MALE CONTRACEPTIVE OPTIONS AND MEN’S ROLE IN FAMILY PLANNING
Population growth is often called the “elephant in the room.” Too many fine people continue to steer a wide berth around the topic for fear of being tagged with one negative label or another.

It may be uncomfortable to talk about population growth. But it’s absolutely essential. In fact, real elephants are endangered today because of the soaring population and shameful behavior of our own heedless species.

A big part of the problem arises because many decent, intelligent people don’t quite know how to talk about population. And, yes, some do tend to worry a bit too much that they might offend someone, somewhere.

Let’s start by acknowledging up front that horrific things have been done under the false flag of “population control.” Some 70,000 American women were forcibly sterilized over the first seven decades of the 20th century. The spurious pseudoscience of eugenics was deployed to promote ideas and practices as a cover for racism. Like some infectious disease, eugenics fever swept up many otherwise estimable people in the late 19th and early 20th centuries, including Charles Darwin, Teddy Roosevelt, and even Helen Keller.

These accomplished, yet imperfect humans were sadly all too willing to consign their fellow imperfect humans to fates they did not deserve.

Now we know better. Social engineering is a blind alley when it comes to that most personal and private of matters — the decision about when and whether to bear children.

We’ve now amassed an avalanche of evidence to demonstrate incontrovertibly that, when we successfully uphold all individual reproductive rights as an ethical imperative, population challenges evaporate.

At the time of our founding as Zero Population Growth in 1968, there were only four nations on Earth at or below “replacement rate” — which is just above two children per woman in places with low mortality. Today, there are nearly 100 such nations. With the exception of China and Peru, (and, to a lesser extent, India) which have engaged in widespread, deplorable coercive practices, it’s been accomplished through voluntary methods. Empowering women works. Smashing all barriers to reproductive healthcare works.

Yet this mission remains far from accomplished. We’re still adding a billion people to our already overcrowded planet every dozen years. Species are vanishing. And climate chaos is a direct result of population growth.

We simply can’t afford not to talk about population growth. Not if we care about our living planet.

The right way to talk population is the rights way: Every person everywhere has the inalienable right to determine their own reproductive destiny. No exceptions, no conditions. Rights are rights are rights.

When the population issue was percolating a century ago, we humans lacked the technology to manage our fertility. Times change, and we need to change with the times. Women now have a wide array of effective options — or they would if it weren’t for retrograde politicians. And this magazine issue highlights the vital, unfinished business of male contraception.

We need to tell the honest truth that population growth threatens our planet. Silence is not an option.

John Seager
john@popconnect.org
A New Push for the Male “Pill”

What Do Men Have to Do with Women’s Reproductive Rights?

Men in Rural Ethiopia Show That Family Planning Is Not Just a Women’s Issue

Can Niger Break Out of Its Cycle of Poverty?

In West Africa, Clinics Confront Suspicion, and Husbands, One IUD at a Time

For Nigerian Mothers, Escape From Boko Haram Shakes Up Childbirth Customs

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Cover Image:
Chum Dam, a 41-year-old Cambodian father, sits in an assessment room prior to his vasectomy procedure. Photo: Marie Stopes International, Courtesy of Photoshare
“What about men?” is one of our members’ most frequent refrains when it comes to talk of family planning — and not in the *Portlandia* sense of the phrase (tinyurl.com/PortlandiaMen).

Right now the chemical burden for contraception relies solely on the female. That’s an unfair balance in the equation,” says Charles Easley, an assistant professor at the University of Georgia, who is involved in the development of a male pill.

I agree with this understatement. I think most people would agree that it’s about time there was an effective, reversible method of male birth control besides condoms. Instead, it seems like we’re always a couple of years away from a pill or injection that will temporarily suspend male fertility. The drug trials continue without producing anything market-ready, and that’s been the case for many years.

A male pill remains elusive for a couple of reasons, Easley says. “I think there’s not much activity in this field because we have an effective solution on the female side.” Others describe the infinitely more difficult job of halting sperm production — millions are created in the testes every single day — over stopping the release of one egg per month or preventing a fertilized egg’s implantation in the uterus.

Here are the reversible methods that have reached the stage of clinical trials (but don’t hold your breath — they’re still at least a few years away from FDA approval):

- An injection to stop spermatogenesis (the creation of new sperm) was very effective in a multi-country trial, but caused such unbearable side effects that the study was ended early. (To the jeers, it should be noted, of women who have endured the side effects of hormonal contraception for over 50 years.)
- Vasalgel has tested effective on monkeys but has not yet been tested on humans. The gel is injected into the vas deferens — the tubes that get snipped in a vasectomy — and blocks sperm from traveling from the testicles to the urethra, thus preventing sperm from leaving a man’s body. The gel can theoretically be dissolved when a man wants to resume his fertility. Another version of the gel, RISUG, is expected to launch in India over the next couple of years.
- Bimek SLV is a valve operated by a switch that is implanted in each vas deferens (there are two, corresponding to each testicle) and can be manipulated through the skin by the user. The only test subject at this point is its creator, Clemens Bimek. Obviously.

For now, men are stuck with condoms, vasectomy, and withdrawal, and whatever method of birth control their female partners may be using.

Vasectomy is an excellent option for those who do not want biological children or have already had as many as they want. The Affordable Care Act doesn’t require vasectomy to be covered by insurance companies, so it’s up to individual insurers whether to cover it and to what level. (Three states — Illinois, Maryland, and Vermont — have laws requiring vasectomy coverage at no cost to the insured because their leaders understand that preventing unintended pregnancy is always the fiscally and socially responsible thing to do.)

And although not a perfect solution for everyone, the effectiveness (when used perfectly) of condoms at preventing pregnancy and sexually transmitted infections cannot be beat.

In the meantime, the role of men is primarily to support their female partners in using whatever method of contraception is right for them. That’s the majority of what the articles in this issue explore.

*Marian Starkey*
marian@popconnect.org
Letters to the Editor

Just want you to know how pleased I am with the work you continue to do — sometimes in the face of great opposition.

Eliezer T. Margolis, PhD

Over these past few years of reading your magazine, I’ve come to realize that “Population Connection” has moved a long way from its earlier “Zero Population Growth” agenda. Rather than supporting ways of reducing population growth and ultimately reducing population, the organization seems to have become a spokesperson for the Democratic platform. Not that I disapprove of the Democratic platform, but I don’t support either party’s platform and will not support either party financially.

Neither Democrats nor Republicans will ever resolve the population problem. They will argue about the actions that are needed to deal with the myriad of symptoms (air pollution, water pollution, global warming, deforestation, species extinctions, etc.). Further, attempts to tie pet Democratic political positions to population growth is counterproductive and confounding.

When your organization returns to the population issue and that issue alone, I will return, but until that time I’ll continue doing what I can on my own.

Steve Albert

Thanks for your comments. We try hard to stick close to our mission (I might add that Population Connection scrupulously avoids partisan electoral activity, while Population Connection Action Fund engages in that area as a sister organization).

Unfortunately, the Republican party (with sadly rare exceptions) has abandoned its once-strong support for programs that advance our mission of population stabilization. Presidents Nixon and Ford supported key programs, as did the young Congressman George H.W. Bush. Even 20 years ago, there were about 40 House Republicans who supported family planning. Today, there is only one, even on a good day (Rep. Charlie Dent (R-PA/15), and he’s retiring.) We appreciate the two Senate Republicans (Lisa Murkowski and Susan Collins) who are great supporters. But the other 50 Republican senators are solidly aligned in opposition.

The fact is that, when Obama took office, funding for international family planning was boosted by 40 percent. Now Trump wants to eliminate all such funding.

