

Mapping Unmet Need for Family Planning and Contraceptive Use Among Married Women in India: A Scoping Review of Recent Evidences

Pushkal Singh¹, Aastha Kalra¹, Nirpal Kaur¹, Manish Kumar Singh²

¹ Department of Community Medicine, Integral Institute of Medical Sciences and Research, Lucknow, Uttar Pradesh, India

² Department of Community Medicine, Dr. Ram Manohar Lohia Institute of Medical Sciences (Dr RMLIMS), Lucknow, Uttar Pradesh, India

Corresponding author: Dr. Aastha Kalra, Former Assistant Professor, Department of Community Medicine, Integral Institute of Medical Sciences and Research, Lucknow, Uttar Pradesh, India.

Email: aasthakalra1511@gmail.com

Citation: Pushkal Singh, Aastha Kalra, Nirpal Kaur, Manish Kumar Singh. Mapping Unmet Need for Family Planning and Contraceptive Use Among Married Women in India: A Scoping Review of Recent Evidences. Indian J Comm Health. 2026;38(4): p-635 - 641

<https://doi.org/10.47203/IJCH.2026.v38i04.002>

Article Cycle: Received: 02/07/2026; Accepted: 21/08/2026; Published: 31/08/2026

Abstract

Background: India has reduced unmet need for family planning and increased contraceptive use, but national averages can conceal geographic, socioeconomic, method-choice and autonomy gaps. **Aims & Objectives:** To map recent evidence on unmet need, contraceptive use, method choice and related determinants among married women in India. **Material & Methods:** A PRISMA-ScR-guided scoping review used a structured PubMed search, Google Scholar as a supplementary sensitivity source, and a preliminary-scoping known-item set. PubMed identified 41 records; two superseded preprints were removed, 39 records were screened and 14 studies met the eligibility criteria. Of 35 known-item candidates, five overlapped with the PubMed set and ten additional unique 2024-2025 primary studies met identical eligibility criteria, yielding 24 included studies. **Result:** Evidence showed declining national unmet need but persistent local inequality, a sterilization-heavy method mix, socioeconomic differences in reversible-method use, gaps in continuation and post-abortion care, and important roles for spousal communication, agency and informed choice. Heterogeneity precluded meaningful statistical pooling. **Conclusion:** Family-planning progress should be assessed through equitable access, continuation support and voluntary, preference-concordant choice as well as coverage.

Keywords: contraception, family planning, India, married women, reproductive agency, scoping review, unmet need

Introduction

Family planning allows women and couples to decide whether and when to have children. Unmet need refers to women who wish to postpone or avoid pregnancy but are not using contraception.^[1] India has increased contraceptive use and reduced unmet need, yet substantial differences persist across states, districts and population groups.^[2] Coverage also does not fully capture quality: women need access to preferred methods, support to continue or switch, and freedom from pressure.^[3] Recent Indian evidence spans national surveys, communities and health facilities. This review maps primary evidence published in 2024-2025 while clearly separating older or broader contextual sources from the synthesis.

Aims and Objectives

To map primary evidence published in 2024-2025 on unmet need for family planning and contraceptive use among married women in India.

To describe geographic, socioeconomic, service-related and interpersonal determinants of contraceptive use, non-use and method choice.

To identify recurring evidence gaps and implications for equitable, rights-based family-planning programmes.

Material & Methods

Review design and reporting

The review followed the five-stage scoping-review framework of Arksey and O'Malley,^[4] used updated JBI guidance for Population, Concept and Context,^[5] and was reported in accordance with the PRISMA extension for scoping reviews (PRISMA-ScR).^[6] The purpose was to map the range and characteristics of recent evidence rather than estimate a single pooled effect.

Eligibility Criteria (PCC)

Population: Married or currently married women of reproductive age in India. Studies of reproductive-age women were retained when the analysis directly addressed contraceptive use or family-planning behaviour relevant to married women. A service-based contraceptive study was retained where marital status was not reported as an explicit eligibility variable; this exception is acknowledged in the limitations and its findings are interpreted descriptively.

Concept: Unmet need; contraceptive use or non-use; method choice; continuation/discontinuation; post-abortion contraceptive use; determinants and inequalities in use; and person-centred constructs directly linked to contraceptive behaviour, including self-efficacy, informed choice, voluntarism and contraceptive concordance.

Context: India, including national, state, district, community and health-facility settings.

