (Kaufman, 1998). This would lead for more temporary measures of use to tally with this cyclical pattern. The women's access to contraceptives when required may also be disrupted due to social barriers; for example, in anticipation of spousal return, they may feel stigmatized to request/access contraceptives since the spouse is not present (Mukherjee et al., 2021). Migration can also disrupt or limited spousal communication on contraceptives as long distance and short communication time will put the dialog on contraceptives to a back seat while prioritizing other household or children's' needs.

METHODOLOGY

The study was conducted in 2015, and is based in selected 'Grama Niladari' Divisions (smallest administrative units) of Kandy district, Sri Lanka. Using a mixed method approach, data was collected using a questionnaire survey and in-depth interviews. Due to the lack of a sampling frame, data was collected from a purposively selected sample of currently married left behind women in the reproductive age group of 15-49, with an international labour migrant spouse. Inclusion criteria was having spent at least 3 years of marital life as a left behind woman who had had at least one spousal return visit during that time. The survey included 108 women and one quarter of them (27), based on their willingness, was included for interviews. In addition, detailed information provided by respondents while conducting the survey is also used for the analysis. The data

collection focused on fertility behavior, contraceptive use, and contraceptive use related issues. Quantitative and qualitative data were analyzed using SPSS and thematic analysis respectively.

FINDINGS

Demographic and socio-economic profile of respondents

Respondents were in the 25-47 age group, indicating they were in their prime reproductive age span. While majority represented the ethno-religious category Sinhala Buddhist, the sample represented Tamil and Moor women as well as Hindus, Muslims and Catholics. Education levels concentrated mainly on two groups – GCE O/L passed and GCE A/L passed with 4 who had degrees. There were no one in the sample with education below grade 9. Based on selection criteria all women had spent at least 3 years as a left behind. Several among them had spent more than 10 years as left behind women with intermittent visits from the spouse. From the respondents, 63 percent were housewives and the others were in a range of employment categories including professionals, self-employed, elementary occupations or agriculture.

Contraceptive knowledge

According to the Sri Lanka Demographic and Health Survey (SLDHS) 2016, which is the latest available data source on national level detailed information on contraceptives, knowledge of contraceptives among currently married women is high (99.7%) (DCS, 2017). Knowledge of any modern method was almost universal (99.7%); knowledge of traditional method was good, but relatively less than modern methods (86.3%). Contraceptive knowledge among the sample was also high, but differed from the DHS pattern when considering individual methods (Table 1).

Table 1: Contraceptive knowledge

Method	Knowledge (Sample)	Knowledge (DHS 2016)
Female sterilization	96.2	96.0
Male sterilization	71.3	67.2
Pill	99.3	97.3
IUD	96.4	95.5
Injectables	97.7	97.3
Implants	90.2	89.5
Male condom	100.0	91.4
Female condom	15.1	19.4
Emergency contraceptives	77.2	53.7
Rhythm	79.8	79.7
Withdrawal	97.2	70.5

Sources: Present study; DCS, 2017

All respondents (100.0%) knew of the of male condom, whereas knowledge of condoms was only 91.4% in the SLDHS. More or less similar knowledge was reported for the pill, IUD and injectables in the sample and the SLDHS. The most contrasting gap on knowledge between sample and SLDHS was for withdrawal (26.7%) followed by emergency contraceptives (23.5%). The findings indicate that respondent women were more knowledgeable on contraceptive methods that needs low pre-repreparation and requires male involvement. Further, in comparison to national level SLDHS data, awareness on emergency remedies and the traditional method withdrawal are more prevalent among the respondents. Views from the respondents gives more insights on their knowledge.

