The U.S. Global Gag Rule and its Effect on HIV/AIDS Services in Africa

By

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Abstract

The U.S. government's "Mexico City Policy" denies U.S. international family planning funding to foreign non-governmental organizations (NGOs) that provide abortion services, provide counseling or referrals regarding abortion, or participate in political discourse or lobbying on the topic, even if they use their own funds to do so. This restriction, known as the Global Gag Rule (GGR) because it restricts speech and would be unconstitutional if applied to U.S. organizations, officially pertains only to family planning monies allocated by the U.S. Agency for International Development (USAID).

While most U.S. international HIV/AIDS funding has been specifically exempt from the GGR, the restriction has nonetheless impacted HIV/AIDS services in a number of ways, to the detriment of the prevention and treatment of the disease. This is because family planning and HIV/AIDS service delivery tend to be integrated in developing countries and also because there has been confusion over the strength of the exemption itself. International NGO representatives and health-care professionals in developing countries are often not aware of the exceptions to the GGR, or they feel pressured to avoid all activities that may be associated with abortion so as to not risk loss of funding. This has resulted in a chilling effect on reproductive health services beyond the scope of those that are abortion-related.

In sub-Saharan Africa, where the unmet need for contraceptive and other reproductive health services remains unacceptably high and where the HIV/AIDS pandemic has been most severe and devastating, the GGR has negatively impacted both areas of reproductive health. It has penalized hundreds of organizations, and the people they serve, not just by denying the women's right to control their reproduction through abortion, but also in effect reducing their access to family planning and other reproductive health services, including the prevention and treatment of HIV/AIDS. This rule has had a detrimental impact on service delivery, not only of family planning and other reproductive health services, but also of HIV/AIDS services, especially to the most vulnerable populations and those who need these services the most.
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INTRODUCTION

The U.S. government's "Mexico City Policy" denies U.S. international family planning funding to foreign non-governmental organizations (NGOs) that provide abortion services, provide counseling or referrals regarding abortion, or participate in political discourse or lobbying on the topic, even if they use their own funds to do so. This policy is recognized to be a violation of the constitutional right to free speech in the United States and, therefore, cannot be applied to U.S.-based groups. It can, and does, however, limit the speech of those in other countries. For this reason, the restriction is widely known as the Global Gag Rule (GGR).

The GGR, as originally written, pertains only to family planning monies allocated by the U.S. Agency for International Development (USAID). Since USAID is the world's largest funder of family planning assistance, the rule has had far reaching ramifications. To compound this situation, however, reinstatement of the GGR in 2001 created confusion about how this rule, initially targeted to family planning services only, would affect the growing area of HIV/AIDS service delivery and policy-making. While most U.S. international HIV/AIDS funding has been specifically exempt from the GGR, the restriction has nonetheless impacted HIV/AIDS services in a number of ways, to the detriment of the prevention and treatment of the disease. This is because family
planning and HIV/AIDS service delivery tend to be integrated in developing countries and also because there has been confusion over the strength of the exemption itself.

In sub-Saharan Africa, where the unmet need for contraceptive and other reproductive health services remains unacceptably high and where the HIV/AIDS pandemic has been most severe and devastating, the GGR has negatively impacted both areas of reproductive health. The most vulnerable populations, such as the young and very poor, have suffered most significantly. This paper examines the history of the GGR and how it has affected, both directly and indirectly, the availability and quality of HIV/AIDS services in Africa.

HISTORY OF THE U.S. GLOBAL GAG RULE

U.S. government assistance for abortion-related services in developing countries has been under attack for many decades. Soon after the 1973 Roe v. Wade decision by the U.S. Supreme Court legalized abortion in this country, restrictions on the use of U.S. funds for abortion-related activities overseas began. Initially, the 1973 Helms Amendment prohibited USAID foreign assistance from being used for “to pay for the performance of abortions as a method of family planning.”

The Global Gag Rule was then enacted as an executive order by President Ronald Reagan at the United Nations conference on population held in Mexico City in August, 1984. While the Helms Amendment restricted the use of USAID

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funds for abortion-related activities overseas, the GGR, for the first time, extended this restriction by prohibiting foreign NGOs who receive USAID family planning funds from using their own, non-USAID monies for this purpose. The following year, a number of new restrictions were added to the policy, including one prohibiting the funding of “information, education, training, or communication programs that seek to promote abortion as a method of family planning.” These restrictions were extremely broad since “abortion as a method of family planning” was interpreted by USAID to include nearly all abortions, including those performed for the physical or mental health of the woman.3

