Impact of Male Out-migration on Health Status of Left behind Wives -A Study of Bihar, India

By

Archana K Roy[*] and Parveen Nangia[**]

Abstract

In developing countries like India, usually rural to urban migration is the most dominant pattern of internal migration. Males who are pushed by structural poverty and enter in migration streams as a survival strategy dominate this migration pattern. While male migration provides economic relief to their families, left behind wives have to bear the burden of increasing responsibilities of managing their households, and meet social expectations, which leads to greater mental stress. Invariably they have to look forward to help from others for outdoor and essential jobs. At the same time, due to disruption of social ties and family life that occur during moves, especially in a situation of poverty and crisis, there is an increased risk of sexually transmitted infections (STIs) as many migrants find new sex partners at the place of destination. Such migrants become carriers of STIs and make their wives more vulnerable to such infections when they visit their homes (at the place of origin).

This paper attempts to examine social well-being, mental stress and physical health, especially reproductive health, of left behind wives of male out-migrants and compares them to the wives of non-migrants. The study is based on a survey of 354 left behind wives and 192 wives of non-migrants conducted in 2001. The results of multivariate analysis show that left behind wives of migrants are more likely to have greater stress and report the symptoms of reproductive morbidity. Thus for small economic gains, the left behind wives of migrants have to pay a heavy price in terms of physical and mental stress. They accept it as their fate and a must for survival of their families.

1. Introduction

Male only migration, leaving families behind at the place of origin, is a predominant form of migration in many African, Latin American and Asian Countries (Population Report, 1998). This form of migration has wide implications on left behind families. Since such migration is adopted mainly as a survival strategy, the major impact is experienced and assessed in terms of receipt of remittances. Many studies (Connell et.al., 1976; Rempel and Lobdell, 1978; Oberai and Singh, 1983; Population Reports, 1983; Yadava, 1989; Mehta, 1990; Ghosh and Sharma, 1995; Rodgers, 2000; Singh, 2000) have concluded that these remittances provide better housing, and raise standard of living of the migrant households.

Apart from socio-economic impact on the area of origin, migration also has a profound influence on the status of left behind wives in the family. Some studies (Gulati, 1993; Hugo, 1995; Hadi, 1999) show that in the absence of husband overall status of women improves as they have greater access to money which they can spend as they wish; they have the freedom of movement; they can take independent decisions regarding the education of their children and type of

[*] Lecturer, Mahila Maha Vidyalaya, Banaras Hindu University, Varanasi-221005, INDIA. E-mail: royarchana@yahoo.com

[**] Research Director, Social Planning Council, and Faculty member, Laurentian University, Sudbury, Canada

treatment to be given to them if they fall sick. Nevertheless, absence of husband makes the life of a wife difficult. Her workload increases as she has to take care of several other things, which culturally are done by men. Apart from doing the regular household chores and taking care of children, she has to work in agricultural fields, look after the livestock, and manage all the outdoor work. In the absence of husband a woman feels isolated (Jetley, 1983; Bose, 2000). A study on 'Filipino wives' (Go et al., 1983) and another one on 'gulf wives' in India (Gulati, 1983) found that wives experience a certain amount of emotional stress when they have to bear the responsibility of making decisions in the absence of their husband. Apart from increased responsibilities, frequent thoughts about the safety of migrant husband add to mental stress of left behind wives. Thus, the added responsibilities of managing family, children and financial matters, anxiety about safety of husband and self, and the problems associated with isolation, altogether create a condition of stress among left behind wives. In the study area, where the phenomenon of migrant families dates back to the pre-industrial period, the folk songs called *Bidesia* and *Birha* refer to the beloved living in a far away country or place and reflect upon the unhappy and lonely existence of spouses of migrants who are left behind (Saxena, 1977). However, there is hardly any available literature focusing on mental stress on wives left behind by migrants.

In recent years, migration has become a new focus of reproductive health care programs in developing countries. The main reason for this concern is that AIDS and other sexually transmitted diseases (STDs) spread faster in a population when it becomes more mobile (Armstrong 1995; Decosas et al., 1995; Population Report, 1998). In different parts of the world, including India, some studies have been conducted to find out a link between male out-migration and HIV/AIDS. Male migrants get indulged in extra-marital sexual relations at the place of destination as they are away from their wives. Separated from their families and regular sex partners for long periods, male migrants may encounter loneliness or even a sense of isolation in a country or region where the language and cultural practices are alien (Haour-Knipe, 2000 cited in Population Reference Bureau, 2001: 19). Some studies (Carlier, 1999; Azarcon, 2000; Mishra, 2002; Luire et.al., 2003) have found that migrants who are settled with their families often have less risky sexual behaviour than those migrants who migrate without their families. Some migrants quickly become part of a new peer group, including a new sexual network. The incidence of condom use among migrant workers is low because of poor accessibility, hesitation in buying condoms, uncertainty about the protection they provide, and reluctance to use them in intimate or steady relationships (Cruz and Azarcon, 2000). Studies conducted in Sub-Saharan Africa and in many Asian countries (Population Reports, 1998) reveal that single male migrants have a much higher chance of getting sexually transmitted diseases (STD) and AIDS. The more people move the faster AIDS and other STDs can spread because migrants become carriers of such infections and they expose their wives to such infections whenever they visit home (Carr-Harris, 1993; Decosas et al., 1995). Thus, the disruption of social ties and family life that occur during migratory moves, especially in situations of poverty and crisis, also increases the risk of STIs as migrants find new sex partners. This suggests that the prevalence of RTIs/STIs may be higher among the left-behind wives of migrant men than among the wives of non-migrant men.

The present study focuses on the health status of wives left behind by migrant men. According to the United Nations "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (http://www.who.int/about/definition/en/ retrieved on 5th June 2005). In this context present study considers health as physical health in general and reproductive health in particular, measures mental well being in terms of stress, and social well-

being in terms of support received from family and friends. The conceptual framework of the study has been presented in Figure 1.

2. Objectives of the Study

This paper intends to examine the impact of male out migration on health status of their left behind wives in the context of (a) physical health, as increase in workload has its toll on the health of women; and reproductive health, since sexual contacts of husbands at the place of destination may make their wives vulnerable to STIs, (b) social well being, as women's dependence on others goes up when husband is away, and (c) mental stress, as the responsibilities and anxieties are likely to increase in the absence of husband. It is hypothesized that left behind wives of migrants undergo greater mental stress and are more vulnerable to STIs in comparison to the wives living with their husbands (wives of non-migrants).

3. Data and Methodology

This study is based on primary data collected in 2001 from nine migration prone villages located in two districts of Bihar. First of all, a complete house listing of all these villages was done and information was collected on - any migrant in the household, marital status of migrants, size of landholding, and caste characteristics. After the complete listing, households were identified as migrant (where at least one male member had out-migrated for employment purposes) and non-migrant (where no male member out-migrated for employment). A systematic random sampling technique was used to select households for a detailed survey. In migrant households, the criteria adopted for participation in the survey were duration of migration (at least one year), marital status and age of woman (currently married and aged 15-45), and duration of marriage (at least one year). If a selected household did not meet these criteria, it was replaced by another household. If there were more than one woman in the household who fitted the selection criteria, only one was selected for the study. Thus, the left-behind wives are considered those whose husbands had been migrant for at least one year. For reference purposes, a group of wives of non-migrants was selected with similar socio-economic conditions (size of land holding and caste characteristics). The criteria for selecting these women were similar, that is, currently married, aged 15-45, and at least one year of marital duration. In all, 354 left-behind wives of migrants and 192 wives of non-migrants were interviewed using a structured questionnaire. The questions were asked in the local language, *Bhojpuri,* using local terminology.