Eligible core sources were original primary studies with a final journal publication date in 2024 or 2025 that directly examined unmet need, contraceptive knowledge or practice, method choice, continuation, acceptability, autonomy or closely related determinants in Indian married/in-union women. Pregnant and postpartum subgroups were eligible when the study population was married or its marital context was documented. Observational, cross-sectional, repeated cross-sectional, retrospective, psychometric and mixed-methods studies with an eligible quantitative component were included. Single-group pre/post-counselling assessments embedded within cross-sectional surveys were eligible; standalone intervention trials and programme evaluations were not. Secondary analyses of NFHS and other population surveys were also eligible. Intervention trials, quasi-experimental programme evaluations, protocols, superseded preprints, editorials, conference abstracts without a full article, studies of health-care personnel, and studies in which contraception was incidental to an unrelated primary outcome were excluded. Sources outside the 2024-2025 window, evidence syntheses/programme reports, or studies whose population or concept did not match the revised PCC were retained only as contextual evidence and were not counted in the synthesis.

Information sources and search strategy

The final structured PubMed search was run on 17 August 2026 and restricted to English-language records published from 1 January 2024 through 31 December 2025. The window was closed at 31 December 2025 to ensure complete indexing and avoid partial-year representation. The strategy combined MeSH terms and title/abstract terms for family planning or contraception, married or reproductive-age women, and India. No free-full-text or open-access filter was applied. The exact search string and yield are reproduced in Supplementary File S1.

Google Scholar was used as a supplementary sensitivity source. The focused query "unmet need for family planning" "married women" India, restricted to 2024-2025, produced an approximate platform estimate of 1,090 results. Because Google Scholar supplies an estimated relevance-ranked count rather than a stable database-style record set, this yield is reported separately and was not merged into the exact PubMed denominator. Backward citation checking of the included studies identified no eligible record beyond those

recovered through the known-item arm. A preliminary-scoping stage had identified 35 candidate sources, which were assessed as a known-item evidence set against the same final Population-Concept-Context and design criteria. Ten 2024-2025 primary studies met these criteria and were not duplicated among the 14 PubMed-included studies. At verification, no PubMed record was identified for six of these ten studies (references 9, 10, 11, 20, 27 and 30); the remaining four (references 12, 26, 28 and 29) were PubMed-indexed but were not captured by the structured search because the population block required specified marital or reproductive-age phrases that were not present in their indexed titles/abstracts. These supplementary identification routes are reported separately rather than attributed to the database search. The remaining previously charted candidates were outside the final eligibility criteria or retained only as contextual evidence.

Study selection

The PubMed search identified 41 records. Two superseded preprint versions were removed before screening, leaving 39 records. Twenty-five records were excluded at title/abstract screening because they represented interventions/protocols or because the primary population, concept or outcome did not match the review question. Fourteen reports underwent full-text assessment and met the final eligibility criteria. In the preliminary-scoping known-item arm, 35 candidate sources were assessed using the same final criteria; five were already represented among the PubMed-included studies, ten additional unique 2024-2025 primary studies were eligible, and twenty were outside the final synthesis or retained only as contextual evidence. The final synthesis therefore comprised 24 studies. The source-specific pathway is shown in Figure 1 and Supplementary File S2.

Data charting and synthesis

For each included study, publication year, setting, design/data source, population and sample size, family-planning construct, and the main result relevant to the review question were charted. Findings were organised into five themes: (1) unmet need and geographic inequality; (2) contraceptive prevalence and method mix; (3) socioeconomic inequality; (4) continuation, counselling and post-abortion opportunities; and (5) agency, communication and informed choice. Table 1 and Supplementary File S3 contain the identical set of 24 included studies.

Rationale for scoping synthesis and absence of meta-analysis

The evidence was heterogeneous in design, population, geographic level, sampling frame, outcome definition and statistical measure. Included studies ranged from a 22-participant mixed-methods study in an urban slum to national survey analyses of over 500,000 women, with community and

facility studies typically enrolling several hundred to several thousand participants. Outcomes ranged from unmet need and any contraceptive use to reversible-method use, discontinuation, post-abortion contraception, self-efficacy, voluntarism and preference-use concordance. A pooled prevalence or effect estimate would therefore combine clinically and programmatically non-equivalent constructs. The broad mapping objective and this heterogeneity supported a scoping-review synthesis rather than statistical meta-analysis.