The GGR remained in effect until 1993 when, during his first week in office, President Bill Clinton rescinded it by executive order. The U.S. Congress reinstated the restriction for federal fiscal year 2000, making it statutory law for the first time. Interestingly, this congressional rule restricted USAID family planning funds not only to organizations that lobby for abortion rights but also to those that lobby against these rights. This law, however, was then omitted from the fiscal year 2001 appropriations bill due to the actions of President Clinton and pro-choice members of Congress.4

On January 22, 2001, upon taking office, President George W. Bush reinstated the GGR by executive order. The restriction took effect once again on March 28 of that year, when President Bush issued a memorandum to the

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4 Ibid.
administrator of USAID reinstating the policy that requires "foreign nongovernmental organizations to agree as a condition of their receipt of federal funds for family planning activities that such organizations would neither perform nor actively promote abortion as a method of family planning in other nations."  

Specifically, the GGR restricts foreign NGOs who receive USAID family planning assistance from using their own funds to:

- Provide safe abortion services to the extent that they are legal (including in cases where a woman's health is harmed by the pregnancy);
- Impart accurate medical counseling about, or referrals for, abortion;
- Petition their own governments to liberalize restrictive abortion laws;
- Advocate against attempts to make abortion laws even more restrictive; and
- Engage in public information initiatives and similar educational measures to ensure that abortions are safe and accessible to the full extent that the law allows.  

This current law is more restrictive than earlier versions. For example, organizations wishing to improve access to safe abortion are now prohibited from lobbying their governments "to legalize or make available abortion as a method of family planning or . . . to continue the legality of abortion as a method of family planning," thus expanding the restriction beyond simply access to the procedure.

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5 Restoration of the Mexico City Policy, 66 Fed. Reg. at 17,303.
6 Ibid.
In addition, through an August 29, 2003 White House memorandum, President Bush extended the rule beyond USAID assistance to all branches of the U.S. State Department that provide population-related assistance.

HEALTH EFFECTS OF THE GGR

Unsafe abortion is one of the most easily preventable and treatable causes of maternal mortality and morbidity. However, more than 80 million women experience unwanted or mistimed pregnancy every year and 46 million undergo induced abortion, twenty million of which, mostly in poor countries, are unsafe. According to estimates by the World Health Organization (WHO), at least 78,000 women die each year as a result of complications of unsafe abortion, 95% of which occur in countries where access to abortion is restricted or illegal or where abortion is legal but largely unavailable (see Table 1). Globally, this means about 13% of pregnancy-related deaths are attributed to complications of unsafe abortion although this figure is over 33% in Kenya and as high as 50% in Ethiopia. The risk of dying from an unsafe abortion in Africa is 1 in 150, while the risk in Europe is 1 in 1900.

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Table 1: Global and regional annual estimates of incidence and mortality, unsafe abortions, United Nations regions, 1995-2000

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated number of unsafe abortions (000s)</th>
<th>Estimated number of deaths due to unsafe abortion</th>
<th>Mortality ratio (deaths due to unsafe abortion per 100 000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WORLD TOTAL</td>
<td>20 000</td>
<td>78 000</td>
<td>57</td>
</tr>
<tr>
<td>MORE DEVELOPED REGIONS*</td>
<td>900</td>
<td>500</td>
<td>4</td>
</tr>
<tr>
<td>LESS DEVELOPED REGIONS</td>
<td>19 000</td>
<td>77 500</td>
<td>63</td>
</tr>
<tr>
<td>AFRICA</td>
<td>5 000</td>
<td>34 000</td>
<td>110</td>
</tr>
<tr>
<td>ASIA*</td>
<td>9 900</td>
<td>38 500</td>
<td>48</td>
</tr>
<tr>
<td>EUROPE</td>
<td>900</td>
<td>500</td>
<td>6</td>
</tr>
<tr>
<td>LATIN AMERICA &amp; CARIBBEAN</td>
<td>4 000</td>
<td>5 000</td>
<td>41</td>
</tr>
<tr>
<td>NORTHERN AMERICA</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OCEANIA*</td>
<td>30</td>
<td>150</td>
<td>51</td>
</tr>
</tbody>
</table>

Figures may not add to totals due to rounding.
* Japan, Australia and New Zealand have been excluded from the regional estimates, but are included in the total for developed countries.

