A Ray of Hope in Rwanda Amid Global Population Challenges
The December 2018 President’s Note addressing the stunning silence regarding the impact of population growth on climate change really struck a nerve — resulting in unprecedented comments that this must be addressed.

Yet why do so many who recognize the dire threats posed by climate change refuse to accept the incontrovertible evidence that population growth is a key driver of greenhouse gas emissions?

Pushback often takes the form of whataboutism: “What about our own sky-high carbon emissions? Why focus on rapid population growth in less developed, low carbon nations when our usage is the real problem?”

Some early references to whataboutism targeted the Soviet propaganda technique whereby U.S. criticism of totalitarianism was hit with the rejoinder, “What about all the lynchings in the American South?” Whataboutism is used to stifle discussion by pointing out some manifest failure on the part of those who raise inconvenient topics. It’s all about evasion.

Of course, highly developed nations must dramatically reduce emissions. And we cannot shift blame onto people struggling with extreme poverty, looming pandemics, and civil strife exacerbated by overcrowded conditions. Faced with few or no options, many flee their homes as a last resort.

Climate change is a global crisis. Everyone can help. Today, there are 214 million women in less developed nations who don’t want to be pregnant but who face barriers to using birth control. Here at home, nearly half of all pregnancies are still unplanned. A modest investment in U.S. foreign assistance can help smash family planning barriers everywhere, so people can have the lives they want, which nearly always results in smaller families. They win. We win. The planet wins.

It seems so obvious. What are we waiting for?

John Seager
john@popconnect.org

What’s small, sweet, wrinkled, and helping us meet the population challenge?

Raisins… Let me explain.

One of our longtime members owned an 18-acre raisin farm outside Fresno, California, thousands of miles from where he lived. A local farmer tended the land — providing income to the owner and to the farmer.

After retiring, the owner of the farm decided to get out of the raisin business. Crops are fickle, and he preferred regular payments without the headaches of remote ownership.

Shauna Scherer, our Vice President for Marketing and Development, worked closely with him. We entered into an agreement whereby he transferred ownership of the farm to Population Connection to establish a lifetime Charitable Gift Annuity, which provides him with guaranteed payments that will never change. We then sold the property, which is still producing crops.

Our generous donor and Population Connection both benefit under the terms of the annuity agreement.

If you’re looking to sell a raisin farm or any other marketable piece of real estate, feel free to email Shauna at shauna@popconnect.org or call her at (202) 974-7730. She’ll be glad to work with you.
Population Connection at the 2018 International Conference on Family Planning in Kigali, Rwanda

Rwanda’s Community Health Workers: Meeting People Where They Are

How Rwanda’s Catholic Clinics Struck a Contraception Compromise

Resiliency in the Face of Harmful Rhetoric From a Heartless Leader Halfway Across the World

How to Grapple with Soaring World Population? An Answer from Botswana

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Cover Image:
A nurse who is a nun at a health clinic in Rwanda. © Riccardo Gangale/USAID, Courtesy of Photoshare
Editor’s Note

Rwanda, the host of the 2018 International Conference on Family Planning (ICFP), would be the perfect destination for someone visiting sub-Saharan Africa for the first time — especially someone who didn’t do well with noise and chaos and small dangers at every turn. Kigali is clean, orderly, and full of fantastic restaurants serving international cuisine. During the five days I spent there — admittedly a very short stay and one that didn’t include any travel outside the capital city — I was only approached for money once, and when I declined offers of taxi rides or invitations to visit people’s shops, one polite response was all it took to conclude the exchange. In November, when the conference took place, the weather was temperate, if a bit rainy, which made walking the safe streets even more enjoyable.

These pleasant surprises caught me off guard because, as I’m sure many do, when I think of Rwanda I think of the 1994 genocide. I was ignorant about the impressive strides that the country has made since then to heal wounds, both physical and emotional, and I was equally ignorant about what a popular foreign investment destination Rwanda has become. In fact, the World Bank ranks Rwanda 29th in its “ease of doing business ranking,” the only low-income economy to make the top 50.

Due to concerted efforts since the mid-1990s to soothe tensions between Hutus and Tutsis, the two ethnic groups that massacred each other, the only obvious evidence of the genocide that I saw was at the museum and memorial dedicated to the atrocity, located on the site of a mass grave where 200,000 bodies lie beneath several planes of cement.

With 12 million people living in a land area smaller than Maryland, which has a population half that size, Rwanda is the most densely populated country in continental Africa. Its population is growing by 2.3 percent a year, at which rate it would double in 30 years. With 60 percent of the population under the age of 25, with the bulk of their childbearing years ahead of them, population growth won’t slow down without continued fertility reduction. When international family planning programs first began in the 1960s, Rwanda’s total fertility rate was 8.2 children per woman. Today, it is 4.2 — still two births above replacement rate,” but trending in the right direction. The UN Population Division’s medium fertility variant projects that Rwanda will reach replacement rate in the late 2050s, and continue declining from there.

In order for that projection to become a reality, however, investment in family planning must remain a top priority, along with investments in education, health, and gainful employment. United States foreign assistance plays a big role in that investment strategy, and we cannot let our own country’s fickle policies, imposed by our so-called leaders, derail the progress that countries such as Rwanda have worked so hard to achieve.

Marian Starkey
marian@popconnect.org

* The genocide was committed by extremist Hutus against Tutsis and moderate Hutus. Once the genocide was officially over, the Tutsi-led Rwandan Patriotic Army slaughtered Hutus — many of them guilty of committing direct acts of genocide — who had been driven to refugee camps in the Congo.

** The UN Population Division estimates Rwanda’s replacement rate fertility to be 2.2. Each country’s replacement rate is dependent on its particular mortality rate.
I read with absolute agreement and frustration John’s President’s Note in the September 2018 issue of Population Connection, wherein he posed the question, “Is population a taboo subject?”

I think we all know the answer.

I have written upwards of a zillion op-ed pieces, which almost never get published due to this same general (cultural? political? religious? economic?) fear of addressing this critical topic.

Human overpopulation is the single greatest threat we — as both a species and a planet — face, so it’s high time to make it the biggest issue of our epoch!

Robert P. Johnson

I read about women and birth control and abortions in every one of your magazines. My question is: When are men going to step up to the plate and take responsibility for their part in the overpopulation issue? Why is it always up to women to deal with this? If men were more conscientious, there wouldn’t be so many unwanted pregnancies in the first place. It’s interesting that there is no birth control for men, but there is Viagra so men can have sex later into their lives. Oh bother!!!

Bonnie Scott

I was shocked to see in John Seager’s December President’s Note that the IPCC’s recent Summary for Policymakers contained not a word about population growth’s impact on the climate crisis. Do not human numbers grow by 80 million annually?

We must all shout from the rooftops that every woman deserves ready and affordable access to contraceptive and birth control information and services. Political and religious opposition must be vigorously opposed for being as archaic, ignorant, and destructive as the medical practice of bleeding sick people to treat illness. The clock ticks.

Nathaniel Batchelder

John, I couldn’t agree more with your editorial. I am 62 years old. When I was 16, I knew there were too many people on this planet, and I became a supporter of ZPG. I didn’t want children and later my then-fiancé and I parted ways over the issue. I have chosen a childfree life, with no regrets.

Fast forward to 2018: I have become a monthly supporter of Population Connection.

As an environmentalist and animal protectionist, there are many quotes I live my life by. Here are two:

“Humans: We’re not the only species, we just act like it.”
– Attribution unknown

“Anyone who believes that exponential growth can go on forever in a finite world is either a madman or an economist.”
– Kenneth Boulding (an economist himself)

I don’t know why we refuse to address the issue. Ego? For people planning a family, I would like to ask them three questions: 1. How many people do you think the planet can support? (Most say there are too many already.) 2. How did you determine that number? 3. How will we stop population growth when it reaches that number? Of course, they don’t have an answer for any of these questions.