We just follow the facts where they lead. Nothing would please us more than to see both major parties competing to do more for our cause. As it is, the members of one party (Democratic) are mostly supportive, while members of the other (Republican) are almost universally opposed.

As Walter Cronkite used to say, “That’s the way it is.”

– John Seager
Contraceptive Methods,
Their Use & Effectiveness

Seven percent of men ages 15–44 have had a **vasectomy**; this proportion increases with age, reaching 16% among men ages 36–45.

**Illinois, Maryland, and Vermont** require private insurers to cover vasectomy, which is not covered without copay under the Affordable Care Act. **New York** is considering a similar requirement.
### Most Effective Method Used in the Past Month by U.S. Women

<table>
<thead>
<tr>
<th>Method</th>
<th>No. of Users</th>
<th>% of Women Ages 15-44</th>
<th>% of Women at Risk of Unintended Pregnancy</th>
<th>% of Contraceptive Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>9,720,000</td>
<td>16.0</td>
<td>23.3</td>
<td>25.9</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>9,443,000</td>
<td>15.5</td>
<td>22.6</td>
<td>25.1</td>
</tr>
<tr>
<td>Male condom</td>
<td>5,739,000</td>
<td>9.4</td>
<td>13.7</td>
<td>15.3</td>
</tr>
<tr>
<td>IUD</td>
<td>3,884,000</td>
<td>6.4</td>
<td>9.3</td>
<td>10.3</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>3,084,000</td>
<td>5.1</td>
<td>7.4</td>
<td>8.2</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>1,817,000</td>
<td>3.0</td>
<td>4.4</td>
<td>4.8</td>
</tr>
<tr>
<td>Injectable</td>
<td>1,697,000</td>
<td>2.8</td>
<td>4.1</td>
<td>4.5</td>
</tr>
<tr>
<td>Vaginal ring</td>
<td>759,000</td>
<td>1.2</td>
<td>1.8</td>
<td>2.0</td>
</tr>
<tr>
<td>Fertility awareness methods</td>
<td>509,000</td>
<td>0.8</td>
<td>1.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Implant</td>
<td>492,000</td>
<td>0.8</td>
<td>1.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Patch</td>
<td>217,000</td>
<td>0.4</td>
<td>0.5</td>
<td>0.6</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>91,000</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Other methods*</td>
<td>133,000</td>
<td>0.2</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>No method, at risk of unintended pregnancy</td>
<td>4,175,000</td>
<td>6.9</td>
<td>10.0</td>
<td>n/a</td>
</tr>
<tr>
<td>No method, not at risk</td>
<td>19,126,000</td>
<td>31.4</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60,887,000</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Note: "At risk" refers to women who are sexually active; not pregnant, seeking to become pregnant, or postpartum; and not sterile.*

### Proportion of Women Who Will Become Pregnant Over One Year of Use, by Method

<table>
<thead>
<tr>
<th>Method</th>
<th>Perfect Use</th>
<th>Typical Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>0.1</td>
<td>0.15</td>
</tr>
<tr>
<td>IUD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levonorgestrel-releasing</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Copper-T</td>
<td>0.6</td>
<td>0.8</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Injectable</td>
<td>0.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Pill</td>
<td>0.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Vaginal ring</td>
<td>0.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Patch</td>
<td>0.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Sponge**</td>
<td>9/20</td>
<td>12/24</td>
</tr>
<tr>
<td>Male condom</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Female condom</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Fertility awareness methods</td>
<td>0.4–0.5</td>
<td>24</td>
</tr>
<tr>
<td>Spermicides</td>
<td>18</td>
<td>28</td>
</tr>
<tr>
<td>No method</td>
<td>85</td>
<td>85</td>
</tr>
</tbody>
</table>

*There are only three male contraceptive methods, and two of them (condoms and withdrawal) have relatively high failure rates with typical use, due to user error (but to be clear: using condoms is still better than not using condoms!). Vasectomy is extremely effective, but permanent. There is a pressing need for a male method that is safe, effective, and reversible. Research on this front continues, but we’re still years away from a method that will be available to patients/consumers. See the article on page 10 of this issue for more in-depth information on current advancements and obstacles in developing this elusive method.*

— Marian Starkey

*Includes diaphragm, female condom, spermicides, cervical cap, sponge, suppository, jelly/cream, etc.

**First figure is for women who have not given birth; second is for women who have given birth.

Source: Guttmacher Institute
Trump Cuts Teen Pregnancy Prevention Funding

The Trump administration slashed teen pregnancy prevention grants by more than $200 million in July. The second cohort of five-year federal grants under the Teenage Pregnancy Prevention (TPP) Program, awarded in 2015, goes to 81 organizations. Their grants were supposed to run through 2019, but recipients were informed by the Department of Health and Human Services that the funding would end prematurely, on June 30, 2018.

The TPP was initiated by President Obama in 2010 to find evidence-based solutions to reducing teen pregnancy, with the aim of replicating those programs that worked best in other areas around the country. The first cohort of grant recipients, from 2010-2014, used either curricula that had been scientifically proven to reduce teen pregnancy rates or tested innovative new programs. This second cohort of grantees is building on that work.

Without TPP funding, 580,000 students will lose their existing medically accurate sex education.

According to the CDC:

- In 2010, teen pregnancy and childbirth accounted for at least $9.4 billion in costs to U.S. taxpayers for increased healthcare and foster care, increased incarceration rates among children of teen parents, and lost tax revenue because of lower educational attainment and income among teen mothers.
- Pregnancy and birth are significant contributors to high school dropout rates among girls. Only about 50 percent of teen mothers receive a high school diploma by 22 years of age, whereas approximately 90 percent of women who do not give birth during adolescence graduate from high school.
- The children of teenage mothers are more likely to have lower school achievement and to drop out of high school, have more health problems, be incarcerated at some time during adolescence, give birth as teenagers, and face unemployment as young adults.

Oregon Expands Abortion Access

Gov. Kate Brown (D) signed the Reproductive Health Equity Act into law in August. It requires insurance companies to cover birth control and abortion without copays and provides funding for the reproductive health of non-citizens who do not receive Medicaid coverage.

Chile Legalizes Abortion in Some Cases

Chile decriminalized abortion in August in cases of rape, when the pregnant woman’s life is in danger, and when the fetus is incompatible with life. President Michelle Bachelet has been urging the lifting of the total abortion ban since 2015, but faced serious opposition from the Catholic Church and evangelicals.

The Chilean Constitutional Tribunal ruled in favor of reversing the ban, 6-4.

Until Augusto Pinochet’s military dictatorship introduced the ban in 1989, abortion had been legal for medical reasons under the 1931 health code. Legislators have been attempting to reverse the ban since 1991.

An estimated 70,000 illegal abortions take place each year in Chile. Until the law changed, getting caught carried a penalty of five years’ imprisonment.

Court Rules Against Anti-Choice Non-Profit

A three-judge panel of the 3rd U.S. Circuit Court of Appeals in Philadelphia ruled in August that secular employers may not opt out of birth control insurance coverage for employees. The lawsuit was filed by Real Alternatives, a Pennsylvania nonprofit whose mission is to “empower women to protect their reproductive health, avoid crisis pregnancies, choose childbirth rather than abortion, receive adoption education, and improve parenting skills.”

Real Alternatives employs three people, who all receive company insurance; their wives and a combined seven children are also insured by the company.

25 Million Unsafe Abortions Worldwide Each Year

Safe Abortion Day, observed each year on September 28, highlights the plight of women who need abortions and can’t obtain them safely, often due to restrictive laws at the country level. The Guttmacher Institute and WHO estimate that of the 55 million abortions each year, 25 million are unsafe — meaning that they are performed by unskilled providers and/or performed using outdated or unsafe methods.
The study's authors found that “In countries where abortion is completely banned or permitted only to save the woman’s life or preserve her physical health, only one in four abortions were safe; whereas, in countries where abortion is legal on broader grounds, nearly nine in ten abortions were done safely. Restricting access to abortions does not reduce the number of abortions.”