"I know of many family planning methods. It is better to use chemical methods (i.e. modern methods) than our cultural methods (i.e. traditional methods). Chemical methods are more successful they say"

"I have not heard of female condom. But 'yes' male condom is well known"

"You need husband's support when you use withdrawal and my husband also knows of this way"

"I heard from friends about emergency method. We women with migrant husbands discuss these things. Its very useful for us"

Sources of knowledge

Sources of knowledge mainly included public health midwife, government or private sector hospital doctors or nurses. This information source is more or less consistent to the SLDHS data (DCS, 2017). However, in the sample other major sources were cited, and this included mostly friends and the husbands, particularly for some methods; i.e. emergency contraceptives and condoms. Consequently, the respondents obtained information more or less equally from both formal and informal sources. Detailed information also indicated that knowledge from formal sources (medical personnel/ midwife etc.) were more related to the time of marriage/child birth or before spousal migration. Knowledge after spousal migration relied more on the spouse him-self and friends, particularly friends with a migrant spouse (Table 2).

Table 2: Sources of knowledge on contraceptives

Respondent response	Researcher analysis	
	Source	Categorization
"When we got married the mid wife used to come and teach us how we must be careful if we don't want to have a baby soon after. Even after I had my baby mid wife advice that it is best to keep a gap before the next baby"	Formal sources	Pre-departure / at child birth
"Because my baby and I was sick after birth, mid wife advised that I must wait for some time before the next baby and she suggested IUD or injections"	Formal source	At child birth
I did not know about emergency contraceptives until my friend told me. Sometimes husband comes without informing and we can't avoid relationships. My friend's husband who is a migrant has told her about it. It is very useful.	Informal sources	Post departure
I knew about condoms but we had not used it before. But when my husband came he brought condoms and I learnt how to properly use from him	Informal source	Post departure
When we were newly married we used withdrawal as we were frightened to use artificial methods…I have heard that they can affect the pregnancies. But I got pregnant and we were not prepared for a baby. Now I have learnt from friends and husband about it well and we use it when he comes. But I know there is a risk as one of my friends got pregnant for second time while using this way	Informal source	Pre and post (mostly post)

Source: Present study

Contraceptive use

Contraceptive use can be analyzed in two ways – current use and ever use. To examine the use pattern of respondents, they were asked the following two questions.

Q1: Have you ever used a contraceptive method?

Q2: Are you currently using any method?

Ever use

104 women answered in the affirmative for Q1 (ever use). The never users were newly married and planning to have children soon. This indicates that nearly all women (96.3%) had used a contraceptive method in their life time. Ever users were asked when they first used contraceptives and based on the answers given (and responses for in-depth interviews - Table 3) the women can be categorized into three groups – first uses of contraceptives for a) postponing births; b) spacing births; and c) stopping births.

Table 3: First use of contraceptives

In-depth interview responses	Categorization based on in-depth interviews and survey	Percentage use for the first time as per survey
*He came only for a short time to have the wedding and then left in about a month. So during that time we used condoms as we did not want to get pregnant immediately after the wedding as he could not stay for long***	Postponing first birth	4.8 (n=5)
After we got married we used the pill for sometime until we settled in life. We had our daughter after two years. He left when daughter was about three years to improve economic situation		
I got pregnant soon after marriage and it was very difficult as he was also away. So we thought we will wait for a while before having the next child	Spacing	94.2 (n=98)
Its not easy to manage small children alone. They fall sick and many issues. So we decided to wait till our son started school before having the next baby		
We now have four children. Three daughters and a son. No - I did not use any method until I had all four children. After the youngest daughter was born the midwife advised me on the operation	Stopping	1.0 (n=1)
Total		100.0 (n=104)

Source: Present Study

Note: **This marriage scenario only pertains to a few women. For most, migration occurred sometime after marriage and for some even after the first birth

From among the ever users (n = 104), the majority (94.2%) used contraceptives for the first time to space births. Only one woman had used contraceptives for the first time to stop births. This woman had four children and had undergone sterilization as per the advice of the midwife. Contraceptive use for the postponement of first births was also not widely practiced (Table 3). Non-use of contraceptives until the first births was especially expressed by women who had married an already migrant male.

"Most often the men come for the wedding and goes off shortly. Usually comes back in a year or two. So, if we don't get pregnant soon after wedding we have to wait for another two years. If we use contraceptive then it will take long time to have baby."