3.1 Physical health

In this study physical health is considered in terms of general and reproductive health. Data were collected on general and reproductive morbidity and symptoms. The reference period for these morbidities was six months prior to the survey. The symptoms of general morbidity on which information was collected were: headache, backache, burning sensation in palms/feet and head, itching in the body, dizziness, weakness and other health problems.

For reproductive morbidity, the list of symptoms was generated on the basis of information obtained from existing literature and verified with the help of physicians. All the women were asked to report if they had any of these symptoms. The study was based entirely on self-reported symptoms and no clinical examination was conducted for verification of the diseases. Moreover,

sometimes an RTI or an STD may not show any symptoms, and therefore, these diseases can be under-reported.

Because of stigmatization of reproductive morbidity, women are often reluctant to report their problems, but every effort was made in this study to elicit accurate information from them. The respondents were assured of the confidentiality of information provided. The symptoms of reproductive morbidity on which information was elicited were, burning sensation or pain or difficulty in passing urine, itching or irritation around vagina, sores on genitals, pain during intercourse, some protruding mass coming out from vagina, abnormal vaginal discharge (white discharge), and any menstrual problem (severe abdominal pain during periods, irregular periods, i.e. shorter or longer periodic cycle, and heavy flow or scanty flow).

3.2 Social well-being

Social well-being is a very broad term, which encompasses economic, environmental and social equity. In a narrower sense it can be used for a safe community where social system takes care of those who do not have means. In the absence of such a system one has to struggle hard to survive and still remain deprived of several benefits and a normal life. In the present study, social well-being is considered in the sense of overall workload on women, and the support which they get from their family members and friends to relieve some of the pressure of work (since there is no institutional support available for that). The ideal measure of workload would have been time allocation of women in different activities, but a large majority of them were illiterate and did not have the concept of number of hours spent in various activities. Moreover, due to overlapping nature of many jobs they were not able to answer very clearly how much time is spent on each chore. Information was also collected on what specific problems they have to face in the absence of husband and who helps them in outdoor chores, as culturally women in India are supposed to do indoor chores and men the outdoor chores.

3.3 Mental stress

For this study self-assessment of mental stress was considered adopting the definition from a study conducted in Kota village in Karnataka (Carstairs and Kapur, 1976). The following questions were asked to the respondents: "Do you get irritated for unreasonable reasons (*chidchidapan*)?", "Do you feel sad or depressed?", "Do you feel loss of interest in work?", "Is there useless pressure that you can not accomplish much?", "Do you feel like ending your life?", "Do you experience too many thoughts coming to your mind at the same time?", "Do you feel that your mind is empty of thoughts or blank?", and "Do you feel lonely or isolated?" Or "do you miss your husband too much?" The information was collected on incidence and frequency. The prevalence rate only tells about the occurrence of the event, but does not give us information on the intensity of the event. Therefore, to make their mental stress level comparable an index is computed.

For computation of the mental stress index, the scores were given on the basis of frequency of occurrence of the above-mentioned issues. If the problem occurs at least once in 15 days (often) then the highest score three is given, if it occurs once a month (sometimes), a score two is given, if once or twice in a year (rare) then score one is given, and if the respondent says that she does not face this problem (never) then zero is allocated. For the present mental stress index the value of Alpha was 0.714, which is within the acceptable limit. The index value ranges from 1 to 27

and the mean is 12. Women having lower value than the mean were categorized as having lower mental stress and woman having value more than the mean were categorized as having greater mental stress.

4. Findings:

4.1 Characteristics of area and women

Bihar, the poorest state in India, has a long tradition of male out-migration in search of jobs. The state is continuously loosing its male population. According to 1991 census, 1.36 million males migrated from Bihar to other states of the country. The study villages are located in the Gangetic Plains of Bihar, four in the north and five in the south of the river Ganga. Agriculture is the prominent occupation in this area, which otherwise is very backward. Generally, two crops are sown in a year. Land productivity is very low because of small farm size and use of traditional methods in agriculture.

Out of 2724 households in the nine villages under study, 1597 were migrant households. Among these migrant households, 91 percent were inter-state migrants. These migrants had their destination mainly in Punjab, Haryana, Delhi, West Bengal (particularly, Calcutta), Gujarat and Maharashtra (particularly, Mumbai). Among inter-state migrants, 58 percent had migrated without family, and the rest were either single or had migrated with family. Thus, migration to other states and leaving the family behind are the predominant characteristics of migrants in these villages.

Table 1 presents the characteristics of women. More than 81 percent of the women belonged to marginalized households♦. Three-fourths of the left behind wives were living with their in-laws (joint families) compared to 47 percent of wives of non-migrants. The literacy rate is significantly higher among left behind wives of migrants (25 %) as compared to wives of non-migrants (19 %). A much higher proportion of left-behind wives (40 %) compared to wives of non-migrants (27 %) got married during the past ten years. The proportion of women working for wages is significantly lower among left behind wives (29 %) than the wives of non-migrants (43 %). A lower proportion of the left-behind wives had experienced an abortion (14%), compared to the wives of non-migrant men (21%). The use of contraception (sterilization and IUD, which may also cause RTI) was relatively low among left-behind wives (10%) compared to the wives of non-migrant men (21%).

A significantly higher proportion of the wives of non-migrants (42%) compared to the left-behind wives (33%) reported that their husbands consumed alcohol quite regularly. Consumption of alcohol may trigger extra-marital sexual relations or divert money required for necessary health care. Fifteen per cent of the wives of non-migrant men and 33 per cent of the left-behind wives knew about, or suspected, extra-marital relations of their husbands. These differences are statistically significant.

♦ Marginalized households are those who have less than one acre of land and who have lower status in social caste hierarchy

4.2 General and Reproductive Morbidity

4.2.a General morbidity

Figure 2 reveals that in both the groups of women, general health symptoms were alike. In both the groups, weakness was reported by 70 per cent of the respondents and dizziness and backache by about 63 percent, each. The majority of left behind wives also reported having frequent headache. The complaint of headache was significantly higher among left-behind wives, whereas a burning sensation in the hands and feet was significantly more common among the wives of non-migrant men. In both the groups, around 6 per cent of the women reported itching in their body and 19 per cent reported other problems. Overall these problems are closely related to poverty, workload, lack of nutrition and mental stress (Sharma and Shiva, 2000).

4.2.b Reproductive morbidity

Reproductive morbidities are mainly determined by menstrual hygiene, the risk-behaviour of one of the partners, contraceptive infection, and health seeking behaviour. In the community-based studies undertaken in India (Bang et al., 1989; Bhatia and Cleland, 1995; Shenoy et al., 1997), the range of self-reported morbidity varies from 40 to 84 per cent. The present study shows that 88 per cent of non-migrant wives and 94 per cent of left-behind wives had reported at least one symptom of RTI/STI (burning sensation during urination, itching, sores on the genitals, pain during intercourse, problems in menstruation, and abnormal menstrual discharge), along with other gynaecological morbidities such as weakness, backache and dizziness. But weakness, dizziness and backache may also be caused by malnutrition or heavy workloads. Even after excluding these symptoms, a significantly higher proportion of the left-behind wives (65%) compared to the wives of non-migrants (55%) reported one or the other symptom of RTI/STI (Table 2).