**House Votes to Allow D.C. Employers to Discriminate Against Employees for Birth Control Practices**

The U.S. House of Representatives voted in September, for the third year in a row, to prohibit the District of Columbia from using federal funds to enforce the Reproductive Health Non-Discrimination Amendment Act, passed by the D.C. Council in 2014.

The law bans employers from discriminating against workers based on their use of birth control or whether they’ve had abortions.

Rep. Gary Palmer (R-AL) filed an amendment to the House appropriations bill for fiscal year 2018, and the House passed it, 214-194. It still has to clear the Senate, which is a long shot, and then get Trump’s signature, in order to become law.

**IL Gov. Rauner Expands Abortion Coverage, Removes “Trigger” Law**

Illinois Gov. Bruce Rauner (R) signed a bill into law in September that extends abortion coverage to Medicaid recipients and state employees. The legislation also overturned a “trigger” law that would have banned abortion in Illinois if Roe v Wade were overturned.

**HHS Reverses ACA Birth Control Benefit**

In October, the Trump administration released a long-rumored rule gutting the birth control coverage requirement in the Affordable Care Act. While not directly a result of the Real Alternatives case on the preceding page, the action will effectively overturn that decision and allow any employer to opt out of birth control coverage for pretty much any reason whatsoever. The birth control benefit required employers to cover all forms of birth control, without copay, in their employees’ health insurance plans. Exceptions existed for houses of worship and closely held private companies (after craft chain Hobby Lobby won a Supreme Court case in 2014), but critics insisted that the exceptions didn’t go far enough — they wanted all employers to be able to refuse coverage based on religious or “moral” objections.

The rule reversal was instituted by the Department of Health and Human Services and applies even to publicly traded companies, effective immediately. The Center for Reproductive Rights, National Women’s Law Center, and ACLU are planning to challenge the rule change in court.

**20-Week Abortion Ban Passes House**

The U.S. House of Representatives voted in early October to impose a 20-week abortion ban. The vote occurred on the very same day that one of the bill’s cosponsors — Rep. Tim Murphy (R-PA) — was publicly outed in the Pittsburgh Post Gazette for encouraging the woman he was having an extramarital affair with to get an abortion during a pregnancy scare in January. Rep. Murphy has announced that he won’t seek reelection in 2018.

Rep. Murphy is a member of the House Pro-Life Caucus. He has long cosponsored the so-called “Pain-Capable Unborn Child Protection Act,” which will go to the Senate for consideration now that it has cleared the House. Trump has said that he’ll sign the bill if it reaches him, which is unlikely, since the Senate would need 60 votes to pass it.

**Trump’s Awful “Wish List”**

A Trump administration “wish list,” submitted to the Office of Management and Budget, was obtained by Crooked Media in October, and it is horrible. It calls for ending UNFPA, Title X, and teen pregnancy prevention funding, and requires a new focus on fertility awareness methods of family planning (the same methods that have a 24-percent failure rate per the chart on page 5). It cuts Healthy Start and childhood obesity programs for the same kids members of the religious right supposedly care so much about.

The atrocious document can be viewed and downloaded on the Crooked Media website: tinyurl.com/CrookedWishList.
Population Connection’s ZPG Society honors those who have included Population Connection in their estate plans. We are grateful to our ZPG Society members for their generosity and far-sightedness. Thank you!

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<thead>
<tr>
<th>Name</th>
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</table>
What Will Your Legacy Be?

If you aren’t yet a member of the ZPG Society, have you considered becoming one? The simplest way for you to ensure that your dedication to Population Connection’s mission continues well into the future is through a gift — a bequest — in your will. You can create a bequest by adding just one sentence to your will. And that sentence can make the difference of a lifetime!

Contact:
Shauna Scherer at shauna@popconnect.org or 202.974.7730 or Abigail Lunetta at abigail@popconnect.org or 202.974.7757

Sample Bequest Language:
After fulfilling all other provisions, I give, devise, and bequeath ___% of the remainder of my estate [or $___ if a specific amount] to Population Connection (Tax ID #94-1703155), a charitable corporation currently located at 2120 L Street NW, Suite 500, Washington, D.C. 20037.
A New Push For The Male “Pill”
AN INTERNATIONAL CLINICAL TRIAL WILL GIVE A CONTRACEPTIVE GEL A TEST DRIVE

By Dina Fine Maron | Originally published by Scientific American

The creators of a male birth control gel designed to inhibit sperm production — while maintaining healthy testosterone levels in the bloodstream — will soon start recruiting 420 couples from around the world to enroll in a new clinical trial.

Male participants will apply the hormonal gel to both shoulders once a day. Then, after lab testing indicates their sperm counts have been suppressed to extremely low levels (which could take two to three months), the couples will be tracked for a year while they use the gel as their lone form of contraception.

The project, led by the U.S. National Institutes of Health (NIH) and the Population Council, is expected to begin signing up couples in early 2018, along with collaborating partners at nine locations in the U.K., Sweden, Italy, Chile, Kenya, and several medical centers in the U.S. Once these sites get institutional and national review board sign-offs, the study will test whether the latest version of a hormonal birth control system for men can overcome the myriad obstacles that have sidelined earlier efforts. Just last year a clinical trial of a hormonal male contraceptive shot was shut down after some participants suffered concerning side effects.

Right now, options for male birth control are few — condoms, vasectomy, and withdrawal — and there is no equivalent of “the pill,” a hormonal contraceptive used by women, that would limit sperm production. Yet vasectomy requires surgery and is not always reversible, condoms are often used inconsistently, and withdrawal is unreliable.

That’s why the NIH team has turned to its new experimental gel. It introduces into the bloodstream a combination of the hormones progestin — which suppresses sperm creation in the body — and testosterone. An earlier version of this approach appeared promising in a small, six-month pilot trial, in which gel application reduced sperm production while maintaining healthy testosterone levels. In about 89 percent of users, sperm counts were reduced to one million per milliliter or less (a point typically considered to indicate successful sperm suppression). “That number — 89 percent — may sound low, but we suspect that there was some level of noncompliance, since the men in that pilot trial were not using this for contraceptive purposes,” says Diana Blithe, who is leading the gel trial as chief of the contraceptive development program at the NIH’s National Institute of Child Health and Human Development. By way of comparison, among women the typical failure rate for oral contraceptives hovers around 9 percent due to noncompliance and imperfect use, putting it in striking distance of the male gel sperm-suppression numbers.

Researchers have been trying for decades to deliver on male hormonal birth control. Theoretically this would inhibit sperm production in men, much as the pill blocks women’s ovaries from releasing eggs. But in practice it is far more complex. In women the pill essentially tricks the body into acting as though it already is pregnant, making it temporarily infertile. Among men a hormonal contraceptive could inhibit testosterone production in the testes, reducing sperm levels. It would, however, simultaneously decrease testosterone in the blood — which would cause intolerable side effects that include impeded ejaculation as well as altered libido and muscle mass. So the biggest hurdle to developing a male contraceptive pill has been the difficulty of providing replacement testosterone in oral form, Blithe says. The hormone would leave the body too quickly, rendering such a pill impractical because men would have to take it too many times a day.

