Heilbrunn Department of
Population and Family Health
Mailman School of Public Health
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COLUMBIA

February 10, 2020

Chairman Eliot L. Engel

U.S House Foreign Affairs Committee

2426 Rayburn House Office Building

Washington, D.C. 20515

Ranking Member Michael McCaul

U.S House Foreign Affairs Committee

2001 Rayburn House Office Building

Washington, D.C. 20515

Re: Unique Challenges Women Face in Global Health Hearing

Dear Chairman Engel, Ranking Member McCaul, and Members of the Committee:

On behalf of Columbia University, Mailman School of Public Health, I, Terry McGovern, JD, Chair of the Heilbrunn Department of Population and Family Health (HDFPH) submit this letter for the record in connection with the House Committee on Foreign Affairs hearing "Unique Challenges Women Face in Global Health," which took place on February 5, 2020. I submit this letter on behalf of a team of researchers who are conducting a multi-country, mixed-methods research study, "Assessing the impact of the expanded global gag rule."

The Heilbrunn Department of Population and Family Health (HDPFH) at Columbia University has a long and proud history of education, scholarship, research, and activism in the areas of human rights and gender equality. Since its founding in 1975, HDPFH works to address public health threats in low-income, unstable, and inequitable environments globally. I serve as Chair of the Department and in this capacity oversee 24 full-time faculty, 11 jointly-appointed faculty, 21 adjuncts, and 21 staff members. As a widely respected academic institution that combines the implementation of high quality research with on-the-ground programming, the HDPFH is well positioned to carry out this research. The following testimony addresses initial, unpublished findings from the multi-country, mixed-methods research study.

Mexico City Policy Background

During his first week in office, President Trump issued an executive order reinstating and broadening the reach of the Mexico City Policy (MCP), better known as the "Global Gag Rule." The reinstated MCP was renamed "Protecting Life in Global Health Assistance" (PLGHA) and prohibits United States Government (USG) global health assistance from being provided to foreign non-governmental organizations (NGOs) that perform abortions in cases other than a threat to the life of the woman, rape, or incest; provide counseling—

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including advice and information campaigns– and/or referral for abortion; lobby or make abortion legal or more widely available in their country.[1] Under President Trump's new order, PLGHA applies to all global health assistance furnished by all departments or agencies. This expanded policy not only affects international family planning programs, but also the broader field of U.S. global health assistance. Funding sources affected include USAID, CDC, DOD.[2] On March 26, 2019 an expanded PLGHA was announced which stipulates that foreign NGOs that receive USG global health assistance as a prime or sub-awardee are prohibited from providing any (including non-USG) financial support to any foreign NGO that engages in activities prohibited by the policy. It extends the policy beyond the organizations receiving USG money to sub-grantees of separate donor projects.[3]

Research Background

In conjunction with research and service delivery partners in Kenya, Madagascar, and Nepal we are conducting a mixed-methods study to determine how the expanded PLGHA affects access to and provision of sexual and reproductive health services. We are collecting qualitative data via key informant interviews with a variety of stakeholders including NGO staff, health workers, and clients in addition to quantitative service delivery data from selected NGO and government health facilities. In all three countries, we convened local organizations, civil society partners and government agencies early in the project to ensure that the research tools were appropriate to the context. In order to ensure that the conclusions we draw are robust, we have undertaken a large number of interviews: 98 interviews in Kenya, 324 interviews in Nepal (over 2 rounds of data collection), and 149 interviews in Madagascar. Moreover, we are not an advocacy organization. We have received approval from ethical review boards in each country where the research is being conducted, and we approach the research with academic legitimacy and dispassion. Thus, results will carry the weight of rigorous research from a renowned academic institution.

The three countries we are studying are diverse, allowing us to examine the impact the PLGHA may have in different contexts. They represent a range of legal, political and cultural contexts around sexual and reproductive health. The analysis is on-going and findings included in this letter are preliminary and unpublished. The following testimony is divided into two parts. Part one offers a summary of our preliminary findings to date and part two contains an excerpt from the American Public Health Association (APHA) policy statement "Preventing and Reducing the Harm of the Protecting Life in Global Health Assistance Policy in Global Public Health," authored by Columbia University researchers.