Results

Study selection

Twenty-four studies were included.⁷⁻³⁰ Fourteen were identified through the structured PubMed screening pathway and ten additional unique 2024-2025 primary studies were retained from the preliminary-scoping known-item set after application of the same final eligibility criteria. Designs included national NFHS analyses, state and district surveys, community-based studies, facility-based studies, a psychometric analysis and mixed-methods studies with quantitative cross-sectional components. Table 1 summarises the included evidence.

Table 1. Characteristics and key findings of included studies (n = 24)

Study	Setting	Design/data source	Population/sample	Focus	Key finding
Devaraj et al., 2024. ^[7]	National; 36 States/UTs	Secondary analysis of five NFHS rounds	Married/in-union women aged 15-49	Unmet need trends	Unmet need declined from 20.6% in 1993 to 9.4% in 2021; 2021 prevalence remained highest in Meghalaya (26.9%), Mizoram (18.9%), Bihar (13.6%) and Uttar Pradesh (12.9%).
Halli et al., 2024. ^[8]	Uttar Pradesh	Cross-sectional state survey	12,200 currently married women	Geographic and socioeconomic inequality	Family-planning coverage varied markedly across divisions (72.4% in Jhansi vs 39.3% in Faizabad), with substantial within-division and ASHA-area inequality.
Pavan Kumari et al., 2024. ^{[9]a}	Rural Nellore, Andhra Pradesh	Analytical cross-sectional study	450 married women aged 15-49 years	Unmet need for spacing and limiting	Reported unmet need for spacing of 10.0% and for limiting of 7.8%; age, education, occupation, family type and reproductive timing were important correlates.
Sundaran et al., 2024. ^{[10]a}	Urban and rural Telangana	Cross-sectional study	306 married women aged 15-49 years	Unmet need for contraception	Overall unmet need was 18.6%; urban prevalence was 24.2% versus 13.1% in rural areas.
Misra et al., 2024. ^{[11]a}	Saurashtra, Gujarat; rural and urban health centres	Hospital-based cross-sectional study	300 married women aged 15-49 years	Unmet need and service contact	Unmet need was 35.7% among 300 participants despite service contact; 51% were current contraceptive users.
Basu et al., 2024. ^{[12]a}	Nadia district, West Bengal; tribal community	Community-based observational cross-sectional study	290 currently married tribal women	Contraceptive use and unmet need	Contraceptive prevalence was 43.8%; unmet need was associated with socioeconomic position, awareness/access, family opposition and husband participation.
Nasreen et al., 2024. ^{[13]a}	Dakshina Kannada, Karnataka	Community-based cross-sectional study	461 Muslim women aged 21-50 years; widowed, divorced and single women were excluded	Family-planning knowledge and practice	Knowledge of family planning was 93.7%, but only 22.3% practised family planning; preference for another child and customary beliefs were common reasons for non-use.
Muralidhar et al., 2024. ^{[13]a}	Rural Mysore, Karnataka; tribal communities	Cross-sectional observational study	303 married pregnant tribal women	Temporary-method knowledge and prior use	Only 39.3% had heard of at least one temporary method and 2.3% had ever used one; knowledge was associated with age, years of marriage, shared household decision-making and institutional delivery.
Mercy et al., 2025. ^{[20]a}	Rural Tamil Nadu	Community-based cross-sectional study	Married women aged 18-45 years from five randomly selected villages; N not reported in the accessible abstract	Contraceptive prevalence and determinants	Overall contraceptive use was 75.7%, dominated by female sterilization (65.2%); fear of side effects and lack of knowledge were important reasons for non-use.
Saya et al., 2024. ^[19]	Puducherry	Community-based cross-sectional study	1,924 currently married women	Knowledge and practice	Current contraceptive use was 78.6%; female sterilization accounted for 62%. Almost all women knew sterilization, but only 10.4% knew more than three methods.
Sen et al., 2024. ^[14]	West Bengal	NFHS-5 secondary cross-sectional analysis	15,841 currently married non-pregnant women	Modern contraceptive use	Female sterilization was the most common modern method; district-level contraceptive use ranged from 43.0% to 77.3%, with age, parity, wealth and residence associated with use.
Shekhar et al., 2025. ^[16]	National	NFHS-5 cross-sectional analysis	512,408 currently married women	Contraceptive uptake and determinants	Contraceptive use increased markedly from NFHS-4 to NFHS-5; uptake varied by age, education, fertility desire, caste, religion, wealth, media exposure and residence.