Blithe’s contraceptive gel aims to get around those problems by steadily adding testosterone back into the bloodstream through the skin — at levels low enough to avoid promoting sperm production in the testes but high enough to prevent problematic side effects. “The amount of testosterone needed for sperm production in the testes is believed to be about 50 to 100 times greater than what is needed in the blood for other functions,” she notes.
Her team’s effort comes on the heels of a troubled, high-profile male contraceptive trial. Last year a study headed by the World Health Organization and a reproductive health institute called CONRAD reported a hormone injection suppressing sperm production in men was about 96 percent effective. (The NIH had no role in that project.) The shot — which men needed to receive every two months — included testosterone and progestin. Despite the injection’s effectiveness, the study was halted early when male volunteers experienced side effects including depression, acne, and mood swings. Twenty of the 320 participants in that trial dropped out citing problems such as mood changes, erectile dysfunction, or pain. One participant’s sperm levels had not returned to normal four years after an injection and remain at levels considered subfertile, says Douglas Colvard, a reproductive expert at CONRAD and one of the lead investigators of the hormonal shot effort.

Yet even with those side effects there was still a lot of interest in the product. The remaining trial participants mostly praised the injections and said they were still interested in continuing to use them, even after the scientists brought the test to a halt.

Blithe and her team expect their approach to be largely free of the side effects seen with the injection, because the daily gel applications would release the hormones more consistently. The most common side effect would likely be acne, according to Blithe. In the pilot study, a small number of men reported acne, increased appetite, decreased libido, mood swings, headaches, or insomnia — side effects also seen among women who take oral contraception. Unlike the gel, Blithe notes, the shots contained large levels of hormones that were introduced every eight weeks and then decreased in the body at varying rates until the next injection, likely contributing to the negative side effects.

Colvard, who is not involved with the gel effort, says it seems promising. “We don’t know for a fact that the fluctuating hormones in [our] study were the only cause of the side effects that occurred, but it’s plausible, given that behavioral changes occur during different hormonal cycles in men — like when teenagers hit puberty,” he says. For now his group is analyzing links between some of the mood swings seen in its study and hormonal fluctuations in the weeks following the injections, he says.

Aaron Hamlin, executive director of the Male Contraception Initiative — a nonprofit organization that funds and advocates for nonhormonal male birth control — says a gel that continuously delivers a hormone makes sense. “If you are able to spread the dosage out over more time, intuitively it seems like a better approach than having spikes that occur every so often, like with the shot,” he says. But he cautions that reversible nonhormonal methods — those that block sperm from fertilizing eggs without introducing hormones into the body — would still be preferable, because any hormone-based intervention would be subject to months-long delays between when a man starts using it and when his sperm production is sufficiently suppressed. The body, Hamlin notes, must also clear a reserve of sperm that existed before the treatment began. He is also concerned about the side effects of hormonal birth control, and the consideration that it may not adequately suppress sperm count in all men.

Yet nonhormonal methods (beyond vasectomies and condoms) that seek to impede egg fertilization have yet to reach the same level of testing in men. Animal tests have been performed with a couple of products including a compound called H2-gamendazole, which keeps sperm from reaching maturity so they are not fully developed when they are ejaculated — causing men to essentially “shoot blanks.” Another non-hormonal product, called Vasalgel, is a polymer hydrogel that physically blocks sperm in the vas deferens so they cannot reach an egg. Researchers published promising results with Vasalgel in rabbits and monkeys earlier this year but its maker says it has no timeline for human clinical trials. Yet another product, Gendarussa, was created by researchers at Airlangga University in Indonesia. It prevents sperm from fertilizing an egg via a mechanism that remains unclear — and the Indonesian team has not published results from its phase I human trials — so it is hard for outsiders to assess the product’s success or science, Blithe and Colvard say. Gendarussa has, however, received clearance from the Indonesian equivalent of the U.S. Food and Drug Administration to proceed with phase II trials, says Paul Feldblum, a senior epidemiologist in global health trials — so it is hard for outsiders to assess the product’s success or science, Blithe and Colvard say. Gendarussa has, however, received clearance from the Indonesian equivalent of the U.S. Food and Drug Administration to proceed with phase II trials, says Paul Feldblum, a senior epidemiologist in global health research at FHI 360, a human development organization that helped develop some protocols for the trial’s next phase. Gendarussa’s creators did not respond to a request for comment.

Despite their different methods, all these products have one thing in common: They are designed to fill the massive need for more contraceptive options. In 2012, 40 percent of all pregnancies worldwide were unintended, according to the Guttmacher Institute. New forms of birth control, reproductive specialists hope, could help slash those numbers.
On his third day in office, President Trump signed the new and worse Global Gag Rule, a restriction on international organizations that receive U.S. global health assistance that blocks them from using their own, non-U.S. funds to provide or refer women to abortion services. And lest we forget: He signed that presidential memorandum with seven men and zero women standing behind him.

The disturbing image of a group of men literally blocking women’s access to abortion conveys the narrative of centuries of men controlling women’s bodies and lives. So, to the question, “What do men have to do with women’s reproductive rights?” the obvious answer in these political times seems to be: Stay out. It might be that we want men to have little or nothing to do with women’s sexual and reproductive health and rights.

But would women be better off? Excluding all men from discussions around sexual and reproductive rights is a disservice to women. It keeps the burden for contraception on women. It halts efforts that encourage men to support the reproductive choices of their female partners, and perpetuates a culture in which no man is perceived to be, or engaged to be, an ally in ensuring reproductive rights of all people.

Clearly, men matter in this discussion. There is the obvious point that, in the context of heterosexual relationships, men are half of the human reproductive process. However, they represent only about one-quarter of total contraceptive use, including withdrawal, vasectomy, and male condoms. That proportion has remained virtually unchanged since the 1980s, despite the fact that vasectomy is cheaper and safer than female sterilization. And, while condoms may not be the long-term contraceptive solution for many couples, they have the added protection of STI and HIV prevention.

There are other male contraceptive methods in various stages of development. The most recent trial of a male hormonal contraceptive method was halted in 2016 due to negative side effects. Some women’s health advocates pointed out that the decision represented a double standard, given that trials for women’s hormonal contraceptives have continued despite multiple side effects experienced by women.

Here’s the other reason we need men on board: Millions of women report not using contraceptives because of their husbands. In 2012, the UN Population Fund (UNFPA), the Gates Foundation, and the UK government, among others, created Family Planning 2020 (FP2020), with the goal of reaching 120 million of the world’s poorest women with contraception. At their meeting in London in July, coordinators of the Family Planning 2020 partnership acknowledged they had only achieved about a quarter of their target and that a key obstacle was men’s attitudes toward women’s usage of family planning. Currently, the FP2020 initiative has no target for increasing men’s use of contraceptives. Given the realities of sex and reproduction, we may never achieve a truly equal sharing of the contraceptive burden — but we can do better.

At the very least, donors, governments, and public health agencies need to talk to men about supporting women’s reproductive health. Studies from many of the world’s poorest countries show that many men want more children than their female partners, while in other countries, many men support their wives’ decisions to have fewer children. We cannot rest until that becomes all men.
What about access to safe and legal abortion? Shouldn’t abortion stay in the realm of exclusively women’s decision-making? The answer is a definitive yes. Her body, her decision. In practice, though, many women confide in male partners on this issue. Household surveys coordinated by Promundo in several countries found that between 40 percent and 90 percent of women said that they involved a male partner in a decision to have an abortion. We can’t assume this is always a positive involvement on the part of male partners. But we can work to make men’s involvement respectful and supportive. Women and men, boys and girls, of all ages should be educated about contraception and abortion, and why both are critical components of comprehensive health services and rights. In addition, surveys in the U.S. show that men are as likely as women to support keeping abortion legal. Maybe it’s time for those men to speak up.

We need men around the world, from the heads of foreign assistance, to health policymakers, to male partners and husbands to join women and show in their voting, their voices, and their decisions that they stand up every day for women’s reproductive rights. We need fathers and mothers around the world to talk to their children, from early on, in open and feminist ways, about sex, sexuality, gender identity and expression, choice, rights, and contraception. We need men and women to vote for school board members who support comprehensive sexuality education, and speak out against violence against women.