Figure 3 shows the prevalence of particular symptoms of reproductive morbidity in both the migrant and non-migrant groups. In both the groups, burning or pain during urination was reported by around 31 per cent of the women. Approximately one quarter of the respondents (27 %) in both the groups reported problems related to menstruation and abnormal vaginal discharge (24%). There was hardly any difference in the proportion of women who reported these problems by the migration status of their husbands. Among those who reported vaginal discharge, 43 per cent said it was ‘normal’ as it occurred during the pre- and post-menstruation periods. Nearly one third of the women complained about a ‘thin creamish discharge with foul smell’, and one in five reported a ‘thick curdy’ discharge. Nearly half of the respondents who had abnormal discharge associated it with either itching or ulcer, or both. Four-fifths of those who had experienced abnormal discharge associated it with either light fever or abdominal pain or backache, or a combination of these. Contrary to expectations, a higher proportion of non-migrant wives, compared to left-behind wives, complained of both itching and ulcer, and backache and fever associated with abnormal vaginal discharge. Among the other symptoms of RTI/STI, 19 per cent of all the women had experienced itching or irritation around vagina, 17 per cent had experienced pain during intercourse, and 14 per cent had sores on their genitals. However, no significant differences were observed in the prevalence of a particular morbidity or combination of morbidities between the two groups of women.

Table 2 presents the prevalence rate of at least one symptom of RTI/STI according to socio-economic and demographic characteristics of women and perceived life style of the husband. By and large, the reporting of morbidity was higher in almost all the sub-groups of the left-behind wives, compared to the non-migrant wives. In both groups of women the prevalence of self-reported morbidity was higher for those women who had lower parity, whose husbands consumed alcohol, gambled or chewed tobacco, and had extra-marital relations. Left-behind wives differed from non-migrant wives in terms of Standard of Living Index[1] (SLI), type of family, marital duration, and ever use of contraceptive methods. Among the wives of non-migrant men, the prevalence of RTIs/STIs was higher among those who belonged to the lower SLI category, lived in a nuclear family, and had lower marital duration. On the other hand, among the left behind wives of migrants, the perceived symptoms of RTIs/STIs were higher among those who had a higher standard of living, lived in a joint family, and had ever used any contraceptive method (sterilization and IUD).

4.2.c Determinants of reproductive morbidity

A logistic regression analysis was carried out to determine the effect of different variables on reproductive morbidity. The dependent variable was the prevalence of reproductive morbidity and the independent variables were standard of living, marital duration, age of the respondent, ever use of contraception, the respondent's perception of her husband's extra-marital relations, consumption of alcohol, and habits such as gambling and chewing tobacco. The results are presented in Table 3.

Left-behind wives were more likely to report morbidity than the wives of non-migrant men. The odds of reporting morbidity were 1.4 times higher for left-behind wives than for the wives of non-migrants. For all women (left-behind and non-migrant wives), women who knew, or suspected, the extra-marital relations of their husbands, and those whose husbands had habits such as gambling and/or chewing tobacco were more likely to report reproductive morbidity, compared to those whose husbands did not have such habits. Women of longer marital durations (more than ten years) were less likely to report symptoms of RTIs/STIs than women of shorter marital durations (less than ten years).

For the wives of non-migrant men, husband’s extra-marital relations had a significant influence on the prevalence of RTIs/STIs in a woman. The odds of acquiring RTI/STI by a woman were three times higher if the husband had extra-marital sexual relations.

For the left-behind wives, women who belonged to a higher SLI group were more likely to perceive reproductive morbidity than women who belonged to a lower SLI group. Women, whose husbands had migrated to the westerns states such as Maharashtra and Gujarat, were also more likely to report reproductive morbidity, compared to women whose husbands had migrated to other parts of the country. It is believed that the prevalent culture in western states is more liberal, and exposure to risk is higher and, therefore, the chances of contracting infections are also higher. The findings of the National AIDS Control Organization also show that the prevalence of these infections is higher in metropolitan areas and in the industrially developed states of Maharashtra and Gujarat (UNAIDS, 2002). Further, women whose husbands migrated

[1] The standard of living index is computed by taking into account possession of household amenities, type of house and land holding size.

after a few years of marriage (five or more) were significantly more likely to report the prevalence of RTIs/STIs than those women whose husbands had migrated before marriage. One plausible explanation could be that these migrant men had experienced such sexual satisfaction in their married life that it was difficult for them to forego sexual relations when they were away from their wives. The likelihood of reporting reproductive morbidity was reduced as marital duration increased.

For the left behind wives of migrants, perceptions about the extra-marital relations of the husband did not have a significant effect on the prevalence of RTI/STI symptoms. It might be possible that such behaviour among migrant men is under-reported by their wives due to their lack of knowledge about their husband's extra-marital relations.

4.2.d Health seeking behaviour

More than a quarter of the women who were suffering from RTI/STI did not discuss these problems with anyone. They silently suffered from sexually transmitted infections and thereby, increased their vulnerability to HIV infection. The stigma attached to these morbidities, the culture of silence, and the fear of ostracism and rejection make many women hide or neglect their condition, even if they know that the only source of infection is their husband (Saran, 2002). If a woman suffering from white discharge discloses her problem to her husband, he, instead of taking her to the health centre for treatment, might make allegations against her as having had relations with other men, and insist that this is the cause of her discharge. That is one of the reasons why women do not dare disclose their reproductive illnesses.

In this study, women who reported health problems were asked whom did they consult about the problem. A large majority of them said that they did not seek any treatment for their reproductive tract infections (65% did not seek treatment for abnormal vaginal discharge, and 80% did not seek treatment for menstrual problems). Many women did not seek treatment because the doctor was male and they did not want to discuss 'dirty' or 'shameful' problems with a man. Others did not perceive the problems as serious; they thought they were 'normal' problems associated with a woman's life. Another reason reported by many of them was non-affordability of the cost of treatment. Those who sought medical advice did not consult government doctors or auxiliary nurses/midwives because the government system does not function properly, forcing poor people to pay for services that are supposed to be free or subsidized. For treatment of discharges, approximately six per cent of the women consulted traditional healers.

Regarding the irregularity of menstruation, a common perception prevails that if a woman has already given birth to children there is no need for her to regulate her menstrual cycle. Rather, irregular periods are considered good for protection against unwanted pregnancies. To treat their reproductive health problems, most of the women depend on home remedies. They may often use a 'herbal paste', or wash their genitals with 'rice water' (left over water after washing the rice grains), *neem* water (*neem* leaves soaked in water), or diluted 'Dettol'.