Lawrence Arkilander
Unmet Need for Family Planning and Unintended Pregnancy Among Adolescents

Roughly half of pregnancies among adolescents aged 15–19 in developing regions are unintended, and about half of these end in abortions, most of which are unsafe.

20 million adolescent women in the developing world have an unmet need for modern contraception.

In Africa, nearly two-thirds (62%) of sexually active adolescents wanting to avoid pregnancy experience unmet need.
Unmet Need for Family Planning and Unintended Pregnancy Among Adolescents

Roughly half of pregnancies among adolescents aged 15–19 in developing regions are unintended, and about half of these end in abortions, most of which are unsafe.

In Africa, nearly two-thirds (62%) of sexually active adolescents wanting to avoid pregnancy experience unmet need. Each year, if all adolescent women who need modern contraceptives were to use them, unintended pregnancies would decrease from 20 million to 14 million. This would result in 2.4 million fewer unplanned births; 2.9 million fewer abortions, of which 1.9 million would have been unsafe; 763,000 fewer miscarriages and stillbirths; and 6,000 fewer maternal deaths. Most of the maternal deaths averted would be in Africa (4,300), the region with the world’s highest maternal mortality.

Young women often report several reasons for not using contraceptives despite not wanting a pregnancy:

- INFREQUENT SEX
- NOT BEING MARRIED
- CONCERNS ABOUT CONTRACEPTIVE SIDE EFFECTS
- BREASTFEEDING OR NOT HAVING RESUMED MENSTRUATION AFTER A BIRTH
- THEIR OWN, THEIR PARTNERS’, OR OTHERS’ OPPOSITION TO CONTRACEPTION

Source: “ADDING IT UP: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents in Developing Regions,” Guttmacher Institute, November 2018.
Federal Judge Blocks Trump Administration from Expanding Birth Control Exemptions

In November 2018, the Trump administration finalized new rules expanding employer exemptions to the birth control benefit of the Affordable Care Act (ACA).

The new exemptions would allow employers that have religious objections to birth control to cease providing contraceptive coverage in their employee health insurance plans. They would also allow employers, as long as they are not publicly traded, to stop covering birth control if they have a moral objection to its use. The new exemptions would also apply to educational institutions that provide health insurance to students.

The day before the new rules were scheduled to go into effect (January 14), District Judge Haywood S. Gilliam, Jr. issued a preliminary injunction, temporarily blocking the rules for the 13 states plus D.C. that challenged the exemptions in court.

The following day (the day the rules were scheduled to go into effect in the states that weren’t part of the lawsuit), U.S. District Judge Wendy Beetlestone issued a preliminary injunction blocking the rules for the entire country.

Legal challenges will certainly follow, and a hearing has already been set for January 23.

Kenya Bans Marie Stopes International from Providing Abortions; Then Reverses Ban

A misunderstanding about radio ads the UK-based organization Marie Stopes International (MSI) was running in Kenya led to a directive in November that they stop providing legal abortions and post-abortion care in their clinics. The ads were interpreted as promoting abortion, but MSI argued that they simply aimed to create awareness around the dangers of unsafe abortion. Abortion is only legal in Kenya when a woman’s health or life are threatened.

After an audit of the organization’s programs, the Kenyan Ministry of Health determined that MSI was not in violation of Kenyan law, and resumed MSI’s permission to serve patients.

Judge Slams Mississippi Abortion Ban

In November, U.S. District Judge Carlton Reeves struck down a Mississippi law that banned abortion after 15 weeks of pregnancy. The law was signed in March, at which point the sole surviving abortion clinic in the state sued and received a temporary restraining order, which prevented the law from ever being enforced.

Judge Reeves wrote in his decision, “The State chose to pass a law it knew was unconstitutional to endorse a decades-long campaign, fueled by national interest groups, to ask the Supreme Court to overturn Roe v. Wade.” He said the Mississippi legislature’s “professed interest in ‘women’s health’ is pure gaslighting.”

An identical law in Louisiana was automatically struck down because of its contingency on the Mississippi law being upheld.

Mississippi’s Democratic Attorney General, Jim Hood, filed an appeal of the judge’s ruling in December with the 5th U.S. Circuit Court of Appeals.

Hormonal Male Birth Control in Testing Phase

The National Institutes of Health (NIH) is conducting a test of a contraceptive gel for men. The gel, called Nestorone, is a combination of progestin and testosterone. It is applied daily to the shoulders and back and works to halt the production of sperm without eliminating men’s libidos.

Diana Blithe, one of the study’s researchers, says, “Many women cannot use hormonal contraception and male contraceptive methods are limited to vasectomy and condoms. A safe, highly effective, and reversible method of male contraception would fill an important public health need.”

The gel was developed in partnership with Population Council. It will be tested on 420 men in Los Angeles and Seattle, and will run from 4-12 weeks, measuring the men’s sperm counts along the way.
This will not be the final trial before approval, even if the results are positive, but it’s a necessary step toward that goal.

**U.S. Supreme Court Refuses to Hear Case Against Planned Parenthood**

In December, in a win for Planned Parenthood, the U.S. Supreme Court refused to consider a case challenging the decisions of five lower courts. The lower courts blocked Kansas and Louisiana from refusing to allow Medicaid patients to challenge laws that prohibit reimbursements to Planned Parenthood for health services they receive.

Only three justices were in favor of accepting the case, but four justices are required to take on any given lawsuit. Among those who did not support hearing the case was newly-confirmed Justice Brett Kavanaugh.

**2018 Saw Lowest U.S. Population Growth Rate in Eight Decades**

The U.S. Census Bureau released its 2018 population estimates in December for the year that spanned July 1, 2017, to July 1, 2018. The country’s population grew by 0.6 percent during that period, with wide variations by state.


California remains the most populous state, at 39,557,045 people, but its numeric growth trailed Texas and Florida by a large margin.

The country’s natural increase was 1.04 million (3,855,500 births minus 2,814,013 deaths). Immigration added 978,826 people to the population.

**Ohio Joins West Virginia and Mississippi in Banning Safest Second Trimester Abortion Procedure**

Former Ohio Gov. John Kasich signed a bill in December that banned the safest and most common second trimester abortion procedure, dilation and evacuation (D&E). Physicians can be charged with a fourth degree felony if they perform such an abortion for any reason other than to save a woman’s life.

The new law, in effect, bans abortion after the first trimester. That is the typical cutoff for vacuum aspiration abortions — after that point, dilation and evacuation is the safest method. In 2017, 14 percent of abortions in Ohio were obtained after 12 weeks of pregnancy.

At the same time, former Gov. Kasich vetoed a “heartbeat bill,” which would ban abortion as early as six weeks, because he feared an expensive lawsuit due to its obvious unconstitutionality. Gov. Mike DeWine, sworn in on January 14, has said he would sign a heartbeat bill. If the new legislature passes a new version of such a bill, he will have that opportunity.

**United States Alone in Opposing UN Resolution**

At the 55th plenary meeting of the UN General Assembly in December, the United States was alone in voting against a nonbinding resolution on the “Intensification of efforts to prevent and eliminate all forms of violence against women and girls: sexual harassment.” The rest of the attending countries either voted yes (130) or abstained from voting (31). Countries that voted yes included Afghanistan, Congo, Myanmar, North Korea, Saudi Arabia, South Sudan, and Yemen.

In another vote that same day, on “Child, early, and forced marriage,” the United States was one of two countries to vote no. The other country was Nauru, a small Pacific island nation that serves as a detention camp for refugees and migrants to Australia. In that vote, 134 countries voted yes and 32 abstained from voting.

References to sexual and reproductive health in both resolutions raised concerns among American delegates that voting yes could be interpreted as supporting or promoting abortion.

