

Review Article

Contraception beyond access: barriers in uptake, perceived health risk and choice gaps in India

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ABSTRACT

India has a long-standing family planning programme, yet contraceptive use remains characterised by reliance on female sterilisation, limited uptake of reversible methods, and high discontinuation of temporary contraception. Despite improvements in overall prevalence, access alone has not translated into sustained or equitable use. This narrative review synthesises epidemiological, qualitative, and policy-oriented evidence to examine how contraception-seeking behaviour in India is shaped by social norms, gendered decision-making, health-system practices, and perceptions of health risk, with particular attention to cancer-related fears. The literature indicates that contraceptive decisions are rarely individual choices, being embedded within marital expectations, fertility pressures, and constrained female autonomy. Fear of side effects, especially concerns about long-term health and cancer, deters uptake and continuation of hormonal methods despite evidence of limited, time-bound risks and substantial protection against ovarian and endometrial cancers. These concerns are reinforced by inconsistent counselling and provider bias, highlighting the need for behaviour-centred, rights-based family planning.

Keywords: Contraception, India, Barriers, Birth control

INTRODUCTION

India was the first country to launch a national family planning programme in 1952, yet modern contraceptive use remains uneven, with a persistent dominance of female sterilisation and comparatively low uptake of reversible methods such as oral contraceptive pills, intrauterine devices, and injectables.^{1,2} National survey data indicate that while overall contraceptive prevalence has improved in recent years, method choice remains limited and discontinuation rates for temporary methods are high.^{3,4} This paradox highlights that access alone does not translate into sustained contraceptive use.

Contraception-seeking behaviour in India is shaped by a complex interplay of fertility intentions, gender norms, household power dynamics, health-system factors, and perceptions of safety.^{5,7} Fear of side effects particularly concerns related to long-term health consequences and

cancer has repeatedly emerged as a dominant deterrent to the adoption and continuation of hormonal contraception.⁸⁻¹⁰

Although extensive epidemiological evidence demonstrates that hormonal contraceptives are associated with site-specific cancer risks as well as substantial protective effects against ovarian and endometrial cancers, these distinctions are seldom reflected in routine contraceptive counselling.¹¹⁻¹³ As a result, public understanding is often fragmented, reinforcing mistrust and avoidance of modern methods.

Existing literature on contraception in India is dispersed across epidemiological surveys, qualitative studies, and policy documents, often addressing use patterns, behavioural barriers, or health risks in isolation. A narrative synthesis is therefore warranted to integrate these strands and to contextualise how perceived and actual health risks particularly cancer-related concerns intersect

with social norms and programme delivery to shape contraceptive decision-making.

This narrative review aims to synthesise evidence on contraceptive use and contraception-seeking behaviour in India, with particular emphasis on demand- and supply-side barriers, gendered decision-making, and the role of perceived cancer risk in influencing contraceptive choices.

METHODS

This narrative review synthesised epidemiological, behavioural, qualitative, and policy-oriented literature on contraceptive use and contraception-seeking behaviour in India. A narrative approach was adopted to integrate diverse forms of evidence and to examine how social norms, health perceptions, and programme contexts interact to shape contraceptive decision-making.

Relevant literature was identified through focused searches of PubMed, Scopus, and Google Scholar. These searches were supplemented with national survey reports (national family health surveys), government family planning programme documents, and key international evaluations relevant to the Indian context. Peer-reviewed articles published primarily between 2000 and 2025 were prioritised to reflect contemporary contraceptive practices and policy frameworks, with earlier landmark studies included where conceptually important.

Both quantitative studies (including cross-sectional surveys and cohort analyses) and qualitative research (such as in-depth interviews and focus group discussions) were considered. Additional references were identified through manual review of bibliographies of selected articles based on relevance and conceptual contribution.

Evidence was synthesised thematically, with attention to patterns of contraceptive use, household and spousal decision-making, perceived health and cancer risks, counselling practices, and health-system and programme-level barriers.

