UNIQUE CHALLENGES WOMEN FACE IN GLOBAL HEALTH

HEARING

BEFORE THE

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CONTENTS

UNIQUE CHALLENGES WOMEN FACE IN GLOBAL HEALTH

Wednesday, February 5, 2020

House of Representatives

Committee on Foreign Affairs

Washington, DC

The committee met, pursuant to notice, at 10 a.m., in room 2172 Rayburn House Office Building, Hon. Eliot Engel (chairman of the committee) presiding.

Chairman ENGEL. The committee will come to order. Without objection, all members will have 5 days to submit statements, extraneous material, and questions for the record subject to the length limitation in the rules.

This morning, we will take a hard look at something the full committee has not held a hearing on in more than a decade, global women's health.

I want to welcome our witnesses to the Foreign Affairs Committee. It is always nice to have colleagues come and talk to us because we know that colleagues have more expertise than anybody else, so I want to welcome them. I want to welcome members of the public and the press as well. And today, we will hear from two panels, first, from two of our distinguished colleagues, and from a panel of experts. So we are grateful to you for your time.

I now recognize myself for an opening statement. This is one of those topics where I think it is helpful to take a step back and look at the big picture so we can understand why this issue, global women's health, should be a foreign policy priority.

We know that when women are able to live fuller and more productive lives, when they have access to education and economic opportunity, when they can be full participants in their communities and societies, it acts like a rising tide. Entire countries become more stable, more open, and more prosperous. When women have a seat at the table, we see better results in resolving conflicts and rebuilding after crises. A whole host of foreign policy challenges are more easily overcome when women are involved, when women can live their lives to their full potential.

And when we dig down it is clear that unleashing that potential is directly tied to women's access to health, healthcare, particularly family planning. Study after study after study has told us improving access to contraception improved women's economic well-being. Women who can plan having children on their own timetable are more likely to get an education, to raise their standards of living, to climb out of poverty. And this is where so many women hit a roadblock. Only about half of the women in developing countries re-

ceive the minimum recommended prenatal care and that number drops in Sub-Saharan African.

Every year, more than 300,000 women die from complications during childbirth. That is a shocking statistic, an estimated third, of which could be prevented if the women had access to contraception and greater choice over whether or not to become pregnant. It is a human tragedy and it wipes away all those positive effects that ripple out when women are able to make choices for themselves and can get the healthcare they need.

American assistance has traditionally played a major role in helping women and girls get better access to healthcare. In fact, global health makes up the largest single share of civilian aid overseas. Over the years, American-backed assistance for family planning, maternal and child health, and PEPFAR have made a real difference around the world.

Unfortunately, the Trump administration has threatened to undo a lot of our progress. It has tried again and again to slash America's investment in family planning and reproductive health. The administration has tried to hobble the U.N. Population Fund, arguably the most important organization in the world for helping women get the care they need. And let me focus on this for a minute.

UNFPA purchases and distributes contraceptives, facilitates safe childbirth, promotes maternal and reproductive health, works to end female genital mutilation, and assists victims of gender-based violence in 150 countries around the world which includes 100 where USAID does not operate. In war-torn areas in the middle of humanitarian disasters, UNFPA is a lifeline for the world's most vulnerable women and girls. These are people with nowhere else to turn.

So what has the Trump administration done with this? The answer, unfortunately, is eliminated American support for it. And of course, the administration has reinStated and expanded the Global Gag Rule. This is a policy of—it does, I think, the opposite of what its supporters say. I will leave it to our witnesses to shine a light on just how much damage it does. It would undermine everything we know can be gained when women get a fair shot. This policy should be repealed permanently and that is what the Global HER Act would do. And one of our witnesses this morning is that bill's author, my friend, my good friend, and neighbor from New York whose district borders mine for 30 years, the chairwoman of the Committee on Appropriations, the first woman to chair that committee, Ms. Lowey.

We will also hear from another colleague, a member of the Energy and Commerce Subcommittee on Health, the distinguished gentlewoman from Washington, Ms. McMorris Rodgers, two great witnesses. I look forward opening statements from our colleagues, pending which I will yield to my friend from Texas, our ranking member, for any opening comments he may have.

Mr. MCCAUL. Thank you, Mr. Chairman, for holding this important hearing. If I were you, I would answer my wife's phone call. I also want to thank my colleagues and friends for being here today. Cathy and I came in to Congress together and Nita has been a dear friend and the role leader in the Congress.

The United States is the largest donor to global health programs by far. We have a long history supporting efforts to improve health outcomes of people all over the world for providing life-saving treatment, to building the capacity of health assistance. The U.S. has also been a global leader in founding and funding programs that support women and girls around the world. As a father of four young women, I recognize the importance of empowering women and girls to succeed and that starts with access to health resources and education.

Through our contributions to the multi-national programs like the Global Health Fund that the chairman and I got fully funded when some tried to cut it, the United States has been a global leader in the fight against HIV/AIDS, malaria, tuberculosis, and other diseases that disproportionately impact the world's most vulnerable populations. This is largely thanks to the visionary leadership, I believe, of President George W. Bush. Bilateral global health programs, as well as broader initiatives like PEPFAR and the President's Malaria Initiative, have saved tens of millions of lives around the world.

Last year, I had the honor to meet the President of Botswana and he told me that thanks to the PEPFAR program that the United States saved, in his words, a generation—what is going on here? Anyway, he told me that PEPFAR saved in his words, "A generation of Botswanans from extinction." From extinction. Very profound.

We can and should be proud of America's continued leadership on these issues. And that is why I was proud to sponsor House Resolution 517, along with Chairman Engel, which reaffirmed the United States' support for the global fund. We were successful in these efforts. The year-end spending package included $1.56 billion for the global fund and substantial increases in assistance for maternal and child health and nutrition among other programs.

In September of last year, the Bush Foundation and Ambassador Birx announced the Go Further partnership to end AIDS and cervical cancer. It had reached over half a million women living with HIV to provide cervical cancer screening. This is a fantastic example of how innovative public/private partnerships can build on successful U.S. Government programs to reach even more women and girls with expanded services. Like the Go Further Partnership, there is unique opportunity to build on the success of the U.S. global health programs and address other health challenges like childhood cancer.

Last week, along with the chairman, the House unanimously passed the Global Hope Act. And I do want to thank Chairman Engel for his support of this effort. This legislation supports efforts to reduce childhood cancer rates in developing countries by facilitating similar public/private partnerships between the Federal Government, the private sector, research institutions, and non-governmental organizations. The mortality rate for children diagnosed with cancer in developing nations is 80 percent.

Tragically, this matches the survival rate in the United States. I do not think it depends where you are born to determine whether you should receive this critical care. And by working together to address the resource gaps that exist and leverage private sector ex-

pertise on the unique challenges that this horrific disease poses, I think we can dramatically reduce childhood cancer mortality.

We must ensure that every child, no matter where they are born, has access to the care and treatment that they need.

So I look forward to working with my colleagues in the Senate to see that the Global Hope Act is signed into law. We saved over 20 million people in Africa thanks to the PEPFAR HIV program. The Global Hope Act has the same opportunity, I think, to save millions of children's lives. And I cannot think of anything more profound that we can do in the Congress than pass a bill that turns into saving millions of lives.

With that, Mr. Chairman, I yield back.

Chairman ENGEL. Thank you, Mr. McCaul.

I will now recognize our witnesses for 5 minutes each. Chairwoman Lowey, we will start with you. Thank you for coming this morning. It is great seeing you.

STATEMENT OF THE HONORABLE NITA LOWEY, MEMBER OF CONGRESS (D-NY)

Ms. LOWEY. It is a pleasure to be here with you, Chairman Engel, and Ranking Member McCaul, and so many good friends from this committee. Thank you for allowing me to testify during this important hearing on the unique challenges women face in global health.

As my fellow witnesses will outline, the number of obstacles that women around the world face in their pursuit of health services is almost too many to list. But instead of tackling these obstacles, President Trump simply created more barriers when he quickly imposed the dangerous, ill-informed Mexico City policy, also known as the Global Gag Rule in 2017.

During previous Republican administrations, this policy cutoff U.S. family planning funds to any foreign, non-governmental organization that provided services for, information about, or referrals for abortion, or advocated for abortion access even where it was legal and even with its own private funds. But this administration radically expanded the policy to apply these restrictions to all global health funding affecting approximately $8.8 billion in U.S. assistance to programs tackling HIV and AIDS, family planning, reproductive health, tuberculosis, malaria, maternal and child health, water, sanitation, and hygiene, and more.

And just this year, the administration announced it was expanding the policy once again, changing the definition of providing financial support contained within the Executive Order standard revisions.

When the Global Gag Rule was simply applied to family planning programs, we saw disastrous impact, not just for women, but also for their families and their communities. Fewer women were able to access family planning services, resulting in more unintended pregnancies and unsafe abortions. Some of our most trusted implementation partners overseas were forced to choose between receiving U.S. funding or providing comprehensive healthcare, often leaving thousands of women without access to the most experienced providers.

This administration's unprecedented expansion which were implemented with no analysis of the potential impact now risks multiplying the damage. We have heard of numerous HIV and AIDS, maternal and child health, nutrition, and WASH programs that were forced to cut services or close because of this policy.

Meanwhile, implementers have tied themselves in knots trying to comply, or even worse, just walked away from partnering with the U.S. altogether. And mass confusion about the policy has led to a chilling effect causing organizations to unnecessarily change or eliminate vital health services. Simply put, this policy hurts the very people we are trying to help.

We should be building on our global health successes, not reversing the gains we have made. That is why I introduced H.R. 1055, the Global Health, Empowerment and Rights, HER, Act which would permanently end this devastating policy once and for all. This bill, which I am hopeful the committee will consider in the near future, sends an important message to international global health partners and has a record number of cosponsors and support from a long list of diverse organizations that know the Global Gag Rule is bad for global health, bad for human rights, bad for gender equality. Passing this legislation would restore our country's role as an international leader and ensure that women, men, and children around the world are able to access the healthcare they so desperately need. Thank you.

[The prepared statement of Ms. Lowey follows:]

House Foreign Affairs Committee
Hearing: Unique Challenges Women Face in Global Health
Representative Nita M. Lowey Testimony
February 5, 2020

Chairman Engel, Ranking Member McCaul, and my fellow colleagues, thank you for allowing me to testify during this important hearing on the unique challenges women face in global health.

As my fellow witnesses will outline, the number of obstacles women around the world face in their pursuit of health services is almost too many to list. But instead of tackling these obstacles, President Trump simply created more barriers when he quickly imposed the dangerous, ill-informed Mexico City Policy, also known as the Global Gag Rule, in 2017.

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When the Global Gag Rule was simply applied to family planning programs, we saw disastrous impacts, not just for women, but also for their families and their communities. Fewer women were able to access family planning services, resulting in more unintended pregnancies and unsafe abortions. Some of our most trusted implementation partners overseas were forced to choose between receiving U.S. funding or providing comprehensive health care, often leaving thousands of women without access to the most experienced providers.

This Administration's unprecedented expansions, which were implemented with no analysis of the potential impacts, now risks multiplying the damage. We have heard of numerous HIV/AIDS, maternal and child health, nutrition, and WASH programs that were forced to cut services or close because of this policy. Meanwhile, implementers have tied themselves in knots trying to comply or, even worse, just walked away from partnering with the U.S. altogether. And mass confusion about the policy has led to a chilling effect, causing organizations to unnecessarily change or eliminate vital health services. Simply put, this policy hurts the very people we're trying to help.

We should be building on our global health successes, not reversing the gains we've made. That it is why I introduced H.R. 1055, the Global Health, Empowerment, and Rights (HER) Act, which would permanently end this devasting policy once and for all. This bill, which I am hopeful the Committee will consider in the near future, sends an important message to international global health partners and has a record number of cosponsors and support from a long list of diverse organizations that know the Global Gag Rule is bad for global health, bad for human rights, and bad for gender equality. Passing this legislation would restore our country's

role as an international leader and ensure that women, men, and children around the world are able to access the health care they so desperately need. Thank you.

Chairman ENGEL. Thank you, Chairwoman Lowey.
Ms. McMorris Rogers.

STATEMENT OF THE HONORABLE CATHY McMORRIS RODGERS, MEMBER OF CONGRESS (R-WA)

Ms. MCMORRIS RODGERS. Thank you, Mr. Chairman, Ranking Member Michael McCaul, to all the members, but especially to the chairman and the ranking member, I want to just applaud your leadership. Both of you are extraordinary leaders and I appreciate your leadership on so many issues before this committee.

Since America's founding, we have cherished every person's inalienable rights, human rights, to life, liberty, and the pursuit of happiness. It is on us, all of us, to uphold these values and make sure they are reflected at home and abroad.

The Trump administration has provided historic leadership on this front. In January 2017, President Trump implemented the Protecting Life in Global Health Assistance policy which has expanded on the Mexico City policy. This affirms the dignity of the unborn life in foreign aid funding. It required foreign, non-governmental organizations to agree not to perform or promote abortion as a method of family planning overseas.

Organizations that provide and promote abortions abroad should under no circumstances be funded by American taxpayers. In fact, according to the latest Marist poll, six out of ten Americans oppose using tax dollars to pay for abortion. More than three in four Americans oppose using tax dollars to support abortions in other countries. The terms of PLGHA are clear and in line with overwhelming public opinion. NGO's can receive global health assistance awards if they agree to abide by PLGHA policy. PLGHA does not reduce the amount of global health assistance that we make available or prohibit any group from receiving U.S. assistance.

And I want to repeat that. This policy does not reduce the amount of global health assistance, nor does it cut funding from any organizations. The only organizations to not receive funding under PLGHA are those who have chosen not to accept the policy restrictions that come with U.S. assistance. It means we are using resources for healthcare and life-saving care of both women and children. It provides essential healthcare, nutritional aid, and humanitarian assistance to people in need at every stage of their lives.

To win the future, America should be leading to affirm the dignity and value of both patients, mothers, and children. That is why here at home I have led on solutions to reduce maternal and infant mortality. Again, as lawyers for human dignity and human value, I applaud this administration's historic leadership on policy like PLGHA from combating human trafficking, to promoting freedom and opportunity, and also improving healthcare for women and our most vulnerable.

America must lead and continue to lead and encourage the rest of the world to follow our leadership. I thank you for the opportunity to be with you today.

[The prepared statement of Ms. McMorris Rodgers follows:]

House Foreign Affairs Committee
Hearing: "Unique Challenges Women Face in Global Health"
Cathy McMorris Rodgers Testimony
February 5, 2020

Thank you Chairman Engel and Ranking Member McCaul for inviting me to testify today.

Since America's founding, we've cherished every person's inalienable human rights to life, liberty, and the pursuit of happiness. It's on us --- all of us--- to uphold those values and make sure they are reflected at home and in our policies abroad.

The Trump Administration has provided historic leadership on this front. In January of 2017, President Trump implemented the Protecting Life in Global Health Assistance policy, which has expanded on the Mexico City policy. This affirms the dignity of unborn life in foreign aid funding. It requires foreign non-governmental organizations to agree to not perform or promote abortion as a method of family planning overseas. Organizations that provide and promote abortions abroad should under no circumstances be funded by American taxpayers. In fact, according to the latest Marist poll, 6 in 10 Americans oppose using tax dollars to pay for abortion. More than 3 in 4 Americans oppose using tax dollars to support abortions in other countries. The terms of the PLGHA are clear and are in line with overwhelming public opinion: NGOs can receive global health assistance awards if they agree to abide by the PLGHA policy. PLGHA does not reduce the amount of global health assistance that we make available or prohibit any group from receiving U.S. assistance. I'll repeat that. This policy does not reduce the amount of global health assistance available, nor does it cut funding from any organizations. The only organizations to not receive funding under PLGHA are those who have chosen not to accept the policy restrictions that come with U.S. assistance. It means we are using resources for the healthcare and lifesaving care of both women and children. It provides essential healthcare, nutritional aid, and humanitarian assistance to people in need, at every stage of their lives. To win the future, America should be leading to affirm the dignity and value of both patients: mothers and children. That's why here at home, I've led on solutions to reduce maternal and infant mortality.

Again, as warriors for human dignity and human value, I applaud this administration's historic leadership on policies like PLGHA. From combatting human trafficking, to promoting freedom and opportunity, and also improving

healthcare for women and our most vulnerable, America must continue to lead and encourage the rest of the world to follow our leadership too.

Thank you.

Chairman ENGEL. Well, thank you both. I always say that words to come out of our colleagues' mouths are always the wisest words, so I want to thank both of you who I know care very much about this issue.

And will now recess briefly to reset the witness table and seat our second panel.

[Recess.]

Chairman ENGEL. Okay, we will continue with our second panel whom I will introduce. First, Dr. Jennifer Kates is Senior Vice President and Director of Global Health and HIV Policy at the Kaiser Family Foundation. She oversees the foundation's policy analysis and research focused on the U.S. Government's role in global health and on the global health and domestic HIV epidemic. Welcome.

Sheba Crocker is CARE USA Vice President for Humanitarian Policy and Practice and is also currently a Centennial Fellow at Georgetown University's School of Foreign Service. She previously served as Assistant Secretary of State for International Organizational Affairs, Director in the Office of Policy Planning, and Chief of Staff to the Deputy Secretary of State. Welcome.

Moses Mulumba is a lawyer with special interests in international human rights, global health, and sexual reproductive health and rights. He is the founder and current Executive Director of the Center for health, Human Rights, and Development based on Uganda.

Lisa Bos is the Director of Government Relations at World Vision US. She leads World Vision's advocacy and education efforts with Congress and the administration. She previously served for nearly 9 years as a staff member here in the House including as Policy Director for the Republican Study Committee.

Welcome to all of you. Without objection, your written testimony will be made part of the hearing record and I will recognize each of you for 5 minutes to summarize your statements. We will start with Dr. Kates. Welcome.

STATEMENTS OF DR. JENNIFER KATES, SENIOR VICE PRESIDENT AND DIRECTOR OF GLOBAL HEALTH AND HIV POLICY AT THE KAISER FAMILY FOUNDATION; SHEBA CROCKER, VICE PRESIDENT FOR HUMANITARIAN POLICY AND PRACTICE, CARE USA; MOSES MULUMBA CENTER FOR HEALTH, HUMAN RIGHTS, AND DEVELOPMENT, UGANDA; AND LISA BOS, WORLD VISION US

STATEMENT OF DR. JENNIFER KATES, SENIOR VICE PRESIDENT AND DIRECTOR OF GLOBAL HEALTH AND HIV POLICY AT THE KAISER FAMILY FOUNDATION

Dr. KATES. Thank you. Good morning, Chairman Engel, Ranking Member McCaul, members of the committee and guests. I am Dr. Jen Kates, Senior Vice President and Director of Global Health and HIV Policy at KFF, the Kaiser Family Foundation, a nonprofit, nonpartisan organization that conducts independent health policy analysis. Thank you so much for inviting me to testify at this important and timely hearing.

I will briefly summarize my written testimony and focus my remarks on three areas: an overview of the U.S. Government's role in addressing the health of women in low-and middle-income countries; what we know about impacts to date; and current and future challenges and opportunities.

U.S. efforts to address the health of women in low-and middle-income countries began decades ago and since then, the U.S. has been and today remains the largest donor in this area globally. Major efforts include USAID's maternal and child health, nutrition, and family planning and reproductive health programs, as well as related efforts, particularly PEPFAR and its DREAMS Initiative. Studies have shown that improving the health of women has significant spill-over effects on the health and economic well-being of their families, communities, and societies.

The U.S. footprint is large, spanning more than 50 low-and middle-income countries, mostly in Sub-Saharan Africa, and reaching tens of millions of women and girls. In Fiscal Year 2020, the U.S. committed $1.4 billion to maternal and child health including nutrition, and $608 million to family planning and reproductive health. And PEPFAR estimates that it will spend nearly $2 billion on efforts to support women and girls. Collectively, these programs support a range of services that address women's health including the provision of contraceptives, family planning and counseling, protecting the health of pregnant women during and after childbirth, addressing child marriage, and gender-based violence, and increasing access to HIV prevention and treatment.

It is important to note that the U.S. by law prohibits the direct use of U.S. foreign assistance for abortion as method of family planning.

U.S. support has contributed to significant impact. USAID reports that its investment has helped to reduce the chances a woman will die in childbirth by more than half in USAID-priority countries. In addition, contraceptive prevalence has increased significantly in these countries and new HIV infections have fallen among women in almost all PEPFAR countries. Despite these successes, numerous challenges remain, and progress has slowed.

Globally, nearly 300,000 women still die during pregnancy and in childbirth, and millions more experience illness and severe adverse consequences each year, largely from preventable or treatable causes.

More than 200 million women would prefer to avoid or delay child bearing, but are not using the modern method of contraception. And one in seven girls faces early or forced marriage.

Further, women are at disproportionate risk of HIV, the leading cause of death globally for women age 15 to 49.

Looking ahead, the population of adolescent girls is expected to grow significantly over the next few decades, particularly Sub-Saharan Africa, yet the global community is not prepared to meet their health needs.

Among key challenges facing the future of the U.S. response are first, while the U.S. remains the largest donor to women's health in the world, in recent years, funding has been mostly flat and cuts have been proposed. Second, although domestic resources have increased in many countries, they have not grown fast enough or

with enough magnitude to replace external aid. And many countries with significant need particularly vulnerable to any reduction in U.S. support. Third, most global health programs, including those that specifically seek to reach women, focus on pregnant women or children under five, leaving a gap in available services and programming for adolescent girls and young women.

Finally, legal and policy requirements, including more than 20 specifically related to family planning and reproductive health, more than any other area of global health, can present barriers. For example, the reinStated and expanded Mexico City policy now known as Protecting Life and Global Health Assistance, for the first time applies to nearly all bilateral U.S. global health assistance including PEPFAR and a much greater number of foreign NGO's than ever before. The policy has presented implementation challenges and left service gaps in some communities.

A recent empirical analysis found that when in place in the past, abortion rates and pregnancies rose, and use of modern contraception fell in the countries most exposed to the policy.

Most of these challenges are concentrated in countries reached by the U.S., suggesting additional opportunities for impact, including exploring the use of incentives for domestically sourced mobilization specific to women's health; better aligning and integrating U.S. efforts internally and with others and pursuing multi-sectoral approaches; better meeting the needs of adolescent girls and young women; and reducing implementation and policy barriers. Together, these efforts can help ensure that the next generation of women and girls is healthier than ever before.

I look forward to discussing these issues with you and anserine any questions you have. Thank you.

[The prepared statement of Dr. Kates follows:]

The U.S. Government Role in Women's Global Health and Key Challenges

Jennifer Kates, Ph.D.

Senior Vice President; Director, Global Health & HIV Policy

KFF (The Kaiser Family Foundation)

Prepared for the Committee on Foreign Affairs

U.S. House of Representatives

Hearing on

Unique Challenges Women Face in Global Health

February 5, 2020

Introduction

Good morning, Chairman Engel, Ranking Member McCaul, Members of the Committee, and guests. I am Dr. Jen Kates, Senior Vice President and Director of Global Health & HIV Policy at KFF (the Kaiser Family Foundation), a nonprofit, non-partisan organization that conducts independent health policy analysis. Thank you for inviting me to testify at this important and timely hearing. I will focus my testimony on three areas: (1) an overview of the U.S. government's role in addressing the health of women in low- and middle-income countries; (2) what we know about impact to date; and (3) current and future challenges and opportunities.

U.S. Role in Women's Global Health

U.S. efforts to address the health of women in low- and middle-income countries began decades ago, starting with family planning activities at USAID in 1965 (soon after the agency was created) and expanding to include maternal health in the late 1980s.[1] In fact, an amendment to the Foreign Assistance Act (FAA) in 1973, recognizing that "women in developing countries play a significant role in economic production, family support, and the overall development process," required that U.S. bilateral assistance "give particular attention to those programs, projects, and activities which tend to integrate women into the national economies of developing countries, thus improving their status and assisting the total development effort."[2] Indeed, studies have shown that improving the health of women has significant spillover effects on the health and economic well-being of their families, communities, and societies.[3]

Since the first U.S. global health programs were created, the U.S. has been – and remains – the largest donor to women's health, including that of adolescent girls and young women, in the world. Today these efforts reach more than 50 countries and provide multiple services.[4]

Major efforts include USAID's maternal and child health (MCH), nutrition, and family planning and reproductive health (FP/RH) programs, as well as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and its DREAMS initiative (a public-private partnership focused on adolescent girls and young women). Other U.S. global health efforts that reach women include USAID's President's Malaria Initiative and programs for water, sanitation, and hygiene (WASH), tuberculosis, and NTDs. U.S. assistance also supports several multilateral initiatives and organizations that address women's health.

Services, Reach, and Impact

A range of services that address women's health are provided across multiple programs (see Table 1). Among the services provided by USAID's bilateral MCH and FP/RH programs are:

- the provision of contraceptives;
- family planning counseling and services such as birth spacing;
- protecting the health of pregnant women during and after childbirth;
- addressing child marriage, female genital mutilation/cutting, and fistula prevention; and
- stemming gender-based violence (GBV).

Table 1: Selected U.S. Government-Funded Women's Global Health Interventions
– Antenatal care, including aseptic techniques to prevent sepsis, and postpartum care
– Biomedical and contraceptive research and development, implementation science, operational research
– Cervical cancer screening, diagnosis, and treatment
– Child marriage prevention and response
– Clean water, sanitation, and hygiene (WASH) efforts
– Contraceptive security
– Counseling and services such as birth spacing
– Emergency obstetric care
– Female genital cutting/mutilation elimination
– Fistula prevention and repair
– Gender-based violence prevention and response
– Health systems strengthening (health workforce, information systems, pharmaceutical management, infrastructure development)
– HIV prevention/treatment/care, including prevention of mother-to-child-transmission (PMTCT) of HIV
– Linking FP with HIV/AIDS & STD information/services
– Linking FP with maternity services
– Malaria prevention (including ITNs) and, for mothers, intermittent preventive treatment during pregnancy (IPTp)
– Nutrition/supplementation
– Post-abortion care
– Public education and marketing
– Sexuality & reproductive health education
– Skilled care at birth

PEPFAR efforts focus on, among other things, increasing access to HIV prevention and treatment and addressing the needs of at-risk populations, including those of adolescent girls. Services include the provision of HIV treatment, HIV testing and counseling, pre-exposure prophylaxis (PrEP) to prevent HIV acquisition, prevention of mother-to-child transmission (PMTCT), and cervical cancer prevention and treatment. Additionally, the DREAMS program provides a core package of services that goes beyond the health sector, to address the structural drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence, and lack of education.[5]

Certain services and activities are not permitted under U.S. law and policy, including abortion. Since 1973, there has been a law prohibiting the direct use of U.S. foreign assistance for abortion as a method of family planning (the Helms amendment).[6] There have also been more stringent restrictions in some years (see "Legal and Policy Restrictions" below).

U.S. global health programs reach tens of millions of women. USAID reports that its programs helped 81 million women and children access essential health services in 2018, and, since 2012, have supported 12 million women in giving birth in a health facility.[7] USAID's nutrition program reports that more than 6.9 million pregnant women were reached with nutrition interventions, including breastfeeding education, counseling and support, in FY 2018.[8] In addition, it is estimated that 24 million women are reached by USAID with voluntary family planning services annually, which help to prevent unintended pregnancy and reduce abortion and maternal mortality.[9,10] Finally, women represent the majority of those served by PEPFAR. For example, in 2019, 66%, or 9.8 million, of those on PEPFAR-supported antiretroviral therapy were women.[11]

Over the course of U.S. engagement, there have been tremendous gains in the health of women around the world. For example, USAID reports that its investments have helped to reduce the chances a woman will die in childbirth by more than half since 1990 in USAID MCH priority countries.[12] Additionally, since the USAID FP/RH program began, modern contraceptive prevalence has increased from under 10% to 32% in countries reached, and average family size has gone from over 6 to 4.3.[13] New HIV infections have fallen among women in almost all PEPFAR countries,[14] and HIV diagnoses have fallen significantly in most DREAMS intervention regions.[15]

Geographic Reach

The U.S. footprint in global women's health is large, with bilateral efforts spanning more than 50 low- and middle-income countries, mostly in sub-Saharan Africa.[16] Over time, many countries have graduated from U.S. assistance under the MCH and FP/RH programs. These two programs have consolidated most of their efforts in a subset of 25 MCH priority countries and 24 FP/RH priority countries with the greatest need. Nearly all of these priority countries overlap (see Table 2).[17] There is also considerable country overlap with other U.S. global health programs that reach women. PEPFAR focuses most of its resources in a subset of countries, 25 of which are required to submit annual Country Operational Plans (COPs) and several others are part of regional planning platforms. About half of PEPFAR's 25 COP countries are also MCH and/or FP/RH priority countries, as are eight of its regional platform countries.[18] PEPFAR's DREAMS program operates in 15 countries, eight of which are priority countries for the MCH and FP/RH programs.[19] Finally, 17 of USAID's 27 nutrition focus countries[20] are MCH and/or FP/RH priority countries.

Table 2: Geographic Reach of USAID's MCH and FP/RH Programs and PEPFAR

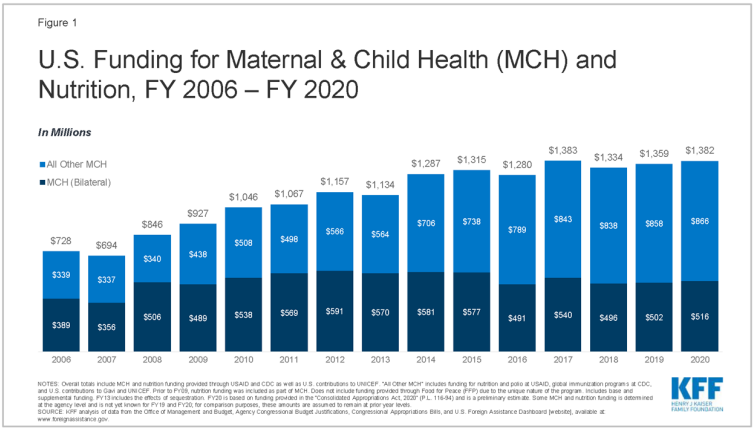
USAID MCH Program Priority Countries[21]	USAID FP/RH Program Priority Countries[22]	PEPFAR COP Countries[23] (DREAMS Countries in Bold[24])
1. Afghanistan	1. Afghanistan	1. Angola
2. Bangladesh	2. Bangladesh	2. Botswana
3. Burma	3. Democratic Republic of the Congo	3. Burundi
4. Democratic Republic of the Congo	4. Ethiopia	4. Cameroon
5. Ethiopia	5. Ghana	5. Cote d'Ivoire
6. Ghana	6. Haiti	6. Democratic Republic of the Congo
7. Haiti	7. India	7. Dominican Republic
8. India	8. Kenya	8. Eswatini
9. Indonesia	9. Liberia	9. Ethiopia
10. Kenya	10. Madagascar	10. Haiti
11. Liberia	11. Malawi	11. Kenya
12. Madagascar	12. Mali	12. Lesotho
13. Malawi	13. Mozambique	13. Malawi
14. Mali	14. Nepal	14. Mozambique
15. Mozambique	15. Nigeria	15. Namibia
16. Nepal	16. Pakistan	16. Nigeria
17. Nigeria	17. Philippines	17. Rwanda
18. Pakistan	18. Rwanda	18. South Africa
19. Rwanda	19. Senegal	19. South Sudan
20. Senegal	20. South Sudan	20. Tanzania
21. South Sudan	21. Tanzania	21. Uganda
22. Tanzania	22. Uganda	22. Ukraine
23. Uganda	23. Yemen	23. Vietnam
24. Yemen	24. Zambia	24. Zambia
25. Zambia		25. Zimbabwe

Funding[25]

The U.S. has made significant investments in women's health, particularly through USAID's MCH and FP/RH programs as well as through PEPFAR. Although PEPFAR is not designed as a women's health program, a substantial share of its funding supports women, including young women and adolescent girls.

MCH/Nutrition: The full funding envelope for U.S. MCH/nutrition efforts includes funding provided for bilateral MCH programming at USAID; funding specifically designated for polio and nutrition; funding for multilateral contributions to Gavi, the Vaccine Alliance (Gavi) and the United Nations Children's Fund (UNICEF); and funding to CDC for global immunization. It totaled almost $1.4 billion in FY 2020 (see Figure 1), accounting for 12% of the U.S. global health budget. While funding for this full envelope has increased over time, most of this growth was driven by increased funding to Gavi, nutrition, and polio, efforts that primarily serve children under the age of five.[26] In fact, when CDC global immunization, Gavi, nutrition, polio, and UNICEF funding are removed, remaining bilateral MCH funding has fluctuated over time and is below its peak level in 2012. In FY 2020, it was $516 million, just over than a third of the MCH and nutrition total.

Figure 1



FP/RH: The majority of U.S. FP/RH funding is provided to USAID for bilateral activities, with additional funding provided for the U.S. contribution to the United Nations Population Fund (UNFPA). Funding for FP/RH rose steadily over its first two decades of U.S. support but has since fluctuated over time and declined in some periods, including during the 2000s. It rose again at the end of that decade, hitting its peak in 2010 ($715 million). It then declined again and has remained relatively flat at approximately $600 million (see Figure 2), accounting for 5% of the U.S. global health budget in FY 2020. Since FY 2017, the administration has invoked the Kemp-Kasten amendment to withhold U.S. contributions to UNFPA (under current U.S. law, any U.S. funding withheld from UNFPA is to be made available to other family planning, maternal health, and reproductive health activities).[27]

Figure 2

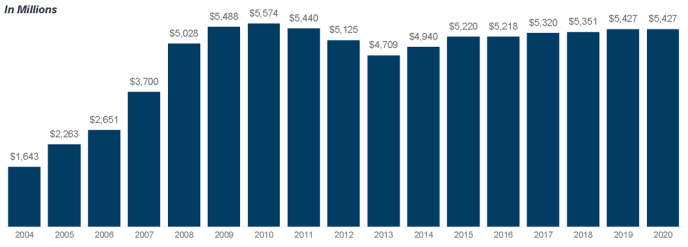
U.S. Funding for International Family Planning/ Reproductive Health (FP/RH), FY 2006 – FY 2020

NOTES: Includes FP/RH funding through USAID as well as U.S. contributions to UNFPA. Includes base and supplemental funding. FY13 includes the effects of sequestration. FY20 is based on funding provided in the "Consolidated Appropriations Act, 2020" (P.L. 116-94) and is a preliminary estimate.
SOURCE: KFF analysis of data from the Office of Management and Budget, Agency Congressional Budget Justifications, Congressional Appropriations Bills, and U.S. Foreign Assistance Dashboard [website], available at: www.foreignassistance.gov.

PEPFAR: PEPFAR estimates that it will spend nearly $2 billion of its $5.4 billion in bilateral HIV funding on efforts to support women and girls; while not specifically earmarked for women, this amount exceeds combined bilateral funding from the MCH and FP/RH programs. PEPFAR's funding includes $800 million invested in the DREAMS program. PEPFAR bilateral funding rose rapidly during the first decade of the program, reaching a peak of $5.57 billion in FY 2010. Between FY 2010 and FY 2013, it declined by more than $800 million. While it has risen since then, it is still $147 million below its peak level and has been mostly flat for the past several years (see Figure 3).

Figure 3

U.S. Funding for Bilateral HIV, FY 2004 – FY 2020



NOTES: Includes HIV funding provided through State/OGAC, USAID, CDC, NIH, and DoD. Bilateral HIV includes funding for UNAIDS, IAVI, the Commodity Fund, and Microbicides research activities. Includes base and supplemental funding. FY13 includes the effects of sequestration. FY20 is based on funding provided in the "Consolidated Appropriations Act, 2020" (P.L. 116-94) and is a preliminary estimate. Some funding for HIV programs provided through the Economic Support Fund (ESF) account at USAID is not yet known for FY19 and FY20 and is assumed to remain at prior year levels.
SOURCE: KFF analysis of data from the Office of Management and Budget, Agency Congressional Budget Justifications, Congressional Appropriations Bills, and U.S. Foreign Assistance Dashboard [website], available at: www.foreignassistance.gov.

Challenges and Opportunities

Despite these successes, numerous challenges remain, and progress has slowed. Most countries are not on track to reach global targets, as agreed to under the Sustainable Development Goals (SDGs).[28] Globally, nearly 300,000 women still die during pregnancy or in childbirth, almost all of whom are in sub-Saharan Africa,[29] and millions more experience illness and severe adverse consequences each year, largely from preventable or treatable causes.[30] More than 200 million women have an unmet need for modern family planning,[31] and 1 in 5 girls face early or forced marriage.[32] Further, women remain at disproportionate risk for HIV, which is the leading cause of death globally for women aged 15 to 49 years.[33] Future trends could exacerbate these challenges. For example, the population of adolescent girls is expected to grow significantly over the next few decades, yet the global community is not prepared to meet their health needs.[34] (See Appendix Table A1 for key indicators across priority countries.)

Most of these challenges are concentrated in countries already reached by the U.S., suggesting important opportunities for additional impact. Key factors contributing to these challenges as well as related opportunities for the U.S. are as follows:

Funding: Global health funding has slowed in the last decade even as the population needing services has grown.[35] While funding is provided by a range of sources, it is highly influenced by the U.S., the largest donor to women's health in the world. However, in recent years, U.S. funding – including for addressing the health of women – has been mostly flat, and significant cuts have been proposed to the MCH and FP/RH programs (including proposing to eliminate the FP/RH program in FY 2018), as well as to PEPFAR. While Congress has so far rejected these cuts, they have created uncertainty in the field each year and around the future of U.S. support more generally; such uncertainty affects country-level planning and programming. Going forward, more predictability in funding would contribute to program stability and sustainability. In some cases, additional funding would be needed to achieve further impact.

Domestic Resource Mobilization: Resources from country governments are a critical part of the global response. Although domestic resources have increased in many countries in which the U.S. provides global health assistance, they have not grown fast enough or with enough magnitude to replace external aid, and many countries with significant need are particularly vulnerable to any reduction in U.S. support.[36] For example, in the 24 USAID FP/RH priority countries, the U.S. provided an estimated 70% of donor funding, and in five of these countries, the U.S. provided more than 90% in recent years.[37] Similarly, most PEPFAR countries are vulnerable to even small losses of U.S. support.[38] One option that could be further explored is the use of incentives to stimulate additional investments specifically focused on women's health by country governments.

Integration and Multisectoral Approaches: Although addressing women's health needs is complex and requires multisectoral and integrated approaches and a range of interventions, U.S. health programs often remain siloed from one other as well as with non-health actors and sectors (such as education). This is true for funding as well as programming, which can limit the ability of donors, governments, civil society and others to work closely together in the field and reach women where they are. Yet the literature shows that greater integration generally supports better health outcomes and is cost effective. There are also documented and mutually reinforcing linkages with other sectors outside of health, particularly the

education sector.[39] While U.S. global health programs have worked to become more integrated,[40] challenges still remain in this area. There are also particular U.S. policy and legal barriers to integration (see below). One model of integration is PEPFAR's DREAMS program, which is designed to be multisectoral and bridge many of these gaps. Going forward, additional efforts to implement multisectoral and integrated approaches, including reducing policy barriers to such integration, could extend the impact of U.S. investments in women's health.

Adolescent Girls and Young Women: Most global health programs, including those that specifically seek to reach women, focus on pregnant women or children under five, leaving a gap in available services and programming for adolescent girls and young women. This gap threatens further global health gains, particularly given the projected growth in the youth population in sub-Saharan Africa over the next few decades.[41] The U.S. could work to specifically address the needs of adolescent girls and young women beyond maternal health, building and/or modeled on PEPFAR's DREAMS Initiative.

Legal and Policy Requirements: There is no other area of global health subject to more U.S. legal and policy requirements than women's health – specifically related to family planning and abortion. Currently, there are more than 20 statutory and policy requirements related to FP/RH programs in place (see Appendix Table A2).[42] While some of these requirements are designed to support principles such as voluntarism in family planning, others can make programming difficult and create confusion in the field, and some have been shown to have adverse health effects. The most far reaching of these requirements is the expanded Mexico City Policy (MCP), now known as "Protecting Life in Global Health Assistance," which requires foreign non-governmental organizations (NGOs) to certify that they would not perform or promote abortion as a method of family planning using funds from any source as a condition for receiving U.S. funding. When in place in the past, it has only applied to family planning assistance. As of 2017, it now applies to nearly all bilateral U.S. global health assistance, including funding for HIV under PEPFAR, maternal and child health, malaria, nutrition, and other program funding (see Table 3).[43] This marks a significant expansion of its scope, potentially encompassing $7.3 billion in FY 2020, to the extent that such funding is ultimately provided to foreign NGOs, directly or indirectly (family planning assistance accounts for approximately $600 million of that total). It also reaches a much greater number of foreign NGOs than ever before.[44] In addition, the policy is at odds with the abortion laws in most of the countries in which the U.S. provides bilateral health assistance.[45]

As of March 2019, the MCP, also for the first time, prohibits foreign NGOs from providing any financial support using any source of funds and for any purpose to other foreign NGOs that perform or actively promote abortion as a method of family planning. This greatly extends its reach to other areas of U.S. development assistance beyond global health and to other non-U.S. funding streams, presenting new barriers for integrating and coordinating with other donors and partners.

Measuring the impacts of the MCP is challenging, and some impacts may not be felt for years. Still, studies have documented service gaps in some communities and implementation challenges, including confusion about the policy's requirements (which can, for example, lead organizations to limit services that are permissible).[46] A recent empirical analysis found that when in place in the past, abortion rates and pregnancies rose and the use of modern contraception fell in countries most exposed to the policy.[47]

Table 3: The U.S. Mexico City Policy Over Time[48]				
Years	**In Effect?**	**Presidential Administration (Party Affiliation)**	**Executive (E) or Congressional (C) Action?**	**Funding Subject to Policy Restriction**
1985-1989	**Yes**	Reagan (R)	E	USAID family planning assistance
1989-1993	**Yes**	Bush (R)	E	USAID family planning assistance
1993-1999 Sept.	No	Clinton (D)	E	--
1999 Oct.-2000 Sept.	**Yes**	Clinton (D)	C	USAID family planning assistance
2000 Oct.-2001	No	Clinton (D)	E	--
2001-2009	**Yes**	Bush (R)	E	USAID family planning assistance; as of 2003, also family planning assistance at State Department
2009-2017	No	Obama (D)	E	--
2017-present	**Yes**	Trump (R)	E	Nearly all bilateral U.S. global health assistance
NOTES: Shaded blue indicate periods when policy was in effect. The 2003 expansion to family planning assistance at the State Department included an explicit exemption for global HIV programs and multilateral organizations.				

Data Limitations and Transparency: Despite improvements in data availability and quality, often with U.S. support, data limitations, particularly at the field/site level, can inhibit assessments of current impact and an ability to course correct in a timely fashion. In addition, where data are available, they are often not provided to policymakers, civil society, and other stakeholders. Without such data, efforts to target investments, coordinate across programs and sectors, and promote transparency are limited. One exception is PEPFAR, for which significant investments in data have been made, allowing for current, site level monitoring and data to be made widely available. Going forward, additional investments in other U.S. global women's health efforts could be needed to improve the timeliness and availability of site level data; in addition, programs could make existing data more readily available.

Conclusion

In summary, there are a number of opportunities for the U.S. to achieve additional improvements in women's health in the next decade. Together, these efforts can help ensure that the next generation of women is healthier than ever before. Furthermore, such investments would not only support improvement in the health of women and girls but also broader economic and development aims. I look forward to discussing these issues with you and answering any questions you may have.

Thank you.

Appendix Table A1: Selected Indicators Across Priority Countries								
Priority or COP Country	**Income Level**[49]	**Priority/COP Country by Program**			**Unmet Need for Modern Contraception** (%) 2018[50]	**Demand Satisfied by Modern Methods** (%) 2009-2018[51]	**Maternal Mortality Ratio** (deaths/ 100,000 live births) 2017[52]	**Women as Share of People Living with HIV** (%) 2018[53]
		MCH[54]	*FP/RH*[55]	*PEPFAR*[56]				
Afghanistan	L	X	X	-	18.5	42.2	638	28
Angola	LM	-	-	X	27.7	29.8	241	61
Bangladesh	LM	X	X	-	15.6	72.6	173	34
Botswana	UM	-	-	X	11.4	-	144	54
Burma	LM	X	-	-	9.7	74.9	250	36
Burundi	L	-	-	X	22.7	38.0	548	54
Cameroon	LM	-	-	X	26	47.0	529	61
Cote d'Ivoire	LM	-	-	X	25.6	39.4	617	57
Dem. Republic of the Congo	L	X	X	X	32.6	18.9	473	62
Dominican Republic	UM	-	-	X	10.6	81.7	95	49
Eswatini	LM	-	-	X	11.6	82.9	437	57
Ethiopia	L	X	X	X	15.7	62.3	401	59
Ghana	LM	X	X	-	24.2	46.2	308	61
Haiti	L	X	X	X	30.2	43.1	480	54
India	LM	X	X	-	18	67.2	145	-
Indonesia	LM	X	-	-	11.4	77.6	177	34
Kenya	LM	X	X	X	12	76.0	342	57
Lesotho	LM	-	-	X	12.4	78.9	544	56
Liberia	L	X	X	-	26.6	41.4	661	56
Madagascar	L	X	X	-	21.7	60.5	335	31
Malawi	L	X	X	X	15.3	73.9	349	58
Mali	L	X	X	-	24	35.0	562	57
Mozambique	L	X	X	X	21.1	55.5	289	55
Namibia	UM	-	-	X	10.8	80.4	195	55
Nepal	L	X	X	-	22.3	56.0	186	40
Nigeria	LM	X	X	X	20.9	42.8	917	53
Pakistan	LM	X	X	-	17.6	48.5	140	30
Philippines	LM	-	X	-	22	52.5	121	6
Rwanda	L	X	X	X	14.9	62.9	248	59
Senegal	LM	X	X	-	18.7	50.9	315	60
South Africa	UM	-	-	X	11.5	77.9	119	61
South Sudan	L	X	X	X	20.1	5.6	1150	53
Tanzania	L	X	X	X	22.1	54.0	524	55
Uganda	L	X	X	X	24.4	53.5	375	55
Ukraine	LM	-	-	X	16	68.0	19	36
Vietnam	LM	-	-	X	13	69.6	43	32
Yemen	L	X	X	-	24.3	37.7	164	22
Zambia	LM	X	X	X	18	62.4	213	58
Zimbabwe	LM	-	-	X	8.8	84.8	458	56
Global	**-**	**-**	**-**	**-**	**14.3**	**75.7**	**211**	**50**

Appendix Table A2: Statutory Requirements and Policies for U.S. Global FP/RH Efforts (as of FY 2019)[57]
Provision (Year First Instituted)
STATUTORY
Helms Amendment (1973) Prohibits the use of foreign assistance to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortion. Note: meaning of "motivate" clarified by Leahy Amendment (1994).
Involuntary Sterilization Amendment (1978) Prohibits the use of funds to pay for involuntary sterilizations as a method of family planning or to coerce or provide a financial incentive to anyone to undergo sterilization.
Peace Corps Provision (1978) Prohibits Peace Corps funding from paying for an abortion for a Peace Corps volunteer or trainee; beginning in FY 2015, allows for payment in cases where the life of the woman is endangered by pregnancy or in cases of rape or incest.
Biden Amendment (1981) States that funds may not be used for biomedical research related to methods of or the performance of abortion or involuntary sterilization as a means of family planning.
Siljander Amendment (1981) Prohibits the use of funds to lobby for or against abortion. When initially introduced, the amendment prohibited only lobbying for abortion, but in subsequent years Congress modified the language to include lobbying against abortion as well.
DeConcini Amendment (1985) Requires that U.S. funds be provided to organizations that offer, either directly or through referral to, information about access to a broad range of family planning methods and services. See Livingston-Obey Amendment (1986).
Kemp-Kasten Amendment (1985) Prohibits funding any organization or program, as determined by the President, that supports or participates in the management of a program of coercive abortion or involuntary sterilization.
Involuntary Sterilization and Abortion Provision (1985) Specifies that U.S. foreign assistance funding could be withheld from a country or organization if the president certifies that the use of such funds would violate key provisions of the FAA of 1961 related to abortion or involuntary sterilization (namely the Helms, Biden, and Involuntary Sterilization Amendments).
Livingston-Obey Amendment (1986) Prohibits discrimination by the U.S. government against organizations that offer only "natural family planning" for religious or conscientious reasons when the U.S. government is awarding related grants. All such applicants must comply with the requirements of the DeConcini Amendment (1985).
Leahy Amendment (1994) Clarifies Helms Amendment (1973) language that uses the term "motivate" by stating that "motivate" shall not be construed to prohibit, where legal, the provision of information or counseling about all pregnancy options.
Conditions on Availability of UNFPA Funds (UNFPA Segregated U.S. Contribution Account; UNFPA Does Not Fund Abortions; Prohibition on the Use of U.S. Funds in China by UNFPA) (1994) States that funds may not be made available to UNFPA unless: – UNFPA keeps the U.S. contribution to the agency in a separate account, not to be commingled with other funds, and – UNFPA does not fund abortions (note: language used beginning in FY00). It also prohibits UNFPA from using any funds from the U.S. contribution in their programming in China.
UNFPA Dollar-for-Dollar Withholding of Amount UNFPA Plans to Spend in China During Fiscal Year (1994) Reduces the U.S. contribution to UNFPA by one dollar for every dollar that UNFPA spends on its programming in China.
Tiahrt Amendment (1998) Prohibits the use of targets/quotas and financial incentives in family planning projects and requires projects to provide comprehensible information on family planning methods. Protects people who choose not to use family planning from being denied rights or benefits and requires experimental family planning methods be provided only in the context of a scientific study. Intended to "promote voluntarism and prevent coercion in family planning programs," it specifically prohibits three types of targets: total number of births, number of family planning acceptors, and acceptors of a particular method of family planning.
Reallocation of Funds Not Made Available to UNFPA (2004) Provides for funds not made available to UNFPA to be reallocated to USAID's family planning, maternal, and reproductive health activities/services (and, in some years, assistance to vulnerable children and victims of trafficking in persons).
Medically Accurate Information on Condoms (2005) Ensures that information provided by U.S.-supported programs about the use of condoms is medically accurate information and includes the public health benefits and failure rates of such use.
POLICY
USAID Policy Paper on Population Assistance (1982) Outlines the longstanding USAID guidelines surrounding its fundamental programmatic principles of voluntarism and informed choice and consent.
Policy Determination 3 (PD-3) and Addendum: USAID Policy Guidelines on Voluntary Sterilization (1982) Describes guidelines for informed consent and voluntarism specifically for voluntary sterilization services, including provisions to ensure ready access to other contraceptive methods and prohibiting incentive payments that might induce a person to select voluntary sterilization over another method.