*These news clips were current as of January 22, our print deadline. For the latest news on these and other items, please visit popconnect.org/population-news/.*

— Marian Starkey
Recognizing Donors for Their Generous Contributions of $1,000 or More a Year

We are deeply grateful to members of Population Connection’s 2018 President’s Circle. Thank you for your generous support of our mission to stabilize global population! If you don’t see your name and believe you should have been recognized as a member of the 2018 President’s Circle, please let us know. Contact Jennifer Lynaugh at jennifer@popconnect.org.

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We are deeply grateful to members of Population Connection’s 2018 President’s Circle. Thank you for your...
Twenty-five years ago, Rwandans experienced the bloodiest and most “efficient” genocide since Hitler’s Holocaust. Upwards of a million people (estimates range from 800,000 – 1 million) were killed over the course of a hundred horrific days in the spring of 1994, wiping out entire families, decimating communities, and trashing the country’s economy and tenuous political stability.

Since the ceasefire, Rwanda has been under the command of Paul Kagame. From 1994-2000, he was the Vice President and Minister of Defense — the de facto leader of the country. In 2000, Kagame became President — a role he still occupies nearly 20 years later.

President Kagame has frequently been accused of running an autocracy, and his administration has certainly been implicated in some very shady dealings — including amending the constitution so he could run for a third presidential term in an election he won with a suspicious 99 percent of the vote. He has been accused of jailing and even assassinating journalists who are critical of his rule, and smearing and imprisoning political opponents and their supporters.

It takes a bit of intellectual compartmentalization for me to say this, but there’s no denying that Kagame has done many positive things as well. The Rwandan economy has been growing at 6-8 percent a year since 2003, inflation is in the single digits, and the population living below the poverty line has gone from 57 percent in 2006 to 39 percent in 2015. Progress in gender equality is impressive as well, especially in the context of political representation. In Rwanda, women hold 64 percent of parliamentary seats, 42 percent of cabinet positions, and 40 percent of the justice seats on the Supreme Court.

Another area where Rwanda has made progress is sexual and reproductive health. The total fertility rate is estimated at 4.2 births per woman, down from 6.2 just before the genocide. Modern contraceptive prevalence is at 48 percent, up from 13 percent in 1992. These achievements, even more impressive in the context of such unimaginable national trauma, made Rwanda a fitting host.
for the 5th International Conference on Family Planning (ICFP). Held November 12-15, 2018, the ICFP drew nearly 4,000 people — health providers, advocates, policymakers, funders, and youth activists — from all over the world to the newly constructed, state-of-the-art Kigali Convention Center.

Among those thousands of attendees were five Population Connection staff members. We hosted an exhibit booth that gave us a home base and an easy way to make connections with conference participants who stopped by to talk with us about our work. Many people were drawn to our booth design, created by Mali Welch, who also designs our magazine’s Pop Facts feature. The dark blue walls were eye-catching, and the provocative quotes from two of our sister organization’s field organizers were great conversation starters.

“For the safety and welfare of women, girls, and people across the world, we must demand the immediate repeal of Trump’s Global Gag Rule and end the disgraceful attacks on women here and around the world.”

Amy McCall
New Hampshire organizer

“I don’t believe that anyone should have a say over what I do with my body and I don’t believe Donald Trump should have a say over what women halfway across the world do with their bodies.”

Brittany MacPherson
Arizona organizer

People tittered over our blatant disdain for Donald Trump, and wanted to know how he got elected and why Americans support his cruel policies. Upon reading the aforementioned quotes and hearing about our organization’s opposition to the Global Gag Rule, many conference attendees told us about their own health programs losing U.S. funding due to their refusal to comply with it.

We exchanged business cards with dozens of people who work for programs on the ground, and our field team is following up with many of them about doing events together and sharing their stories with our American grassroots activists.

More on that in a future Field and Outreach column!
In the 25 years since Rwanda’s genocide, the country’s government has made expanding access to reproductive health care a core component of its development strategy, and Rwanda has consequently experienced striking improvements in health outcomes. From 2000 to 2015, modern contraceptive prevalence among married women rose from 5.7 to 47.5 percent, and the fertility rate decreased from 5.8 to 4.2 births per woman. In addition, maternal mortality dropped by 84 percent, from 1,558 to 253 maternal deaths per 100,000 live births; infant mortality decreased by 64 percent, from 117 to 42 infant deaths per 100,000 live births; and life expectancy at birth increased by nearly 20 years, from 48 to 67 (during the years immediately before, during, and after the genocide, life expectancy hovered around 30 years).

To explain Rwanda’s dramatic improvements, many point to the country’s network of community health workers (CHWs) and mobile outreach programs to reach the most isolated rural people. First implemented in 1995, the Rwandan government crafted its CHW program to provide local community members with the training and tools necessary to educate their peers on crucial reproductive health topics. By 2005, Rwanda had over 45,000 CHWs working within communities, with much of their work focused on providing evidence-based information about modern forms of contraception and breaking down the stigma against contraceptive use.

Today, each village of approximately 100-150 households elects two women and one man who cater to the health needs of their communities. These CHWs counsel, treat, and provide referrals to their peers on a broad range of health interventions, including modern contraception, nutrition services, HIV and infectious disease prevention, integrated community case management, and maternal and child health.

CHWs work in tandem with over 500 health centers in hard-to-reach communities across Rwanda. The health centers provide the same range of services as CHWs, as well as consultation...
with nurses, hospitalization, pharmacy services, HIV testing and treatment, and gender-based violence care.

Participants of the 2018 International Conference on Family Planning (ICFP) had the opportunity to visit one of these health centers in Rwamagana, a district about 30 miles east of Kigali, and to speak with health center staff and CHWs working out of the facility. The Rwamagana Health Center was founded in 1997 and now serves a community of 51,592 people, spanning 52 villages in the region.

In 2018, the Rwamagana Health Center trained six providers on modern methods of family planning, two providers on postpartum family planning, two providers on gender-based violence care, and 156 new CHWs on community-based family planning provision.

Of course, there is still more work to be done. While the country has made major strides in increasing access to family planning, Rwanda’s adolescent pregnancy rate increased slightly, from 6.1 percent to 7.3 percent in recent years, health center staff and CHWs face challenges in bringing men into conversations about family planning, and nearly one-fifth of Rwandan women who want to avoid pregnancy still aren’t using modern contraception. As a whole, the health sector faces financial instability that could undermine the success of the country’s many efforts, made even worse by U.S. policies that threaten the reliability of development aid.

However, the Rwamagana Health Center’s staff and CHWs working throughout the region clearly demonstrate that Rwanda’s innovative approach of integrating comprehensive reproductive health services into its development strategy is essential to ensuring the fundamental right to a healthy life for all of the country’s people, regardless of where they live. By meeting people where they are and working to provide contraception and destigmatize its use, Rwanda has set itself as an example, for both the East African region and developing countries across the world.
Often, religion can divide when it comes to policies like contraception. But in Rwanda, both sides have found a compromise even as their faith has led them in different directions.

The Roman Catholic health center that hugs the main road here announces its faith plainly. ARCHDIOCESE OF KIGALI, reads the sign sprawled across the facade of the stout red brick building in this small town just outside Rwanda’s capital. Holographic portraits of Jesus and Mary stare down from the walls of every exam and consultation room, and nuns wander the corridors in full gray habits.

For decades, if you needed health care in this town, this was your option. And that included women looking for birth control — most forms of which the Catholic Church forbids.

“That is our faith. We cannot change what we believe,” says Mary Goretti Nyirahabahutu, the nun in charge of the health center.