4.3 Workload and social support

4.3.a Physical workload and responsibilities of women

Migration of males directly affects the economic status of their wives through receipt of remittances. It also enhances their decision-making power. At the same time, increase in

workload affects the physical condition of women. Due to migration of husbands, women headed 44 percent of the migrant households. Women were asked about their routine work in the peak agricultural season and lean agricultural season. Contrary to expectations, a relatively higher proportion of wives of non-migrants were engaged in agriculture and livestock activities in comparison to the left behind wives of migrants. This might be because of shortage of working members in their households. In 22 percent of the migrant households land had been given for shared cropping. In many cases, parts of remittances might have been used for hiring labourers for agricultural work. Many migrants also return to their homes to work in their fields during peak agricultural season. While interpreting the results it should be kept in mind that as per the socio-cultural norms of traditional rural society in Bihar, engagement of a woman in outdoor work is considered as an indicator of low status of the family in the society.

Apart from this, absence of husband increases the responsibility of managing the household affairs (such as financial crisis, education and health related problems of children, and additional work). In non-migrant households most of the decisions are taken by husband, whereas in case of migrant households, independent decisions, particularly related to seeking treatment during sickness, and education of children are taken by left behind wives. Women's involvement in decision-making is a positive sign of their autonomy, but when they are forced to take that role in the absence of husband, they might have to undergo severe mental stress, as they are illiterate and less exposed to the outside world in a male dominated society. In such a situation their dependence on others (family members and friends) increases even for petty things.

4.3.b Social support

In the absence of husband relatives and friends provide social support. More than half of the left behind wives reported that they depend for outdoor jobs on their fathers-in-law or brothers-in-law. Gulati (1993) also found that in the absence of their husbands, left behind wives of gulf migrants were dependent on close relatives. Presence of adult males in the family provided left behind wives a kind of protective umbrella and saved them from potential exploitation. For seven percent of the left behind wives neighbours provided help in outdoor chores, but 16 percent of them had to do such jobs by themselves (Table 4). One exhausted woman said, "I have to work like a man and do all the manual work myself, such as preparing channels for irrigation, repairing roof of my house, etc." Nearly one-fifth of the left behind wives perceive dependency on others as a major problem. In the absence of any supportive male member in the family, they have to repeatedly request others for help in the work related to agriculture, marketing, buying medicines or fulfilling social obligations. At times they have to accept whatever others demand in lieu of help. In the process, sometimes they get cheated or do not get satisfactory services. The common opinion of such women is expressed in the following words - *"I have to depend upon others for everything (small jobs). Had my husband been here he would have taken care of everything".*

4.4 Mental stress

Increasing workload and lack of social support lead to mental stress. Figure 4 shows that the prevalence of irritation and depression/sadness is very high in both the groups. Whereas, there is not much variation in the prevalence of irritation for small reasons and suicidal tendency between the two groups, depression and feeling of loneliness are remarkably high in the left behind women.

The bivariate distribution (Table 5) shows that a significantly higher proportion of left behind wives are under greater stress (51 %) compared to wives of non-migrant household (37 %). Further, it is found that mental stress is higher across all the subgroups of left behind wives in comparison to wives of non-migrant households except for perception about husband's extra marital relations. Time of migration, number of visits and duration of stay do not affect the prevalence of mental stress among the left behind wives.

A multiple regressions analysis was applied to examine the effect of each predictor variable on the mental stress, while controlling for other variables for all (total) women, left-behind wives of migrants and wives of non-migrants. The dependent variable was the mental stress index and independent variables were related to socio-economic, migration, and personal characteristics of women and their husbands. The result of multiple regression analysis clearly demonstrate that mental stress is significantly higher among left behind wives than wives of non-migrants (Table 6). The effect of migration of husband increases the mental stress of left behind wives by 0.98 units. Among all the women (total) mental stress was significantly higher for those who belonged to the lower economic class, who earned to supplement their family income, who faced conflict in the family related to sharing of money, who reported having more worries, and the philandering nature of their husbands (drinking and visiting other women).

Analysis of wives of non-migrant and left behind wives shows that one unit increase in SLI has brought down mental stress by 0.14 units among wives of non-migrants and 0.08 units among left behind wives, controlling for the effect of other predictor variables. However, for left behind wives this relationship is not significant. Work status of women is positively related in both the groups, but it is significant only for left behind wives. It implies that working for wages significantly increases mental stress on left behind wives. The number of worries is positively and significantly related with mental stress for both the groups. Similarly, suspected extra marital relations of husband significantly increase mental stress on both non-migrant and left behind wives. The women whose husbands have a drinking habit are significantly more stressed than women whose husbands do not drink, irrespective of the migration status of the husband. In case of left behind wives, conflict with other family members over sharing of cash (remittances) results in a significantly higher mental stress.

Thus, among left behind wives, women who worked for the sustenance of family, had more number of worries, faced conflict with other family members in sharing remittances, and whose husbands were alcoholic and had extra marital relations suffered more from mental stress. But, frequency of visit of migrants and their duration of stay at home have no significant effect on mental stress of women.

4.5 Dealing with Specific Situations – some case studies

Rural women do not feel comfortable in discussing extra marital relations of their husbands, but their perception can be understood from the following comments made by one respondent: "If a man goes to several women he is still considered pure, but if a woman goes even to one man she is considered impure" (*mard 17 handi dhund ke aai to bhi paak rahi par mehraru ek handi bhi dhundi to paak na rah*). Another woman says that husbands have license to do anything (indulge in extra marital relations), they can pay and enjoy their lives. Such statements show the mindset

of rural women; traditional social norms related to sexual behaviour are different for men and women.

There are several situations that cannot be quantified, but are essential to understand the trauma that some wives left behind by migrants may face. The following case studies show some of the extreme situations faced by these women.

4.5.a Husband did not return for years

Sometimes husband does not come home for a long period and the wife keeps waiting for his return. Since he does not communicate she remains tense and prays for his safety. Her tension mounts if she does not receive remittances in time and she has to borrow money from moneylenders. One such case shows the reaction of a woman when her husband did not come home for a long period.

Sheela, 21, is illiterate and belongs to backward caste Hundu community. She is a mother of two children and lives in a joint family. Her husband had migrated even before his marriage. For the past 12 years he has been working as an operator in a hosiery factory in Ludhiana. Last time he left home when his wife was pregnant with their second child. The child is two years old now but the father has not seen him even once. He neither remits money nor takes any interest in family affairs. He is addicted to drinking and smoking. He also has relations with another woman in Ludhiana. Sheela is very depressed and angry over this relationship. She does not support this type of migration where spouses are forced to live separately.

4.5.b Husband abandoned his wife and children

Sunita is a 40 years old illiterate upper caste Hindu woman, having a 21year-old married daughter. Sunita got married at the age of nine and started living with her husband after four years. Before the birth of her daughter her husband migrated to Burnpur in West Bengal. He did not accept this girl as his legitimate child because she has a dark complexion. He accused his wife of having extra marital relations. On the other hand, he himself had an affair with another woman and got married to her in Burnpur. When Sunita learnt about it she went to Burnpur and tried to stop this marriage. But there was no effect of her request. Now her in-laws have also accepted the second wife of her husband and their two sons. They visit the house regularly. Sunita does not like her husband or that other woman. Her husband had given money for her daughter's marriage, but he does not give her anything and support her anymore. She lives in a deep grief. While narrating her story she started crying and strongly opposed migration of husband without wife.