"My husband left three weeks after the wedding. He came after two years. So, I had to wait for more than two years to get pregnant. But usually women get pregnant within about a year after marriage."

Even women who married a man who was a non-migrant at the time of marriage expressed their view on non-use before first birth.

"We get married when we are young no… So, then we don't know much about contraceptives…we think it will affect pregnancies. So, we are frightened to use."

"Until you get the first baby you don't know the difficulties of rearing children…so we try to have a baby soon"

The first two response above shows how migration automatically creates a gap between marriage and first birth without contraceptive use. The study by Shuttuck et al. (2019) in Nepal also shows left behind women's desire to become pregnant and indicates that they try to maximize their opportunity to become pregnant. Majority of the women in the sample had married in their mid-20s, and as indicated by some respondents in the in-depth interviews, they did not want to postpone first birth until they reached their 30s by using contraceptives.

Current use, non-use and reasons

For the question on current use, from among the 104 ever users, 12.5 per cent (n=13) noted that they are currently using contraceptives while 87.9 % (n=94) noted that they are not using. This high figures of non-use among currently married women in the reproductive age resulted in further probing, and unraveled a unique situation regarding left behind women's current use of contraceptives as seen below.

In surveys and particularly the SLDHS, current use means the use of contraceptives at the time of the survey. However, for the respondents in this study (except those who are sterilized) their current contraceptive use was directly connected to the presence or absence of the migrant spouse – i.e. the women only used contraceptives when their migrant spouse returned as seen by the responses below.

"*Husband comes only every two years. He stays here for about 1 ½ to 2 months. So, there is no need to use contraceptives continuously. Not good for physical health also no. We only use when he comes"*

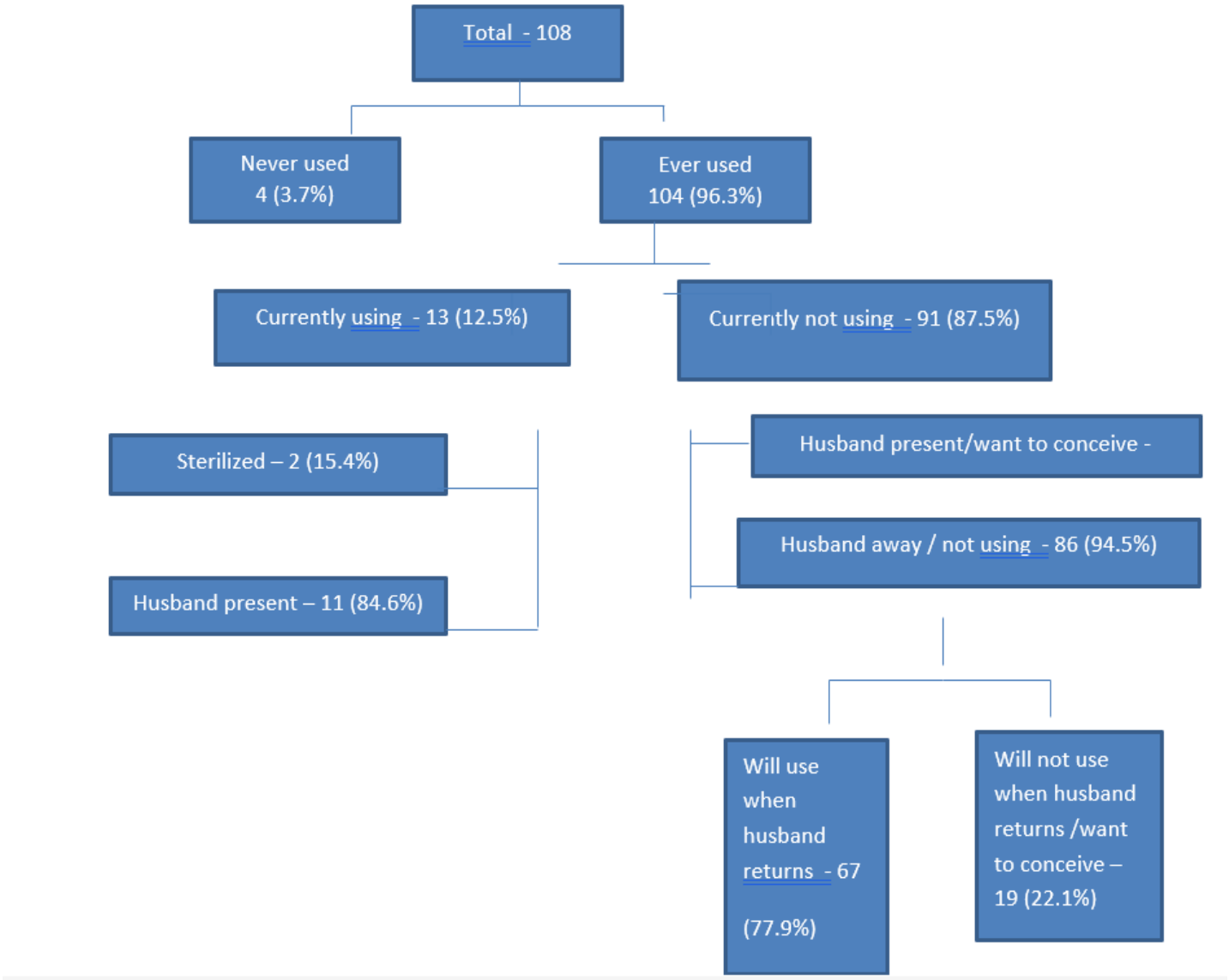
"Sometimes he comes with short notice. I used the pill before he migrated and stopped when he migrated. When he comes back we need to use something again. But it is not easy to use pills at short notice. So, we use condoms when we want"