But now, around the corner, wedged into half of an old municipal office at the end of a long dirt road, a tiny government health center whispers an alternative. Its door is unmarked except for a tiny sign above the doorway reading, “Kuboneza Urubyaro.” Family Planning.
“I’m also a woman of prayer,” says Jackie Buseruka, the nurse who runs the clinic. “But your religion must not interfere with doing what is right.”

Battles over access to birth control and abortion are often cast as a fight between a secular left and a religious right. But in Rwanda, as in much of Africa, people on both sides of the aisle feel God is with them. Both advocates and opponents of modern family planning frequently cite faith as their motivation.

And that has led to strikingly different ideas for how to expand access to birth control to the women who need it most.

When Rwanda’s government was looking for ways to increase the number of women using contraception a decade ago as part of a broader push to improve health care and promote development, they knew they had to include the Catholic Church, since half of Rwandans are members. Long a powerful institution here, the church runs about a third of the country’s hospitals and clinics, according to the Catholic charity Caritas — many of them in remote areas where there is no government-run alternative.

The church, meanwhile, was resolute — it wouldn’t provide artificial birth control. That was against Rome’s doctrine.

But it didn’t make much sense to build new hospitals in those areas. So the church and the government struck a deal.

Women who came to Catholic facilities looking for contraceptives would be told their options — all their options — and then pointed down the road to the new mini “health posts” the
government was setting up in the shadow of every Catholic hospital. Tiny, bare-bones operations, they had a single purpose: to give out birth control. Today, there are 88 of these, tethered to about 80 percent of the Catholic hospitals and clinics in the country.

“The way we see it, people are responsible for their own health and their own faith,” says Prince-Bosco Kanani, the director of Rwanda Catholic Health Services. “Our spiritual mandate is to let people choose.”

Many Rwandan women have chosen modern birth control. Since 1995, the country’s fertility rate has fallen from six children per woman to under four. Two-thirds of married women and nearly one-third of women total now use contraceptives.

**Difficult Conversations**

Sex is, perhaps, not the first topic the church wants to discuss. But in Africa, more than anywhere in the world, sex and public health have collided in ways that forced the church into the conversation.

“When HIV came to finish us, that’s when we realized we couldn’t keep sex in the dark. We had to begin speaking about it in broad daylight,” says Ronald Kasyaba, the deputy executive secretary at Catholic Medical Bureau in neighboring Uganda. “And the conversation has progressed from there.”

In Rwanda, as in many countries, the prevalence of Catholic health centers means they have been close to the HIV epidemic for decades. (The Vatican has estimated that it provides 25 percent of the care HIV and AIDS patients receive worldwide.) That, in turn, necessitated a tough moral reckoning among many Catholic health officials about the need to talk loudly and clearly to parishioners about protection against sexually transmitted diseases — a subject the church had historically spoken about only in whispers.

Yet it has been reluctant to approve of the use of condoms to prevent HIV, let alone as contraception. But Kigali is also far from Rome, and when church teachings and practical need diverge, many will quietly choose the latter.

“I cannot be limited by my faith when it comes to family planning,” says Adrian Hakorimana, a herdsman in Masaka. “The most important thing to me as a Catholic is to have a family that is a size I can take care of.”

**“It’s a Calling”**

Inside Ms. Buseruka’s dimly lit government clinic, she spreads out a menu of options for her patients. There are packets of pills and intrauterine devices, silver condom packets, and little vials of injectable contraceptives. “I never turn anyone who comes to this place away,” she says. “If they’re worried about religion, I tell them, God helps those who help themselves.”

Buseruka’s clinic has about 7,000 patients, from shy teenage girls to the wives of local pastors, who often send her text messages asking if they can come by the clinic after hours, when no one will be around to see.

Down the road, at the Catholic health center, Ms. Nyirabahutu leads her own spirited family planning crusade — to interest couples in church-sanctioned forms of “natural family planning.” She clutches a string of beads in her hand like a rosary, explaining that couples can use it to count the days of a woman’s cycle.

But it’s a hard sell. She sees only about 1,000 patients regularly for such services, she says, and only couples. “If you don’t have a husband, what do you need family planning for?” she says, breaking into a wide-brimmed laugh. “You have nothing to plan.”

Still, she says she fully supports the government outpost down the road.

“Of course they are serving more people than us [at the secondary health posts]. They have more to offer,” she says. But it isn’t a competition. “Health care, for us, it’s a calling. And the most important thing is that women are healthy, that having children is their own choice. They must be free to choose what is right for them.”

* Nasra Bishumba contributed reporting to this story. Reporting for this story was also supported in part by a fellowship from the United Nations Foundation.

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*The UN Population Division projected in 2017 that Rwanda’s 2019 total fertility rate (TFR) would be 3.8 births per woman; the last fertility estimate, from 2015, put Rwanda’s TFR at 4.2.

—Marian Starkey
Volunteer with Population Connection!

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Resiliency in the Face of Harmful Rhetoric From a Heartless Leader Halfway Across the World

By Lauren Salmiery, National Field Director
When Donald Trump reinstated the Global Gag Rule on January 23, 2017, nurses, doctors, lab technicians, advocates, and, most importantly, patients all felt the impact. International family planning providers were faced with a stark choice: They could keep quiet about abortion as an option, or they could refuse, and lose their U.S. funding.

To make matters worse, as if the original version of the Global Gag Rule, levied previously by Reagan, Bush One, and Bush Two, wasn't bad enough, the Trump administration announced that it would expand the rule from its traditional application to family planning aid (currently $525 million) to all $8.8 billion in global health assistance. This means providers working on child nutrition, malaria prevention and treatment, and antiretroviral (ARV) provision for HIV/AIDS patients are all subjected to the mandate: sign, or lose funding.

Established in 1962, Family Health Options Kenya (FHOK) is one of the longest standing providers of reproductive health services in Kenya, reaching diverse groups through its clinics, its outreach services to remote communities, and its youth friendly centers. FHOK has provided millions of Kenyans with access to contraception, cervical cancer screenings, antenatal care, HIV/AIDS testing, counseling, and treatment, and general health services for decades. An International Planned Parenthood Federation (IPPF) affiliate, FHOK has historically refused to sign the Global Gag Rule because its service providers believe that access to the full range of reproductive health care, including abortion services, is a human right.

In November, on the heels of attending the International Conference on Family Planning (ICFP) in Rwanda, my colleague Lindsay Apperson and I had the opportunity to visit a few of the sites where FHOK provides safe, comprehensive, and client-focused services in the Nairobi area. What we witnessed was not a community broken by the policies of a heartless leader halfway across the world, or an organization torn over how to react to the threat of losing funding in exchange for the stifling of its free speech by a government that claims to be an ally. Instead, we saw a resilient organization fueled by the fight that lies ahead. Despite the harmful policies of the U.S. government, FHOK showed an eagerness to work alongside American allies like Population Connection to achieve a collective goal: permanent repeal of the Global Gag Rule.

Since Trump’s Gag Rule was imposed, FHOK has had to close clinics and cut back on its services in hard-to-reach communities. While in the past, many clients received services free of charge, depending on their financial standing, they may now have to pay. A once free consultation may now cost 100-150 KSh ($1.00-1.50) — unaffordable for people struggling to put food on the table.

In Kenya, abortion is only allowed in order to protect the health or save the life of the pregnant woman. For women who find themselves with an unwanted pregnancy, but don’t meet the legal criteria, an unsafe abortion may seem like the only option. Aggrey made it clear that back alley abortions are often more accessible to the Kibera community than the safe abortion services offered at the FHOK clinics. The cost of transportation (50-70 KSh, or 50-70 cents) to the Nairobi West clinic for a safe surgical abortion may be prohibitive, or patients may fear they don’t fit the criteria for legal abortion and will be turned away.

Mercy Atieno, a 23-year-old mother of an eight-month-old boy, Liam, came to FHOK after an unsafe abortion left her septic and near death. Mercy’s boyfriend had left her when she told him she was pregnant — when Liam was only six months old — and her family was unable to support her having another child. Feeling she had no other option, Mercy found a quack doctor to terminate her pregnancy.

