How Existing U.S. Policy Limits Global Health and the Achievement of Millennium Development Goals to Improve Maternal Health and Promote Gender Equality

By Jamila Taylor and Anu Kumar

The nexus between global health and U.S. national security, including women’s rights and health, is explicitly discussed in the U.S. National Security Strategy. This accompanies the announcement of the $63 billion Global Health Initiative (GHI). This article argues that the U.S. role is hampered by policies and practices that diminish its potential impact, specifically, the Helms Amendment and the ongoing effects of the Mexico City Policy. Additionally, the disproportionate level of funding for global HIV/AIDS programming overshadows other health concerns that impact women on a global scale and the complexity of the global health bureaucracy makes it difficult to achieve significant impact.
Introduction

The issue of global health has increased in prominence steadily in U.S. foreign policy circles for the past decade. Some have described the change in the relationship between health and international relations as a “political revolution” in that health has become a politicized topic. Early indications of a shift in thinking were Secretary of State Colin Powell’s address on HIV/AIDS to the United Nations in 2001 followed by the creation of the President’s Emergency Plan For AIDS Relief (PEPFAR) by President George W. Bush. The nexus between global health and U.S. national security interests is now explicitly discussed in the Obama administration’s National Security Strategy (NSS). This represents the first time that a strategic, overarching view of the United States’ role in health and development has been expressed in a national security policy document. In addition to recognizing the need to achieve the Millennium Development Goals, the NSS highlights the importance of women’s rights including the promotion of maternal and child health as part of a broader strategy to instigate peace and prosperity.

This rhetoric accompanies targeted financial resources with $63 billion proposed by the United States over a six-year period (from fiscal year 2009 to fiscal year 2014) for the Global Health Initiative (GHI). A total of $8.6 billion has been allocated for fiscal year 2010 alone. Indeed, federal funding for the GHI plus funding for other global health programs comes to a total of approximately $10 billion in fiscal year 2010. It does appear that global health has moved from “really low politics” to higher status in the political hierarchy, though women’s health continues to be significantly low in both political and budgetary terms.

As impressive and laudable as this may be, it is safe to say that global health continues to be lower down on the list of budgetary priorities relative to other issues. The GHI represents less than 1 percent of the overall federal budget and HIV/AIDS takes the lion’s share of that while spending on maternal and child health, along with family planning and reproductive health, has actually declined over the last several years (see Figures 1 and 2).

Figure 1

U.S. Global Health Initiative (GHI), Proposed Funding for the President’s Emergency Plan for AIDS Relief (PEPFAR), Malaria, & Other Global Health Priorities, Fiscal Years 2009–2014

In Billions

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Global Health Priorities</td>
<td>$12</td>
<td>19%</td>
</tr>
<tr>
<td>PEPFAR &amp; Malaria</td>
<td>$51</td>
<td>81%</td>
</tr>
<tr>
<td>Total</td>
<td>$63</td>
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Thus, it appears that what we are witnessing is a slight turn toward health and development by the United States government rather than a complete pivot.

While the funding scenario is generally positive, the governance of the GHI and global health programs in general by the United States government has only become more complicated. Currently, five different federal departments or agencies govern the GHI: the Department of State (State), the U.S. Agency for International Development (USAID), the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Department of Defense (DOD). The agencies serve on an Interagency Task Force, which is overseen by the White House. This structure reflects the various agencies and departments that currently have a role to play in the implementation of U.S. global health programs. How the agencies and departments coordinate the United States’ first comprehensive global health strategy is still largely unknown and untested.

This paper argues that despite the new commitment to global health and women’s health by the United States government, the U.S. role is hampered by the existence of the disproportionate level of funding for global HIV/AIDS programming through PEPFAR has made it difficult to raise the profile of other burgeoning health concerns affecting women on a global scale.
of policies and practices that diminish its potential impact. Specifically, this paper argues that the Helms Amendment and the lingering effects of the Mexico City Policy both work to undermine U.S. efforts to reduce maternal mortality and morbidity. Additionally, the disproportionate level of funding for global HIV/AIDS programming through PEPFAR has made it difficult to raise the profile of other burgeoning health concerns affecting women on a global scale. Insufficient implementation of the GHI in terms of coordination among government entities, restrictive U.S. foreign policies, disproportionate funding for U.S. global health programs, and the overall complexity of the global health bureaucracy make it difficult to achieve significant impact.