4.5.c Husband got infected with HIV/AIDS

Sonamati (30) is a mother of three children. She is a landless woman from a lower backward caste. Her husband works in a power loom in Mumbai and migrated after 4 year of marriage. He earns Rs 70 per day. Last year he sent Rs. 4000, which was used in buying items for daily consumption. She lives in a kachcha house, which is falling apart and needs repairs. The condition of house is so bad that nobody can enter the house easily and even staying inside the house is not safe.

Sonamati has passed 10th grade and teaches in a school (informal education programme). Since this programme is not running well, she does not get salary on a regular basis. Other than teaching and taking care of her household chores, she also works as agricultural labourer.

Her husband does not send her money on a regular basis. Since he is sick now most of his earning is spent on treatment. His doctor told him that he is suffering from AIDS. She had never heard of AIDS before and her husband blames her for his disease. Other than facing tight economic condition, she is also worried about acquiring AIDS and her husband's suspicion on her character.

5. Conclusion

Male out-migration from the poverty stricken areas in Bihar has a long history. The poor men migrate mainly in search of jobs. Remittances provide relief from poverty to some extent but the absence of husband from the household has an impact on the lives of women. Contrary to expectation, a majority of these women retain their traditional role of caregivers, remain within the premises of their houses and bear a lower workload than the wives of non-migrants, partially because of their family support. On the other hand, in the absence of husband, their responsibilities regarding their children's health and education, social expectation and dependency on others, even for minor jobs increases. Those who do not get any support, fight a lonely battle caring for their children and elders. Added to the absence of husband are emotional crisis, non-cooperative behaviour of relatives, drinking habit and extra marital relations of migrant husband, which make their condition worse and increase their mental stress.

The prevalence of any reproductive morbidity (RTIs/STIs) among left behind wives is found to be significantly higher, although perceived risky sexual behaviour of migrants does not show a direct effect on left behind wives' reproductive morbidity. But women whose husbands migrate towards the western part of India (Maharashtra and Gujarat) and whose husbands migrate after five or more years of marriage are more likely to report symptom of any RTIs/STIs. This indirectly points towards the open culture in western part of India. Based on the sentinel data, National Aids Control Organization (NACO) has found that prevalence of HIV is high in this region. This indicates that the migrants are more likely to have sexually transmitted infections, and in turn, more likely to transmit these infections to their wives. Another important finding is that reporting of any RTI/STI symptom is more among the women from higher SLI group.

In a nutshell, one can say that migration of men provides some economic relief to their families, but the women have to pay a heavy price in the form of excessive physical and mental stress. It does not improve the health status of left behind women; rather, it puts them at a greater risk of developing mental stress and acquiring STDs and HIV.

Note

Some part of this paper will appear in a paper "Reproductive health status of wives left behind by male out migrants: A study of rural Birah, India", in the book *Migration and Health in Asia* edited by Jatrana Santosh, Toyota Mika and Yeoh Brenda S A, publisher- Routledge Taylor and Francis Group, London and New York from page 209 to 241. (Forthcoming)

Acknowledgements

We acknowledge the Ford Foundation for providing us grant at International Institute for Population Sciences under the project titled 'Strengthening the Teaching and Research Activities in Reproductive Health at IIPS (1996-2000) by Grant No. 950-1006 for undertaking fieldwork for this research.

References:

Armstrong, S. (1995), "AIDS and migrant laborers", *Populi* 22 (12), December 1994-january 1995: 13.

Bang, R, A. Bang, M Baitule, Y. Chaudhary, S. Sarmukaddam, and O. Tale (1989). "High prevalence of gynaecological disease in rural Indian women", *Lancet* 8629: 85-88.

Bhatia J.C and J. Cleland (1995). "Self reported symptoms of gynecological morbidity and their treatment in south India". *Studies in Family Planning* 26 (4): 203-213.

Bose, Ashish (2000). "Demography of himalayan villages: missing men and lonely women", *Economic and Political Weekly* 35 (27): 2361-2381.

Carlier, Jean-Yves. (1999. *The Free Movement of Person Living with HIV/AIDS.* Brussels: HIV/AIDS Programme of the European Union.

Carr, Harris, J. (1993). "Eco- health in the rural environment", *Health for the Millions*, April 1(2): 2-6.

Castrairs G.M, and R.L. Kapur (1976). *Great Universe of Kota: Stress Change and Mental Disorder in an Indian Village*, London: Hogarth Press.

Connell, J., Biplab Dasgupta, Roy Laishley and Michael Lipton (1976), *Migration from rural areas: the evidences from village studies*, Delhi: Oxford University Press.

Cruz, Pennie and Azarcon Dale (2000), "Filipinos and AIDS: It could happen to you", *Conveying Concerns: Media Coverage of Women and HIV/AIDS*, Population Reference Bureau: 20-21.

Decosas, J., F. Kane, J.K. Anafri, K.G. Sodji, and H.U. Wagner (1995). "Migration and AIDS", *Lancet* 346 (8978): 826-828.

Ghosh, P.P. and A.N. Sharma (1995). "Seasonal migration of rural labour in Bihar", *Labor and Development* 31 (50): 118-136.

Go, S. P., L.T., Postrado and P.R. Jimenez (1983). *The effects of International Contract Labour (Philippines)*, Vol.1, Manila: Integrated Research Centre, De La Salle University.

Gulati Leela (1993). *In the Absence of their Men: the Impact of Male Migration on Women*, New Delhi: Sage Publication limited.

Hadi, Abdullahel (1999), "Overseas migration and the well being of those left behind in rural communities of Bangladesh," *Asia-Pacific Population Journal* 14 (1): 43-58

Hugo, G., (1995). "International labor migration and family: some observations from Indonesia", *Asian and Pacific Migration Journal* 4(2-3): 273-301.

Haour-Knipe, M. (2000) *Migration and HIV/AIDS in Europe*, Geneva: International Organization for Migration (IOM) and the University Institute for Social and Preventive Medicine: 4.

Jetly, S. (1987). "Impact of male migration on rural females," *Economic and Political Weekly* 22 (44): WS47-W53.

Lurie, M.N. B.G. Williams, K. Zuma; D. Mkaya-Mwamburi; G.P. Garnett (2003). "The impact of migration on HIV-1 transmission in South Africa. A study of migrant and non migrant men and their partners", *Sexually Transmitted Diseases*. Feb; 30 (2):149-156.

Mehta, Swarnjit (1990). *Migration a Spatial Perspective (a case study of Bist Boab, Punjab).* Jaipur: Rawat Publication.

Mishra, Anurag (2002). *Male Sexual Behaviour and Reproductive Health with Family and away from Family in Delhi*. Unpublished Ph.D Thesis. International Institute for Population Sciences, Mumbai.

Oberai A.S. and H.K.M. Singh (1983). *Causes and Consequences of Internal Migration (A Study in the Indian Punjab*, Delhi: Oxford University Press.

Population Reference Bureau (2001). *Conveying Concerns: Media Coverage of Women and HIV/AIDS*. Washington: Population Reference Bureau: 19.

Population Reports (2002). *Youth and HIV/AIDS Can We Avoid Catastrophe? 29* (3).

Population Reports (1983). *Migration, Population Growth and Development*. 11(4).

Rempel, H. and Richard A. Lobdell (1978). "The role of urban to rural remittances in rural development", *Journal of Development Studies* 14 (3): 324-41.