"I don't like to use this chemical stuff. I get body aches. I put on weight also. So, when husband left I stopped using…no need no. I only use contraceptives when he comes"

"These days I am using condoms as my husband came for a vacation. But when he goes again I will not use anything"

The migration specific, unique use patterns of current users and non-users are clearly depicted in Figure 1. Among the 13 current users, 2 had undergone sterilization and 11 were using a contraceptive as their husband was present. 91 women were currently not using a contraceptive; 5 among them reported that the husband was present at the time of the survey and they were not using contraceptive as they planned to get pregnant. Among the remaining 86 respondents, 67 will use a contraceptive when the husband returns and 19 will not use as they plan for pregnancy.

Figure 1: Current use/non-use of contraceptives and reasons



Methods used and method switch

The general pattern of use among the majority in the sample was use of contraceptives before spousal migration, stopping use at migration, resuming use when spouse returned, and stopping when he migrates. Hence except the women who are sterilized, the women using temporary methods use them only for a very short period. Therefore, it is interesting to understand what methods they use currently (i.e. when spouse returns) and whether method switching was practiced or women continued to use the same methods pre and post migration. To examine, ever-users were asked the last method they used pre-migration and the method they used most recently[1]. The results are given in Table 4.

Table 4: Use of contraceptives pre and post migration

	Most recent use (after spouse migrated)		Pre-migration use	
	%	No	%	No
Female sterilization	1.9	2	-	-
Male sterilization	-	-	-	-

[1] Most recent method indicates the method used during the last visit of the spouse.

Pill	-	-	17.3	18
IUD	5.8	6	29.8	31
Injectables	-	-	13.5	14
Implants	-	-	3.8	4
Male condom	54.8	57	12.5	13
Female condom	-	-	-	-
Emergency contraceptives**	7.7	8	-	-
Rhythm	-	-	10.6	11
Withdrawal	24.0	25	5.8	6
Not used at last visit	5.8	6	NA	NA
Not used pre-migration	NA	NA	6.7	7
Total	100.0	104	100.0	104

Source: Present Study

Note: ** More details of emergency contraceptives use are given below

The vast majority of the women (54.8%) uses male condoms, a modern method, followed by withdrawal (24%), which is a traditional method, post migration. As shown above (Table 1) knowledge of these two methods is also very high among the respondents. Use of both methods are possible without pre-preparation but needs male support. The use switch from pre-migration to post is also very contrasting (Table 4). Though condom use was only 13 percent pre-migration it shows an increase of 45.3 percentage points and withdrawal shows an increase of 19.4 percentage points between the two periods. Use of IUD which indicated the highest use pre-migration, has shown a drastic decrease.

