

Impact of Socio-Economic and Cultural Determinants of Contraceptive Method Choice in India: Evidence from NFHS-5

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ABSTRACT

Socio-economic and cultural factors play a crucial role in shaping contraceptive method choice in India. While contraceptive prevalence has increased, the method mix remains heavily skewed toward female sterilization, with a relatively low use of reversible spacing methods. This study examines the socio-economic and cultural determinants of contraceptive method choice in India using data from the National Family Health Survey (NFHS-5, 2019-21). The analysis focused on the use of permanent, modern, and traditional methods among currently married women aged 15-49 years. The findings show that female sterilization dominates India's contraceptive landscape, accounting for 67.2% of all methods, with an overall modern contraceptive prevalence rate (mCPR) of 56.5%. The choice of method varies markedly by age, place of residence, education, wealth, religion, and caste. Adolescents and young married women predominantly use condoms, pills, and injectables, whereas older married women mainly rely on sterilization. Urban, more educated, and wealthier women are more likely to adopt spacing methods, while rural, less educated, and poorer women disproportionately depend on sterilization. Hindu women are more likely to use permanent methods, whereas Muslim women show higher use of spacing and some traditional methods. The multivariate regression results confirm these patterns with statistical significance. This study highlights the need to diversify India's contraceptive method mix, strengthen access to high-quality spacing methods, and design culturally sensitive and equity-oriented family planning strategies.

Key Words: Female Sterilization, Modern Contraceptive Prevalence Rate (mCPR), family planning (FP), Family Planning Method-Mix, Socio-Economic Determinants, National Family Health Survey (NFHS-5), Modern Spacing Methods, Total Fertility Rate (TFR)

INTRODUCTION

India's fertility decline is closely linked to the rising contraceptive prevalence rate (CPR); however, the distribution of contraception is skewed towards female sterilization and an increase in traditional contraceptive methods in the country. Although awareness of contraception is high, its use is constrained by socio-economic factors, and spacing contraception is not easily accessible to some population groups. India's total fertility rate (TFR) has declined to 2.0, below the replacement level, and the contraceptive prevalence rate (CPR) is 66.7% (NFHS-5, 2019-21). Notably, female sterilization comprises over two-thirds of contraception use in the country, but male sterilization is only 0.3-0.5%.

Age, education, wealth, residence, religion, and caste are critical determinants of contraceptive use in India. Younger women are more likely to use contraception for spacing, whereas older married women opt for permanent contraception, such as female sterilization. Higher levels of education and wealth are positively associated with the use of reversible modern contraception, whereas low-income women, especially in rural areas, are more likely to use permanent contraceptive methods such as sterilization. In addition, Hindu and Christian women are more likely to use sterilization, whereas Muslim women prefer spacing contraception and

traditional methods. This study will be significant in understanding contraceptive use in India and providing recommendations for promoting the use of spacing contraceptive family planning (FP) methods and male involvement in family planning. The findings will also highlight the critical role of socioeconomic and cultural determinants in contraceptive use and the need to address gender inequality in accessing contraception and reproductive health services in India.

REVIEW OF LITERATURE

Patterns of Contraceptive Use and Method Mix

Various studies have assessed contraceptive use and its determinants in India using National Family Health Survey (NFHS) data. Several studies have documented a paradoxical rise in the use of traditional methods alongside the increased use of modern contraception. Scholars have also reported wide variations in contraceptive methods between states and population groups and have identified multiple sociocultural factors influencing family planning. For instance, Namasivayam et al. (2023) examined contraceptive methods in Uttar Pradesh and found an increase in the use of traditional methods alongside modern methods. Traditional methods were preferred because they were perceived to have fewer side effects and required less involvement from health professionals than modern methods did. Similarly, Prakash et al. (2022) reported that the use of traditional methods nearly doubled between NFHS-4 and NFHS-5, while also identifying important sociocultural predictors of contraceptive use and family planning in India.