In addition, millions more women suffer serious injuries and permanent disabilities from unsafe abortion. In the absence of safe, legal and accessible abortion services, women seek the procedure from medical or lay practitioners or they attempt to perform it on themselves. Many of these procedures are unsafe and are regularly a source of postabortion infection and other complications,
especially in developing countries. At least one in five women who have an unsafe abortion suffer a reproductive tract infection as a result. Some of these are serious infections, leading to infertility and other permanent conditions.\textsuperscript{14} Two-thirds of gynecological admissions to some hospitals in Africa in the 1990s were women suffering from complications of unsafe abortion.\textsuperscript{15} This is true even though fewer than half of all women who require postabortion treatment receive it, either because it is not available or because they do not seek treatment due to fear of prosecution or stigmatization.\textsuperscript{16} In addition to increasing maternal mortality and morbidity, these restrictions also increase the cost of related health-care services. In some countries, treating the complications of unsafe abortion consumes up to 50% of the resources of some hospitals.\textsuperscript{17}

The GGR is contributing to this global crisis of unsafe abortion. The rule jeopardizes women's lives not only by creating barriers to accessing abortions themselves, but also by hampering the efforts of local advocates to address policies that would make safe, legal abortion accessible. This is especially so in parts of Africa, particularly the former colonies, where abortion laws are extremely antiquated and in need of reform. By restricting NGOs' rights to free speech and association and their ability to freely participate in public debate on

\begin{footnotesize}
\begin{itemize}
\item\textsuperscript{17} WHO, \textit{Unsafe Abortion: Global and Regional Estimates of Incidence of And Mortality Due to Unsafe Abortion with a Listing of Available Country Data} (1997). From \url{http://www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_chapter2.en.html}
\end{itemize}
\end{footnotesize}
the issue, but without posing similar restrictions on NGOs working to criminalize or limit abortion access, local debate on the issue becomes biased and unreflective of true local attitudes on the issue.

Conversely, in countries where abortion has been decriminalized, rates of abortion-related maternal mortality have declined dramatically. In the U.S., for example, legalization of abortion resulted in a dramatic decline in deaths and medical complications due to unsafe abortion. For instance, the number of abortion-related deaths per million live births in the U.S. fell from nearly 40 in 1970 to 8 in 1976.¹⁸

In Romania, the number of abortion-related deaths increased sharply after the government tightened a previously liberal abortion law in 1966. Abortion was legalized again in December 1989 and, by the end of 1990, maternal deaths caused by abortion had dropped drastically (See Graph 1).¹⁹ Similarly, South Africa experienced a 91.1% reduction in deaths from unsafe abortion between 1994-2001, following the Choice on Termination of Pregnancy Act that went into effect in February 1997.²⁰

Clearly, keeping abortion safe, legal and accessible, in combination with affordable, accessible contraception, has a profound impact on the lives and health of reproductive age women around the world. The Global Gag Rule compromises this access in these countries and, compounding the problem, its affect is not limited to those that are abortion-related. Access to family planning and HIV/AIDS prevention and treatment services, which can reduce the incidence of abortion, are also negatively affected.

THE IMPORTANCE OF REPRODUCTIVE HEALTH/HIV INTEGRATION

The GGR has not only affected access to abortion and other reproductive health services but also HIV/AIDS prevention and treatment. This is due to the widespread integration of these services in the countries affected. Integration in the health sector has been defined as offering two or more services at the same facility during the same operating hours, with the provider of one service actively
encouraging clients to consider using the other services during the same visit, in order to make those services more convenient and efficient.  

For the past several decades, global health guidelines have favored the integration of HIV/AIDS services with family planning and other reproductive health services in most situations. Governments and leading donor institutions throughout the world, such as USAID, the World Bank and the European Union, strongly support integrated family planning and HIV prevention programs, especially in areas with high HIV prevalence, as a matter of good public health practice and economic efficiency.  

Not only does integration permit providers to offer more convenient, comprehensive services to clients, it can also expand access to services while making them more cost-effective. Since the two fields enjoy many synergies, international guidelines recommend that linkages between reproductive health and HIV/AIDS include not only service delivery but also combined efforts related to advocacy, policy and program development, resource mobilization, program monitoring and evaluation, and research. With integration, more people can be reached with needed services and have their needs better met, resulting in fewer HIV infections and unintended pregnancies, while cost savings can be enjoyed through reduced duplication of services and consolidation of functions such as

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21 Foreit KGR, Hardee K, Agarwal K. When does it make sense to consider integrating STI and HIV services with family planning services? Int Fam Plann Perspect 2002;28(2):106-7.
record keeping, infrastructure expenses, etc. Therefore, integration can benefit clients, providers and the healthcare system in a number of ways.