Sikdar & Bansod, 2025. ^[16]	National; district-level	NFHS-5 cross-sectional analysis	512,408 currently married women	Wealth and method choice	Non-use fell from 37.8% in the poorest to 30.6% in the richest quintile; reversible modern use rose from 15.9% to 25.0%, showing a pro-rich gradient.
Ghosh et al., 2025. ^[17]	National	NFHS-5 cross-sectional analysis	6,626 married women reporting alcohol use; comparison group 468,142 women without alcohol or tobacco use; tobacco-only and alcohol-plus-tobacco records were excluded	Contraceptive use in a vulnerable subgroup	Alcohol use was associated with lower odds of effective contraceptive use (AOR 0.86); 31.2% of women who drank alcohol reported no contraceptive use.
Ray et al., 2024. ^[18]	West Bengal; tertiary hospital serving rural women	Retrospective cross-sectional study	200 women of reproductive age using DMPA (Antara); marital status was not reported as an explicit eligibility variable	Method continuation/discontinuation	64.5% had discontinued DMPA; menstrual changes, amenorrhea and apprehension were prominent reasons, with lower education and socioeconomic status associated with discontinuation.
Jose et al., 2025. ^[19]	National	Repeated cross-sectional NFHS reproductive-calendar analysis	5,473 (NFHS-4) and 5,103 (NFHS-5) women after abortion	Post-abortion contraception	Post-abortion contraceptive use increased from 49% to 57%; method use varied by abortion setting, gestational age, prior use and fertility context.
Rani et al., 2024. ^[20]	Urban slum, North India	Community-based mixed-method study with cross-sectional quantitative compo	22 married women from an urban slum	Abortion-pill use and contraceptive knowledge/practice	Participants reported 35 unwanted pregnancies, most ending in abortion; easy access to abortion pills and fears or myths about modern contraceptive methods shaped contraceptive behaviour.
Sawant Dessai et al., 2025. ^[20]	Goa; tertiary postnatal wards	nent Cross-sectional study	360 married postnatal women aged 18-36 years	Reversible contraception awareness and acceptability	Before counselling, 38% reported modern contraceptive use; after counselling, 73.1% expressed readiness to use a contraceptive method.
Bhan et al., 2024. ^[21]	Bihar	Psychometric/cross-sectional survey analysis	13,901 non-sterilized currently married women	Family-planning self-efficacy	The 9-item scale showed good reliability ($\alpha=0.82$). Higher self-efficacy was associated with spousal communication (AOR 2.35) and reversible modern contraception (AOR 1.58).
Paul et al., 2025. ^[22]	Uttar Pradesh and Bihar	Cross-sectional UDAYA survey analysis	5,018 currently married girls aged 18-22	Marital agency, communication and use	17.5% used contraception. Self-choice marriage was associated with higher contraceptive self-efficacy (AOR 1.56) and contraceptive use (AOR 1.68).
Shrivastav et al., 2025. ^[23]	Western Gujarat	Community-based mixed-methods study	840 married women; plus qualitative component	Contraceptive use and socio cultural determinants	Contraceptive prevalence was 60.4% (46.7% modern). Education, parity and joint decision-making were positive correlates; family-led decisions and sociocultural barriers reduced use.
Shruthi et al., 2025. ^[24]	Kanchipuram, Tamil Nadu	Community-based cross-sectional study	390 married women aged 18-44	Rights-based and voluntary family planning	Only 36% were offered two or more modern contraceptive choices. The authors defined forced contraception as provision without knowledge or consent and coerced contraception as acceptance compelled through misinformation, intimidation or conditional access to services; 8.5% reported forced and 2.0% coerced use.
Karra & Canning, 2024. ^[25]	National; NFHS-5	Secondary cross-sectional analysis of NFHS-5	NFHS-5 analytic sample N=724,115 women aged 15-49 years; UFP denominator restricted to married/in-union, sexually active, fecund women	Unwanted family planning and sterilization autonomy	Conventional unwanted family planning was 0.9%; estimates rose to 2.3% when sterilization regret was included and to 6.9% when lack of information about permanence was also considered.
Vincent et al., 2025. ^[25]	Rural India	Cross-sectional survey	1,958 married women	Contraceptive concordance	60.0% were concordant; 24.8% wanted contraception but were non-users, while 15.2% were users who reported not wanting contraception.

*Identified through the preliminary-scoping known-item arm; all other included studies were identified through the PubMed arm.