Dominance of Sterilization

Evidence consistently shows that India's contraceptive method mix is heavily skewed towards female sterilization. Agrawal et al. (2023) documented a strong socioeconomic gradient in the use of permanent methods, with poorer and less educated women being more likely to rely on sterilization than their better-off counterparts. This reliance on permanent methods, rather than a balanced mix that includes reversible options, raises concerns about informed choice and equity in accessing a full range of methods.

Education and Wealth Disparities

Age, education, and wealth are important predictors of contraceptive behavior in India. Faujdar Ram et al. (2013) found that education and household wealth significantly increased the likelihood of using contraception, including traditional methods, and that method choice varied markedly across socio-economic groups. Other studies similarly report that more educated and wealthier women are better able to access a range of contraceptive options, including modern spacing methods, while less educated and poorer women tend to rely on sterilization or have unmet need for contraception (Agrawal et al., 2023; Pradhan & Dwivedi, 2015).

Religious Influences

Religion is another key determinant of contraceptive behavior and method choice. According to Jejeebhoy and Santhya (2011), Muslims are less likely than Hindus to use sterilization and are more inclined towards spacing methods, reflecting differing religious norms and preferences regarding fertility and contraception. Other studies have documented that Muslim women face distinct cultural and social constraints that shape their contraceptive choices, including concerns about the side effects and acceptability of permanent methods (Population Research Centre, 2016).

Caste-Based Patterns

Caste-based inequalities intersect with religion, education, and wealth to influence the use of contraceptives. Studies have found significant differences in the method mix between Scheduled Castes, Scheduled Tribes, Other Backward Classes, and other caste groups. Panda et al. (2023) reported low use of modern contraceptive methods and heavy reliance on female sterilization among tribal women, shaped by perceptions of side effects and husbands' attitudes towards contraception. These findings highlight the importance of caste and community-specific approaches to family planning programs, particularly for marginalized groups.

Objectives

This study aimed to assess the association between socioeconomic and cultural determinants and the choice of specific contraceptive methods: permanent, modern spacing, and traditional contraceptive methods.

METHODOLOGY

This study used data from the National Family Health Survey Round 5 (NFHS-5:2019-21). This study employed a cross-sectional and nationally representative design to generate estimates at the national, state, and district levels. Data were collected using a two-stage stratified cluster sampling framework. In the first stage, Primary Sampling Units (PSUs) - villages, and Census Enumeration Blocks (CEBs) - cities, were selected using the Probability Proportion to Size (PPS) method. In the second stage, households were selected using systematic random sampling within the identified PSUs. The survey covered 636,699 households across 707 districts, representing approximately 99.3% of the eligible population.

Computer-assisted personal interviews were conducted using standard questionnaires, focusing on collecting information on contraceptive prevalence, use of different contraceptive methods such as permanent contraception, modern spacing, and traditional contraceptive methods, and maternal health and family planning indicators. The dependent variables included permanent, modern spacing, and traditional contraception. The independent variables were age, residence, religion, caste, education, and wealth.

This study used descriptive statistics to describe the prevalence of contraceptive use and its determinants using the NFHS 5 (2019-2021) survey data. In addition, Pearson's correlation matrix was used to assess the correlation between various socio-cultural variables and contraceptive use. The study also used multivariate regression models to determine the association between sociodemographic determinants and contraceptive prevalence and the use of specific contraceptive methods such as permanent contraception, modern spacing contraception, and traditional contraceptive methods.

RESULTS

India's contraceptive usage is heavily dominated by female sterilization, which accounts for 67.2% of all methods. However, as we look closely at the demographic breakdowns, a distinct story emerges: the choice of contraception shifts dramatically based on a woman's life stage, socioeconomic status, and educational background.