Until every woman in the world has access to modern contraceptives, safe abortion, and bodily autonomy, we all must talk about family planning. At home, in the classroom, and in the halls of power.
Sileshi Deguale was busy working alongside his family, preparing their land for planting season, but he paused to recall how difficult the work was last year. His wife had been too ill to help with the farming. It was around that time he made the biggest decision of his life, a choice that would help his wife regain her health by protecting her from unplanned pregnancies — he got a vasectomy.

Vasectomies are a relatively common form of contraception in places like Australia, South Korea, and the United Kingdom, according to recent UN statistics. But the procedure is less popular in other parts of the world, and in Ethiopia, vasectomies are rare. Perceptions about masculinity prevent many men from considering it as a contraceptive option.

Still, Mr. Sileshi says he is confident he made the right decision.

He and his wife already have six children. He did not want to burden her with sole responsibility for their family planning.

“My wife tried both short- and long-term family planning methods for some time, but they did not go well with her health,” he remembered.

Improving Access to Family Planning

Ethiopia is working to improve access to modern, reliable forms of contraceptives. In recent years, the country’s health extension program has brought family planning services to people’s doorsteps.

UNFPA is supporting these efforts by training healthcare workers — including physicians, nurses, midwives, and health extension workers — to provide sensitive counselling about contraceptives. All family planning decisions must be fully informed and voluntarily.

UNFPA also supplies Ethiopia with a variety of modern contraceptives, aiming to increase the family planning options available. Around one-third of the required reproductive health commodities and life-saving reproductive health medicines in Ethiopia are being provided through the UNFPA program known as UNFPA Supplies.

These efforts are showing results.

The use of modern family planning methods among married women increased from 8 percent in 2000 to 36 percent in 2016, according to a recent survey. And since 2012, the country has added over two million new users of modern contraception.

Family planning saves lives by decreasing the incidence of pregnancy complications and unsafe abortions. The increased contraceptive use in Ethiopia is estimated to have averted two million unsafe abortions and 20,000 maternal deaths.

Still, the country has a long way to go.

Currently, over one in five Ethiopian women has an unmet demand for
family planning, according to the recent national survey, and this figure is much higher in rural areas.

**A Trailblazer**
Most users of contraceptives are women, and in many communities, family planning is considered a women’s issue.

Mr. Sileshi saw things differently. In this way, he has been a trailblazer.

When community health workers visited his area to talk about family planning, he was eager to listen. And when the contraceptive methods were explained, he knew immediately what he wanted to do.

He conferred with his wife, and then headed to the nearby Yeduha District Hospital to get the vasectomy.

He is one of three men in his sub-district who have undergone the procedure.

“I have no regrets for the decision I took, despite the fact that people in the community continue to ridicule me,” Mr. Sileshi said.

His wife’s health has improved, and with it, the welfare of their family, he said.

He now advises other men in his community to consider this method of family planning.

unfpa.org/news/men-rural-ethiopia-show-family-planning-not-just-womens-issue
Africans's population is expected to double by 2050, but in the country with the highest birth rate in the world it's on track to triple.

In Niger, women have an average of 7.6 children each — and in rural Zinder the rate is even higher.

Not surprisingly, it's more than just a statistic in almost every village you visit — there are kids everywhere.

Even the children have children — more than half the girls are married before the age of 15.

As economies grow and both countries and their people get richer, the number of babies being born naturally begins to fall, but Niger is also one of the world's poorest countries.

“In Niger, we have a national characteristic which is pro-birth, where having children is considered a traditional sign of wealth and power,” said Dr. Hassane Atamo, head of the government’s family planning division.

“The immediate consequences of having such a high birth rate is that it’s impossible to feed, educate, and care for all these children in the short term.

“In the long term, the very survival of the country is threatened unless we take this window of opportunity to make the most of this youth dividend.”

Most of the economy is in agriculture — subsistence agriculture — and barring a dramatic transformation it’s an opportunity that may not be taken.

And so in the village of Angoual Gao they’re getting plenty of outside help to try to encourage better family planning.

Tucked away amid the thick mud-walled compounds a group of young women are sitting having very frank conversations about contraception, forced marriage, or the problems of marrying young and having children early.

It’s what the aid workers call “a safe space” for girls — and some of them are as young as 10.

Saratou Kanana, 27, is one of three older girls trained to lead the conversation.

She’s had four children, but despite all the talk of “spacing” births — leaving it longer between each child — she won’t say how many more kids she wants.

“It all depends on Allah,” she said. But it is a little more complicated than that.

After dodging a question asked a few different ways, the translator finally explained.
As a woman, she has no say. It depends on her husband. If her husband decides to stop having children, then she can go to the health center and stop. “But here it all depends on the husband. The last word is from the husband.”
As a woman, she has no say. It depends on her husband. If her husband decides to stop having children, then she can go to the health center and stop. “But here it all depends on the husband. The last word is from the husband.”

Smaller Families

And so on the other side of town the men are sitting cross-legged under a tree and chatting about similar things — they call it husband school.

Health, education, and talk of the millet harvest is interspersed with chats about breastfeeding and spacing children.

Although Musa Malamharu, 47, is leading the conversation, he has two wives.
If there’s more certainty in life people don’t need as many children, but it’s getting over the “national characteristic.”

Mudaha Musa, 27, seems persuaded that five or six children — two or three more than he has at the moment — are probably sufficient.

“Truly there is a problem here with having too many children,” he admitted, “but with husband school we’ve begun to see the benefits.”

Education appears to be the key to reducing the number of babies born.

At a mobile clinic well off the main road a small open room is packed full of women and small children.

The nurses are handing out different contraceptive methods for the crowd to inspect.

There are condoms, femidoms [female condoms], pills, IUDs, and even a discussion about birth control implants.

That’s when Nana Aisha, 28, stepped up and said that’s what she’s agreed — despite fears about the pain and the dangers — to have a three-year implant injected in front of everybody.

“I’m just going to show to the other ladies, because there are some false rumors that it might be something that can get stuck inside of muscles,” she said, and it was over in an instant.

Some of the women gathered round to prod and poke at her arm — the implant clearly visible beneath her skin.

She has three children, but will put off having any more for at least the next three years.

“My husband is an educated person. He’s actually the one who’s encouraging me to go to the health center for family planning,” she said.

But even if many people are persuaded, the dramatic growth of population in Niger will take a long time to slow down.

Its population of 21 million people is predicted to exceed 68 million in the next 30 years.

“Yes the culture is changing. Because it’s women themselves who understand that having many children is a problem for themselves,” said midwife Furera Umarou.

She believes those couples who are persuaded may have four or five children rather than eight or nine — it’s a start.

There’s much talk of a “demographic dividend” — the ability of a young and active workforce to catapult economies out of poverty as fertility and mortality decline, but that needs investment and jobs for them to fill.

“If we don’t capture the benefits of the demographic dividend, we will be thrown into a total state of disequilibrium,” said Dr. Hassane Atamo.

“That could threaten the survival of the country and encourage different things like terrorism and emigration.”

A vast pool of jobless young people could be set on the migrant trail to Europe, or into the hands of Islamist extremists like Boko Haram.

Massive population growth is everyone’s problem.
In West Africa, Clinics Confront Suspicion, and Husbands, One IUD At a Time

By Ike Swetlitz; Kate Sheridan contributed reporting | Originally published by STAT

It was after dark when a woman and her husband arrived. They crossed the dirt road and entered the cement building in a western neighborhood of this sprawling West African capital.