Appendix Table A2: Statutory Requirements and Policies for U.S. Global FP/RH Efforts (as of FY 2019)[57]
Provision (Year First Instituted)
Mexico City Policy / Protecting Life in Global Health Assistance (1984) As a condition for receiving U.S. family planning assistance and, now, also other global health assistance (see "Applies to"), requires foreign NGOs to certify that they will not perform or promote abortion as a method of family planning using funds from any source.
USAID Post-Abortion Care Policy (2001) Clarifies that post-abortion care – the treatment of injuries or illnesses caused by legal or illegal abortion – is permitted under the Helms Amendment and that any restrictions under the Mexico City Policy, when in force, do not limit organizations from treating injuries or illnesses caused by legal or illegal abortions (i.e., providing post-abortion care). Notes USAID does not finance manual vacuum aspiration equipment purchase/distribution for any purpose.
Guidance on the Definition and Use of the Global Health Programs Account: Section on Allowable Uses of Funds for Family Planning/Reproductive Health (2014) Outlines allowable uses of funds for FP/RH by providing a description of activities allowed and examples of activities not allowed, addressing not only FP/RH activities but also family planning activities' integration with other global health and multisectoral activities.
PEPFAR FY 2019 Country Operational Plan Guidance Outlines certain FP/RH activities that may be reported under specific PEPFAR budget categories, including: adolescent-friendly sexual and RH services that are part of prevention targeting priority populations; assessment of FP needs and, if indicated, contraception referral or safer pregnancy counseling or referral for FP services for HIV-positive individuals; access to adolescent-friendly RH services in support of vulnerable children; RH services that support the needs of adolescents with HIV; and integrated programming messages for women's health. Includes explanation of implementation of the Mexico City Policy/Protecting Life in Global Health Assistance policy in PEPFAR programs.

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Chairman ENGEL. Thank you, Dr. Kates.
Ms. CROCKER.

STATEMENT OF SHEBA CROCKER, VICE PRESIDENT FOR HUMANITARIAN POLICY AND PRACTICE, CARE USA

Ms. CROCKER. Chairman Engel, Ranking Member McCaul, distinguished members of this committee——
Chairman ENGEL. If you could just pull the mic a little closer to you.
Ms. CROCKER. Sorry.
Chairman ENGEL. No, that is Okay.
Ms. CROCKER. Let me see if I can do that. Better?
Chairman ENGEL. I think so, yes.
Ms. CROCKER. Thank you for the opportunity to testify today as you examine the challenges facing women's health globally. These are critical issues and I am thankful for the committee's attention to this matter. I have abbreviated my testimony and I encourage the committee to consult my full written testimony for further recommendations and I ask that they be entered into the record.

My name is Sheba Crocker. And I am the Vice President of Humanitarian Policy and Practice at CARE USA. CARE was established nearly 75 years ago when a small group of Americans sent the first CARE packages overseas to survivors of World War II. Today CARE works in a hundred countries to address the root causes of suffering and to provide life-saving humanitarian assistance to people in need.

CARE's work focuses on women and girls because our experience has taught us that we must help communities address gender inequality in order to respond effectively to crises and to their underlying factors.

Before I begin, I would like to take this opportunity to thank this committee and Congress for continued bipartisan commitment it has shown for development in humanitarian assistance. Helping those in need around the world is not and has never been a partisan issue and CARE is grateful that the United States has such strong champions for continuing U.S. leadership on foreign assistance on both sides of the aisle.

I would like to focus my remarks on four challenges to the health of women and girls in humanitarian settings: inadequate funding, lack of access of humanitarian workers to populations in need and of those populations to healthcare; social norms that expose women and girls to greater health risks; and issues that heavily affect or are unique to women, specifically gender-based violence and access to sexual and reproductive health services which include contraceptives, quality obstetric care, pre-and post-natal services, and sexually transmitted infections, prevention, and treatment.

First, although the number of people who require humanitarian assistance continues to rise, funding particularly for emergency healthcare lags. In 2019, the U.N. requested $2.4 billion to provide healthcare to vulnerable populations around the world, but global contributions totaled just 33 percent of that request, only some of which was dedicated to the unique needs of women and girls. Moreover, of the total humanitarian funding allocated between the years 2016 and 2018, gender-based violence prevention and response

services received just .12 percent or only one third of the amount identified as needed for gender-based violence prevention and response.

Second, access of humanitarian agencies to people in need and of women to healthcare is crucial. If we cannot reach people, we cannot help them. Even when humanitarian workers are on the ground, conflicts and natural disasters damage healthcare facilities and kill, displace or disincentivize staff. For example, at least 60 health facilities in northwest Syria alone were damaged in air strikes over just an 8-month period in 2019, affecting tens of thousands of people. In some societies, women are unable to attend clinics if no female staff are present or if male family members cannot accompany them, further compromising women's access to healthcare.

Third, social norms can expose women and girls to greater health risks. Women and girls are often expected to nurse family members and are also typically the last to receive assistance. This means that they are both at a higher risk of contracting communicable diseases and are less likely to receive the timely care they need. For example, 56 percent of confirmed and probable cases in the ongoing Ebola outbreak in the eastern Democratic Republic of the Congo has been among women and 28 percent among children under 18 years old. Just 11 percent of cases have been reported among men over the age of 18.

Fourth, there are some risks that particularly affect women and girls, namely gender-based violence and sexual and reproductive health. Available evidence suggests that multiple forms of gender-based violence remain pervasive in emergencies, including emotional, physical, and sexual assault, intimate partner violence, sexual exploitation and abuse, and child early and forced marriage. Gender-based violence can have sexual and reproductive health consequences for women compounding the risks inherent in pregnancy and childbirth which are dangerous even under the best of circumstances. However, for the millions of women who require humanitarian assistance and may lack access to healthcare, the risks are even higher. Sixty percent of all preventable maternal deaths and 45 percent of all preventable newborn deaths occur in vulnerable States, many of which are affected by conflict and humanitarian emergencies.

I would like to briefly share three priority areas for your action based on CARE's experience. First, the United States must prioritize funding for women's health services including gender-based violence and prevention and response and family planning and reproductive healthcare from the outset of the humanitarian response.

Second, CARE strongly encourages strengthening policies that promote the health of women and girls in emergencies and addressing policies that restrict access. CARE supports the Safe from the Start Act, a bipartisan bill that strengthens the humanitarian system's capacity to prevent and respond to gender-based violence. Policies that restrict NGO's' ability to provide life saving health services such as the Mexico City policy, have been shown to reduce access to care and lead to poor health outcomes for women and CARE calls for this policy's repeal.

And CARE regrets the administration's decision to halt all funding to the United Nations Population Fund, despite consistent bipartisan support for that agency. CARE urges a speedy restoration of funds to UNPFA.

And finally, to support the protection of women and girls and their access to humanitarian assistance including healthcare assistance, the United States should continue its long-standing commitment to principled humanitarian actions and be a global leader in promoting and ensuring compliance within international humanitarian law by all parties to conflict.

The unique needs of services and girls must be treated with urgency during humanitarian response. CARE is committed to working with women, girls, men, and boys to elevate women's and girls' potential so they can help build stronger and more resilient societies. Thank you very much and I look forward to answering your questions.

[The prepared statement of Crocker follows:]

Ms. Sheba Crocker
Vice President of Humanitarian Policy and Practice
CARE USA

Testimony Submitted to the House Foreign Affairs Committee
"Unique Challenges Women Face in Global Health"

February 5, 2020

Chairman Engel, Ranking Member McCaul, distinguished members of the Committee, thank you for the opportunity to testify today as you examine the challenges facing women's health globally and the U.S. government's response. These are critical issues, and I am thankful for the Committee's attention to them.

My name is Sheba Crocker, and I am the Vice President of Humanitarian Policy and Practice at CARE USA. CARE began its story nearly 75 years ago when a small group of dedicated Americans sent the first CARE packages overseas to survivors of World War II. Today, CARE works in 100 countries around the world to address the root causes of suffering and to provide lifesaving humanitarian assistance to people in need. CARE's work focuses on women and girls because our experience has taught us that we must help communities address gender inequalities between women and men to respond effectively to crises and their underlying factors.

Before I begin, I would like to take this opportunity to thank this Committee and Congress for continued bi-partisan commitment it has shown development and humanitarian assistance. Helping those in need around the world is not, and has never been, a partisan issue. CARE is grateful that the United States has such strong champions for continuing U.S. leadership on foreign assistance on both sides of the aisle.

Around the world emergencies amplify inequalities. Community and household dynamics often shift during crises, creating new roles and opportunities, as well as new challenges and risks. Women and girls are often disproportionally affected and may have difficulty accessing food, health care services, shelter, and other resources.

Today, I will focus my remarks on four challenges to the health of women and girls in humanitarian settings and how the United States can provide critical support for their protection and empowerment. These challenges are: inadequate funding; lack of access of humanitarian workers to populations in need and of those populations to health care; social norms that expose women and girls to greater health risks; and issues that heavily affect or are unique to women and girls, specifically gender-based violence (GBV) and sexual and reproductive health, which includes access to contraceptives, quality obstetric care, pre- and post-natal services, and the prevention and treatment of sexually transmitted infections.

First, funding for humanitarian operations is failing to keep pace with need. Today 132 million people -- or one in every 70 people -- around the world require relief assistance, an unprecedented figure. In 2019, the UN requested $2.4 billion to provide health care to vulnerable populations globally. Although the United States is the world's largest humanitarian donor, contributions from the international community met just 33 percent of that request, according to the UN Office for the Coordination of Humanitarian Affairs. Moreover, a report by the International Rescue Committee and VOICE found that

GBV prevention and response services received just 0.12 percent of the $41.5 billion allocated for humanitarian funding from 2016–2018, fulfilling only one-third of the amount requested for GBV programming. Without sufficient funding in place, we cannot address the challenges that women face to obtaining physical and psychosocial health care services in humanitarian emergencies.

Second, access—of humanitarian agencies to people in crisis, and of women to health care—is crucial. Without access, relief workers cannot reach populations in need. Access challenges for humanitarian workers take several forms. The Center for Strategic and International Studies Task Force on Humanitarian Access, of which I was a member, found that these include violence and insecurity; bureaucratic constraints, such as import restrictions on relief items; onerous visa processes that prevent humanitarian workers from entering a country; or donor-imposed requirements that may limit access. These issues might seem trivial, but they have consequences. For example, on January 29, 2020, the UN reported that 400,000 medical items that relief agencies had planned to deliver to Syria were being held at the Iraqi border, which will result in decreased medical services and supplies available in Northeast Syria. Humanitarian organizations have been unable to deliver the supplies after the UN Security Council failed to renew the authorization of cross-border deliveries from Iraq and Jordan into Syria early last month.

Vulnerable populations, such as women and children, face their own challenges in accessing health care during crises. Conflicts and natural disasters damage health care facilities and kill, displace or disincentivize staff . For example, Physicians for Human Rights reported that at least 914 Syrian health workers have been killed since the start of the conflict, while the UN found that at least 60 health facilities in Northwest Syria were damaged in airstrikes in just eight months in 2019, affecting tens of thousands of people. In some areas, where women are unable to attend clinics if no female staff are present or if male family members cannot accompany them, women's access to health care is further compromised.

Third, social norms—such as expectations that women and girls will nurse sick family members and receive assistance last, after men and boys—can expose women and girls to greater health risks. These norms mean that women and girls are more likely to contract infectious diseases but less likely to receive the timely care they need to keep their health concerns from worsening. For example, in the ongoing Ebola outbreak in the Democratic Republic of Congo (DRC), 56 percent of the confirmed and probable cases have been amongst women and 28 percent have been amongst children under 18 years old, the World Health Organization (WHO) reports. Only 11 percent of the cases recorded have been amongst males over the age of 18. The expectation of women to act as caregivers follows them outside of the home too; women comprise more than 75 percent of the health care workforce in many countries, according to the Human Resources for Health Global Resource Center. Women's higher participation in the health care workforce adds to the likelihood that they will be more exposed to infectious diseases and highlights the importance of ensuring that they can access appropriate health care services, particularly in emergencies when health systems and coping mechanisms are often severely degraded. The existence of harmful social norms, such as those noted above, also highlights the importance of CARE's work to address the gender inequalities that perpetuate imbalanced access to and availability of health care.

Finally, I would like to discuss the health risks that disproportionately affect or are unique to women: GBV and sexual and reproductive health. Although men, boys, and other groups can experience GBV, I will focus my remarks on the risks and effects of GBV as they pertain to women and girls. In times of crisis, available evidence suggests that GBV incidents increase—with women and girls among those most

affected. GBV can take many forms—including emotional, physical and sexual assault—and it can begin with something as simple as a security risk. Refugee camps and other displacement settings often lack adequate lighting and gender-appropriate showers and toilets. Women and girls frequently need to travel long distances to access basic commodities, such as food and water. These circumstances increase their risk of sexual assault by the people around them, as well as by armed groups. The UN estimates that 1 in 5 internally displaced or refugee women living in humanitarian crises or armed conflict have experienced sexual violence.

The strains of living in a humanitarian crisis, from financial to physical insecurity, weigh on families and can lead to other forms of GBV, such as intimate partner violence (IPV), sexual exploitation and abuse (SEA), and child, early and forced marriage (CEFM). IPV is one of the most common forms of violence against women and girls and includes physical, sexual, emotional and economic abuse and controlling behaviors by an intimate partner. Health organizations have estimated that one in three women worldwide have experienced IPV or non-partner sexual violence in their lifetimes, and evidence suggests that the rate of IPV is much higher in humanitarian crises. In fact, research by the IRC suggests that IPV may be the most common type of violence women and girls experience during emergencies. IPV can result in profound physical and psychosocial harm, treatment for which is often complicated by a lack of available health facilities and services.

Unfortunately, even those who are meant to help sometimes end up doing harm. Sexual exploitation and abuse of vulnerable populations by humanitarian personnel, a horrifying breach of trust, has begun to be better recognized and addressed but remains a serious concern. Statistics on the prevalence of SEA are often lacking, partially due to sensitivities around reporting, and vary by context, but SEA can have serious emotional and physical health complications for those affected.

In addition, child, early, and forced marriage often increases during emergencies. CEFM impedes women and girls from making decisions about their lives; disrupts their education; makes them more vulnerable to abuse, discrimination, and violence; and prevents their full participation in economic, political, and social spheres. The UN Office of the High Commissioner for Human Rights notes that CEFM is often accompanied by early and frequent pregnancy and childbirth, resulting in higher than average maternal morbidity and mortality rates.

GBV, particularly in crises, has serious implications for women and girls. Because obtaining health care, including contraceptive services, is so difficult, incidents of GBV can subject women and girls to additional psychosocial and physical harm. Health consequences may include anxiety, depression, exposure to sexually transmitted infections—including HIV—genital injuries, post-traumatic stress disorder, and unintended and unsafe pregnancies. Even where health care services are available, the stigma associated with GBV can hinder women and girls from reporting it and seeking help.

Pregnancy and childbirth can expose women to additional risk wherever they live. For the millions of women who require humanitarian assistance and may lack access to health care, the risks are even higher: globally, more than 60 percent of all preventable maternal deaths and 45 percent of all preventable newborn deaths occur in vulnerable states, many affected by conflict and humanitarian emergencies, according to WHO. GBV, coupled with lack of access to contraception and other forms of reproductive health care, can result in pregnancy complications, dangerous deliveries, and an increased risk of exposure to HIV/AIDS and other sexually transmitted infections.

As I mentioned above, gender inequalities are often exacerbated in emergencies. Relief agencies must take thoughtful action to meet the unique needs of women and girls in crises. Providing appropriate health care is every bit as important as providing clean drinking water, food and shelter. We must ensure that women and girls have access to the health care, including reproductive and contraceptive services, that they need from the beginning of an emergency response to its end.

Effectively responding to the needs of women and girls in emergencies is achievable, assuming adequate resources and political commitment. Around the world, organizations like CARE are helping address the health needs of women and girls with support from the United States and other donors.

For instance, CARE is working to meet the needs of Rohingya refugees in Cox's Bazar, Bangladesh, through women and girls' safe spaces that provide health checks, private psychosocial counseling and referrals to other services, such as specialized medical care. CARE is also training other camp-based staff in counseling and psychosocial support techniques, first aid and how to mitigate and respond to SEA.

In eastern DRC, we are training local partners to operationalize the Minimum Initial Service Package for Reproductive Health in Emergencies (MISP) and strengthen women and girls' access to quality health care and support. CARE is also partnering with women-led organizations to undertake GBV assessments and programming and to support capacity-strengthening and advocacy activities.

However, much more can—and must—be done. I would like to share with the committee six key recommendations based on CARE's experience in the field:

- First, the United States must prioritize funding for women's health services, including comprehensive GBV prevention and response efforts and family planning and reproductive health care, including access to contraceptives, quality obstetric care, pre- and post-natal services, and sexually transmitted infections prevention and treatment, from the outset of a humanitarian response.
- Second, and relatedly, CARE asks the Committee to urge humanitarian organizations to work directly with affected women and girls, to ensure that their concerns and priorities inform the direction of humanitarian programs. It is not enough to simply fund health care activities; we must do so in a way that allows women and girls to lead and participate in the design, implementation, and evaluation of emergency health interventions from inception to completion.
- Third, CARE strongly encourages the passage of legislation strengthening existing policies that promote the health of women and girls in emergencies. CARE supports the *Safe from the Start Act*, a bipartisan bill that has been referred to this Committee. The bill strengthens the U.S. government's current Safe from the Start program, which helps prevent and respond to GBV from the onset of a humanitarian crisis. Addressing GBV is integral to any legitimate and sustainable efforts to address the health burdens that women and girls are exposed to during humanitarian emergencies. CARE strongly encourages Congress to take up and pass this important bill.
- Fourth, CARE encourages the United States to address its own policies, where they are having detrimental effect on women's health in humanitarian settings. U.S. policy governing global health should reflect evidence-based methods that help prevent maternal and child death, including access to pre/post-natal care, safe delivery services, access to contraception and other primary health care services. Any action that jeopardizes the resources needed to achieve this

goal will have dire implications for the women, men and families that CARE works with and that the United States so generously supports with its assistance.
    - Policies that unnecessarily restrict NGOs' ability to provide life-saving services, such as the *Mexico City Policy*, have been shown to reduce access to health care and lead to poorer outcomes for women. CARE calls for this policy's repeal.
    - CARE regrets the Administration's decision to halt all funding to the United Nations Population Fund (UNFPA) despite consistent, bipartisan support for the agency. In more than 150 countries, UNFPA combats GBV and provides lifesaving reproductive health services, often in complex and dangerous settings. CARE has worked closely with UNFPA in many countries, including DRC, Nigeria, Syria, and Yemen, and has seen firsthand the important role it plays in supporting women's health, especially in emergency settings. CARE urges the speedy restoration of funds to UNFPA.
- Fifth, CARE recommends that the Committee encourage the implementation of the MISP at the onset of every crisis. The MISP is a series of actions aimed at preventing and managing the consequences of sexual violence; reducing HIV transmission; preventing maternal and newborn death and illness; and planning for sexual and reproductive health care. By bringing a standardized approach to GBV and sexual and reproductive health care in emergencies, the MISP can help save lives.
- Sixth, to support the protection of women and girls and their access to humanitarian assistance, the United States must continue its longstanding commitment to principled humanitarian action and be a global leader in promoting and ensuring compliance with international humanitarian law by all parties to conflicts.

I would like to thank the Committee for examining the issue of women's health in humanitarian settings around the world. This is a critical issue that has serious implications for millions of people. Supporting the particular health care needs of women and girls helps address existing gender inequalities and is an essential component of responding effectively to emergencies and their underlying factors. Moreover, it is critical to building a more secure and prosperous world, which is a central component of America's foreign policy.

I appreciate today's conversation. I hope that women's health in emergencies remains an ongoing priority for this Committee.

Thank you very much. I look forward to answering your questions.

Chairman ENGEL. Thank you very much, Ms. Crocker. Mr. Mulumba.

STATEMENT OF MOSES MULUMBA, CENTER FOR HEALTH, HUMAN RIGHTS, AND DEVELOPMENT, UGANDA

Mr. MULUMBA. Thank you, Mr. Chairman, Ranking Member McCaul, and the members of the Foreign Affairs Committee. I appreciate the attention this committee is devoting to global women's health and I welcome the opportunity to share some of the challenges vulnerable communities, notably women and girls——

Chairman ENGEL. Mr. Mulumba, let me ask you again, could you pull the microphone a little closer to you?

Mr. MULUMBA. Thank you. I appreciate the attention this committee is devoting to global women's health and I welcome the opportunity to share some of the challenges vulnerable communities, notably women and girls in Uganda face in accessing healthcare.

I have summarized my opening statement, but ask that the full, written testimony be entered into the record.

For close to 15 years, I have been working as a health and human rights advocate. In my current role as the Executive Director of my organization, my work focuses on ensuring social justice in health systems for the most vulnerable. My experience with the health system is much longer than my professional life. I grew up with a mother who was a nurse working in private not for profit health place, who also had a small clinic. I still clearly remember verbal autopsies and stories of how women died. The women with babies that flocked to the health facility and my mom's clinic who needed treatment interventions, but always had difficulty meeting the bills for care. As a young boy, I did not inquire into the deaths and barriers that women were facing daily. I was not a lawyer and not an activist yet.

I grew up knowing child delivery as "Lutalo Iwa Bakyala," that is in my language. This means it is a battle for the women. Going through child delivery was and is still a matter of life and death. I also remember a number of cases that involved young girls, and sometimes married women died after an unsafe abortion. Emergency cases of obstetric care after unsafe terminations were common then and continue to be common today. Lack of access to contraceptives, deplorable maternal health services, and a highly restrictive legal environment on access to safe abortion services continue to dominate our health system to date.

As a lawyer and a social justice activist now, I keep wondering why do women and girls continue to face disproportionate gaps in access to care and rights? Why has the global community not done enough?

In Uganda, for instance, we still lose 16 women each day to preventable issues in pregnancy and childbirth. I have witnessed, advocated, and even litigated cases in which women are struggling to have what would ideally be basics for controlling their bodies, from access to maternity kits, to supporting safe deliveries of women and their newborns, to contraceptive methods of their choice.

I note and I agree that a population's health and well-being is primarily a national responsibility, Mr. Chairman. But at the same time, I note that the health is also a global responsibility which

creates duties on other States to ensure a safe and healthy population, with particular attention to the needs of the world's poorest people. This particular responsibility on other States is often misunderstood, underrated, abused, and lately traded as part of politics.

The reinstatement and the expansion of the Global Gag Rule, Mr. Chairman, demonstrates how a repressive political decision from another country can affect population health and well-being in countries like mine. The Global Gag Rule has led to cutting off funding for much needed health services, especially among the communities that are already under served. As a result of the Global Gag Rule, my organization has lost key advocacy grants. We had to close our work halfway into a 4-year USAID project on advocacy for better health, despite progress and good performance. The accusation then was that we are interpreting the laws what a lawyer does every single day.

So the reason cited then was that we had failed to sign the addendum that incorporates the Global Gag Rule. The closure of this project brought immediate termination to our advocacy interventions. And some of these promoted accountability in the supply chain of essential medicines in Uganda, including anti-malarials and HIV testing kits. The goal of our work was ultimately to ensure patients had access to the needed facilities where they accessed them. The closure also meant immediately terminating the contracts of our key project staff and distortion of coalition work that we are doing with other organizations that hold the government accountable on health systems.

It is not an easy, Mr. Chairman, to simply comply and keep the resources or simply make a choice to lose the access to these resources. Jobs and indeed lives are on the line. Nonetheless, my organization's work cannot be just in one area of health and not another. I think this would highly compromise the values of the institution that we have.

Through my work, I can make the following conclusions, Mr. Chairman. I have witnessed a clear linkage between politics, the law, and health outcomes. In the area of reproductive rights, it is undeniable that political decisions have played a critical role in shaping the development of reproductive rights approaches and indicators for women. Unfortunately, our fundamentalism sometimes has continued to dominate over women, girls', and mothers' health, especially when it comes to their ability to decide when, if, and how many children to have. Maternal and reproductive health should not be a privilege for some, a but a right for all.

My hope for Uganda, Mr. Chairman, and the committee, is Uganda and the world that is where a future of women, and mothers, and girls, no one dies simply because of their biological composition. Thank you very much.

Thank you

[The prepared statement of Mr. Mulumba follows:]

Moses Mulumba (Uganda)
Executive Director, Center for Health, Human Rights and Development (CEHURD)
Testimony for House Committee on Foreign Affairs hearing entitled "Unique Challenges Women Face in Global Health" on February 5, 2020

Thank you Mr. Chairman, Ranking Member McCaul, and members of the Foreign Affairs Committee.

I appreciate the attention this committee is devoting to global women's health and I welcome the opportunity to share with you some of the challenges vulnerable communities, notably women and girls, in Uganda face in accessing health care.

For close to 15 years of my professional career, I have been working as a health and human rights advocate. In my current role as Executive Director of Center for Health, Human Rights and Development (CEHURD), a civil society organization based in Kampala, Uganda, my work focuses on ensuring social justice in health systems for the most vulnerable. Our work at CEHURD involves deconstructing health and human rights and use of the law, ground-breaking public interest litigation and policy engagements including evidence-based advocacy and community mobilization as the major entry points that informs our interventions at national level. We focus on issues where there are significant gaps in the right to health, like access to medicines, expanding reproductive and maternal health and rights, including youth-friendly services, and addressing underlying determinants of health including access to a clean and healthy environment, water and sanitation, education, food and housing. We have worked on HIV and AIDS, tuberculous, gender-based violence, and more. Unsurprisingly, I have witnessed that women, mothers and young girls continue to be the major users of the health system, and this is largely because of the critical maternal function they perform in society. It is hard to believe, but I note that in low income countries, systems have been designed in a way that continues to punish these sisters, wives and friends because of their nature.

My experience with health systems is much longer than my professional life. I grew up in a home with a mother who was a nurse working in private not for profit nursing home, who also had her own small clinic. I have fresh experiences of verbal autopsies and hearing the stories of how women died. I still clearly remember the number of women with babies that flocked both the health facility and my mum's clinic. They clearly needed treatment

interventions but always had difficulty meeting the bills for care. Back then, as a young boy I did not inquire into the deaths and barriers that women were facing daily. I was not a lawyer and an activist yet!

Even at that time, I remember a number of cases of maternal-related complications at both childbirth and a few days after the delivery. I grew up knowing child delivery as the '*Lutalo lwa Bakyala,'* which means the Battle for the Women. Going through child delivery was and still is a matter of life and death. I also remember a number of cases that involved young girls, and, at one time, a married woman that died after an unsafe abortion. Emergency cases of post abortion care after unsafe terminations were common then and continue to be common today. Lack of access to contraceptives, deplorable maternal health services and a highly restrictive legal environment on access to safe abortion services continue to dominate our health system to date.

As a lawyer and a social justice activist now, I keep wondering! Why do women and girls continue to face disproportionate gaps in access to care and rights? Why has the global community not done enough? The global solidarity espoused in compacts like the Sustainable Development Goals are not realized. In Uganda, reproductive rights seems to be an issue for women. We invest less and yet seem to be more interested in controlling the tail end of the consequences (the women's actions on their bodies)—and this seems to be okay nationally and globally. In Uganda, we still lose sixteen women each day to preventable issues in pregnancy and childbirth. I have witnessed, advocated and litigated cases in which women are struggling to have what would ideally be basics for controlling their bodies—from access to kits to support safe deliveries for women and their newborns to the contraceptive method of their choice. From my mother's practice, I have witnessed the real struggle women, mothers and young girls go through to be empowered to have information, resources and the courage to access the most basic reproductive rights services. These sisters, wives and friends endure the cost and difficulty of accessing reproductive services in private sector facilities instead of the public health system. How can we ensure that regardless of where a woman enters the health system she receives the quality and acceptable services she deserves?

I note and agree that a population's health and wellbeing is primarily a national responsibility. Every state owes all of its inhabitants a comprehensive package of essential

health goods and services under its obligations to respect, protect, and fulfil the human right to health. But at the same time, I know that health is also a global responsibility which creates duties on other states to ensure a safe and healthy world, with particular attention to the needs of the world's poorest people. This particular responsibility on other states is often misunderstood, underrated, abused and lately traded as part of politics. Uganda provides a clear example of the impact donor policies can have on national priorities. As a country, we are dependent on external donor financing for health care. In effect, the United States, one of Uganda's largest providers of global health assistance, is disrupting our national priorities and undermining the progress we have made as a nation.

The recent developments on reinstatement and expansion of the global gag rule demonstrates the consequences of the repressive political decisions from other countries and how these can affect population health and wellbeing in countries like Uganda. The global gag rule wreaked havoc by cutting off funding for much needed health services, especially amongst communities that are already underserved. Such policies like the global gag rule have both direct impacts on the beneficiaries of health services, especially sexual reproductive health care, and other indirect effects like undermining coalitions and other organized groups seeking to support the development of progressive sexual reproductive health and rights policies and services.

As a result of the global gag rule, my organisation has lost key advocacy subgrants. For instance, we had to close down our work halfway into a four-year USAID-funded project on advocacy for better health, despite progress and our good performance on the project. The only reason cited in this project closure was our failure to sign the new addendum (incorporating the global gag rule) when our subgrant was up for renewal. The closure of the project brought an immediate termination of our advocacy interventions that promoted accountability and follow-up on the supply chain of essential medicines in the country. Under this project, CEHURD led an advocacy and accountability strategy which focused on ensuring the national medical stores properly managed their stock of key medications and supplies, including anti-malarials and HIV testing kits. The goal for our work was to avoid wasted and expiring stock and ultimately to ensure patients had the medicines they needed at the facilities where they access health care. Internally, the closure also meant immediately terminating the contracts of the key project staff, disruptions of the

relationships created with project partners, and distorted our coalition's work with partners involved in accountability work for health systems. The non-clarity of the policy and absence of visible efforts to explain the global gag rule including its scope did not help the situation either. Ultimately, another partner did not take over CEHURD's role in the project at the time of the subgrant renewal and the project was closed.

It is not an easy choice to comply and keep the funding or refuse and lose access to those resources: jobs and indeed lives are on the line. Nevertheless, for CEHURD, this policy is incompatible with our mission and work. Our organization promotes social justice and human rights to ensure access to health care for vulnerable communities. We cannot work on one area of health and not others, or prioritize some human rights and not others This would compromise our mission and values as an institution.

Through my work, I can make the following conclusions. I have witnessed a clear linkage between politics, the law and health outcomes and it's very undeniable that throughout history, political decisions have played a critical role in shaping the development of reproductive rights approaches and indicators for women. Fundamentalism seems to have a continued dominance over women, girls and mothers, especially when it comes to their ability to decide when, if, and how many children to have. We need to operationalise the human rights-based approaches—evidence-based policies and global solidarity should not be ignored as a key factor in health systems strengthening. Maternal and reproductive health should not be a privilege for some, but a right for all.

My hope for Uganda and the world is for a future where no woman, mother or young girl dies simply because of their biological composition.

Chairman ENGEL. Thank you very much, Mr. Mulumba.
Ms. BOS.

STATEMENT OF LISA BOS, WORLD VISION US

Ms. BOS. Chairman Engel, Ranking Member McCaul, and members of the committee, thank you for this opportunity to testify today on the important issue of women's health. I greatly appreciate your interest in this topic and hope that my testimony today will shed some light on how faith-based organizations like World Vision are prioritizing and improving the health of women, girls, and their families around the world.

As one of the largest faith-based organizations working in humanitarian relief and development, World Vision's work reaches vulnerable children and families in nearly 100 countries around the world. We have nearly one million private donors across every State and congressional district, partner with over 16,000 churches around the country, and work with a wide variety of corporations and foundations in addition to public donors like the U.S. Government.

In our work, we seek to ensure that every child has the opportunity to reach their full potential and a healthy start in life is crucial to transforming the lives of children and their families. World Vision is a pro-life organization and we believe that human life begins at conception. We do not take a position on the Mexico City policy and have not taken a position on this policy under any administration.

Given that World Vision is a child-focused organization, much of work on women's health is focused on maternal health, ensuring that a woman's reproductive years are also her healthiest years. In seeking fullness of life for every child, we believe all mothers and their babies deserve to have the basic information, medical support, and care needed to ensure safe deliveries, protection from preventable disease, but we also work on many issues impacting adolescent girls as well, including programs that address child marriage, early pregnancy, and menstrual hygiene.

We should be proud of the progress that has been made in women's health and maternal mortality and the significant contributions of the U.S. Government to that effort, but we cannot rest in this work. Progress is possible. We have seen it, but it is also fragile. We know from experience that vulnerabilities in health systems are easily exposed in crisis or disaster. We know that climate change will continue to impact health in growing ways. We know that there are places where appropriate resources and services are still not accessible. We know that we have challenges with quality and equitable care.

To drive all of this, I cannot emphasize enough the need for better data. Legislation that this committee has supported like the Foreign Aid Transparency Act has focused on improving data from USAID, but quality global health data that show what interventions are being supported by USAID and where are still lacking.

As an implementing organization, data are crucial to our own decisionmaking and program design, not to mention how important it is to taxpayers who are funding these investments. I would also like to emphasize a point that you will find throughout my written

testimony which is the critical role of faith leaders in addressing global health challenges.

Faith leaders have considerable influence in their communities. Unfortunately, like other leaders, some faith leaders spread misinformation creating social barriers that prevent women from visiting health facilities, getting tested and treated for HIV, and using birth-spacing methods. Misguided influence can also encourage child marriage and the poor treatment of women and girls and discourage the involvement of men in maternal and child health.

Our training process for faith leaders replaces misinformation and stigma with truth and acceptance. Our program teaches about birth spacing and the importance of good nutrition for children and pregnant women, encourages greater involvement of men at all levels of health, and addresses difficult issues such as HIV and gender norms.

We have a moral imperative to transform the lives of women, girls, and their communities to give them good health, hope, and opportunity. I hope this hearing today will help us all recommit to this work and unify us around our shared goals. I look forward to our continued discussion and any questions you might have.

[The prepared statement of Ms. Bos follows:]

Testimony of Lisa Bos

Director of Government Relations, World Vision US

Unique Challenges Women Face in Global Health

House Foreign Affairs Committee

February 5, 2020

Chairman Engel, Ranking Member McCaul, and members of the Committee, thank you for this opportunity to testify before the Committee on the important issue of women's health. I greatly appreciate your interest in this topic and hope that my testimony today will shed some light on how NGO's and faith-based organizations like World Vision are prioritizing and improving the health of women and their families around the world.

As one of the largest faith-based organizations working in humanitarian relief and development, World Vision's work reaches vulnerable children and families in nearly 100 countries around the world. We have more than one million private donors across every state and Congressional district, partner with over 16,000 churches around the country, and work with a wide variety of corporations and foundations in addition to public donors such as the U.S. government. In our work, we seek to ensure every child has the opportunity to reach their full potential, and a healthy start in life is crucial to transforming the lives of children and their families. World Vision is a pro-life organization and we believe life begins at conception. We do not take a position on the Mexico City Policy and have not taken a position on this policy under any Administration.

Given that World Vision is a child-focused organization, much of our work around women's health is focused on maternal health, ensuring that a woman's reproductive years are also her healthiest years. In seeking fullness of life for every child, we believe all mothers and their babies deserve to have the basic information, medical support, and care needed to ensure safe deliveries and protection from preventable disease.

At World Vision, we recognize that it is impossible to separate the health of a child from that of his or her mother – a mother's health is the biggest determinant of an infant's start in life. Unfortunately, we know that women face additional challenges and risks in pregnancy in the developing world, and when a mother dies in childbirth, her infant has only a 19% chance of surviving his or her first month. A child's physical and cognitive development and lifetime potential are inextricably linked to their mother's health as well as their own good health and nutrition from conception through the first years of life.

There have been significant improvements in child and maternal mortality globally, with both decreasing dramatically between 1990 and 2015 – maternal mortality decreased by 44% and child mortality decreased by 58%. The investments of the U.S. government have been essential in this progress, and USAID is a global leader, partnering with governments to meet the health needs of their women and children. In the past ten years, USAID has helped save the lives of more than 9.3 million children and 340,000 women. By helping keep women and children healthy, these efforts of the U.S. government are supporting countries on their pathway to self-reliance.

Still, every day, an estimated 810 women die from preventable, pregnancy-related causes. 94% of maternal deaths occur in developing regions, and 80% of them are preventable. Nearly 2 in every 3 of these maternal deaths occur in countries affected by a humanitarian crisis or fragile conditions. Additionally, for over 800,000 babies each year, their day of birth is also their last day of life, and an additional 1 million newborns die within seven days of their birth. Nearly one third of global under-five deaths are attributed to preterm birth complications and intrapartum-related events – both of which can be addressed in part with better prenatal and pregnancy care for women of reproductive age. It is essential that the U.S. government continues to build on its proven leadership in maternal and child health by investing in evidence-based solutions and exploring innovative ways to better address maternal mortality, and to provide equitable, respectful and quality care to every woman, especially in humanitarian and fragile contexts.

Having access to the right services and messages at the right time can make the difference between life and death for a mother and her child. World Vision has seen success in utilizing Timed and Targeted Counseling (TTC) as an integral part of our development programming. TTC is a family-inclusive behavior change model that targets pregnant women, caregivers, and parents of children up to 2 years of age through appropriately timed household visits. TTC utilizes and trains community health workers in accurate, preventative, and care-seeking information and support, to create demand for services and empower families to improve health outcomes and practices. Information given is timed to when behaviors can best be put into practice and targeted to both those who practice the recommended behaviors and those who influence adoption of the behaviors. Since the approach targets the whole household – husband, in-laws, etc. – it promotes issue awareness, knowledge, behavior change, demand for services, and identification of social barriers, ultimately empowering caregivers and children to keep themselves healthy. For women, TTC means getting the right messages about antenatal care visits, nutrition, and family planning, as well as more specific messages based on other health conditions such as HIV. TTC has been evaluated in several countries as an effective method for behavior change programming. For example, the method contributed to an increase in exclusive breastfeeding from 23% to 48% in India, 26% to 45% in West Bank/Gaza, and 81% to 83% in Ethiopia in 2016.

Community health workers are often best positioned to deliver appropriately timed and targeted messages to encourage specific behaviors and those who influence the decision to adopt those behaviors at the household level. By proactively visiting households, community health workers are better equipped to understand challenges or potential challenges in the household and address health, HIV, and nutrition issues. Community mapping and registers track and inform follow-up of women during pregnancy and antenatal care, including care for HIV and update of family planning services. This is an essential way to reach mothers, particularly during the postpartum period, when follow-on care is necessary for women's reproductive health. World Vision's network of more than 220,000 community health workers and volunteers is one of the largest in the world. The U.S. government must continue to invest in frontline health workers and prioritize community-based care to ensure that community health workers are supported and resourced in the hardest to reach areas.

Another key area of women's health addressed in World Vision programming is through integration of menstrual hygiene management in our water, sanitation and hygiene projects. Menstrual hygiene is vital to the empowerment and well-being of women and girls worldwide. Globally, at least 500 million women and girls lack proper access to menstrual hygiene facilities, and in some cases, poor practices

such as menstrual huts can be life-threatening. Menstrual taboos are most often compelled by elder family members, including mothers, grandmothers and other senior women, which is why it is crucial to ensure girls and young women have access to accurate information about reproductive health. Adolescents have unique needs because of the social and cultural pressures as they begin menstruation that threaten their education and ability to contribute to their local economy. Menstrual hygiene management is a key area of women's health, and the U.S. government must address these interventions not only through its work in the areas of water, sanitation and hygiene, but across relevant sectors like education.

World Vision also addresses reproductive health as a vital area of women's health, recognizing that reproductive health issues can be difficult to discuss in some contexts. It is important to find culturally appropriate ways to discuss sensitive issues which allow for differing beliefs and sound health practices to co-exist. For example, World Vision believes human life begins at conception and we support methods of family planning which are non-abortive. We prioritize family planning by using a messaging approach focused on the healthy timing and spacing of pregnancies (HTSP), which is designed to help women and families plan their pregnancies so that they may have the best opportunity at living a full, healthy life alongside their children. With an emphasis on healthy fertility and achieving healthy pregnancy outcomes, HTSP captures all aspects of voluntary family planning. HTSP also reduces the risk of pre-eclampsia, anemia, premature rupture of membranes, third-trimester bleeding and high blood pressure. By empowering women with the knowledge and resources they need to decide when and how many children they will have over the course of their life, HTSP leads to better outcomes for women, their families, and their communities.

Healthy timing and spacing of pregnancies (HTSP) ensures babies are born during a mother's healthiest years, and not born too soon or too close together. In many communities, family planning is a difficult topic. Using HTSP messages, women and their partners learn quickly the health benefits of timing and spacing pregnancies and that the goal of family planning is to meet their desired fertility objectives. HTSP and family planning goals for reaching underserved women have been ambitious, but we should be concerned that we are falling short.

Healthy timing and spacing of pregnancies is essential because the age of a mother, the number of children she has, and the timing and spacing of her children are the primary determinants of maternal and infant mortality. Teenage girls ages 10-15 are five times more likely to die from complications during pregnancy or childbirth than girls over the age of 20. In addition to the increased risk for these girls and young women, babies who are born to very young mothers are also at significantly higher risk of dying before their first birthday. In the least developed countries, 41% of girls under 18 are already married.

As young brides, girls are often pressured to become mothers very early, and they also experience social isolation and are at greater risk of mental health issues as a result of moving out of their community to live with their husbands. Children are bearing children, and as a result, complications in pregnancy and childbirth is the leading cause of death for adolescent girls. The U.S. government should ensure girls' and women's health interventions, including HTSP and family planning, are widely available and integrated where appropriate into other programming that focuses on the health, economic security and well-being of women. In addition, the U.S. government should expand work to create supportive, open environments that empower women and girls.

The role of the faith community is also vital in order to address cultural values that impact the health of women and the safety of pregnancy and childbirth. We have found that educating and mobilizing local faith leaders to talk to their congregations and communities about what are sometimes viewed as "taboo" women's health issues, including family planning, HIV, and menstrual hygiene management, can be the most effective catalyst for change. The U.S. government must continue to engage deeply with the faith community to ensure that programs recognize the convening power, reach, and influence of faith-based organizations in the developing world.

World Vision engages faith leaders because most people in the world have a faith of some kind. The Pew Research Center's Forum on Religion & Public Life reports that 5.8 billion adults and children are affiliated with a religion, 84% of the 2010 world population of 6.9 billion.[1] We see this first-hand as a faith-based organization working in nearly than 100 countries. So, faith leaders have considerable influence in their communities. Unfortunately, like other leaders, some faith leaders sometimes spread misinformation, creating social barriers that prevent people from visiting clinics, receiving vaccinations, and using birth spacing methods. Misguided influence can also encourage child marriage and the poor treatment of women and girls and discourage the involvement of men in maternal and child health. Our training process for faith leaders replaces misinformation and stigma with truth and acceptance. Our program teaches about birth spacing and the importance of good nutrition for children and pregnant women, encourages greater involvement of men at all levels (family planning, HIV testing, health visits of mother and child, etc.), and addresses difficult issues such as HIV and gender norms.

I'd like to share an example from a USAID-funded project in which World Vision focused on building an enabling environment through advocacy with Ministries of Health to improve policies and strengthen the health system and service quality by training health workers to counsel and provide contraceptives to women and men. By utilizing TTC to households with pregnant mothers and those with children under two years of age, women were encouraged to discuss healthy timing and spacing of pregnancies with their husbands in India. Within 14 months, there were 67,989 new modern contraceptive users, with an estimated contraceptive prevalence rate of 77% in targeted communities, compared to 21% in other districts. In Haiti, we leveraged several platforms within the community network to integrate family planning into the maternal and child health and nutrition health package or the agriculture and livelihoods program components. By equipping community health promoters and nurses to provide fertility awareness and family planning in prenatal and postnatal visits, make home visits to new family planning users, and follow up with drop-outs, family planning was as integral part of maternal and child health and nutrition programming. This resulted in the total number of contraceptive users rising from 1,900 to 11,500 in just two years.

We have also seen positive results in a similar USAID-funded project that World Vision has been implementing in Garba Tulla, Kenya since 2014. This is an effort to improve voluntary family planning and maternal, newborn, and child health in a remote part of Kenya, primarily through training and mobilizing of community health workers and volunteers. Given that most decisions regarding conception are made by men in this context, it was important to acquire their support from the beginning, thus

[1] Pew Forum on Religion and Public Life, "The Global Religious Landscape: A Report on the Size and Distribution of the World's Major Religious Groups as of 2010," December 2012: www.pewforum.org/2012/12/18/global-religious-landscape-exec

almost twice as many male community health workers and volunteers were trained in HTSP/FP counseling skills. We also worked closely with a range of community leaders to diffuse messages and facilitate dialogue to reinforce healthy behaviors. This project has reached nearly 25,000 community members with family planning messages. Community leaders, such as male and female religious leaders, teachers, women's groups, elected officials, and community health volunteers have a considerable influence on societal attitudes and norms. It is imperative that the U.S. government continue to prioritize programming with organizations that engage an array of local leaders to support healthy behavior change that will have a positive impact on the health of women and their communities.

Behind all of these issues, is the need for leadership, funding and data that helps drive decision-making and ensures that we know we are having an impact on women's health with the limited resources available. We ask the Committee to support the Reach Every Mother and Child Act, which would authorize the position of a Maternal and Child Survival Coordinator. This position, which previously existed at USAID, was critical in ensuring coordination across programs and prioritization of resources toward the highest impact interventions. This leadership is also vital to ensure that USAID stays committed and grows its capacity for data collection. Data around where and how funding is spent on interventions at the country level is lacking in global health, which impacts both the U.S. government and implementing partners in our ability to make informed, data-driven decisions. The Reach Every Mother and Child Act includes vital reporting provisions that would improve data collection and dissemination.

But we also need Congress' continued commitment to strong funding for programs that impact women's health. We appreciate that global health programs have strong bipartisan support and that some accounts have seen funding increases, including maternal and child health. But we know we are not meeting growing and increasingly complex needs around the world, particularly with respect to family planning in both humanitarian and development settings.

Improved health for the world's most vulnerable people is not only a moral imperative but also a pragmatic investment for peace, security, and worldwide economic growth. Thank you to the Committee for this opportunity to testify today and I look forward to our continued discussion on how we can better respond to the health needs of women around the world.

Chairman ENGEL. Well, thank you very much Ms. Bos and thank all of you very much for excellent testimony.

I will now recognize members for 5 minutes each and pursuant to House rules, all time yielded is for the purposes of questioning our witnesses.

So I will start by recognizing myself. And let me say as I mentioned in my opening statement, I am very disturbed by the administration's reimposition and expansion of a Global Gag Rule. In 2018, the State Department released its 6-month review of its policy, where they claim there have been no service disruption due to the policy. Yet, that is not consistent with what we have heard from the field and seen in the media.