Rodgers Gerry. (2000). "Growth in western India reduces poverty in Bihar", E-seminar on Poverty, Available on: http//www.bihartimes.com.

Saran, Sathya. (2002). "Are you positive? Women at risk". *Conveying Concerns: Media Coverage of Women and HIV/AIDS.* Washington: Population Reference Bureau pp. 9.

Saxena, D.P. (1977). *Rural Migration and Cultural Change*. Bombay: Popular Prakshan Private LTD: 175-178.

Sharma, G, and Shiva M. (2000) (edited**),** *National Profile on Women, Health and Development, Country Profile-India*, New Delhi: Voluntary Health Association of India: 156-67.

Singh, Indu, B. 2000,"Bihar, Yet to Reap the Bonus of Her Backwardness" E-Seminar on Poverty in Bihar, www.bihartimes.com.

Shenoy, K.T, S. Shenoy and K Gopalkrishnan (1997). "Reproductive health and gynecological morbidity in Kerala", Unpublished Paper.

Yadava, K.N.S. (1989). *Rural-Urban Migration in India: Determinants, Pattern and Consequences,* Delhi: Independent Publishing Company.

UNAIDS (2002), "Focus: AIDS and mobile populations" *Report on Global HIV/ AIDS Epidemic*: 114-119.

Figure 1: Conceptual model showing relationship between migration of men and health of left behind wives

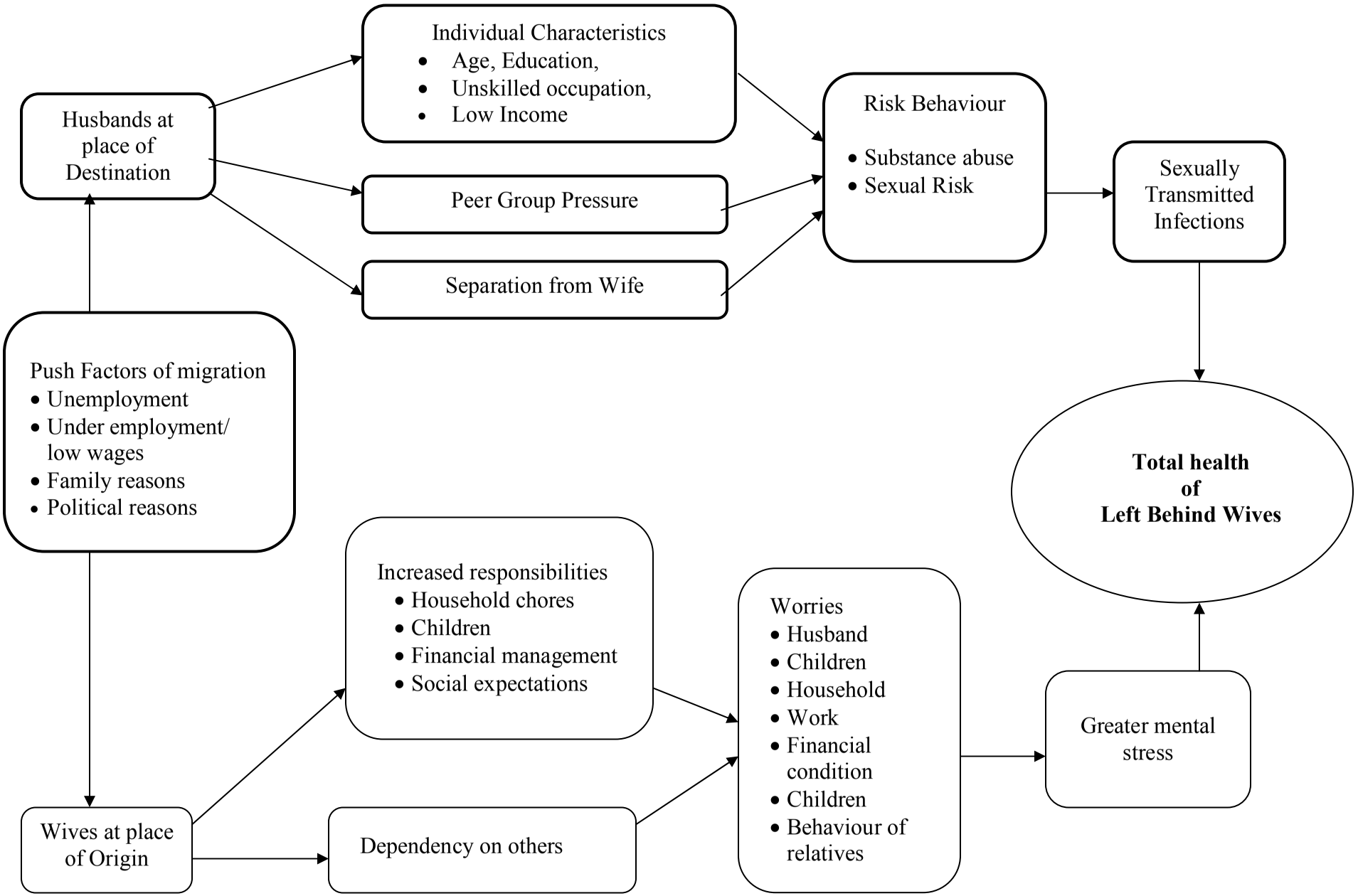

Table no. 1: Percentage distribution of women by their background characteristics

Background characteristics	*Wives of non-migrants (%)*	*Left behind wives of migrants (%)*	*Total women (%)*
Caste / community			
Upper caste (Hindu)	10.4	13.0	12.2
Backward caste (Hindu)	53.0	46.0	48.3
Scheduled caste (Hindu)	21.3	17.5	18.7
Muslims	15.2	23.4	20.8
Size of land holding			
Less than one acre	83.5	81.1	81.9
More than one acre	16.5	18.9	18.1
Standard of living index (SLI)			
Low	34.1	29.9	31.3
Medium	42.7	39.5	40.5
High	23.2	30.5	28.2
Type of family* **			
Staying with in-laws (Joint)	47.0	75.7	66.6
Staying without in-laws (Nuclear)	53.0	24.3	33.4
Mean age (years)**	29.5	27.9	28.4
Age at marriage (years)	13.4	13.6	13.6
Age at starting cohabitation (year)	14.2	14.2	14.2
Literacy*			
Literate	18.9	24.7	23.6
Marital duration**			
Less than 10 years	27.4	40.1	36.1
10-20 years	48.8	40.4	43.1
More than 20 years	23.8	19.5	20.8
Children ever born (CEB)* **			
≤ 3 CEB	39.0	61.9	54.6
≥ 4 CEB	61.0	38.1	45.4
Mean CEB	4.2	3.1	3.2
Ever experienced abortion**	21.3	14.4	16.6
Work for wages**	42.7	29.4	33.6
Ever use of contraceptive @ (Sterilization or IUD)* **	20.7	9.6	13.1
Duration of migration			
Up to 5 years	-	34.5	-
5-10 years	-	30.5	-
More than 10 years	-	35.0	-
Habits of husband			
Drinking habit of husband**	42.1	32.5	35.5
Smoking habit of husband	26.8	29.4	28.6
Any other habit (gambling, chewing paan, tobacco)	47.0	42.4	43.8
Extra-marital relations of husband***			
Yes	7.9	12.7	11.2
Cannot say	7.3	20.6	16.4
Total	164	354	518

Note: Chi-square Significant level *** at 1%; ** 5%; *10%.