Synthesis of findings

Unmet need has fallen, but the residual burden is geographically concentrated.

The national trend analysis found that unmet need declined from 20.6% in 1993 to 9.4% in 2021, but the decline was uneven

across states.^[7] Uttar Pradesh also showed large within-state differences in family-planning coverage.^[8] Smaller studies demonstrated why national averages should not be treated as local estimates. In rural Nellore, unmet need for spacing was reported as 10.0% and for limiting as 7.8%.^[9] In Telangana,

overall unmet need was 18.6%, with a higher estimate in urban than rural participants (24.2% vs 13.1%).^[10] A Saurashtra health-centre study reported 35.7% unmet need among married women already in contact with services,^[11] while the West Bengal tribal study documented low contraceptive coverage and determinants related to awareness, access, family opposition and husband participation.^[12]

Contraceptive use has increased, but the method mix remains narrow.

NFHS-5 analyses showed substantial contraceptive uptake but continued reliance on permanent methods. Shekhar et al. reported a marked increase in contraceptive use between NFHS-4 and NFHS-5; the article contains a minor internal discrepancy between the abstract and main-text trend figure, so the exact NFHS-5 percentage is not repeated here.^[13] In Puducherry, 78.6% of participants were current users, but female sterilization accounted for 62% and knowledge of non-permanent methods was weaker.^[14] In West Bengal, modern contraceptive use varied widely between districts and female sterilization remained the dominant modern method.^[15] In rural Tamil Nadu, overall contraceptive use was 75.7%, with female sterilization accounting for 65.2%.³⁰ Among Muslim women in Karnataka, 93.7% knew of family planning but only 22.3% reported practising it, while among married pregnant tribal women in Mysore only 39.3% had heard of at least one temporary method and 2.3% had ever used one.^[16,17] The pattern therefore reflects improved coverage without equivalent diversification of choice or translation of knowledge into practice.

Socioeconomic position influences method choice as well as use.

The national wealth analysis showed a clear gradient: non-use fell from 37.8% among women in the poorest quintile to 30.6% in the richest, whereas reversible modern-method use rose from 15.9% to 25.0%.^[18] Geographic and socioeconomic inequalities were also apparent in Uttar Pradesh and West Bengal.^[8,15] Among married women who reported alcohol use, 31.2% used no contraception, and alcohol use was associated with lower odds of effective contraceptive use after adjustment.^[19] These findings show that both coverage and method choice are socially patterned.

Continuation and post-abortion care are important service opportunities.

The DMPA (Antara) study found substantial discontinuation, with menstrual changes, amenorrhea and apprehension among prominent reasons.^[20] Post-abortion contraceptive use improved from 49% in NFHS-4 to 57% in NFHS-5 but remained incomplete and varied by abortion setting, gestational age, previous contraceptive use and fertility context.^[21] In a Goa postnatal study, only 38% reported modern contraceptive use before counselling; after counselling, 73.1% of married women

expressed readiness to use a contraceptive method.^[22] An urban-slum study of 22 married women reported 35 unwanted pregnancies and described easy access to abortion pills, inconsistent contraceptive supply, and fears or myths about modern methods as influences on behaviour.^[23] Together, these studies identify counselling, expectation-setting, switching support and post-pregnancy contacts as modifiable service opportunities.

Agency, communication and informed choice add information beyond contraceptive prevalence.

Family-planning self-efficacy in Bihar was associated with spousal communication and reversible modern contraceptive use.^[24] Among newly married girls in Uttar Pradesh and Bihar, self-choice marriage was associated with higher contraceptive self-efficacy and use.^[25] In western Gujarat, education, parity and joint decision-making were positive correlates, whereas decisions dominated by other family members reduced uptake.^[26] A rights-based study from southern India documented incomplete method choice and instances of forced or coerced use in a minority of participants.^[27] National estimates of unwanted family planning rose from 0.9% to 2.3% when sterilization regret was incorporated and to 6.9% when lack of information about permanence was also considered.^[28] The concordance study showed that 24.8% wanted contraception but were non-users, whereas 15.2% were using contraception despite reporting that they did not want it.^[29] These findings show why programme performance should include choice and agency in addition to prevalence.