The United States Global Health Initiative (GHI)

The Global Health Initiative was announced by the Obama Administration on May 5, 2009. The Initiative was developed in order to usher in a new model for implementing U.S. global health programs in the developing world. With a price tag of $63 billion over six years—of which 81 percent is allocated for AIDS relief through PEPFAR and malaria alone—the Obama administration described the program as a new, comprehensive global health strategy that demanded integration of critical global health programs to match the interconnectedness of this world.

In addition to prioritizing maternal and child health and family planning, the GHI focuses on six other global health concerns, including HIV/AIDS, malaria, tuberculosis, nutrition, neglected tropical diseases, and health systems strengthening. Core principles of the Initiative include implementing a woman-girl centered approach; increasing impact through strategic coordination and integration; strengthening and leveraging key multilateral organizations, global health partnerships, and private sector engagement; encouraging country ownership and investing in country-led plans; building sustainability through health systems strengthening; improving metrics, monitoring, and evaluation; and promoting research and innovation.

Improving coordination across U.S. government agencies is a goal included in the GHI’s operational plan and is encapsulated in one of the four main components of GHI implementation. A GHI Strategic Reserve Fund, also known as GHI Fund, will be put in place in order to provide financial support beyond the funding allocated for specific global health programs. Another purpose of the Fund is to assist in maintaining a system of outputs that will be linked to programs for reporting, leading to common performance goals across U.S. government agencies. This is the mechanism for which collaboration across agencies is projected to operate efficiently and effectively.

In addition to the GHI Fund, two collaborative bodies have been put together to oversee and monitor implementation. An Operations Committee, which includes the Administrator of USAID, the U.S. Global AIDS Coordinator, and the Director of the CDC, is tasked with leading the initiative alongside the Deputy Secretary of State. A Strategic Council is to work in tandem with the Operations Committee in providing policy support and advisement to administration officials. As stated previously, it is unknown how this model for implementation of global health programming will work. A more formal structure for coordinating the GHI would seem more useful. It will be critical for the programmatic rollout of the GHI that a process for collaboration
works almost seamlessly. If it does not, the GHI will face mishaps in its operations that may be detrimental to countries where health systems are already constrained and infrastructure to reach populations most vulnerable to ill health is lacking.

A key aspect of the GHI is the focus on addressing the challenges faced by women and girls, which are multifactorial when considering the compromised position of the population within communities and family structures. The challenges go beyond access to comprehensive, integrated health services. They also encompass dealing with the realities of structural inequalities as well as gender inequities that are profound within developing societies. This makes the GHI an important contribution for addressing national security and meeting the MDGs. However, because certain U.S. policies restrict access to vital reproductive health services and funding throughout the global health portfolio is disproportionate, the GHI will be limited in its reach and the U.S. role in meeting broader development objectives risks being deficient at best.

Flawed Policies

Two of the U.S. foreign policies that have direct bearing on maternal health are the Mexico City Policy and the Helms Amendment. These policies are often conflated with each other so each policy will first be explained and followed by a discussion of their impact on women’s health overseas.

The Helms Amendment was appended to the U.S. Foreign Assistance Act in 1973. The Amendment stipulates that “no foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions.” The law also states that the Helms Amendment will not prohibit the funding of information or counseling about all pregnancy options, according to local law.

The Mexico City Policy, also known as the Global Gag Rule, is an extension of the Helms Amendment. It denies foreign organizations receiving U.S. family planning assistance the right to use their own non-U.S. funds to provide legal abortion, counsel or refer for abortion, or lobby for the legalization of abortion in their country. The policy originally was announced by the Reagan administration at the 1984 United Nations International Conference on Population in Mexico City. It was rescinded in 1993 by President Clinton, and subsequently reinstated in 2001 by President George W. Bush on his first business day in office. With the election of President Barack Obama, the Mexico City Policy was rescinded, though the extent to which this action and the implications of it have been communicated with overseas organizations is questionable. In addition, the fact that the existence of the policy depends on which political party is in power in Washington, D.C. leads to confusion on the part of overseas groups and an understandable desire to avoid the whole issue.

