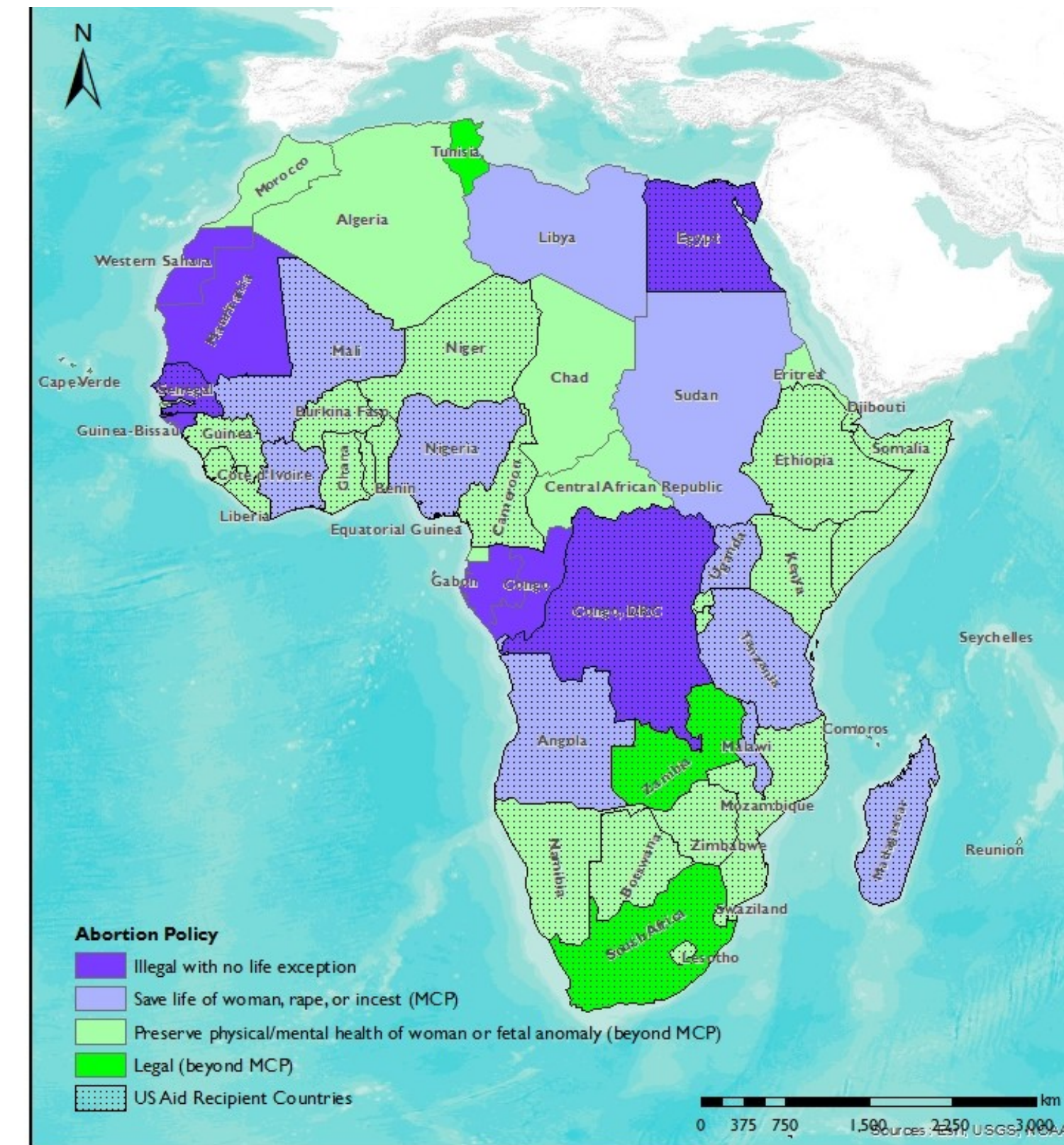


# Assessing the Risk of the Global Gag Rule for Women's Health in Africa

## Background

President Donald Trump reinstated the “Mexico City Policy” (MCP) or “global gag rule” which requires foreign non-governmental organizations (NGOs) to certify that they will not “perform or actively promote abortion as a method of family planning” using funds from any source as a condition for U.S. government funding (as a direct or sub-grantee.) Since 1973, US aid does not provide funding for abortions.



This policy defunds organizations who provide counseling on women's legal options, including in countries where abortion is legal beyond the policy exceptions for rape, incest, or to save a woman's life. President Trump expanded this condition from family planning funding (\$544 million in FY2017) to all of U.S. global health funding, approximately \$9.5 billion. He withdrew funding from the UN Population Fund (UNFPA), Marie Stopes International (MSI), Planned Parenthood Federation International (PPFI), and the International HIV/AIDS Alliance have cut services due to lost funding.