CONTRACEPTIVE USE IN INDIA

National survey data indicate that contraceptive use among married women in India has increased over the past decade, from 53.5% in NFHS-4 to around two-thirds of women in NFHS-5.^{3,4} Despite this apparent progress, the expansion in use has been driven largely by permanent methods, with female sterilisation continuing to dominate the method mix. In contrast, uptake of reversible methods such as oral contraceptive pills, intrauterine devices, and injectables remains limited, particularly among rural and socio-economically disadvantaged women.¹⁴

Temporary methods are also characterised by high discontinuation rates, often within the first year of use, suggesting dissatisfaction, side effects, or inadequate counselling.^{6,15} These patterns indicate that contraceptive

behaviour in India is driven not merely by availability, but by perceived acceptability and trust in methods.

CONTRACEPTION-SEEKING BEHAVIOUR AND DECISION-MAKING

Contraception-seeking in India is rarely an individual decision. Fertility intentions are shaped by marital expectations, pressure to demonstrate fertility soon after marriage, and son preference in certain settings.^{5,7} There is significant societal and familial pressure for women to prove their fertility by conceiving immediately after marriage to establish their social status and prove womanhood. Decision-making regarding family planning is heavily influenced by the desire for a male child, which is deeply rooted in cultural and economic benefits. Women's autonomy in reproductive decision-making is frequently constrained, with husbands and older family members exerting substantial influence.^{16,17} Family planning decisions are frequently dominated by husbands, and many women receive meagre support from their spouses or mothers-in-law. In some urban slum settings, husband's disapproval is reported as the primary reason for non-usage. Women, particularly those who are younger or less educated, often lack the power to assert their own reproductive interests, leading to submissiveness in decision-making.⁶

Evidence from qualitative research suggests that many women postpone contraceptive use until childbearing goals are met.¹⁸ Where spousal opposition limits open negotiation, covert contraceptive use emerges as a coping strategy, reflecting constrained reproductive autonomy within households.¹⁹ Accessing family planning services is difficult for unmarried or divorced women due to the burden of social stigma.

SOCIO-CULTURAL AND RELIGIOUS INFLUENCES

In some communities, including certain Muslim, Hindu, and tribal groups, contraceptive use or sterilization is viewed as a "sin" or contrary to God's wish. Discussions surrounding sex and family planning are often considered a taboo subject, leading to shame, embarrassment, and a lack of open communication.⁶

PERCEIVED HEALTH RISKS AND INFORMATIONAL BARRIERS

Fear of side effects remains a major deterrent to both the uptake and continuation of contraceptive methods in India.^{8,9} Women's concerns extend beyond immediate effects such as menstrual changes or perceived infertility to more diffuse anxieties about long-term bodily harm. One of the most prevalent psychological barriers is the fear of side effects (such as weight gain, bleeding, or long-term health impacts) associated with modern reversible methods like IUDs and oral pills. There are widespread myths regarding specific methods; for instance, male sterilization

is often avoided due to fears it causes "loss of vitality" or impotency. While awareness of methods exists, there is often a lack of awareness regarding proper use, which contributes to high discontinuation rates.⁶

Within this broader landscape of apprehension, fears related to cancer appear especially salient in community discourse and can exert a disproportionate influence on contraceptive decision-making, despite limited scientific evidence to support such beliefs.^{10,20}

Such concerns are further reinforced by limited counselling, dependence on informal or community-based sources of information, and the lack of clear, balanced discussion of risks and benefits during family planning encounters.²¹ The persistence of misconceptions across educational and socio-economic groups suggests that these are not isolated gaps in knowledge, but reflect broader systemic shortcomings in communication.

CONTRACEPTION AND CANCER RISK

Large cohort studies and pooled analyses demonstrate that combined oral contraceptives are associated with a small, time-limited increase in breast cancer risk during current or recent use, which diminishes after discontinuation.^{11,12} In contrast, long-term use confers substantial and sustained protection against ovarian and endometrial cancers, with risk reductions persisting for decades.^{12,13}

The International Agency for Research on Cancer classifies combined oral contraceptives as carcinogenic based on site-specific associations, a designation that is frequently misinterpreted in public discourse without consideration of protective effects and absolute risk.¹³ This imbalance in communication contributes to exaggerated fears and avoidance of hormonal methods.