Source: Fieldwork, 2001.

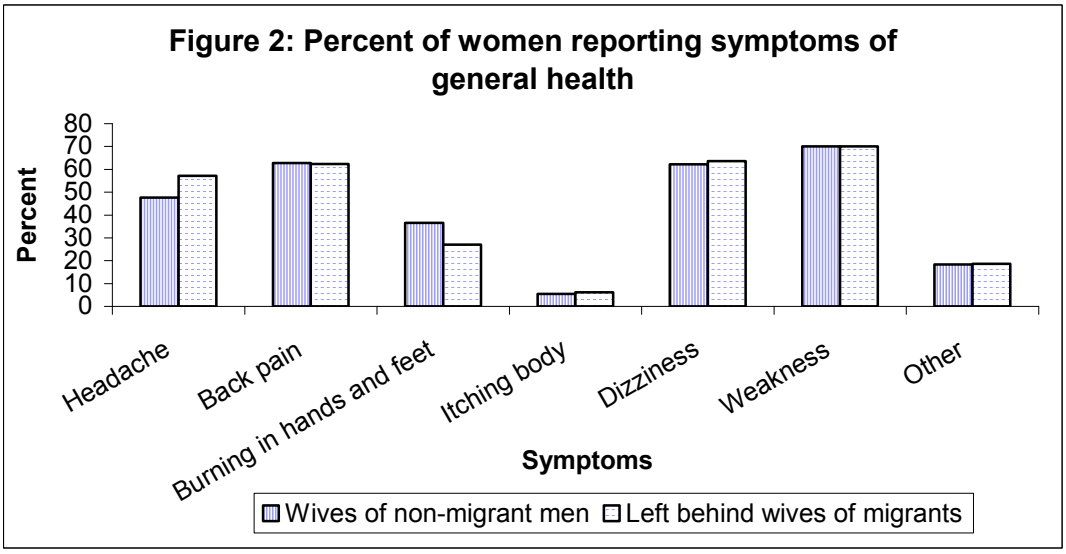
Figure 2: Percent of women reporting symptoms of general health
Percent
80
70
60
50
40
30
20
10
0
Headache
Back pain
Burning in hands and feet
Itching body
Dizziness
Weakness
Other
Symptoms
Wives of non-migrant men
Left behind wives of migrants

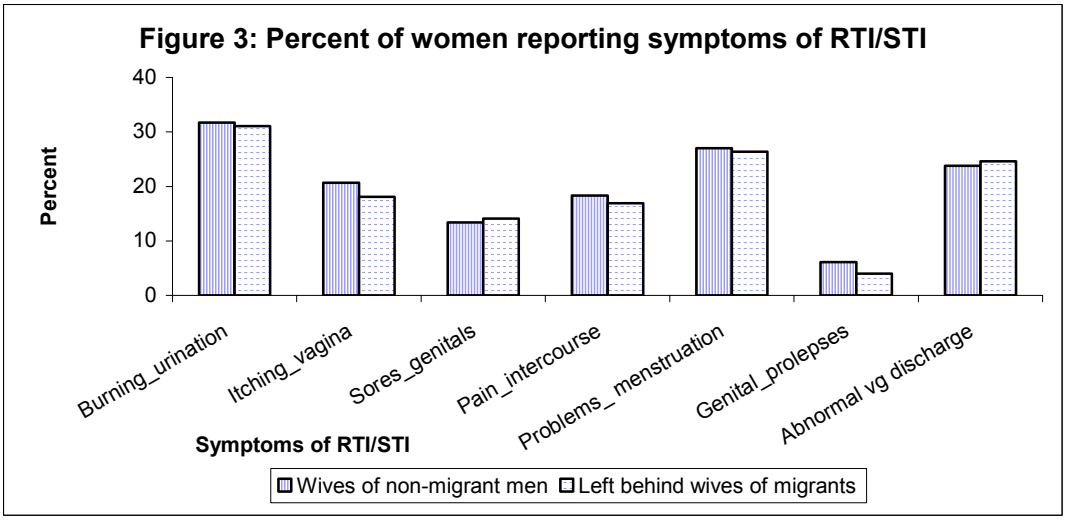
Figure 3: Percent of women reporting symptoms of RTI/STI
Percent
40
30
20
10
0
Burning_urination
Itching_vagina
Sores_genitals
Pain_intercourse
Problems_ menstruation
Genital_prolepses
Abnormal vg discharge
Symptoms of RTI/STI
Wives of non-migrant men
Left behind wives of migrants

Table 2: Prevalence of any reproductive morbidity among women according to their background characteristics and husband's perceived behavior

Background characteristics	Wives of non-migrants (%)	Left-behind wives of migrants (%)	Total women (%)
Standard of Living (SLI)			
Low	61.4	60.7	60.9
High	34.2	75.0	64.4
Type of family			
With in-laws (Joint)	50.6	67.2	63.5
Without in-laws (Nuclear)	58.6	59.3	59.0
Age of respondent			
< 25 years	57.5	65.7	63.8
> 25 Years	54.0	65.0	61.0
Literacy			
Illiterate	54.9	64.6	63.8
Literate	54.8	67.0	61.0
Marital duration			
Less than 10 years	60.0	66.2	64.7
10 to 20 years	53.8	61.5	58.7
More than 20 years	51.3	71.0	63.9
Children ever born (CEB)			
≤ 3 CEB	59.4	66.7	65.0
≥ 4 CEB	52.0	63.0	58.3
Ever experienced and abortion	54.3	68.6	62.8
Never experienced any abortion	55.0	64.7	61.8
Ever used (IUD or sterilization)	41.2	79.4	60.3
Never used (IUD or sterilization)	58.8	63.8	62.2
Perception about life style of husband			
Consume alcohol	56.5	70.4	69.2
Does not consume alcohol	53.7	62.8	59.2
Any extra-marital relations of Husband	72.0	68.6	69.2
No extra-marital relations of husband	51.8	63.6	59.2
Any other habit (Gambling, chewing paan, tobacco)	61.0	69.3	66.5
No other habit	49.4	62.3	58.4
Duration of migration	-		-
Up to 5 years	-	68.0	-
5-10 years	-	63.9	-
More than 10 years	-	63.7	-
Time of migration	-		-
Before marriage	-	63.3	-
Within 5 years of marriage	-	63.4	-
After 5 years of marriage	-	72.8	-
Destination*	-		-
Western states of India	-	72.5	-
North western States of India	-	61.4	-
Other states of India	-	65.6	-
Total	164 (54.9)	354 (65.3)	518 (62.2)

* Western states (Maharashtra, Gujarat, Madhya Pradesh, Rajasthan); Northwestern states (Punjab, Haryana, Himachal Pradesh, J&K, Delhi Metro Region, Uttaranchal); Adjoining states of Bihar, North Eastern and Southern states.