So let me start with you, Dr. Kates. What have you seen in the research that has been produced about the expanded Global Gag Rule, and what do we already know from previous versions of the policy?

Dr. KATES. Thank you for your question. First, I wanted to say on that 6-month review that you mentioned, the review also noted that it was too early at that time to assess impact. So there is another review that is expected which might have more information.

I can tell you with some of the analyses we have done at KFF and some of the other analyses that have been put out. One of the things we looked at when the policy was first put in place and expanded was how many of the countries in which the U.S. provides global health assistance have abortion laws that are more permissive than the Mexico City policy would allow. So in other words, where is the U.S. working where there might be policies of the U.S. at odds with country policies?

What we found at the time was that more than half of the countries in which the U.S. provides bilateral global health assistance did have an abortion law that was more permissive than the policy in at least one case. We have just updated that to the more recent period and found a similar finding. So that just shows that it presents potentially some challenges for providers and others working in those countries where there is a difference between a country policy and the U.S. policy.

We have also looked at the number of non-governmental organizations, foreign non-governmental organizations that may be subject to the policy because we were interested to see how—what does the expansion look like potentially. We looked at this soon after it was announced and we found out that conservatively there were probably around 1300, at least, NGO's, foreign NGO's, that were subject to the policy. And this is a conservative estimate because it is very challenging to get data on sub-recipients of U.S. support.

What we also found is that most of these NGO's were newly exposed to the policy for the first time, so they had not had to take a position on a policy when it had been in place in prior iterations.

In terms of studies that have come out, probably the most well-known and largest that has been done was just published in The Lancet last year. It is a large scale, empirical, economics analysis that looks across the periods of time to better understand when the policy has been in effect, was there a correlation between the policy and health outcomes. This is often a challenge to look at. You have to look retrospectively. What this study found was that there was

a pattern. When the policy was in place abortion rates went up. Pregnancy rates went up and contraceptive prevalence went down.

There was also a recent analysis that was done by amFAR and Johns Hopkins University in which they surveyed PEPFAR implementers to assess PEPFAR implementers who were newly exposed to the policy having to adjust what they were doing. And what they found was that a third had actually altered their operations including service delivery. And that included services like HIV testing, TA, things that were important for the HIV response, closing a youth-friendly clinic. In one particular district in one country, a major provider of voluntary medical male circumcision had actually stopped providing its services leaving a gap there.

Human Rights Watch has also put out studies showing that they have found that providers have canceled services including things like cervical cancer and HIV testing.

And finally PAI has released several studies from the field finding similar results. And this is an on-going thing to look at to be able to assess what the policy's impact might be on actual lives that the U.S. is trying to save and reach.

Chairman ENGEL. Thank you, Dr. Kates. Let me ask you, Ms. Crocker. The humanitarian system today is facing a whole array of crises from Venezuela to Syria to Yemen and we see time and again across these conflicts the outsize impact they have on women and girls.

Can you highlight, Ms. Crocker, some of the ways women's health is uniquely jeopardized in conflict?

Ms. CROCKER. Thank you for the question, Chairman. Women face a range of additional health challenges in the face of conflict which include increases in gender-based violence, including intimate partner violence, and you know, things like access to family planning.

Health systems are always degraded further during a conflict, and as I noted in my opening statement, women both have some unique challenges that they face and also are often the last to reach—to be able to get assistance either to reach it or to have assistance given to them.

And so what we see time and again, for example, just yesterday, we released a statement with a number of other big NGO's about the situation in northwest Syria where over the course of 2019 in northern Syria as a whole, 85 health facilities were targeted. CARE was running, has been running, a maternity and pediatric hospital in northwest Syria which we just had to suspend services at due to a nearby hospital having been hit, but because so many hospitals in the surrounding area had been hit with this hospital sort of being flooded with people in need of care, and we are seeing almost a million people now in northwest Syria because of the increase in violence there who have been displaced. And these situations always impact women and girls more.

In camps, some things that sort of not always top of mind, but end up being incredibly important to the health of women and girls include questions around placement of water and other commodities that are needed. When they are placed very far away from the center and women have to go, it places them at additional risk of facing gender-based violence as an example. And again, because

health systems generally are degraded, it means that things that women just need such as access to family planning, access to contraceptive, things the life of CARE's work have been shown to be the No. 1 thing to help prevent maternal mortality are just more challenged.

Chairman ENGEL. Thank you very much. I will now call on members for questioning. I will start with Mr. McCaul, our Ranking Member.

Mr. MCCAUL. Thank you, Mr. Chairman. I want to thank all of you for being here today. The NGO's are really vital to our missionary work across the world and you really do God's work here on earth. Kaiser Foundation, CARE, World Vision, and sir, what you do in Uganda, is to be commended.

Ms. Crocker, thank you for mentioning the bipartisan nature of this committee. We have accomplished I think more than any other committee in this Congress and in this very partisan, hyper-partisan time in our history.

And I want to list some of those accomplishments because I think it is worth mentioning, Mr. Chairman. We re-authorized PEPFAR which we know is saving millions of lives. We passed the Global Fragility Act. When you talk about conflict, this is an attempt to bring our State Department and USAID and Department of Defense together to stabilize those destabilized nations, particularly in the Sahel region where the conflict is getting worse, not better. And we know when that happens it impacts women first.

The Global Hope Act, as I mentioned, Mr. Mulumba, I will be Botswana in 2 weeks. So this is at the Texas Children's Clinic and they are also in Uganda, in your country, introducing the pilot program to do what we do with PEPFAR and HIV, with childhood cancer, building on the infrastructure that we laid with the PEPFAR HIV program.

We just passed on the floor the other week the Keeping Girls in School Act which I think it was Stated by one of my colleagues from the military, the most powerful weapon against extremism is a girl with a book and education.

We passed the Women's Economic Empowerment Act to help boost women's rights and economic rights throughout the world, particularly in Africa. And finally, the Child Marriage Act where we see children at the hands of their governments getting married at a very, very young age.

And so I guess I have a lot of questions to ask, but one with respect to World Vision, Ms. Bos. You mentioned, and I appreciate the faith-based nature and I think the faith-based community is very generous and is leading, but you mentioned with some countries how they work actually against women's treatment and I wonder if you could expand on that and which countries are you talking about?

Ms. BOS. So when we are talking about access which I hope is what you are getting at a little bit, access for women to care, there are often a lot of misperceptions about what it means to go to a health facility. Sometimes those are cultural barriers. Sometimes those are religious barriers. There is a lot of misinformation that happens in communities and we found that for HIV programs, gen-

der-based violence programs, early marriage, pregnancy, and family planning issues.

So really what we feel is important and the role that we can really play uniquely at times as a faith-based organization is how are we working with those faith leaders who play such a critical role in either sharing good messages with their community or sharing at times misinformation.

So the trainings that we do through our program model are really critical. We use biblical text for pastors. We use the Quran when we are working with the moms in Muslin contexts. So this is an inter-faith approach depending on the context, just to make sure that churches, faith leaders, because of the role that religion plays in people's lives, that that is not serving as any sort of barrier for women to get the care and services that they need, both for themselves and for their children.

Mr. MCCAUL. And following up with the remaining time I have, Ms. Crocker, Ms. Kates, and Mr. Mulumba, if you care to talk about this, how can we—what are kind of some lessons learned of these private-public partnerships? Where do you see improvement? How can we do a better job?

Dr. KATES. Thank you for the question. Obviously, we have to do something different in the future to have greater impact, right? So public-private partnerships are one that the U.S. Government has pursued and some have been quite successful.

One I want to highlight is PEPFAR's Dreams Initiative which was started a few years ago and the idea behind it was because adolescent girls and young women are so vulnerable to HIV, much more likely to become infected, 6,000 new infections a week among young women, this is a population that faces multiple barriers, many of which we heard. What PEPFAR decided to do was to try to reach that population with all of the supports and address the structural challenges they may fact, lack of education as you were talking about, challenges with income, needing to find ways to have access to employment.

How could PEPFAR do that? PEPFAR formed a major public-private partnership working with many private companies and donors to really build this idea out and has since been able to expand it to 15 countries. What is really exciting about this initiative is that the data show that it is actually working. New HIV diagnoses among young women in the districts that the intervention is in are going down. And that is a really important thing. So the public-private partnership has leveraged commodities. It has leveraged other platforms. It has leveraged other sectors.

I actually heard Ambassador Burk speak yesterday about this and she talked specifically about the education sector and her intention to look to other donors who are specifically working in that sector to build on what PEPFAR has done. It is very clear that those kind of partnerships, whether it is with private companies, foundations, other governments, are really essential.

Mr. MCCAUL. Ms. Crocker, just very briefly.

Ms. CROCKER. Thank you. I think I will pick up on maybe two things. One is just in addition to some of these sort of larger public/private partnerships that were just discussed, we have seen real success as CARE, for example, in the Great Lakes region using vil-

lage savings and loan groups and other forms of collective action to mobilize communities and importantly, to engage men and boys to tackle social norms which, as you know, are so often what underpin some of these gender and power inequities that lead to things like increased gender-based violence.

And so the other thing I wanted to just pick up on was your mention of women's economic empowerment which this committee has taken such a lead on and just the important link between women's health as an underpinning and a basis for a healthy economy. And so as the committee continues to pursue the importance of women's economic opportunity, just to make sure that we all acknowledge and understand the importance of the link between a focus on women's health, including women's health and humanitarian emergencies and development settings and what that can do to help further women's economic empowerment.

Mr. MCCAUL. That is excellent. Thank you so much for what all you do and I yield back.

Chairman ENGEL. Thank you, Mr. McCaul. Mr. Sires.

Mr. SIRES. Thank you, Chairman, for holding this hearing and thank you for our witnesses being here today.

Ms. Crocker, CARE released a report last year indicating that Venezuelan women and girls migrating to Colombia are extremely at high risk of gender-based violence and human trafficking. And in my trip to Venezuela and Colombia last year, I spoke with single mothers who were deeply concerned about their safety and their children.

Can you speak about the dangers facing these women and children, as they flee this this crises and what else can we do, the U.S. and international communities to help women and children in this area?

Ms. CROCKER. Thank you so much for the question. There are, as you are probably aware, 4.7 million refugees and migrants already from Venezuela and an expectation that there will be 4,000 people a day fleeing that country over the course of 2020. This is due to numerous factors that you are very familiar with that are bedeviling the country of Venezuela right now.

And what CARE found in that rapid gender assessment that we did on the Colombia and Venezuela border was almost a normalization of gender-based violence against Venezuelan refugees and migrants that are leaving that country. And what we are also seeing is that many of the health systems in a number of the host countries which are already overburdened. For example, in the Colombian city of Cucuta, births have increased by 150 percent and maternal morbidity has increased by 71 percent. And for those that remain inside Venezuela, there are also increasing challenges. For example, much more difficulty in accessing contraceptive care and contraceptive services. The price of contraceptives has—it is estimated to have increased 25 fold in the past 5 years inside of Venezuela. And quality pre-natal and delivery services are difficult to obtain which is, of course, partly why, as you know, so many Venezuelan women are ending up fleeing or going across the border and having to come back.

So it is very important. It is an enormous crisis at the moment that is not getting enough attention from a global perspective. And

so the totality of the crisis is something that we need to be more focused on as both a priority, a place for greater U.S. leadership, as well as global humanitarian funding, but very important to also recognize the ways in which this particular crisis is really impacting women and girls in a very direct way.

And so I really thank you for raising that issue because it is one that CARE continues to be focused on. We are also doing Rapid Gender Assessment throughout the region to look at the health impacts of Venezuelan migrants and refugees who are leaving and ending up in a number of other of countries across the region as well.

Mr. SIRES. I read an article in The New York Times that was stating that the children at the schools because of lack of food and lack of medicine. I wonder if you can talk a little bit about that?

Ms. CROCKER. I saw the same story. I do not have first-hand knowledge of that.

Mr. SIRES. Okay.

Ms. CROCKER. But I think what we are seeing and what certainly the U.N. and a number of NGO's have been seeing and reporting coming out of Venezuela is an overburdened health system, crumbling public institutions and services and capacities, a crumbling economy, right? And all of these things lead to inability to access basic services, both inside of Venezuela itself as well as for those who are fleeing.

And so it is shocking when we read reports like that and I think it only highlights the need that we should all be—the need we all have to be paying attention to what is going on right near us and to be paying appropriate attention and again, focusing on the funding and the prioritization that is needed to address the real dire humanitarian challenges inside of Venezuela, as well as the needs of those who are fleeing the country.

Mr. SIRES. Just a quick question. I know that the Venezuelan issue is just not Colombia. Now it has expanded into the other countries in the region and not enough attention seems to be focused there because those countries really do not have the ability to take in all these migrants and the health issues, they cannot deal with it because they have their own population to deal with.

I just do not see the world coming to the aid of this travesty that is happening. Thank you very much.

Chairman ENGEL. Thank you, Mr. Sires. Mr. Smith.

Mr. SMITH. Thank you very much, Mr. Chairman. Mr. Chairman, on Friday, there was a White House event and we were asked a few of us, including the Ranking Member, marking the 20th anniversary of the Trafficking Victims Protection Act. I am the prime author of that bill. It has saved countless women and children and many men stuck in labor trafficking, especially, and none of you have mentioned that. I do hope you will speak to that issue because I do believe modern-day slavery is one of the most heinous crimes. It is disproportionately focused on women and I have met many women who have been trafficked. I have had hearings with trafficking victims and they need our love, our concern, and they certainly need rescue.

Second, according to the World Health Organization, between 2000 and 2017, the maternal mortality rate declined by 38 percent

worldwide and also according to WHO the majority of maternal deaths can be prevented if women give birth in hospitals or attended to by skilled health personnel with access to emergency obstetric care and safe blood is very much a part of that.

I do believe that USAID has embarked and this is part of PEPFAR as well, to try to provide a means to assist these women. Countries should have a plan. Communities should have a plan so that if the woman is pregnant, particularly in the final 3 months of that child's life before birth, that she will be attended to by someone if there is a problem so that we can dramatically continue to reduce maternal mortality.

Let me also point out that PEPFAR was the brainchild, frankly, of George Walker—George W. Bush. And this man over here, where is he now? My good friend and colleague, Henry Hyde, joined by Tom Lantos, in a bipartisan way pushed through the PEPFAR legislation and that has saved countless Africans and others from the horrible death due to that terrible disease called HIV/AIDS, also malaria and the other issues that are attendant to opportunistic infections as well have been greatly mitigated.

In 2018, I was the prime author of the re-authorization for 5 years of PEPFAR, joined by Barbara Lee and a group of bipartisan lawmakers so about $30 billion, roughly, will be authorized and hopefully appropriated to help those.

Now one of the points that is brought out that women represent the majority of those served by PEPFAR. ARV therapy, for example, 66 percent or 9.8 million of those with ARV therapy were women. And I think that is a great thing that this policy is having such a positive impact.

Now on the Protecting Life in Global Health Assistance, that legislation or that policy I should say, is designed to ensure that U.S. taxpayers do not subsidize foreign non-governmental organizations that perform or promote abortion as a method of family planning and build on what was originally called the Mexico City policy created by Ronald Reagan.

In 1985 and 1984, I offered amendments on the floor to affirm the policy and it was widespread statements made on the floor in debate that nobody will accept this. Well, the 6-month reviews found 99.5 percent of the people that we want to support accepted those pro-life guidelines.

Let me also point out, you know, the issue of abortion, we forget somebody when we talk about that. I do believe we need to care for both. We need to love both, mother and baby, and do everything humanly possible to ensure that there is a safe delivery. I am the author of Pain-Capable Unborn Child Protection Act. We know beyond any unreasonable doubt that unborn children feel pain at least from the 20th week on and maybe even earlier and because of prenatal surgery children ought to be seen as another patient, the unborn child, the other patient, along with the mother when they present to a healthcare professional.

Abby Johnson, some of you may have read her book, maybe not, maybe this panel has or has not, but she was a Planned Parenthood activist, ran a clinic, an abortion clinic in Texas for 8 years. When she assisted in an abortion and this was the first, whether it was an ultrasound guided abortion, she held the probe and she

saw that baby dismembered right before her eyes. She walked out the door and said I will never be a part of this again. Now she is a very articulate spokeswoman for the pro-life cause.

Birth is an event that happens to all of us. It is not the beginning of life. Ultrasound has shattered the myth that somehow there is no baby there. So I would encourage you, Bernard Nathanson, the founder of NARAL, one of the three co-founders, he said I have come to the agonizing conclusion that I presided over 60,000 deaths. He wrote that in The New England Journal of Medicine and became a strong pro-lifer. Let us affirm them both. This policy affirms them both and says contraception, this does not cut it by one dollar. It says that who we support, not just what, matters. And if a group is trying to bring down pro-life laws in other countries or provide abortions, perform dismemberment or chemical poisoning abortions, we have got to look at the facts, just like Abby Johnson did and say what actually happens in that abortion? A baby is dismembered or a baby is killed. RU–486 starves the baby to death, one is a chemical and the other provides a expulsion of the child from the womb.

These children deserve better. Women deserve better. And you know, I would ask Mr. Mulumba, you know, you know what the three exceptions are to the Protecting Life and Global Health Assistance are because you turned down the policy?

Mr. MULUMBA. Thank you, sir, for the question. My expertise is on the implications of the policy back home.

Mr. SMITH. So you do not know the three exceptions? I am really out of time. The exceptions are rape, incest, and life of the mother. We do not want family planning abortions and that is what the policy starting with Ronald Reagan was designed to ensure.

Chairman ENGEL. Thank you, Mr. Smith. Mr. Bera.

Mr. BERA. Thank you, Mr. Chairman. I disagree with my colleague on the perceptions here, but there is a lot that I have heard today where we actually agree on. I am glad that the minority party really cares about maternal health. I am glad that they care about child health. I am glad that we heard the President last night talk about wanting to invest millions of dollars in reducing maternal health.

Our foreign policy should be based on American values and what we think about. And if we think about American values, 65 percent of women aged 15 to 49 use contraception methods. Ninety-nine percent of women who have been sexually active at some point have used contraception. Those are American values. And that is voluntary family planning. They are choosing to use those methods. Yet, we talk about being a faith-based nation, 98 percent of Catholic women have used modern contraception. Ninety-nine percent of Protestant women have used modern contraception. Those are American values.

So we are talking about making voluntary family planning available around the world to reduce maternal mortality, to reduce child mortality. In developing countries when you do proper pregnancy spacing from 1 year to 2 years, you nearly halve infant mortality rates. So we all should agree on making voluntary family planning available to women around the world, one of the most effective things.

I am glad that the ranking member talked about the things that we passed: PEPFAR, the Global Fragility Act, particularly focused on the youth bulge in Sub-Saharan African focused on fragile States in that region. The one thing that we actually could do to address the youth bulge is make voluntary family planning readily available to empower women.

The Keeping Girls in School Act, the one thing we could do is to make sure there isn't that unintended pregnancy by making voluntary family planning available to those young girls. Women's Economic Empowerment Act, if we actually want to have impact for women around the world, we ought to put them in charge of their own reproductive health and allow them to do active pregnancy spacing.

Dr. Kates, let me ask you a question. When you look at the impacts of the Global Gag Rule, both in past years and through this administration's expansion, has it limited access to voluntary family planning?

Dr. KATES. So as has been mentioned the policy—U.S. policy supports voluntary family planning and that is part of policy and the U.S. provides funding, is the largest donor in that area in the world. But as I pointed out, the implementation of the policy has presented barriers and there has been documented studies looking—going into the field and talking to providers and looking at what has happened and doing surveys to say that they have faced barriers in being able to implement the programs that they are legally able to provide. They have lost partners. They have closed services. So it is not as simple as something as something is funded and the policy does not affect that. I think that is the complication here and what is very hard to assess, but is clearly being seen in the field.

The study I mentioned from The Lancet is important to note because it looked back in different periods to try to say is there a relationship between certain health outcomes because ultimately that is what we are looking at, health outcomes, and the policy. And it found a pretty strong relationship. That definitely warrants further attention because one of the challenges is we cannot immediately measure health impacts, we might not see the negative effects if there are any for years to come.

Mr. BERA. My impression is the way the administration implemented the Global Gag Rule. It has had this rebound effect, closing family planning clinics, et cetera, and limiting access.

In the limited time I have left, Ms. Crocker, I had the chance to visit the Zaatari refugee camp in Jordan with the chair and visited the maternity clinic that UNFPA is running. It was a pretty amazing facility. There was State Department funding to help start it and of the 7500 babies that were born at the time I visited, there was not a single maternal death. Pretty impressive. That is what UNFPA can do.

Is that clinic still running and what is the impact of our not properly funding the UNFPA?

Ms. CROCKER. Thank you for the question and I am so glad you had the chance to travel with us. The clinic happily is still operating and now there have been 12,000 live births without a single maternal mortality at the Zaatari camp, over 12,000 live births.

Until the U.S. stopped funding UNFPA in 2017 every bassinet in that camp displayed a U.S. flag.

As of July 2019, the UNFPA was facing about a $200 million gap in the over $500 million that it had asked for to date by that point. And so while some other donors have stepped in to try to help fill the gap since the U.S. has stopped funding, there still is a very significant gap.

What we can talk to is the incredible good work that UNFPA does around the world in over around 150 countries. And most particularly, I think, with the focus on what they do in humanitarian response where they are sometimes the sole provider of quality reproductive and obstetric care. But they do even more than that. So in the ways in which CARE partners with them around the world, they do everything from providing clean birthing kits to training midwives to dealing with gender-based violence to dealing with prevention and treatment of sexually transmitted infections, as well as again the very important access to both family planning and reproductive healthcare in ways that are deeply needed in the context of humanitarian crisis and in certain circumstances where UNFPA is the only operator providing those services.

Mr. BERA. So if we actually care about maternal health, if we care about child health, if we care about empower women and girls, we ought to fund UNFPA.

Chairman ENGEL. Thank you. Mr. Chabot.

Mr. CHABOT. Thank you, Mr. Chairman. Ms. Bos, I will begin with you if I can. Back in 2003, I was the lead sponsor in the House on the Partial-Birth Abortion Ban Act which went all the way to the U.S. Supreme Court. President Bush signed it into law. It was appealed with the U.S. Supreme Court and it was upheld in the Supreme Court.

I have also been a long-time supporter of the Mexico City policy, both in this administration and I would like to thank President Trump for that and under President Bush's administration.

So if I could ask you this, has the administration's protecting life and global assistance rule impacted your ability in any way to provide life-saving treatment and other health services to women across the globe?

Ms. BOS. The short answer to that would be we have had some additional administrative requirements, but we have our own internal policy, again as a pro-life organization, where we neither receive nor give funding to organizations that provide abortions. So from a practical operational standpoint in our programs, I am not aware of any impact, but there has been some administrative, slight administrative burden, just we have to ensure our partners are complying so that we can continue doing the work that we want to do.

Mr. CHABOT. Thank you. Ms. Crocker, let me turn to you for a different question. A few congresses back, Senator Rubio in the Senate and myself and some other members here in the House, it was a bipartisan bill, passed legislation, the Girls Count Act which, in essence, encouraged the State Department to work with other governments to make sure that children, especially girls, were actually registered upon their birth.

We have seen time and again where if especially girls aren't registered, they basically can disappear into all kinds of horrific circumstances. They can be trafficked, international gangs. People do not know they exist, so they can be sold off into horrific circumstances.

So could you discuss how birth registration or lack thereof could impact access to healthcare for women and girls?

Ms. CROCKER. Thank you for the question. It is not actually something that I am expert in or have knowledge of myself, so I wonder if I might ask if my co-panelists might be able to came in and address this question.

Mr. CHABOT. If somebody else wants to handle it, I am happy to hear that. Yes, Ms. Bos.

Ms. BOS. I am happy to jump in, Mr. Chabot. I have seen some of our birth registration programming in Kenya. It really is vital and thank you for championing that issue because if any child does not have a birth certificate, the lack of access to education, to health services, it is really as if that child does not exist. So it is a critical piece. It is something we are trying our programming in, just recognizing the barriers that follow that child if they do not have that simple piece of paper at the beginning.

Mr. CHABOT. Thank you. And then one final question, similar to that, Senator Rubio over in the Senate, and myself and others here in the House, pushed a bill called Protecting Girls' Access to Education Act and it was also signed into law by President Obama which seeks to promote education in conflict zones, in conflict settings.

In your work, do you see a correlation between access to education and access to healthcare?

Ms. BOS. Absolutely, and we found that the lack of access to formal education really does increase vulnerabilities, especially for girls. Being in school actually helps protect them from gender-based violence, early marriage, early pregnancy. So it is really critical.

Right now in places like Bangladesh, we are working in Cox's Bazar. There is not formal education. We are working with UNICEF on some informal mechanisms, but it is really an important issue in these protracted crises, working with displaced populations, access to formal education is a huge need.

Mr. CHABOT. Thank you very much. Mr. Chairman, I yield back.

Mr. LEVIN [presiding]. Thank you, Mr. Chabot. I now recognize myself for questioning.

Last fall, I was in Bangladesh with CARE on a trip there and our trip mainly focused on nutrition. So I was not expecting to hear about the impact of the Global Gag Rule, but one of the partners we met with highlighted the Global Gag Rule as a barrier to their work.

Bangladesh is a country where more than one in three children under the age of five suffer from chronic malnutrition. But I heard of cases in which the U.S. could not allocate precious global health dollars to the organization best suited to meet the needs of those 5.5 million children. Tragically, we are only able to fund groups willing to operate within this administration's extreme ideology instead of our most trusted, capable, and experienced implementers.

Dr. Kates, I was surprised and disturbed to see the far-reaching impact of this harmful policy. Would you talk us through the scale of the expanded Global Gag Rule outside of family planning and reproductive health programs narrowly speaking?

Dr. KATES. Thanks for the question. So the policy as announced in 2017 expanded upon all previous versions and now it encompasses virtually all of U.S. bilateral global health assistance. So that means anywhere between $7 and $8 billion a year, depending to the extent that that money goes to a foreign NGO. This includes HIV programming, maternal and child health, nutrition as you mentioned, the President's Malaria Initiative, all of the sort of main areas that the U.S. works in. So that opens up a whole new set of programs.

We have also, as I mentioned earlier, have looked at the number of NGO's that might be affected and we found that conservatively it is at least 1300, probably many more because there are so many other sub-recipients.

Mr. LEVIN. Oh, 1300 NGO's.

Dr. KATES. In the sense that they would have to certify—or make a decision about compliance with the policy. And I think just to pick up on something you said, what we have seen in studies and other things is many of these implementers are quite confused about the policy. They are not sure if it applies to them. What it means for what they do provide and some have over-implemented it, meaning that they think that they cannot do a service when they can. And that can create service challenges.

One of the other challenges to think about from the perspective of a barrier, as you mentioned, some of these partners are the most trusted in their communities and are the places maybe the only provider in a particular part of a country. So affecting their ability to participate in the program could really affect the reach of the U.S. Government for its health goals.

And then finally, one other thing I will mention, importantly, PEPFAR right now is putting a big emphasize on localization and really trying to build capacity in local partners. USAID is also moving toward the Journey of Self-Reliance. These are critical things to be focused on for sustaining capacity and building capacity in country so that the U.S. hopefully can work itself out of a job in these areas. If you lose partners or if partners are unsure about their ability, or make a decision not to participate, it could really impede that effort.

Mr. LEVIN. So we are shooting ourselves in the foot. Well, Ms. Crocker, CARE works with many partners across various programs that support women's empowerment. Is it typical that organizations would work across a range of women's health, education, economic empowerment, and political engagement issues?

Ms. CROCKER. Thank you for the question. And I am so happy that you also had a chance to travel with CARE. And yes, I mean I think you will both at the international level as well as the national and local level organizations that do work across a range of issues including CARE is one. And while it is unfortunate, I think it is not surprising to hear that there are implementers who may be affected by the policy when their focus might be in the case that you were looking at, nutrition, as an example.

Mr. LEVIN. So there would be negative ripple effects across a range of policy areas.

Yes, given the shortness of time, I just wanted to offer Mr. Mulumba a chance to answer as well whether you have seen impacts of the Global Gag Rule reaching beyond family planning and reproductive health in Uganda and whether reproductive health providers and advocates also work on other health and development issues.

Mr. MULUMBA. Thank you so much. What I have actually observed is that much of the USAID funds that is withdrawn is not funds that we are meant to being doing work on abortions. So what we actually observe is that people are losing out on resources which are making other interventions in the case of the example that I gave you, the funds that we lost as an institution were for health systems strengthening. So the intervention that we were doing were affected. But we have also observed that those that are doing service delivery, they have had immediate withdrawal from the communities where they are working. So the immediate withdrawal of services, beyond reproductive health services to include services—because of the integration that everyone is talking about, it includes services like HIV/AIDS. So adherence to treatment becomes a very big problem.

But you also observed that many NGO's work in coalitions and so when NGO's are not clear on what the policy actually means in Uganda we have not seen an intervention where, for instance, the U.S. Government is explaining what this policy is all about. So you find that very many people have heard about the policy in theory, but they do not know the boundaries of what the policy means. So working in coalition is extremely difficult.

Mr. LEVIN. Thank you. My time is up and despite the fact that I am sitting in the chair, I am going to move on to my next colleague which is Ms. Wagner. You are recognized for your questioning now.

Mrs. WAGNER. I thank you, Mr. Chairman. Let us be clear here. The purpose of U.S. global health and economic development programming is to recognize, promote, and protect the dignity of all individuals and extend a helping hand so that the marginalized, poor, and vulnerable around the world may build a better future. But promotion of abortion is incompatible with this mission.

Abortion is not healthcare. Children and families should not be enumerated as barriers to prosperity, but sources of strength and beauty, purpose, meaning, and potential.

I am proud that the United States has recommitted itself to global health policies that recognize the inherent worth of all people and leverage the boundless human capacity for generosity, cooperation, and ingenuity to overcome global poverty.

We will not make the challenge of ending poverty a little simpler in the short term by pushing women to end the lives of their children. That is not a compassionate position for either the mother or child. We will not tell women that they must choose between their children and prosperity. Instead, we will work in partnership with countries around the world to ensure that all women and children have access to opportunity and success. The President's Protecting Life in Global Health Assistance policy ensures that American tax

dollars are used for actual healthcare, not awarded to global organizations that push abortion on women, instead of doing the hard work of helping these vulnerable women to have both their baby and their dreams.

We must continue to build healthcare capacity in communities to fill any gaps left by these funding changes. In this way, we can best serve women and children around the world. Abortion is both a symptom and a tool of the oppression of women. Research by the United Nations Population Fund indicates that widespread access to prenatal testing and abortion in countries with patrilineal and patrilocal traditions is linked directly to gendercide, the global epidemic of violence against women. One hundred and 26 million women are demographically missing around the world due to sex-selective abortions, female infanticide, and gender-based violence against young girls. Sex-selection abortions have been banned in many countries, the U.S. notably not included in those, but social pressures on women to eliminate their baby girls remain.

In the northern Indian State of Uttarakhand, for example, 132 villages reported that no girls were born over a 3-month period in 2019. In the U.K. medical journal, The Lancet, has found that as many as 12 million baby girls were aborted in India between the 1980's and 2011.

Ms. Bos, what is the role of abortion in accelerating the global gendercide?

Ms. BOS. In our experience, and we actually had a program on this subject in Armenia that we were very proud of where really we did want parents and families and communities to understand both boys and girls have value, that they deserve love, that their lives had meaning. And so, we really did have an approach that worked with both the Government of Armenia and the Armenian Church to address those challenges of, really, equal value of boys and girls, and address that issue of sex-selective abortion.

So we were very proud of that work. I think it is something we continue to look at ways we can contribute to both of those issues, really, hopefully reducing sex-selective abortion and just lifting up the value of girls.

Mrs. WAGNER. Thank you very much. My time is about to expire. I have many more questions that I will submit for the record, Mr. Chairman. Thank you.

Mr. LEVIN. Thank you so much, Mrs. Wagner. I now recognize Ms. Houlahan for your questions.

Ms. HOULAHAN. Thank you, Chairman. And thank you very much to the panel for coming. I have a couple questions. My first one is, the current administration has expressed support for women's economic empowerment which I wholeheartedly support, but globally more than one in five girls is married before—I am sorry—one in five girls is married before the age of 18, which means the end of their formal education and the very beginning of motherhood. The UNFPA along with UNICEF runs the U.N. program to end childhood marriage; unfortunately, the U.S. does not currently fund the UNFPA.

I was wondering if you might be able to comment, Ms. Bos, on whether or not you couldn't—the economic empowerments of child

brides and why is ending child marriage central to women's economic empowerment, please.

Ms. BOS. Thank you, Congressman, for that question. You know, the economic benefits of girls being in school and not being put in the situation of being married early, there is a lot of data, a lot of evidence that backs that up. We actually did a report that we released last fall that included four case studies on child marriage across both development and humanitarian contexts.

Speaking from own experience, you know, the data is there, the evidence is there; I think we really need to again focus on keeping girls in school. And the committee's support of the Keeping Girls in School Act hopefully will be critical in enhancing the U.S. Government's approach to really looking at the preventive measures we can take to reduce child marriage.

Ms. HOULAHAN. And so, if the UNFPA is not there especially in places like Yemen and other places that are war-torn, who else is there that can help with this particular issue?

Ms. BOS. It can be a challenge. I do think some of us who are in humanitarian context—CARE, World Vision, Save the Children, you know, we do attempt to address these issues as well. World Vision, we have had past partnerships with UNFPA. We do not take a position on the Kemp-Kasten policy, per se, but there are contexts, certainly, where, you know, I think we have seen UNFPA contribute significantly to this kind of work.

Ms. HOULAHAN. Thank you very much. Does anybody else have anything to add on, on child marriage at all or—Dr. Kates?

Ms. KATES. I would just add to those excellent comments that I mean we have to understand this has a tremendous health impact on girls when they are married young. It is not just the economic impact. It is the health impact on having children young. And so all of these are very synergistic. Investing in women's education, investing in economic opportunity, and investing in health serve the same goal.

Ms. HOULAHAN. Thank you.

And my next question is for Mr. Mulumba. Can you describe the correlation between laws that are discriminatory between the LGBTQ community and countries like Uganda and the health outcomes for those communities for women in particular?

Mr. MULUMBA. Thank you very much. I think that one of the areas that has often come up as a difficult area in Uganda is the LGBTI issues. We have had a history of laws, many of these are colonial laws that we still have. Even before the proposed introduction of the new legislation that was, we had the criminal law that criminalizes the acts.

So the criminalization does not only affect the target people, but it also affects the service providers, so people and service providers have been put in a very difficult situation on how they go about LGBTI issues. So the laws, in fact, have become determinants of access to care where the laws are disenabling, then those particular populations are affected.

And in the Ugandan context, the LGBTI community has really had a rough time. We know that part of the investments that the U.S. Government had done were to remind the State to even develop guidelines on mainstreaming LGBTI issues, but at the same

time the LGBTI communities, just one of those that has been affected by some of the funding cuts that we have witnessed over the past years. Thank you.

Ms. HOULAHAN. Thank you. And I just have one more followup question for Ms.—is it Bos or Bos?

Ms. BOS. Bos.

Ms. HOULAHAN. Bos. So, you sort of alluded to the fact that CARE and the World Vision organization were trying to fill the void that UNFPA is not able to fill in some areas. Is that what you are intending to say? It sounded as though you were saying that there really was not a solution in places like Yemen to address these particular issues without the UNFPA.

Ms. BOS. I cannot speak specifically to that. I do not know if Sheba Crocker is able to. But, yes, I do not know if there are gaps. I am just not as familiar with that kind of program. I do know that in some of the humanitarian contexts there are other partners. I do not know that certainly that is addressing all of the gaps that there may be if UNFPA is not present.

Mr. LEVIN. Ms. Crocker, did you have a quick word to add?

Ms. CROCKER. Well, I would just note that there are some places as I alluded to before where UNFPA is actually the only provider of some services in Yemen. For example, they are the only international provider of reproductive health services. And I also noted that they are currently facing a several hundred million dollar gap in their funding in terms of what they have put out what they need.

And so, while I do not have it on my fingertips exactly where those gaps might now lie, they are facing gaps because they just do not have all of the funding that they need to carry out their activities. And, you know, as I noted, in humanitarian settings in particular, UNFPA does both incredibly important lifesaving work, but is often the only provider on the ground.

Ms. HOULAHAN. Thank you. And as we know, and I will conclude with this, the UNFPA, the United States were one of the founding partners of that organization and we had provided until the last several years the third largest, I think, amount of resources, meaning money, to that organization. And if there is a gap, then that gap is probably coming from the places where it is no longer provided. And thank you so much for your testimony today. I yield back.

Mr. LEVIN. Thank you. We now recognize Mr. Perry for his questions. Mr. Perry?

Mr. PERRY. I thank the gentleman and I thank the witnesses. I would like to expand the conversation, if you will. I do not think that women and girls can be successful or really even happy members of society when they face forms of gender-based violence often resulting in physical harm to their bodies.

I particularly want to highlight the impact of FGM, female genital mutilation, on women and girls. It is a harmful practice that severely affects a girl's health, development, education, and her quality of life. It is commonly performed on girls from infancy to 15 years old, leaving a lifelong impact on the most innocent among us. Girls who are subjected to FGM are more likely to drop out of

school. Girls affected by FGM are also at increased risk of becoming child brides.

Just last week I heard of a devastating story in Egypt, you might be aware. A 12-year-old girl bled to death after having FGM performed. Her parents and her aunt made the choice to take this young, innocent girl to a private clinic, and I said "clinic," to have the practice done and she lost her life. This case exemplifies how difficult it is for the international community to end the harmful practice, because Egypt actually banned FGM in 2008 and criminalized it in 2016, yet Egyptians are still struggling to eradicate the practice.

In the past year, we have FGM convictions out of the United Kingdom and Ireland. In the U.K., a mother became the first person convicted of FGM in the country after she was found guilty of performing the practice. She performed it herself on her 3-year-old daughter. And in Ireland, a married couple was found guilty of carrying out the practice on their 1-year-old daughter.

The practice has also been happening right here in the United States. We saw the 2017 landmark arrest of two Michigan-based doctors. I underscore "doctors," accused of performing FGM on at least nine underaged girls from 8 to 13 years old. The majority of the victims were brought across State lines, all traveled with their parents. The testimony of the young, innocent girls included in the criminal complaint against the doctors, it is harrowing to say the least. Two of the young victims believed that they were traveling with their moms to Michigan for a fun girls' weekend. I mean that is the ultimate betrayal, in my opinion.

The 2017 Michigan case was the first time the United States used our 1996 Federal statute banning the practice. Unfortunately, the Michigan case resulted in the Federal statute being ruled unconstitutional by a Federal district judge. It has now been 16 months since a Federal district judge ruled in the United States' Federal ban on FGM unconstitutional, putting the onus on Congress to pass new legislation. And, indeed, tomorrow, February 6th, is the International Day of Zero Tolerance for FGM.

Now I proposed legislation to not only reinState a ban on FGM in the United States, but also to make our laws stronger to ensure successful prosecution in the future. And there is a new, you know, I mentioned doctors in this and the advent is not only overseas, but in the United States where the terminology used is, it is being medicalized, a medicalized felony practice.

Ms. Bos, what message do you think it sends to the international community including governments that have yet to ban the practice that the United States does not currently have a Federal ban on FGM?

Ms. BOS. I do think it is critical that the U.S. show leadership in some of these places where we are, you know, oftentimes as implementors trying to enforce laws. There are many places, thankfully, where there are laws banning FGM. But you are right, there is a critical gap in how we enforce them even in the work that we do. So we really are focused again on working with law enforcement, the judiciary communities to really halt this practice, because the kind of tragedy you mentioned, unfortunately, it is all too common.

So, you know, I do hope the U.S. continues to show leadership in this space and really continues to model, really, the best of what we want to do to the rest of the world.

Mr. PERRY. I appreciate it. I find it hard to find proponents, advocates of FGM even in this body, but yet we cannot seem to move a bill. And I get it if they do not like my bill. One should be offered that they do like. I think it just absolutely, we have to send a very strong message.

Ms. Crocker, Dr. Kates, do you have anything to add in this regard? I am sure you work in this space as well.

Ms. CROCKER. I would just like to thank you for your focus on gender-based violence and the many different forms it can take including in the context of emergencies. And as I noted in my opening remarks there is a bipartisan bill, the Safe from the Start Act, which would expand and strengthen existing U.S. Government policy and efforts to support countering gender-based violence in its many forms and we would strongly encourage passage of that bill.

Mr. PERRY. I thank the chair.

Mr. LEVIN. Thank you. And I now recognize Mr. Deutch for his questions.

Mr. DEUTCH. Thank you, Mr. Chairman.

Mr. Chairman, the Trump administration authorized, I think, what can only be described as a radical, unprecedented expansion of the Mexico City policy, the Global Gag Rule, extending it to apply to all global health assistance where previous iterations applied specifically to family planning funds. Earlier this year, Secretary Pompeo announced in a press conference that the State Department would be taking action to "implement this policy to the broadest extent possible." But while the purported intention of the Global Gag Rule is to reduce the number of abortions taking place, that is simply not the result of the policy.

And, Dr. Kates, you mentioned the new study published in Lancet found that when the Global Gag Rule was in effect between 2001 and 2008, abortion rates increased by about 40 percent among women in countries most affected by the policy. It also found a symmetric reduction in the use of modern contraception while the policy was enacted, coinciding with an increase in pregnancies.

This pattern of more frequent abortions, many of which are unsafe in the impacted countries, and lower contraceptive use was reversed after the policy was rescinded in 2009. And it seems based on the research and our witnesses' testimony today that not only does the Global Gag Rule accomplish the opposite of its Stated goal, but it puts women already at risk, poor women and women in developing countries, at further risk by removing their access to safe reproductive care as well as restricting their access to quality health care more broadly.

So, Dr. Kates, can you tell us more about the research and what it foreshadows for the impact of the expanded Global Gag Rule if it is not repealed?

Ms. KATES. So the research has, and particularly the study that you were just citing from the Lancet does show a strong correlation between this policy being in place and increased abortion rates, increased pregnancy and reduction of contraceptive prevalence, and when the policy is not in place the opposite.

One of the—and so that really suggests that there is a relationship here that really needs to be assessed, because that is not really what the goal of the policy seems to be. And as I mentioned earlier, there have been more recent—that is a retrospective analysis. There are current studies that have gone into the field to try to understand, is there a disruption in services, is there confusion, is there maybe overimplementation, and those have been documented.

I think one challenge that I heard Ms. Bos speak to and I want to also echo is that we do not always have at our fingertips the data we need to understand the impact on women's lives right now, and that would be one area I would look to you all to potentially strengthen, which is having a better sense of what is happening in the field with U.S.-funded programs so we understand the impacts more in real time. This is something PEPFAR does quite well. It is not necessarily the case in some other global health programs.

But just to come back to your question, there has been a lot of confusion about this policy, and the research as you said does suggest that there is a strong relationship here.

Mr. DEUTCH. Thank you. And I have more questions on this that I will submit for the record. I just want to spend a moment to talk about the administration's repeated efforts to discontinue funds to UNFPA, the U.N. sexual and reproductive agency which provides essential women's health services around the world especially where there is otherwise little or no access to care.

As chairman of the Middle East Subcommittee, I am especially concerned because of the agency's critical, irreplaceable, and lifesaving work that is done in Yemen and in Syria. As we know, the humanitarian crisis in Yemen remains the worst in the world, and in a country where rising food shortages have left more than a million pregnant and lactating women malnourished and where an estimated 114,000 women are likely to develop childbirth complications, UNFPA is the sole provider of lifesaving reproductive health supplies and medicines.

And the importance of that work is also true at the Zaatari refugee camp in Jordan, the world's largest Syrian refugee camp. At Zaatari, the U.S. through this program was a major supporter of the camp's central maternity ward where UNFPA has facilitated over 12,000 births with zero maternal deaths. Thousands of babies have been born healthy, many with American flags on their bassinets, thanks to the important work of the agency and thanks to the United States financial support for their work. That is something that I think on both sides of the aisle we should be proud of, and I worry that by the continuing attacks by this administration on UNFPA funding that we will threaten those important and fragile global health gains.

And I would like to just submit for the record the January 2020 report called, "Counting the Three Transformative Results," which identifies the specific interventions needed to achieve three transformative results in women's and girls' health by 2030.

Mr. LEVIN. Without objection.

[The information follows.]

COSTING THE THREE TRANSFORMATIVE RESULTS

Produced by United Nations Population Fund

January 2020

UNFPA

● Ending preventable maternal deaths ● Ending the unmet need for family planning ● Ending gender-based violence and all harmful practices, including child marriage and female genital mutilation

COSTING THE THREE TRANSFORMATIVE RESULTS

The cost of the transformative results that UNFPA is committed to achieving by 2030

United Nations Population Fund

This publication focuses on new research to estimate the costs associated with a programmatic approach and the global cost of achieving these three transformative results by 2030.

The costing analysis pertains to the global effort led by UNFPA towards: (a) ending preventable maternal deaths, (b) ending the unmet need for family planning, (c) ending gender-based violence and all harmful practices, including child marriage and female genital mutilation.

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CONTENTS

FOREWORD

Since the 1994 Cairo Conference, the global community has undertaken a concerted and largely effective effort to advance the sexual and reproductive health and rights of women and girls in developing countries, guided by the International Conference on Population and Development (ICPD) Programme of Action. The number and rate of women dying from complications of pregnancy or childbirth has been halved. Tens of millions more women have access to modern methods of family planning. Harmful traditional practices such as female genital mutilation (FGM) and child marriage are declining.

Yet, 25 years on, many women and girls are still left behind. Sexual and reproductive health and harmful traditional practices remain a leading cause of death, disability and economic and social disempowerment for women in the developing world.

Over 300,000 women die in childbirth of preventable causes every year. Ninety-seven per cent live in low- and middle-income countries (LMICs). Over 200 million women lack access to modern methods of family planning. Many millions of girls continue to suffer negative lifelong health, social and economic consequences from early marriage, FGM and gender-based violence (GBV).

The global community is reflecting on the progress and promise of the ICPD on its 25th anniversary and the deadline to achieve the Sustainable Development Goals (SDGs), convening at the Nairobi Summit where world leaders agreed to come together and end these scourges once and for all. Consensus has converged around the three transformative results set forth by UNFPA, the United Nations Population Fund, to be achieved by 2030:

- ending the unmet need for family planning
- ending preventable maternal deaths
- ending gender-based violence and all harmful practices against women and girls

With the publication of this report, the final, critical piece of knowledge is in place to move boldly forward. **For the first time, the global community knows the cost and the new investments that must be made to achieve these three world-changing goals.** With this information in hand, we are at *kairos* – that ancient Greek word for the opportune and decisive moment when conditions are right for the accomplishment of this crucial action.

ICPD25 and the Nairobi Summit represent a decisive moment to accelerate the groundbreaking promise of the ICPD Programme of Action and critical elements of the Sustainable Development Goals embodied in UNFPA's strategic plan to achieve the three zeros on behalf of women and girls globally. We are working towards zero unmet need for family planning, zero preventable maternal deaths and zero gender-based violence and harmful practices. Governments and donors must seize the opportunity to "create financing momentum" – one of the five thematic areas of the Nairobi Summit – around this well-defined and ambitious, but entirely achievable, set of objectives.

Now that the path has been clearly defined, the decisions we make, the actions we initiate and the funding we commit will determine whether we achieve the three transformative results, live up to the ICPD promise and achieve the Sustainable Development Goals by 2030. It is truly a defining moment.

This new analysis makes clear that the costs of achieving the three zeros will be high, but the benefits will be much greater. Our work is firmly grounded in recognizing and respecting the human rights for all women, girls, men and boys. It is difficult to calculate the very real harm caused when a child grows up without its mother or a young girl experiences FGM. The emotional, social and economic harms may last a lifetime and impact future generations. But the economic benefits of ensuring that all women can freely plan and space pregnancies, no woman dies of preventable maternal complications and girls can complete their schooling and join the job market by avoiding child marriage are **quantifiable** and over time will **far exceed** the investment made in achieving the three transformative results.

This new analysis is a true road map to achieve these critical goals. It goes beyond calculating costs. It also identifies the specific interventions needed to achieve the three transformative results by 2030 and sets the stage for next steps, including developing country investment cases and costing of the work of UNFPA country programmes to achieve the transformative results.

Armed with this new costing information, encouraged by new commitments made at Nairobi and emboldened by the focused energy generated by the Nairobi Summit, we stand at a defining moment for global human rights and women's health and development.

Ramiz Alakbarov
Director
Policy and Strategy Division
UNFPA

INTRODUCTION

UNFPA embraces the vision set forth in the 2030 Agenda for Sustainable Development and the targets contained in the 17 Sustainable Development Goals. UNFPA has organized its work around three transformative and people-centred results in the period leading up to 2030. These are: (a) ending preventable maternal deaths; (b) ending the unmet need for family planning; and (c) ending gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage.