The national mCPR is 56.5%, with female sterilization accounting for 67.2% of all methods, followed by IUCD/PPIUCD (3.7%), condoms (16.8%), pills (9.0%), injectables (1.1%), and male sterilization (0.5%). The mCPR increased with age, reaching 68.1% among women aged 35-39 years and declining to 18.8% among women aged 15-19 years. Modern contraception peaks in women aged 35-39 years, largely driven by female sterilization, which accounts for 73.9% of all contraceptive methods in this age group. Women aged 15-24 years have the lowest use of contraception for spacing, suggesting short birth intervals followed by sterilization once they reach their desired family sizes. The mCPR was slightly higher among urban women (58.5%) than among rural women (55.5%). However, female sterilization is more prevalent in rural (69.6%) than in urban areas (62.1%), whereas condom use is higher in urban (23.2%) than in rural areas (13.7%). The use of spacing methods was also higher in urban areas than in rural areas.

The table1 also shows that women with no education had the highest mCPR (60.1%) and relied on female sterilization (80.7%), using few reversible methods. Women with primary education had slightly higher mCPR (61.9%); sterilization declined (74.4%), while spacing contraception, especially male condoms, increased. Women with higher education had the lowest mCPR (48.2%) but relied more on male condoms (40.6%) than on other methods of contraception. mCPR rose with wealth, from 50.7% (poorest) to 58.7% (richest), while sterilization declined (68.1 to 57.0%), and male condom use increased (9.8 to 30.3%).

Table 1- Distribution of Modern Contraceptive Method Use (mCPR) by Background Characteristics of Women Aged 15-49 Years, India

Background characteristics	mCPR	(% out of total mCPR of the method)					
		Female Sterilization	Male Sterilization	IUCD/ PPIUCD	Injectables	Pills	Male Condom
Age of Women							
15-19	18.8	2.1	0.0	11.1	1.9	26.2	50.4
20-24	31.8	24.8	0.1	9.7	2.4	19.2	36.8
25-29	49.4	49.6	0.3	6.1	1.7	13.2	26.3
30-34	62.3	63.7	0.5	4.3	1.1	10.0	19.0
35-39	68.1	73.9	0.7	2.7	0.7	7.8	13.3
40-44	67.4	82.6	0.7	1.8	0.5	4.9	8.9
45-49	65.2	89.4	0.7	0.8	0.3	3.2	5.0
Place of Residence							
Urban	58.5	62.1	0.4	4.6	0.8	7.4	23.2
Rural	55.5	69.6	0.6	3.3	1.1	9.7	13.7
Religion							
Hindu	58.0	70.0	0.6	3.6	0.9	7.4	15.8
Muslim	47.4	46.1	0.2	4.2	1.7	22.8	22.7
Christian	54.5	76.8	0.8	6.4	0.6	6.9	7.4
Sikh	53.7	48.3	0.9	6.0	0.3	3.8	40.0
Others	58.9	67.6	1.0	5.2	0.9	6.0	17.5
Caste							
Schedule Caste	57.0	69.8	0.5	3.3	1.0	8.2	15.3
Schedule Tribe	55.1	73.1	1.3	4.1	0.9	9.1	9.0
Other Backward Class	56.6	71.4	0.5	3.5	1.0	5.9	15.8
Others	56.3	58.8	0.5	4.3	0.9	10.4	23.8
Highest Educational Attainment							
No Education	60.1	80.7	0.6	1.5	1.0	6.1	8.6
Primary	61.9	74.4	0.6	2.3	0.8	9.9	10.5
Secondary	54.9	62.5	0.5	4.8	1.0	10.9	18.4
Higher	48.2	40.1	0.3	7.4	1.2	7.8	40.6

Wealth Quintile							
Poorest	50.7	68.1	0.6	2.9	1.4	14.1	9.8
Poorer	55.5	69.2	0.6	3.0	1.2	12.2	11.9
Middle	58.3	72.6	0.5	3.3	0.9	8.3	12.8
Richer	58.5	69.2	0.5	4.0	0.8	6.7	17.4
Richest	58.7	57.0	0.5	5.3	0.7	4.9	30.3
All India	56.5	67.2	0.5	3.7	1.0	9.0	16.8

Table 2 shows Pearson's correlation coefficients, which indicate the associations between married women's background characteristics and overall contraceptive use. Urban residence was positively correlated with modern contraceptive use ($r = 0.028$), spacing methods ($r = 0.065$), and men's condom use ($r = 0.095$) but negatively correlated with permanent methods ($r = -0.023$) and female sterilization ($r = -0.022$). This suggests that urban women are more likely to use reversible contraception, while rural women are more likely to use permanent contraception.