Part I: Preliminary Research Findings

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[1] Protecting life in global health assistance fact sheet, 2017. *United States Department of Defense, Office of the Spokesperson*. https://www.state.gov/protecting-life-in-global-health-assistance-2/

[2] Henry J, Foundation KF. *Breaking down the US global health budget by program area.* https://www.kff.org/global-health-policy/fact-sheet/breaking-down-the-u-s-global-health-budget-by-program-area/

[3] Global Health. *The pro-life agenda: Secretary Pompeo's bold leadership fact sheet.* https://globalhealth.org.

Chilling effect

- PLGHA does not apply to US global health assistance money provided directly to governments, therefore governments are not required to comply with PLGHA. In Nepal, USAID works closely with the Nepalese government at the national and district levels, often providing funding support for national trainings and technical meetings; and for the development of national health planning documents and strategies. NGOs that do not comply with PLGHA report no longer being included in these government-run processes or technical trainings, even on topics unrelated to abortion. Similarly, we have learned that abortion-related information has been deleted from some Nepalese government policies and guidelines. Our data suggests that over-interpretation on the part of USAID missions and the government of Nepal is the cause. Examples like these demonstrate how the policy undermines national sovereignty and influences entities that are supposed to be exempt, and possibly national health policy, budgetary, and programming decisions as well.
- In Kenya, organizations that comply with PLGHA are dropping out of coalitions, and are often unwilling to come to meetings with organizations that do not comply. This disruption causes unnecessary duplication of efforts and poor coordination, the undoing of government supported health strategies, a culture of fear and mistrust between groups, and siloed spaces within sexual and reproductive health advocacy, policy, and programs.

Service delivery impacts

- In Nepal, we are seeing that service delivery and referral networks are disrupted in two ways:
  - Through routine implementation of the policy—e.g., an NGO that complies with PLGHA can no longer provide, counsel, or refer women for abortion services.
  - Through over-interpretation of the policy—e.g., facility managers and providers who work for NGOs that comply with PLGHA report that they are no longer referring women for any sexual and reproductive health service (e.g. contraception) to facilities where safe abortions are also performed. However, PLGHA only restricts referrals to those facilities for abortion.
- In Kenya, NGOs report being forced to choose between continuing their reproductive health or their HIV programming. Prior to this iteration of PLGHA, USG global health funding priorities emphasized service integration, particularly for sexual and reproductive health and HIV care. Now, some NGOs are forced to dismantle trusted and successful integrated care models, creating inefficiencies. For example, patients have to travel to different providers and even different service delivery points in order to access care.
- Madagascar has experienced many stock outs of family planning supplies since 2017. Sometimes, certain contraceptives that women use are not available anywhere in the country. Facilities are experiencing long-term stock outs of contraceptives, especially oral contraceptives and injectables. These stock outs are caused by several factors, including the US defunding of UNFPA and PLGHA. As a result,
  - Many women do not have access to any contraception, and they spend a lot of time and money trying to find them (women are going to multiple providers to access services),
  - Women have limited method choice; clients are denied their preferred contraceptive method,
  - The costs of family planning supplies has gone up; clients are asked to pay for contraceptives that used to be free or to make a payment for services,
  - Women lose trust in the health care system, so that even when supplies are restored, women may not seek services.

Loss of funding to NGOs

- In Kenya, organizations that do not comply with PLGHA reported having to downsize, cut staff, and reduce support to local facilities. In turn, these facilities receive fewer commodities, have to reduce outreach activities and clinic hours, eliminate community health workers and providers, and/or reduce salaries.
    - Facility-level respondents report that the Kenyan Ministry of Health is not equipped to meet demand for contraception and safe abortion commodities. Typically, the NGO sector fills this gap and provides commodities when the public sector cannot. So, when the NGO sector is weakened by PLGHA it becomes even harder for women to access the services that they need in both sectors.
    - Several facilities report having to charge women for contraceptives (which used to be free) as a direct result of losing financial support from an NGO that did not sign PLGHA. Respondents also report that many women are unable to pay for family planning and left without their desired method or without a method at all.
- In Madagascar, one NGO that chose not to comply with PLGHA was forced to close many of its health facilities and end mobile services when it stopped receiving US global health assistance for family planning. This organization had previously been the largest NGO provider of family planning in the country and the only provider in some regions. An estimated 40% of Malagasy women who use modern contraception received their services through this organization, which delivered 60% of all long-acting reversible contraceptives in the country. What has happened since the end of USG funding:
    - End of program providing free contraceptives to 170,000 women and girls living in poverty.
    - Reduction in number of providers; reduced staff salaries.

