HEALTH POLICY

Reproductive health in culture wars crossfire

The “Gag Rule” is endangering health in Africa and globally

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In his third day in office, President Trump ordered new abortion restrictions on U.S. foreign aid. Worldwide reaction against the policy was immediate (1). Recognizing that unsafe abortion is a major health risk for women in poor countries—estimated by the World Health Organization (2) to result in 47,000 deaths and millions of injuries annually—opponents and supporters are seeking ways to measure the policy’s effects as well as to minimize its harmful consequences.

Although far broader in application, the Trump administration policy is similar in intent to a policy originally announced in 1984 under President Reagan at an international conference in Mexico City, a policy that has been in place under every Republican president since then (3). Through prohibitions on what overseas private organizations can do with their own, non-U.S. government funds, the “Mexico City Policy” substantially tightened the grip of legislation such as the Helms Amendment that has for decades restricted the use of U.S. foreign aid funding for abortion-related activities (4). President Trump further expanded the policy to apply not only to family planning grants but to all global health funding (with few exceptions)—approximately $8.8 billion per year in grants and contracts, much of which is implemented through foreign private organizations that must comply. The policy guidelines were issued in May 2017, entitled “Protecting Life in Global Health Assistance” (5). Subsequently, the Administration proposed elimination of family planning funding and deep cuts in other global health funding, which is still under debate in Congress.

Under the new Trump restrictions, labeled by opponents as the “Global Gag Rule,” organizations receiving U.S. foreign aid funding may not provide abortions “as a method of family planning” or counsel women, even when legal in their countries, or advocate for access to safe abortion or liberalization of abortion laws. Supporters of the policy hope to see fewer abortions as a result. Opponents emphasize its violation of basic principles of human rights, democracy, and free speech; the loss of essential health and family planning services provided by effective, community-based organizations that become ineligible for U.S. funding; the high administrative costs at all levels to monitor and enforce the policy; and most important, evidence that by reducing access to contraception for many women, the policy will lead to an increase rather than decrease in abortions—with fatal results for many women compelled to resort to backstreet abortions. The policy’s negative consequences are expected to be greatest in Africa, where health and family planning programs tend to be heavily dependent on U.S. funding to serve highly vulnerable women and their families.

ASSESSING HEALTH CONSEQUENCES OF THE RESTRICTIONS

When the Mexico City Policy was last in effect under President George W. Bush from 2001 to 2008, various studies were published on its consequences, most using case studies and anecdotal evidence (6). There was only one major multiple-country study, by researchers at Stanford University (7). They found that the policy had the opposite of its intended effect; greater increases in abortion rates occurred in those African countries that were the biggest per capita recipients of U.S. family planning assistance before the policy took effect, compared with countries with lower levels of per capita assistance. Abortion rates for each country were estimated based on standardized data from periodic Demographic and Health Surveys.

Although the overall conclusion of the Stanford study is plausible, the study methodology did not take into account other confounding factors during the same period that also likely increased abortion rates, such as an increase in abortion services across Africa and a shift in U.S. funding in a number of countries away from family planning and toward HIV/AIDS (8). Findings of the Stanford study are nevertheless reinforced by a separate quantitative study in Ghana, which found that reduced access to contraceptives associated with the policy led to more unplanned births and abortion among disadvantaged rural women (9).

Concerned organizations are already communicating about its expected harms. An analysis published by the Kaiser Family Foundation found that compliance by organizations with the policy will likely limit women’s access to legal abortion in Ethiopia, Ghana, Kenya, and 19 other countries in Africa (10). Substantial health harms are also expected with the loss of U.S. funding and reduced services from organizations that have already announced their rejection of the policy on principle, such as the International Planned Parent-

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Services in Kenya, such as providing contraceptive information, may be endangered by U.S. policies.
required for surgical or vacuum aspiration abortions—although unmet need for contraception and safe abortion will remain high for years to come (14).

THE THREAT TO SCIENTIFIC AND PROFESSIONAL ORGANIZATIONS

Less visible and as yet rarely discussed harms of the policy will be its interference with the scientific research underpinning health interventions that save women’s lives, the dissemination of evidence-based clinical guidelines, and the professional autonomy of health care providers.

Under the previous Mexico City Policy, for example, one important organization, the International Center for Diarrheal Disease Research in Bangladesh (ICDDR,B), decided in 2006 to give up its USAID funding, citing its need to continue providing highly valued scientific advice to the Bangladesh government on menstrual regulation programs (15, 16). ICDDR,B, which currently receives funding from U.S. government health agencies, will likely be facing such a choice again. Similarly, the Nairobi-based African Population and Health Research Center, a respected regional scientific organization, may not be able to remain eligible for U.S. funding if it continues to conduct policy-and program-relevant abortion research (17).

The Trump administration policy is thus a threat to researchers in organizations around the world receiving U.S. government funding, effectively precluding them from studying abortion-related issues objectively, choosing their partners freely, and bringing the policy implications of their findings to the broader attention of the scientific community and the public.

In the past two decades, global medical professional organizations, including the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM)—together with most of their regional and national counterparts—have endorsed access to safe abortion, aligned with World Health Organization guidelines (18). Medical professional organizations regularly feature clinical and public health information and international guidelines on comprehensive abortion care in their position statements, meetings, journals, training, and other activities. These organizations now must either curtail relations with the U.S. government-funded health community, and lose valuable professional partnerships and funds, or violate basic principles of medical ethics, freedom of speech, and human rights if they comply with the new unilateral restrictions.

Tracing the many possible ways in which these effects will be felt over time will require both quantitative and qualitative approaches and help from field-based investigators. Although precise information on abortion rates and trends remains difficult to obtain, assessing the policy’s consequences for contraceptive access and other health indicators should be undertaken without delay. Despite the challenges, robust data are needed to inform the policy-makers who will one day be in a position to review U.S. policy from an evidence-based perspective.

REFERENCES AND NOTES


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