Hindu women were positively correlated with permanent methods ($r = 0.118$) and female sterilization ($r = 0.118$) and negatively correlated with spacing ($r = -0.065$). Muslim women were negatively correlated with permanent methods ($r = -0.130$) and female sterilization ($r = -0.129$) but positively correlated with spacing ($r = 0.073$), traditional methods ($r = 0.033$), and pills ($r = 0.101$).

Women from SC, ST, and OBC were positively correlated with permanent methods and female sterilization, whereas women from the general caste were negatively correlated with permanent methods ($r = -0.052$) and female sterilization ($r = -0.052$) but positively correlated with spacing ($r = 0.063$) and traditional methods ($r = 0.0280$). Women with no education were positively correlated with modern ($r = 0.0281$) and permanent ($r = 0.0282$) contraceptive methods and female sterilization ($r = 0.0283$) but negatively correlated with spacing ($r = -0.111$), male condoms ($r = -0.090$), and pills ($r = -0.039$). Women with primary education were positively correlated with modern ($r = 0.0284$) and permanent ($r = 0.0285$) contraceptive methods and female sterilization ($r = 0.0286$) but negatively correlated with spacing ($r = -0.029$) and condom ($r = -0.041$) use. Women with secondary and higher education levels were negatively correlated with modern methods, permanent contraception, and female sterilization but positively correlated with spacing contraception, pills, or condoms.

Poor women were negatively correlated with modern ($r = -0.056$) and permanent contraception ($r = -0.033$) but positively correlated with traditional methods ($r = 0.0287$).

Women from the richest households were positively correlated with modern contraceptive methods ($r = 0.0288$) and spacing contraception ($r = 0.0289$) but negatively correlated with permanent contraception and sterilization ($r = -0.046$). Male condoms were correlated with the wealthiest households ($r = 0.0650$), suggesting that poor women rarely used contraception, while rich women could afford contraception for spacing.

Table 2 - Pearson's correlation coefficient matrix of Contraceptive Users by Background Characteristics of Currently Married Women Aged 15-49 Years, India

Background characteristics	Modern Methods	Permanent Methods	Spacing Methods	Traditional Methods	Female Sterilization	IUCD/ PPIUCD	Injectables	Pills	Male Condom
Place of Residence									
Urban	0.028***	-0.023***	0.065***	0.011***	-0.022***	0.028***	-0.011***	-0.022***	0.095***