Comprehensive reproductive health services, including abortion services or referral as permitted by law, are of particular interest to many HIV-positive women, while HIV/AIDS counseling and testing services are important for many sexually active women. This is especially so since the key target clientele for the two types of services are increasingly becoming one and the same. Family planning services primarily target women of reproductive age while HIV prevention services are primarily aimed at individuals at high risk of HIV infection. In developing countries, most HIV infection is sexually transmitted through heterosexual contact. About half of the 40 million people now living with HIV/AIDS are women of reproductive age, with this percentage approaching 60% in some African countries. Although reproductive health providers in developing countries largely serve married women, these women may be at particular risk of HIV/AIDS specifically because they are married and do not have the power to negotiate sex and/or condom use with non-monogamous husbands. As women of reproductive age becomes one of the groups with the highest incidence of HIV infections, the potential benefits of integration of these services become especially clear.

Often, HIV/AIDS services are integrated into family planning programs. The WHO Global Sector Strategy for HIV/AIDS recognizes that existing family planning programs "provide a clear entry point for the delivery of HIV/AIDS

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interventions. Family planning providers are particularly essential in the fight against HIV/AIDS since they have the expertise to counsel individuals about safer sex, help people avoid high-risk behaviors and screen for and treat sexually transmitted infections (STIs) which increase susceptibility to HIV infection. Family planning services can offer women HIV/AIDS services in a familiar setting that is free from the stigma often associated with stand-alone HIV/AIDS programs. Specific reasons why family planning services integrate well with HIV/AIDS services include:

- HIV/AIDS, like contraception, is a reproductive health issue: 75% of all new infections result from heterosexual sexual transmission, with this figure approaching 90% in Sub-Saharan Africa. It is therefore critical to discuss HIV/AIDS prevention in the reproductive health context, especially for women of reproductive age.

- Family planning providers target groups at particularly high risk for HIV/AIDS — youth and women — for whom family planning services can be the main point of contact with the health care system. Family planning programs are especially important for reaching adolescent women with HIV/AIDS information, counseling and services. These young women, including those who are married, are an important and growing demographic for HIV/AIDS incidence.

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Family planning providers are a primary source of contraceptive supplies, including barrier methods such as male and female condoms, that are key to preventing HIV/AIDS transmission.

Family planning providers can increase access to and use of voluntary counseling and testing (VCT), an important opportunity for targeting people with effective HIV/AIDS prevention and treatment information.

In many places, community-based distributors work with family planning providers to reach members of outlying communities who might not have access to or the opportunity to visit clinics. During these visits they can also provide HIV prevention information and other HIV-related services.

In addition, contraceptive and other reproductive health services can effectively be integrated into HIV/AIDS programs. Unmet need for contraception averages 19.4% in sub-Saharan Africa. Integration of contraceptive services with HIV/AIDS services can increase contraceptive access for the women presenting, thus helping them avoid unintended pregnancy — regardless of their HIV status. Helping the women already infected can avert unintended pregnancies and thus reduce the number of infected infants while also helping the women meet their own reproductive goals. Likewise, contraception can also help those at risk avoid infection while helping them postpone pregnancy if desired. Integrated HIV/AIDS services can also reach male clients with information about condom use for...
disease protection as well as pregnancy prevention, increasing their awareness of and access to contraceptive methods. Of course, comprehensive reproductive health also includes abortion and/or abortion referral, where legally permitted, as part of the continuum of care that should be available to HIV-positive, and all, women.

These family planning linkages are effective with a variety of HIV/AIDS services, including VCT, antiretroviral (ARV) treatment programs, and prevention of mother-to-child-transmission (PMTCT) programs. VCT sites can effectively serve sexually active women and men, regardless of their infection status. In addition to offering counseling on HIV/AIDS, they can offer family planning counseling targeted according to the clients' HIV serostatus. This can include increasing awareness of dual protection strategies, such as using condoms for both pregnancy prevention and disease protection or using a second method for pregnancy prevention in addition to condoms for disease protection.

Women who test positive for HIV, whether or not they are on ARV treatment regimens, have the same right to bear children as other women. However, they also have the right to equal access to comprehensive reproductive health and family planning services, especially since pregnancy for these women is associated with increased maternal mortality and a variety of adverse birth outcomes including low birth weight, infant death and transmission of the infection to the infant. For these women, contraception can be especially desirable, with a wide range of contraceptive options safe for them to use. Women on ARV treatment in particular may have to address their reproductive health
needs as their health improves and they become more sexually active. Further, some ARV drugs are potentially harmful for developing fetuses and so women on such regimens may want to avoid pregnancy or be able to access abortion.