At the FHOK clinic in Kibera, the largest slum in East Africa, the likelihood of a patient being unable to afford services is high, but the rate of denial of services is zero. Nearly all — 95 percent — of the services provided at the Kibera clinic are free, thanks to Gag Rule mitigation funds from various sources and grants from organizations like Population Connection. Aggrey Marita, the FHOK Kibera Medical Center Manager, does not allow a single patient to go unseen. He says it’s worth it to forgo clinic improvements to avoid denying vulnerable people service. While there used to be five or six providers at the clinic, there are now only two, each of whom sees 50–60 patients in a single day.

Mercy was lucky, and with the post-abortion care that Aggrey provided her and some bed rest, she was able to recover. Before she left, Mercy was counseled on family planning — something she knew little about. After learning about her options and what family planning could do to help her, Mercy chose
the contraceptive implant. She also decided to take on a leadership role to counsel other young women, and has since become a community advocate for comprehensive reproductive health care in her Kibera neighborhood. She hosts weekly talks with other young women, both with and without children, to discuss how important contraception is. Conversation is open, honest, and led by a woman with a story all too common for many of the people in the room.

Unlike the clinic in Kibera, some Nairobi area clinics have begun to charge clients because they don’t have access to the same Gag Rule mitigation funds that Kibera has. When patients can’t afford fees and clinic expenses cannot be paid, facilities are forced to close. Clinics in Mombasa, previously a hub for mobile outreach services to rural communities; Kitengela, which served one of the most vulnerable communities on the fringe of Nairobi County; and Isiola have closed. FHOK’s Director of Clinical Services, Amos Simpano, anticipates more closures in 2019.
More often than not, FHOK is the only health care provider in a Kenyan community, and even more frequently the only provider of reproductive health care services. Patients have built generations-long relationships with providers, and communities trust the clinics for safe, honest, and comprehensive care.

Closing clinics also has an impact on staff. Olivia Tuti, the former Medical Center Manager at the Kitengela clinic, and her staff lost their jobs due to the reinstatement of the Global Gag Rule. In the short while that Olivia struggled to find work in the competitive Nairobi job market, Amos had applied for a grant from IPPF, which manages a Gag Rule response fund that its affiliates can access. That grant was awarded to FHOK, and Olivia now leads the Global Gag Rule Mitigation Project for the program.

The FHOK Nairobi Youth Center in the neighborhood of Eastleigh, run by Josephine Kimani, is more than just a place where young people go to receive health care. It’s a place for young people to be themselves; to discuss intimate-partner violence in the weightlifting gym; to share emotions and bond over pop culture in the henna salon; to talk about the changing political atmosphere in the barbershop; and to celebrate each other’s individuality in the photography studio.

Through the Young People Advocating for Health (YAH) program, youth leaders are trained to facilitate discussions within their communities about reproductive health care, something that has helped break down cultural barriers. For Muslim youth leaders, many of them Somali refugees, the time spent
communicating with religious leaders has paid off. As a result of these discus-
sions, sheiks and imams have given the youth permission to facilitate conver-
sations about sexual and reproductive health with other members of their faith communities.

Through the drama club, they create messaging calling for women’s empower-
ment and access to contraception. Through the YAH program, young people are advocating with county leaders about the importance of funding contraceptive services and encouraging comprehensive sexuality education in schools.

When we asked the young people at the youth center why family planning was important to them, we got the usual range of responses: “I’m not ready for children,” or “I want to start a career first,” or “I want to be able to space my births so that I can have healthy pregnancies.” But one young person offered a much more grim response: “My area is not safe to be there because maybe there are rape cases, so it’s a sense of security.” The idea that contraception provides a “sense of security” in the event of sexual assault is the reality for so many young women in Nairobi, in Kenya, and around the world. 

During our discussion, one young man demanded that the leadership at FHOK, present in the room with us, increase commodities at the youth center. There are shortfalls of antibiotics and other medications, and sometimes of contraceptives. But these stockouts have nothing to do with bureaucracy at FHOK, and everything to do with foreign assistance bureaucracy in the United States. The Gag Rule, combined with Trump’s refusal to fund the United Nations Population Fund (UNFPA), which provides FHOK with medications and supplies, is having a devastating effect on the availability of commodities.

About an hour outside of Nairobi lies Thika, a peri-urban center with an economy based on livestock and pine-
apple farming. Brian Waithaka, Medical Center Manager of the FHOK Thika clinic, delivered a clear message as we sat down: “We don’t turn patients away.” While a list of service costs is available, clients who are unable to pull together the funds may be given a subsidized cost, or receive a cost-free service, dependent on their income level.

That includes HIV/AIDS clients, who sometimes travel long distances to reach the clinic. Brian and his colleague Moses Okanda, SRH/HIV/AIDS Counselor, discussed how the stigma of being HIV positive is still very prominent. For many patients, that means seeking care within their own communities is not an option. Some travel the 200 kilometers from Nakuru to Thika to receive their ARVs for the month just to protect the confidentiality of their status. When clients arrive at the clinic, they are not quarantined in an HIV/AIDS specific counseling room, as is common at many medical facilities. At FHOK Thika, clients are seen in any clinic room regardless of HIV/AIDS status in order to protect their privacy; this is the standard at all FHOK clinics. If the FHOK Thika clinic were to close, patients who rely on the confidentiality of its HIV/AIDS testing, counseling, and ARV provision services could lose access to their only trusted provider.

When asked what they would do with hypothetical additional funding, Brian and Moses didn’t hesitate: more outreach services to the remote rural communities in Thika, and a 24-hour maternity ward. “That is the pressure we are having at the moment — the maternity ward. The clients are streaming in saying, ‘You guys, why don’t you have a maternity?’ That actually is the only thing we are missing at the moment,” Moses explained.

Clinics choosing not to bend to the harmful rhetoric of a president who is on the other side of the world are champions of free speech and of a commitment to comprehensive health care. Service providers and program managers like Aggrey, Amos, Olivia, Josephine, Brian, and Moses are saving lives through their work every single day. Though Trump’s Global Gag Rule puts a strain on their ability to provide care, it doesn’t stop them.
HOW TO GRAPPLE WITH SOARING WORLD POPULATION? AN ANSWER FROM BOTSWANA

Botswana has one of the fastest falling fertility rates. As global population expands, there are lessons to be learned.

At the end of a dusty road in the southern African hinterland sits a small concrete building with an orange door. It is a structure so modest and remote that it is hard to believe it could hold lessons for addressing one of the world’s biggest challenges.

The unit is the medical hub for Gasita, a village of 2,000 people in the south of Botswana. Inside one of the rooms, pharmaceutical supplies are neatly stashed on shelves while a photograph of the country’s president, Mokgweetsi Masisi, is propped up on a counter next to a window that is ajar, letting in a warm breeze.

Outposts like these — offering family planning services, contraception, education — have helped bring about one of the world’s most remarkable demographic shifts. In a continent where fertility rates are the highest in the world and populations are soaring, Botswana has a different story to tell.

Fifty years ago, Botswanan women would have seven children on average. Now they have fewer than three. It’s one of the fastest falling fertility rates anywhere in the world — a dramatic decline that merits scrutiny.

The world’s population is on track to hit 8 billion in 2023, and almost 10 billion by 2050. Sub-Saharan Africa is set to grow faster than anywhere: there were 1 billion Africans in 2010, but that number will grow to 2.5 billion by 2050.

Some have warned that this growth risks “driving civilization over the edge,” a controversial view given that it is rich countries, not poor, that lead the way on consuming the world’s resources.
In a continent where fertility rates are the highest in the world and populations are soaring, Botswana has a different story to tell.