The Nepal Example

Confusion and dismay over the application of U.S. foreign policy restrictions related to abortion and family planning through the Helms Amendment and the Mexico City Policy have caused large percentages of women to remain without access to
reproductive health care. In 2009, research was conducted by Ipas, an international non-governmental organization that works to reduce maternal deaths and injuries resulting from unsafe abortion,\textsuperscript{16} in order to examine the impact of the Helms Amendment and the Mexico City Policy on the provision of safe abortion care in Nepal. Nepal was in a unique position politically as the country had undergone legal reform in 2002. At that time, its abortion law was changed to allow for the provision of abortion care up to twelve weeks gestation for any reason and in certain circumstances for later gestational ages.\textsuperscript{17} The 11th Amendment to the Nepal Country Code was also instituted in 2002 and proved to be an additional move forward in the advancement of women's rights. The Amendment ended existing discriminatory laws around marriage, property, and sexual harassment. After the liberalization of local abortion law, the Nepali government began to implement a comprehensive abortion care plan in 2004. A national safe abortion program was prioritized through the Ministry of Health and Population, and safe abortion care became available in all seventy-five districts of Nepal by 2009.\textsuperscript{18}

Ipas’s research yielded the finding that understanding of current U.S. foreign policy restrictions varies widely in Nepal. Non-governmental organizations and Nepali government staff who receive funding from the U.S. government (through USAID), as well as other international donors and development agencies, display a wide array of misinformation about and misunderstanding of the repeal of the Mexico City Policy. Perceptions regarding the repeal of the policy range from a complete lift of U.S. restrictions on any abortion-related activities, to organizations believing they are still bound by the policy. Additionally, the Helms Amendment and the Mexico City Policy are being conflated. Because of the lack of understanding about the interaction between the two policies, health workers and health professionals fail to comprehend the impact on the provision of comprehensive reproductive health care.

Another key finding included the bifurcation of services into family planning and abortion, which is further fragmented due to U.S. funding for post-abortion care\textsuperscript{19} while funding for safe abortion\textsuperscript{20} is prohibited through the Helms Amendment. Implementation of policy, along with the allocation of funding in this manner, serves to entrench a lack of service integration in the public health care system. The GHI rests on a framework developed for the purpose of implementing an integrated model for global health, yet the Initiative will be implemented under the same circumstances—stifled by U.S. foreign policy restrictions on reproductive health care and governed by a segmented funding structure. The Nepal example also shows that the application of U.S. foreign policy restrictions has led to perverse situations where abortion services either had to be forgone or be provided out of maternity delivery rooms because USAID did not permit the use of the post-abortion care rooms for safe abortion services. The artificial separation of a critical continuum of reproductive health care harms access to services vital for women’s health and lives.\textsuperscript{21} An HIV-positive woman is disadvantaged if she attends a clinic for the treatment of an AIDS-related illness, yet has no access to information about family planning, safe abortion, or any of her reproductive options. Although it may seem practical to separate the services due to administrative burdens or funding shortfalls, it is noted throughout the literature that such a model can overburden clients as well as the health system.\textsuperscript{22}
Achieving the Millennium Development Goals and National Security

The United States joined with other members of the United Nations in signing on to the Millennium Declaration in 2001.\textsuperscript{23} The document was later translated into goals, what we now know as the Millennium Development Goals. A year later, the United States would declare a promise to “secure public health” and “emphasize education,” among other aspects key to global development, in its National Security Strategy.\textsuperscript{24} Similar statements can also be seen in the most recent U.S. National Security Strategy, unveiled in May of 2010. Hence, the U.S. government is on the record in supporting the world’s developing countries and has made critical investments in certain programs, like PEPFAR. However, the United States has failed to match its policies with its rhetoric.