For HIV-positive women, family planning and access to abortion are key elements in the fight to reduce transmission of the virus to children. In 2005, 26% of infants born to HIV-infected mothers were infected during gestation, delivery or breastfeeding. In 2001, the United Nations General Assembly set a goal of reducing HIV infections among infants by 50% by 2010. Efforts to minimize the number of these births can be achieved through preventing HIV infection among reproductive-age women, reducing unintended pregnancies among HIV-infected women and through prevention of mother-to-child transmission (PMTCT) programs.

A recent USAID-funded study demonstrated that adding voluntary family planning to services for PMTCT can prevent an additional 55,000 child deaths and avert more than 150,000 unintended pregnancies in high HIV/AIDS prevalence countries. Further, a cost-effectiveness analysis by Family Health International demonstrated that any level of expenditure for the provision of contraception as part of a PMTCT program would be more effective than providing Nevirapine treatment alone in reducing mother-to-child transmission.

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The lack of discussion about abortion in the context of reducing unintended pregnancies in HIV-positive women is particularly worrisome given the potential risks of pregnancy and delivery on the health of HIV-positive women and the risk of transmission to the fetus. The World Health Organization estimates that “[w]ithout preventative treatment [such as Nevirapine] up to 40% of children born to HIV-positive women will be infected,” and even with preventative treatment the likelihood of HIV infection is only reduced by half.\textsuperscript{31} Further, as already noted, some ARV drugs are potentially toxic to fetuses. These women especially need to be able to control their reproduction, with elective abortion an important option where it is legally permitted.

U.S. HELPS FUND THE FIGHT AGAINST HIV/AIDS INTERNATIONALLY

In the past 25 years, the HIV/AIDS epidemic has grown from one whose urgency was little recognized or acknowledged by policy makers to one of the greatest public health crises in the world. The latest global figures estimate that, by the end of 2005, 25 million people had lost their lives to AIDS and 38.6 million were living with HIV.\textsuperscript{32} Further, an estimated 4.1 million became newly infected in that year, 95% of them in sub-Saharan Africa, Eastern Europe, or Asia.\textsuperscript{33}

After decades of minimal attention paid to the crisis by the U.S. government, substantial funding was pledged to address the pandemic by

\textsuperscript{33} Ibid
President Bush in his January, 2003 State of the Union Address. In May 2003, the U.S. Congress approved, and President Bush signed into law, the "United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003" Known as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and administered by the U.S. State Department, this legislation approved the expenditure of up to $15 billion over 5 years to the problem of HIV/AIDS in Africa and elsewhere. This new legislation positioned the U.S. government as a major funder in the global fight against HIV/AIDS, making it disproportionately influential, similar to its role in the field of international family planning.

In connection with this initiative, however, the Bush administration indicated in February 2003 that the GGR would be expanded to all funding under the purview of the Department of State, including PEPFAR. This announcement generated an international outcry, with leading U.S. public health, human rights, HIV/AIDS and reproductive health organizations joining parliamentarians, public health practitioners, researchers, religious leaders and prominent AIDS activists from across the world to protest the policy restrictions. A letter sent to Bush signed by these leaders stated that "Rather than saving lives, this policy will have the opposite effect: consigning untold numbers of women and girls to infection, suffering and premature death that could otherwise have been prevented." Even U.S. Representative Henry Hyde, Republican from Illinois, Chair of the House International Relations Committee and a primary author of the original global AIDS legislation as well as earlier U.S. government abortion restrictions, in

partnership with U.S. Representative Tom Lantos, Democrat from California, advised against applying the GGR to PEPFAR funding, saying "In negotiating [global AIDS funding] with the White House, I felt it was extremely important not to become bogged down in gag rule politics." In response to this public pressure, President Bush issued an executive order on August 29, 2003, specifically exempting PEPFAR funds from gag rule restrictions by stating that the Global Gag Rule "shall not apply to foreign assistance furnished pursuant to the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003." However, this exemption does not extend to other U.S. international assistance to HIV/AIDS. Although the vast majority of U.S. international HIV/AIDS funding falls under the purview of PEPFAR, subjecting other HIV/AIDS monies to the GGR restricts the use of these funds while adding to the confusion over how funds may be spent.

PEPFAR FUNDING IS AFFECTED BY THE GGR

As noted above, foreign NGOs receiving U.S. family planning assistance must comply with the GGR while organizations receiving only HIV/AIDS funding are, ostensibly, not subject to this restriction. This policy has serious implications for reproductive health/HIV/AIDS integration and has created much confusion and over-interpretation over the scope of the gag rule. PEPFAR funding

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has, in fact, been negatively affected by the rule in three key ways. Because of widespread integration with gag rule-affected family planning services, HIV/AIDS services are affected both by integration with family planning services that have not signed on to the rule as well as by integration with services that have become signatories. In addition, recent U.S. government actions appear to be eroding the HIV/AIDS exemption to the rule.