Sources: Fieldwork (2001)

Table 3 Logistic regression showing the effect of various socio-economic and behavioral characteristics on prevalence of any reproductive morbidity

Predictor variables	Reference Category	Total women	Wives of non-migrants	Left behind wives of migrants
		Exp (B)	Exp (B)	Exp (B)
Migration status of husband				
Left behind wives of migrants	Wives of non-migrants	1.420*		
Standard of living (SLI)				
High SLI	Low SLI	1.100	0.552	1.714**
Age of respondent =		1.019	1.002	1.041
Marital duration				
10-20 years	Less than 10 years	0.427**	0.537	0.342***
More than 20 years		0.407**	0.483	0.277**
Contraceptive methods (sterilization of IUD)				
Ever used	Never used	1.169	0.698	1.569
Experience of abortion				
Ever experienced	Never experienced	1.074	1.028	1.003
Life-style of husband				
Any extra-marital relation of husband	No extra-marital relations of husband	1.534*	3.084**	1.403
Husband drinks	Does not drink	1.179	0.953	1.408
Husband smokes	Does not smoke	0.936	0.668	0.961
Any other habit **(gambling, Chewing *paan*, tobacco)**	No other bad habit	1.536**	1.634	1.491
Destination of migrant				
Western states	Other states of India			1.590*
Time of first move				
Within 5 years	Before marriage			1.121
After 5 years of marriage				1.834*
Number of visits to place of origin in a year =				0.701
Constant		1.050	2.812	0.688

Significance p *** < 0.01 p ** < 0.05 p * < 0.1

= Continuous Variable

Table 4: Percent distribution of women by persons who does outdoor work		
Person	Wives of non-migrants	Left behind wives of migrants
Self	0.5	15.8
Husband	99.5	0.3
Brother/Father-in-law	-	56.5
Mother-in-law	-	7.6
Son	-	12.7
Neighbour	-	7.1
Total number of women	192	354

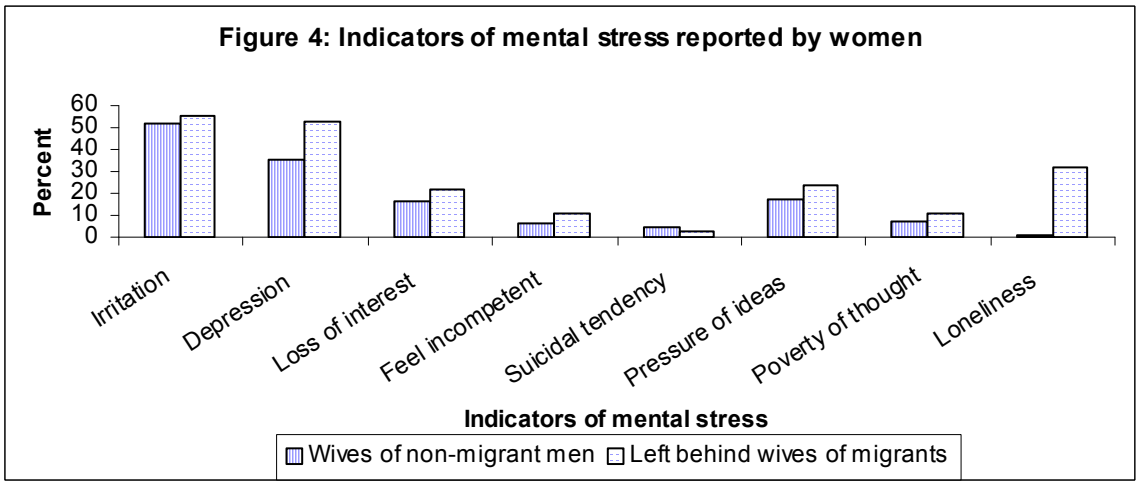

Table No. 5: Prevalence of greater mental stress (Index score more than mean) among women by their background characteristics

Background Characteristics	Wives of non-migrants		Left behind wives of migrants		Total women	
	Total No.	% Under greater stress	Total No.	% Under greater stress	Total No.	% Under greater stress
Standard of Living (SLI)						
Low	150	41.1	246	58.25	396	51.7
High	42	21.4	108	38.9	150	34.0
Type of family						
Joint	89	33.7	268	48.9	357	45.1
Nuclear	103	38.8	86	59.3	189	48.1
Literacy						
Illiterate	156	39.7	263	54.0	419	48.7
Literate	36	22.2	91	44.0	127	37.8
Children ever born (CEB)						
≤ 3 children	88	36.4	240	50	328	46.3
≥ 4 children	104	36.5	114	54.4	218	45.9
Marital Duration						
More than 10 years	54	27.8	142	48.6	196	42.9
10 to 20 years	91	44.0	143	50.3	234	47.9
More than 20 years	47	31.9	69	59.4	116	48.3
Work for wage	80	42.5	104	66.3	184	56.0
Does not work for wages	112	32.1	250	45.2	362	41.2
Conflict-sharing remittance	15	46.7	65	58.5	80	56.3
No conflict _ sharing remittances	177	35.6	289	49.8	466	44.4
Conflict-sharing of work & food	25	40.0	91	48.4	116	46.6
No conflict-sharing of work & food	167	35.9	263	52.5	430	46.0
Any decision making except personal purchasing	41	43.9	193	56.5	234	54.3
No decision making except personal purchasing	151	34.4	161	45.3	312	40.1
≤ 3 worries	164	32.1	271	43.2	435	39.3
≥ 4 worries	28	57.1	83	78.3	111	73.0
Perceived life style of husband						
Any extra-marital relations	29	65.5	118	62.7	147	63.3
No extra-marital relations	163	31.3	236	45.8	399	39.8
Husband consume alcohol	75	45.3	115	62.6	190	55.8
Does not consume alcohol	117	30.7	239	46.0	356	41.0
Other habit (Gambling, tobacco)	95	33.7	150	50	245	43.7
No other habit	97	39.2	204	52.4	301	48.2
Smoking habits	49	42.8	104	61.5	153	55.6
No smoking habit	143	34.3	100	47.2	393	42.5
Total	192	36.5	354	51.4	546	46.2

Sources: Fieldwork (2001)

Table 6: Results of multiple linear regression analysis for determinants of mental stress				
Background characteristics	Reference Category	Total women	Wives of non-migrants	Left behind wives of migrants
Migration status of husband				
Left behind wives of migrants	Wives of non-migrants	0.979*		
Family Type				
Nuclear	Joint	-0.325	-1.291	-0.403
SLI =		-0.097**	-0.137*	-0.084
Marital duration =		0.041	0.110**	
Children Ever Born				
≤3 CEB	≥ 4 CEB	-0.348	-0.240	0.347
Family-decision making				
Can decide	Can not decide	0.397	1.205	0.325
Work status				
Earning	Not earning	1.240**	1.010	1.493**
Number of worries =		3.031***	2.610**	3.230***
Conflict for sharing cash				
Yes	No	1.327**	-0.853	1.873**
Drinking habit of husband				
Yes	No	1.400***	1.281*	1.619**
Suspect extra marital relation of husband				
Yes	No	1.667***	2.628***	1.308**
Migration duration =				-0.006
Time of migration				
Migrated after marriage	Migrated before marriage			-0.310
Number of visits of husband				
Visit twice	Visit once			-0.533
Visited more than thrice				-0.245
Constant		9.661***	9.640***	11.151***
R^2	17.4	16.7	17.4	
Significance p *** < 0.01 p ** < 0.05 p * < 0.1 = Continuous Variable				