Discussion

The evidence shows substantial national progress alongside persistent local inequity. The 2024-2025 studies converge on three points: unmet need can remain high in specific districts or social groups despite favourable national averages; increased contraceptive prevalence has not eliminated a sterilization-heavy method mix; and women's preferences and decision-making power are not fully captured by conventional coverage indicators.^[7-30] The supplementary eligible studies strengthen these conclusions by adding evidence on local unmet need, tribal and sociocultural gaps, counselling, post-abortion behaviour and contraceptive autonomy.^[9-12,16,17,23,28,30]

Rights-based and person-centred evidence strengthens the interpretation of conventional coverage indicators. National estimates of unwanted family planning increased when sterilization regret and lack of information about permanence were considered.^[28] A community rights-based study and the contraceptive-concordance analysis similarly show that observed contraceptive use does not necessarily equal informed, voluntary or preference-concordant use.^[27,29] These findings support judging programme performance by autonomy and satisfaction as well as prevalence.

Service and community context also matters. The Antara, post-

abortion and postnatal studies indicate that counselling quality and continuity can influence acceptance and continuation.^[20-22] In an urban-slum mixed-method study, married women described choosing easily available abortion pills over modern contraceptive methods in the setting of fears, myths and inconsistent contraceptive supply.^[23] Among married pregnant tribal women, only 39.3% had heard of at least one temporary method and 2.3% had ever used one.²⁸ Among Muslim women in Karnataka, knowledge was high but reported family-planning practice remained low, with custom and preference for another child among reasons for non-use.^[16]

The social context of contraceptive behaviour deserves equal attention. Spousal communication, marital agency and joint decision-making were repeatedly associated with self-efficacy or contraceptive use.^[24-26] Couple-sensitive communication may therefore be useful, but it should preserve the woman's individual right to decide. Awareness campaigns alone are unlikely to be sufficient where women face family pressure, limited negotiating power, concern about side effects or weak access to preferred reversible methods.

A meta-analysis was not undertaken because the studies did not estimate a common, sufficiently comparable outcome. They differed in populations, sampling, settings and constructs and reported measures ranging from prevalence and odds ratios to psychometric associations, discontinuation and concordance. Statistical pooling would create a summary number with limited clinical or programme meaning. The appropriate contribution of this review is therefore to map convergent patterns, contextual variation and evidence gaps.

Public Health Implications and Recommendations

Family-planning programmes should use sub-state data to identify pockets of unmet need rather than rely only on state averages. A consistent basket of reversible and permanent methods should be available across socioeconomic groups, supported by non-directive counselling, expectation-setting for side effects and practical switching pathways. Post-abortion, antenatal and postnatal contacts should routinely include voluntary family-planning counselling. Programme dashboards should complement contraceptive prevalence and unmet need with indicators of informed choice, voluntarism, satisfaction, self-efficacy and preference-use concordance. Future research should move beyond repeated prevalence studies toward prospective, implementation and health-systems research that tests how equitable choice and continuation can be improved.

Limitations

This review has five main limitations. First, PubMed was the only formal bibliographic database. Of the 15 known-item sources meeting the final criteria, the PubMed arm independently retrieved five. Six of the ten additional eligible known-item studies had no PubMed record identified at

verification, and four were PubMed-indexed but were not retrieved because their indexed titles/abstracts did not match the specified population phrases in the search block. This illustrates the limited sensitivity of a single-database strategy for Indian family-planning literature and findings should be read as a map of retrievable recent evidence rather than an exhaustive census. The known-item route applied identical eligibility criteria to 35 preliminary-scoping candidates but is not a substitute for a second bibliographic database. Second, the Google Scholar count was an approximate platform estimate and was not treated as a record-level denominator. Third, the focused 2024-2025 window provides a recent publication snapshot; several studies analysed earlier data, particularly NFHS-5, and older studies or programme reports were used only as contextual background. Fourth, formal risk-of-bias grading was not undertaken because the objective was scoping and evidence mapping. Fifth, one facility-based contraceptive study enrolled women of reproductive age without reporting marital status as an explicit eligibility variable, and one mixed-methods study enrolled only 22 participants. These studies are interpreted descriptively and do not contribute generalisable estimates for all married women in India.

Conclusion

Recent Indian evidence shows substantial progress in family planning, but the remaining challenge is not captured by contraceptive prevalence alone. Unmet need remains geographically and socially concentrated, reversible method choice is uneven, and continuation may be undermined by side effects or inadequate counselling. Women's preferences, self-efficacy and decision-making power do not always align with observed contraceptive use. Public-health programmes should therefore combine geographic targeting and a reliable method basket with high-quality follow-up and rights-based indicators of informed, voluntary and preference-concordant choice.