Rural	-0.028***	0.023***	-0.065***	-0.011***	0.022***	-0.028***	0.011***	0.022***	-0.095***
Religion									
Hindu	0.066***	0.118***	-0.065***	-0.026***	0.118***	-0.008***	-0.007***	-0.078***	-0.022***
Muslim	-0.071***	-0.130***	0.073***	0.033***	-0.129***	-0.003**	0.013***	0.101***	0.017***
Christian	-0.006***	0.012***	-0.023***	-0.014***	0.012***	0.014***	-0.005***	-0.009***	-0.028***
Sikh	-0.007***	-0.031***	0.029***	0.017***	-0.031***	0.010***	-0.007***	-0.017***	0.051***
Others	0.005***	0.005***	0.001	-0.011***	0.004***	0.007***	-0.001	-0.008***	0.003**
Caste									
SC	0.006***	0.021***	-0.018***	-0.005***	0.020***	-0.008***	-0.001	-0.010***	-0.013***
ST	-0.009***	0.018***	-0.034***	-0.010***	0.016***	0.004**	-0.003**	-0.001	-0.049***
OBC	0.003*	0.044***	-0.052***	-0.012***	0.045***	-0.007***	0.002	-0.069***	-0.015***
General	-0.002	-0.052***	0.063***	0.029***	-0.052***	0.011***	-0.002*	0.018***	0.069***
Highest educational Attainment									
No Education	0.046***	0.135***	-0.111***	-0.006***	0.134***	-0.051***	0.002	-0.039***	-0.090***
Primary	0.044***	0.068***	-0.029***	-0.011***	0.067***	-0.019***	-0.003**	0.019***	-0.041***
Secondary	-0.029***	-0.068***	0.049***	0.006***	-0.068***	0.033***	-0.000	0.037***	0.020***
Higher	-0.064***	-0.148***	0.105***	0.010***	-0.147***	0.039***	0.001	-0.023***	0.133***
Wealth Quintile									
Lowest	-0.056***	-0.033***	-0.030***	0.020***	-0.034***	-0.022***	0.010***	0.046***	-0.074***
Second	-0.009***	0.005***	-0.018***	0.005***	0.005***	-0.016***	0.006***	0.038***	-0.049***
Middle	0.019***	0.046***	-0.034***	-0.014***	0.046***	-0.006***	-0.001	-0.005***	-0.034***
Fourth	0.021***	0.027***	-0.007***	-0.017***	0.027***	0.009***	-0.005***	-0.027***	0.013***

Highest	0.023***	-0.046***	0.088***	0.007***	-0.046***	0.035***	-0.010***	-0.050***	0.143***
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* P<0.01, ** p<0.05 , ***p<0.0

Table 3 presents the results of a multivariate regression analysis examining the association between background characteristics and the use of different contraceptive methods among currently married women aged 15-49 years in India (NFHS 5). The dependent variables included the overall modern contraceptive prevalence rate (mCPR), permanent methods, spacing methods, and traditional methods. Rural residence was significantly negatively associated with overall mCPR (-0.006, $p < 0.01$) and spacing methods (-0.015, $p < 0.01$), but positively associated with permanent (0.008, $p < 0.01$) and traditional methods (-0.012, $p < 0.01$). This suggests that rural women are less likely to use modern and spacing contraceptives but more likely to rely on permanent and traditional methods, consistent with the patterns observed in the NFHS data.

Compared to Hindu women (the reference group), Muslim women showed significantly lower use of overall mCPR (-0.134, $p < 0.01$) and permanent methods (-0.220, $p < 0.01$), but higher use of spacing (0.086, $p < 0.01$) and traditional methods (0.013, $p < 0.01$). Similar but smaller negative associations with mCPR and permanent methods were observed among Christians, Sikhs, and other religions. These findings align with Jejeebhoy and Santhya's (2011) report of religious differences in contraceptive preferences, with Muslims favoring spacing methods over sterilization methods.

Scheduled Castes (SC) and Other Backward Classes (OBC) showed negative associations with overall mCPR (-0.018 and -0.008, respectively, $p < 0.01$) but positive associations with permanent methods (SC: 0.017; OBC: 0.051, $p < 0.01$), indicating a higher reliance on sterilization. Scheduled Tribes (ST) showed a negative association with mCPR (-0.027, $p < 0.01$) but no significant link with permanent methods. These patterns reflect the caste-based disparities in contraceptive use and method choice.

Increasing educational attainment was strongly associated with lower overall mCPR and permanent method use but higher spacing and traditional method use. For example, women with higher education had a substantial negative coefficient for mCPR (-0.220, $p < 0.01$) and permanent methods (-0.387, $p < 0.01$), but positive for spacing (0.167, $p < 0.01$) and traditional methods (0.033, $p < 0.01$). This indicates that education promotes reversible contraceptive use and reduces sterilization dependence, corroborating Pradhan and Dwivedi's (2015) findings.