Use of emergency contraceptives

Another specific finding related to contraceptive use among the respondent women was their use of emergency methods. As shown in Table 1, knowledge of emergency methods was very much higher among the respondents (77.2%) compared to national level figures (53.7%). Among the respondents, 7.7 percent had used emergency contraceptives as the sole method during the last spousal visit (Table 4). But the current use at national level is 0.1%. Further, among the respondents 39.43% had used emergency contraceptives at some time during their life, especially after spousal migration. But other than for few women it has never been the sole use. In-depth interviews revealed different scenarios regarding its use.

Table 5: Different contexts of using emergency contraceptive methods

In-depth interview responses	Researcher Interpretation
I did not know of emergency method before but a friend informed me. Sometimes we are not prepared for protection when husband comes and she said easiest way is to use them. I have used it several times now	Unplanned sexual activity
Actually, my husband came without informing once. And then we got concerned that I might get pregnant. My children were grown. So he got it for me.	Unplanned sexual activity
We practice withdrawal – but when we are not sure we use the emergency pill	Unsure of method reliability
Taking the emergency pill is very easy. No pre-planning. I was told not to use it often	Easy use /no pre-planning
Our relationships are not planned. Not like when husband is here. Then its really tension situation for me as I can't refuse sex. But knowing this is available is a relief	Reduces sex-relations related stress
No need to ask anyone like midwife for advice. You need it you go buy it	Less constraints in access

Source: Present Study

However, though many were aware of this method, they did not have proper knowledge and fear of consequences were relatively high among the women as seen by the below response.

"I have used it many times as I did not have an option. But people say its bad and not good for my health"

" I take it as I have no other alternative"

"They say it affects child birth, but now since I have two children its ok"

"Its supposed to have a lot of side effect – so far I have been ok. May be because I used only once or twice"

Reasons for Method switch

Women were asked their reasons for the method switch as given in Table 4, and it was reported that long separations do not warrant for continuous use of a method, and couples prefer to use a temporary easy method which can be practiced at short notice during spousal visits. In addition, temporary methods such as condom and withdrawal were very easy to discontinue. Both methods are also seen to produce no side effects.

Vulnerabilities

Unintended pregnancy

Non-use of contraception is mainly connected to unintended pregnancy (Mosher et al., 2016). In this study around 26.9 percent reported of an unintended pregnancy. These were mainly related to a second or subsequent pregnancy. The pregnancies were unintended because births were either sooner than planned or an additional child than planned as seen by the responses below (Table 6). Only a few reported of an unintended first pregnancy.

Table 6: Unintended pregnancies and impacts

"I had my second child around two years after the first. Though we wanted a second child I did not want to have a baby when the first one was very small. It's difficult to look after children alone. However, when husband came to see the first baby I conceived again, though we used withdrawal….actually, I did not know of the emergency pill at that time…"	Impact on spacing
"I used injections before (before migration). But after he went I stopped it as there is no point. And we used withdrawal. But sometimes it is not very successful and I got pregnant quite late in my life with the third child though we were not intending…."	Impact on stopping

Induced abortions

Only two women in the sample reported of undergoing induced abortion. However, since this is a taboo topic the figures could be higher. One woman reported that she had resort to induced abortions as she was in her late 40s and having grown up children. It was reported that she did not anticipate pregnancy risk as at her age. The other woman already had three children, and had used withdrawal which she feels failed. The vulnerability here arose due to the stress these women faced in obtaining the abortion alone and the fear of being stigmatized in the case of others finding out. One woman reported *"I realized that I was pregnant only after husband left. We had no option but this – it was so scary attending to this alone. I feared children would know. And people will say I got pregnant when husband was not there……".*

Concentration on a few methods and access issues

As seen above, the contraceptive use among most women are concentrated around a few methods. Among them there is a risk involved in using withdrawal and also the condom if not properly used and its quality. Hence

women were asked why they used only these methods instead of others that can also be used with little prior planning. The responses highlight some gaps in service delivery, structurally as well as culturally.