Part II: Excerpt from the American Public Health Association (APHA) Policy Statement Number 20199, Preventing and Reducing the Harm of the Protecting Life in Global Health Assistance Policy in Global Public Health. [4]

This policy statement was adopted by the APHA on November 5, 2019. APHA is a reputable public health association with a wide-ranging member community consisting of academics, policymakers, and practitioners. APHA policy statements are written by members and are accepted after approval by the APHA Governing Council. This statement was authored by Columbia University researchers on behalf of the International Health and Sexual and Reproductive Health sections of the APHA. The following paragraphs are excerpted from the "Problem Statement" section of the policy statement:

[4] Policy Statement, American Public Health Association, Preventing and Reducing the Harm of the Protecting Life in Global Health Assistance Policy in Global Public Health, (Nov. 25, 2019), https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2020/01/14/preventing-and-reducing-the-harm-of-the-protecting-life-in-global-health-assistance-policy.

Paragraphs 7-13:

Quantitative and qualitative research on the MCP and PLGHA have revealed three key domains of public health impact: (1) reduced access to contraception and an increased number of unintended pregnancies and induced, unsafe abortions; (2) decreased stakeholder coordination related to contraception and a general "chilling" of discussion related to contraception and abortion in policy forums; and (3) negative outcomes in domains of health other than reproductive health, including deterioration of broader health system functioning. Each of these domains of impact is outlined in detail below. These changes often disproportionately affect the most vulnerable; foreign NGOs undertake significant health outreach activities, and when funding for these activities is curtailed or ended, women in rural areas or highly stigmatized groups may have fewer options for health care.[9]

Reduced access to contraception and increased unintended pregnancies and induced abortions: Women of reproductive age who have access to family planning are less likely to experience unintended pregnancy, unsafe abortion, infant mortality, HIV/AIDS (when using condoms), and maternal mortality.[10]

Impacts on organizations that opt not to comply with the MCP/PLGHA: Foreign NGO providers of family planning services that decline to certify their compliance with the policy forfeit their access to U.S. government funding to provide health services under PLGHA. Notably, Marie Stopes International (MSI) and International Planned Parenthood Federation (IPPF) affiliates have chosen not to comply, as have many other foreign NGOs. As a result, MSI, the IPPF, and other foreign NGOs may close clinics providing services and/or impose (increased) fees for services. According to the IPPF, it "stand[s] to lose up to $100 million over the course of the policy," and MSI stated in June 2019 that it faced a "funding gap of $50 million through to 2020." [11,12] Client referrals between compliant and noncompliant organizations may be precluded. Referral disruptions may disproportionately affect rural areas, where clients rely on NGO-funded extension workers and have few if any other options for obtaining contraception or other health services.[9] USAID may eventually identify an NGO that is willing to comply and offer health care previously provided by the NGO that decided not to comply, but the new recipient may lack the client load capacity, management skills, local knowledge, and client familiarity of the previous grantee.[9]

Impacts on organizations that comply with the MCP/PLGHA: Organizations that opt to receive U.S. global health assistance and that work in domains related to reproductive health might deny their clients evidence-based medicine insofar as they cannot counsel or refer a woman for abortion unless she explicitly states that she has decided to have an abortion or unless national policy requires appropriate counseling and referral by providers.

Documented health outcomes of the MCP: Four quantitative studies indicate that access to modern contraception decreased and induced abortions increased in three world regions after implementation of the MCP.[13–16] One of the studies showed that these trends were reversed when the MCP was not in effect (from 2009–2014), providing further evidence that the policy was the cause of the trends.[16] The countries most affected by unsafe abortions, which result in 4.7% to 13.2% of maternal mortality annually, often rely heavily on USAID for family planning funding.[17–19] Due to the sizable proportion of USAID funding for these countries, NGOs serving women have few choices to replace this funding should they want to offer services that educate women on the diverse array of family planning options. This leads

women to seek alternatives such as unsafe abortions when they are not ready to raise a child. These decisions can lead to unintended long-term morbidity or mortality, including hemorrhage, infection, injury to the genital tract and internal organs, and death.[17]