Article by Nicola Davis
Photos by Pako Lesejane
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Supported by The Skoll Foundation

The health center in Gasita, a village of 2,000 people in the south of Botswana
But enabling women to control their fertility — a move that almost inevitably leads to them having fewer babies — is not just about a tussle over resources, or the environment: It brings enormous ramifications for women’s health, education, and employment — with knock-on effects for society and the economy.

So what did Botswana get right?

In a ground floor office at the University of Botswana, in the country’s capital of Gaborone, Dr. Chelsea Morroni considers the issue. “Everyone is always asking, ‘how did this happen?’

An expert in international sexual and reproductive health at the Liverpool School of Tropical Medicine, Morroni has lived in Botswana with her family for five years. As founder and director of the Botswana Sexual and Reproductive Health Initiative, she spends her days delving into issues around fertility and contraception.

But Morroni says understanding Botswana’s dramatic fertility decline involves teasing apart a complex web of factors.

“There’s been a huge amount of change in Botswana,” she says, pointing out that since Botswana became an independent country in 1966, the landscape developed quickly, with high levels of economic growth and development of both health care infrastructure and education infrastructure, enabling young women to become educated and have employment opportunities.

“All of those things on the macro level are really important to fertility declines anywhere in the world,” says Morroni, whose work is part of the Botswana UPenn...
Partnership: a collaboration between the Botswana health ministry, the University of Botswana, and the University of Pennsylvania.

But the country made more direct strides, too. “Botswana also was very proactive in the early years in establishing a family planning program, so in setting up a program that was far-reaching in terms of its geographical reach, providing access to most people in the country to a range of contraceptive methods,” says Morroni.

Maternal and child health and family planning services were integrated from the outset more than 40 years ago. A suite of contraceptives are now available through facilities ranging from the most rural health posts to urban hospitals. An NGO, the Botswana Family Welfare Association (Bofwa), works with the government to reach out to even the most rural of locations around the country to improve access to sexual and reproductive health services, particularly among young people.

There are other considerations, too. The infant mortality rate decreased from 97.1 deaths per 1,000 live births in 1971 to 17 in 2011, while an increasing proportion of the population living in urban settings could also play a role: Fertility rates are generally higher in rural areas.

And there is another issue. “Botswana … has been very hard hit by HIV, one of the hardest hit countries in the world,” says Morroni. And as she points out, research suggests there is an association between HIV infection and reduced fertility, although how much of a contribution that has made to the steep fertility decline is very difficult to say. “Luckily with the advent of universal access to antiretroviral therapy we are seeing a narrowing of the gap between fertility in HIV infected and uninfected people which is really, really a step in the right direction,” she says.

All of which mean that women like Chyna are becoming statistically rarer. “I have seven children and all the time I was bearing these seven children, there was never a break in between eight years,” says the 30-year-old, sitting inside the Gasita room, the fabric around her hair bright with the colors of the Botswana flag.

A single mother, Chyna found respite from multiple pregnancies through the work of Bofwa.

“I eventually got to find out about the implant from Bofwa — I asked for help because the pregnancies were getting out of hand and, knowing myself, if it wasn’t for the implant I would still be pregnant now,” says Chyna, speaking through an interpreter.

“I am very, very grateful. My only problem is that I have got so many kids that I can barely take care of [them]. They need clothing, they need to be fed.”

While the health post is government run, Bofwa makes a visit about once a quarter to Gasita and nine other

Fifty years ago, Botswanan women would have seven children on average. Now they have fewer than three. It’s one of the fastest falling fertility rates anywhere in the world — a dramatic decline that merits scrutiny.
settlements around Kanye, led by nurse and midwife Phenyo Ntoko. These outposts are replicated across rural Botswana, where women are increasingly keen to embrace contraception, including the implant, which sits in the upper arm and lasts for years.

Their priorities are as individual as the women themselves. For some it is about preventing pregnancies at an early age, for others the main goal is to space children. Many women gathered at the health posts said they only want two, with many years between them to help them raise their first child well.

Despite the complex range of factors behind the dramatic fertility decline, and the fact that different countries have different political histories and cultural and social influences that make comparisons difficult, Morroni believes other nations could take a leaf out of Botswana’s book.

“They are, from my perspective it is really about having the political will for the development and implementation of a high quality family planning program with reach,” she says.

A World Bank report on Botswana’s fertility revolution says myriad other factors contribute to a more measured approach to family planning: the education of girls, encouraging women to enter into the workforce, and reaching individuals in their homes by means of visits by family welfare educators.

Una Ngwenya, the chief executive of Bofwa, agrees that the family welfare educators were a key factor behind the fertility decline. But, she adds that national averages don’t tell the whole story.

“Where I work, mothers still have six kids,” she says. “People tell you in Botswana you have an average of women having two kids — I ask you, where? I cannot see that.

“We are one of the most unequal countries in the world — what happens here in the big villages and in the cities does not necessarily happen in Lorolwane,” she adds, referring to a remote village beyond Gasita, as yet without electricity.

A member association of the International Planned Parenthood Federation, Bofwa receives core funding from the organization, as well as some government funding and contraceptive commodities and antiretroviral drugs from Botswana’s Ministry of Health and Wellness. Other partners include the Positive Action for Children Fund from private firm ViiV Healthcare.

“We have five centers,” Ngwenya says, ticking off sites around the country. “It gives me satisfaction to see a group of girls speaking very confidently about how they want to make their choices.” Ngwenya rejects the idea that contraception is being pushed on women, pointing out that communities are impatient for Bofwa to work with them. “It used to be difficult to go into a community and talk about contraception. Now they even say, ‘hey you are taking too long, come to our community; we need you people here, now,'” she says.
But Bofwa has had to close at least two centers because of Donald Trump’s reinstatement of the controversial Global Gag Rule, which prevents U.S. federal funds going to any group that performs or even provides information about abortions.

Among the Bofwa services suspended are projects specifically engaging with populations, including sex workers and men who have sex with men, as well as another working with vulnerable children.

“Ah, that was such a blow,” says Ngwenya with a sigh. “The impact of the Gag Rule was so much on the clients, but also on Bofwa’s reputation. It really impacted our work in a very negative manner.”

Bofwa does not provide abortions, but it does counsel women who might be seeking one — which is legal under certain conditions in Botswana — and those who have had an abortion.

“For me, it is rewarding to see Bofwa help one girl to terminate a pregnancy that came from incest,” says Ngwenya, adding that improving understanding of when abortion is currently legal is important. “We want the community to know their rights,” she says, noting that the team sees cases of young teenagers becoming pregnant. “Our research tells us there is a lot of need here. What has happened to these kids? Could it be rape, could it be defilement?”

Nonetheless, Ngwenya is sanguine. “Bofwa is a very resilient organization; we have been here for 30 years and we will go on for a good while to come.”
The 116th Congress has already made history.

There were a number of firsts in this freshman class, which was sworn in on January 3. Ilhan Omar (D-MN) and Rashida Tlaib (D-MI) became the first Muslim American women elected to Congress. Sharice Davids (D-KS) and Deb Haaland (D-NM) are the first Native American women to serve. Davids is also the first openly LGBTQ person sent to Congress by the state of Kansas. Veronica Escobar (D) and Sylvia Garcia (D) became the first Latinas to represent Texas.

Overall, a record 117 women — 102 in the House and 15 in the Senate — will serve in the 116th Congress. Twenty-four of the new House members are people of color, including 13 women of color. Six states now have two female senators: Arizona, California, Minnesota, Nevada, New Hampshire, and Washington. In Arizona, Rep. Kyrsten Sinema (D) narrowly defeated Rep. Martha McSally (R) for the seat of retiring Senator Jeff Flake (R). McSally was later appointed to replace Sen. Jon Kyl (R), who had agreed to serve temporarily after the August death of Senator John McCain.