HEALTH-SYSTEM BARRIERS

Provider bias, limited method choice at public facilities, and inconsistent counselling practices further constrain

contraceptive uptake.^{15,22} Undesirable or indifferent attitudes of healthcare staff can lead to mistrust and underutilization of government health services. Factors such as high costs, long waiting times, lack of trained staff, and distance to facilities hinder access, particularly for rural and poor populations.⁶

Studies document reluctance among some providers to offer contraception to unmarried youth, driven by moral norms rather than medical eligibility, effectively restricting access.²³

Women belonging to scheduled tribes (ST), those residing in rural areas, and those with uneducated husbands are statistically less likely to utilize modern temporary contraceptives. Limited exposure to mass media (like TV or newspapers) is correlated with lower contraceptive utilization.²¹

Health-system emphasis on targets and sterilisation performance has historically undermined choice-based family planning, despite policy shifts toward spacing methods.²⁴ Emergency contraception illustrates this tension, with widespread availability coexisting alongside provider apprehension and judgement.²⁵ These behavioural and interpersonal patterns are embedded within broader structural conditions, including gender hierarchies, caste-based stratification, and historical programme priorities that continue to shape contraceptive choice in India.

POLICY CONTEXT AND IMPLEMENTATION GAP

Recent policy frameworks, including India's FP 2030 commitments, emphasise informed choice, spacing methods, and male engagement.²⁴ However, implementation gaps persist, particularly in integrating comprehensive counselling on side effects and long-term health risks. Cancer risk communication remains notably absent from routine family planning services, representing a missed opportunity for informed decision-making.

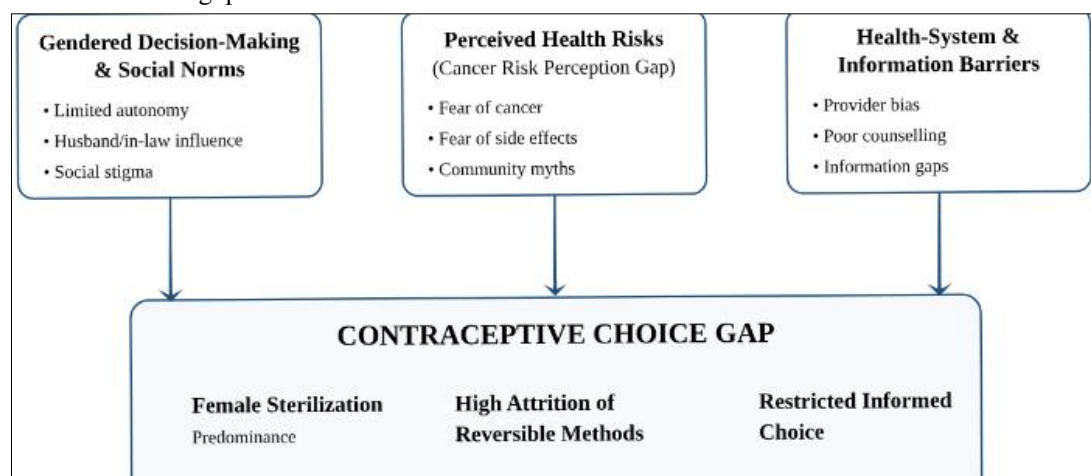


Figure 1: The barriers linked to contraceptive choice gaps.

IMPLICATIONS FOR PRACTICE AND RESEARCH

India's FP2030 commitments emphasise informed choice, method mix expansion, equity, and quality of care. Subnational analyses demonstrate wide variation in contraceptive prevalence and unmet need across Indian states, indicating that uniform national targets are insufficient to address local barriers and that decentralised, context-specific programme planning is essential.² Tailoring family planning strategies to local socio-cultural norms, fertility expectations, and health-system capacity is critical for achieving equitable demand satisfaction.

Evidence from countries that have successfully expanded family planning coverage highlights the importance of sustained multi-sectoral policy engagement, integration within primary healthcare, and systematic investment in counselling quality rather than reliance on single-method promotion.²⁶ In India, persistent fears regarding long-term health effects and cancer risk remain inadequately addressed in routine counselling, despite robust evidence on both risks and protective benefits of hormonal contraception. Integrating balanced cancer risk communication into family planning services and strengthening provider training to reduce bias could directly support FP2030 goals related to informed choice, method continuation, and reproductive autonomy.

CONCLUSION

Contraceptive use in India is shaped by gaps in informed choice rather than access alone. Persistent reliance on permanent methods and discontinuation of reversible contraception reflect misperceptions of health and cancer risks, inconsistent counselling, and provider bias. Strengthening person-centred counselling, transparent risk communication, and meaningful method choice is essential to support sustained contraceptive use and reproductive autonomy.

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