UNFPA selected these results based on the mandate, comparative advantage, work experience and capacity for advancing elements of the Sustainable Development Goals. While UNFPA's mandate supports all 17 Sustainable Development Goals, the Fund is most directly aligned to the following:

- **Goal 3:** Ensure healthy lives and promote well-being for all at all ages
- **Goal 5:** Achieve gender equality and empower all women and girls
- **Goal 10:** Reduce inequality within and among countries
- **Goal 16:** Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
- **Goal 17:** Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

All of these Goals contribute directly to Goal 1, to end poverty. Goals 10, 16 and 17 are enabling conditions to help attain 3 and 5. In this context, the three transformative results reflect UNFPA's prioritization and commitment to achieve Sustainable Development Goal 3 and Goal 5.

More specifically, the three transformative results are aligned with the following targets:

- **Target 3.1:** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births[1]
- **Target 3.7:** By 2030, ensure universal access to sexual and reproductive health-care services, including family planning, information and education and the integration of reproductive health into national strategies and programmes

Figure 1. Universal and people-centred transformative results

Implemented through:
UNFPA "bull's eye" for three consecutive strategic plan cycles

Enabled by:
Evidence and population expertise

Focusing on:
Empowerment of women and young people, especially adolescent girls

Delivered in:
Humanitarian and development settings

Source: DP/FPA/2017/9

1 Ending preventable maternal deaths is also part of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

- **Target 5.2:** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
- **Target 5.3:** Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

UNFPA, working with partners across the globe, plans to attain the three transformative results by 2030 through three consecutive strategic plan cycles: (a) Strategic Plan 2018–2021, Set the vision and start action; (b) Strategic Plan 2022–2025, Consolidate gains; and (c) Strategic Plan 2026–2030, Accelerate achievements.

With this publication, the final, critical piece of the puzzle to achieve the three transformative results is now available. For the first time, **we know the global price tag** to achieve these three world-changing goals. This new research makes clear that the costs of achieving the three transformative results will be high, but the benefits will be much greater.

Table 1. The three transformative results advance the ICPD Programme of Action and Sustainable Development Goals

UNFPA transformative results (2018)	End the unmet need for family planning, including modern methods of contraception	End preventable maternal deaths	End gender-based violence and all harmful practices against women and girls, including child marriage and female genital mutilation
Sustainable Development Goals (2015)	Achieve zero unmet need for family planning information and services, SDG target 3.7 and SDG target 5.6	Reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030, SDG target 3.1	End gender-based violence, SDG target 5.2. End child marriage, SDG target 5.3. End female genital mutilation, SDG target 5.3
ICPD Programme of Action (1994)	"Universal access to reproductive health services, including family planning..." (Section 1.12)	"To achieve a rapid and substantial reduction in maternal... mortality." (Section 8.20)	"Eliminate child marriages and female genital mutilation." (Section 5.5) "Advancing... the elimination of all kinds of violence against women" (Principle 4)

MESSAGES AND KEY FINDINGS

PRINCIPAL MESSAGES

1. The world will not achieve the transformative results by 2030 without substantially accelerating progress towards these goals. The acceleration will not happen without filling the resource gaps and stepping-up political commitment.

   The global community has spoken with a clear voice for over 25 years in support of ending the unmet need for family planning, preventable maternal deaths and harmful practices against women and girls. As 2030 fast approaches, the real work of bridging the substantial resource gap and implementing the broad-ranging programmes necessary to achieve these results must be embraced with a sense of extreme urgency. Political will must rapidly evolve beyond words to become concrete commitments of resources followed by immediate actions to implement programmes to achieve the three transformative results.

   Funding must be increased now, substantially and from all quarters – no stakeholder should stand back wondering if they are needed in this effort. Everyone is critical to success and everyone will be asked for more than they anticipate and quite probably more than they will be comfortable contributing. But even substantial new funding is not enough. Backed by increased resources, acceleration of the many and diverse programmes described in this paper must start today and increase exponentially, not in a linear trajectory, without rest or cessation until 2030. If political will mobilizes the needed resources to fund the full range of appropriate programmes, then this vision for transformational change can be realized.

2. Filling the resource gaps to achieve the three transformative results means accelerating 2030 Agenda through implementation of the ICPD Programme of Action and achieving the Sustainable Development Goals.

   Global efforts to achieve the three transformative results align with and support the existing global framework and consensus to end poverty and improve the lives of people around the world. The resources being mobilized and the programmatic actions being taken to achieve the three transformative results are in alignment with the ICPD Programme of Action, which supports the Sustainable Development Goals and will ultimately contribute to the achievement of the 2030 Agenda.

   Global approaches in achieving transformative results need to be complemented by national actions from all stakeholders including governments, the private sector, civil society and individuals.

   It is essential that every relevant category of funder contribute fully to planning and programmes to achieve the three transformative results. The inputs of multilateral and other international donors will be indispensable, but the rapid development and robust implementation of ambitious national plans will be critical to success. The early, visible and enthusiastic participation of national actors in each country, including the government, the private sector, civil society and individuals, will be a clear gauge of the level of national commitment to these goals and the likelihood of success within the tight time frame.

4. Domestic resources are the most sustainable source of investment in achieving the transformative results.

   While all categories of donors have a major role to play in this effort, ultimately national governments are the most reliable and sustainable source of funding for programmes that benefit their citizens. Early action by national governments that demonstrate commitment to the three transformative results, identify areas where the government can make additional investments and also identify gaps where outside assistance is needed will mobilize and effectively target the most resources and help ensure success at the national level.

5. The transformative results need to be incorporated in public budgets and development cooperation efforts.

   The level of new resources needed to achieve the three transformative results is substantial, and increases rapidly year-on-year as coverage targets are projected to increase steadily. In order to achieve this level of sustained commitment, it will be imperative that national governments factor these new resource needs into their public budgets, perhaps with new budget lines earmarked for this initiative or a robust increase in relevant existing budget lines. Likewise, all donor governments will be facing a new and sustained demand for additional funding through their development assistance budgets. Private sector donors will have to coordinate their enhanced efforts with governments and donors to ensure coordinated programming focused on results. It will be necessary to develop strategies to make this new funding available while maintaining current commitments.

MAJOR FINDINGS

Groundbreaking research undertaken by UNFPA and its partners has for the first time determined a preliminary cumulative global price tag to achieve the three transformative results by 2030.

Achieving the three transformative results by 2030 in priority countries will cost $264 billion. Of this sum, $42 billion is currently projected to be provided by donors in the form of development assistance during this period.

This means that **new investment of $222 billion will be required** to meet the three transformative goals by 2030. This new investment will come from domestic government spending, additional development assistance, the private sector, civil society and individuals.

Investment needed to end preventable maternal deaths:

- The cost from 2020 to 2030 of ending preventable maternal deaths is $115.5 billion for 120 priority countries.
- The amount in development assistance that will be spent in 120 priority countries is $11.9 billion. Ending preventable maternal deaths by 2030 in 120 priority countries requires investments totalling $103.6 billion.

Investment needed to end the unmet need for family planning:

- The cost from 2020 to 2030 of ending the unmet need of modern family planning is $68.5 billion in 120 priority countries.
- The amount in development assistance that will be spent in 120 priority countries is $8.6 billion. Ending the unmet need for modern family planning by 2030 in 120 priority countries requires investments totalling of $59.9 billion.

Investment needed to end harmful practices:

- The cost from 2020 to 2030 of ending female genital mutilation in 31 priority countries is $2.4 billion. The amount in development assistance that will be spent in 31 priority countries is $275 million. Ending female genital mutilation by 2030 in 31 priority countries requires investments totalling of $2.1 billion. Only $95 are required to avert one case of female genital mutilation.
- The cost from 2020 to 2030 of ending child marriage in 68 countries with a high burden of child marriage is $35 billion. The amount in development assistance that will be spent in 68 priority countries is $10.9 billion. Ending child marriage by 2030 in 68 priority countries requires investments totalling $24.1 billion. Only $600 are required to avert one case of child marriage.

Investment needed to end gender-based violence

- The cost from 2020 to 2030 of ending gender-based violence in 132 priority countries is $42 billion. The amount in development assistance that will be spent in 132 priority countries is $9.5 billion. Ending gender-based violence by 2030 in 132 priority countries requires investments totalling $32.5 billion.

Table 2. Achieving the three transformative results: cost and funding gap

Transformative result	Total amount needed, 2020–2030	Projected amount available to spend, 2020–2030 as development assistance at the country level	New investment needed, 2020–2030
End preventable maternal death	$115.5 billion	$11.9 billion	$103.6 billion
End the unmet need for family planning	$68.5 billion	$8.6 billion	$59.9 billion
FGM	$2.4 billion	$275 million	$2.1 billion
Child marriage	$35.0 billion	$10.9 billion	$24.1 billion
GBV	$42.0 billion	$9.5 billion	$32.5 billion
Total	**$264 billion**	**$42 billion**	**$222 billion**

* Figures may not add due to rounding.

Table 3. Road map for achieving UNFPA's three transformative goals

The goals are set	End preventable maternal deaths	End the unmet need for family planning	End harmful practices against women and girls
The challenges are known	Nearly 300,000 women die as a result of childbirth annually, usually of preventable causes	232 million women in developing countries have an unmet need for family planning	High rates of child marriage, female genital mutilation and gender-based violence
The solutions are at hand	A set of known interventions to prevent and treat the leading causes of maternal death	Reduce barriers, enhance demand and make modern contraception accessible to all women and provide other essential services	Targeted programmes (e.g. secondary education, community empowerment, social norms and other targeted programmes) in affected countries to end harmful practices
The partners are in place	Governments, donors, NGOs, UNFPA and other multilaterals	Governments, donors, NGOs, UNFPA and other multilaterals	Governments, donors, NGOs, UNFPA and other multilaterals
Now... the investments must be made	The cost from 2020 to 2030 of ending preventable maternal deaths is $115.5 billion for 120 priority countries New investment of $103.6 billion is needed	The cost from 2020 to 2030 of ending the unmet need of modern family planning is $68.5 billion in 120 priority countries New investment of $59.9 billion is needed	The cost from 2020 to 2030 of ending child marriage in 68 countries with a high burden of child marriage is $35 billion. Ending child marriage by 2030 in 68 priority countries requires investments totalling $24.1 billion The cost from 2020 to 2030 of ending gender-based violence in 132 priority countries is $42 billion. Ending gender-based violence by 2030 in 132 priority countries requires investments totalling $32.5 billion The cost from 2020 to 2030 of ending female genital mutilation in 31 priority countries is $2.4 billion. Ending female genital mutilation by 2030 in 31 priority countries requires investments totalling of $2.1 billion

"A new investment of $222 billion will be required to meet the three transformative goals by 2030.

"Every day 810 women die from preventable causes related to pregnancy and childbirth.

TRANSFORMATIVE RESULT:
ENDING PREVENTABLE MATERNAL DEATHS

CHAPTER 1
COST OF ENDING PREVENTABLE MATERNAL DEATHS

SUMMARY

Ending maternal deaths from preventable causes is a cornerstone of the ICPD Programme of Action and an important indicator in the Sustainable Development Goals. Substantial progress has been made in reducing maternal mortality over the past 25+ years and globally, the number of maternal deaths has dropped 38 per cent since 2000. However, an estimated 295,000 women still die at or around the time of childbirth annually, with the least developed countries bearing the majority of the burden and 86 per cent of maternal deaths occurring in sub-Saharan African and Southern Asian countries. To drive progress towards Goal 3.1 for a "global maternal mortality ratio (MMR) less than 70 per 100,000 live births by 2030," the *Every Woman Every Child* global movement was launched in 2010 to mobilize international and country-level action "to address the major health challenges facing women, children and adolescents around the world". Many maternal deaths and injuries are preventable by scaling up evidence-based interventions to be delivered through high-quality and timely care.

The Bloomberg School of Public Health at Johns Hopkins University has developed a model to estimate the global cost of ending preventable maternal deaths in 120 low- and middle-income countries using available country-level data. The evidence-based approach assumes that maternal mortality and morbidity will decline if all women gain access to a core subset of 29 maternal health interventions spanning the continuum of care from the periconceptual to postpartum periods (the time around conception and after childbirth). To estimate impact, the number of lives saved or mortality rate reductions attributable to expanded coverage of key interventions was quantified using a linear and deterministic modelling platform that applies country-specific conditions of mortality and health form population-based surveys or global databases.

THE PRINCIPAL FINDINGS

- **The cost from 2020 to 2030 of ending preventable maternal deaths is $115.5 billion for 120 priority countries.**
- **From 2020 to 2030, $11.9 billion is available to spend as development assistance at the country level towards ending preventable maternal deaths in the next decade.[2] The total new investment needed to end preventable maternal deaths is $103.6 billion.**

2 This estimate of donor funding to address maternal mortality and morbidity 2020–2030 was developed by the Institute for Health Metrics and Evaluation (IHME), an independent global health research centre at the University of Washington. www.healthdata.org/

1.1 OVERVIEW

Global consensus exists on the need to end preventable maternal deaths. Eliminating preventable maternal deaths is a cornerstone of the ICPD Programme of Action and is an important indicator of both Sustainable Development Goal 3.7 and Goal 5.7.

Supported by this global consensus, progress has been made to reduce preventable maternal deaths. Since 2000, the global maternal mortality ratio has fallen a total of 38 per cent, from 342 maternal deaths per 100,000 live births in 2000 to 211 deaths per 100,000 live births in 2017. Many countries have halved their maternal death rates in the last 10 years.

Despite global agreement and several decades of progress, nearly 300,000 women still die annually from preventable causes at or around the time of childbirth – more than one maternal death every two minutes.

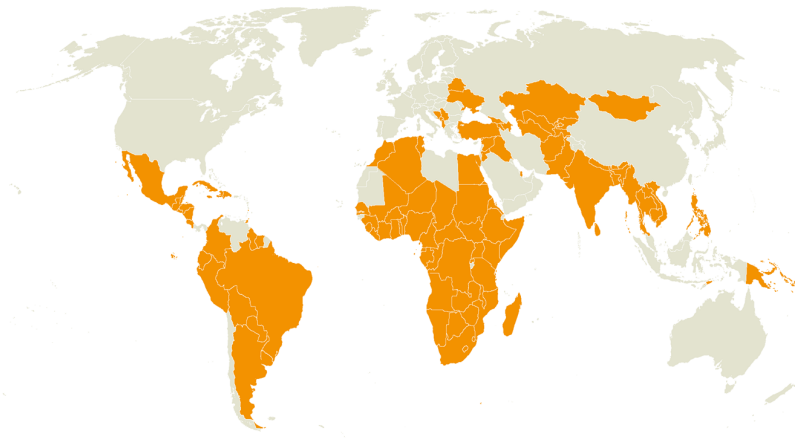
Every maternal death is a human tragedy for the woman and her family. About one million children are left motherless each year. These children are more likely to die within two years of their mothers' death than children with both parents living. And for every woman who dies, 20 or 30 suffer injuries, infections or disabilities. Ongoing high levels of maternal death and disability are also detrimental to the social development and economic well-being of communities and countries.

The majority of maternal deaths are preventable. About three quarters of all maternal deaths are caused by postpartum haemorrhage, hypertensive disorders such as pre-eclampsia/eclampsia, infections, unsafe abortion and other delivery-related complications. In theory, all of the major causes of maternal death can be treated with timely clinical interventions supported by quality care. In practice, however, even if a woman manages to access prenatal care and deliver in a health facility with a skilled birth attendant, poor quality of care can be life-threatening. Non-communicable diseases also play an important and growing role and may contribute to underlying cause of deaths that occur during pregnancy, delivery and the postpartum period.

1.2 OPERATIONALISING ENDING PREVENTABLE MATERNAL DEATHS

Ending preventable maternal deaths can only be achieved if all women have access to a core subset of high-quality maternal health interventions spanning across the continuum of care from periconceptual to postpartum. Ending preventable maternal deaths centres on improvements in maternal health interventions in a total of 120 priority LMICs, representing various levels of engagement dependent on country needs. These countries account for more than 99 per cent of all maternal deaths worldwide. For the purposes of this study, ending preventable maternal deaths is achieved when these evidence-based interventions for maternal health have been scaled up to reach 95 per cent of women in the targeted 120 countries. This study includes the needs of internally displaced persons and refugees.

Figure 2. Map of 120 priority countries for ending preventable maternal deaths



1.3 SCOPE

The estimated global price tag for ending preventable maternal deaths includes the commodity, service delivery and programmatic costs of delivering a package of 29 lifesaving medical interventions to all women during periconceptual, pregnancy/antenatal, and post-partum periods in 120 countries which account for more than 99 per cent of maternal deaths globally.[3]

1.4 METHODOLOGY

Ensuring that all women have access to a basic package of health services for prevention and treatment of complications of pregnancy and childbirth will reduce preventable maternal mortality and morbidity. To estimate impact quantified as the number of lives saved or mortality rate reductions attributable to expanded coverage of key interventions, the Lives Saved Tool (LiST) was used to

Table 4. The path to ending preventable maternal deaths

Ensure that these 29 interventions are universally available...	Folic acid supplementation/fortification Safe abortion services Post-abortion case management Ectopic pregnancy case management Blanket iron supplementation/fortification TT – Tetanus toxoid vaccination IPTp – Intermittent preventive treatment of malaria during pregnancy Syphilis detection and treatment Calcium supplementation Iron supplementation in pregnancy Multiple micronutrient supplementation in pregnancy Balanced energy supplementation Hypertensive disorder case management Diabetes case management Malaria case management MgSO4 management of pre-eclampsia Immediate drying and additional stimulation Neonatal resuscitation Antibiotics for preterm or prolonged PROM Parenteral administration of anti-convulsants Parenteral administration of uterotonics Parenteral administration of antibiotics Assisted vaginal delivery Manual removal of placenta Removal of retained products of conception Surgery Blood transfusion Induction of labour for pregnancies lasting 41+ weeks Maternal sepsis case management
In these 120 countries. . .	Afghanistan, Albania, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bangladesh, Barbados, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, Colombia, Comoros, Congo, Costa Rica, Côte d'Ivoire, Cuba, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Jamaica, Jordan, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mexico, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Occupied Palestinian Territory, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Qatar, Rwanda, Saint Lucia, Samoa, São Tomé and Príncipe, Senegal, Serbia, Sierra Leone, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Viet Nam, Yemen, Zambia, Zimbabwe
At the appropriate time for women . . .	Periconceptual, pregnancy/antenatal, postpartum
Ends preventable maternal mortality caused by... [1]	Embolism (3.2 %), abortion (7.9%), hypertensive disorders (14.0%), postpartum haemorrhage and antepartum haemorrhage (27.1%), other direct causes (9.6%), indirect causes[2] (27.5%), sepsis (10.7%)[3]
Which results in...	Zero preventable maternal deaths

[1] Percentages represent the global causes of maternal death.

[2] Indirect causes of death are defined as those resulting from previous existing disease or disease that developed during pregnancy, which was not due to direct obstetric causes, but which was aggravated by the physiologic effects of pregnancy. Indirect causes include infections (e.g. malaria and hepatitis), cardiovascular disease, psychiatric illnesses (e.g. suicide and violence), tuberculosis, epilepsy and diabetes (WHO et al., 2010).

[3] Percentages may be found at: www.thelancet.com/journals/langlo/article/PIIS2214-109X(14)70227-X/fulltext

3 Source: Johns Hopkins Nairobi Slide #11

SPOTLIGHT ON MIDWIFE TRAINING AS A LIFESAVING INTERVENTION: UNFPA MATERNAL AND NEWBORN HEALTH THEMATIC FUND

Launched in 2008 the Maternal and Newborn Health Thematic Fund (MHTF) works in 39 countries with some of the highest maternal mortality rates in the world. The Fund is committed to making childbirth safer for all women, girls and newborns by supporting training for midwives and strengthening health systems overall, especially in their ability to deliver lifesaving emergency obstetric and newborn care. Only 51 per cent of women in low-income countries benefit from skilled care during childbirth. Well-trained midwives could help avert roughly two thirds of all maternal and newborn deaths and deliver 87 per cent of all essential sexual, reproductive, maternal and newborn health services.

Ethiopia: In less than a decade, the number of midwives increased 10 times, while the maternal mortality rate fell by 40 per cent.

In 2009, Ethiopia had only 1,275 midwives caring for a population of over 85 million people. This critical shortage contributed to some of the highest maternal and newborn death rates in the world. Through the support of the UNFPA MHTF, policy changes were implemented and resources mobilized from other partners. Today, 12,069 midwives are equitably distributed across Ethiopia. The maternal mortality ratio has fallen over 40 per cent between 2008 and 2015.

Bangladesh: 3,000 new professional midwives have been trained and maternal deaths have fallen by nearly 61 per cent.

Since 2010, the UNFPA MHTF has supported the Government of Bangladesh in its pledge to train an additional 3,000 midwives and double the share of births attended by a skilled health professional. Bangladesh has launched two new midwifery programmes, resulting in significant improvements in maternal and newborn health and declines in mortality and morbidity.

model country-specific conditions of mortality and health. LiST is a mathematical modelling tool that allows users to estimate the impact of coverage change on mortality in low- and middle-income countries. Scenarios incorporate baseline coverage of interventions drawn from routine household surveys such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) and the effectiveness of interventions to reduce specific causes of death.

This basic package of health services is intended to be representative of the types of services and costs that are required; it is not a recommendation of what each country, or regions within countries, should do. The actual package would be tailored to each country context. The cost of the programme is estimated by multiplying the number of women reached with each service by the unit cost of providing that service. In addition to these service delivery costs, infrastructure and programme costs for support functions such as administration, research, training and monitoring and evaluation have also been estimated.

1.5 RESULTS AND FINDINGS

The causes of preventable maternal death are well known. The solutions to ending most preventable maternal deaths are equally well known. Now, for the first time, the total resources needed to end preventable maternal mortality are known.

- **The total investment needed is $115.5 billion between 2020 and 2030.**
- Donors are projected to provide $11.9 billion of this amount between 2020 and 2030. The new investment required is $103.6 billion.

Figure 3. Methodology for estimating impact of coverage in number of lives saved

- Annual spending needs to increase from $4.0 billion in 2020 to $16.1 billion by 2030 to meet this goal.
- Ending preventable maternal deaths centres on improvements in maternal health interventions in a total of 120 priority countries representing various levels of engagement dependent on country needs.
- There is a relationship between unmet need for contraception and the incidence of preventable maternal death, where countries with high unmet need for family planning often have higher rates of maternal complications and deaths. This study assumes that ending unmet need for family planning will also be achieved by 2030. If unmet need for modern forms of family planning is not eliminated by 2030, the costs of ending preventable maternal deaths by 2030 could be substantially higher.
- More investment in maternal health would also make easily preventable and treatable conditions that arise from complications in childbirth – such as obstetric fistula – extremely rare.
- Providing these interventions in all 120 countries would also have the added effect of reducing newborn deaths by 33 per cent and still births by 57 per cent.

While the resources required are known, what is not known is whether the global community will take the action necessary to end preventable maternal deaths by 2030. Based on this new information, all that stands in the way is a commitment to implement all available and known interventions to save women's lives.

> "Ending preventable maternal deaths by 2030 in 120 priority countries requires investments totaling $103.6 billion.

"There are 232 million women in developing countries who want to prevent their pregnancies but are not using modern contraceptives.

TRANSFORMATIVE RESULT:
ENDING THE UNMET NEED FOR FAMILY PLANNING

CHAPTER 2
COST OF ENDING UNMET NEED FOR FAMILY PLANNING

SUMMARY

Substantial progress has been achieved in making voluntary family planning available to women globally over the past 25 years. Women have experienced a 25 per cent increase in global modern contraceptive prevalence since 1994, which has led to a decline in unintended pregnancies and contributed to a decline in maternal death. Ending unmet need for modern methods of family planning is a cornerstone of the ICPD Programme of Action and an important indicator in the Sustainable Development Goals .

Avenir Health has developed a model to determine the global cost of ending unmet need for modern family planning in 120 low- and middle-income countries. The study assumes that a country's unmet need will be satisfied when the projected modern contraceptive prevalence rate (mCPR) meets the current level of unmet need for any contraception plus the current rate of traditional family planning use and modern contraception use, accounting for population change over the 10-year period. The costs of providing a range of modern methods of contraception to all women is calculated on a country-by-country basis factoring in cost differentials based on each country's specific situation, including commodities, service delivery and programmatic costs.

THE PRINCIPAL FINDINGS

- **The cost from 2020 to 2030 of ending the unmet need of modern family planning is $68.5 billion in 120 priority countries.**
- **The amount in development assistance that will be spent in 120 priority countries from 2020 to 2030 is $8.6 billion. Ending the unmet need for modern family planning by 2030 in 120 priority countries requires investments totalling of $59.9 billion.**

2.1 OVERVIEW (INCLUDING NEED)

Global consensus exists on the importance of making voluntary family planning available to all women. Advancing universal access to family planning is a cornerstone of the ICPD Programme of Action and is an important indicator of both Sustainable Development Goal 3.7 and Goal 5.7.

Progress has been made in the last 25 years. The number of women using modern methods of contraception has almost doubled from 470 million in 1990 to 840 million in 2018.

Universal access to family planning is a human right and will save lives and have the effect of promoting healthier populations, more efficient health systems and stronger economies. Voluntary access to modern methods of contraception and related services prevents unintended pregnancies and births, lowers the number of abortions and reduces maternal death and illness related to complications of pregnancy and childbirth. If all women in developing countries with an unmet need for family planning had access to modern methods of contraception, maternal deaths would fall by about 76,000.

Despite consensus on this simple goal, in 120 low- and middle-income countries an estimated 232 million women are not using contraception despite wanting to avoid pregnancy. This gap in access to safe and effective modern family planning methods threatens women's health and undermines women's ability to build a better future for themselves, their families and their communities.

Making modern methods of family planning accessible to all women is a proven and cost-effective intervention.

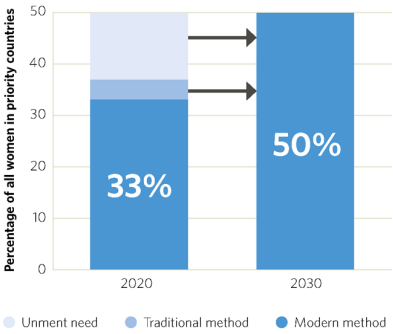
2.2 OPERATIONALIZING ENDING UNMET NEED FOR FAMILY PLANNING

UNFPA's goal of eliminating unmet need by 2030 has been operationalized for the purposes of this costing exercise as increasing the use of modern contraception to the level of current unmet need plus current use of all methods. This means that by 2030 the modern contraceptive prevalence rate would rise in each country by the amount of current unmet need and current use of traditional (vis-a-vis modern) methods of family planning. A small number of countries that currently have low contraceptive use and low unmet need would remain low, but by eliminating unmet need most countries would have a much higher modern contraceptive prevalence rate in excess of 45 per cent by 2030.

2.3 SCOPE

This analysis addresses 120 low- and middle-income countries that are home to a majority of the unmet need for family planning globally. Achieving the goal of ending unmet need will require a 40 per cent increase in users of modern methods. One quarter of that increase is due to population growth and three quarters is due to the increase in the modern contraceptive prevalence rate. The study has costed on a country-by-country basis a variety of programmatic interventions including access to a steady, reliable supply of quality modern contraceptive commodities, service delivery, programme management, research, training, data systems, NGO strengthening and other components. The study has also accounted for other causes of unmet need including access barriers, concerns about side effects and demand creation.

Figure 4. Operationalizing "ending unmet need" for family planning



2.4 METHODOLOGY

The use of modern methods of contraception (see table 5) by all women of reproductive age (15-49) varies from a low of about 4 per cent to a high of 68.5 per cent in low- and middle-income countries. Unmet need for family planning refers to the percentage of women of reproductive age who want to avoid or space pregnancy within the next two years, but are not using any method of family planning. Unmet need varies from a low of 3 per cent to a high of 27 per cent in LMICs.

The costs of family planning programmes include the costs of commodities but also service delivery, programme management, research, training, data systems and other components. Rather than estimate the cost of each component, this study estimates of the total expenditure on family planning programmes by country published by FP2020.[4] These estimates are based on work by the Track20 project, Kaiser Family Foundation, Netherlands Interdisciplinary Demographic Institute, UNFPA and the World Health Organization to estimate expenditures on

4 Family Planning 2020. (2018). *FP2020: Catalyzing Collaboration 2017-2018*, November 2018. www.familyplanning2020.org/

Table 5. Interventions needed to end the unmet need for modern methods of family planning by 2030

Ensure that these interventions are universally available...	A steady, reliable supply of quality modern contraceptives (pills, implants, injectable methods, IUDs, male and female condoms, male and female sterilization, lactational amenorrhea, emergency contraception and Standard Days Method®) Service delivery, programme management, research, training, data systems and other components
In these 120 countries...	Afghanistan, Albania, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bangladesh, Barbados, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, Colombia, Comoros, Congo, Costa Rica, Côte d'Ivoire, Cuba, Democratic Republic of the Congo, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Jamaica, Jordan, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mexico, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Occupied Palestinian Territory, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Qatar, Rwanda, Saint Lucia, Samoa, São Tomé and Príncipe, Senegal, Serbia, Sierra Leone, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Viet Nam, Yemen, Zambia, Zimbabwe
End the unmet need for family planning by...	Ensuring that all women in the 120 target countries have ready access to a mix of modern contraceptive methods and appropriate programmes to support universal access
Which results in...	No unmet need for family planning

family planning by country from international donors, domestic governments and consumers. From this work we can estimate the expenditure per modern method user for 120 countries. For countries without data this study uses the regional average expenditure per modern method user as an input for scaling up national-level cost projections.

Projections of the number of women of reproductive age in target countries are available from the United Nations Population Division.[5] This study estimates the number of women using modern methods of contraception by multiplying the annual number of women of reproductive age by the per cent projected to use modern contraception. The calculation indicates that the number of modern method users would increase from about 685 million in all low- and middle-income countries in 2019 to about 970 million by 2030 if the goal is met.

From this work the study estimates the expenditure per modern method user for 120 countries. The average cost is about $12. For some countries with incomplete data the study has assigned regional average costs per user. There is a wide range from less than $5 per user to as much as nearly $40. Countries with higher rates of contraceptive use have less variation in unit costs. By 2030, countries with low unit costs may be expected to experience higher costs as they improve quality and those with high unit costs will experience reductions as they become more efficient. Therefore, the study assumes that by 2030 all countries will have unit costs in the range of $10 to $20. For countries already in that range the study assumes constant unit costs. For countries outside that range the study assumes that costs will gradually increase or decrease to be within the range by 2030.

2.5 RESULTS AND FINDINGS

All that stands in the way of ending unmet need for modern methods of family planning is a commitment to provide the resources to implement the known interventions.

The causes of unmet need for family planning are well known. The solutions to ending unmet need for family planning are equally well known. Now, for the first time, the total resources needed to end the unmet need for family planning are known.

- The total investment needed to end the unmet need for family planning is approximately $68.5 billion between 2020 and 2030.
- Donors are currently projected to provide $8.6 billion of this need between 2020 and 2030 leaving the new investment required $59.9 billion.
- Total resources from all sources will have to increase from about $6.3 billion annually in 2020 to about $10.8 billion annually by 2030.
- The global price tag for ending unmet need is 0.20 cents per person on earth per day between 2020 and 2030.

While the expenditures required to scale up family planning to end the unmet need are large, net savings are likely to be realized. With reduced requirements for maternal health care and delivery, child health care, education and other services, **the savings will be many times larger than the expenditure** on family planning.[6]

5 United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Population Prospects* 2019, Online Edition.

6 www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017

The largest amount of funding will be required in Asia and the Pacific (63 per cent), followed by Latin America and the Caribbean (16 per cent), East and Southern Africa (8 per cent), West and Central Africa (6 per cent), North Africa and the Middle East (5 per cent) and Eastern Europe and Central Asia (1 per cent).

The largest amount of resources is needed for upper-middle-income countries (47 per cent), followed by lower-middle-income countries (43 per cent) and low-income countries (9 per cent)

(Note: Sums may not total 100 per cent due to rounding).

Figure 5. **Resources required for family planning in low- and middle-income countries, by region (in US dollars)**

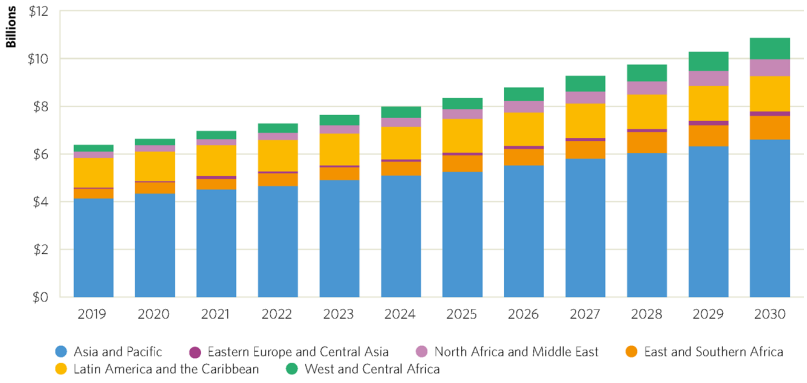
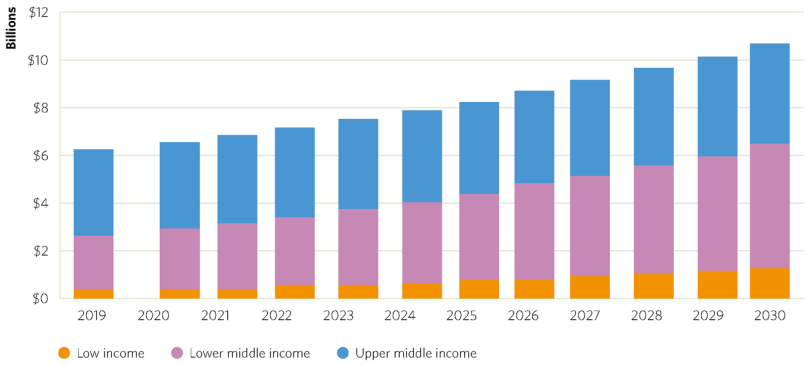


Figure 6. **Resources required for family planning in low- and middle-income countries, by income category (in US dollars)**



> "An overall investment of $68.5 billion would end the unmet need for family planning in 120 priority countries.

"Over 200 million girls and women alive today have experienced female genital mutilation.

TRANSFORMATIVE RESULT:
ENDING GENDER-BASED VIOLENCE AND ALL HARMFUL PRACTICES

CHAPTER 3
COST OF ENDING FEMALE GENITAL MUTILATION

SUMMARY

An estimated 200 million women alive today have undergone female genital mutilation. FGM is a violation of girl's human rights and is often a precursor to early marriage, which usually ends the girl's education and dims her economic prospects. The causes of FGM are varied and programmes to promote its abandonment include prevention, protection and treatment and care.

This analysis seeks to identify and estimate the cost of implementing interventions that would result in ending female genital mutilation in 31 high-incidence countries. The operational definition of ending FGM for the purposes of this study is reaching all communities in 31 high-incidence countries with direct or indirect community empowerment programming to promote abandonment of female genital mutilation.

THE PRINCIPAL FINDINGS

- **The cost from 2020 to 2030 of ending female genital mutilation in 31 priority countries is $2.4 billion.**
- **The amount in development assistance that will be spent in 31 priority countries from 2020 to 2030 is $275 million. Ending female genital mutilation by 2030 in 31 priority countries requires investments totalling of $2.1 billion.**
- **The average cost of preventing one case of female genital mutilation is $95.**

3.1 OVERVIEW

An estimated 200 million women alive today have undergone female genital mutilation. FGM is a violation of girl's human rights and is often a precursor to early marriage which usually ends the girl's education and dims her economic prospects.

The causes of female genital mutilation are varied and may include social, religious and economic elements. Programmes to promote the abandonment of female genital mutilation commonly focus on changing social norms around female genital mutilation at the community and institutional level, enabling girls, women, men and families to more easily abandon the practice. Pre-existing programmes encouraging its abandonment along with growing urbanization, education and other dynamics have led to historic trends that will avert 46.5 million cases of female genital mutilation between 2020 and 2050 in the absence of additional interventions. Nevertheless, an additional 68 million girls are at risk of undergoing female genital mutilation between 2015 and 2030 if current age-specific rates remain constant.

3.2 OPERATIONALIZING ENDING FEMALE GENITAL MUTILATION

The operational definition of ending female genital mutilation utilized for this study is when all communities with majority approval for FGM in the 31 high-incidence countries are reached with direct or indirect community empowerment programming to promote abandonment of the practice.

3.3 SCOPE

This analysis seeks to identify and estimate the cost of implementing interventions that would result in the ending of female genital mutilation in 31 high-incidence countries. These interventions include prevention, protection and care and treatment.

Grouping countries by historic trends and levels of approval for FGM makes it possible to identify where investment will have the greatest impact. The most cost-effective investments are in the countries with relatively more communities with majority approval rates for the practice and limited historic change. In these instances, the average cost per case of female genital mutilation averted is between $2 and $56. Countries with many communities with majority approval and a pre-existing historic trend downward, interventions are still cost-effective, but impacts attributable to new prevention programmes are lower. In these instances, interventions costing approximately $200 per case averted.

3.4 METHODOLOGY

We calculated the incidence of FGM for children aged 0–14 using a multistage process. We tabulated the age-specific incidence of FGM from Demographic and Health Surveys or

Figure 8. Target countries for elimination of female genital mutilation

Benin
Burkina Faso
Cameroon
Central African Republic
Chad
Côte d'Ivoire
Djibouti
Egypt
Eritrea
Ethiopia
Gambia
Ghana
Guinea
Guinea-Bissau
Indonesia
Iraq
Kenya
Liberia
Maldives
Mali
Mauritania
Niger
Nigeria
Senegal
Sierra Leone
Somalia
Sudan
Togo
Uganda
Tanzania
Yemen

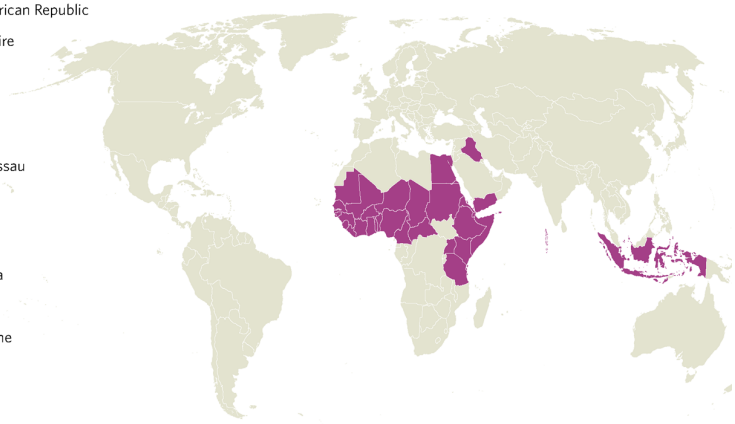


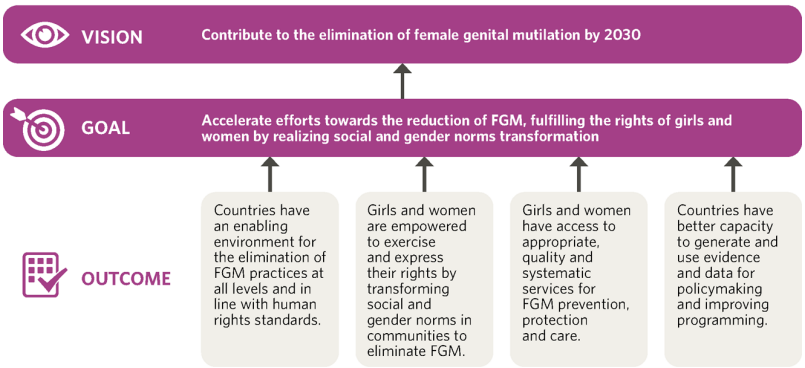
Table 6. Interventions necessary to end female genital mutilation

Sector	Intervention
Prevention	Supporting agency of girls and women Community empowerment prevention programmes, including: Education, dialogue and consensus-building for all Religious and traditional leaders engagement Schools and social services strengthening to prevent the practice Men and young people mobilization
	Mass and social media education and amplification of the new norm
	Health and social providers capacity building on prevention
Protection	Legislation and policy development, including costed plan of action, political public statements, advocacy for domestic budget lines
	Laws enforcement and mobile courts
	Capacity building for legal personnel
	Psychosocial support
Treatment and care	Capacity building for health providers on treatment and care

Multiple Indicator Cluster Survey data sets for the year of the survey based on responses of a mother to queries about whether her child has been cut, and if yes, at what age she was cut.

1. We calculated a time trend for FGM reduction based on a tabulation of the historical age-specific incidences for the age at which incidence of FGM is greatest in a country. This age varies by country – in most West African countries it is children less than 1 year old, while in East and North Africa the ages range mostly from 5 to 12 years old.
2. We calculated an intervention-specific reduction based on the regression described in the subsequent section. This reduction is spread across 12 years (for consistency with cost estimates).
3. We applied a year-to-year incidence reduction at every age, calculated as the sum of the historical trend (step 2) and the intervention-based reduction (step 3). Note that the historical trend is applied at every year between the year of the latest survey and the end of the projection period. The intervention-based reduction is applied only to the years 2018 through 2030.

Figure 9. Theory of change of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation



The age-specific prevalences of FGM are the sum of incidences at each age and year previous to current year.

We calculated the impact of community programmes as follows:

1 A regression was run to calculate logistic equation coefficients that were used to calculate probabilities that a daughter is cut. The independent variables included: mother's support for FGM, community support for FGM, age of mother, household wealth status, education, religion and residence.

2. Women's support status was changed based on the effectiveness of programmes on changing attitudes. Levels of community support were recalculated based on the changes in individual women's support.

3. The new probability of a daughter being cut was calculated by using the regression coefficients applied to a specific country data set with the women's and community attitudinal changes adjusted via the effect sizes above to reflect the effect of the women's attitude changes on community support.

3.5 RESULTS AND FINDINGS

The estimated total investment needed to end female genital mutilation by 2030 is $2.4 billion for 31 high-incidence countries. This equals less than three cents per year for every person on earth. Of the $2.4 billion:

- $2.1 billion will be used for prevention programmes
- $225 million will be used for protection programmes
- $130 million will be used for care and treatment

Donors are currently projected to provide $0.3 billion of this need between 2020 and 2030. The total new investment needed to end female genital mutilation is $2.1 billion.

If a programme to end female genital mutilation globally were implemented, the average cost of preventing one case of female genital mutilation is $95.

Figure 10. Methodology to calculate the impact of community programmes on FGM

"Ending female genital mutilation by 2030 in 31 priority countries requires investments totalling of $2.1 billion.

"Each year, 12 million girls are married before the age of 18.

TRANSFORMATIVE RESULT:
ENDING GENDER-BASED VIOLENCE AND ALL HARMFUL PRACTICES

CHAPTER 4
COST OF ENDING CHILD MARRIAGE

SUMMARY

Nearly 650 million women alive today became brides before they turned 18 years old – some even before age 10 – and an additional 12 million girls are expected to be married each year. Child marriage is a human rights violation that deprives girls of their education, health and security. Child brides often drop out of school and have diminished economic opportunities. They are at elevated risk for domestic violence and adolescent pregnancy, increasing the risk of maternal and newborn death and injury. Child marriage also has intergenerational impacts. Interventions are emerging that hold great promise to reduce the incidence of child marriage.

This study has developed a methodology for estimating the cost of ending child marriage in 68 countries that are host to about 90 per cent of the current global burden of child marriage. For the purposes of this study, ending child marriage is defined as lowering the rate of child marriage below 5 per cent in the 68 target countries.

THE PRINCIPAL FINDINGS

- **The total cost of ending child marriage for the 68 countries modelled over the period 2020 to 2030 is $35 billion.**
- **The amount in development assistance that will be spent in 68 priority countries is $10.9 billion. Ending child marriage by 2030 in 68 priority countries requires investments totalling $24.1 billion.**[7]
- **Only $600 are required to avert one case of child marriage.**

7 This estimate of donor funding that addresses child and early marriage 2020–2030 was developed by the IHME.

4.1 OVERVIEW

Globally, 650 million women and girls alive today were brides before they reached the age of 18. The impact of child marriage on these women and girls, the estimated 12 million additional girls who are married each year and the societies in which they live is significant. Child marriage is a human rights violation that deprives girls of their education, health and security. Child brides often drop out of school and have diminished economic opportunities. They are at elevated risk for domestic violence and adolescent pregnancy, increasing the risk of maternal and newborn death and injury and child marriage has intergenerational impacts.

Ending child marriage is an objective of Sustainable Development Goal 5.3.

Child marriage is caused by a variety of social, cultural, religious and economic factors. The most significant among them are: prevailing gendered social and cultural norms; poverty; financial transactions around marriage such as dowry or bride price, and a lack of positive alternatives for girls and families such as quality education and opportunities for decent work. The girls at greatest risk of early marriage are often from poor families, marginalized groups or rural areas and may be the hardest to reach.

Interventions are emerging that hold great promise to reduce the incidence of child marriage. A set of programmes focus on directly impacting early marriage include life skills (generally including information on sexual and reproductive health and rights), conditional economic incentives and community mobilization. A complementary cadre of programmes support girls' education by focusing on transfer payments to girls to stay in school, school infrastructure, the special needs of rural schools, pedagogical changes and teacher training. These programmes seeks to lower dropout rates and increase the number of years girls stay in school.

4.2 OPERATIONALISING ENDING CHILD MARRIAGE

The objective of the model is to identify the interventions necessary to achieve the practical elimination of child marriage, that is, a marriage rate below 5 per cent, at least intervention cost.

4.3 SCOPE

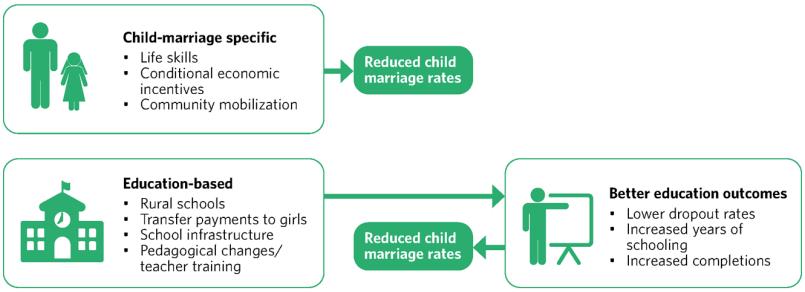
The study focuses on 68 countries with about 90 per cent of the global child marriage burden. Educational interventions as well as interventions related to changing social norms are assumed to reduce the incidence of child marriage in these target countries.

4.4 METHODOLOGY

The Child Marriage Optimal Interventions (CMOI) Model was utilized in this study to identify the interventions necessary to achieve the operational elimination of child marriage in 68 target countries at the lowest intervention cost by 2030.

In many countries and regions, child marriage rates are declining rapidly as a result of existing child marriage programmes and changing community attitudes. These trends are incorporated into the model as the "base" against which an intervention scenario is compared. The intervention scenario applies a set of education and specific child marriage interventions to further reduce the underlying base trend to the target level. Child marriages averted are the difference between the base and the intervention scenario.

Figure 11. Interventions to reduce child marriage



The function of the CMOI Model is to determine the optimal mix of interventions for each country that can reduce child marriage to at least 5 per cent by 2030 at the least cost. The CMOI Model covers 68 countries that account for 87 per cent of all child marriages across the globe. Given that child marriage rates vary substantially between urban and rural areas, the optimal mix of interventions was modelled for both urban and rural settings. In addition, as India represents approximately 28 per cent of the total estimated child marriages, the CMOI Model analysed India in greater detail. Each of 13 Indian states with the largest number of child marriages were separately modelled. Unfortunately, this level of granularity was not available for other countries with large child, early and forced (CEF) marriage burdens, such as Bangladesh, Brazil, Ethiopia and Nigeria.

The sources of data needed to construct the CMOI Model include the following: current rate and trend of child marriage, population forecasts, intervention costs and urban/rural splits.