Compared to the poorest quintile, higher wealth quintiles showed positive associations with overall mCPR and permanent methods, except for the richest quintile, which had a small positive association with spacing methods (0.008, $p < 0.01$). The richest group also showed a negative association with traditional methods (-0.038, $p < 0.01$). These results suggest that wealthier women are more likely to use modern contraception, particularly spacing methods.

Table 3 - Multivariate Regression Analysis of Type of Contraceptive methods in India

Background characteristics	mCPR	Permanent Methods	Spacing Methods	Traditional Methods
Place of residence				
Urban [@]	1.000	1.000	1.000	1.000
Rural	-0.006***	0.008***	-0.015***	-0.012***
	(-0.010 - -0.003)	(0.005 - 0.012)	(-0.018 - -0.012)	(-0.015 - -0.010)
Religion				

Hindu@	1.000	1.000	1.000	1.000
Muslim	-0.134***	-0.220***	0.086***	0.013***
	(-0.138 - -0.130)	(-0.224 - -0.216)	(0.083 - 0.090)	(0.011 - 0.016)
Christian	-0.133***	-0.150***	0.017***	0.004**
	(-0.139 - -0.127)	(-0.156 - -0.144)	(0.013 - 0.023)	(0.000 - 0.008)
Sikh	-0.086***	-0.150***	0.063***	0.044***
	(-0.096 - -0.077)	(-0.158 - -0.141)	(0.056 - 0.071)	(0.038 - 0.050)
Others	-0.049***	-0.111***	0.063***	0.001
	(-0.058 - -0.040)	(-0.120 - -0.103)	(0.056 - 0.070)	(-0.004 - 0.007)
Caste				
General@	1.000	1.000	1.000	1.000
Schedule Caste	-0.018***	0.017***	-0.035***	-0.014***
	(-0.022 - -0.014)	(0.013 - 0.021)	(-0.037 - -0.032)	(-0.017 - -0.012)
Schedule Tribe	-0.027***	0.002	-0.029***	-0.016***
	(-0.032 - -0.022)	(-0.003 - 0.007)	(-0.033 - -0.025)	(-0.019 - -0.013)
Other Backward Class	-0.008***	0.051***	-0.060***	-0.013***
	(-0.012 - -0.005)	(0.048 - 0.055)	(-0.063 - -0.057)	(-0.015 - -0.010)
Highest educational Attainment				
No education@	1.0000	1.000	1.000	1.000
Primary	-0.0107***	-0.056***	0.045***	0.006***
	(-0.0151 - -0.0063)	(-0.060 - -0.052)	(0.042 - 0.049)	(0.003 - 0.008)
Secondary	-0.1103***	-0.208***	0.098***	0.024***
	(-0.1137 - -0.1069)	(-0.211 - -0.205)	(0.095 - 0.101)	(0.021 - 0.026)
Higher	-0.2200***	-0.387***	0.167***	0.033***
	(-0.2253 - -0.2146)	(-0.392 - -0.382)	(0.163 - 0.171)	(0.029 - 0.036)
Wealth index				
Poorest@	1.000	1.000	1.000	1.000
Poorer	0.069***	0.073***	-0.005**	-0.017***

	(0.064 - 0.073)	(0.069 - 0.077)	(-0.008 - -0.001)	(-0.020 - -0.014)
Middle	0.113***	0.141***	-0.028***	-0.037***
	(0.108 - 0.117)	(0.136 - 0.145)	(-0.032 - -0.025)	(-0.040 - -0.034)
Richer	0.137***	0.168***	-0.031***	-0.046***
	(0.132 - 0.141)	(0.163 - 0.172)	(-0.035 - -0.027)	(-0.049 - -0.043)
Richest	0.170***	0.162***	0.008***	-0.038***
	(0.165 - 0.176)	(0.157 - 0.167)	(0.0040 - 0.013)	(-0.041 - -0.034)
R-squared	0.031	0.089	0.033	0.004