Among the many changes in the HIV/AIDS epidemic over the past two decades is its increasing impact on the lives of women. Where women once accounted for only a fraction of infections, almost 50% of all persons living with HIV/AIDS today are women.\(^{38}\) The impact on women is most acute in sub-Saharan Africa, the region hardest hit by the AIDS epidemic, where women account for 58% of all HIV-positive adults and the rate of new infections is highest among married women in their twenties and thirties in most countries in the region.\(^{39}\) The loss of integrated services due to the GGR is reducing the ability of HIV/AIDS programs to provide their clients with needed contraceptive methods. It is also hindering the ability of family planning clinics to reach uninfected women with HIV/AIDS prevention messages and HIV-positive women with care and treatment. Reproductive health, family planning, and maternal and child health programs need to be strong and effective partners with HIV/AIDS organizations in order to reach the core client group for both programs — married women of reproductive age — with cost-effective, evidence-based HIV prevention, testing and treatment services, as well as to provide basic


\(^{39}\) Ibid
services, such as maternal and pre-natal care, to both HIV-negative and HIV-positive women.

For those family planning/reproductive health organizations that declined to sign on to the Global Gag Rule’s provisions, the resulting loss of family planning funds not only reduces their ability to provide contraceptive counseling and services (thereby increasing unwanted pregnancies and subsequent abortions) but also has had a negative impact on HIV/AIDS prevention services. This is an increasingly serious problem as women become a greater proportion of new HIV cases in many developing countries. In addition, when family planning organizations refuse to accept the terms of the gag rule, STI prevention services (including condom distribution) that were routinely provided are also disrupted. These organizations that previously relied on large amounts of U.S. money have had difficulty securing alternative funding and have either had to close, reduce hours of operation or number of staff, or otherwise cut services in the name of reducing expenses. A few specific examples:

- Loss of U.S. assistance forced the Cameroon National Association for Family Welfare (CNAFW) to close a youth center. CNAFW’s youth centers teach young people about responsible parenthood and sexually transmitted infections, including HIV/AIDS. In addition, family planning service delivery was eliminated in two branches: the North Province branch, where 9% of the 576,000 inhabitants live with HIV/AIDS, and the
Western Province branch, where 6% of the 256,800 inhabitants live with HIV/AIDS.  

- 697,000 Planned Parenthood Association of Ghana clients lost access not only to family planning services, but also to voluntary counseling and testing, other counseling services, and HIV/AIDS prevention education.  
- The St. Lucia Planned Parenthood Association was forced to cancel plans to train 218 "peer helpers" from eight secondary schools and one primary school. This program would have reached 12,000 school-aged children with comprehensive reproductive health information including HIV/AIDS prevention messages.  
- FHOK (formerly Family Planning Association of Kenya), an International Planned Parenthood Federation (IPPF) member association, introduced HIV/AIDS prevention, care and treatment into its reproductive health program. Given that the program reached over 32,000 women with family planning services in 2005, they had the potential to be a useful entry point for HIV/AIDS services. However, they lost U.S. funding when they refused to sign the GGR. “Loss of this funding has severely undermined efforts to reduce unintended pregnancy in Kenya through expansion of

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41 Ibid
42 Ibid
voluntary family planning as well as to prevent HIV infections in women," according to Dr. Godwin Mzenge, Executive Director of FPAK.  

- The Family Guidance Association of Ethiopia (FGAE) and Marie Stopes International Ethiopia (MSIE) refused to abide by the GGR restrictions in 2002. As a result, FGAE lost 35% of its budget, while MSIE lost 10%, forcing them to scale back services. Even though FGAE does not perform abortions, which are illegal in most cases in Ethiopia, as an IPPF affiliate it advocates for liberalized abortion policies.  

Further, while family planning organizations that are not gag rule signatories are permitted to work on the HIV/AIDS side of a project, they cannot work on any reproductive health/family planning elements. Mark Dybul, then-deputy U.S. global AIDS coordinator (and recently promoted to U.S. global AIDS coordinator), attempted to clarify this issue in a letter to IPPF: "[I]n an integrated program, different organizations may be responsible for different types of activities, as not all organizations necessarily do both voluntary family planning and HIV/AIDS activities. Any partner that receives funds solely for HIV/AIDS is thus not subject to the Mexico City Policy." However, services that are jointly

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supported with U.S. family planning and HIV/AIDS funds are subject to the gag rule.\textsuperscript{46}

For organizations that are signatories to the GGR, the segregation of safe abortion services from other reproductive health services has been particularly harmful, especially for women with special health concerns such as HIV/AIDS. Gagged family planning organizations that serve patients with HIV/AIDS have been unable to provide abortion services because, while the global gag rule technically does not apply to HIV/AIDS funding, any organization subject to the gag rule restrictions that also provides HIV/AIDS services is forbidden from providing abortion-related services, including counseling and referrals, to those patients.