4.5 RESULTS AND FINDINGS

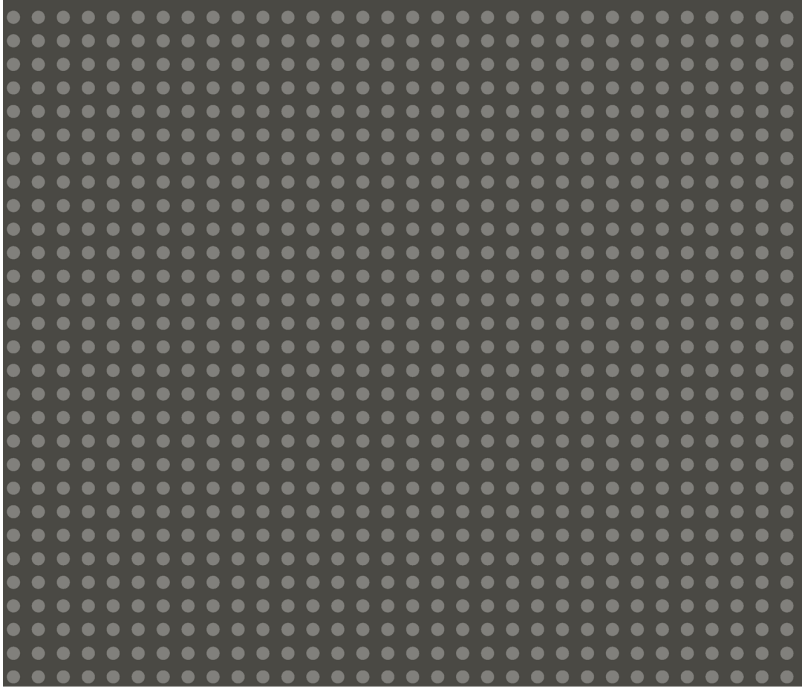
Donors are presently projected to provide $10.9 billion between 2020 and 2030 to reduce child marriage with a substantial amount of this contribution related specifically to investments in secondary education. The total cost of ending child marriage for the 68 countries modelled over the period 2020 to 2030 is estimated to require an additional $35 billion.

If this investment is realized, approximately 58 million child marriages will be averted over this period at an average, non-discounted cost of $600 each.

The benefits of ending child marriage extend well beyond those directly addressing immediate human rights, health and other direct effects of child marriage. The increased educational outcomes generated by ending child marriage provide girls with the opportunity to get jobs in the formal economy or make a more productive contribution to the household enterprise if they continue to work in the informal sector.

> "Ending child marriage by 2030 in 68 priority countries requires investments totalling $24.1 billion.

"1 in 3 women worldwide have experienced physical and/or sexual intimate partner violence or sexual violence by a non-partner.



TRANSFORMATIVE RESULT:
ENDING GENDER-BASED VIOLENCE AND ALL HARMFUL PRACTICES

CHAPTER 5
COST OF ENDING GENDER-BASED VIOLENCE

SUMMARY

The number of women and girls impacted by gender-based violence (GBV) are staggering, with some estimates indicating that as many as one in three women and girls globally will be victims of GBV in their lifetimes. Gender-based violence undermines the health, dignity, security and autonomy of its victims and also has local, national and global impacts, limiting the contributions women and girls make to international development, peace and progress.

For the purposes of this analysis we assume that a range of anti-GBV programming will be scaled up to impact 80 per cent of women in 132 target low- and middle-income countries by 2030. Funding will be deployed slowly at first, expand rapidly around 2025 and then slow as target coverage of the interventions is achieved in 2030. For the purposes of costing an end to gender-based violence this analysis has identified a basic package of prevention and treatment services for intimate partner violence (IPV) based on the available data.

THE PRINCIPAL FINDINGS

- **Implementing prevention and treatment programmes to end gender-based violence in 132 countries by 2030 will cost a total of $42 billion.**
- **The amount in development assistance that will be spent in 132 priority countries is $9.5 billion. Ending gender-based violence by 2030 in 132 priority countries requires investments totalling $32.5 billion.**
- **The need for these funds is not steady over the course of the decade with relatively large sums needed in years 6 through 10.**

5.1 OVERVIEW

Gender-based violence occurs in all countries and economic and social groups and takes on many forms.[8] The number of women and girls impacted by GBV are staggering with some estimates indicating that as many as one in three women and girls globally will be victims of GBV in their lifetimes. The self-reported incidence of GBV in LMICs indicate that GBV impacts an average of 17 per cent of women across these countries, with a range of between 4 to 46 per cent.

Gender-based violence undermines the health, dignity, security and autonomy of its victims and also has local, national and global impacts, limiting the contributions women and girls make to international development, peace and progress. Victims of gender-based violence can suffer sexual and reproductive health consequences, including forced and unwanted pregnancies, unsafe abortions, traumatic fistula, sexually transmitted infections including HIV, and even death.

To date, the global community has dedicated only limited resources to finding solutions and implementing programmes to end GBV. However, solutions to GBV are slowly emerging as more prevention and treatment programmes are implemented, new approaches are explored and results are analysed. Using available data, analysis suggests that most new resources are needed for programmes addressing three areas: community mobilization, outreach to male youth and economic empowerment of women and girls. Additional programming is needed for reaching women in the workplace, outreach to female sex workers, mass media, counselling and treatment and NGO strengthening.

5.2 OPERATIONALIZING ENDING GENDER-BASED VIOLENCE

For the purpose of this analysis, ending GBV is defined as a global scale-up of GBV prevention and treatment programming that would increase to cover 80 per cent of appropriate populations with effective interventions by 2030.

5.3 SCOPE

For the purposes of this analysis we assume that a range of anti-GBV programming will be scaled up to impact 80 per cent of women in 132 target LMICs by 2030. Funding will be deployed slowly at first, expand rapidly around 2025 and then slow as target coverage of the interventions is achieved in 2030. Interventions will include community mobilization, mass media, sensitivity training for male youth, economic empowerment, outreach for sex workers, counselling and treatment and strengthening non-governmental organizations. It outside the scope of this effort to expect to reach all women everywhere as some countries experience very low rates of GBV and interventions in those countries would be cost prohibitive.

5.4 METHODOLOGY

There is not a large body of research on the effectiveness of a range of interventions to combat GBV. This analysis relied on 63 articles that reported GBV prevention interventions and included measures of impact or cost. Among those studies that found significant results and reported odds ratios or information that could be transformed into odds ratios, there were 36 results. There is not enough information to extract different impact values by type of intervention, setting and indicator measured. However, a massive scale-up of efforts to prevent GBV would quickly expand knowledge about what works and how to tailor interventions to specific cultural settings.

For the purposes of costing an end to gender-based violence this analysis has identified a basic package of prevention and treatment services for IPV based on the available data. This package may contain elements of the following interventions depending on country: reaching women in the workplace; community mobilization; education and sensitivity training for adolescents; gender sensitivity training for male youth; enabling environment for sex workers; gender perspectives in health services; and NGO strengthening. In addition, the analysis calculated the cost of treatment, which generally consists of counselling to help with the trauma of violence and care for injuries in the case of rape or severe injury.

This package is not intended to be a recommendation of what each country, or regions within countries, should do, but rather representative of the types of services and costs that are required. The actual package would be tailored to each country context. The cost of the programme is estimated by multiplying the number of people reached with each service by the unit cost of providing that service. To this base cost we add $100,000 per country for NGO strengthening and 15 per cent for support functions such as administration, research, training and monitoring and evaluation.

5.5 RESULTS AND FINDINGS

Implementing prevention and treatment programmes to end gender-based violence in 132 countries by 2030 will cost a total of $42 billion. Donors are currently expected to provide $9.5 billion for this purpose, leaving a finding gap of $32.5 billion over the next decade. The need for these funds

8 GBV takes on many forms including violence against children and elder abuse as well as physical and/or sexual intimate partner violence, sexual assault, forced or unwilling sex, and physical or sexual violence by anyone. The GBV indicator most reported is intimate partner violence (IPV). IPV is the experience of physical or sexual violence committed by husband/partner in the past year. For the purposes of this analysis women's self-reported experiencing IPV is the main measure of GBV.

is not steady over the course of the decade with relatively large sums needed in years 6 through 10.

A comprehensive global effort to address GBV would provide counselling to over 180 million women by 2030 and treatment to nearly 700,000 victims of rape.

The largest amounts of resources are needed in East Asia and the Pacific (33 per cent) followed by roughly equal shares for the other regions as shown in figure 13.

Figure 12. Resource needs to end gender-based violence in 132 countries by 2030, by intervention

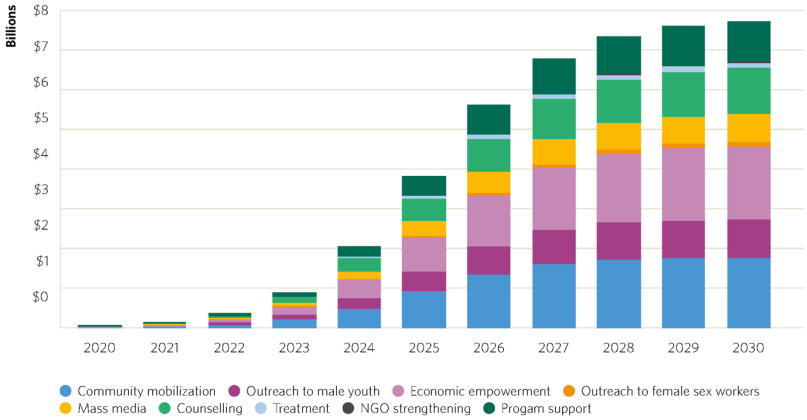
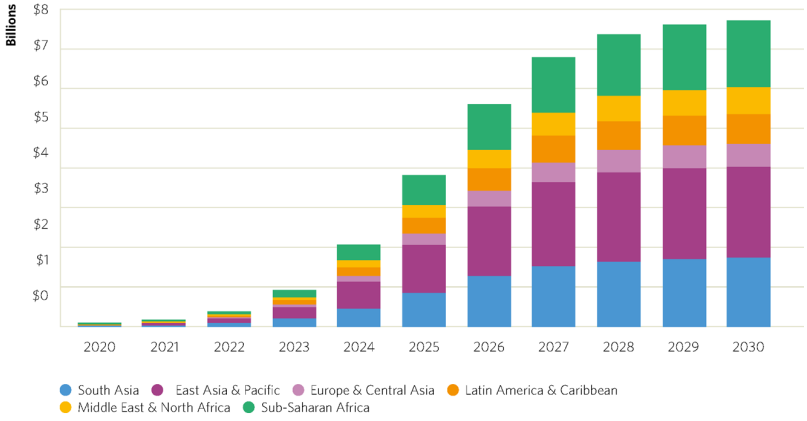


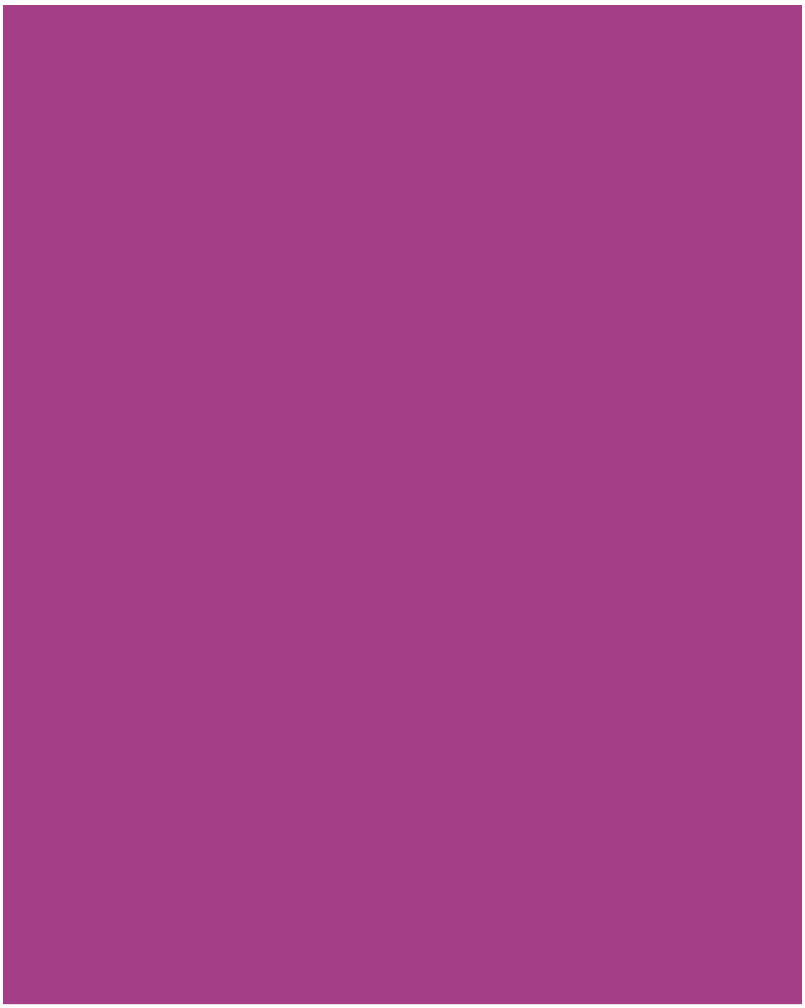
Figure 13. Resource needs by region



"$42 billion would end gender-based violence in 132 priority countries. Of this sum, $32.5 billion is needed in new investments.

ABBREVIATIONS AND ACRONYMS

CEF	Child, early and forced
CMOI	Child Marriage Optimal Interventions
DHS	Demographic and Health Surveys
FGM	Female genital mutilation
GBV	Gender-based violence
ICPD	International Conference on Population and Development
IPV	Intimate partner violence
LiST	Lives Saved Tool
MHTF	Maternal and Newborn Health Thematic Fund
MICS	Multiple Indicator Cluster Surveys
MMR	Maternal mortality ratio
NGO	Non-governmental organization
SDG	Sustainable Development Goals
UNFPA	United Nations Population Fund
US	United States
WHO	World Health Organization



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Mr. DEUTCH. Thank you, Mr. Chairman.

I am so grateful for the witnesses for being here today to highlight a critical issue that this committee needs to address. And, Mr. Chairman, I appreciate the time. I yield back.

Mr. LEVIN. Thank you, Mr. Deutch. I now recognize the gentleman from Tennessee, Mr. Burchett.

Mr. BURCHETT. Thank you, Mr. Chairman. I will try not to run over and I will just get to my point here very fast.

As one of the longest standing U.S. global health priorities, what have we learned from PEPFAR programs in terms of building health systems, accessing at-risk populations, and ensuring effective use of our taxpayer dollars? And I will just throw that out to the committee. Any of you all want to answer it and take a shot at it?

Ms. KATES. I will start. Thank you for that question.

Mr. BURCHETT. Yes, ma'am.

Ms. KATES. We have learned a lot from PEPFAR and I cannot possibly highlight all the things we have learned, but some I want to focus on. First of all, there has been a bipartisan commitment to this program from the start and that is really important. It sends an important signal to the field so this program is seen as having lots of backing back home and that is important.

The other thing that PEPFAR has done from the get-go is really focused on both delivering the lifesaving interventions that are needed, but figuring out how to do that in settings where there are no systems or were systems that weren't adequate. And that was a challenge, but there has been a lot that has been learned from that experience.

PEPFAR has also done something fairly unique, which is it engages very regularly with civil society in both sharing information and getting feedback from civil society in how programming should be done. That has been an incredible effort that has led to better programming, and PEPFAR would probably be the first to say that.

Something I mentioned earlier was data. We cannot always know that we are doing the best thing and reaching the people that need help the most unless we have the information as close to real time as possible. PEPFAR is probably the best model we have in the U.S. Government for doing that. There has been investments in that and that has been another lesson.

And then, finally, I think PEPFAR has, through its leadership diplomatically as well as its programming, sent a strong message that you cannot leave anyone behind. That to truly have the impact on HIV incidents and on reaching more people with treatment you have to reach everybody. That is going to be hard and PEPFAR recognizes that, but the program has a lot of lessons in that regard.

Mr. BURCHETT. Any of the others? Ms. Bos?

Ms. BOS. I would mostly just ditto what Jen said. She said it very well. But just to add as well, I really do think because PEPFAR has focused so much on health work force and health systems, we owe PEPFAR a lot of gratitude. The Ebola outbreak in West Africa would have been much worse had it not been for PEPFAR being present and on the ground.

It was noted earlier, you know, some programs, global health programs, are moving to localization. PEPFAR is one of them. How

do we build the capacity of local partners, again, the journey to self-reliance that is a priority of the administration, we have to look at ways to buildup local structures and local institutions, and PEPFAR, really, I think, has prioritized that and we can learn lessons from that across other programs.

Mr. BURCHETT. Thank you. I remember when the AIDS epidemic kind of came on and we had missionaries in our church come talk about it. And what impacted me as a young man was the fact that we lost entire, you know, they talk about losing entire villages. But, dadgum, they lost entire languages because of just the outbreak was just so widespread. So, thank you all.

So, any others want to comment or out of you all's wheelhouse?

Ms. BOS. No, I mean certainly the lifesaving benefit has tremendous impact. You know, PEPFAR, when we started doing HIV/AIDS programming, you know, Pastor said, "I just spend all my time going to funerals. That is my job. I do not actually preach, I go to funerals." And that was a tragedy.

And I would say, you know, I have been able to travel a lot of places where PEPFAR has been investing resources. People know that that support is coming from the United States and their gratitude and appreciation is real. So, you know, thanks to the Congress for continuing to support that investment. People do appreciate it and they know where it comes from.

Mr. BURCHETT. All right.

Yes, ma'am?

Ms. KATES. Oh, I just want to add, since the focus of the hearing is on women and girls and women's health, PEPFAR isn't thought of as a women's health program, but it actually serves millions of women each year and spends a significant amount of its resources on women. It has done many innovative things to reach women and address the many structural challenges that women have. So I think it is really important that we are talking about it today and recognizing its role in that regard.

Mr. BURCHETT. I think also the fact that, you know, when I was a kid when the outbreak kind of happened, you know, Rock Hudson, and it just kind of swept the country, you know, folks died. I had friends that died, HIV and AIDS, and now that is just not necessary if we can get them the proper medication. So thank you all for what you all are doing for the least amongst us. We appreciate it so much. Thank you.

Thank you, Mr. Chairman. Madam Chairman, excuse me. You slipped in on me. I yield back the remaining 14 seconds of my time. Please use it wisely.

Ms. TITUS [presiding]. We appreciate that.

Ms. Spanberger, you are recognized now for 5 minutes.

Ms. SPANBERGER. Thank you very much, Madam Chairwoman.

And thank you to our witnesses today. Thank you for your testimony and thank you for your incredibly hard work on these issues that are so incredibly important to not just the United States or to Uganda, but to the larger world. I will be joining many of my colleagues for an Asia Subcommittee hearing on the coronavirus this afternoon, and experts agree that medical threats like SARS, Ebola, and now coronavirus, pose a risk to U.S. national security and global security. And I have a background in the intelligence

community, so I do tend to think about public health issues in a broader context, particularly that of the national security consequences.

So, it was discussed, the number, the disproportionate percentage of girls that were impacted by Ebola, by women, or the disproportionate number of women impacted by Ebola in the DRC, and so I was wondering, Ms. Crocker, could you expand a little bit more on how many of these outbreaks do uniquely impact women?

Ms. CROCKER. Thank you for the question. And just to, you know, to sort of start where we maybe ended is that for sure one of the lessons we learned from the Ebola outbreak in West Africa is the importance of making investments in primary health systems and infrastructure, and I think as Jen importantly took us back to why that is particularly important in the context of the subject of the hearing that we are having today.

And women and girls face unique challenges in a number of different ways. We have discussed some of them: gender-based violence, and sexual and reproductive health access. And, in addition, they are uniquely challenged when it comes to being, you know, vulnerable to contagious and infectious disease, both because of sometimes social norms and the role that they play within their own communities and within their own families, and because of the role out sized that they play.

In many countries around the world, it is estimated that at least 75 percent of the healthcare work force is women, which is on the one hand a positive; on the other hand, also means that they are the first line of defense, often. But what we also see is again due to social norms and access issues that we have also discussed, women are often the last to receive care in the communities and in their families. And so, it is sort of that twin, you know, it is both aspects. It is both they are more vulnerable, they are more exposed, and they are the least likely to be, you know, first in line to receive the assistance that is needed.

So again, it speaks to the importance of having a focus from the outset of humanitarian emergencies all the way through development programming on the health needs and protection needs of women and girls in particular, but it also—anyway, sorry.

Ms. SPANBERGER. Well, and so drawing on that point that they are oftentimes the first and/or more exposed, but then among the last to actually get treatment, what does that do for these sorts of outbreaks in terms of our ability to contain them and address them? It sounds to me that it would actually elongate that process because of the fact that women are overly exposed and perhaps last to receive treatment. Could you comment on that?

Ms. CROCKER. Well, I mean, I think again it just speaks to the importance of making sure that we have the right kind of assistance and support systems in place. And often we aren't thinking first and foremost about women's health needs when we think about responding to humanitarian emergencies, but we have certainly found that addressing the unique needs of women and girls, especially their health needs in the context of emergencies, is as important as things like food and water and access to shelter.

And because they are often overlooked, I think, as you say it sometimes then prolongs or means more exposure and that women

are even more vulnerable to things like contagious and infectious disease, when we know they are already facing significant and unique challenges in accessing health care and because of the unique needs of women and girls in the context of emergencies.

Ms. SPANBERGER. And, Dr. Kates, would you add anything in terms of what we could be doing in our health systems more broadly to improve our preparedness and our resilience against communicable diseases?

Ms. KATES. Yes, so the U.S. Government has played a leading role, clearly, in global health security around the world, strengthening other health systems, helping to set norms, leading the global health security agenda, but clearly there is going to be more outbreaks. That is a given. That is the one thing we know. There will be another outbreak after this outbreak.

So, how do—what are the interventions that the U.S. can employ generally, and then I will get to women and girls specifically. Being able to work now to prepare for what we know is inevitable is really critical, it is very hard to do that. It is much easier to respond. But preparedness, we know, makes a huge difference. When the U.S. can help other health systems through the ministries of health in particular and this has worked, for example, CDC does, that can have long-lasting ramifications. That is what we want. We want a system that it can immediately respond to a potential outbreak. So that is critical work and I know that will be something you will discuss later today.

Just to add to what Sheba said around what happen—we do not always think about women's needs in these contexts and for all the reasons she mentioned women are particularly vulnerable. The other thing that tends to happen is if a health system isn't robust, the very basic services that women need whether it is a skilled birth attendance, delivering in a hospital, getting basic maternal health needs met, family planning services get disrupted and resources and attention get diverted and that happens every single time. The more robust a system is in the beginning, the less likely that is going to happen. So it is a win-win, but one that definitely needs more attention.

Ms. SPANBERGER. Thank you very much. I yield back.

Ms. TITUS. Thank you. Mr. Pence, you are now recognized.

Mr. PENCE. Thank you, Madam Chair. To all the witnesses for being here today, thank you very much on such important issues.

Ms. Bos, I found your testimony to be particularly interesting. First, I would like to thank you for World Vision's work in promoting the sanctity of life in combating maternal and infant mortality in developing countries. I agree that abortion is not health care and that vulnerable women seeking true, comprehensive care around the world deserve better than abortion-centric facilities.

In my home State of Indiana, working toward lowering the infant mortality rate is a priority for Hoosiers. In fact, in 2018, Indiana's infant mortality rate showed the biggest decrease in 6 years. While this is encouraging progress, we must remain vigilant. Similar to World Vision's Time and Targeted Counseling home visiting program, Indiana recently launched OB Navigator in 20 of the 92 counties to support women in high-risk communities, six of which

are in my communities. The goal of this program is to improve prenatal and pregnancy care for vulnerable Hoosiers.

Ms. Bos, as we continue to expand this program, what advice would you give to new home visiting programs and are there key challenges to new home visiting programs that must be overcome to reach the most vulnerable populations in Indiana?

Ms. BOS. Well, kudos to Indiana for their leadership in this space and I say that carefully as a native Michigander. I do think there are challenges in doing home visits. Our programs, we work with volunteers. As others have noted these volunteers are mostly women, these health workers, so they are taking time away from their own homes, their own families, potentially businesses, livelihoods. I think that is one of the biggest barriers.

I do not know how Indiana is addressing that issue, but, you know, as we look at how we do programs, you know, how do you start to integrate those health volunteers into the formal health system, maybe get them a stipend is something we are starting to look at. There needs to be some incentive at times for these health volunteers to continue doing this work.

I would say the other barrier, oftentimes, is just having the right information at the right time, and really that is where we are trying to use mobile phones more often. Our Timed and Targeted Counseling messages are often now coming to women and to the health volunteers just right through a mobile phone. You have all probably heard about, you know, women might not have access to a health facility that is nearby, but they will have access to a mobile phone.

So using technology is increasingly critical. And I know in the domestic sphere, you know, that has been something that the U.S. Government has been looking at as well, how do we better leverage technology.

Mr. PENCE. Thank you. Thanks again for all that all of you do. Madam Chair, I yield back.

Ms. TITUS. Mr. Cicilline, you are now recognized for 5 minutes.

Mr. CICILLINE. Thank you, Madam Chair, and thank you to our witnesses for your important testimony.

Dr. Kates, I want to start with you. There was some suggestion made by some of my friends on the other side of the dais that access to abortion services cannot be part of a woman's health care. Would you like to respond to that assertion?

Ms. KATES. Well, I am here as an expert on what the U.S. Government does and the policies and so I am not going to take a position either way. But I will, just to reiterate what I said before that the services that the U.S. Government does support—voluntary family planning, HIV treatment and prevention, a range of reproductive health services and many more—to the extent that these may be disrupted by a policy, I do not think the intention of the policy is to disrupt them, but when there is evidence that that could be happening it is cause for concern.

Mr. CICILLINE. Thank you. And despite the expansion of access to prevention and treatment for HIV, TB, and malaria, these epidemics continue to threaten the health of women and girls worldwide. Maternal health services have been identified as a point

of entry for improving access to prevention and treatment of HIV, TB, and malaria in women.

And again, Dr. Kates, in what ways are we tailoring interventions, if we are, to protect women, particularly those of reproductive age?

Ms. KATES. So I think that is a fundamental thing. We have to understand where women are going to get their health care, what kinds of services they need. I am a parent. You want to do what is best for your kid always, and so reaching women where they are going for their health care and for their kids is a critical approach.

PEPFAR is doing that more and more. I know that the USAID's MCH, Maternal and Child Health, and family planning programs over the last few years have really started to integrate much more their work so that they are trying to meet women together, but there is a lot more that could be done. So there is real opportunity for the U.S. to do, to step back and understand where it is working, which countries in terms of overlap with the programs, and where they could meet women most in need, what sites is the U.S. Government working in.

Mr. CICILLINE. Thank you. And we know that LGBTI persons face higher levels of stigma and discrimination in their communities including when seeking healthcare options. However, when—LGBTI persons also require a unique set of services including HIV prevention and treatment, comprehensive sexual education and family planning. And we know that as a result of this, their clinics have developed programs specifically designed for the LGBTI population and they are seen as trusted sites for other medical providers to refer LGBTI patients.

And my question is, given the Global Gag Rules expansion to all of U.S. global health assistance including PEPFAR, these same clinics may have been forced to close or have gagged, have had to scale back their integrated and comprehensive healthcare services, and so, Dr. Kates, what has been your assessment of the impact of the Global Gag Rule on the LGBTI populations who require this kind of integrated and comprehensive range of services?

Ms. KATES. So as you mentioned, there has been a lot of effort by the U.S. Government through PEPFAR, through USAID to enhance services for LGBTI populations because those populations are often criminalized, face violence, face stigma in their countries, and not reaching them has tremendous impacts on their health. And, in fact, in the context of HIV, key populations including men who have sex with men and transgender women, make up more than half of new HIV infections. So ending the epidemic—ending AIDS is not going to happen unless key populations are reached.

I think in the context of this expanded Mexico City policy, the studies that have been done so far suggest that there have been service disruptions and clinics have closed in some places. Many times, with the populations like the LGBTI community, there are very few providers to begin with and the U.S. has often worked with them to bring them on and help build their capacity.

To the extent that those providers choose not to be a partner with the U.S. Government, choose to stop offering some services that may be legal in their country because they do not understand a policy, that could really affect the availability of services to the

most vulnerable and I think that is something the U.S. Government should pay very close attention to.

Mr. CICILLINE. Thank you. In my view, reproductive rights are human rights and without full access to reproductive health care including information about comprehensive sexuality education, contraception, and access to abortion, women and girls are undermined in their ability to make decisions about their bodies and health.

Mr. Mulumba, is there value in the United States reporting on reproductive rights in countries? We have lost that reporting and really understanding what the condition has been and the impact for the last two to 3 years. By cutting these sections out of the State Department reports, are we losing the ability to kind of understand the full impact of these decisions?

Mr. MULUMBA. Thank you so much for the great question. I think, historically, human rights have been divided and much of the time we focus on civil political rights and forget about socioeconomic rights. And the nature of reproductive rights is that they are cross-cutting and, unfortunately, we only look at them as socioeconomic rights.

At the national level, there is a lot of focus on civil political rights and not socioeconomic rights, so it would really help if United States focuses on comprehensive reporting on human rights because other countries where sometimes do not appear to respect human rights, the human rights reporting is used as a tool, as mobilization of shame for the countries and compliance, and it would therefore be a missed opportunity if the United States does not require the reporting on sexual reproductive health rights.

Mr. CICILLINE. Thank you very much. I yield back, Madam Chair.

Mr. ENGEL. Thank you.

Mr. Guest.

Mr. GUEST. Thank you, Mr. Chairman. Members of our panel, as we meet today to discuss challenges and global health, I believe it is important that we address the challenges faced by the most vulnerable of our society, by our children both born and unborn. The World Health Organization reported in their last report that between 2010 and 2014 that over 55 million abortions were performed each year across our globe. That equates to over 150,000 abortions each day, a hundred abortions each minute. During the 5-minutes that I have to address this panel, over 400 children will lose their lives because of abortion.

I believe that all life is precious. I believe that it is a gift from our Heavenly Father, and I believe that our founding fathers held that same belief. We find that in our earliest documents, the Declaration of Independence, where our founding fathers held that we hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness.

We have seen great medical advances and medical treatments. Last night that was on display when President Trump recognized a young lady who was born after 21 weeks and 6 days. To our friends at World Vision, I want to thank them and their 220,000

community health workers and volunteers, and I want to thank you for your belief that life begins at inception. World Vision along with the other organizations and USAID have helped save the lives of more than nine million children and over 340,000 women over the last 10 years. Ms. Bos, I agree with the statement that you gave and the conclusion of your written statement. "Improving health for the world's most vulnerable people is not only a moral imperative, but also a pragmatic investment for peace, security, and worldwide economic growth."

Ms. Bos, my question to you is, what role do you see telemedicine playing in improving the health of women and children across our globe?

Ms. BOS. Thank you for the question, Congressman. As I mentioned to Congressman Pence as well, I do think technology presents some great opportunities for how we do health care in the developing world. Having done domestic health work when I was here working as a staff member in the House, you know, we saw the opportunities that telemedicine presented in rural areas in bringing resources to people.

I do think there are some challenges with that in the developing world, but challenges we are trying to overcome. If there is not electricity, if you cannot, you know, purchase the right kind of equipment that does present some barriers. That is why we tend to lean right now more toward kind of mobile phone technology.

But I do think there are unique opportunities for new partnerships in how we better use telemedicine, especially because there is such a lack of physicians and really high-quality trained professionals, we need to start looking at those other new innovations.

Mr. GUEST. Thank you.

And thank you, Mr. Chairman. I yield back.

Mr. ENGEL. Thank you very much.

Ms. Titus.

Ms. TITUS. Thank you, Mr. Chairman. We have heard a lot today about how the Global Gag Rule has a negative impact on women, generally. We have heard a lot of pontificating about the sanctity of life from those who often vote to cut critical services for children in vulnerable communities. We also heard a little bit about some the specifically more vulnerable populations among women including LGBTI. I would like to now look at two other groups that we haven't talked about as much and that would be female sex workers who are certainly vulnerable, and also women with disabilities.

Sex workers are a population that faces a significant amount of stigma in their communities. This often extends to healthcare settings, discrimination in interaction with healthcare providers. In particular, they have unique family planning, contraceptive, maternal health, and abortion needs that are related to their work and they often report limited access to information about these services. Data also show that female sex workers face a disproportionately high risk of acquiring HIV, 21 times higher than the general population.

Given this clear need for services, treatment among female sex workers, some healthcare services have created specific outreach programs to build entrusted relationships and provide stigma-free

care. Unfortunately, we hear that these programs are being forced to scale back or even shut down due to the Global Gag Rule.

Also, we know the other vulnerable population I would ask you to address is women and girls with disabilities. They too are at a higher risk of HIV infection as well as stigma and discrimination, and also difficulty in just getting access to the healthcare services that they need.

Starting with you, Dr. Kates, would you address some of the problems and how we can do better serving those two communities?

Ms. KATES. Certainly. I will focus on the first that you mentioned, female sex workers, because as you mentioned they are at much higher risk of HIV and other health challenges, are often overlooked, criminalized, not given access to services. Within the U.S. Government's purview, PEPFAR is the program that has probably moved the furthest on this and makes female sex workers and male sex workers a priority key population that it focuses on.

One of the challenges though is working in environments where they are not able to get services at all. So in some cases, PEPFAR has helped to create those services, but others it is working with challenging local laws and cultural beliefs. One thing PEPFAR is doing now and is planning to scale up is PrEP, pre-exposure prophylaxis, which is antiretroviral medication one takes before exposure to HIV that prevents HIV acquisition by close to 99 percent. This is a tremendous intervention and PEPFAR is going to be scaling that up, but that still the uptake is very, very low.

So, I would just think looking at PEPFAR's ability to do more in the countries in which it works, as well as USAID's other programs that haven't had as much of an emphasis on reaching female sex workers.

Ms. CROCKER. Thank you for the question. And, I think, you know, one thing that it highlights is that there are unique challenges that are faced by marginalized parts of the population. So just to sort of bring it up to a level of generalization and to note that, you know, the importance of protection activities in the context of humanitarian emergencies, sometimes those may be specific to women and girls, generally; sometimes those may be specific to particularly discriminated against groups within society.

I think your question also raises again the importance of ensuring that women and girls and, in fact, all members of the population have access to the tools and education they need to make informed decisions and voluntary decisions about their own family planning needs. In certain cases, there is enormous stigma due to social norms in certain communities around things like even reporting. So we have talked a bit today about the statistics around gender-based violence as an example, but because of stigma we actually think that those statistics are probably underreported, right. So as high as they sound, they are probably actually worse than what we know.

And I think in terms of female sex workers, you know, the stigma is only heightened and, certainly, I think in terms of having, you know, enabling access by disabled people, whether girls or otherwise, in humanitarian emergencies is only more challenged. We have talked a lot about the degraded health systems, generally, in

the context of humanitarian emergencies and the difficulty around access issues that again especially marginalized members of societies face.

[Audio malfunction in hearing room.]

Mr. MULUMBA. Thank you. Very quickly, I think one of the immediate impacts when programs are cut to special groups like sex workers and women with disabilities the argument has been that you will find alternatives in other areas. But these groups receive treatment as a result of trust, so trust is created with providers over some time. So once you have immediate cuts they may not be able to receive services because of the lost relationships that they have had with the institutions that have lost funds, and it is a really a serious problem with the Global Gag Rule.

Ms. BOS. Just really quickly, recognizing the time, disability inclusion is a huge priority for us in our programs. It is something we factor in to all of our programming, making sure, you know, identifying the barriers, you know, and really focusing on that, so it is definitely a priority in our work.

Ms. TITUS. If you have some specific information on that could you send it to me, or any of the Federal programs?

Ms. Kates.

Ms. KATES. Yes, I just want to add one thing. While clearly there are NGO's that do that work, it has not been something—it is a gap in USG programs and policies. There is not an emphasis on this in the global health programs that are supported.

Ms. TITUS. That is what I feared.

Thank you, Mr. Chairman.

Mr. ENGEL. Thank you, Ms. Titus.

Mr. Keating.

Mr. KEATING. Thank you, Mr. Chairman.

First of all, I just want to reaffirm my support as original cosponsor for Representative Lowey's bill, the Global HER Act, as well as, you know, work as cosponsoring the International Violence Against Women Act and the recent resolution we had showing our concern as a Congress with treatment of children and violence in that regard. You know, the way women are treated, the way children are treated, I am reminded when you are on a plane sometimes and they warn you, the flight attendant will warn you if the pressure goes, "The mask will come down. Put your mask on first before helping others." And I think as we talk about protecting children, it is just inextricably connected to protecting women and mothers and their family members in that regard. So this has been an important hearing in bringing that together and it is a terribly important issue.

I want to hit something that probably has not been discussed as something that could interrupt your program, besides the fact that our policy is an on-again/off-again policy, which really hurts, I think, the ability of you to do your jobs, but I want to touch base on how climate change can affect and disrupt your programs as well. You know, you have areas of Africa, Sub-Sahara, where there is really this problem with children is the greatest, and I do not think it is coincidental that that is an area struck by climate change and the challenges that is around that.

So if you can talk about how sometimes climate change, not just in the long-term effects of this, the result in famine, drought, water supply, other things, but also what happens when there are natural disasters that occur and how that disrupts the program and how that leaves women and children more vulnerable. I guess, Ms. Crocker, that is something that you could speak to.

Ms. CROCKER. Thank you. And I mean, for sure the impact of climate change and the climate crisis is having, is impacting our own programming. But I think, more importantly, and as your question alludes to, really impacting countries and communities around the world including those that aren't necessarily used to dealing with those kinds of disasters. And so we saw, for example, last spring with the double cyclones in Mozambique, hitting a country that had just not seen that type of disaster before and, you know, the implications that that has in terms of the ability of the local communities and local governments to muster the right kind of response and also the resilience of those communities.

CARE sees in our work all over the world the impacts of climate change, the things you mentioned—drought, famine, other things—and we work with communities both to help them respond in times of crisis when sometimes you might be in a longer-term development posture but then there is a rapid onset crisis of some kind, but also, importantly, to help build and create the conditions under which communities themselves can build their own resilience.

But of course, when countries, including here and communities here in the United States are facing disasters of types that they have never seen before, that is more challenging. You know, the confluence of impacts of the climate crisis and the protracted conflicts and crises we are seeing around the globe are also not something to forget, right. So we both are seeing an enormous wave of displacement due to conflict around the world, but we are also increasingly seeing displacement due to climate. And I think what we will all need to be watching for is how also those two things come together.

Mr. KEATING. Yes. And I honestly believe that, tying my two comments together, that it is so important whether it is a short-run emergency or whether it is a longer run climate change effect that women have to be more a party to dealing with the programs around that. There shouldn't be this divide—well, we are going to take care of this here, but then you are doing all your work where it is there.

So I hope there is more of an integration into that in the future. I think it is necessary. And I do not know if anyone else wanted to briefly comment.

Ms. CROCKER. If I could just add, briefly——

Mr. KEATING. Yes.

Ms. CROCKER [continuing]. Just to note that in all of our responses as CARE, we do a rapid gender assessment to understand the gendered implications of a disaster whether it is manmade or natural disaster. And I think you are exactly right, and it alludes to some of the things we have been discussing earlier around the importance of addressing the particular needs of women and girls, protection needs and health-related needs——

Mr. KEATING. Yes.

Ms. CROCKER [continuing]. From the outset of a disaster all the way through.

Mr. KEATING. And if women and those mothers aren't involved in that planning, it could get left out. In fact, it does. So, I yield back, and thank you for all the work you are doing.

Mr. ENGEL. Okay, thank you.

I understand that Mr. Smith would like a second opportunity to ask questions.

Mr. SMITH. Thank you, Mr. Chairman.

Mr. ENGEL. So, Mr. Smith, you are recognized for 5 minutes.

Mr. SMITH. Mr. Chairman, thank you very much for that courtesy. Let me just—I learned of the forced abortion policy in the PRC, in China, in 1983. In 1984, offered an amendment saying that any organization that supports it should no longer receive U.S. funding. Jack Kemp and Senator Kasten added to the appropriations bill and we have had Kemp-Kasten ever since. Kemp-Kasten says voluntary yes, involuntary no. China is the most brutal example of coercion.

I have chaired many hearings with women who have been forcibly aborted who told their stories, and the degradation, the impact on their bodies and especially on their minds as the government coerced them to kill their babies. Unwed mothers in China have to abort. I mean in this country, thankfully, we put our arms around unwed mothers and try to protect them and help them through. All of UNFPA that is denied by the U.S. Government goes to family planning and maternal health, so it is a one-for-one, dollar-for-dollar. We do support that.

I had a number of hearings on the missing girls both in China and in India, and I had one woman, an expert, Mara Hvistendahl, who wrote a book called, and I read it and I encourage all to read it, "Unnatural Selection: Choosing Boys Over Girls, and the Consequences of a World Full of Men." She said, and quote from the book, "By August 1969, when the National Institute of Child Health and Human Development and the Population Council convened another workshop on population control, sex selection had become a pet scheme."

She goes on to say, "Sex selection, moreover, had the added advantage of reducing the number of potential mothers." Kill the girl child in the womb and she will never be a mother perhaps in her 20's or 30's or even before. If reliable sex determination technology could be made available to a mass market, there was a rough consensus that sex selection abortion would be an effective, uncontroversial and ethical way of reducing the global population. Fewer women, fewer mothers, fewer future children. At the conference, she goes on to say, one abortion zealot, Christopher Tietzi, co-presented sex selection abortion as one of the 12 new strategies representing the future of global birth control.

We are missing, and my good friend Mrs. Wagner mentioned in her comments, well over a hundred million women who should be here, but for the reason of their gender, the fact that they were a girl child in utero, was killed by abortion. My question is, do any of you support sex selection abortion? Have you seen the impact it has had on India? And in China, it has had an impact on human trafficking.

For years, I tried to get the TIP Office, Trafficking in Persons Office, to recognize that when women are killed in utero because they are girls, the girl child, that creates a huge space for the human traffickers to fill a void because men cannot find women to marry, and that is a huge problem in the People's Republic of China as a direct result of the missing daughters.

There is also the suicide issue. China is one of the countries, I think it is the only one where the rate among suicide among females far outnumbers the rate of men. The coercion clearly has something to do with it. The UNFPA has supported the Chinese program. We have asked them to leave, and yet you know as well as I that they have to comport with all of the China's laws and policies and regulations to do business there.

Marie Stopes had to do that when they were there. They probably are still there. I am not sure of that. But they were denied money under Kemp-Kasten, and certainly the UNFPA has to comport with those laws, which makes them part of that coercive machinery. Remember, no unwed mothers. One child, now two-child per couple policy. For a long time, all brothers and sisters were illegal.

So I would ask you, do you support sex selection abortion and are you concerned about this huge, you know, and we have two girls, two boys in my family, my wife and I. When we found it was a baby girl, we celebrated. Couldn't have been happier. "It is a girl." That phrase is one of the most dangerous phrases in some parts of the world, and 20 countries like I said have these disparities of male to female.

On that question, and do you believe that China's program is coercive? Ms. Crocker?

Ms. CROCKER. Well, I would say to start off that CARE is, of course, is vehemently opposed to sex-selective abortion as well as any form of systemic gender discrimination, and sex-selective abortion as you know is usually premised on harmful gender norms and stereotypes that stem from a belief that a male has greater value than a female, a belief, actually, that CARE seeks to address in our programming.

We believe that the most effective way to address harmful gender norms that devalue women and girls is to address the root causes of gender inequality. CARE works with local partners and communities around the world to engage not only women and girls, but also men and boys as well to improve education, to improve health, to improve economic opportunities for women, and to create lasting change that benefits everyone in a community.

Ms. KATES. My organization is not an implementer and we do not take positions. But I would just echo what Sheba said that the overall gender discrimination and conditions that create such hardship for women and girls in societies is something that the U.S. does work to combat and address, but clearly there are significant challenges and it is a very serious issue.

Mr. ENGEL. I am going to have to cut it now because your time has lapsed, Mr. Smith.

Ms. Omar.

Ms. OMAR. Thank you, Chairman, for having this important conversation. Thank you all for being here. My apologies if my line of questioning has already been dealt with in committee.

I really think that there is a pressing global challenge of child marriage. Currently, we have 650 million women who are alive who have been married before their 18th birthday and 12 million girls who are at risk of becoming child brides each year. We know that issues are compounded, that issue is compounded by poverty, safety, and security.

Many countries have implemented laws to outlaw child marriage, but there are countries like the United States that allow, with consent, for some States to have young girls get married before they are 18. And so, I am wondering if, Jennifer, if you have any thoughts to how we can create a societal shift in recognizing how harmful this practice is and what would it take beyond the implementation of laws for us to be able to outlaw this global crisis?

Ms. KATES. Thank you for the question. Clearly, a really critical global issue. One of the biggest ramifications of child marriage is the physical and emotional harm for young girls and that in and of itself goes against what the U.S. Government is trying to do just to enhance the lives and livelihoods of young people and women in countries in which it works.

I think what the U.S. has done and probably would continue to have the biggest impact is addressing the root causes of the structural challenges that create the conditions that would lead to young women, against their will or without any say, being married at young ages and ultimately giving birth at very young ages and that is more access to education, more access to income-generating opportunities, things that will keep them healthy and also allow them to not—to have more voice and opportunity. The U.S. Government does work in this area, but clearly there is a lot more to do. Thanks.

Ms. OMAR. Do any of you want to chime in?

Ms. BOS. I am happy to just add briefly from World Vision's perspective, you know, preventing child marriage is a complex issue. We need to work with parents. We need to work with schools. We need to work with faith leaders or traditional leaders who are performing the marriages. You are correct in that the enforcement piece is critical. In so many of these countries laws are on the books, but we still see girls getting married ages 12, 13, 14, so it is a critical issue.

I agree with Jen, you know, the U.S. Government is doing some work in this space. I really have appreciated especially PEPFAR through the DREAMS program focused on adolescent girls, really helping girls feel empowered and feel like they can say no to early marriage.

Ms. OMAR. Yes.

Ms. CROCKER. Sorry. If I could just add, I mean, to bring it back to the context of humanitarian emergency also, which we have been discussing a lot, and just to know that child early enforced marriage also often increases during emergencies. It is a negative coping mechanism sometimes that families need to resort to or feel that they need to resort to in the context of emergencies.

And I have flagged several times today the Safe from the Start Act, which is a bipartisan bill before Congress, and one of the things that the Safe from the Start Act would seek to address is child early enforced marriage in the context of emergencies.

Mr. MULUMBA. So on that point, I think in Uganda where I come from it is one of the biggest problems with children having children. It is such a huge problem, but it moves beyond the law to changing the societal norms. And one of the big challenges we have seen is that these are not arranged as marriages, but, you know, a young girl comes when she is pregnant and she is still in the same society, and the side of the offenders, you know, begin to negotiate with the other side.

So, we have systems where even safe spaces are not provided. We are challenging the Government of Uganda for having no single safe space for girls that have been offended in situations like this. So it will take laws, but it will also take engagement within the communities but also challenging the governments.

Ms. OMAR. And the children having children is a huge problem. I have found it be quite alarming in the number of countries that have policies on the books that have increased the age, the legal age for a young woman to get married, but still have this problem persist because it is such a societal norm. I was even shocked as someone who comes from the same part of the world as you come from, to find that even in my own State of Minnesota that you do not legally have to be 18 to be able to get married.

And it is such a tragedy that there are so many young women's opportunities for education, for a stable life that does not get to be advanced because they are sometimes forced to become mothers and care for others. So I appreciate you all for the work that your organizations do and to many of my colleagues who deeply care about ending this crisis. Thank you.

Mr. ENGEL. Well, thank you. Thank you, Ms. Omar.

I also want to thank our witnesses and the members who participated in this very important and interesting hearing. I want to thank the audience for being here today and showing their support, and with that the hearing is adjourned.

[Whereupon, at 12:45 p.m., the committee was adjourned.]

APPENDIX

FULL COMMITTEE HEARING NOTICE
COMMITTEE ON FOREIGN AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515-6128

Eliot L. Engel (D-NY), Chairman

February 5, 2020

TO: MEMBERS OF THE COMMITTEE ON FOREIGN AFFAIRS

You are respectfully requested to attend an OPEN hearing of the Committee on Foreign Affairs to be held in Room 2172 of the Rayburn House Office Building (and available live on the Committee website at https://foreignaffairs.house.gov/):

DATE: Wednesday, February 5, 2020

TIME: 10:00 a.m.

SUBJECT: Unique Challenges Women Face in Global Health

WITNESS:

Panel I
The Honorable Nita Lowey
Member of Congress (D-NY)

The Honorable Cathy McMorris Rodgers
Member of Congress (R-WA)

Panel II
Jennifer Kates, Ph.D.
Senior Vice President and Director of Global Health and HIV Policy
Kaiser Family Foundation

Ms. Sheba Crocker
Vice President for Humanitarian Policy and Practice
CARE

Mr. Moses Mulumba
Executive Director
Center for Health, Human Rights, and Development

Ms. Lisa Bos
Director of Government Relations
World Vision

By Direction of the Chairman

The Committee on Foreign Affairs seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202/225-5021 at least four business days in advance of the event, whenever practicable. Questions with regard to special accommodations in general (including availability of Committee materials in alternative formats and assistive listening devices) may be directed to the Committee.