The fact is everyone knows that husband is away. And I feel shy to go and get from the mid wife or buy from the pharmacy

Like when we have a baby or when we get married the mid wife comes to us and educates. But when husband is coming for a visit we have to go and tell her. I feel shy to do that.

When husband says he is coming I can't say bring condoms. What will he think of me. So, its best to use withdrawal or use emergency method

We go to clinic only if we are pregnant and after child birth. We can't go to just discuss contraceptives

Poor couple communication

When spouses are physically separated their communication methods also change from the usual face to face conversations. Majority of the respondents used telephone, WhatsApp, skype and Facebook to communicate with their spouses. The below quotes highlight the communication issues regarding contraceptives.

There are so many things to discuss when he calls. Children's schooling, sickness, managing alone, household needs ...many things. So actually, contraceptives are not even a topic that comes to mind"

"When he is here we can privately talk about contraception as we could find time. Now usually he talks to the family together and then we can't have private conversations

He has told me that he lives with other people. So, may be everyone hears what he says when we phone. So, I don't talk of private things

Sexually Transmitted Infections

This study will not delve particularly in to details of STIs as none of the women reported of contracting them. However, 65 percent of the women reported concern regarding husband's risk of contracting a STIs. Some reported that they were quite positive that the husband engaged in extra marital sexual relationships, because friends and neighbours who worked in these countries informed them. As noted a large number of women use condoms as a protection against pregnancy, though none used condoms in connection to avoiding the transmission of STIs. However, condom use can be acting as a barrier for STI transmission and is extremely important for all women.

DISCUSSION AND CONCLUSION

This study examines the contraceptive use among women in the context of spousal out migration. Contraceptive behaviour of these left behind women takes a unique pattern which can generate different issues and necessities in comparison to other women. The study findings indicate that migration should be considered an important factor to analyse and explain contraceptive behaviour in a country context where spousal separation due to high contract labour migration prevails.

It is clear that women whose husbands have migrated are not using contraceptives while the husband is away, and there is a cyclical behaviour in use, synchronizing with spousal visits and return. Similar views are expressed in other studies also; for example, Kaufman (1998) in relation to South Africa, Lindstrom and Munoz-Franco, (2005) in for rural Guatemala and Shuttuck et al., (2019) regarding Nepal. This pattern is logical due to low coital frequency among migrant couples. However, this unique pattern is also connected with adhoc use of contraceptives and reliance on less effective methods such as withdrawal. Women also tend to use emergency contraceptives, which though having no lasting health impacts can have certain consequences like menstrual irregularities (Cleland et al., 2014). Given the special scenario of unannounced returns and unplanned

intercourse, emergency contraceptives act as a protective mechanism to this special group of women. Yet their knowledge on the method come more from informal sources than formal, and there can be gaps in knowledge.

The above, connects to the knowledge source among respondents. A relatively high reliance is observed on informal sources such as spouse or friends. As noted by Roosen and Siegal (2018) in the context of Afghanistan, migrants remit information on contraceptives to the left behind. This study also shows that knowledge, especially on the emergency methods, was obtained from the migrant spouse or from other left behind women who had also got the information from friends or their migrant spouses. Hence educating everyone, especially the spouse on contraceptives is essential. In addition, especially modern contraceptives are still connected to side effects by some women, and non-use therefore supports their view of not getting side effects. Yet especially for these women, use of reliable modern temporary methods are essential.