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

DISCUSSION

The findings indicate a need to promote spacing contraception in India and address factors influencing contraceptive use and family planning. Women aged 15-24 had lower contraceptive prevalence than older women, suggesting closely spaced pregnancies and sterilization after reaching desired family size. Population control efforts should shift from female sterilization to spacing methods, such as condoms, to support pregnancy interval. The government has initiated programs such as “Nayi Peהל,” which provides family planning kits to newlywed couples through Accredited Social Health Activists (ASHA), and “Saas Bahu Sammelans,” where influential family members discuss family planning.

Female sterilization is the preferred contraceptive method among poor and less-educated women, suggesting limited access to other methods. Wealthy women are more likely to use contraception and spacing methods such as male condoms. Therefore, spacing contraception should be promoted by offering contraceptive “choices” and ensuring local availability and affordability. The availability of Antara (injection), Chhaya (pills), Subdermal Single-Rod Implant, and Antara-SC (subcutaneous injection) will enable women to select methods that suit their needs.

The study also revealed a low use of male sterilization and male contraception, with condom use limited to urban and wealthy males. Men’s involvement should be promoted by removing myths about male sterilization, promoting No-scalpel Vasectomy (NSV), and increasing the local availability of male contraception, such as condoms. Interpersonal and hyper-local media should sensitize poor rural women to spacing contraception. As India’s fertility rate nears the replacement level, programs should shift from population control to healthy pregnancy and childbirth spacing, while promoting male involvement, demand generation, and female education and empowerment to increase contraceptive use and reduce socio-cultural inequalities nationwide.

Limitations

This study has several limitations. First, the NFHS-5 data are cross-sectional, which means that the observed associations between socio-economic and cultural characteristics and contraceptive method choice cannot be interpreted as causal. Second, contraceptive use was based on self-reported information and may be subject to recall and social desirability bias, particularly for sensitive topics such as traditional methods or male involvement. Third, although the analysis includes a wide range of socio-demographic factors, it does not capture all potential influences on contraceptive choice, such as quality of care, provider bias, or detailed community norms. Future research using longitudinal data and mixed-methods approaches could deepen our understanding of the pathways linking social context, service environments, and contraceptive decision-making.

CONCLUSION

This study provides a detailed, nationally representative analysis of how socio-economic and cultural factors shape contraceptive method choice in India, using the NFHS-5 data and distinguishing between permanent, modern spacing, and traditional methods. The findings confirm that India's family planning program remains heavily reliant on female sterilization, particularly among rural, poorer, and less educated women, while urban, better educated, and wealthier women are more likely to adopt spacing methods. Marked differences by religion and caste further highlight the deep-rooted sociocultural stratification in access to and use of various methods.

By documenting these patterns and their correlates, this study contributes to the literature in three main ways. First, it updates evidence on the method mix using NFHS-5, clarifying whether diversification in the method mix is occurring and for whom it is occurring. Second, it jointly examines socio-economic and cultural determinants—residence, education, wealth, religion, and caste—across permanent, spacing, and traditional methods, providing a more nuanced understanding of inequities in contraceptive choices. Third, it offers an empirical basis for designing equity-oriented and culturally sensitive family planning strategies for India.

Policy Implications

The policy implications of this study are clear. India's family planning program must move beyond its long-standing focus on female sterilization and prioritize the expansion of high-quality, client-centered counselling and access to a broader range of modern spacing methods. Policymakers and program managers should invest in targeted interventions in rural, poor, and less educated communities, strengthen supply chains and service infrastructure, and ensure that counselling is responsive to religious and cultural norms. Promoting female education and meaningful male involvement in family planning is also essential to increase informed choice and reduce socio-cultural inequities in contraceptive use. Addressing these priorities will be critical for achieving more equitable reproductive health outcomes and aligning India's family planning strategy with rights-based and choice-enhancing approaches.

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