COMMITTEE ON FOREIGN AFFAIRS
MINUTES OF FULL COMMITTEE HEARING

Day *Wednesday* Date *02/05/2020* Room *2172 RHOB*

Starting Time *10:07 a.m.* Ending Time *12:45 p.m.*

Recesses *1* (*10:27* to *10:29*) (____ to ____) (____ to ____) (____ to ____) (____ to ____) (____ to ____)

Presiding Member(s)
Chairman Eliot L. Engel; Representative Andy Levin; Representative Dina Titus

Check all of the following that apply:

Open Session ☑
Executive (closed) Session ☐
Televised ☑

Electronically Recorded (taped) ☐
Stenographic Record ☑

TITLE OF HEARING:
Unique Challenges Women Face in Global Health

COMMITTEE MEMBERS PRESENT:
See attached.

NON-COMMITTEE MEMBERS PRESENT:

HEARING WITNESSES: Same as meeting notice attached? Yes ☑ **No** ☐
(If "no", please list below and include title, agency, department, or organization.)

STATEMENTS FOR THE RECORD: *(List any statements submitted for the record.)*
SFR - Engel (7), Bera, Espaillat
IFR - Deutch
QFR - Deutch, Wagner, Phillips

TIME SCHEDULED TO RECONVENE _____
or
TIME ADJOURNED *12:45 p.m.*

Full Committee Hearing Coordinator

HOUSE COMMITTEE ON FOREIGN AFFAIRS

FULL COMMITTEE ATTENDANCE

PRESENT	*MEMBER*
X	Eliot L. Engel, NY
	Brad Sherman, CA
	Gregory W. Meeks, NY
X	Albio Sires, NJ
	Gerald E. Connolly, VA
X	Theodore E. Deutch, FL
X	Karen Bass, CA
X	William Keating, MA
X	David Cicilline, RI
X	Ami Bera, CA
X	Joaquin Castro, TX
X	Dina Titus, NV
X	Adriano Espaillat, NY
X	Ted Lieu, CA
	Susan Wild, PA
X	Dean Phillips, MN
X	Ilhan Omar, MN
	Colin Allred, TX
X	Andy Levin, MI
X	Abigail Spanberger, VA
X	Chrissy Houlahan, PA
X	Tom Malinowski, NJ
	David Trone, MD
	Jim Costa, CA
X	Juan Vargas, CA
	Vicente Gonzalez, TX

PRESENT	*MEMBER*
X	Michael T. McCaul, TX
X	Christopher H. Smith, NJ
X	Steve Chabot, OH
	Joe Wilson, SC
X	Scott Perry, PA
	Ted Yoho, FL
	Adam Kinzinger, IL
X	Lee Zeldin, NY
	James Sensenbrenner, Jr., WI
X	Ann Wagner, MO
X	Brian J. Mast, FL
X	Francis Rooney, FL
X	Brian K. Fitzpatrick, PA
	John Curtis, UT
X	Ken Buck, CO
	Ron Wright, TX
	Guy Reschenthaler, PA
X	Tim Burchett, TN
X	Greg Pence, IN
X	Steve Watkins, KS
X	Michael Guest, MS

PLANNED PARENTHOOD AYERS STATEMENT

Written testimony of Planned Parenthood Federation of America
Jacqueline Ayers, Vice President, Public Policy and Government Affairs

Submitted to the U.S. House of Representatives Committee on Foreign Affairs

Congressional Hearing on "Unique Challenges Women Face in Global Health"

February 5, 2020

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit testimony for the record for the House Committee on Foreign Affairs hearing "Unique Challenges Women Face in Global Health."

For more than a century, Planned Parenthood has been one of the United States' leading providers of high-quality, affordable health care for women, men, and young people, and the nation's largest provider of sex education. Planned Parenthood health centers provide millions of people with contraception, testing and treatment for sexually transmitted infections (STIs), lifesaving cancer screenings, and safe, legal abortion. With a presence in all 50 states and Washington, D.C., Planned Parenthood has 49 affiliates, which operate more than 600 health centers. Our international arm, Planned Parenthood Global, supports local partners in 12 focus countries, reaching over 2.4 million patients with reproductive health information and services. Women, men, and young people from every community and income level view Planned Parenthood as their first-choice provider of care.

Planned Parenthood firmly believes every person should have access to the tools and information they need to lead healthy lives and live up to their full potential no matter where they live, and access to comprehensive sexual and reproductive health care is essential. However, an estimated 214 million women in developing countries who want to delay or avoid pregnancy face barriers to effective family planning. Forty-three percent of all pregnancies that occur in developing countries are unintended, and recent analysis estimates that approximately 308,000 women worldwide die each year from pregnancy-related causes.[1] This includes tens of thousands of women who die as a result of the 25 million unsafe abortions each year; unsafe abortions most frequently occur in countries that ban or otherwise legally restrict access to abortion, forcing women to seek clandestine procedures.[2] The U.S. has been a leading global donor for family planning and we must sustain this role if we are to see

[1] Singh, S., Darroch, J.E., & Ashford, L.S. Adding it up: The costs and benefits of investing in sexual and reproductive health 2017, New York: Guttmacher Institute, 2017
[2] Ganatra, B, et al. Global, regional, and subregional classification of abortions by safety, 2010–14. *The Lancet.* 390.10110 (2017): P2372-P2381. [Online].https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/fulltext.

progress—and not declines—in the health of women and families worldwide. Unfortunately, actions by the current administration are derailing this progress and threaten the health and rights of individuals around the world, from the radical expansion of the global gag rule to include all global health assistance, to politically motivated efforts to withhold funding for UNFPA under the Kemp-Kasten amendment and censoring reproductive rights reporting in the State Department's annual Country Reports on Human Rights.

The current administration took swift and severe action to undermine sexual and reproductive health and rights for the millions of individuals served by U.S. global health programs upon taking office by imposing policies driven by ideology instead of evidence. On January 23, 2017, President Trump issued an executive order reinstating and significantly expanding the global gag rule (also known as the Mexico City Policy or "Protecting Life in Global Health Assistance"). The global gag rule prohibits U.S. global health funding to foreign non-governmental organizations (NGOs) that advocate for or provide access to abortion information, referrals, or services, even if this is done with the NGO's own, non-U.S. funds. Extremely limited exceptions are made in the cases of rape, incest, or life endangerment. On March 26, 2019, Secretary of State Pompeo announced the U.S. would interpret and enforce further expansion of the global gag rule, extending the global gag rule to also prevent foreign NGOs from providing sub-grants on any program or project using funding from any source to any organization that provides, counsels, refers, or advocates for abortion as a condition of receiveing U.S. global health assistance.

While this policy is often framed as an issue related to abortion, the expansion is impacting providers offering a range of health care services, including family planning, maternal and child health, nutrition, and HIV/AIDS prevention, care, and treatment. It restricts the medical information health care providers may offer, limits free speech by prohibiting local citizens from participating in public policy debates, and impedes access to basic health care by cutting off funding for many of the most experienced health care providers who provide a range services.

The global gag rule has devastating effects on reproductive health care access for individuals around the world. Under previous versions of the global gag rule, which more narrowly applied to U.S. international family planning funding rather than all global health assistance, the global gag rule resulted in increased unintended and high-risk pregnancies, unsafe abortions, and maternal deaths. Research published on August 1, 2019 in the Lancet found that under President George W. Bush, the global gag rule corresponded with a 14% decrease in access to modern contraceptives, a 12% increase in pregnancies, and a 40% increase in abortion rates, many of which were likely to be unsafe, across 26 impacted countries in sub-Saharan Africa.[3]

In addition to this previous impact, early research on the current version of the global gag rule demonstrates the policy is disrupting health care service delivery, weakening civil society, and halting national policy progress on health while bolstering anti-human rights agendas.[4] Others are observing

[3] Brooks, N., Bedavid, E., & Miller, G. USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy. *The Lancet Global Health.* 7.8 (2019):E1046-E1053. [Online].
https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30267-0/fulltext#seccestitle10
[4] Planned Parenthood Global (2019). Assessing the global gag rule: Harms to health, communities, and advocacy [Online].
https://www.plannedparenthood.org/uploads/filer_public/81/9d/819d9000-5350-4ea3-b699-1f12d59ec67f/181231-ggr-d09.pdf

over-implementation by complying organizations driven by fear of losing funding, as well as chilling effects of the policy felt from health facilities to national civil society dialogue and policy development. Complying organizations are scrubbing programs and services of information related to legal abortion. In their pursuit of compliance, they often over-implement the policy, blocking the delivery of non-abortion related information and services as well. Those hardest hit by the impact of this policy are people who already face systemic barriers to accessing care and for whom the disruption of or decreased quality of services, or loss of a trusted provider, may be particularly devastating. Interviews conducted by Planned Parenthood Global indicate it is those who are most underrepresented in the halls of power on the national and international stage, particularly women living in rural or underserved communities, key populations affected by HIV, LGBTQI people, and adolescents and young people, among others, who are most impacted by the global gag rule.[5]

The global gag rule disrupts the delivery of a range of health services in areas of the world that are most in need. With cuts in funding for non-complying organizations, these disruptions occur either for a brief period of time while new funding is mobilized or the program is transitioned to a complying organization, or indefinitely. Loss of funding has led to discontinued programs and reductions in services from high-quality providers, including those who offer youth-friendly access to contraception, treat children for malaria and malnutrition, and support pregnant women with HIV prevention and treatment services. For example, in Mozambique, AMODEFA was forced out of U.S. global health programs due to the global gag rule even though it previously received two-thirds of its funding from U.S. sources. Following the loss of funding at an AMODEFA clinic in Gaza Province, where the HIV prevalence rate is 24.4 percent, the number of people tested for HIV over a three-month period dropped from 5,981 to 671 immediately. There was also a rapid reduction in the provision of other services at the clinic, such as gynecology consultations and counseling for cancer prevention, which reduced to zero within three months.[6]

Recent research by amfAR demonstrates the global gag rule has resulted in many PEPFAR implementing partners altering the health services and information that they provide, including non-abortion related services such as contraception and HIV, and their partnerships.[7] These disruptions were reported in 31 of the 45 countries surveyed including in areas with high HIV-prevalence, like South Africa, Eswatini, and Mozambique.[8] The research indicates there may be a disproportionate impact on key and marginalized populations, such as adolescent girls, young women, and men who have sex with men, who are more reliant on outreach services and integrated care models that are adversely impacted by the global gag rule because organizations who provide comprehensive reproductive health care are also often the ones best able to serve and reach key and marginalized populations.

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[5] Planned Parenthood Global (2019). Assessing the global gag rule: Harms to health, communities, and advocacy [Online]. https://www.plannedparenthood.org/uploads/filer_public/81/9d/819d9000-5350-4ea3-b699-1f12d59ec67f/181231-ggr-d09.pdf

[6] CHANGE. (2018). Prescribing Chaos in Global Health: The Global Gag Rule from 1984-2018 [Online]. http://www.genderhealth.org/files/uploads/change/publications/Prescribing_Chaos_in_Global_Health_full_report.pdf.

[7] amfAR. (2018). Impact of Mexico City Policy in PEPFAR [Online]. https://www.amfar.org/pepfar-mexico-city/.

[8] amfAR. (2019). How Expanded Mexico City Policy Is Disrupting Global HIV Programs [Online]. https://www.amfar.org/infographic-expanded-mexico-city-policy/.

Fragmentation of health services caused by the global gag rule forces a shift away from person-centered care. The loss of funding for leading health service delivery organizations as a result of the global gag rule has led to discontinued programs and reductions in services by high-quality providers. The policy has also created new financial and operational challenges for both complying and non-complying organizations. Helping to ensure a person can receive the information and care that they need more effectively and efficiently where they enter the health system through the integration of services is prioritized in global health frameworks such as the 2030 Agenda for Sustainable Development. It is also in the U.S. government's own priorities on women's empowerment, ending preventable maternal and child deaths, HIV prevention for adolescent girls and young women, and self-reliance programming. Yet the global gag rule breaks apart partnerships and complementary funding efforts which undermines these efforts, exacerbates existing barriers to integration, and creates breakdowns in the referral chain. All of these challenges make it more difficult and inefficient for people to access the health services.

Polarization of civil society caused by the global gag rule undermines collaboration and serves as a barrier to sustainability. This effect on civil society across health and human rights sectors creates often self-imposed barriers, breaking up long-standing partnerships and undermining the strength of coalitions. This has weakened civil society effectiveness, particularly smaller, newly affected organizations. For example, the Coalition to Stop Maternal Mortality Through Unsafe Abortion has lost several members who are complying with the global gag rule, which has hurt the group's efforts to end preventable maternal deaths in Uganda, where eight percent of maternal deaths are a result of unsafe abortion.[9] Coalitions and joint projects minimize costs and maximize impact, yet the global gag rule weakens these platforms for collaboration. This is a direct contradiction to the fundamental principles of development, and even the U.S. government's own priorities for sustainable foreign aid, which rely on strengthening the capacity of in-country partners.

The global gag rule is stalling progress on national agenda-setting on sexual and reproductive health, causing a negative ripple effect across health and development. This policy, driven by ideology instead of evidence, is aligned with broader anti-human rights agendas currently unfolding around the world. All of this has rolled back hard-won gains for women, people living with HIV, and other communities. The global gag rule has in some cases undermined national policy progress on reproductive and maternal health and the role of access to safe abortion, in addition to closing space for dialogue and advocacy on these issues. Partners indicate this backward slippage is likely due in large part to the influence of the global gag rule and national governments' fear of losing U.S. funding.

We commend the committee for holding this hearing and prioritizing the health and rights of people around the world who are reached through U.S. global health assistance. The global gag rule is a policy that seriously impedes efforts by governments, advocates, and non-governmental organizations to improve women's health globally. Recent polling demonstrates 70% of Americans - and 75% of women - disapprove of the global gag rule.[10] Nearly 170 diverse U.S.-based organizations representing domestic

[9] Guttmacher Institute. (2017). *Abortion and Post-abortion Care in Uganda* [Online]. https://www.guttmacher.org/fact-sheet/abortion-and-postabortion-care-uganda.
[10] Hart Research Associates. (2018, May 22). Results from Recent National Survey [Online]. https://www.plannedparenthood.org/uploads/filer_public/43/39/43391cc6-1b73-4588-b7e9-d35182ab6e9c/ppfa_poll_release_may_23_final.pdf

and global reproductive health and justice, human rights, public health, HIV/AIDS, LGBT, faith-based, environmental, maternal and child health, youth, development, academic, medical, and refugee organizations oppose the global gag rule.[11] At a time when many countries are stepping up to better address the needs of women and young people by investing in health programs and advancing policies that expand access to critical life-saving services, the U.S. should be building on, and not standing in the way of, progress.

We strongly urge Congress to take immediate action to advance the Global HER Act (H.R. 1055/S. 368), critical legislation which would promote health, human rights, civil society participation, and effective use of U.S. global health assistance. It is time to end the global gag rule once and for all.

[11]Coalition Statement Opposing the Global Gag Rule (2019) [Online]. https://www.plannedparenthood.org/about-us/planned-parenthood-global/coalition-statement-opposing-global-gag-rule

COALITION STATEMENT OPPOSING THE GLOBAL GAG RULE 2019

Coalition Statement Opposing the Global Gag Rule
2019

We join together as diverse voices from a variety of sectors to oppose the harmful global gag rule, also known as the Mexico City Policy. While the Helms Amendment restricts U.S. foreign assistance funding for abortions "as a method of family planning," the global gag rule goes a step further by blocking aid to foreign organizations who use their own non-U.S. funds to provide information, referrals, or services for legal abortion or to advocate for access to abortion services in their own country.

The global gag rule causes serious harm in countries around the world. The policy interferes with the doctor-patient relationship by restricting medical information healthcare providers may offer, limits free speech by prohibiting local citizens from participating in public policy debates, and impedes women's access to family planning by cutting off funding for many of the most experienced health care providers who chose to prioritize quality reproductive-health services and counseling over funding that restricts care and censors information.

When in place, the negative impacts of the global gag rule have been broad and severe: health services have been dismantled in a number of communities; clinics that provided a range of reproductive, maternal, and child health care, including HIV testing and counseling, were forced to close; outreach efforts to hard to reach populations were eliminated; and access to contraceptives was severely limited, resulting in more unintended pregnancies and more unsafe abortions. Here is the testimony of one organization that experienced the impact of the global gag rule:

> *"After refusing the terms of the gag rule in 2001, at Family Health Options Kenya we lost a significant amount of funding from USAID with serious and damaging effects on our ability to provide crucial reproductive health and family planning services. We were forced to close six clinics, all of which provided critical services to poor and underserved populations in urban, peri-urban and rural areas including family planning, voluntary counseling and testing for HIV, management of sexually transmitted infections, post-abortion care and maternal and child health services. Following the closure of these clinics in 2005, at least 9,000 people – primarily women and children – were left with little or no access to health care." - FHOK, 2013*

Countries around the world are making significant progress in improving women's health and the global gag rule undermines that momentum. Developing and donor countries alike are stepping up to prioritize and make tangible headway in closing the gap on access to modern family planning through increased funding and better policies. This momentum, which includes global partnerships like Family Planning 2020, builds on the essential foundation of U.S. investments in this sector. The global gag rule seriously hinders the effectiveness of U.S. global health investments and the growing global progress that we, as a global community, have made in expanding access to family planning for couples worldwide and in reducing maternal mortality.

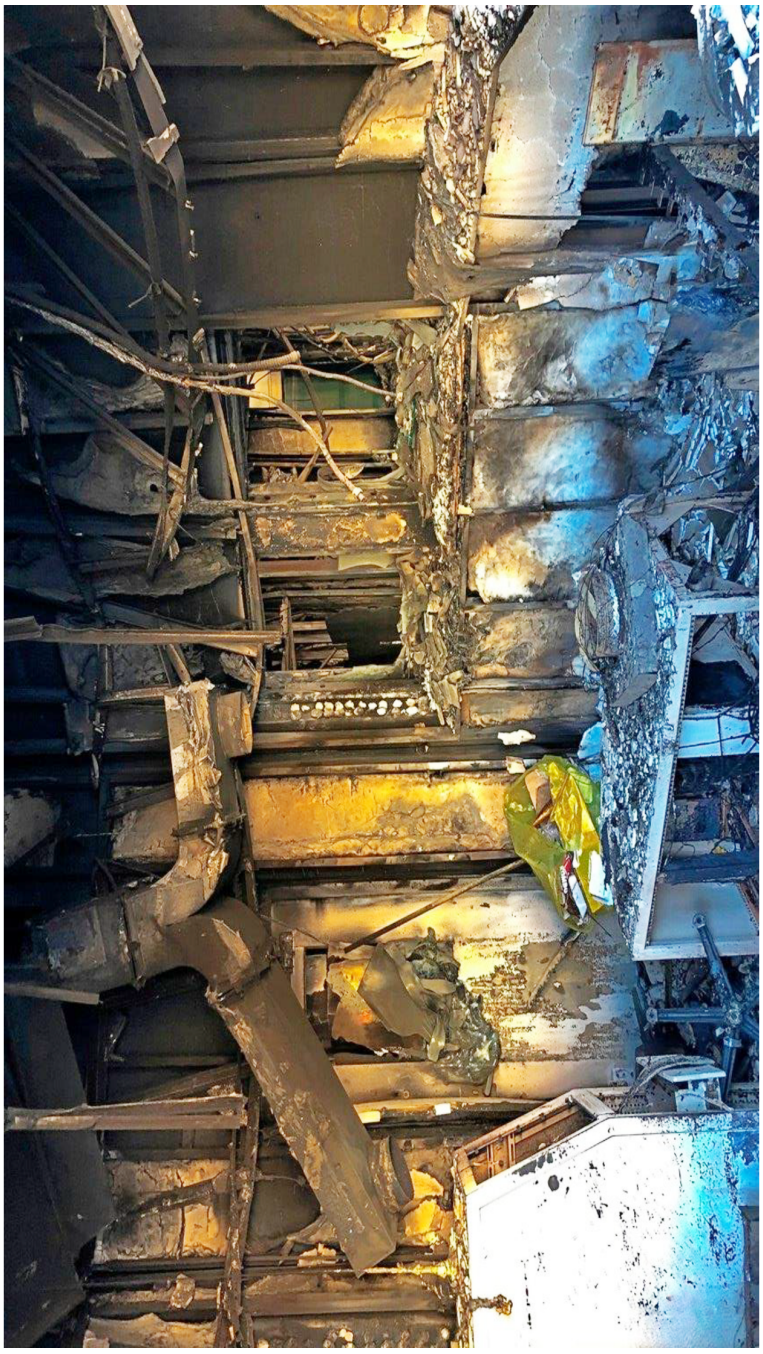
The U.S. has been a leader when it comes to promoting democracy, women's health, and human rights around the world. U.S. foreign aid should never be used as a tool to limit women's access to health care or to censor free speech. Organizations should not be disqualified from receiving U.S. assistance because they use their own funds to provide health services and information that are legal in their home country and legal in the U.S. **Supporters of global health and development, women's rights, gender equality, and free speech oppose the harmful global gag rule and reject efforts to undermine the health and rights of women around the world.**

Endorsing Organizations:

1. 30 for 30 Campaign
2. Advocates for Youth
3. AFL-CIO
4. AIDS Foundation of Chicago
5. AIDS United
6. ACT UP NY
7. Alliance to End Slavery & Trafficking
8. American Academy of Pediatrics
9. American Association of University Women (AAUW)
10. American Civil Liberties Union
11. American College of Nurse-Midwives
12. American Congress of Obstetricians and Gynecologists
13. American Federation of Teachers
14. American Humanist Association
15. American Jewish World Service
16. American Medical Student Association
17. Americans United for Separation of Church and State
18. amfAR (The Foundation for AIDS Research)
19. Amnesty International USA
20. Amref Health Africa
21. Anti-Defamation League
22. Association of Reproductive Health Professionals
23. AVAC
24. Black Women's Health Imperative
25. Breakthrough
26. carafem
27. CARE USA
28. Catholics for Choice
29. Center for Biological Diversity
30. Center for Health and Gender Equity (CHANGE)
31. Center for Inquiry
32. Center for Reproductive Rights
33. Center for Women Policy Studies
34. Coalition for Children Affected by AIDS
35. Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
36. Columbia University Mailman School of Public Health
37. Concerned Clergy for Choice
38. Consortium of Universities for Global Health
39. Council for Global Equality
40. CREDO
41. Disciple Public Witness; Disciples of Christ
42. Disciples for Choice
43. Disciples Justice Action Network
44. DKT International
45. Elizabeth Glaser Pediatric AIDS Foundation
46. End Rape on Campus
47. EngenderHealth
48. Everywoman Everywhere
49. Feminist Majority
50. First Unitarian Church of Dallas
51. First Unitarian Church of Portland
52. Foreign Policy for America
53. FP2020
54. Freedom From Religion Foundation
55. Funders Concerned About AIDS (FCAA)
56. Global Doctors for Choice

57. Global Health Council
58. Global Initiatives for Human Rights (GIHR)
59. Global Justice Clinic, NYU School of Law
60. Global Justice Institute, Metropolitan Community Churches
61. Global Progressive Hub
62. Guttmacher Institute
63. Gynuity Health Projects
64. Hadassah, The Women's Zionist Organization of America, Inc.
65. Health GAP
66. Healthy Teen Network
67. HIV Medicine Association
68. Human Rights Campaign
69. Human Rights Watch
70. Ibis Reproductive Health
71. If/When/How: Lawyering for Reproductive Justice
72. In Our Own Voice: National Black Women's Reproductive Justice Agenda
73. Ipas
74. Institute for Science and Human Values
75. International Center for Research on Women
76. International Medical Corps
77. International Planned Parenthood Federation
78. International Planned Parenthood Federation/Western Hemisphere Region
79. International Women's Convocation
80. International Women's Health Coalition
81. International Youth Alliance for Family Planning
82. IntraHealth International
83. John Snow, Inc.
84. JWI
85. Lutheran Women's Caucus
86. LWC Policy Consulting Inc.
87. MADRE: Demanding Rights, Resources & Results for Women Worldwide
88. Management Sciences for Health
89. Marie Stopes International-US
90. Medical Students for Choice
91. Methodist Federation for Social Action
92. Muslims for Progressive Values
93. NARAL Pro-Choice America
94. NASTAD (National Alliance of State & Territorial AIDS Directors)
95. National Abortion Federation
96. National Asian Pacific American Women's Forum (NAPAWF)
97. National Center for Lesbian Rights
98. National Center for Transgender Equality
99. National Council of Jewish Women
100. National Family Planning & Reproductive Health Association
101. National Latina Institute for Reproductive Health
102. National LGBTQ Task Force
103. National Network of Abortion Funds
104. National Organization for Women
105. National Partnership for Women & Families
106. National Women's Health Network
107. National Women's Law Center
108. New Voices for Reproductive Justice
109. Norwegian Refugee Council USA
110. Outright Action International
111. PAI
112. Partners for Development
113. PATH
114. Pathfinder International

115. People For The American Way
116. Physicians for Reproductive Health
117. Plan International USA
118. Planned Parenthood Clergy Advocacy Board
119. Planned Parenthood Federation of America
120. Population Connection Action Fund
121. Population Council
122. Population Institute
123. Population Media Center
124. Population Reference Bureau
125. Positive Women's Network - USA
126. PSI
127. Public Health Institute
128. Refugees International
129. Religious Institute
130. Reproaction
131. Reproductive Health Technologies Project
132. Save the Children
133. Secular Coalition for America
134. Secular Student Alliance
135. Sexuality Information and Education Council of the U.S. (SIECUS)
136. Sierra Club
137. SisterLove, Inc.
138. SisterSong Women of Color Reproductive Justice Collective
139. Society for Humanistic Judaism
140. Society for Maternal-Fetal Medicine
141. Student Global AIDS Campaign
142. The Global Forum on MSM & HIV (MSMGF)
143. The Hunger Project
144. The Religious Coalition for Reproductive Choice
145. Transgender Law Center
146. Treatment Action Group
147. UltraViolet
148. Union for Reform Judaism
149. Unitarian Universalist Association
150. Unitarian Universalist Women's Federation
151. United Methodist General Board of Church & Society
152. United We Dream
153. URGE: Unite for Reproductive & Gender Equity
154. UU Humanist Association
155. Voices for Progress
156. WaterAid
157. White Ribbon Alliance
158. Whitman Walker Health
159. WIN (Women's Information Network)
160. Women at the Center
161. Women's Law Project
162. Woman Care Global
163. Women Deliver
164. Women of Reform Judaism
165. Women's Refugee Commission
166. Women’s Research & Education Institute
167. Woodhull Freedom Foundation
168. Young Professionals Chronic Disease Network
169. YWCA USA



RESPONSES DEUTCH

Questions for the Record from Representative Ted Deutch
Unique Challenges Women Face in Global Health
February 5, 2020

Question:

"Can you describe the present challenges with access to contraception and incidence of unsafe abortion in Uganda? Do you also see evidence of the global gag rule making the situation worse?"

Answer:

Mr. Mulumba: According the demographic health survey, Uganda continues to experience poor sexual reproductive health and rights (SRHRs) indicators with young people continuing to bear the brunt of the effect of negative SRHRs indicators including teenage pregnancies, HIV/AIDS and other STIs, morbidity and mortality -related to pregnancy among others. Indeed, Uganda's current statistics indicate a high rate of maternal deaths at 336/100,000 live births; 25% of adolescents between 15-19 have begun child bearing; 19% of women between 15-19 have given birth; 28% of married women have an unmet need for family planning with a total demand for family planning among unmarried sexually active women at 83% among others[1].

Part of the problem is the stigma and wrong information spread around Sexual Reproductive Health Services in an unfavorable light including by equating it to sexual immorality, sexual permissiveness, and as being against acceptable norms and values of society. This rhetoric has particularly taken root in Uganda as evidenced, when the government of Uganda passed into law the Anti-homosexuality Act of Uganda that sought to among others criminalize same sex relations. This was followed by a push back against and indeed leading to the stay of implementation of the Standards and Guidelines for the Reduction of Morbidity and Mortality due to unsafe abortion (S&Gs). Most recently, there has been a spate of government actions fueled by religious fundamentalist groups in either recalling or altogether banning Sexual Reproductive health and Rights policies, plans and even programs. The two most prominent events include the recalling of the National Policy Guidelines and Service Standards for Sexual Reproductive Health and Rights. One of the major reasons fronted for this is the fact that the document proposed access to contraceptives for teenagers younger than 18, an issue that was viewed contrary to Ugandan values where girls younger than 18 are not expected to have sex. The banning of the teaching of sexuality education everywhere in Uganda also marked a key manifestation of the efforts of opposition in Uganda. Specifically the Family Life Network a Key opposition group played a critical role in ensuring the ban by spreading propaganda about Comprehensive Sexuality Education being akin to sexual immorality including practices like masturbation, LGBIQ practices and sexual permissiveness. The Global Gag Rule will be a catalyst for making worse the already volatile situation for SRHRs.

[1] Uganda Demographic and Health survey 2016

Question:

"Can you speak to the confusion among civil society groups on the ground surrounding compliance with the global gag rule and the impact that has on their work?"

Answer:

Mr. Mulumba: Apart from the Global Gag Rule leading to the cutting off funding for much needed health services, especially amongst communities that are already underserved. This rule has other indirect effects like undermining coalitions and other organized groups seeking to support the development of progressive Sexual Reproductive Health and Rights Policies and Services. With some organizations signing unto the rule and others not signing, the transparency around the rule has been largely missing. As such, the organizational reflective spaces have been affected and a lot of suspicion created across the organizations. Confusion with the parameters of the rule has also continued to dominate the work of organizations, there has not been deliberate efforts at the country level to explain what the GGR means and as such, organizations continue to struggle with comprehending the rule.

Question:

"Dr. Kates, you discussed in your written testimony that in the global health space, there tends to be a gap in resources when it comes to addressing the unique needs of adolescent girls and young women—a gap that threatens the gains the international community has made in global health. The global population of adolescent girls is also expected to grow significantly over the coming decades, and you say we are not prepared to adequately address their healthcare needs.

What unique healthcare needs do adolescent girls and young women have that are not currently being met?"

Answer:

Dr. Kates did not submit a response in time for printing.

Question:

"What are the greatest areas of future concern that you see with regard to their health as the number of adolescent girls and young women expands, particularly in developing nations?"

Answer:

Dr. Kates did not submit a response in time for printing.

Question:

"How does the Administration's expansion of the global gag rule impact the accessibility of services for adolescent girls and young women?"

Answer:

Dr. Kates did not submit a response in time for printing.

Question:

"Does CARE have a team working in Yemen? Do you work with UNFPA there or rely on their supply chains?"

Answer:

Ms. Crocker: CARE does work in Yemen, where 14.3 million people are currently in need of acute humanitarian assistance. 75,000 pregnant women are at risk of developing complications due to the dire state of health services, and more than 3.25 million women of reproductive age face increased health and protection risks as conditions for women and girls continue to deteriorate.

CARE works with UNFPA regularly around the world. In Yemen, CARE is receiving clean delivery and midwifery kits from UNFPA and is collaborating with UNFPA to operate a Women and Girls Safe Space. Additionally, CARE is coordinating with UNFPA to provide livelihoods training for survivors of gender-based violence.

Question:

"In the absence of U.S. funds for operations at Zaatri Refugee Camp's maternity wards, what are the short- and long-term risks to women and girls' health at Zaatri?"

Answer:

Ms. Crocker: UNFPA's clinic in Zaatar refugee camp provides care to tens of thousands of women and newborns. In fact, the Zaatari clinic recently delivered the 12,000th birth without a single maternal death. While the U.S. no longer funds this clinic, UNFPA has ensured that its doors have stayed open and that women and girls are still able to access quality care.

Since the U.S. decision to defund UNFPA, other nations have increased their funding to the organization, but UNFPA is still $200 million short of its $536 million humanitarian appeal as of July 2019.

Question:

"If UNFPA can't be at Zaatri due to lack of funding - are there others who can easily step in to fill the gaps?"

Answer:

Ms. Crocker: It is possible that other service providers could be able to provide reproductive health services to the population of Zaatari if UNFPA were forced to cease operations. However, no single service provider has the same organizational capacity, expertise or integration within the current context that UNFPA possesses. It would be a significant loss to the population if UNFPA were to leave.

RESPONSES WAGNER

Questions for the Record from Representative Ann Wagner
Unique Challenges Women Face in Global Health
February 5, 2020

Question:

"The Protecting Life in Global Health Assistance Policy will ensure that U.S. global health policies are respectful of local populations and reflective of their beliefs, cultures, and traditions. Many African countries stand with us at the United Nations against elitist, Western-led efforts to promote abortion. Ms. Bos, how has the policy improved coordination with local governments and health systems?"

Answer:

Ms. Bos: In World Vision's experience, NGOs have long focused on coordination with local governments and health systems. This is partly out of a desire to align with the priorities of the country in which we are working, but also out of desire to ensure that programs are sustainable. For example, World Vision does a lot of work with community health volunteers, training them to do household visits that serve as a first point of contact with mothers and children. They are trained to share health messages around breastfeeding, handwashing, family planning and preventing malaria, among other things. When they see a sick child or a pregnant mother, they ensure that they go to the health facility to receive care. So these health volunteers are an extension of the local health facility and in some cases, are paid a stipend or over time are integrated into the Ministry of Health's community health worker cadres. We coordinate very closely to ensure our community health work is aligned with Ministry objectives and with what is most needed in a community, in some cases addressing gaps where the Ministry doesn't have the capacity to support certain projects.

Being respectful of local beliefs, cultures and traditions is a critical piece of global health work, which is why World Vision and many other NGOs also work with local leaders, including faith leaders and other traditional leaders. While in general we are respectful of those beliefs, there are times when traditions are actually harmful. Traditions like wife inheritance increase the spread of HIV/AIDS and female genital mutilation is devasting for the young girls subjected to the practice. So the approach we need to take is to work alongside leaders to educate them and to find alternatives to some of these practices. This requires a lot of trust, respect and listening to one another and for an NGO, building that can take time and a consistent relationship.

Question:

"The UNFPA was complicit in the tragic and highly coercive implementation of China's One and Two Child Policies, which have relied on the use of forced sterilizations and abortions as forms of population control. Under the Protecting Life in Global Health Assistance Policy, the Administration has made it clear that the United States will not support an organization that has been associated with China's dystopian population control system. Ms. Bos, what do we know about the psychological, emotional, and medical implications of forced abortions and

sterilizations on women? What is the UNFPA's current involvement in China's Two Child Policy?"

Answer:

Ms. Bos: I think you will find broad agreement that China's One Child Policy was devasting in terms of lives lost and the trauma to women and mothers who were coerced or forced into abortion or sterilization. UNFPA as well has publicly condemned the kinds of coercive practices used by China under the one-child policy. World Vision does some work currently in China, but unfortunately we don't have the expertise to speak more broadly on the impact of the current two-child policy.

Under Kemp-Kasten, the Administration has determined that UNFPA is not eligible for U.S. government funding. World Vision does not take a position on Kemp-Kasten. However, I will say that World Vision, as a pro-life organization, has partnered with UNFPA and have found their work to be critical to address maternal and child health, family planning, FGM, fistula, child marriage, gender-based sex selection, and other issues vital to improve women's health. My understanding is that UNFPA has been very transparent around their China programs and is willing to speak with any Member of Congress who has concerns, so I would refer you to them to share more about their current programming.

RESPONSES PHILIPS

Questions for the Record from Representative Dean Phillips
Unique Challenges Women Face in Global Health
February 5, 2020

Question:

"Thank you for being here today to talk about global women's health; I appreciate you taking the time to have a conversation with us on this important topic.

The United States has historically been a leader on the issue of global women's health, and many countries and organizations rely on the funds we provide to address this critical issue. However, the Trump administration does not share this committee's concern for the health of women and girls across the world. The U.S. no longer contributes to the U.N. Population Fund, an important supporter of maternal and child health that works in more than 150 countries. In addition, the President's proposed budgets would make substantial cuts to humanitarian assistance, including cuts to important efforts to eliminate HIV/AIDS.

Can you speak to the consequences of these cuts, both implemented and proposed? In this environment, humanitarian groups must face incredible uncertainty regarding their funding levels. Does this impact their ability to plan for the future or diminish the efficacy of their work on the ground?"

Answer:

Dr. Kates did not submit a response in time for printing.

Ms. Crocker: CARE is grateful to this Committee and Congress for the continued bi-partisan commitment it has shown development and humanitarian assistance. Helping those in need around the world is not, and has never been, a partisan issue. CARE is grateful that the United States has such strong champions for continuing U.S. leadership on foreign assistance on both sides of the aisle. This Congressional support has ensured that many proposed spending cuts have not been implemented.

However, challenges remain. We know that instability due to government shutdowns, threats of rescissions, and budget uncertainty has led to difficulties in planning and forecasting and has impacted programs. An analysis by our colleagues at Catholic Relief Services on the impact of programming in Sierra Leone found that this uncertainty led to premature project closures, gaps in lifesaving services, and reductions in both quality of care and the number of beneficiaries served.

We also know that policies like the Mexico City Policy and the decision to defund UNFPA have a harmful impact on women and girls around the world. Several quantitative studies have demonstrated that when previous versions of the Mexico City Policy have been in place, mothers and children suffered poorer health outcomes and reduced access to contraception and family

planning services, which has led to an increase in unsafe abortions. Further expansion of the Policy would only exacerbate its harmful effects. [1]

Mr. Mulumba: Thank you for this important question. Indeed the United States has over the years been a global champion on solidarity for improving the health of women and girls across the world. We have unfortunately in country like Uganda noted that this critical support is going down. The impacts are enormous in a country like Uganda which is arguably the largest recipients of U.S. global health assistance. The government contribution to the health budget is justly about 15% with 35% provided from foreign assistance and by non-governmental organization and the out of pocket expenditure at a high 50%. This means that communities that can't afford health care by out of pocket, they rely largely on foreign support.

It is also notable that in conflict areas, the humanitarian groups have been the single sources of health care to the affected communities and areas such as northern Uganda and the Rwenzori regions that have experiences conflict have survived on humanitarian groups. Uganda is also one of the most welcoming environments for refugees but all the funding to support these refugees is largely provided by the humanitarian groups. Over the past years, Uganda has for instance hosted over a million refugees from South Sunday and this included girls and women that have needs for their sexual reproductive health and also have to deal with sexual violence. All these are beneficiaries of the work of humanitarian groups. Therefore, by passing retrogressive policies and budgets the critical work of these groups is affected and therefore impacting on the lives of those that are most vulnerable.

Ms. Bos: Congressman Phillips, the cuts proposed by the Administration do have impact and you are correct, the uncertainty of funding is a deep concern for our programs, communities, and partners on the ground.

When it comes to foreign assistance, the cuts proposed by the Administration are unlikely to occur, but USAID still plans to that budget at the USAID Mission level. So while they know that Congress will likely restore funding to be more in line with current and historical levels, they plan for less and that often causes confusion on the ground around how to plan. In the areas where there have been actual cuts or delays in funding, both of which World Vision has faced, we have had to slow down or cut programs, which often impacts the most vulnerable beneficiaries the most – those who might rely on that program as their only source of support. And it has also broken community trust that we have spent years or even decades to build. We make commitments to these communities when we start a program. To be unable to provide them with good answers about why programs are not working as promised causes them to lose trust not only in NGOs, but in the U.S. government. This absolutely jeopardizes our ability to be effective in future programs.

We've had funding delays for some of our global health programs, but most notably, have lost funding for a program in the Northern Triangle that was focused on a model we call "Hope at Home" that provides economic and social support to families and children in some of the most violent and impoverished communities. This model has been hugely successful in helping families find ways to stay in their home communities rather than make the choice to migrate. This project was a lifeline for many, and out of thousands of program participants, only 2 decided to migrate. Without these kinds of successful

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6714436/

programs, the Administration will not achieve its goal of reducing migration to the United States from the Northern Triangle.

For most humanitarian programs, which are often funded for shorter terms than development programs, these issues have not been as concerning. But for development programs that are often 3-5 year grants, both the proposed and implemented cuts in funding are having real impact and I hope the Committee will continue to look at ways it can support strong funding and also ensure that funds are being released to the field as quickly as possible after the annual appropriations bill is completed.

Question:

"The issue of women's health is not only a global health issue, but also a national security one.

Can you please speak to the national security implications of women's health and how U.S. support for programs such as UNFPA can fit strategically into our national security objectives?"

Answer:

Ms. Crocker: As an agency that observes humanitarian principles, CARE is not well qualified to discuss the security implications of humanitarian assistance. However, it is important to note that UNFPA provides lifesaving services for women and girls in numerous humanitarian settings, many experiencing armed conflict or political instability. The decision to defund UNFPA means that the United States is no longer a partner in these critical efforts

Question:

"The world currently has the largest generation of young people ever. This presents tremendous opportunities for global development but also means that we must take action to promote the health and well-being of adolescents and youth everywhere. Yet complications during pregnancy and childbirth are the leading cause of death for adolescent girls (ages 15-19 years). Adolescents, both married and unmarried, face a range of barriers to accessing reproductive health care including lack of knowledge, stigma, and health worker bias and unwillingness to acknowledge young people's reproductive health needs.

How does the global gag rule impact communities who already face serious barriers to care, especially young people?"

Answer:

Dr. Kates did not submit a response in time for printing.

Question:

"Gender-based violence is one of the most pervasive and pernicious human rights abuses in the world today. One in three women will face physical abuse in their lifetimes, and gender-based violence affects women regardless of their socio-economic status.

You have been a strong advocate for integrated, multi-sectoral approaches to address women's health, especially with regards to HIV prevention.

Do you believe that this kind of approach would be effective in our effort to combat gender-based violence as well?

What can Congress do to help facilitate these kinds of whole-government efforts to address issues in women's health?"

Answer:

Dr. Kates did not submit a response in time for printing.

ENGEL LETTER TO POMPEO

ELIOT L. ENGEL, NEW YORK
CHAIRMAN

JASON STEINBAUM
STAFF DIRECTOR

MICHAEL T. MCCAUL, TEXAS
RANKING REPUBLICAN MEMBER

BRENDAN P. SHIELDS
REPUBLICAN STAFF DIRECTOR

One Hundred Sixteenth Congress
U.S. House of Representatives
Committee on Foreign Affairs
2170 Rayburn House Office Building
Washington, DC 20515
www.foreignaffairs.house.gov

January 22, 2020

The Honorable Mike Pompeo
Secretary
United States Department of State
2201 C Street NW
Washington, D.C. 20520

Dear Mr. Secretary:

I am deeply concerned about recent events in Iraq and the risk and legality of the use of U.S. military force in the region.

Tensions have grown following the December 29th strike against Kata'ib Hezbollah, the January 3rd killing of Qassem Soleimani in Iraq, and recent Iranian ballistic missile attacks on Iraqi bases housing American troops. Additionally, news reports indicate that the United States targeted another Iranian official in Yemen on the same day as the strike against Qassem Soleimani. To prepare for possible further escalation, the United States dispatched a brigade from the 82nd Airborne Division, a variety of ships and aircraft, and additional Marines to our embassy in Baghdad.

The risks and consequences of this escalatory pattern are very serious, and I am firmly committed to ensuring that the Trump Administration does not engage in ill-advised military action against Iran without the prior approval of Congress.[1]

No existing congressional Authorization for Use of Military Force (AUMF) can legitimately be interpreted as authorizing the strike against Qassem Soleimani or any other Iranian official. On June 28, 2019, the Department of State wrote to me that "the Administration has not, to date, interpreted either AUMF as authorizing military force against Iran, except as may be necessary to defend U.S. or partner forces engaged in counterterrorism or operations to

[1] *See U.S. to send 3,000 more troops to Middle East after embassy attack, Soleimani killing,* NBC News, January 4, 2020 (online at, https://www.nbcnews.com/news/military/u-s-sending-thousands-more-troops-mideast-after-baghdad-attack-n1110081).

establish a stable, democratic Iraq."[2] On July 16, 2019, Secretary Esper confirmed in an exchange with Senator Duckworth that neither the 2001 AUMF, which authorized the President to use force against those responsible for the 9/11 attacks, nor the 2002 AUMF, which authorized the use of force to confront the threat posed by Saddam Hussein's Iraq, authorizes the use of military force against Iran.[3] Yet, the President's National Security Advisor, Robert O'Brien, claimed on January 3 that the President's actions against Iran were "fully authorized under the 2002 AUMF."[4]

The Administration owes the American people and Congress a clear explanation of how and why it suddenly believes an 18-year-old authorization for the Iraq War can now be used to fight Iran. The Administration's initial assertion that this AUMF may provide congressional authorization for defensive action against Iran was already legally problematic. That legal theory is further undermined by the lack of evidence provided in support of the Administration's shifting and unsubstantiated claim that offensive military action was necessary to prevent an imminent attack.[5]

This is not the only example of President Trump acting with disregard for the law. On January 4th, the President indicated the U.S. may be considering striking targets "important to Iranian culture." I applaud Secretary Esper's acknowledgment that doing so would violate the laws of armed conflict.[6] As you know, targeting Iranian cultural sites would also be a war crime under U.S. law.[7] It would, thus, be an unlawful order under both domestic and international law.[8] While I appreciate Secretary Esper's public statement that the military would not follow such an order, openly contemplating and publicly signaling the intention to do so greatly undermines U.S. credibility. The fact that our national security professionals were unable to prevent the President from making such threats of illegal action raises profound and troubling questions about how decisions regarding the use of force, including those which could plunge the United States into a war, are being made in the Trump Administration.[9]

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[2] Letter from Assistant Secretary of State for Legislative Affairs Mary Elizabeth Taylor to Eliot L. Engel, Chairman, House Committee on Foreign Affairs, June 28, 2019.
[3] Testimony of Mark Esper before the Senate Armed Services Committee, July 16, 2019.
[4] *White House says Trump used Iraq War authorization to kill Qassem Soleimani*, The Washington Examiner, January 3, 2020 (online at: https://www.washingtonexaminer.com/news/white-house-says-trump-used-iraq-war-authorization-to-kill-qassem-soleimani).
[5] *Esper Says He Saw No Evidence Iran Targeted 4 Embassies, as Story Shifts Again*, The New York Times, January 12, 2020 (online at: https://www.nytimes.com/2020/01/12/us/politics/esper-iran-trump-embassies.html).
[6] *See*, e.g., 1907 Hague Conventions Respecting the Laws and Customs of War on Land, Art. 22 ("In sieges and bombardments all necessary steps must be taken to spare, as far as possible, buildings dedicated to religion, art, science, or charitable purposes, historic monuments, hospitals, and places where the sick and wounded are collected, provided they are not being used at the time for military purposes.").
[7] *See* 18 U.S. Code § 2441.
[8] *See* Uniform Code of Military Justice, 10 U.S. Code § 892 (requiring military personnel to follow lawful orders).
[9] *See Trump faces Iran crisis with fewer experienced advisers and strained relations with traditional allies,* The Washington Post, January 5, 2020 (online at: https://www.washingtonpost.com/national-security/trump-faces-iran-

As the world's leading sponsor of international terror, Iran continues to play a destabilizing role in the region. On that there is no disagreement. I share a commitment to protecting U.S. military and diplomatic personnel, as well as our allies. However, any potential military action must be based on an honest calculation of regional threats, have clear objectives and end-states in mind, and be lawful under the Constitution and War Powers Resolution.

Therefore, I request that you provide to the Committee the following no later than **Friday, January 31**:

1. A detailed explanation of the President's domestic legal authority to conduct and the lawfulness under international law of:
    a. the December 29, 2019 targeted strike operation against Kata'ib Hezbollah;
    b. the January 3, 2020 targeted strike operation against Qassem Soleimani in Iraq; and
    c. any other strikes conducted in the past 30 days targeting any Iranian officials, Iranian military forces, or other forces supported by Iran.

2. A detailed explanation of whether, and if so why, there was no "possible instance" in which the President could have consulted with Congress as required under section 3 of the War Powers Resolution prior to each strike described above.[10]

3. A detailed explanation of whether, and if so how, each strike described above complies with the United States Government's prohibition on assassinations.[11]

4. A detailed explanation of whether the United States has been in an armed conflict with Iran at any point in the past year, including:
    a. when and the conditions under which any such armed conflict started;
    b. whether any such armed conflict is ongoing and, if not, the conditions under which it ended;
    c. whether Congress was notified of any such armed conflict and, if so, when and in what manner; and
    d. a detailed explanation of the legal implications under domestic and international law of being in an armed conflict with Iran.

5. An analysis of how, in the view of the Executive Branch, the presence of ground troops, the open-ended mission and time frame, the escalatory nature of the U.S. strikes, and any

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crisis-with-fewer-experienced-advisers-and-strained-relations-with-traditional-allies/2020/01/05/9b42a240-2f1a-11ea-9b60-817cc18cf173_story.html).

[10] 50 U.S. Code § 1542.