The policy has serious health implications for African countries, the largest recipient of US global health aid and the continent with the highest rate of abortion-related deaths. AA WHO study found that the Bush administration MCP reduced contraceptive use and increased induced abortion rates (adjusted odds ratio of 2.55). Abortion incidence is higher in countries with restricted access (37 per 1,000 women) than in countries where it is broadly legal (34 per 1,000 women). Every year, six million African women end their pregnancies unsafely, and 1.6 million are treated for complications. MSI estimates that more than two million women could lose access to contraception leading to an additional 2.5 million unintended pregnancies, 870,000 unsafe abortions, 6,900 avoidable maternal deaths, and £107m increase in direct healthcare costs. In addition, reduced funding for rural integrated health programs has serious ramifications on family health.

## Methodology

I used spatial analysis to determine which countries in Africa have the highest potential women's health impact from implementation of the global gag rule. I created a comparative index based on key criteria: *exposure to the MCP policy* (0-9), *demand for family planning services* (1-4 quartile based on unmet demand for contraceptives), and *mortality risk*. The exposure score includes a 1-4 scale of now required-MCP US health funding per capita from 2008 to 2016, presence of NGOs with revoked funding (1 point each), and MCP-restricted or expanded abortion policy (0 or 2 points). Countries with more liberal abortion policies will be especially affected since the policy curtails “promotion” of existing legal abortion services. I estimated “mortality risk” score for women who cannot access family planning. The Guttmacher Institute estimates that 8% of maternal deaths worldwide are due to complications from induced abortion. I used population and maternal mortality rate statistics multiplied by 8% to estimate the proportion of women at risk of fatal induced abortion (scored 1-4 by quartile) and subtracted .5 points for national post-abortion care services, which could mitigate this risk. Finally, I multiplied “policy exposure,” “family planning demand,” and “mortality risk” to create an overall women's health risk score from 0 to 144.

There are several limitations. The survey data varies by source date and only represents married women, as statistics for single women were not widely available. I did not include HIV/AIDS prevalence, assuming that this population would overlap with women who have an unmet need for contraception. This project does not extend the analysis to the impact for men and children. I was not able to capture the impact to date of any differential effect of lost funding across MSI, PPFI, and International HIV/AIDS Alliance locations, the impact of lost UNFPA funding, and FY17 funding, which was incomplete.

## Findings

The composite scores range from 0 (countries who do not receive USG bilateral health aid and so are unaffected by the MCP) to 96 (Liberia), out of a possible 144 points. Liberia (96), Burundi (80), and Tanzania (60) demonstrated the greatest overall risk to women's health among the 34 aid recipient countries. All three countries scored as “high” in policy exposure and “very high” in all other categories. Liberia scored as “high” in policy exposure as it had the second-highest health aid spending per USG per capita (\$1.42 - total of \$58.7 million) spending on health during the Obama administration, and very high for all other criteria - as 32% of married women cannot meet family planning needs and an estimated 6 women of every 100,000 births die from induced abortion complications. Egypt, Botswana,

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	Exposure to MCP Policy (1-9)	Demand for Family Planning Services (1-4)	Mortality Risk (0.5-4)	Total Score \ (0-144)
<b>Low</b>	Egypt (1) Angola (1) Mali (2)	Botswana (1) South Africa (1) Namibia (1)	Botswana (0.5) South Africa (0.5) Namibia (0.5)	Egypt (1) Botswana (3) South Africa (3.5)
<b>Moderate</b>	Togo (3) Cameroon (3) Malawi (3)	Zambia (2) Uganda (2) Ethiopia (2)	Togo (2) Swaziland (2) Ghana (2)	Cameroon (9) Angola (10) Rwanda (12)
<b>High</b>	Zambia (5) Uganda (5) Mozambique (5)	Sierra Leone (3) Ghana (3) Burkina Faso (3)	Mali (3) Cameroon (3) Zimbabwe (3)	Ghana (22.5) Niger (24) DR Congo (24)
<b>Very High</b>	South Africa (7) Namibia (7) Ethiopia (7)	Madagascar (4) Senegal (4) Angola (4)	DR Congo (4) Guinea (4) Burundi (4)	Burkina Faso (42) Côte d'Ivoire (42) Somalia (42)

\*Unmet demand statistic not available - infer through 15% prevalence rate for all contraception  
\*\*Unmet demand statistic not available - infer through 19% prevalence rate for all contracep-

and South Africa respectively had the lowest risk scores due primarily to higher women's health outcomes and relatively low health spending in Egypt. This study provides a preliminary analysis of which countries would be most impacted by the MCP. Research demonstrates that these policies have a chilling effect on women's health outcomes, as depressed access to family planning results in higher induced abortion rates with high mortality risk.

## Sources

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