India's Blueprint to Navigating Reproductive Choice

By Emma Beck, Account Executive, LEVICK

Amid the rhetoric of this presidential campaign cycle, women's reproductive health has emerged—and remains—a prominent talking point across party aisles. From passionate appeals to defund Planned Parenthood to Supreme Court proceedings weighing the legality of existing Targeted Regulation of Abortion Providers laws, the crusade for reproductive choice toes a challenging line. But while the U.S. confronts the showdown of government involvement in female reproductive matters, developing nations elsewhere have made progressive strides by offering women a new course in their right to reproductive choice.

Breaking decades-old traditions, Indian Prime Minister Narendra Modi has pledged to introduce the injectable contraceptive Depo-Provera (DMPA) into India's public health system by 2017. The landmark effort—one sanctioned by the World Health Organization as effective in preventing pregnancy for three months after the injection— represents an alternative to the mass female sterilization at the core of India's family planning processes. In a country of 1.2 billion, population control remains an undisputed priority.

While international observers have praised DMPA's

introduction, a micro glance at India's complex society makes the shift toward a safer and, importantly, temporary birth control option a challenging one. Rampant poverty, widespread illiteracy and general health misperceptions permeate the country, bearing the heaviest consequences among the nation's 68 percent rural population. The government's effort, therefore, will require a tailored approach that accounts for India's tremendous linguistic diversity and cultural sensitivities. This campaign must apply a hyperlocal focus on streamlining messaging and training health providers to reach the ultimate goal: enabling women to make an informed decision about their reproductive rights.

Among the steps the Indian government can take:

- **Cement the messaging:** Messaging will need to balance the delicate line of adhering to cultural sensitivities while ensuring transparency in disseminating information. Messaging across all streams must walk women through the tremendous health benefits of spacing out pregnancies via a reversible contraceptive option; underscore DMPA's safety and effectiveness; and emphasize that the injection will not be used coercively. Tapping into broadcast marketing—from aired commercials to packaged videos for smartphone applications—and the efficacy of on-the-ground and in-person conversations by health professionals, messaging must tailor appropriately to all facets of the population, both literate and illiterate. Moreover, these efforts should concentrate heavily on the nation's most vulnerable population most likely affected by coercive birth control methods: India's poor, rural women.
- **Start by educating local healthcare facilities and sterilization clinics:** In India's predominantly rural landscape, hyperlocal health professionals will serve as mouthpieces to inform the patients they work directly

with. Via partnerships with state and local healthcare providers, field workers can receive training on how to relay information in a manner that accounts for cultural diversity while establishing trust. Concurrently, implementing education programs across sterilization clinics will offer a foundation to teach health care providers about DMPA's viability as a birth control alternative.

- **Meet the women where they are:** Establishing trust begins by meeting women where they are. Field workers can go door-to-door across Indian cities, towns and villages to engage directly with the young women who would benefit most from DMPA.
- **Men, too:** In India's traditional society, men have significant sway in the health decisions made. Messaging must additionally target males to educate them on safer sex and contraceptive choice.
- **Incentivize the alternative:** Sterilization camps currently offer their patients, predominantly Indian women in their 20s, anywhere from 600 to 1400 rupees (roughly $10- $20) – funds welcomed and too oft needed to provide an impoverished family food for the week. Sourcing government funding, healthcare providers can work alongside healthcare facilities and sterilization clinics to offer incentives that match those currently provided to encourage sterilization.

Indeed, the myriad of challenges surrounding this initiative require a grasp of India's historical population control practices. Sterilization emerged as the dominant family planning method in the 1960s, with the government issuing quotas and monetary incentives to those who underwent the procedure. At the time, men received the brunt of coercive tactics forcing them to receive vasectomies. By the 1980s, intense male resistance realigned sterilization expectations

onto women of childbearing age. Today, of the 54 percent of the Indian population who use contraception, female sterilization accounts for 34 percent of all methods. Male vasectomies, which make up one percent of contraceptive use, remain a highly scrutinized practice.

India's DMPA introduction will set important precedence for countries such as China and Peru in which dated methods of birth control, including sterilization, remain the norm. This campaign presents a chance to address the 21st century's reproductive concerns within the context of cultural complexities. Done correctly, India could leave developing nations a promising blueprint to educate and empower women on the value of reproductive choice.

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