[11] Exec. Order No. 12,333, 3 C.F.R. 200 (1981).

other relevant factors connected with striking Iran could "rise to the level of a 'war' for constitutional purposes."[12]

6. An analysis of the potential policy consequences of killing Gen. Soleimani, including but not limited to whether killing Gen. Soleimani would prevent or deter future Iranian attacks, disrupt ongoing operations against the Islamic State, increase the risk of escalation, require additional U.S. troops in the region, and increase threats to U.S. persons, facilities, and allies.

7. A detailed description of the imminent attack the U.S. sought to prevent by killing Gen. Soleimani.

8. A description of the options presented to President Trump as potential responses to protests at the U.S. Embassy in Baghdad on December 31, 2019 and January 1, 2020.

9. Any and all documents related to targeting "Iranian sites . . . important to Iran & the Iranian culture," as President Trump threatened to do on January 4, 2020.[13]

10. An analysis of how the United States views any potential or actual request by the Government of Iraq that U.S. forces leave Iraq in the wake of the killing of Qassem Soleimani, including but not limited to the legal and national security implications of such a request.

Thank you for your prompt attention to this matter.

Sincerely,

Eliot L. Engel

ELIOT L. ENGEL
Chairman

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[12] *See, e.g.*, OLC Opinion re April 2018 Airstrikes Against Syrian Chemical-Weapons Facilities (May 31, 2018) (arguing that, in the case of the 2018 Syria strikes, "Given the absence of ground troops, the limited mission and time frame, and the efforts to avoid escalation, the anticipated nature, scope, and duration of these airstrikes did not rise to the level of a 'war' for constitutional purposes").

[13] Tweet by @realDonaldTrump, January 4, 2020, 5:52 PM (online at: https://twitter.com/realDonaldTrump/status/1213593975732527112).

ENGEL LETTER TO ESPER

ELIOT L. ENGEL, NEW YORK
CHAIRMAN

JASON STEINBAUM
STAFF DIRECTOR

MICHAEL T. MCCAUL, TEXAS
RANKING REPUBLICAN MEMBER

BRENDAN P. SHIELDS
REPUBLICAN STAFF DIRECTOR

One Hundred Sixteenth Congress
U.S. House of Representatives
Committee on Foreign Affairs
2170 Rayburn House Office Building
Washington, DC 20515
www.foreignaffairs.house.gov

January 22, 2020

The Honorable Mark T. Esper
Secretary
United States Department of Defense
1000 Defense Pentagon
Washington, D.C. 20301-1000

Dear Mr. Secretary:

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Iranian official. On June 28, 2019, the Department of State wrote to me that "the Administration has not, to date, interpreted either AUMF as authorizing military force against Iran, except as may be necessary to defend U.S. or partner forces engaged in counterterrorism or operations to establish a stable, democratic Iraq."[2] On July 16, 2019, you confirmed in an exchange with Senator Duckworth that neither the 2001 AUMF, which authorized the President to use force against those responsible for the 9/11 attacks, nor the 2002 AUMF, which authorized the use of force to confront the threat posed by Saddam Hussein's Iraq, authorizes the use of military force against Iran.[3] Yet, the President's National Security Advisor, Robert O'Brien, claimed on January 3 that the President's actions in Iran were "fully authorized under the 2002 AUMF."[4]

The Administration owes the American people and Congress a clear explanation of how and why it suddenly believes an 18-year-old authorization for the Iraq War can now be used to fight Iran. The Administration's initial assertion that this AUMF may provide congressional authorization for defensive action against Iran was already legally problematic. That legal theory is further undermined by the lack of evidence provided in support of the Administration's shifting and unsubstantiated claim that offensive military action was necessary to prevent an imminent attack.[5]

This is not the only example of President Trump acting with disregard for the law. On January 4th, the President indicated the U.S. may be considering striking targets "important to Iranian culture." I applaud your acknowledgment that doing so would violate the laws of armed conflict.[6] As you know, targeting Iranian cultural sites would also be a war crime under U.S. law.[7] It would, thus, be an unlawful order under both domestic and international law.[8] While I appreciate your public statement that the military would not follow such an order, openly contemplating and publicly signaling the intention to do so greatly undermines U.S. credibility.

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[5] *Esper Says He Saw No Evidence Iran Targeted 4 Embassies, as Story Shifts Again*, The New York Times, January 12, 2020 (online at: https://www.nytimes.com/2020/01/12/us/politics/esper-iran-trump-embassies.html).
[6] *See*, e.g., 1907 Hague Conventions Respecting the Laws and Customs of War on Land, Art. 22 ("In sieges and bombardments all necessary steps must be taken to spare, as far as possible, buildings dedicated to religion, art, science, or charitable purposes, historic monuments, hospitals, and places where the sick and wounded are collected, provided they are not being used at the time for military purposes.").
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[8] *See* Uniform Code of Military Justice, 10 U.S. Code § 892 (requiring military personnel to follow lawful orders).

The fact that our national security professionals were unable to prevent the President from making such threats of illegal action raises profound and troubling questions about how decisions regarding the use of force, including those which could plunge the United States into a war, are being made in the Trump Administration.[9]

As the world's leading sponsor of international terror, Iran continues to play a destabilizing role in the region. On that, there is no disagreement, and I share a commitment to protecting U.S. military and diplomatic personnel, as well as our allies. But, any potential military action must be based on an honest calculation of regional threats, have clear objectives and end-states in mind, and be lawful under the Constitution and War Powers Resolution.

Therefore, I request that you provide to the Committee the following no later than **Friday, January 31**:

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    b. the January 3, 2020 targeted strike operation against Qassem Soleimani in Iraq; and
    c. any other strikes conducted in the past 30 days targeting any Iranian officials, Iranian military forces, or other forces supported by Iran.

2. A detailed explanation of whether, and if so why, there was no "possible instance" in which the President could have consulted with Congress as required under section 3 of the War Powers Resolution prior to each strike described above.[10]

3. A detailed explanation of whether, and if so how, each strike described above complies with the United States Government's prohibition on assassinations.[11]

4. A detailed explanation of whether the United States has been in an armed conflict with Iran at any point in the past year, including:
    a. when and the conditions under which any such armed conflict started;

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[9] *See Trump faces Iran crisis with fewer experienced advisers and strained relations with traditional allies,* The Washington Post, January 5, 2020 (online at: https://www.washingtonpost.com/national-security/trump-faces-iran-crisis-with-fewer-experienced-advisers-and-strained-relations-with-traditional-allies/2020/01/05/9b42a240-2f1a-11ea-9b60-817cc18cf173_story.html).
[10] 50 U.S. Code § 1542.
[11] Exec. Order No. 12,333, 3 C.F.R. 200 (1981).

b. whether any such armed conflict is ongoing and, if not, the conditions under which it ended;
c. whether Congress was notified of any such armed conflict and, if so, when and in what manner; and
d. a detailed explanation of the legal implications under domestic and international law of being in an armed conflict with Iran.

5. An analysis of how, in the view of the Executive Branch, the presence of ground troops, the open-ended mission and time frame, the escalatory nature of the U.S. strikes, and any other relevant factors connected with striking Iran could "rise to the level of a 'war' for constitutional purposes."[12]

6. An analysis of the potential policy consequences of killing Gen. Soleimani, including but not limited to whether killing Gen. Soleimani would prevent or deter future Iranian attacks, disrupt ongoing operations against the Islamic State, increase the risk of escalation, require additional U.S. troops in the region, and increase threats to U.S. persons, facilities, and allies.

7. A detailed description of the imminent attack the U.S. sought to prevent by killing Gen. Soleimani.

8. A description of the options presented to President Trump as potential responses to protests at the U.S. Embassy in Baghdad on December 31, 2019 and January 1, 2020.

9. Any and all documents related to targeting "Iranian sites . . . important to Iran & the Iranian culture," as President Trump threatened to do on January 4, 2020.[13]

10. An analysis of how the United States views any potential or actual request by the Government of Iraq that U.S. forces leave Iraq in the wake of the killing of Qassem Soleimani, including but not limited to the legal and national security implications of such a request.

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[12] *See, e.g.*, OLC Opinion re April 2018 Airstrikes Against Syrian Chemical-Weapons Facilities (May 31, 2018) (arguing that, in the case of the 2018 Syria strikes, "Given the absence of ground troops, the limited mission and time frame, and the efforts to avoid escalation, the anticipated nature, scope, and duration of these airstrikes did not rise to the level of a 'war' for constitutional purposes").
[13] Tweet by @realDonaldTrump, January 4, 2020, 5:52 PM (online at: https://twitter.com/realDonaldTrump/status/1213593975732527112).

Thank you for your prompt attention to this matter.

Sincerely,

Eliot L. Engel

ELIOT L. ENGEL
Chairman

INTERNATIONAL WOMEN'S HEALTH COALITION DOORLEY

IWHC

A BOLD AND INDEPENDENT VOICE FOR THE RIGHTS OF WOMEN AND GIRLS

February 5, 2020

Rep Eliot Engel, Chair
2170 Rayburn House Office Building
Washington, DC 20515

Rep. Michael McCaul, Ranking Member
2066 Rayburn House Office Building
Washington, DC 20515

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

On behalf of the International Women's Health Coalition, I submit this statement for the hearing record.

The International Women's Health Coalition (IWHC) thanks the Committee for its attention to this critical issue. IWHC has worked to protect and promote the health and human rights of women and girls globally for over 35 years. We do this work, in large part, through close, long-term partnerships with grantee organizations around the world. Local organizations are not only the most effective driver of change, they also know best what's happening in their community – their voices and experiences are critical to understanding the full impacts of US health and development policy.

Any discussion of the challenges facing women around the world must focus on the devastating impacts of the Trump Administration's anti-reproductive health policies, particularly the Protecting Life in Global Health Assistance Policy, also called the Global Gag Rule. This dangerous and discriminatory policy, as established by this Administration, prohibits foreign NGOs from receiving US global health funds if they perform, counsel, or refer patients for abortion care, or if they advocate for the liberalization of abortion laws. This rule applies to what they do with their own, non-US government funding, and it applies irrespective of national laws. The Global Gag Rule denies women health care, undermines U.S. global health investments, and forces providers to make heartbreaking choices about whether to provide women with the services they need or forgo US funding altogether.

For the past three years, IWHC has worked in partnership with local organizations in Kenya, Nepal, Nigeria, and South Africa to document the consequences of this policy. As part of this documentation project, IWHC and partners have conducted over 275 interviews with those impacted by the policy, including health care providers, members of civil society, and government officials.

With three years of data, IWHC's research clearly confirms what previous studies have found: the Global Gag Rule harms women's health. It decimates health systems, makes quality health care more difficult to access, and has lasting impacts on civil society organizations and their work.

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The policy forces providers to choose between taking critical funding for a wide range of health initiatives and providing the full spectrum of legal reproductive health care to women. As clinics lose their funding, contraception, maternity care, and care for cancer and HIV, among other critical services, become out of reach. These impacts fall disproportionately on the most vulnerable and marginalized.

To date, IWHC's documentation project has detailed a number of key findings:

1) **The policy is harmful to the health and well-being of women, young people, and marginalized communities, such as LGBTQI, rural, poor, and religious minority communities.** The policy is making health services less accessible, affecting not only comprehensive abortion care, post-abortion care, and contraceptive services but also other sexual and reproductive health and related services, including HIV/AIDS testing and treatment, antenatal care, screening for cervical cancer, breast cancer, prostate cancer, and support for survivors of gender-based violence.

   IWHC's documentation project demonstrates how a loss of funding has forced health services to retrench staff, close clinics and reduce community outreach. These impacts affect all women in a community, but they have particularly severe consequences for already marginalized groups. IWHC's research has emphasized that young people, LGBTQI individuals, poor women and girls, and other groups already facing barriers to health care are disproportionately affected by clinic closures.

   Across multiple countries, our research has documented how the policy is also impacting services for survivors of gender-based violence (GBV). While the policy permits abortion-related services in cases of rape, incest, or life endangerment, interviews conducted as part of this project consistently showed that this distinction is poorly understood in the field. In practice, service providers over-implement the policy. For example, in Nigeria, IWHC's partners have recently documented how prime recipients of US funds are forcing government-run sexual assault referral centers to sign the policy but failing to provide without proper information or training about its implementation. Even if not over-implemented, the policy itself has serious implications on GBV programming: for example, in South Africa, IWHC has documented that organizations that specialize in providing integrated services for survivors of gender-based violence are losing funding and closing as a result of the Global Gag Rule, creating significant gaps in quality services and making it harder for survivors to access care.

2) **The policy is creating funding shortfalls, causing the fragmentation of health services, and halting critical health programs, including those strengthening the delivery of government services.**
   IWHC's research has consistently found that NGOs play critical roles in ensuring the health of communities not only through direct service provision, but also by providing technical and financial assistance to governments, building capacity

among health workers, and strengthening health systems. The Global Gag Rule has increasingly created gaps that can be difficult and time-intensive, if not impossible, to fill.

In the most recent phase of documentation, we have found increasing instances where US policy and funding creates a barrier for national governments seeking to meet their own health objectives. In Nepal, where the government has committed to improving sexual and reproductive health access, the Global Gag Rule and a loss of funding and partnerships for civil society organizations has meant that the government has, in turn, increasingly struggled to find effective implementing partners in pursuit of its stated health goals. By making it harder for governments to meet their obligations to their own citizens, the Global Gag Rule is infringing upon the sovereignty of other countries.

In addition, our research demonstrates that the policy is causing a loss of skilled professionals in sexual and reproductive health fields, a deficit that will have long-lasting repercussions. In the most recent phase our research, our interviews uncovered increasing evidence suggesting that the loss of funding for reproductive health care, coupled with growing stigma driven by US policy may be driving skilled professionals and students into other fields, creating a gap that will be felt long after the policy was ended. Across multiple countries, we have documented growing concerns about a reduced number of providers of sexual and reproductive health services, the interruption of training programs for health care providers, and a growing inability to meet demand for reproductive health services.

A further long-term concern is the policy's effect on health systems, and specifically the splintering of integrated health services, which has been well documented by IWHC and by others. Despite years of investment by the US and other global health donors in a health care delivery model where people can access multiple services for patients in a single location, the Global Gag Rule – a policy that targets one specific health service – is causing breakdowns in integrated health systems. In practice, the policy is driving wedges between sexual and reproductive health providers and other health services, a division that is perhaps most acutely felt in the HIV care, treatment, and prevention fields.

3) **The policy is harming civil society work and collaboration by burdening organizations, shrinking civil society spaces, silencing voices, and creating distrust.**

The burden of implementing and monitoring the requirements of the policy bears heavily on organizations that have implement and closely monitor compliance. Organizations that sign the policy report being forced to restructure, re-train staff, and re-write manuals and informational materials; in addition, they face increased internal monitoring and compliance measures.

Further, the policy is fracturing partnerships and coalitions and limiting civil society's ability to work together effectively, hindering their ability to do work ranging from service provision to advocacy and holding governments accountable. Due to the so-called "chilling effect" that it creates, the policy has opened up new divisions in civil society organizations, particularly between organizations that are gag compliant and those that are not; it has also reinforced existing silos between sexual and reproductive health and other sectors. IWHC's research has documented cases where the exit of organizations that lose US funding leave gaps in expertise on technical working groups. In addition, the growing competition for increasing scarcity of resources is leading to further breakdown in longstanding civil society partnerships.

This civil society fracturing has very immediate impacts on the quality of services available to local communities and the ability of civil society organizations to carry out their work. In many cases, organizations that sign the policy and lose sub-grantee partners because those organizations opt not to sign, report that finding new, qualified partners can be challenging and time consuming, and, in some cases, impossible.

4) **Confusion and misunderstanding about the policy are still common among key stakeholders.**

Three years into implementation of the Global Gag Rule, IWHC continues to document widespread misunderstanding, lack of clarity, and confusion around the policy. Stakeholders, including leaders of organizations receiving US global health funding, reported a lack of knowledge about the policy's specifics, a dearth of training from both US agencies and prime implementers, and a lack of awareness about the policy's limits and exceptions.

IWHC's documentation has found that implementers often interpret the policy as being broader than it is; in particular, organizations reported little awareness that the policy allows for the provision of post-abortion care or referrals for services in cases of rape and incest. Specifically, across all four countries, several organization receiving US global health funding interpreted the policy as allowing "absolutely no opportunity" for providing any information, service, or referral relating to abortion. Even when prompted, many organizations did not or could not explain that the policy does not apply to abortion in cases of rape, incest, and when the woman's life is in danger, and that it allows for post-abortion care.

This lack of awareness and understanding is amplified by widespread fear about being found to be in violation of the policy. Organizations report avoiding of any areas of work that may be considered risky, even when permitted by the policy. The confusion and fear combine to create further barriers to health care for women.

These findings, together, paint a picture of ever-increasing and extremely serious consequences of a bad US policy. Across all four countries, throughout three years of

research, IWHC has heard countless examples of how this policy is impacting individual communities and providers. Perhaps nowhere are the consequences of the policy more apparent than in Western Kenya, where the Kisumu Medical and Education Trust (KMET), an IWHC partner organization, faced a devastating choice about whether or not to sign the policy. The Global Gag Rule put KMET in an untenable position: forgo US funding and scale back medical services and close clinics or cease to offer rural Kenyan women the full range of reproductive health services to which they're legally entitled. Whichever option KMET chose, Kenyan women would lose options, and would suffer health consequences.

KMET is far from alone. Another Kenyan organization eliminated their community outreach programs due to loss of funding under the policy, a change that meant many patients could now no longer seek health care. An organization in Nigeria is no longer able to provide free contraception, meaning that, in a country where over half the population lives below the poverty line, the cost was now prohibitive for many people. In Nepal, a long-term project focused on strengthening health systems to deliver family planning services in remote areas, was forced to end early - because the only two organizations capable of implementing this project could not sign the policy. The evidence clearly indicates that, as long as the Protecting Life in Global Health Assistance/Global Gag Rule policy is in place, United States policy is making it harder for women around the world to access quality health care.

As the Committee examines challenges to women's health globally, IWHC strongly urges Members to consider the evidence around the devastating impacts of this policy, and to pursue a permanent legislative solution to ending it. The Global HER Act (HR 1055) would permanently end the Global Gag Rule and ensure that facts and best practices, rather than ideology, drive US funding decisions. The Global HER Act would make sure that organizations cannot be disqualified from receiving US funding because they provide legal abortion services with their own, non-US government funding. IWHC strongly supports this legislation and urges the Committee to advance this important bill.

The full findings from the first two years of our documentation project are available on our website, IWHC.org, and the report from the third year will be released in the coming months. For additional information, please contact Nina Besser Doorley at nbesser@iwhc.org.

Thank you for your attention to this important issue.

Sincerely,

Nina Besser Doorley
Associate Director of Advocacy and Policy
International Women's Health Coalition

بیانیه جدید سپاه در پی شهادت سپهبد سلیمانی: انتقام سخت خونهای به‌ناحق ریخته‌شده را می‌گیریم

سپاه پاسداران در بیانیه‌ای با تبریک و تسلیت شهادت سپهبد شهید قاسم سلیمانی و شهدای جنایت اخیر آمریکایی‌ها در بغداد، بر تداوم راه این شهید والامقام و انتقام سخت خونهای به‌ناحق ریخته‌شده از جنایتکاران تأکید کرد.

۱۳ دی ۱۳۹۸ - ۱۴:۲۶ | سیاسی | نظامی ا دفاعی ا امنیتی |

به گزارش گروه دفاعی خبرگزاری تسنیم، سپاه پاسداران انقلاب اسلامی در بیانیه‌ای با تبریک و تسلیت شهادت سپهبد شهید حاج قاسم سلیمانی و شهدای جنایت اخیر آمریکایی‌ها در بغداد، بر تداوم راه این شهید والامقام و انتقام سخت ازجنایتکاران تاکید و تصریح کرده است: سردار سلیمانی نه تنها یک شخص، بلکه باور و مکتبی تمام نشدنی است و از این پس جلوه‌گری‌های معنادارتر آن را در جغرافیای سلطه و حضور نامشروع و اشغالگرانه خود در اقصی نقاط عالم تجربه خواهند کرد .

متن بیانیه سپاه به این شرح است:

بسم الله الرحمن الرحیم

با گذشت 41 سال از پیروزی انقلاب شکوهمند اسلامی برغم توطئه‌ها، فتنه آفرینی‌ها، بحران سازی‌ها، نیرنگ‌ها، ترفندها و عملیاتی کردن پروژه‌های متعدد جبهه دشمن به ویژه رژیم جنایتکار و تروریستی ایالات متحده امریکا علیه جمهوری اسلامی و ملت ایران ، از جمله طراحی و اجرای جنگ‌های نیابتی و تروریسم تکفیری و هدف قرار دادن فرماندهان و رزمندگان غیور و فداکار جبهه مقاومت ، انقلاب اسلامی و ملت عظیم الشان ایران و جریان مقاومت اسلامی پر فروغ تر و پویا تر از هر مقطع تاریخی به سمت آرمان‌های بلند تمدن‌ساز خود پیش می رود و دشمنان را مبهوت عظمت و اقتدار خود می‌سازد.

در شرایطی که دشمنان متکثر و خبیث امت اسلامی با شکست‌های پی‌درپی و زنجیره‌ای در منطقه راهبردی غرب آسیا، ناامید و مستاصل در پی ارتکاب هر جنایت و توطئه‌ای برای نجات از باتلاق خود ساخته هستند، در بامداد امروز جمعه (13 دیماه 98)جهان بشریت از جمله امت اسلامی شاهد جنایت حمله هوایی نیروهای متجاوز و تروریستی امریکا به خودروی حامل سردار حاج قاسم سلیمانی، همراهان و جمعی از فرماندهان حشدالشعبی عراق از جمله مجاهد بزرگ ابومهدی المهندس- که برای برنامه ریزی مقابله با توطئه جدید آمریکایی‌ها در احیای داعش و گروهک‌های تکفیری و برهم زدن مجدد امنیت عراق، در حال عزیمت به مقر مورد نظر بودند_ و شهادت افتخارآمیز آنان بود.

به فضل الهی شهادت سرباز ولایت و امت اسلامی، حاج قاسم سلیمانی و دیگر فرزندان تربیت یافته در مکتب ولایت فقیه و مقاومت اسلامی ،بر خلاف نیت و غایت این اقدام شوم ،فصل نوین و گشاینده جبهه های جدیدی در روند مقاومت ضد صهیونیستی و مقابله با تروریست‌های متجاوز و اشغالگر امریکایی در منطقه خواهد شد.

این سردار محبوب و مجاهد نستوه، فرمانده مقتدر و سرباز پاکباخته ولایت و عاشق امت اسلامی و ملت ایران، عمر پر برکت خود را در مسیر اعتلای اسلام عزیز و پاسداری از حریم قرآن و عترت و دفاع از امنیت ، منافع و مصالح ملی سپری کرد و به عنوان مصداق جامع و کامل "مجاهد فی سبیل الله" ، نقش‌آفرینی‌های افتخار آمیز و ماندگاری در این صراط مستقیم برای همیشه این سرزمین به ودیعت نهاد تا

الهام‌بخش نسل‌های امروز و فردای جامعه اسلامی قرار گیرد.

سپاه پاسداران انقلاب اسلامی به ولی امر مسلمین، آحاد امت اسلامی بویژه ملت شهید پرور و حماسه ساز ایران و رزمندگان جبهه مقاومت اسلامی و ضد صهیونیستی منطقه اطمینان می‌دهد با انتقام سخت خون های پاک و به ناحق ریخته شده این شهیدان والامقام از جنایتکاران، راه سپهبد شهید حاج قاسم سلیمانی توسط همرزمان آن عزیز در این نهاد انقلابی و مردمی با قوت بیشتری ادامه خواهد یافت و جبهه مقاومت اسلامی نیز مصمم تر از گذشته آرمان‌های بلند او را دنبال خواهد کرد و به دشمنان امت اسلامی به ویژه دولت شرور و تروریست پرور آمریکا و رژیم جعلی و منفور صهیونیستی یادآوری می‌کند: سردار سلیمانی نه تنها یک شخص، بلکه باور و مکتبی تمام نشدنی است و از این پس جلوه‌گری های معنادارتر آن را در جغرافیای سلطه و حضور نامشروع و اشغالگرانه خود در اقصی نقاط عالم تجربه خواهند کرد .

به ارواح تابناک این شهیدان گرانقدر و تاریخ‌ساز درود می‌فرستیم و با عرض تبریک و تسلیت به پیشگاه مقدس حضرت بقیه الله الاعظم (روحی له الفدا) و نایب بر حقش مقام معظم رهبری و فرماندهی کل قوا حضرت امام خامنه‌ای(مدظله العالی)، آحاد امت اسلامی و خانواده‌های معظم و سرافراز آنان، از اقشار مختلف ملت قدر شناس و فهیم ایران اسلامی برای حضور حماسی و باشکوه در آیین‌های استقبال، تشییع، خاکسپاری و تکریم و ترحیم سپهبد شهید حاج قاسم سلیمانی و دیگر شهدای جنایت اخیر آمریکایی‌ها در بغداد، که متعاقباً اعلام خواهد شد، دعوت به عمل می‌آید.

سپاه پاسداران انقلاب اسلامی

13 دی ماه 1398

انتهای پیام/

sTANFORD LETTER

Stanford | CHP/PCOR Center for Health Policy/Center for Primary Care and Outcomes Research FSI Freeman Spogli Institute for International Studies

February 5, 2020

Rep Eliot Engel, Chair
2170 Rayburn House Office Building
Washington, DC 20515

Rep. Michael McCaul, Ranking Member
2066 Rayburn House Office Building
Washington, DC 20515

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

We submit the enclosed memo based on findings from our publication "USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy" for the hearing record.

The key takeaways from our research, summarized below, are relevant to any discussion on the impact of US international policy on women's health:

- The Mexico City Policy has led to increases in abortion in a range of sub-Saharan African countries.
- These findings are based on an analysis of contraception, pregnancy, and abortion trends across the Clinton, Bush and Obama administrations.
- In countries that depend heavily on U.S. support for family planning and reproductive health programs, contraceptive use decreased 14 percent, pregnancies rose 12 percent, and abortions climbed 40 percent when the policy was in effect relative to countries less reliant on U.S. support.
- The evidence suggests that the policy leads to a reduction in contraceptive use and increased pregnancies and abortions.

The full publication can be found online with the Lancet Global Health and the original version of the enclosed policy brief can be found online at the Stanford Institute for Economic Policy Research (SIEPR).

Sincerely,

Nina Brooks
PhD Candidate
Stanford University

Eran Bendavid
Associate Professor of Medicine
Stanford University

Grant Miller
Associate Professor of Medicine
Senior Fellow, SIEPR
Stanford Univeristy

POLICY BRIEF | SEPTEMBER, 2019

Stanford | Institute for Economic Policy Research (SIEPR)

How US government restrictions on foreign aid for abortion services backfired

By Grant Miller, Eran Bendavid and Nina Brooks

KEY TAKEAWAYS

- The Mexico City Policy has led to increases in abortion in a range of sub-Saharan African countries.
- Those findings are based on an analysis of contraception, pregnancy, and abortion trends across the Clinton, Bush and Obama administrations.
- In countries that depend heavily on U.S. support for family planning and reproductive health programs, contraceptive use decreased 14 percent, pregnancies rose 12 percent, and abortions climbed 40 percent when the policy was in effect relative to countries less reliant on U.S. support.
- The evidence suggests that the policy leads to a reduction in contraceptive use and increased pregnancies and abortions.

Abortion is an issue that stirs up deeply felt passions and seems to offer little basis for compromise. But there is one thing that both sides of the debate agree on — fewer abortions are better. The pro-life side opposes abortion in principle, while pro-choice advocates generally hold that preventing unwanted pregnancies is preferable to terminating them.

That shared outlook could provide common ground on one of the most important federal initiatives concerning abortion — the Mexico City Policy. This executive order, announced in 1984 by the Reagan administration at the United Nations International Conference on Population and Development, requires all foreign nongovernmental organizations that get U.S. family planning assistance to certify they will not perform abortions or provide counseling about the procedure.

The Trump administration has greatly expanded the policy to condition almost all U.S. global health aid on compliance with these restrictions, including HIV, malaria, and maternal and child health programs. The U.S. spent more than $7 billion on international health assistance in 2017.

We recently published research (Brooks, Bendavid, and Miller 2019) indicating that, rather than reducing abortion, the Mexico City Policy has had the unintended effect of significantly raising abortion rates in a set of African countries that rely heavily on U.S. family planning and reproductive health aid. Many of these abortions are likely to have been performed unsafely, endangering the health of women who had them, previous studies of abortion indicate (Grimes, et al 2006).

Why would abortions go up under a policy that bans promoting the procedure? We found strong evidence that, when the policy was in force from 2001 to 2009, contraceptive use dropped in countries more reliant on U.S. aid and was accompanied by increases in pregnancies and abortions.

That is not surprising. International organizations that offer abortion counseling, such as the International Planned Parenthood Federation, are also major suppliers of contraceptives and family planning information. Their decision to continue offering abortion information made them ineligible for U.S. funding, which forced them to scale back a broad range of family planning services. Our research suggests that cutbacks such as these are driving the higher pregnancy and abortion rates we find.

Groups opposed to abortion and those that believe it is a woman's right to choose do not agree on much, but they may share the view that the jump in abortion rates associated with the Mexico City Policy is a significant problem.

Shifting policy offers natural test of Mexico City Policy effects

Only a few studies have rigorously examined the Mexico City Policy's impact (Bendavid, Avila, and Miller 2011; Jones 2015). Our research stands out for the long period of time and large number of countries we examined. In addition, we took advantage of a peculiar feature of the Mexico City Policy — it has alternately been imposed and lifted by successive Republican and Democratic administrations. We looked at trends in contraception use, pregnancy, and abortion in 26 sub-Saharan African countries[1] from 1995 to 2014 during the presidencies of Bill Clinton, who rescinded the policy; George W. Bush, who reinstated it in January 2001; and Barack Obama, who overturned it again in January 2009.

As a result, the organizations that were the most important providers of family planning and reproductive health services in the countries we studied lost U.S. funding when George W. Bush was in the White House, a gap other donors did not fill. Funding resumed under President Obama. This stop-and-start pattern serves as a natural experiment testing what happens to abortion when the policy is in place and when it is no longer in effect.

Our main data source for abortions and pregnancies was Demographic and Health Surveys (DHS), funded by the U.S. Agency for International Development. Information on contraception came from the United Nations Population Division's World Contraceptive Use dataset.[2] We obtained data on U.S. family planning and reproductive health aid by country and year from the Organization for Economic Cooperation and Development and also used the World Bank's World Development Indicator for data on a range of economic and demographic variables. In total, we examined data on pregnancies and abortions for nearly 750,000 women.

In our statistical analysis, we separated countries into those with relatively high or low exposure to the Mexico City Policy, which was a measure of how much countries relied on U.S. family planning assistance, when the Mexico City Policy's funding restrictions were not in place. We then compared rates of contraception use, pregnancy, and abortion in high- and low-exposure countries when the policy was in effect and when it was not.

The results were striking. In the highly exposed countries, contraceptive use was 14 percent lower, while pregnancies and abortions were, respectively, 12 percent and 40 percent higher when the policy was in force during the George W. Bush administration compared with the rates during the Clinton and Obama presidencies. Simply put, when the Mexico City Policy was active, there was less contraception and more pregnancy and abortion. When the policy was voided and family planning aid restored, those trends reversed.

1 Benin, Burkina Faso, Burundi, Comoros, Eswatini, Ethiopia, The Gambia, Ghana, Guinea, Kenya, Liberia, Lesotho, Madagascar, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Tanzania, Uganda, Zambia, Zimbabwe

2 We focused on modern methods of contraception, defined as female and male sterilization, oral hormonal pills, the intra-uterine device, the male condom, injectables, implantables, vaginal barrier methods, the female condom, and emergency contraception.

Could other factors account for more abortions?

An obvious question is whether something besides the Mexico City Policy might explain the abortion ups and downs that we found. Our investigation was not a randomized trial in which variables can be carefully controlled. In a statistical study like ours, there is always a chance that some unobserved factor may drive the results.

Nevertheless, we are confident that our interpretation of the Mexico City Policy's effects — that abortion and pregnancy rates varied depending on access to contraception — is correct. Any confounding factor would have to vary systematically both with the sharp off-again, on-again pattern of the policy and with the degree to which family planning programs in each African country benefits from U.S. assistance — an unlikely scenario.

There could also be natural concerns about abortion reporting. Consider two related potential issues. First, abortions are notoriously difficult to measure, largely because many are illicit and women are uncomfortable reporting these. In particular, the DHS survey data is widely considered to underreport abortions. In addition, it can be hard to distinguish induced abortions from spontaneous abortions in the DHS data.

However, as with any other potential confounder, underreporting would have to vary with the sharp off-again, on-again pattern of the policy and also with the degree to which family planning programs in each African country benefit from U.S. assistance. We conducted extensive simulations to determine the extent to which underreporting of abortion could have influenced our findings and ultimately concluded that although underreporting is present, it did not meaningfully bias our study's results.

Second, the Mexico City Policy could have made women more reluctant than usual to report if it altered in some fashion the legal or cultural environment for abortion. Because our abortion data is reported by individual women rather than governments or private organizations, this seems less likely. But importantly, if there were selective incentives for abortion reporting under the policy, the most likely scenario would be relatively less reporting of abortions when the policy was active and in countries benefiting more from U.S. aid. If present, this would therefore lead us to *underestimate* the unintended consequences of the Mexico City Policy that we find — or the true extent of the rise in abortions when the policy was in effect would be greater than our analysis suggests.

Our research did not look at the effects on women's health of the changes in contraceptive use, pregnancies, and abortions under the Mexico City Policy, but it is reasonable to believe that maternal deaths and injuries have risen, perhaps significantly. Abortion incurs risk, and more abortions are likely to drive up mortality rates. Beyond that, to the extent that international organizations are forced to cut back family planning services, more abortions are probably performed under unsafe conditions, putting women in greater danger.

This study, unprecedented in scope, strengthens the case that making family planning services and contraception more widely available is an effective way to reduce abortion. From that perspective, the Mexico City Policy does exactly the opposite of what is needed to prevent the unwanted pregnancies that prompt many women to seek abortions.

In this regard, it seems possible that everyone could agree that a policy designed to curb abortion but winds up increasing it is a failure.

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Nina Brooks is a PhD student in environment and resources, obtaining a joint MA in economics. Her research explores the social and environmental determinants of population health.

Sam Zuckerman contributed editorial assistance to this policy brief.

CHANGE LETTER

CHANGE Sexual & reproductive health & rights for all.

February 5, 2020

The Honorable Eliot Engel, Chair
The U.S. House of Representatives Committee on Foreign Affairs

The Honorable Michael McCaul, Ranking Member
The U.S. House of Representatives Committee on Foreign Affairs

RE: Committee Hearing on the *Unique Challenges Women Face in Global Health*- February 5, 2020

On behalf of CHANGE (the Center for Health and Gender Equity) and our supporters, we submit this statement for the record.

CHANGE is a U.S.-based nongovernmental organization that promotes sexual and reproductive health and rights as a means to achieve gender equality and empowerment of all women and girls, by shaping public discourse, elevating women's voices, and influencing U.S. and global policies. We are guided by our vision of a world that respects, protects, and honors sexual and reproductive rights for all. Our four-pronged impact model—advocacy, research, partnerships, and communications—is grounded in and driven by a human rights framework at the intersection of multiple sectors including women's rights, human rights, family planning, maternal health, HIV and AIDS, and gender-based violence.

We thank the House Committee on Foreign Affairs for holding today's hearing on the challenges faced by women in global health, the first hearing on this subject in over a decade. As documented by decades of research, one of the major challenges to the health and wellbeing of women and girls across the globe is the Mexico City Policy (MCP), also known as the Global Gag Rule (GGR). In the years since its introduction in 1984 by President Ronald Reagan, the GGR has been instituted and removed by presidential memoranda along party lines and, most recently, renamed Protecting Life in Global Health Assistance (PLGHA) and expanded by the Trump administration to apply to all global health assistance- impacting nearly fifteen times the amount of funding previously impacted.[1]

PLGHA is a barrier to the provision of critical health services around the globe and undercuts the intent of U.S. global health investments. The U.S. government is the leading donor of global health assistance and these funds sustain vital programs that improve the health and lives of people, as well as health systems.[2] As a result, PLGHA restrictions have wide-ranging implications in recipient countries and in the international arena. The policy has been detrimental for public health worldwide, particularly in the areas of family planning (FP), HIV and AIDS, maternal and child

[1] The Mexico City Policy, 82 Fed. Reg. 8495 (Jan. 23, 2017).
[2] KAISER FAMILY FOUNDATION, THE U.S. GOVERNMENT AND GLOBAL HEALTH 1 (January 2019), *available at* http://files.kff.org/attachment/fact-sheet-The-US-Government-and-Global-Health

health, and gender-based violence (GBV).[3] The policy has had severe negative impacts on the health and well-being of key populations such as LGBTQI+ individuals, sex workers, and adolescent girls and young women globally.[4]

A full literature review of the impacts of the MCP during the Bush administration was published in the journal Global Health Research & Policy in August 2019.[5] It includes the data on loss of contraceptives, negative maternal and child health outcomes, and an increase in abortion.[6]

Expansions and Unmonitored Consequences

In addition to the expansive PLGHA introduced by then Secretary Tillerson in May 2017, on March 26, 2019 Secretary of State Pompeo gave a press conference in which he announced an additional expansion of the policy to extend to all the money sub-granted by non-U.S. NGOs, not just U.S.-funded projects.[7]

This announcement, and the subsequent guidance and Standard Provisions released in May 2019, reversed a clarification in the State Department's 6 month review regarding the meaning of "financial support" for foreign organizations that receive U.S. global health assistance.[8] The Pompeo Expansion will have an enormous impact on funds from other donors, including other bilateral donors, private foundations, and multi-laterals who fund organizations who also receive U.S. global health assistance.[9] The implications, on both health outcomes and donor efficiency and coordination, have not been addressed by the State Department.

The extraordinary scope of the policy also creates new conflicts with the constitutions, laws, and medical guidelines of countries that receive global health assistance. This incompatibility between U.S. ideological policy and the national laws and protections governing vulnerable health systems and providers is driven, unmonitored, by the Administration, and forces implementers and health care providers into the midst of practical, legal, and ethical conflicts.

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[3] CHANGE, *PRESCRIBING CHAOS IN GLOBAL HEALTH: THE GGR FROM 1984-2018* 5 (June 2018), *available at* http://www.genderhealth.org/files/uploads/change/publications/Prescribing_Chaos_in_Global_Health_full_report.pdf [hereinafter CHANGE, PRESCRIBING CHAOS].

[4] GLOBAL FUND FOR WOMEN, *Infographic: How does the GGR affect women?*, *available at* https://www.globalfundforwomen.org/infographic-global-gag-rule/; *see also* CHANGE, PRESCRIBING CHAOS, *supra* note 3, at 41-48.

[5] Constancia Mavodza, Rebecca Goldman, & Bergen Cooper, *The impacts of the global gag rule on global health: a scoping review*, 4 Global Health Research & Pol. 26 (2019). Available at https://doi.org/10.1186/s41256-019-0113-3

[6] Eran Bendavid, Patrick Avila & Grant Miller, *United States aid policy and induced abortion in sub-Saharan Africa,* Bulletin of the World Health Organization 2011;89:873-880C. doi: 10.2471/BLT.11.091660, available at https://www.who.int/bulletin/volumes/89/12/11-091660/en/; *see also* Nina Brooks, Eran Bendavid & Grant Miller, *USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy*, 7 Lancet Global Health e1046–53 (2019), *available at* https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(19)30267-0.pdf

[7] Mike Pompeo, Remarks to the Press, (March 26, 2019) *available at* https://www.state.gov/remarks-to-the-press-7/

[8] United States Agency for International Development (USAID), Standard Provisions for Non-U.S. Nongovernmental Organizations: A Mandatory Reference for ADS Chapter 303 85 (2019), available at https://www.usaid.gov/sites/default/files/documents/1868/303mab.pdf. [hereinafter USAID, Standard Provisions].

[9] amfAR, *The Expanded Mexico City Policy: Implications for the Global Fund* (Nov. 2019) *available at* https://www.amfar.org/uploadedFiles/_amfarorg/Articles/On_The_Hill/2019/issuebrief-globalfund.pdf

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The Impact of the Trump Administration's PLGHA Policy

Three years into the implementation of Trump's PLGHA, there is already evidence of widespread harm caused by the expansion. Research conducted by multiple organizations suggests that Trump's PLGHA will increase unsafe abortion, maternal mortality, unintended pregnancies, and HIV infections, and will harm women and girls' empowerment efforts around the world.[10] While many of the impacted areas are similar to those affected in past iterations of the MCP, the scope of the harm of Trump's PLGHA is likely to be broader because the policy applied to *all* global health assistance partners. A 2018 CHANGE report, "Prescribing Chaos in Global Health: The GGR from 1984-2018," anticipates that Trump's PLGHA will affect a broader range of health areas than ever before, such as nutrition, malaria, tuberculosis, and GBV, which are all subject to the policy.[11]

1. Trump's PLGHA directly impacts HIV and AIDS

   Trump's PLGHA now explicitly includes PEPFAR funding which supports HIV and AIDS programs in more than 50 countries.[12] CHANGE's report includes findings from HIV and AIDS programs in Mozambique and Zimbabwe, and reveals that in both countries, Trump's PLGHA is hampering efforts to reduce HIV. In Zimbabwe, one PEPFAR DREAMS implementing organization, Roots, lost funding due to PLGHA, leaving young women without access to SRHR information and left out of economic and enrichment activities.[13] In Mozambique, the Mozambican Association for Family Development

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[10] CHANGE, PRESCRIBING CHAOS, *supra* note 3; *see* PAI, ACCESS DENIED: SENEGAL PRELIMINARY IMPACTS OF TRUMP'S EXPANDED GGR (Nov. 2018), *available at* https://pai.org/wp-content/uploads/2018/12/Access-Denied-Senegal.pdf; *see also* PAI, ACCESS DENIED: NEPAL PRELIMINARY IMPACTS OF TRUMP'S EXPANDED GGR (Sept. 2018), *available at* https://pai.org/wp-content/uploads/2018/09/Access-Denied-Nepal-Brochure-V6.pdf; *see also* PAI, ACCESS DENIED: ETHIOPIA PRELIMINARY IMPACTS OF TRUMP'S EXPANDED GGR (July 2018), *available at* https://pai.org/wp-content/uploads/2018/07/Access-Denied-Ethiopia-JULY-2018.pdf; *see also* PAI, ACCESS DENIED: NIGERIA PRELIMINARY IMPACTS OF TRUMP'S EXPANDED GGR (Mar. 2018), *available at* https://pai.org/wp-content/uploads/2018/03/Access-Denied-Nigeria-2.pdf; *see also* PAI, ACCESS DENIED: UGANDA PRELIMINARY IMPACTS OF TRUMP'S EXPANDED GGR (Mar. 2018), *available at* https://pai.org/wp-content/uploads/2018/03/Access-Denied_Uganda_March-2018.pdf; *see also* PAI, *With the Stroke of the Pen- Trump's GGR Dramatically Expands Harmful Health Impacts* (Jan. 26, 2017), *available at* https://pai.org/newsletters/stroke-pen-trumps-global-gag-rule-dramatically-expands-harmful-health-impacts/; *see also:* International Women's Health Coalition (IWHC), *Crisis in Care: Year Two Impact of Trump's Global Gag Rule* 34-35 (2019), *available at* https://iwhc.org/wp-content/uploads/2019/06/IWHC_GGR_Report_2019-WEB_single_pg.pdf [hereinafter IWHC, Crisis in Care]; WaterAid & PAI, *How the Expanded Global Gag Rule Affects Water, Sanitation and Hygiene (WASH)* 4 (2019), *available at* https://pai.org/wpcontent/uploads/2019/06/PAI-3285-PAI-and-Wateraid-FINAL.pdf.

[11] CHANGE, PRESCRIBING CHAOS, *supra* note 3, at 53-54, 56.

[12] PEPFAR, WHERE WE WORK, *available at* https://www.state.gov/where-we-work-pepfar/

[13] CHANGE, PRESCRIBING CHAOS, *supra* note 3, at 44-45; *see generally* PEPFAR, DREAMS PARTNERSHIP, *available at* https://www.state.gov/wp-content/uploads/2020/01/DREAMS-Partnership-Fact-Sheet_WAD_2019.pdf *(DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) is a public-private partnership between PEPFAR, the Bill & Melinda Gates Foundation, Girl Effect (formerly the Nike Foundation), Johnson & Johnson, Gilead Sciences, and ViiV Healthcare to reduce HIV infections by 40% among adolescent girls and young women (AGYW) in sub-Saharan Africa within two years of its launch in 2014. According to 2019 data, DREAMS reached over 1.5 million AGYW with a core package of comprehensive HIV prevention interventions to address the facts that make AGYW vulnerable to HIV acquisition.)*

(AMODEFA), the International Planned Parenthood Federation (IPPF) affiliate, also discontinued a DREAMS initiative as a result of PLGHA, laying off almost 90 percent of their community health workers in their clinic in the Xai-Xai district.[14] AMODEFA has closed 10 of its 20 youth-friendly clinics around the country, terminated 30 percent of its staff, and lost over 500 community health workers that worked on HIV prevention for adolescent girls and young women in one rural clinic due to PLGHA.[15]

Trump's PLGHA increases the risk of the de-integration of FP and HIV services. Organizations report having to make a choice between continuing to provide comprehensive SRH information and services or to accept U.S. global health assistance funding, which restricts their services and programs.[16] The de-integration of FP and HIV services can lead to decreased access to FP services, especially for women living with HIV who are more likely to use modern contraception while accessing integrated services.[17]

Since the implementation of PLGHA, one-third of 286 prime PEPFAR implementing partners (IPs) surveyed by amfAR have reduced their HIV prevention and treatment services with widespread closures of HIV prevention and treatment outreach services for youth and clinical HIV treatment services for rural communities.[18] Current PEPFAR IPs across 31 countries are unable to share comprehensive SRH information, including information about safe abortion services and pregnancy, contraception, and referrals, with beneficiaries.[19]

In 2018, one PEPFAR IP in Eswatini had to close all of the voluntary medical male circumcision (VMMC) services in its district as a result of Trump's PLGHA. The facility had provided 42 percent of the district's VMMC services in 2017. As a result, the availability of VMMC as an HIV prevention intervention decreased in that district.[20]

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[14] CHANGE, PRESCRIBING CHAOS, *supra* note 3, at 43.
[15] CHANGE, PRESCRIBING CHAOS, *supra* note 3, at 70, 74; *see also* Global Gag Rule - one year on, International Planned Parenthood Federation (Jan. 23, 2018), *available at* https://www.ippf.org/resource/global-gag-rule-one-year.
[16] Jennifer Sherwood et al., Mapping the impact of the expanded Mexico City Policy for HIV/ family planning service integration in PEPFAR supported countries: a risk index, 18 BMC Public Health 1, 5-10 (2018) [hereinafter Sherwood et al., Mapping the impact of the expanded Mexico City Policy for HIV/ family planning service integration]; IWHC, Reality Check: Year One Impact of Trump's Global Gag Rule 13-14 (2018), *available at* https://iwhc.org/wp-content/uploads/2018/05/GGRFormatted-Report_FINAL.pdf [hereinafter IWHC, Reality Check]; CHANGE, DATA SHEET: TRUMP'S GLOBAL GAG RULE (2020), *available at* http://www.genderhealth.org/files/uploads/change/publications/GGR_Data_Sheet_F.pdf [hereinafter CHANGE Trump's GGR Data Sheet].
[17] Sherwood et al., Mapping the impact of the expanded Mexico City Policy for HIV/family planning service integration, *supra* note 16, at 9; *see also* CHANGE Trump's GGR Data Sheet, *supra* note 16, at 1.
[18] amfAR, The Effect of the Expanded Mexico City Policy on HIV/AIDS Programming, *supra* note 9, at 3-5; *see also* CHANGE Trump's GGR Data Sheet, *supra* note 16.
[19] *Id.*; *see also* Sherwood et al., Mapping the impact of the expanded Mexico City Policy for HIV/ family planning service integration, *supra* note 16, at 5-7; *see also* CHANGE Trump's GGR Data Sheet, *supra* note 16.
[20] CHANGE, Policies That Don't Work in U.S. Global Health Assistance, YouTube (Jan. 30, 2019), https://www.youtube.com/watch?v=cMWrqIwjPeo; *see also* CHANGE Trump's GGR Data Sheet, *supra* note 16.