Because of concern that the GGR was negatively affecting integrated HIV/AIDS services, the U.S. government accountability office conducted an analysis that looked at the impact of the GGR on PEPFAR. It found that “adjustments in U.S. policy approaches will be necessary to allow PEPFAR teams to promote effective integration strategies. Sensible exceptions to these policy restrictions would go a long way toward furthering reproductive health/HIV/AIDS integration by creating space for groups with different areas of expertise to come together and create more effective AIDS programs”\textsuperscript{47} The report continues to say that the Global Gag Rule “has serious implications for reproductive health/HIV integration, since it often precludes organizations with


years of experience in reproductive health from bringing their expertise into an integrated program approach...Given the important overlap between the two fields, there are serious concerns that this policy is contributing to a weakening of reproductive health systems in HIV-affected countries."  

Further, because of over-interpretation of the rule, and the resulting chilling effect, there is evidence that even U.S.-based NGOs are shying away from advocating for liberalized abortion laws, even though they are permitted to do so since they are legally exempt from the rule.

Because the rule and its exceptions can appear complex, in order for organizations to ensure they are not risking their USAID funding, many have been avoiding any connection with abortion-related issues. For example, a U.S.-based NGO working on the issue of HIV/AIDS in Ethiopia was unwilling to discuss exceptions to the abortion law for HIV-positive women even though, by law, it is exempt from the gag rule. Further, the official restrictions may not be the only constraints on the type of work that is carried out under the GGR.

According to one of PEPFAR's implementing partners in Nairobi: "There are perceived restrictions in PEPFAR about what you can discuss with whom, so everyone is being very cautious... People are afraid to discuss family planning, condoms, abortion — so many groups don't address them at all." In addition, a "well-known U.S.-based NGO" wanted to include Family Guidance Association of Ethiopia (FGAE) sites as part of an HIV/AIDS project but decided against it on

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50 Ibid, page 23.
the assumption that FGAE was ineligible for participation by not signing the GGR.\textsuperscript{51}

In addition, field research by the Center for Health and Gender Equity (CHANGE) has shown that since 2003, family planning organizations that did not sign the gag rule in Botswana, Kenya, Namibia, Nigeria, Tanzania, and Uganda have been denied funding under PEPFAR due to confusion about the application of the rule.\textsuperscript{52} The deterioration of basic family planning services and the inability to respond effectively to client needs for HIV prevention services was a key concern identified by the 22 representatives of six PEPFAR focus countries that attended a meeting held by CHANGE in Kenya in September, 2005.\textsuperscript{53}

Further, recent activities on the part of the Bush administration demonstrate a third way that the rule is affecting U.S. international HIV/AIDS assistance. In a little noted action that could set a dangerous precedent, gag rule restrictions appeared as part of a five-year, $193 million USAID request for applications (RFA) for HIV/AIDS prevention, treatment and care in Kenya. The RFA, released November 18, 2005 and entitled, "HIV/AIDS and Tuberculosis, Treatment, Care and Support" referenced the GGR twice in its eligibility criteria. According to the RFA, the proposed activities were expected to improve and expand facility- and community-based HIV/AIDS services, reproductive health and family planning programs, and selected maternal and child health services.

\textsuperscript{53} CHANGE. November 23, 2005. Bush administration "breaks the promise" by expanding global gag rule to HIV funding on eve of world AIDS day. From http://www.africafocus.org/docs05/gag0511.php
While HIV/AIDS services were the primary component of the project, they were to be linked with these other services. The RFA included the statement that "applicants must:

- Apply as a consortium that includes at least one Kenyan organization;
- Agree, and have all consortium partners agree, to abide by the Mexico City Policy, the Tiahrt Amendment, and all USAID policies and regulations." \(^{54}\) (emphasis added)

Including HIV/AIDS services in the GGR restrictions and the resulting reduction of integrated services would have grave consequences in Kenya. Complications of unsafe abortion, pregnancy and HIV/AIDS are the main causes of death and illness among women in that country. \(^{55}\) Some 300,000 abortions take place there every year, causing an estimated 20,000 hospitalizations due to complications and 2,600 deaths of women and girls. Further, an estimated 13% of young women ages 15-24 attending antenatal clinics are infected with HIV. \(^{56}\) Estimates indicate that at least 25% of all married women of reproductive age want but do not have access to contraceptive supplies and family planning services \(^{57}\). This unmet need for contraception appears to be worsening with the reduction of funding for basic reproductive health and family planning services,