During spousal visits, condom and withdrawal use appears to be the most favoured. Migration is noted for changes in contraceptive methods among migrant women (Cau, 2016; Lindstrom & Hernandez, 2006). This study indicates the same for left-behinds as a method switch towards condoms and withdrawals are observed in the study. These are methods that needs men's participation more. In this aspect it means that migrant males are more adoptable to use contraceptives and paly their part in contraceptive behaviour which is an important fact. It is noted that due to the experience of migration, men are more likely to take reproduction task as a shared responsibility (Maternowska et al., 2014). Both methods need no pre-preparation, and thus relieves pre-plannng. In contrast Pills, IUD, and injections will need more pre-preparation. A high proportion of women seem to use withdrawal as a contraceptive method. As noted by DeGraff and Siddhisena (2015) the dominant view regarding contraceptives is that traditional methods are less effective compared to modern methods in pregnancy prevention. Flippen and Schut (2022) notes that migration can contribute to less effective method use. Unintended pregnancy was reported by around a quarter of the respondents and most of them had used withdrawal. Migrant women are often more vulnerable to negative sexual and reproductive health outcomes, including higher rates of unintended pregnancies and lower access to contraception compared to native-born populations (Mosher et al., 2015). The study shows that the same applies to left-behind women. Since spousal visits are short term, unplanned coital relations are more likely among the women. Further, these women then need to rear the children mostly alone. Hence contraceptive knowledge for good pregnancy planning is more essential to these women.

Increase of left behind women's autonomy is a factor connected to migration (Asis, 2003; Schmalzbauer, 2004). But in certain aspects like use of family planning services this may not be so due to cultural reasons as seen in the study. Women were reluctant to approach service providers due to fear of stigma that can be attached to obtaining contraceptives while spouse is away. Shuttuck et al., (2019) also reports that left behind women have less access to family planning services and Mukherjee et al., (2021) reports on women's perceptions regarding stigma attached to obtaining contraceptive in the absence of a spouse.

However, as Hughes et al. (2006) notes, women may not use condoms to show their trust in husband's fidelity or to prove own fidelity. Similar behaviour can happen from the migrant spouse's side. Though condom use was high in the present sample there can be isolated incidents similar to what is proposed by Hughes et al. (2006) and this could be a reason for using emergency contraceptives. Since migration is associated with STI transmission, encouragement of condom use is important. Though not discussed in detail in this paper, 65 percent of the women reported concern regarding husband's risk of contracting a STI and some were quite positive regarding spouse's extra marital relations. In this regard, the women using condoms can be protected from STIs, though their intention is only avoiding pregnancy. In a cultural context where discussions on spouse's extramarital relations and contracting STIs is taboo, this is an indirect way of negotiating protection.

Migration and resulting separation could also lead to less communication on the subject of contraception due to lack of coital frequency (Hughes et al., 2006). However, communication between spouses is an essential part in the effective use of contraception (Challa et al., 2020). As seen, it is unlikely that couples discuss about contraception before the husband returns, necessitating them to embark on quick or emergency methods. Though specific policy measures cannot be adopted for spousal communication, social media, telefilms etc. can be used to inform couples of the importance of communication regarding sexual behaviour and contraceptives. In a

country where the family health workers role is very strong regarding pre-marriage, pregnancy and childbirth, it is now essential that their role is expanded to incorporate the emerging new trends. Having clinics for left behind women and spouses can be an essential part, where culturally appropriate counselling is provided. Further, innovative methods of contraceptive delivery for women who are identified as not needing contraceptives are necessary.

The paper concludes by showing the importance of analyzing contraceptive use in different contexts, in this case migration. It also shows the importance of reaching out to specific sub populations that escapes the national averages, and understanding and targeting their specific needs regarding contraceptive use. Special attention is drawn to the fact that migration or similar phenomenon can have both obvious and visible implications as well as the not so visible. Context specific and /or sub-population specific knowledge dissemination and expanding family planning services to diverse groups based on specific contexts and needs is recommended.

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