He had a demand: Remove the metal rods you've put in my wife's arm. He'd heard rumors that the strange technological device was going to give her cancer, and it needed to go.

The nurse on duty at the health clinic, Bernadette Nassa, was insistent. She explained that the tiny rods were there for a reason: They provided the woman's body with a hormone to keep her from having children. She needed to give her body rest before becoming pregnant again. Eventually, the husband relented.

But, Nassa said, there’s not always a happy ending. She’s seen women whose husbands insist on a divorce if their wives use contraception.

Such encounters underscore the difficulty of providing contraceptive services and women's healthcare in [Burkina Faso] — and in other developing countries — where reproductive health education is limited and husbands make many decisions for their wives.

But since May, the clinic has had a new partner: Pathfinder International, a nonprofit geared toward increasing global access to reproductive health services. And soon many more clinics could receive their help. In November Pathfinder received two grants totaling about $10 million from the Bill and Melinda Gates Foundation, based in part on the work they’ve done in Burkina Faso, to study how to help women get access to contraception.

For instance, Nassa’s clinic is one of 84 in Burkina Faso that have received the tools to insert an intrauterine device, or IUD, from Pathfinder, according to Dr. Bruno Ki, the organization’s technical director in the country. Before that, the clinic didn’t even have the basic specula and tongs used in gynecological exams. Since May, Nassa estimates, the clinic has performed 30 or 40 IUD insertions a month, and the devices remain effective for up to 12 years.

Counseling New Mothers

Each morning, a hundred women crowd into Nassa’s small waiting room and spill out into the courtyard; she and her staff, just under a dozen, can’t take care of all of them. Her cement clinic only has four rooms for patients, so one doubles as a birthing suite and a family planning consultation room.

Demand for the clinic’s services has soared since the government started subsidizing healthcare for new mothers and young children in April. Now, healthcare is free for women for six weeks after they give birth.

That makes for a crucial juncture for Nassa to intervene. Back-to-back births carry higher risks for both mother and baby, and non-hormonal methods of contraception, including IUDs, are safe to use while the woman is still breastfeeding.

“If she comes in with her child, we can use that opportunity to chat with her about contraceptive methods before she gets pregnant again,” Nassa said through
a translator. She tells the women about all kinds of contraceptive methods, including IUDs.

Pathfinder is also funding improvements at other health clinics around the city. It is building a cement incinerator for medical waste at a health clinic in Bangpooré, a poor neighborhood by the railroad tracks to Abidjan, where the current incinerator was nothing more than a brick fire pit in which a stack of papers smoldered next to a jumble of aluminum and a can of insecticide that had not yet exploded.

Meanwhile, the organization is working at a national level to change the country’s laws on abortion.

“[The] abortion law is very restrictive in Burkina Faso,” Ki said. “In 2012, we [had] more than 105,000 unsafe abortions in Burkina Faso.”

Currently, abortions are only legal if ordered by a judge, and only in four cases: rape, incest, if the [woman’s] health is at risk, or if there is a high probability the child will be born with an incurable congenital disorder.

As a result, many women try to induce an abortion, with horrifying results. Ki has heard stories about women who stuck bleach pills into their vaginas or drank soup laced with ground glass.

If the new statute is adopted, women would be able to receive an abortion if their mental health or social well-being is at risk. The legislature was supposed to vote on the changes in October, but never did, Ki said, and he’s not sure when they will pick it up in the future.
Nested among dozens of pregnant women huddled together on benches in the clinic’s antenatal ward, their children clad in jumpers, jackets, and woolly hats against the morning chill, Fatima Abdulai is glad to have the company.

Having fled her home in northeast Nigeria when Boko Haram militants struck in 2015, Abdulai is preparing for the birth of her eighth child — her first since arriving in Maiduguri, the capital of Borno state. But this time, she won’t be alone. “I gave birth to the others on the floor at home, alone,” she told the Thomson Reuters Foundation at the Maimusari health center in Borno, the heart of Boko Haram’s seven-year-long campaign to carve out an Islamic caliphate in the northeast. “There was no hospital in my village, so I had no choice,” said Abdulai, who now lives in a rented apartment, rather than a camp for the displaced. “But some women in Maiduguri told me to come here ... now I know the risks of having a baby at home.”

In Nigeria, where many women deliver without medical care, around one in 125 die during or just after childbirth, making it the world’s fourth most dangerous country in which to give birth, according to the World Health Organization (WHO).

Many women in the northeast do not have a health facility nearby, cannot afford the transport or healthcare costs, or are compelled to deliver at home by their husbands and families.

But the destruction wrought by Boko Haram in the northeast, which has uprooted more than two million people, may eventually improve the sexual and reproductive health of countless women across the region, health workers and experts say.

Some 1.4 million of the displaced are now residing in camps and communities in Borno state, where aid agencies are offering free health services in camp clinics and state health centers.

For many women uprooted by Boko Haram, like Abdulai, this is the first time they have set foot in a health facility, or heard about antenatal care, birth control, and family planning.

“We can challenge the norm of giving birth at home ... and have more conversations about women’s health,” said John Agbor, Nigeria chief of health for the UN children’s agency (UNICEF).

Family Planning Fears
Many of the women arriving at health centers for the first time are fearful that using contraception may leave them permanently infertile, betray their Muslim faith, or spark a violent reaction from their husbands, several midwives said.

“Concerned about a cultural and religious backlash, we chose to raise awareness about the services by using local volunteers in camps and host communities,” said Shehu Dasigit, reproductive health manager at the International Rescue Committee (IRC).

Yet the fact that more than two-thirds of the displaced in Borno live among communities rather than in camps makes it harder to reach and encourage women to seek health services, Dasigit said.
However, in health centers and camp clinics across Maiduguri, dozens of women queued patiently in the heat, saying that they would happily wait three or four hours to be seen.

While some of the women in Bakassi camp had decided to come without telling their husbands, 25-year-old Zuwaira Ali could not stop smiling as she attended her latest antenatal check-up.

“My husband knows my check-up schedule, and even reminds me when I have my next visit,” said Ali, who had not been able to afford antenatal care for her first four pregnancies in Gwoza, the first town Boko Haram fighters claimed control of in 2014.

Many like Ali are considering family planning for the first time in a country where only around one in 20 married women use contraception, according to the Population Reference Bureau.
“Being displaced and living in a camp is not the perfect situation for children,” said Ali, who is due next month.

“After this child is born, we will use family planning to wait before having any more,” she added, sitting next to a pinboard covered with condoms, contraceptive pills, and posters.

**Taking On Tradition**

Not all women have such understanding husbands and families, according to Clara Afolyana, a nurse who works in Bakassi camp.

Men in the camps are often against birth control because they believe having many children will lead to more humanitarian aid, or prosperity in the future, several health workers said.

“Some men divorce, beat, and even rape their wives if they merely bring up the idea of family planning,” said Afolyana, who provides victims of such violence with counseling, anti-HIV medication, and emergency contraceptive pills.

With many of the displaced contemplating a return home soon as Nigeria’s army secures areas previously held by Boko Haram, several women said they hoped to challenge traditional beliefs about reproductive health in their home communities.

“The influence of grandmothers — who themselves gave birth at home and often every year — is strong across the northeast,” said Fatima Kolo Lawan, a 23-year-old midwife at Maimusari who provides antenatal care to up to 100 pregnant women each day.

“We want those women giving birth now, the next generation of grandmothers, to deliver a different message to their daughters,” she said, beckoning yet another woman into her room.

The state government is repairing some 500 health centers damaged or destroyed by Boko Haram, two-thirds of facilities in Borno, and aims to offer maternal and child health services in all of them, said Muhammad Ghuluze, director of emergency medical response in the state health ministry.

While such an approach would benefit women like Abdulai, she laughs heartily at the prospect of having a ninth child.