\(^{54}\) RFA quoted in USA/Africa: Global Gag Rule Expands AfricaFocus Bulletin Nov 28, 2005 (051128) http://www.africafocus.org/docs05/gag0511.php
\(^{55}\) CHANGE. November 23, 2005 Bush administration “breaks the promise” by expanding global gag rule to HIV funding on eve of world AIDS day. From http://www.africafocus.org/docs05/gag0511.php
\(^{56}\) Ibid.
\(^{57}\) Ibid.
and the shift to HIV/AIDS programs that are not integrated with, nor providers of, these basic family planning services.

According to Jodi Jacobson, executive director of CHANGE, “Application of the Global Gag Rule to HIV/AIDS funding will further undermine effective prevention strategies by denying funding to those programs that are best poised to meet the needs of the most vulnerable. Family planning and maternal and child health programs are the "first responders" for women and girls in the global AIDS epidemic, trusted sources of information, education, and access to critical commodities, such as male and female condoms.”

To some extent, this apparent expansion of the gag rule to HIV/AIDS funding represents a "formal admission" of what many in the reproductive health/family planning field had feared. Some believe that the inclusion of the GGR in this RFA was meant to make denial of funds under the GGR to HIV/AIDS services official. This move, if intentional, “further undermines the ability of reproductive health, family planning and maternal and child health programs to reach women and girls with life-saving information and technologies for the prevention of HIV infection at a time when lives are being lost to HIV/AIDS every year and when an increasingly disproportionate number of those deaths are among women,” stated Jacobson.

Once word of the RFA language became known, outrage from various organizations followed. USAID then withdrew the RFA claiming that inclusion of

59 Ibid.
the GGR language was a mistake made by contract staff and they subsequently reissued the request without the objectionable phrase. Whether inclusion of the restriction was an honest mistake or intentionally added due to over-interpretation of, or confusion over, the GGR is unknown. But it did clearly raise the issue of the difficulty of integrating services when some are subject to the rule and some are not. It also demonstrates that there remains confusion in general about how the gag rule relates to HIV/AIDS funding, even among USAID staff, and that some organizations are possibly being denied funds as a result.

CONCLUSION

Under the U.S. Mexico City Policy, in order to receive USAID funding for family planning purposes, foreign NGOs are prohibited from using their own funds to provide abortion services, counseling, referral, or information about safe abortion; advocate for the liberalization of abortion laws in their own country; conduct research on the effects of unsafe abortion; or otherwise work on safe abortion issues. This restriction is known as the Global Gag Rule because it restricts speech and would be unconstitutional if applied to U.S. organizations. Since the United States controls a large proportion of the resources available for family planning and reproductive health care globally, many women in developing countries have been negatively affected by this policy.

In the 1980's, international donor organizations including USAID recognized that, because their services are complementary, the integration of

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family planning/reproductive health services with sexually transmitted infection services would result in financial and infrastructural economies while reaching greater numbers of women and others with needed services. With the growth of the HIV/AIDS pandemic, this integration became more essential as the target clientele for one type of service increasingly becomes the clientele of the other. Issues such as access to condoms for disease prevention, prevention of mother to child transmission of the virus, and the right of HIV-positive women to control their reproduction became key aspects of international reproductive health policies. However, because of widespread integration of these services, reinstatement of the GGR in 2001 has caused HIV/AIDS programs funded by the U.S. President's Emergency Plan for AIDS Relief monies to be affected, despite the government's stated intention that they would be specifically exempt.

While it does not technically apply to HIV/AIDS funds, the GGR has caused the closing or scaling back of programs that provide HIV/AIDS services as well as family planning and other reproductive health care, effectively undermining these services under the guise of reducing abortion prevalence. To compound the problem, NGO representatives and health-care professionals are often not aware of the exceptions to the GGR, or they feel pressured to avoid all activities that may be associated with abortion so as to not risk loss of funding, resulting in a chilling effect on services beyond the scope of those that are abortion-related.
Therefore, the GGR has penalized hundreds of organizations, and the women they serve, in nearly sixty countries around the world, not just by denying the women's right to control their reproduction through abortion, but also in effect reducing their access to family planning and other reproductive health services, including the prevention and treatment of HIV/AIDS. This rule has had a detrimental impact on service delivery, not only of family planning and other reproductive health services, but also of HIV/AIDS services, especially to the most vulnerable populations and those who need these services the most.

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