Documented health impacts of PLGHA: Several organizations have collected data from countries in sub-Saharan Africa and Asia regarding the early impacts of PLGHA. Early results suggest that the MCP and PLGHA produce the same chain of consequences: reducing access to contraception and increasing unintended pregnancies, unsafe abortions, and poor birth spacing. In addition, the findings revealed negative effects on organizational resources, including family planning program budget cuts, staff terminations, clinic closures, increased costs passed to patients for contraceptive services, reduced availability of contraceptives, and cessation of rural outreach activities.[9,20]

Decreased stakeholder coordination related to contraception and a general "chilling" of services and discussion related to abortion: Some compliant organizations have overinterpreted the MCP—and now PLGHA—such that they refrain from engaging in allowable activities (e.g., stakeholder discussions about the health impacts of current laws in a given country). Such overinterpretation can stem from incomplete or incorrect information received from USAID missions and/or fear of jeopardizing an important source of funding. As a result, compliant grantees may withdraw from coordinating bodies or platforms related to reproductive health, depriving these bodies of important expertise. [21] For example, studies in Uganda, Ethiopia, Kenya, Peru, and Nepal undertaken during the course of the MCP revealed that, as a result of this "chilling effect," fewer stakeholders were involved in discussions about abortion law reform and lawmakers lacked access to critical information. This chilling effect can extend to services, such that organizations that opted to certify the MCP stopped providing permitted reproductive health services such as postabortion care and emergency contraception.[22–24]

Paragraphs 15 &17:

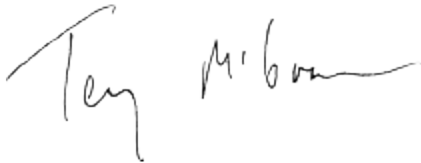
Negative outcomes in non-reproductive health domains, including deterioration of broader health system functioning: U.S. foreign assistance is essential to the health system infrastructure in many low- and middle-income countries. The United States is the largest bilateral source of global health assistance, contributing more than a third of all official health development assistance and 45% of total bilateral funding for family planning. [26] It is not feasible for another donor to provide a comparable level of replacement funding. Moreover, the global health community has invested significant human and financial resources to integrate health services, an approach that, if implemented well, can improve cost effectiveness and better serve patients.[27] Research shows that the MCP and PLGHA fragment health systems, as the policies result in broken relationships between organizations that do and do not comply and disrupt coordination and referral networks between contraception and related services.[13] In addition, clinics providing contraceptive services often provide other services, particularly HIV prevention. When these clinics are shuttered, community members lose access to contraception as well as to other HIV prevention services, potentially contributing to the spread of HIV.[13] An electronic survey of 286 prime President's Emergency Plan for AIDS Relief (PEPFAR) implementing partners showed that 33% of respondents across 31 countries experienced an impact from PLGHA, including reducing their provision of non-abortion-related information such as information about HIV.[28]

Given the expanded nature of PLGHA and the fact that many health systems have become further integrated since the previous version of the MCP was in force, it is widely expected that PLGHA will have an impact on health systems well beyond sexual and reproductive health.[30] For example, WaterAid, a large water, sanitation, and hygiene organization operating in 34 countries, has decided not to certify PLGHA because it refers women who experience sexual assault while fetching water to the closest appropriate clinic, which may be run by a noncompliant organization. As a result, USAID-funded programs and partnerships have ended, depriving long-term partners and beneficiary communities of WaterAid's work.[31] Moreover, groups similar to WaterAid that do choose to comply can no longer cooperate with organizations providing comprehensive sexual and reproductive health and rights services. Along similar lines, a "risk index" for the harm of PLGHA in PEPFAR-supported countries, developed with data from governments and bilateral donors, suggests that countries with generalized HIV epidemics, high reliance on U.S. bilateral assistance, and a high degree of service integration could face significant disruptions to referrals and HIV and contraceptive service provision. [32]

PLGHA has affected health systems on a global scale and has proven effects on the health of women, health systems strengthening, and service delivery. In addition to the research findings above, Congress should consider reforms to PLGHA.

If you have questions, please contact me at tm457@columbia.edu.

Sincerely,



Terry McGovern

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