“For now, I’m just happy to be having this baby at a health center,” she said. “It feels good to be here.”
For family planning supporters, every day is a new (and mostly unpleasant) adventure under Donald Trump. Here’s what the last quarter of the year brought us.

Budget Outcome Remains Unsettled
In our last issue, I wrote about the House version of the State Department/Foreign Operations Appropriations bill. To recap: It was really, really bad. It limited funding for international family planning to not more than $461 million and codified Trump’s expanded Global Gag Rule and the ban on funding for the United Nations Population Fund (UNFPA). Democrats offered amendments to fix these problems, but they were defeated 23-29, with only retiring Rep. Charlie Dent (R-PA) crossing party lines to vote with the Democrats.

The Senate Appropriations Committee met in early September to consider their version of the bill. Initially, it wasn’t any better than the House bill. However, the outcome in committee was quite a bit better. During markup, Sen. Jeanne Shaheen (D-NH) offered an amendment to increase funding to $585 million, remove the Gag Rule and insert the language of the Global HER Act, and allocate $37.5 million for UNFPA. The amendment passed 16-15, with Sens. Susan Collins (R-ME) and Lisa Murkowski (R-AK) voting for the changes, along with all Democrats except for West Virginia’s Sen. Joe Manchin.

The disparities between the two bills will have to be worked out before there can be any vote on a final funding package.

Because it was believed to be unlikely that both chambers would get all their funding bills done by the end of the fiscal year (September 30), Congress had already passed a three-month Continuing Resolution, which will fund the government at current levels through December 8.

House Passes 20-Week Abortion Ban
In early October, the House passed a bill to ban abortion nationwide after 20 weeks of pregnancy. The justification for the measure, which passed 237-189, was the medically dubious theory that a fetus can feel pain by that point in a pregnancy. The bill contains exceptions for pregnancies caused by rape and incest, and for those that are life-endangering to the pregnant woman. Although Donald Trump has vowed to sign it if it reaches his desk, the bill currently remains mostly a symbolic gesture, since passage in the Senate would require 60 votes.

“The Global Gag Rule is a dangerous and ill-conceived policy that blocks millions of women and their families from receiving critical aid and assistance. . . I’m very pleased that this amendment was approved on a bipartisan basis and hope that Congress can continue to make progress to repeal this disastrous policy.”

– Sen. Jeanne Shaheen
Trump Administration Rolls Back Birth Control Benefit …

Only days after the passage of the House abortion bill, the Trump administration added its own attack on reproductive rights: the rollback of the Affordable Care Act’s birth control benefit.

At least 55 million women have gained access to birth control without a copay since the benefit was first introduced. In 2013 alone, birth control pill users saved $1.4 billion in out-of-pocket costs. Upfront costs for IUDs — one of the most effective long-acting methods — fell to $0 for most women with insurance.

The new rule specifically says that the ACA does not require that birth control be covered. And it dramatically expands the religious and “moral” exemptions that were the result of the Hobby Lobby case in 2014. Previously, entities that objected to covering birth control had to notify the government that they would not comply. Insurers were then required to offer separate birth control coverage at no additional cost to the affected employees. The new rules do away with all of that. They let any employer, large or small, religious or secular, assert a religious or moral objection to birth control and refuse to cover it. They don't have to notify anyone but their employees, and insurers don't have to do anything in response to offer the coverage to enrollees.

Part of the administration’s stated rationale for the change? Access to birth control might promote “risky sexual behavior” among teens and young adults.

And as with so many of the actions taken by this administration, they’re not even pretending to follow the normal process for making changes like this. Most regulatory changes go through what’s called a “notice and comment” period before they take effect. It’s done so groups or individuals affected by the changes have an opportunity to have their objections heard. Not so with this change — the new rules were final as soon as they were issued.

In response, Senate Democrats, led by Patty Murray (D-WA) released a bill designed to undo the rollback. A group of Democratic women in the House have indicated that they will release companion legislation soon. Additionally, multiple advocacy groups and the attorneys general for several states have already either filed suit against the administration, or announced that they plan to do so.

… and Undercuts the ACA

Removing the birth control benefit wasn’t the only attack on the ACA. Congress failed to repeal the healthcare bill, but the administration is doing everything in its power to make sure it doesn’t work anymore. They had already refused to allow states to make requested fixes to their marketplaces. They cut the advertising budget so people wouldn’t know they needed to sign up, and limited the open enrollment period to create less opportunity. And then, shortly after the birth control rule change, Trump announced that he would not make the cost-sharing payments required by law — payments that help prevent premiums from skyrocketing for some customers.

Soon after that decision, a bipartisan group of senators, led by Lamar Alexander (R-TN) and Patty Murray (D-WA) announced that they had arrived at an agreement that would make the payments and stabilize the marketplaces. As of our deadline, Trump had spent several days waffling on whether he would support the measure, and Speaker Paul Ryan had made no comment.
Each demonstration, each event — big and small — that our activists host or participate in is an important effort toward resisting Trump’s deadly agenda and promoting the health, empowerment, and rights of people all around the world.

Join us in the resistance by texting FIGHT to 52886, visiting IWillFight4HER.org, and following our sister organization, Population Connection Action Fund, on Twitter (twitter.com/popconnect) and Facebook (facebook.com/PopConnectAction). We need your support to push our movement forward!

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**World Contraception Day, September 26**

We joined Planned Parenthood Generation Action and NARAL Pro-Choice North Carolina to co-host the “Defending Access at Home and Abroad” panel at Duke University. The event featured local, national, and international perspectives on reproductive health from human rights activist Lisa Shannon, NARAL-NC student advocate Anna Katz, and Gender Studies Professor Kimberly Lamm. Population Connection Field Coordinator Lauren Salmiery moderated.

Our sister organization, Population Connection Action Fund, co-sponsored a Twitter chat with CHANGE and columnist and non-fiction author Jennifer Wright. The chat prompted 320 people to tweet or retweet 870 posts using #TrumpGlobalGag, potentially reaching over 1.6 million Twitter users. Several notable influencers engaged in our chat, including author and actress Mara Wilson (Matilda, Mrs. Doubtfire).

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**SisterSong’s “Let’s Talk About Sex” Conference in New Orleans**

Our Deputy Field Director, Tanisha Humphrey, along with Field Coordinator Lauren Salmiery and Field Organizer Lindsay Apperson, presented the workshop “Advocacy in Action: Defending Global Reproductive Rights in the Face of 45.” The conference welcomed over 1,000 attendees who gathered together to talk about ways to strengthen the voices of women of color in reproductive justice.

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**Pride Festivals in Colorado and North Carolina**

We tabled at pride festivals in Aurora, CO, and Charlotte, NC, to support LGBTQ rights and highlight how Trump’s Global Gag Rule will harm access to healthcare for LGBTQ people all around the world. At Aurora Pride we collected over 100 #Fight4HER petition signatures, and 45 people sent photo petitions featuring our cardboard cutout of Sen. Cory Gardner directly to him via Twitter. We collected several hundred #Fight4HER petition signatures at Charlotte Pride.
International Safe Abortion Day, September 28

We teamed up with the Population Institute, Reproaction, Advocates for Youth, and Physicians for Reproductive Health to make some noise for safe abortion access at our own *cacerolazo* (English translation: casserole — a type of very noisy protest popular in Latin America). We gathered outside the White House with pots, pans, wooden spoons, cowbells, and almost anything that could make racket to let Donald Trump know that supporters of safe abortion are watching.

Activists in New Hampshire also held a mini-*cacerolazo* with about twenty students.

Supporters in Ohio and Colorado held photo petitions so constituents could tell their members of Congress to repeal Trump's Global Gag Rule and keep abortion safe, legal, and accessible.