The election results mean there is now a solid pro-family planning majority in the House. The Senate remains another story. However, with Sens. Susan Collins (R-ME) and Lisa Murkowski (R-AK) maintaining their seats on the powerful Appropriations Committee, that committee still has a pro-family planning majority. We will be watching with great interest as the Fiscal Year 2020 appropriations process unfolds (eventually, one presumes — see below).

Now that the new Congress is in place, we expect the Global Health, Empowerment, and Rights Act (Global HER Act) to be reintroduced in both the House and Senate in early February. During the 115th Congress, the bill had 165 cosponsors in the House and 47 in the Senate.

Trump Rollback of Birth Control Benefit Stymied by Courts
The day it was set to take effect, a federal judge in Pennsylvania issued a nationwide preliminary injunction against the Trump administration’s rollback of the Affordable Care Act’s (ACA) birth control benefit. The benefit requires that insurance plans cover all FDA approved methods of birth control without co-pays. The Obama administration had previously allowed some narrow exemptions to the rule for churches and other religious institutions, but the Trump administration has sought to allow any entity to opt out of the requirement based on religious or moral objections. The preliminary injunction is not permanent. Rather, it delays implementation of the policy until the remaining lawsuits are settled.

Budget Impasse Leads to Record-Setting Shutdown
At the time of our press deadline, the United States was a month into a partial government shutdown. It’s a new record, easily eclipsing the previous mark of 21 days set in January 1996.

A quick recap of how we got here:

Back in September, Congress approved a full-year budget package for several parts of the government, including the Department of Health and Human Services, which oversees Title X, the nation’s family planning program for low-income people. The State Department, however, which has jurisdiction over our international family planning programs, was among the agencies that did not see its Fiscal Year 2019 budget passed.
Instead, Congress passed a Continuing Resolution (CR), extending funding for those agencies at FY 2018 levels through early December. The expectation was that after the November elections, the lame-duck Congress would either pass the remaining full-year bills or agree to another CR, keeping the government open until the 116th Congress was seated.

For a time, they appeared to be on track to follow the first course. Believing they were on the verge of an agreement, legislators passed a short CR extending funding through December 21, in order to give themselves more time to finalize the details. Although Donald Trump had previously claimed he would not sign any bill that did not appropriate billions of dollars for a wall on the United States/Mexico border, congressional leadership had assurances that he would sign the package when it was ready.

At the last minute, however, egged on by voices from the far right, Trump reneged on his agreement and announced he would refuse to sign the measure due to its lack of funding for a border wall. Legislators scrambled for a solution, but the government entered a partial shutdown at midnight on December 22.

Approximately 75 percent of the government was funded through the bills passed in September, but the shutdown is nonetheless having significant and growing effects. Many national parks are closed, some food inspections have stopped, and the Internal Revenue Service has indicated that tax filings and refunds may be delayed if the shutdown continues. Personnel deemed “essential” are required to work during the shutdown, though they are not being paid. Affected employees include TSA and air-traffic control personnel, along with members of the Coast Guard and some 13,000 FBI agents. As has happened during previous shutdowns, government workers are expected to receive back pay once the government reopens, though most contractors will not.

What does all this mean for international family planning programs? Right now, the shutdown means no new money is flowing, and many of the people who administer the programs are furloughed. Going forward, the situation is murkier. The bill negotiated before the shutdown maintained the status quo for international family planning — no change to the Global Gag Rule, $575 million for bilateral programs, and a U.S. contribution to the United Nations Population Fund (UNFPA) of $32.5 million — although the current Kemp-Kasten determination barring funding to UNFPA means that money would be “reprogrammed” to other women’s health initiatives.

The new House of Representatives, however, wasted no time in signaling where it stands on these issues, passing a funding bill that included the Senate Appropriations Committee’s family planning language — higher funding than had been passed by the previous House, a repeal of the Global Gag Rule, and funding for UNFPA.

Anti-family planning members immediately offered a motion to strip those provisions from the bill, but, fortunately, it failed 199–232. Democrats Collin Peterson (MN) and Dan Lipinski (IL) joined all Republican members of the House in voting for the motion. The Senate declined to take up the measure.

Whatever ultimately happens, we’ve all been put on notice that this new House of Representatives is willing to fight for these priorities, and it’s a thrilling thing to see.
Just over two years ago, we launched our #Fight4HER campaign to push back against attacks on reproductive health and rights under the Trump administration. Our grassroots volunteers across the country have maintained their unwavering activism while collecting over 25,000 petitions to repeal Trump’s Global Gag Rule, activating hundreds of volunteers in communities across the country, and hosting hundreds of events to show Trump and his cronies that we will not stand by as they undermine access to reproductive health care worldwide.

As we continue the fight in 2019, we reflect on all of the progress we’ve made in the #Fight4HER so far.

2017

• We launched our campaign in six states (Arizona, Colorado, New Hampshire, North Carolina, Ohio, and Pennsylvania), hiring organizers and hosting silent demonstrations, photo petitions, press conferences, teach-ins, and petition drops to protest Trump’s deadly Global Gag Rule.

• We hosted Capitol Hill Days 2017, drawing 333 activists from 34 states across the country to Washington, DC, for a weekend of advocacy training and meetings with their members of Congress.

• We joined the Protect Our Care coalition to push back against attempts by the Trump administration to repeal the Affordable Care Act.

• We attended the “Let’s Talk About Sex” conference, hosted by SisterSong in New Orleans, where we learned how to be better allies to the reproductive justice movement. Our field staff also presented a workshop at the conference on how activists can effectively #Fight4HER.
• On International Safe Abortion Day, we were joined by Population Institute, Reproaction, Advocates for Youth, and Physicians for Reproductive Health for a protest outside of the White House to “Make Some Noise for Safe Abortion Access.”

• After gaining momentum, we expanded our campaign into Nevada and Wisconsin, where two new organizers joined our ranks.

• We traveled around seven states with Family Health Options Kenya (FHOK) Director of Clinical Services Amos Simpano, FHOK Kibera Clinic Director Melvine Ouyo, and human rights activist Lisa Shannon to share stories about the catastrophic effects of the Global Gag Rule in Kenya with our grassroots supporters.

2018

• On the anniversary of Trump imposing his expanded Global Gag Rule, we staged a visual protest — a light projection of snarky messages on the Trump International Hotel in DC — garnering national media attention. We also sent out mobile billboards in Nevada and Wisconsin to shame Trump and then-Speaker of the House Paul Ryan for their disregard for women’s health and lives.

• We hosted our largest Capitol Hill Days ever in 2018, with nearly 350 participants from 25 states and 169 congressional districts.

• We launched our Summer of HER project in our eight campaign states, collecting nearly 8,000 petitions, engaging 52 fellows, recruiting 121 volunteers, and receiving 105 #Fight4HER campaign endorsements from community leaders, businesses, and coalition partners.

• We hosted Summer of HER summits in all eight #Fight4HER campaign states, engaging a total of 424 participants — among them Reps. Ruben Gallego (AZ-7), Ann Kirkpatrick (AZ-2), David Price (NC-4), and Susan Wild (PA-7).

• We pushed back against the nomination of Brett Kavanaugh to the Supreme Court, rallying in DC and key states and urging senators to reject his nomination.

The House now has a majority supportive of family planning and reproductive health programs. On its very first day, the House passed a government funding bill that included provisions repealing the Global Gag Rule and restoring aid to the United Nations Population Fund (UNFPA). Rep. Nita Lowey and Sen. Jeanne Shaheen are expected to reintroduce the Global Health, Empowerment, and Rights (HER) Act in early February.