In Kenya, an organization serving young women and sex workers had to sign onto Trump's PLGHA in order to stay open and keep providing HIV services to their clients. As a result of not being able to provide information and abortion referrals, two adolescent girls died due to complications from unsafe self-induced abortions.[21]

Family Health Options Kenya, the Kenyan affiliate of IPPF, has had to discontinue their outreach services that reached 76,000 women per year, leaving patients without their antenatal care, FP, and HIV and AIDS counseling and testing.[22]

The Family Planning Association of Malawi (FPAM) operates a national network of SRH clinics for female sex workers and people who have experienced sexual and gender-based violence (GBV).[23] FPAM could not comply with PLGHA and is therefore no longer implementing Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES), a flagship USAID HIV program. FPAM's work through LINKAGES had trained sex workers to be peer educators in an effort to reduce HIV among key populations, and it had to lay off staff and deny approximately 8,000 services to clients as a result of the expanded PLGHA. Because the project saw a reduction in HIV prevalence among LINKAGES supported female sex workers, cutting this program could cause an opposite ripple effect on HIV prevalence.[24]

The International Centre for Reproductive Health (ICRH-M), an SRHR organization in Mozambique that used to receive PEPFAR/USAID funding, is experiencing a 40 percent budget cut due to Trump's PLGHA and discontinued vital integrated HIV services like night clinics that predominantly serve sex workers.[25]

IPPF estimates that the loss of funding due to PLGHA will render them unable to provide antiretroviral treatment to 275,000 pregnant women living with HIV and 725,000 HIV tests to people at risk of acquiring HIV.[26]

2. Trump's PLGHA has negative effects on nutrition

Trump's PLGHA applies to global health funding for nutritional programs and is detrimental for food-insecure populations. Nutrition is an essential element of health, including maternal and child health, FP, and chronic disease management. Proper adolescent nutrition of young girls is directly tied to reducing the rate of adolescent

[21] IWHC, Crisis in Care, *supra* note 10, at 13.
[22] *Id.*, at 21.
[23] Family Planning Association of Malawi (FPAM), Global Gag Rule Hurts Malawians 2-4, *available at* https://www.fpamalawi.org/images/stories/FPAM%20leaflet.pdf.
[24] *Id.*, at 2-4.
[25] CHANGE, PRESCRIBING CHAOS, *supra* note 3, at 47-48.
[26] Planned Parenthood Global, Assessing the Global Gag Rule: Harms to Health, Communities, and Advocacy 18 (2019), *available at* https://www.plannedparenthood.org/uploads/filer_public/81/9d/819d9000-5350-4ea3-b699-1f12d59ec67f/181231-ggr-d09.pdf.

pregnancy and early marriage.[27] Further, those living with chronic illness like HIV and AIDS require additional food to maintain proper health and the ability to maintain lifelong antiretroviral therapy (ART).[28] As a result of the PLGHA, WaterAidAmerica, a U.S.-based WASH NGO, was forced to cancel two nutrition programs because the funding they provided to their non-U.S.-based sub-partners would be subject to Trump's PLGHA and the organization could not comply with the policy.[29]

3. Trump's PLGHA imposes barriers to providing comprehensive and integrated services

Over the last decade, the U.S. has advocated for integrated health service systems for people to have access to a variety of services in the same clinic or program.[30] In order to facilitate integration of services, the U.S. has worked towards more intermingled funding in its grants and awards.

However, Trump's PLGHA threatens this important goal because it silos services when funding types are limited. PLGHA is disrupting NGO coalitions; fracturing integrated service provision; hindering the provision of legal abortion services; and acutely affecting populations of specific concern, including youth, sex workers, and the LGBTQI+ community.[31]

Reproductive Health Network Kenya (RHNK) had provided training for health care providers on integrated SRH services. As a result of Trump's PLGHA, RHNK lost two-thirds of their funding, so were forced to lay off multiple staff members and cut the training curriculum for health care providers.[32]

4. Trump's PLGHA is impacts partnerships among organizations

In Mozambique, U.S.-based organizations such as Pathfinder International report that they can no longer partner with certain local organizations working in SRHR because of Trump's PLGHA policy, limiting opportunities for local NGOs to provide services in their community.[33]

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[27] ERIN HOMIAK, CONCERN WORLDWIDE, ADOLESCENT NUTRITION: THE MISSING LINK IN THE LIFE CYCLE APPROACH 4-7 (2016), *available at* https://admin.concern.net/sites/default/files/media/migrated/steering_document_adolescent_nutrition_march2016.pdf.
[28] CHANGE, PRESCRIBING CHAOS, *supra* note 3, at 53.
[29] *Id.*, at 53.
[30] KAISER FAMILY FOUNDATION, A REPORTER'S GUIDE TO U.S. GLOBAL HEALTH POLICY (Jan. 1, 2013), *available at* https://www.kff.org/report-section/the-basics-of-global-health/; *see* CHANGE, PRESCRIBING CHAOS, *supra* note 3, at 51.
[31] CHANGE, PRESCRIBING CHAOS, *supra* note 3, at 40-50; *see* USAID, DREAMS: PARTNERSHIP TO REDUCE HIV/AIDS IN ADOLESCENT GIRLS AND YOUNG WOMEN (last updated on September 17, 2019), *available at* https://www.usaid.gov/global-health/health-areas/hiv-and-aids/technical-areas/dreams.
[32] Skye Wheeler, The Devastating Domino Effect of the Global Gag Rule in Kenya, Human Rights Watch, Dec. 7, 2017, *available at* https://www.hrw.org/news/2017/12/07/devastating-domino-effect-global-gag-rule-kenya.
[33] CHANGE, PRESCRIBING CHAOS, *supra note 3, at 35.*

In Nepal, some local NGOs are reluctant to partner with USAID programs such as SIFPO2 because they are unwilling to violate Nepal's constitutional mandate guaranteeing the right to safe and legal abortion.[34]

In Senegal, the USAID funded Neema project lost partnerships with organizations like MSI Senegal who had effective approaches and a high level of trust within hard-to-reach communities. The loss of this partnership created delays in contraceptive mobile outreach, leading to service gaps.[35]

5. Trump's PLGHA is impacting reproductive and maternal health

In Nigeria, one FP organization estimates that if not for PLGHA, it would have reached an additional 8 million women and averted up to 15,000 maternal deaths by the end of the 2020 with USAID-funded programming.[36]

Although Nepal has made monumental progress in addressing maternal mortality and morbidity, PLGHA threatens to stall or reverse this progress by undermining the constitutionally guaranteed rights of Nepal's citizens to comprehensive SRH services.[37]

An international NGO in Nigeria reported that they could no longer sustain a program providing around 500 women with long-acting contraception because of the loss in funding from Trump's GGR.[38]

The Senegal chapter of MSI lost 45 percent of their budget from the loss of U.S. government (USG) funds following Trump's GGR. Because of this, MSI Senegal will have 20 percent fewer clients for FP, 30 percent fewer cervical cancer screenings, and 30 percent fewer STI treatments.[39]

6. Trump's PLGHA is impacting gender-based violence services

In Uganda, the MSI affiliate cut 27 mobile health teams that would have provided integrated health care services to hard-to-reach communities due to Trump's PLGHA.

In South Africa, organizations that provide services for people who have experienced GBV have lost funding and have had to close due to Trump's PLGHA. As a result, survivors of GBV cannot access crucial medical and social services that they need.[40]

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[34] PAI, Access Denied: Nepal, *supra* note 10, at 9-10.
[35] PAI, Access Denied: Senegal, *supra* note 10, at 5.
[36] PAI, Access Denied: Nigeria, *supra* note 10*, at 7.*
[37] IWHC, Crisis in Care, *supra* note 10, at 13-14.
[38] IWHC, Crisis in Care, supra note 10, at 15.
[39] PAI, Access Denied: Senegal, *supra* note 10, at 5.
[40] IWHC, Crisis in Care, supra note 10, at 17.

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Recommendation and Conclusion:
PLGHA is a policy that is based in ideology- not in evidence- and has caused irreparable harm to the health and wellbeing of women and girls across the globe. The documented impacts of the policy prove that it strips people of their access to integrated health care services, leaving women more susceptible to unintended pregnancy and induced abortion. As the most expansive version of the policy, Trump's PLGHA policy has ramifications well beyond the documented impacts of Bush's MCP. As long as any iteration of the Mexico City Policy is in effect, organizations around the world are restricted in providing quality, comprehensive care to their beneficiaries. Ending this destructive policy would save lives.

It is time for Congress to act to permanently end the Global Gag Rule and stand up for the health and human rights of people across the globe. In February of 2019, Congresswoman Nita Lowey and Senator Jeanne Shaheen introduced the Global Health, Empowerment and Rights (HER) Act (S. 368, H.R. 1055) that would permanently end the GGR by removing dangerous eligibility restrictions on international recipients of U.S. global health assistance. **CHANGE calls on Members of Congress to request that the House Committee on Foreign Affairs markup H.R. 1055, the Global Health, Empowerment, and Rights (HER) Act, and pass the legislation to end the harm caused by this policy once and for all.**

Sincerely,

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SAVE THE CHILDREN LETTER BORSH

Global Women's Health Hearing
House Foreign Affairs Committee
February 5, 2020

Smita Baruah
Senior Director, Global Health and Development Policy
Save the Children
Written Testimony

Thank you for the opportunity to submit testimony on the importance of continued robust U.S. government leadership to improve the health of women and girls globally. Save the Children is a nonprofit, child-focused organization working in 19 states across the nation as well as in more than 120 countries around the world.

Save the Children works to improve maternal, newborn, infant, and child health (MNCH) and survival in the most vulnerable communities around the world. We recognize the significant contributions maternal health (MH) and family planning (FP) have on the health and development of children. Our work to support vulnerable children includes attention to prevent and reduce maternal and newborn deaths mainly attributed to preventable causes such as hypertensive disorders of pregnancy, sepsis, post-partum hemorrhage, birth asphyxia, and prematurity.

Save the Children works with local partners, health workers, and communities to mobilize resources for health services, promote healthy behaviors and practices, and improve access and utilization of quality maternal health through evidence-based interventions during antenatal care. We also help provide post-natal and post-partum care. Our family planning work focuses on providing family planning information and services to help girls delay childbearing and to help women and couples plan and space their pregnancies for improved health outcomes.

Importance of Investing in Women's Global Health: Family Planning and Maternal Health Interventions

In 2012, the United States and other world leaders and stakeholders committed to the ambitious goal of ending preventable maternal and child deaths by 2030. We must continue to prioritize global maternal health issues. Maternal and child health are closely linked. Improving maternal and child health drives broad-based economic growth and serves as the backbone for healthy and thriving societies. Nearly one-half of all deaths in children under the age of five occur in the newborn period. Moreover, increased access to antenatal care and skilled birth attendants not only prevents maternal deaths (by preventing bleeding or infections) but also contributes to newborn survival.

Maternal health interventions reduce the risk of infections among newborns and also prevent complications from pre-term births. When a mother dies as a result of pregnancy or childbirth, it threatens her newborn's chance of survival, lowers her other children's chances for survival and education, and hurts her family and her country's prosperity. Research studies have frequently shown that children whose mothers have died are less likely to be enrolled in school or are malnourished.

The world has made significant progress in reducing maternal mortality over the past two and one-half decades, but the agenda for maternal survival is not yet finished. Southern Asia reduced its maternal mortality by 60% and other regions such as Eastern and Central Asia have reduced maternal mortality by one-half. However, 86% of maternal deaths are still concentrated in South Asia

Save the Children.

and sub-Saharan Africa. Every day, more than 800 women and girls die from preventable causes related to pregnancy or childbirth, such as postpartum hemorrhage, hypertension, infection, and obstructed labor. Ninety-nine percent of these deaths occur in low-resource settings where women and girls are unable to access adequate quality health services. In addition, other barriers are poverty, lack of access to a health care worker or health facility, inadequate and/or poor quality service, and lack of information.

Access to family planning is essential to achieving the goal of ending preventable child and maternal deaths. Overall, an estimated 214 million women and girls in the developing world have an unmet need for family planning, leading to 67 million unintended pregnancies. This number is higher among the most vulnerable and hardest to reach populations.

Getting pregnant too young or in rapid succession increases risk for complications in pregnancy and childbirth. For adolescent girls the risks are especially high – the risk of pregnancy-related death is twice as high for girls aged 15 to 19 and five times higher for girls aged 10 to 14 compared to women in their twenties. Complications related to pregnancy or childbirth remains the leading cause of death for adolescent girls aged 15-19. Yet, globally, more than 13 million adolescent girls give birth each year and adolescent girls have the highest unmet need for family planning services. Ninety percent of adolescent births occur within a child marriage, highlighting the need to prevent and respond to child marriage and address adolescent pregnancy simultaneously and holistically.

If all women and adolescent girls in developing regions with an unmet need for contraceptives had access to family planning services, maternal deaths would be reduced by a quarter and child deaths would decrease by as much as one fifth.

Family planning also contributes to better nutritional outcomes. Malnutrition is the underlying cause of 45% of deaths in children under the age of five. Healthy timing and spacing of pregnancies can reduce the prevalence of stunting, a form of malnutrition, among children under the age of five. According to findings from USAID's Health Policy Project, a study in India found that children of mothers having more than two children within two years or less were nearly five times more likely to suffer from undernutrition. Family planning indirectly affects nutrition via its impact on infant and young child feeding practices. Research shows that when pregnancies are planned and occur when women are older than 18 years, breastfeeding practices improve, leading to improved nutrition.

Family planning also empowers women and girls by providing them the chance to time and space their pregnancies or prevent unintended pregnancies, enabling them to attain higher education and pursue better economic opportunities – thereby reducing poverty. Estimates find that up to 30% of girls who drop out of school do so because of adolescent pregnancy or child marriage.

Impact of U.S. Leadership in Addressing Child and Maternal Deaths

Over the last two decades, U.S. investments have contributed to the global success of reducing the number of child deaths by one-half and maternal deaths by nearly 40%. Since 2012, USAID, through partnership with other donors and partner countries, has helped 12 million women give birth in a health facility. USAID has also reached 24 million women through voluntary family planning services.

To continue on the path of progress, the U.S. must maintain its leadership role in addressing global women's health and promoting global gender equality. In 2014, USAID launched a new framework for ending preventable child and maternal deaths known as *Acting on the Call*. In this framework, USAID committed to including family planning and reproductive health services as a part of its approach. USAID should continue to help countries realize the vision of ending preventable child and maternal deaths and promote highest-impact evidence-based interventions.

Save the Children.

In 2012, USAID launched its Gender Equality and Female Empowerment (GE/FE) policy, which has been a critical foundation for progress on the promotion of women's and girls' empowerment and global gender equality throughout development and humanitarian assistance efforts, including through identifying and addressing gender gaps, needs, opportunities, and barriers for achieving development outcomes across USAID's work. Significantly, the USAID GE/FE Policy takes an inclusive, holistic, and gender-transformative approach to women's and girls' empowerment, recognizing that addressing women's and girls' health cannot be separated from other experiences and realities of their lives, such as gender-based violence, women's economic empowerment, access to quality education, and political participation.

To support its approach and interventions, USAID should continue to improve equitable access to gender-transformative quality maternal health and family planning services, promote respectful care for maternal health, and improve adolescent girls' access to family planning and other health services. The U.S. should robustly fund programs that address maternal and child health and family planning, including drivers of increased risks, such as child marriage.

Improving Access to Quality Health Services for the Marginalized and Vulnerable

Despite the progress in improving maternal health, challenges remain in reaching the most vulnerable and marginalized women and girls, especially in fragile and conflict-affected settings. In hard-to-reach and rural areas, physical distances from health centers increase risks of gender-based violence. Child marriage, and gender-driven mobility restrictions, particularly for adolescent girls, pose a significant challenge to accessing basic health care services. It is common for a woman or girl to have to walk 10 miles – each way – to reach a health center, or not be able to travel at all.

For women and girls living in conflict-affected environments, childbirth can be a particularly dangerous and traumatic experience. Many have no choice but to give birth unassisted and in unsanitary conditions, increasing the likelihood of trauma, long-lasting physical illness, and death.

Bringing Health Care to Those without Access

To improve equitable access to quality health services, USAID MNCH programs should scale up programs like MaMoni in Bangladesh. MaMoni is a Maternal, Newborn, Health/Post-Partum Family Planning project that provides direct support to 10 districts and supports national level activities that extends to all the remaining 54 districts through the Ministry of Health. It is helping local governments build capacity to deliver quality maternal and newborn health services.

During the first five-year phase, MaMoni helped a young women named Asma Begum prevent the loss of another child during birth by ensuring access to a health facility. Due to lack of financial resources, Asma did not seek medical care during her first two pregnancies. Sadly, her second child died during birth at home. For her third pregnancy, Asma was introduced to the Durgapur Union Health and Family Welfare Center that MaMoni helped strengthen and which provides free services. Asma received her first pre-natal care in her ninth month of pregnancy. She experienced several complications, including anemia, pre-eclampsia, and a breech presentation. A paramedic at the Welfare Center arranged for an immediate C-section at the district hospital. There, Asma successfully gave birth to a daughter and she was also treated for complications after birth. Asma said, "I am alive because MaMoni came to Begumaganj. I believe many Asmas will be saved because of this project."

Identifying Innovative Ways to Reach the Most Vulnerable and Marginalized

The U.S. should scale up innovative ways to reach the most vulnerable and marginalized with family planning services. The needs of women and girls in nomadic and semi-nomadic settings have been neglected resulting in high maternal mortality rates, high fertility rates, and low use of health services,

including family planning. Sixty percent of the estimated 50-100 million nomads and semi-nomads globally live in Africa, across East Africa, South Sudan, the Horn of Africa, and the Sahel region.

Thanks to funding from the Bill and Melinda Gates Foundation and in partnership with the London School of Hygiene and Tropical Medicine, Save the Children is working to provide access to quality family planning services among nomadic and semi-nomadic populations in Northeast Kenya. This project is known as the Nomadic Health Program.

Integrating Family Planning with Other Health Services

Integrating family planning into other health and development services is another way to improve access to these services. Save the Children, through funding from the Pfizer Foundation, implements the Family Planning and Immunization Project in Malawi. This program integrates family planning into monthly child immunization outreach clinics in three districts that serve hard-to-reach communities. By capitalizing on an existing network of outreach clinics, women have the opportunity to access family planning counseling closer to where they live. Between September 2015 and December 2018, these integrated clinics served more than 23,000 women and 97 percent of women counseled accepted family planning methods.

USAID, through the Maternal Child Survival Program (MCSP), implemented similar projects elsewhere in Malawi. MCSP trained over 300 health surveillance assistants at the community level to provide family planning counseling and contraceptives. These health workers engaged with community leaders to advocate effectively for integrated services and greater male involvement in family planning and infant health. Mothers and fathers noted that integrating family planning with immunization services helped save time, increase access to family planning, and improve understanding of these services.

Integrating Family Planning into Humanitarian Assistance Programs

Reproductive health is a necessary component of humanitarian health responses. U.S. government emergency health programs should include family planning services, post-abortion care services (lifesaving treatment for women and girls who experience complications due to unsafe abortion or miscarriage), and the Minimum Initial Service Package (MISP) for reproductive health, a globally agreed upon standard for humanitarian settings.

In 2017, in partnership with CARE and the International Rescue Committee, Save the Children integrated family planning services into our primary health care package as an essential component of the Rohingya response in Bangladesh. Our goal is for all women and girls of reproductive age to receive information about contraception when accessing any services through Save the Children-supported sites in Cox's Bazar, Bangladesh. These sites have offered outpatient reproductive health services, including antenatal and postnatal care, family planning, and infant and young child feeding services. This resulted in reaching nearly 20,000 new family planning users between November 2017 and December 2018.

In addition to improving access to maternal health and family planning services, USAID should continue to work with governments in improving the quality of these services. Poor quality of care also increases the risk of illness and lifelong disability. Mothers may develop pelvic infection, fistulas, uterine prolapse, fatigue, and depression. Babies may be at risk of infection, or suffer asphyxia or trauma during labor, which can lead to neurodevelopmental impairment and disabilities.

Improving Adolescent Girls' Access to Health Services

U.S. government approaches to improving global women's health must include an increased focus on improving the health of adolescent girls. The period of adolescence is a time of transformation and increased vulnerability, particularly for girls. Adolescent girls face exacerbated risks of gender-based

violence, disruptions in education, often driven by child marriage and/or adolescent pregnancy, malnutrition, increased unpaid domestic and childcare responsibilities in their homes, and increased limitations on their mobility as harmful gender norms around women's and girls' roles in public solidify for them.

Adolescent girls often do not have access to adequate adolescent-friendly, and gender-sensitive, quality health services, including information about and access to family planning counseling and services. Health services traditionally focus on young children and women, and when adolescents (including adolescent mothers) do seek health services, they are often treated with disrespect and stigmatized. Approximately 16 million girls aged 15-19 and 2.5 million girls under 16 years give birth each year in developing regions.

Adolescent pregnancy has long-term consequences. Adolescent mothers face a much higher risk of maternal mortality and morbidity than older women and are often malnourished. Their children face a higher risk of neonatal, infant, and child mortality and morbidity, and early childbearing perpetuates the intergenerational cycle of malnutrition. In addition, adolescent pregnancy often disrupts girls' education and drives child marriage. Child brides are frequently deprived of their rights to health, education and safety. They are frequently isolated and feel disempowered. And they are vulnerable to sexually transmitted infections and multiple forms of violence. Adolescent pregnancy and child marriage have a drastic and long-term impact on girls' ability to achieve their full potential, and drive cycles of poverty and gender inequality.

Adolescents in fragile settings are disproportionately vulnerable to poor physical and mental health, harassment, assault, and multiple forms of gender-based violence (including sexual violence, child marriage, and sexual exploitation). Risks of gender-based violence, lack of access to adolescent-friendly, safe, and quality reproductive health services, and other gender-related barriers to accessing services, such as mobility limitations, are all exacerbated in fragile and conflict-affected settings. Nine of the 10 countries with the highest prevalence rates of child marriage are considered fragile or extremely fragile. Around three-fifths of all maternal deaths take place in humanitarian and fragile contexts. Every day, 507 women and adolescent girls die from pregnancy and childbirth complications in emergency settings.

The benefits of ending all early child births (both within and outside marriage) could exceed $700 billion per year by 2030. Cumulatively, the welfare gains from ending child marriage and early childbirth would be almost $5 trillion. Yet, despite adolescent girls' distinct experiences, they often remain absent from policy-making spaces, their needs invisible and their voices unheard. Ensuring adolescent girls are supported to engage in health sector policy making, and in the development, execution and monitoring of health programming, will ensure that their priorities and needs are integrated, making policies and programming more efficient, sustainable, and responsiveness to the needs of adolescent girls.

USAID maternal and child health programs should focus on reaching adolescent girls and support consultations with adolescent girls as key stakeholders in their own lives as programs and policies affecting them are developed and implemented. USAID should continue its attention to and deepen its focus on working with national and subnational governments in including a comprehensive package of adolescent-friendly and gender-transformative services, including information, counseling, and services for reproductive health and family planning, maternal and newborn care, and prevention/elimination of maternal to child transmission of HIV/AIDS. The package of services should also include referral services for nutrition and mental health.

Strong Funding for USAID Maternal and Child Health and Family Planning Programs

We commend Congress, including the support of the House Foreign Affairs Committee, for steadily increasing funding for USAID Maternal and Child Health programs and for ensuring U.S. investments in family planning are protected on a bipartisan basis.

We request that Congress again show support for U.S. leadership for these issues and robustly fund these programs. Continued investments for USAID Maternal and Child Health and Family Planning programs are needed to help partner governments tackle pressing barriers to improving maternal and child survival. These barriers include access for the hardest-to-reach populations, supporting communities and their families in conflict-affected or fragile states, and reaching adolescent girls. The U.S. cannot afford to decrease its support at a time when countries are increasing their ownership in addressing maternal and child health issues, thanks to U.S. leadership to encourage countries' journey to self-reliance. In addition to bilateral assistance, USAID should continue efforts to foster domestic resource mobilization for health services.

Conclusion

The U.S. has provided significant leadership in improving maternal and newborn health globally. In its *Ending Preventable Maternal Mortality: USAID Maternal Health Vision for Action*, the U.S. envisioned a world where no woman dies from preventable maternal causes and maternal and fetal health are improved. We must continue to help countries realize this vision. To continue this progress toward ending preventable maternal and child deaths, the U.S. should:

- Prioritize highest-impact, evidence-based interventions in its maternal and child health programs.
- Work with countries to improve access to maternal health and family planning services including in humanitarian settings and promote respectful maternal care.
- Ensure a holistic and gender-transformative approach in its maternal and child health programs, guided by a gender analysis at all stages of program development, implementation, monitoring and evaluation.
- Maintain strong funding for maternal and child health and family planning programs.
- Promote and support adolescent girls' safe and meaningful participation in policy and programmatic decisions about their own lives, including health sector policies and planning at national level.

HUMAN RIGHTS WATCH

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February 5, 2020

HUMAN RIGHTS WATCH
HRW.org

Members of the House Foreign Affairs Committee
2170 Rayburn House Office Building
Washington, DC 20515

Dear Members,

We wish to submit the attached letter from Human Rights Watch to then-Secretary of State Rex Tillerson on October 13, 2017, with regard to the "Early Impact of the Protecting Life in Global Health Assistance Policy in Kenya and Uganda" for the House Foreign Affairs Committee hearing on the "Unique Challenges Women Face in Global Health" on February 5, 2020. The letter provides an overview of our findings and key recommendations, but for additional detail, please visit: https://www.hrw.org/news/2017/10/26/re-early-impact-protecting-life-global-health-assistance-policy-kenya-and-uganda.

The US government has made important long-term investments in Kenya and Uganda, including supporting lifesaving HIV/AIDS and sexual and reproductive healthcare services. The research detailed in the attached letter studied the first months after the roll-out of the Protecting Life in Global Health Assistance policy, also known as the "global gag rule," announced by President Donald Trump in January 2017. Human Rights Watch found that even at that early stage of implementation, the policy was harming laudable efforts paid for by the US taxpayer to improve global health.

Under this policy, foreign nongovernmental organizations receiving US global health assistance must certify that they do not use their own, non-US funds to provide abortion services except in cases of rape, incest, or to save the life of the woman, counsel patients about the option of abortion or refer them for abortion, or advocate for the liberalization of abortion laws.

We interviewed with 45 representatives of organizations affected by the policy in 2017 and found at that time there were significant problems with how the policy was communicated to recipients of US government funding. We also found that less than a year into implementation, there were already:

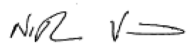
- Reductions of key sexual and reproductive health services from well-established organizations that would not be easily replaced.
- Loss of training and technical support to government clinics providing safe and legal abortion care, including under circumstances permissible under the policy, and post-abortion care.
- Concerns from healthcare providers about the likelihood of increased unsafe abortions and associated maternal deaths.
- Weakening of partnerships and coalitions working to end maternal mortality.
- Negative impacts for PEPFAR's work with key populations, the most vulnerable to new infections of HIV/AIDS.

From the attached letter, you can see we raised these findings directly with the State Department. We did not receive a reply, and we did not see these findings reflected in the department's six-month review of the policy, issued in early 2018.

Our research is a snapshot of the early impacts of this harmful policy, and raised concerns about what could unfold if the policy continued. There have been many organizations since that have added to the broad collection of research on the ongoing detrimental impact of this policy on the lifesaving work of healthcare providers serving some of the world's poorest women. We urge the members of the committee to examine this factfinding and other reporting by healthcare and women's rights organizations.

We hope that members of the House will take this hearing and other opportunities to learn more about the harmful impacts of this policy in countries like Kenya and Uganda struggling with high rates of maternal mortality and poor access to health care. Members of Congress should consider visiting recipient countries to see for themselves what the impact has been and ask the Departments of State and of Health and Human Services for details on the impact of the policy on US global health priorities, including reducing maternal morbidity and mortality and ending the HIV/AIDS pandemic. Furthermore, Congress should also permanently repeal the policy, for example by passing the Global HER Act.

Sincerely,



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HUMAN RIGHTS WATCH

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October 15, 2017

The Honorable Rex Tillerson
Secretary of State
U.S. Department of State
2201 C Street NW
Washington, DC 20520

Re: Early Impact of the Protecting Life in Global Health Assistance Policy in Kenya and Uganda

Dear Secretary Tillerson:

We are writing to share our initial research findings and recommendations on early implications of the US government's "Protecting Life in Global Health Assistance" policy (hereinafter "the policy"). This research included interviews with representatives of 45 organizations in Kenya and Uganda that currently receive US global health funding, many of whom had planned to apply for renewals or new funds in the coming year. These organizations provide health services or conduct health advocacy and range from small community-based organizations to large nongovernmental organizations (NGOs) that work in many different countries. We have been in touch with USAID during this process and have incorporated information provided by USAID in an October 11, 2017 letter responding to our research queries.

As you know, over many decades, the US government has made deep and long-term investments in Kenya and Uganda that have saved lives and contributed to important health gains. However, both countries still confront high incidence of HIV/AIDS and poor reproductive health indicators including high rates of preventable maternal deaths.

We have outlined our key findings below on how early impact of the policy is already beginning to undermine local health systems and health gains and have attached a detailed summary of our research for your consideration ahead of the six-month review of the policy scheduled for November.

Key Findings

Lack of information about the policy and overreach in implementation.
Most of the representatives and almost all of those from groups that are directly implementing programs, said that their organizations have not received any direct communications or explanations of the policy from US government grant administrators. In its response letter to us, USAID noted that it has provided trainings on the policy to staff, published the standard provisions added to grants and cooperative agreements on its website, and created an online course. However, these have not met the need for public outreach, which should include widely-disseminated, user-friendly guidelines that explain the policy in detail. Despite this effort by USAID, many organizations we interviewed had questions about the scope and implementation of the policy, particularly on whether the policy applied to them; on access to US government-funded commodities; and, for those that choose to comply with the policy, on whether they could partner and meet with groups that do not. Several of the concerns and expected program shifts raised by these groups suggested an overly broad understanding of the policy's restrictions, for example, ending community outreach on the risks of unsafe abortion.

Reductions of key sexual and reproductive health services from well-established organizations that cannot easily be replaced.
Family Health Options Kenya (FHOK) runs 16 healthcare facilities in Kenya, providing three million health services in 2016. FHOK will forego US funds to avoid being bound by the policy's restrictions, and said this means about 60 percent of its funding will be lost or is under threat and they may have to cut as many as half of its services. FHOK has already canceled 100 planned outreach programs, including for cervical cancer screening, HIV testing, and family planning counseling, that typically reach 100 people each time. Due to losing US funds, FHOK has already, in August, closed one clinic in Kenya's coastal region that typically served 50 individuals a day and specialized in providing women with long-acting contraceptives such as intrauterine contraceptive devices (IUCDs). FHOK is particularly worried about being forced to close additional clinics or reduce services where they are the only provider and there are no comparable alternatives, for example in a slum in Nairobi. Groups that are losing US funding were initially chosen as grantees or subgrantees because they were the best placed and qualified to do the work, and often there may not be comparable alternatives.

Loss of training and technical support to government clinics providing safe and legal abortion care, including under circumstances permissible under the policy, and post-abortion care.
Although government entities receiving US funds are exempt from the policy, many will be indirectly harmed and weakened. We interviewed four organizations in Kenya that provide training, equipment, and legal support to government clinics to provide safe abortion care. All expressed concerns about the capacity of these clinics to

continue to provide safe abortion care in cases permissible under national law, including in cases of rape, incest, or to save the life of the mother, without this support. For example, an organization that supports government clinics said the Kenyan ministry of health does not equip their facilities with abortion-related commodities.

Concerns from healthcare providers about the likelihood of increased unsafe abortions and associated maternal deaths.
Many of the health care providers we spoke to outlined the reasons they expected to see increased unsafe abortions and associated maternal deaths, including the cuts in community outreach and education efforts, drops in referrals, cuts to clinics and services where there is no likely replacement, uncertainty about accessibility of commodities, and the reduced capacity of government clinics that rely on NGO support to provide health services including safe abortion care.

Weakening of partnerships and coalitions working to end maternal mortality.
In Uganda, several members of the Coalition to End Maternal Mortality through Unsafe Abortion say they will have to leave the coalition as a result of the policy's restrictions, weakening the strength and breadth of efforts to end preventable maternal deaths. Many groups that are planning to comply with the policy's restrictions in order to keep their US funds also expressed confusion about the extent to which they could still attend meetings or trainings offered by groups that do not adhere to the policy's requirements.

Negative impacts for PEPFAR's work with key populations.
Sex worker organizations felt they had to make cruel programmatic choices as a result of this policy. For instance, we interviewed groups who had to choose between funds for lifesaving antiretroviral therapy for their members or lifesaving reproductive health services. Both are desperately needed. These programming shifts and choices undermine hard-won relationships of trust developed with a key population on the frontlines of efforts to fight HIV.

A six-month review is insufficient to monitor impacts.
Many organizations have not yet come up for initiation or renewals of grants and have not yet had to cut or shift their programs and advocacy. A six-month review cannot provide a meaningful assessment of the policy's full impacts. The upcoming review should emphasize this fact and outline plans for subsequent and comprehensive assessments of impact.

Recommendations

This expansive policy is detrimental to the contributive role the US government has proudly played in building sustainable health systems and saving lives. In order to reverse these harmful and negative effects we believe President Trump should

rescind this draconian policy. Until that time, however, the State Department, USAID, and other US agencies that provide global health funding should take every step to ensure that harmful consequences, such as setbacks in the prevention and treatment of HIV, and increased maternal deaths and injuries are avoided, including through:

- Conducting a comprehensive, transparent, annual review of the policy to assess its impact and outlining actions it will take to address harms. The review should include robust consultation with a wide variety of stakeholders and assess changes in health outcomes such as injuries and deaths from unsafe abortions.
- Disseminating clear and detailed information about the policy and compliance requirements in an accessible way to organizations, including sub-recipients and others with no direct contact with grant administrators. Ensure that organizations that have certified compliance have a full understanding of the policy and are not driven by misunderstanding to unnecessarily curtail their programs.
- Strengthening sexual and reproductive health programs, including for post-abortion care services and for safe abortion care in the case of incest, rape and to save the life of the woman.
- Utilizing the Secretary's power to grant case-by-case exemptions to mitigate the harm to US investments in global health and security.

We appreciate your attention to these important issues and would be happy to meet to discuss them further.

Sincerely,

Sarah Margon
Washington Director

Nisha Varia
Advocacy Director, Women's Rights

Cc
Mark Green, administrator, US Agency for International Development
Brenda Fitzgerald, MD, director, Centers for Disease Control and Prevention

CHAMPIONS OF GLOBAL REPRODUCTIVE RIGHTS LETTER

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PAI
Testimony for the record
U.S. House of Representatives Committee on Foreign Affairs hearing entitled, "Unique Challenges Women Face in Global Health"
February 5, 2020.

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

PAI advocates for policies that put women in charge of their sexual and reproductive health. We work with policymakers in Washington, D.C., and a vast network of partners in the Global South to remove roadblocks between women and the services and supplies they need. For over 50 years, we've helped women succeed by upholding their basic rights.

PAI appreciates the committee dedicating time to consider the unique challenges women face in global health. We know that a woman's ability to be an agent of change for her family and community is eroded and undermined when her health needs, including her sexual and reproductive health needs, are not being met.

Since assuming office, the Trump Administration has focused their global health policy agenda on undermining women's health. As detailed in our testimony, this has proven detrimental to America's foreign policy objectives, to health programs in the 60+ countries around the world who benefit from U.S. global health assistance and to women's health.

On January 23, 2017, in one of his first actions as president, Donald Trump reinstated and significantly expanded the application of the Mexico City Policy, officially renamed "Protecting Life in Global Health Assistance," and widely known by its critics as the Global Gag Rule. This policy risks women's health and lives by forcing foreign nongovernmental organizations (NGOs) to choose between receiving U.S. global health assistance and providing comprehensive sexual and reproductive health care.[i] In order to comply with the Global Gag Rule, providers must agree not to provide information, referrals or services for abortion or to advocate for the liberalization of abortion laws in their country with their own, non-U.S. funds.

PAI has documented the impacts of the Global Gag Rule on family planning since its inception in 1984 under President Reagan. Now, we are documenting the impact of the policy on all U.S. global health assistance, as well as the impact on funding from non-U.S. bilateral donors, private foundations and multilateral organizations as a result of the policy being expanded twice under this administration.

The Trump administration's Global Gag Rule goes further than previous iterations of the policy, extending its restrictions to all global health assistance provided through the U.S. Agency for International Development (USAID), the Department of State, and the Department of Health and Human Services in more than 60 low- and middle-income countries. Now, in addition to all foreign NGOs providing family planning and reproductive health care, those providing services related to HIV/AIDS, maternal and newborn health, malaria, tuberculosis, other infectious diseases, nutrition or any other global health program are required to comply with the policy in order to continue to receive U.S global health assistance.

The Global Gag Rule reaches beyond longstanding limitations on using U.S. government funds for safe abortion care, even though unsafe abortion is a leading cause of maternal morbidity and mortality in the Global South. The Helms Amendment has restricted the use of U.S. foreign assistance funds for "abortion as a method of family planning" since 1973.[ii] The Global Gag Rule restricts what an organization can do with its private, non-U.S. government funds. Since its initial expansion under the Trump administration, an interpretation of the language implementing the policy was released in March 2019. This interpretation effectively prohibits a foreign sub-recipient from using its non-U.S. government assistance to support any kind of health or development work of a foreign partner that receives no U.S. government global health assistance, if that partner separately engages in abortion-related work with its own funding—essentially blacklisting those organizations.[iii] Under this interpretation, in order to remain in compliance with the Global Gag Rule, a foreign NGO would have to track funding they flow-down to a subgrantee from a bilateral donor or a private foundation, for example related to girls education, and ensure that their foreign partner organization is not engaged in any of the prohibited activities, even without any U.S. government assistance.

The Global Gag Rule is not—and has never been—about U.S. taxpayer funding for abortion. It is about the Trump administration placing politics above the health and lives of women around the world. As in the past, the Global Gag Rule will not prevent abortion. What it is doing is shuttering clinics. Communities are losing access to their most trusted and skilled health care providers. The ability of women and their families to access contraceptives, safe delivery and newborn care or HIV testing, counseling and treatment are being limited.

Evidence of Harmful Impacts

PAI has documented the impact of the Global Gag Rule for decades in our research series *Access Denied*. With the reinstatement and massive expansions of the policy under the Trump administration, we have conducted fact-finding trips in eight countries (Burkina Faso, Ethiopia, India, Kenya, Nepal, Nigeria, Senegal, and Uganda) to record the effects thus far.[iv] These documentation efforts have complemented the work other NGOs and research institutions have also undertaken to monitor the impacts of the policy.[v]

While it will take years for the full scope of the policy's impact to appear, our four published case studies confirm the policy has already caused harm to NGOs, health systems and women and their communities. Given the role NGOs play in sexual and reproductive health service provision and advocacy in the countries receiving U.S. global health assistance, they—and consequently the wider health system—are affected by the policy.

Below are some key preliminary findings that demonstrate the policy's harmful impacts on women's health and its further repercussions on wider health services and systems, as documented by PAI:

Contraceptives out of reach: The Global Gag Rule has affected the ability of vulnerable populations, including those in rural areas and young people, to access the voluntary contraception of their choice. These groups rely heavily on the private sector, especially NGOs, for reproductive health services and contraception, including some of the most trusted and best equipped organizations that will not comply with the policy.

- Reproductive Health Uganda lost $300,000 in 2017—30% of its budget—and was forced to end U.S.-funded projects to strengthen advocacy, rights-based services and introduce injectable contraceptive Sayana Press to 6,000 adolescents seeking protection against unwanted pregnancy.
- ABBEF, the International Planned Parenthood Federation (IPPF) member in Burkina Faso, was forced in 2017 to prematurely end its U.S.-supported pilot initiative to distribute contraceptives in secondary schools where there is a huge family planning need.
- Marie Stopes International (MSI) received 17% of its donor income from USAID at the time the Global Gag Rule was reinstated.[vi] These funds were exclusively used for voluntary contraception services and the loss of funding has impacted work with poor and marginalized communities most in need of accessing services.
- Marie Stopes Ethiopia, with its expertise reaching remote communities, ended its U.S.-funded program providing vasectomies and tubal ligations to rural populations. No other organization has the technical skills and expertise to provide the same quality of service and choice.
- Marie Stopes International (MSI) affiliate FRHS India, which has not had U.S. funding since 2005 and does not provide abortion services, had to shut down a program in Uttar Pradesh as MSI redirected "core" funds to countries harder hit by the Global Gag Rule.

Fewer points of service: Organizations that chose not to comply with the Global Gag Rule were forced to close clinics and end services as a result of funding deficits, disproportionately affecting vulnerable groups including youth, people living with HIV/AIDS and rural populations.

- IPPF had 53 projects in 32 countries funded by U.S assistance in 2017. They projects were managed by its member associations that provide essential and life-saving healthcare to underserved and marginalized communities. For some of those member associations, service delivery decreased by up to 42% from 2016 to 2017, in part due to the reinstatement of the Global Gag Rule.[vii]
- In 2018 the IPPF member Family Guidance Association of Ethiopia would have had to close 10 confidential, sex worker-friendly clinics once funded by the U.S. Centers for Disease Control and Prevention if not for short-term replacement funding from the government of the Netherlands.
- In 2018, Marie Stopes Senegal lost approximately 45% of its budget due to the Global Gag Rule. Without replacement funds, this meant that its outreach services would reach 20% fewer clients for family planning, provide at least 30% fewer cervical cancer screenings and offer nearly 30% fewer STI treatments than in the previous year. These services are critical because adolescents and young people rely heavily on the private sector for sexual and reproductive health in Senegal.
- USAID had been funding ten Marie Stopes mobile outreach teams in Burkina Faso, which ended in April 2018. While other donors have stepped in to support the organization, as of November 2019, three mobile outreach teams are no longer operational in the country's most volatile zones, cutting populations off from health services.
- In Uganda, with the close out of a U.S. funded program, in 2017 MSI projected that it would have had to cut 27 mobile health teams across the country—a key, integrated service for hard-to-reach populations. Five outreach teams had to shut down, with 12 more at risk.

Stalled efforts to improve health outcomes: NGOs compliant with the Global Gag Rule must often discontinue working with noncompliant organizations on critical initiatives to advance health care access and quality. Stigma and confusion around the technical complexities of the policy also lead NGOs to self-censor and overly restrict their activities, including those allowable under the policy, out of caution.

- In Uganda, an NGO working with family planning providers and advocates through the Uganda Family Planning Commission to Decrease Maternal Mortality Due to Unsafe Abortion stopped engaging in the work out of fear of reprisals.
- Efforts by an NGO that trains health workers in Nepal to integrate abortion provision with other basic health services faltered because partner organizations complying with the policy were no longer available.

- An NGO in Ethiopia lost not only U.S. funding due to the Global Gag Rule, but also its partnerships with two compliant prime recipient organizations that had provided subgrants for programmatic work and an estimated 550,000 Euros annually in contraceptive supplies.
- In Ethiopia, the largest network representing midwives – often the first points of service for reproductive health – had to stop safe abortion care training that reduces maternal mortality, due to compliance with the Global Gag Rule. The organization can no longer train the public sector on safe abortion care, proving the Global Gag Rule reaches beyond NGOs to affect the wider health system.
- In several countries, PAI heard from NGOs complying with the Global Gag Rule stating their unwillingness to continue providing or participating in trainings on post-abortion care out of fear of the policy. Post-abortion care is a service that is entirely permissible under the Global Gag Rule and is integral to saving lives.

Administrative burdens: The Global Gag Rule creates a heavy operational burden for NGOs—both compliant and noncompliant. They must spend valuable resources on unanticipated overhead, time seeking clarification from funders and other costs, which detracts from service provision and directly impacts clients and beneficiaries.

- One Ugandan NGO's implementation of services fell four to six months behind because of staff time and resources spent on legal and administrative fees and office and personnel changes in efforts to comply with the Global Gag Rule. The organization also lost knowledgeable technical staff in key geographic locations, impacting the most vulnerable populations.
- A U.S. organization's local affiliate in Nigeria shut down a key women's health program because of compliance-associated costs of duplicating operational structures to function under the Global Gag Rule. It lost over 40 staff as a result.
- WaterAid, which decided not to comply with the Global Gag Rule, expended many hours of additional work on the part of in-country, regional fundraising and U.S. policy and fundraising staff to ascertain sources of funding for multiple USAID grants. USAID responses have been delayed, confusing and on occasion completely incorrect—at times asserting that the policy would apply to funding streams not subject to the Global Gag rule or remaining unresponsive throughout award timelines.

Opportunity costs: The Global Gag Rule unsettles plans for organizations working to sustain and grow operations, topples local government efforts to prioritize and improve quality and accessibility of health care and imposes extraordinary burdens and disruptions on non-U.S. donors—all resulting in diminished and delayed programs at the expense of reaching beneficiaries.

- Reproductive Health Uganda operates in almost 50% of Ugandan refugee camps, serving as the main sexual and reproductive health organization in the settlements. Because of the Global Gag Rule, the NGO has had to scale back humanitarian services, diverting $100,000 per year from providing sexual and reproductive health care in refugee camps.
- In Nepal, the two lead reproductive health NGOs were forced to close their respective U.S.-funded projects in 2018 due to the Global Gag Rule and USAID allegedly struggled to find new partners willing to subvert the constitutional mandate guaranteeing the right to abortion. As a result, efforts to improve disadvantaged populations' family planning access, provider trainings, quality assurance and public health sector contraceptive supply chain will be lost. Both NGOs have withdrawn from 22 districts, and one will have to lay off 140 staff as a result.
- A Dutch-funded project of $9 million over four years for comprehensive abortion care in Ethiopia was terminated in 2017 because the lead organization was complying with the Global Gag Rule and could no longer carry out the work.
- The United Kingdom's Department for International Development dedicated 90 million pounds over four years in Ethiopia for work with the Ministry of Health to provide modern family planning services. Because of the Global Gag Rule, one NGO could no longer continue working with the other recipients. The program came to a nine-month halt to redesign the grant in a way that fragmented safe abortion care from the rest of the reproductive health portfolio, delaying the rollout of services.

PAI's research on the Global Gag Rule was initiated early in the policy's rollout, while several foreign NGOs were still closing out their U.S. government programs, in the process of finding stopgap funding from non-U.S. government donors and determining how compliance or noncompliance would affect their work. As a result, quantifiable loss for activities and beneficiaries remains unknown and may be difficult to determine because of a range of factors, including timing and replacement funding. The confusion and fear that the policy has engendered among NGOs also meant that certain organizations receiving U.S. government funding were unwilling to be interviewed and consequently the impact to their activities is unknown. With the March 2019 expanded interpretation of the policy, there may be additional effects that will need to be captured as foreign NGOs and non-U.S. government donors adapt to those changes.

Even at an early stage, this policy has disrupted contraceptive uptake and health services, stalled efforts to improve health outcomes and placed administrative burdens that derail the efficacy of U.S. investments in women's health. Private NGO providers are vital for service delivery to at-risk populations, including adolescents and youth, people living with HIV/AIDS, rural communities and sex workers. The reduction in U.S. global health assistance going to qualified, trusted NGO providers negatively impacts the health system broadly in countries receiving U.S. funding and potentially the health and lives of women, girls and community members.

The harmful impacts of the Global Gag Rule, as documented by PAI and several other organizations and research institutions, underscores the urgent need to end the Trump Administration's expansive Global Gag Rule. Though the harm caused by the policy likely can never be fully undone, repealing the policy would allow trusted and effective organizations to once again compete for critical U.S. global health assistance to rebuild clinical and referral networks and reestablish their partnership and advocacy networks to ensure women, girls and their communities have access to critical health services.

However, it is not enough to end the Trump Administration's Global Gag Rule. For nearly 36 years, this policy has bounced between being in effect and repealed every time there is a change in the party affiliation of the White House. This creates an uncertain environment for organizations, who rely on the United States as the world's largest global health donor but can never trust the United States' long-term commitment. Every presidential election here brings with it a concern among health organizations around the world that a much needed or innovative new project could be terminated early, that knowledgeable and trusted staff would have to be let go and that clinics could be shut down.

The Global Gag Rule must be brought to a permanent end. Congressional action is needed to not only end the current iteration of the policy but to ensure that future administrations cannot reinstate the policy when they come into office. For this reason, PAI calls on the Committee to take up the Global Health Empowerment and Rights Act, introduced by Rep. Lowey (D-NY-17) and cosponsored by 190 members of the House of Representatives, for consideration, and urges it passage by the full chamber.

Thank you once again Chairman Engel, Ranking Member McCaul, and Members of the Committee. PAI looks forward to working with you to ensure that U.S. foreign policy, specifically global health programs, puts women in charge of their sexual and reproductive health.

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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/
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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.

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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:

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[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.

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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

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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]

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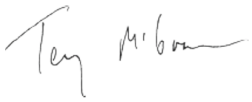
Given the expanded nature of PLGHA and the fact that many health systems have become further integrated since the previous version of the MCP was in force, it is widely expected that PLGHA will have an impact on health systems well beyond sexual and reproductive health.[30] For example, WaterAid, a large 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,



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