International Day of the Girl Child, October 11

Nearly fifty students, volunteers, and activists at the University of Denver in Colorado highlighted the challenges faced by girls around the world. They shared their support for the health and empowerment of girls everywhere by writing messages on paper dolls to create a moving visual display.
In time for the 2017-18 school year, PopEd launched an ambitious new curriculum. Aimed at teaching middle school students about population trends, their impacts, and our paths to a sustainable future, People and the Planet develops students’ understanding of the interdependence of people, the environment, and our connections as a global family. This fourth edition of People and the Planet not only updates already popular lesson plans, but includes many new ones that reflect current environmental and social issues relating to population. The curriculum addresses the latest content standards across a range of disciplines and incorporates innovative ways for teachers to measure students’ grasp of the concepts.

As citizens growing up in the 21st century, students face innumerable global challenges: climate change, global wealth gaps, water scarcity, deforestation and biodiversity loss, gender inequality, and more. But as tomorrow’s leaders, voters, and policy makers, they are also in a position to steer our planet toward a sustainable future.

While People and the Planet originally debuted in 1996, this is the first edition to be produced online. The online format has many new features and a number of activities that were not available in previous editions. The home page introduces teachers to the seven units: The History of Population Growth, Population Concepts, Land Resources, Water Resources, Air Pollution and Solid Waste, Our Global Family, and Sustainable Future. Each unit includes a background reading and lesson plans — 41 in all. There are also short case studies featuring specific stories of challenges and crises (like the Deepwater Horizon oil spill and overfishing of Bluefin tuna) but also inspiring projects like the Nashua River clean-up and Malala’s work to promote girls’ education.

The content and teaching techniques employed in People and the Planet activities make them relevant in today’s classroom and representative of best practice instruction. To keep students engaged, lessons use a mix of memorable, hands-on strategies including inquiry, games, role-playing, debate, small group problem solving, science labs, and more. The activities also require students to use higher order thinking skills to tackle complex real-world problems. This encourages learning to be applied outside of the classroom and prepares students to make informed decisions as global citizens in the years ahead.

The blend of real-world content and higher order thinking make People and the Planet activities an ideal match for addressing current educational standards including Common Core, Next Generation Science Standards (NGSS), and the National Curriculum Standards for Social Studies. Both the units and individual activities can be integrated across subject areas to allow for interdisciplinary learning and easy incorporation into existing curricula.

Each unit in People and the Planet includes a summative assessment. These are project-based and designed to measure student learning on key unit concepts, while building skills such as writing, designing, policy analysis, and advocacy. Some of the assessment projects reinforce concepts learned (like creating a trivia game to test each other’s command of demographic terms and trends). Others challenge students to design ads, comic strips, eco-friendly products, and community service action plans. To enhance the lessons, People and the Planet provides teachers with over 30 infographics on unit topics and dozens of suggested resources (books, websites, videos, and articles).

People and the Planet is password protected. Teachers have the option of accessing the entire curricula online or downloading individual units. More information is available at populationeducation.org/store/people-and-planet-lessons-sustainable-future.
The new *People and the Planet* includes 22 of the teaching activities from previous editions. The other 17 activities are new to the curriculum. Here’s a sampling of some of those new activities.

**Almighty Aquifers:** Aquifer depletion is threatening water resources around the globe. As the human population grows, so does the demand for groundwater. In this board game, students play the roles of different states drawing from the Ogallala Aquifer underneath the High Plains. Each round of play represents a decade (1950-2000) and the amount of water withdrawn mirrors the demand from each state during that time period.

**Fracked or Fiction:** Students analyze a dozen different pieces of data on fracking, including articles, graphs, charts, and maps from a variety of sources (government agencies, energy industries, environmental advocacy groups, and mainstream news outlets) to determine bias, gather information, and, ultimately, form their own opinions about fracking.

**Meat of the Matter:** A quarter of the planet’s ice-free land is used for livestock grazing and a third of cropland goes to produce food for livestock. Meanwhile, we need to grow more food for our human population. In this activity, students graph global meat consumption, use bingo chips to explore the environmental impact of four different types of protein, and discuss the pros and cons of a shifting global diet.

**Population Future:** According to the UN, 11 billion people are projected to be on the planet by 2100. Much of that growth will be in sub-Saharan Africa. In this graphing activity, students draw gridded bars to represent the population sizes of world regions in 1980, 2015, 2050, and 2100. They also analyze fertility and mortality trends for the past, present, and future.

**The Secret Life of Stuff:** As population and affluence grow around the globe, so does the demand for more “stuff.” In this STEM-based activity, students compare the life cycle stages of four everyday products (jeans, earbuds, sneakers, and a lamp) in order to hypothesize which item has the lowest environmental footprint. They then pick one product and brainstorm improvements that could be made along the product’s life to minimize its eco-impact.

**Lessons for Life:** There is a strong link between education and fertility; the more education women have, the more likely they are to have small families. Raising the status of women and making education equally available to girls and boys is key to breaking the complex cycle of poverty that traps so many women around the world. In this activity, students read the story of two girls in an Ethiopian village with different educational opportunities. They also view photo essays of girls around the world describing their day-to-day routines and their hopes for the future.
"WE'RE ALMOST THERE, HAPPY ANNIVERSARY, DEAR!"
Under the new U.S. Department of Health and Human Services rule, any employer with a “sincerely held” religious or moral objection to contraception can stop covering the cost of birth control. The federal government doesn’t have to vet those objections for sincerity; companies can halt coverage just because they don’t feel like paying for it.

What’s more, companies that have opted out are no longer required to allow workers to access copay-free birth control coverage directly from insurance companies. So millions of American women who get employer-sponsored insurance may lose all coverage of contraception — forcing them to either pay out of pocket or forgo the well-known benefits to their health and financial stability they get from being able to plan their pregnancies.

Aside from the religious objections, the Trump DHHS — which is packed full of believers in misinformation about birth control — also presents a weak health-based case, saying that the rollback will help keep access to contraception from encouraging “risky sexual activity” among teens and young adults. (The fact that far fewer teens are having sex or giving birth today than in the 1980s would seem to lead to the opposite conclusion.)

But it’s obvious that this isn’t about the facts. It’s about (again) catering to the president’s base. And it would be almost laughable if the implications for women’s lives and health weren’t so serious.

– October 11, 2017

For more than a century, some conservatives have tried to prevent American couples from using birth control. Planned Parenthood pioneer Margaret Sanger was jailed eight times under puritanical Comstock Laws for teaching contraception.

Several hidebound states banned birth control until 1965, when the U.S. Supreme Court ruled that married couples have a right to use contraception in the privacy of their bedrooms — and 1972, when a follow-up ruling extended the right to unwed couples.

Now President Donald Trump has signed a directive saying all employers with strong religious beliefs may block their company health plans from covering birth control.

Why is it “religious freedom” to try to block contraception and cause some women to have babies they don’t want? Why is religious freedom only for bosses? Why don’t female employees have religious freedom to choose birth control if they want it?

We think birth control should be a human right for every couple and every female in the world. With the population explosion still soaring out of control, all people everywhere should have a right to choose whether they want more children. No outsider, such as a boss, should have “religious freedom” to interfere with that choice.

Birth control is a secure part of the modern safety net. Politicians shouldn’t try to gain votes by damaging it.

– October 19, 2017
WAYS TO GIVE

There are many ways to support Population Connection and end rapid population growth.

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- Leave a portion of your life insurance or retirement plan assets to Population Connection
- Give through a Population Connection Charitable Gift Annuity to receive income for life and leave a legacy for our planet

WORKPLACE GIVING
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- Combined Federal Campaign for federal employees—Population Connection’s designation number is 11632

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