Over the past two years, we’ve made enormous progress, with thousands of people standing up and speaking out for the right of every person in the world to have access to comprehensive reproductive health care and family planning services. Join us as we continue the battle for Health, Empowerment, and Rights.
Fall is the busiest time of year for PopEd, and the 2018 season was no exception — over 250 workshops were held from September through December. While we rely heavily on our network of volunteer facilitators to achieve this impressive showing, our staff also travels throughout North America to fulfill workshop requests and expand our program into new regions. About a quarter of last fall’s workshops were led by PopEd staff. Working face-to-face with educators gives us new perspectives on the benefits of our materials and the impacts of our program. Here’s a sampling of some of the insights gained from our travel last fall.

Kate Anderson
Education Associate

Last September marked my second PopEd visit to Alberta, Canada. I worked with future teachers in the Red Deer and Edmonton regions, and enjoyed seeing beautiful “Wild Rose Country” in the fall. My favorite campus visit in Alberta was Burman University, Canada’s only Seventh Day Adventist school.

I will admit, I was a little nervous when my first workshop of the day started with a reading from a devotional book and a whole-group prayer. My worry, however, proved to be unnecessary. Many of the students enthusiastically shared how the PopEd lessons aligned with their religion’s values of environmental stewardship and humanitarian work. After our simulation of the “Tragedy of the Commons,” students wondered how the sustainable resource distribution game would play out in different cultures, especially in more communal-minded societies like the indigenous communities in their province.

Everyone loved learning about Malawi and comparing a typical daily budget for a family there with that of an average family in Canada in our activity, “Global Cents.” They were so engaged that they suggested new ways to arrange the paper cup “prey” in our popular carrying capacity activity “Panther Hunt.” For example, knowing that beavers live in small groups, they decided to cluster those cups for an added touch of realism. It was also nice that, unlike their U.S. counterparts, no college students here batted an eye about the metric system measurements that we use in our lessons!

Lindsey Bailey
Senior Teacher Training Manager

We depend on relationships to grow the PopEd program, and some of the most important relationships are with the professors who invite us to present in their pre-service classrooms year after year. On one such trip to New Jersey City University last fall, I was reminded of another important relationship: the one that we cultivate with the participants who attend our workshops. During the professor’s introduction to her class of future science educators, she mentioned that she had participated in a PopEd workshop as part of her graduate program a few years back. She found it so relevant as a student that she has included a PopEd workshop in her syllabus every semester since becoming a professor.

I have heard similar testimonies in the past and am struck by how a short workshop experience can have a lasting effect on participants, even years down the road. I credit this type of sustained interest in our program to the quality of our materials and presentations, and also to our ability to keep past workshop participants involved with continued communication. After attending a workshop, teachers can opt to receive a bimonthly newsletter to keep them up to date with the PopEd program and resources; they can also engage through our Facebook and Twitter posts, and they can elect to receive targeted marketing about new products that they may find useful in their classrooms.
Nurturing these relationships has clearly proven effective in the past, and will continue to be a key part of our work.

Carol Bliese  
**Senior Director of Teacher Programs**

“The activity that stood out to me the most was the population circle game representing how crowded the world is and how quickly our population has exploded. It gives a tangible, relatable sense of our population’s growth.”

Bringing population growth to life is one of our goals in the PopEd program, and this quote from a participant’s evaluation form indicates that our workshops are making that happen. This particular workshop was for a group of geography teachers in Ontario. We covered several methods for teaching the history of human expansion — the interactive simulation mentioned above, our World Population “dot” video, and a graphing activity comparing population growth curves.

Offering different ways to teach a topic means teachers can select whatever method(s) will fit their students’ various learning styles (kinesthetic, spatial, mathematical, etc.). I’m confident that the 24 educators in this workshop will be using PopEd lessons down the road, if they haven’t started already. Their enthusiastic conversations during the workshop quickly moved from praise for the resources to logistical planning on gathering props and specific placement in their syllabi. One participant isn’t keeping us guessing, noting on her evaluation form, “Everything was a lesson plan and so practical. I thoroughly enjoyed this presentation and will 100 percent use this in the classroom.”

Isabelle Rios  
**Senior Education Associate**

Last fall, I had the pleasure of traveling to Florida to share PopEd resources with students at Florida International University (FIU) and Miami Dade College. Most of the classes I worked with focused on elementary science education.

During my workshops I found that students were engaged and energetic, often scribbling down little notes here and there. It wasn’t until we debriefed several activities that I became aware of just how much participants were enjoying the presentation. At FIU, students shared that many of the K-5 students in the area are not native English speakers, and they found the hands-on nature of our activities to be an excellent way to break down language barriers in their classrooms. Several of the lessons I presented utilized movement, non-verbal communication, and visuals as teaching tools. It was very gratifying to hear that our curricula will be directly applicable to the populations these future teachers will serve.

Top: A student dumps pollutants into a simulated ocean in the activity, “Code Blue”  
Bottom: Students collect “prey” during the activity, “Panther Hunt”
THE JEOPARDY OF PROGRESS

This graph shows the increase in crop yields due to improved agriculture.

This graph shows the increase in the human population due to the increased crop yields.

This graph shows the increase in environmental degradation due to the increased population.

This graph shows the increase in despair as we realise that we can use the same graph to measure them all.
A
ccess to birth control is crucial to ensuring women can control their lives, plan their families, and, in many cases, manage ongoing medical conditions.

Yet by pushing to let more employers deny insurance coverage for contraceptives, the Trump administration is treating birth control as some kind of novelty, rather than the medical necessity it is for millions of women.

Final rules issued by the federal government this month will let many more employers claim religious or moral exemptions from providing birth control coverage. And, unlike in many cases before, a third party such as an insurance company will no longer be required to step in and provide that coverage when employers refuse to do so.

To preserve women’s access to birth control, the Trump administration should retract these rules, which are set to take effect January 14. If the administration fails to reconsider its approach, Congress should vote to override the new rules.

A separate proposal by the Trump administration would allow women whose employers claim a religious or moral exemption to access Title X family planning services, which are meant for low-income people. But this plan is woefully insufficient, given that the federal Title X program is already underfunded and unable to meet current levels of demand. Federal officials didn’t respond to a question this week about whether the administration would also try to increase funding for the Title X program.

Rather than continuing what promises to be a prolonged legal battle, federal officials should swiftly reverse course.

If they do not, members of Congress should not hesitate to pass legislation protecting women’s contraceptive coverage long into the future.

— November 25, 2018

P
resident Donald Trump is continuing his assault on the Affordable Care Act, and women’s health care is the latest casualty. The Trump administration issued new rules last year that are scheduled to take effect this month and would allow more employers to deny birth control coverage through their health plans. The rules are billed as “conscience protections” for employers with religious or moral objections to contraceptives, but where is the morality in denying millions of women basic health care?

The new rules would allow more entities to claim exemptions on religious grounds, under the illogical notion that a corporation can have religious beliefs. They also would let nonprofit organizations and small businesses claim non-religious moral convictions in denying birth control coverage. These rules aren’t upholding the constitutional right to freedom of religion — they’re contorting it by making a woman’s access to health care subject to the religious beliefs of her employer. That also amounts to blatant sex discrimination.

The administration also has proposed that women whose employers don’t provide birth control be allowed to obtain it from federally funded family planning clinics for low-income people. Those clinics already struggle to keep up with demand and never have enough money. Requiring them to spread their dollars even further to subsidize these new exemptions is an unnecessary drain on scarce public money. And this proposal comes with other bitter pills, including new restrictions and requirements on clinics that provide abortions.

By making it easier for employers to deny birth control coverage, the Trump administration would be making it harder for women to access basic health care and family planning measures. Religious organizations already enjoyed reasonable accommodations for opting not to provide contraceptives. The beliefs of CEOs, company presidents, and business owners should be irrelevant beyond their own families. Instead they are being elevated above the health needs of women.

— January 2, 2019
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