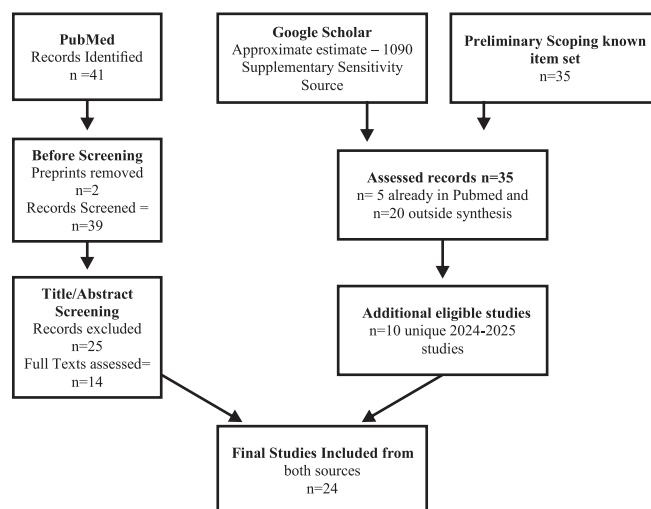


Figure 1. PRISMA-ScR flow of study selection

Note: The exact PubMed record flow is shown separately from supplementary evidence-identification routes. The focused Google Scholar query returned an approximate platform estimate of 1,090 results and did not contribute an additional included study. The preliminary-scoping known-item set contained 35 candidate sources: five were already represented in the PubMed-included set, ten additional unique 2024-2025 primary studies met the final eligibility criteria, and twenty were outside the final synthesis or retained as contextual evidence. Backward/manual checking contributed no additional eligible study.

Ethics approval: Not applicable; this review used published literature only.

Financial Support and Sponsorship : Nil

Conflict of Interest: None

Declaration of Generative Ai And Ai-assisted Technologies in the Writing Process: None

Supplementary File Link here:

https://drive.google.com/file/d/1tdlTDYn4UaiYO10xQ_n8c539gCVaLw/view

References

- Bradley SEK, Croft TN, Fishel JD, Westoff CF. Revising unmet need for family planning. DHS Analytical Studies No. 25. Calverton (MD): ICF International; 2012.
- International Institute for Population Sciences (IIPS), ICF. National Family Health Survey (NFHS-5), 2019–21: India. Mumbai: IIPS; 2021.
- Senderowicz L. Contraceptive autonomy: conceptions and measurement of a novel family planning indicator. *Stud Fam Plann*. 2020;51(2):161–176.
- Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol*. 2005;8(1):19–32.
- Peters MDJ, Marnie C, Tricco AC, Pollock D, Munn Z, Alexander L, et al. Updated methodological guidance for the conduct of scoping reviews. *JBI Evid Synth*. 2020;18(10):2119–2126.
- Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Ann Intern Med*. 2018;169(7):467–473.
- Devaraj K, Gausman J, Mishra R, Kumar A, Kim R, Subramanian SV. Trends in prevalence of unmet need for family planning in India: patterns of change across 36 States and Union Territories, 1993–2021. *Reprod Health*. 2024;21(1):48.
- Halli SS, Alam MT, Namasivayam V, Prakash R, Anand P, Blanchard J, Wehrmeister F. Geographic and socioeconomic inequalities in the coverage of contraception in Uttar Pradesh, India. *Reprod Health*. 2024;21(1):50.
- Pavan Kumari J, Chakri Sarvani B, Arun Sagar T, Conjeevaram J. Study on prevalence of unmet need for spacing and limiting and their associated factors among reproductive age group women in rural areas: an analytical cross-sectional study. *Int J Pharm Res Technol*. 2024;14(1):117–124.
- Sundaran S, Darivemula SB, Bala S, Tondare DP, Kumar SA, Molagala S. Prevalence of unmet need for contraception among married women aged 15–49 years in urban and rural areas of Telangana. *Indian J Health Sci Biomed Res KLEU*. 2024;17(2):119–124.
- Misra S, Damor KK, Naveen Shyam Sundar R, Gupta EK, Parmar D. Unlocking the silent struggle: addressing unmet family planning needs in Saurashtra's health centres. *Natl Board Exam J Med Sci*. 2024;2(6):553–565.
- Basu G, Chakraborty U, Halder I. Contraceptive use, unmet need and its determinants among tribal married reproductive women: a community-based observational study in a district of West Bengal. *J Family Med Prim Care*. 2024;13(6):2389–2396.
- Shekhar C, Sahoo H, Das L. Usage of contraception among the married women in India, 2019–21: a cross-sectional study. *Contracept Reprod Med*. 2025;10(1):60. doi:10.1186/s40834-025-00375-2.
- Saya GK, Premarajan KC, Roy G, Sarkar S, Kar SS, Krishnamoorthy Y, et al. Contraceptive knowledge, practice, and associated factors among currently married women of reproductive age group: a community-based study in Puducherry, India. *Health Care Women Int*. 2024;45(1):86–100.
- Sen S, Banerjee A, Ali A, Chakma N. Modern contraceptive use among currently married non-pregnant women (aged 15–49 years) in West Bengal, India: a reflection from NFHS-5. *Contracept Reprod Med*. 2024;9(1):63.
- Nasreen I, Guthigar M, Veigas I. The knowledge and practice of family planning among Muslim women in rural Karnataka, India. *Cureus*. 2024;16(4):e58088.
- Muralidhar K, Nishimura H, Coursey K, Krupp K, Jaykrishna P, Srinivas V, et al. Knowledge and practice of family planning among pregnant tribal women in Southern India: an observational study. *Contracept Reprod Med*. 2024;9(1):2.
- Sikdar R, Bansod DW. Wealth differentials and contraceptive choices among women in India: insights from NFHS-5 (2019–21). *BMC Public Health*. 2025;25(1):3191.
- Ghosh A, Verma A, Saha PK, Choudhury S. Contraceptive use among married women who drink alcohol in India: a cross-sectional analysis of NFHS-5 survey. *Alcohol Alcohol*. 2025;60(4):agaf040.
- Ray S, Sing K, Biswas T, Manepalli ST, Chaturvedi A. Experiences of "Antara": the injectable contraceptive in rural Indian women presenting to a tertiary care hospital of Eastern India. *J Obstet Gynaecol India*. 2024;74(3):243–249.
- Jose J, Kannaujiya AK, Kumar K, McDougal L, Hay K, Singh A. Post-abortion contraceptive use among currently married women in India: new evidence from National Family Health Survey 2019–2021 (NFHS-5). *PLoS One*. 2025;20(5):e0322784.
- Sawant Dessai BP, Krishnan M, Shah HK, Costa Noronha LE. Awareness and acceptability of reversible contraceptive methods in post-natal females in a tertiary care setting: a cross-sectional study. *J Med Evid*. 2025;6(1):10–15.
- Rani M, Bairwa M, Sharma N, Jaswal N, Kumar R. Use of abortion pills as a family planning method among women living in urban slum of North India: a mixed-method study. *Med J Dr DY Patil Vidyapeeth*. 2024;17(3):539–546.
- Bhan N, Thomas EE, McDougal L, Nanda P, Mahapatra T, Das A, et al. Validation of a family planning self-efficacy measure with married women in Bihar, India: findings from the Bihar Integrated Family Planning Survey. *Contracept X*. 2024;6:100113.
- Paul P, Saha R, McDougal L, Gopalakrishnan L. Marital choice, spousal communication, and contraceptive self-efficacy and use among newly married girls in India: evidence from the UDAYA study. *Soc Sci Med*. 2025;373:118006.
- Shrivastav V, Yogesh M, Parmar D, Gandhi R, Sojitra SA, Subhash KT, et al. Voices unveiled: a mixed-methods exploration of family planning education, access, and sociocultural determinants for enhancing contraceptive decision-making in western Gujarat, India. *Contracept Reprod Med*. 2025;10(1):23.
- Shrutee SG, Arasi S, Seenivasan P. Voluntary and rights-based family planning for women: observations from a community-based study in southern India. *Indian J Med Ethics*. 2025;X(3):183–190.
- Karra M, Canning D. Unwanted family planning including unwanted sterilization: preliminary prevalence estimates for India. *Stud Fam Plann*. 2024;55(4):349–359.
- Vincent S, Herrera-Almanza C, Anukriti S, Karra M. Contraceptive concordance. *Stud Fam Plann*. 2025;56(3):532–549.
- Mercy M, Konduru RK, Murugan, Purty AJ. Prevalence and determinants of contraceptive use among married women in a rural area of Tamilnadu: a cross-sectional study. *Indian J Health Sci Biomed Res KLEU*. 2025;18(1):Article 11.