The Helms Amendment and the Mexico City Policy are especially relevant for the achievement of MDG 5 to improve maternal health. MDG 5 has two target areas, 5A and 5B. The former calls for a three-quarters reduction of the maternal mortality ratio and the latter for universal access to reproductive health care by 2015.\textsuperscript{25} MDG Target 5B also highlights the need for adequate funding for family planning as a key investment in the improvement of women’s health.\textsuperscript{26} Unsafe abortion is one of the leading causes of maternal death and disability.\textsuperscript{27} The public health literature is definitive that this cause of death must be addressed along with others in order to reduce the maternal mortality ratio.\textsuperscript{28} Every year about 47,000 women die as a result of complications brought on by unsafe abortions.\textsuperscript{29} Access to modern contraception, coupled with access to safe abortion care, increases a woman’s chance of leading a healthy and productive life—a life free of preventable death and injury. The World Health Organization asserts that where there are few restrictions on the provision of safe abortion care, deaths and injuries resulting from unsafe abortions are reduced dramatically.\textsuperscript{30} Given the significance of the role of maternal health and family planning in the GHI, it is difficult to imagine how it will be possible to achieve either or both parts of MDG 5 with existing U.S. foreign policies that restrict access to comprehensive reproductive health care.

U.S. Funding Structure and Policy Implementation

The conflation of U.S. foreign policy restrictions has led to misunderstandings about the provision of certain reproductive health services paid for with U.S. funding, along with imposed limitations on how that funding can be spent within global health programs. To make matters more difficult, the U.S. global health funding structure is dictated by a vertical model, which apportions funding by health concern or condition. For example, funding for international family planning and reproductive health is allocated as its own funding stream through the global health and child survival account of the U.S.
international affairs budget. Funding for maternal and child health is allocated in the same manner and through the same account, as well as funding for global HIV/AIDS. As we have seen in Figures 1 and 2, the levels of funding for each of these programs differ drastically. A more effective model could be to appropriate funds in an integrated manner, without the stipulations brought on by foreign policy restrictions, in order to help complement the framing of the GHI.

The purchase of contraceptives is permitted through both maternal health funding and family planning/reproductive health funding (disbursed to USAID), while global HIV/AIDS funding (disbursed to the Office of the Global AIDS Coordinator, which administers PEPFAR) is not currently being spent on contraceptive commodities. This is a policy decision that has been made by senior staff within the Office of the Global AIDS Coordinator. It should be noted that there is no legal stipulation prohibiting the use of global AIDS funds for contraceptive commodities. Arbitrarily withholding the provision of a vital reproductive health service can cause confusion under an integrated global health strategy, especially with high rates of unmet need for family planning among HIV-positive women. Additionally, U.S. law under the Helms Amendment entitles funding for post-abortion care, whereas funding for safe abortion is prohibited. Since the purpose of the GHI is to institute an integrated model for global health, including all of the aforementioned global health concerns, questions about the implementation and rollout of the GHI are only natural as disproportionate funding across global health concerns remains, as well as misunderstandings about the application of certain U.S. foreign policy restrictions.

Disproportionate funding for the health sectors included in the GHI may also pose a problem for its implementation. The Obama administration allocated just over $5 billion for HIV/AIDS in fiscal year 2011, while funding for maternal and child health was allocated at $700 million and family planning/reproductive health at $590 million. The other health sectors were allocated funding amounts in the several hundred millions. Because the GHI’s focus is to ensure the health and well being of women and girls, inadequate funding for the most significant global reproductive health programs seems nonsensical. The global need for both maternal and newborn health, as well as family planning, is an estimated $24.6 billion. Investing at least $1 billion in each of the reproductive health areas (maternal and child health and family planning/reproductive health) would put the United States on course toward fulfilling its fair share of the global need. According to the Guttmacher Institute, investments in family planning and maternal and newborn health result in fewer unintended pregnancies, fewer maternal and newborn deaths, strengthened economies, greater productivity, and reduced pressure on natural resources in developing countries. These are all key aspects of meeting the MDGs as well as national security.

Conclusion and Recommendations

The United States has elevated its commitment to achieving the MDGs and national security with the development of the GHI. Although the GHI makes concrete targets and allocates dedicated funding over the next several years, shortfalls in the funding of certain reproductive health programs and the institution of U.S. foreign policy
restrictions will make it difficult to implement an integrated approach to global health with women and girls at the center. Further, due to the number of U.S. government agencies tasked with implementing the GHI, questions have been raised about the efficient and effective collaboration of those agencies. Such collaboration is paramount to the implementation of a comprehensive and integrated approach to global health, one that calls for a more formal collaborative structure.

The conflation of the Mexico City Policy and the Helms Amendment has led to an array of misinformation among local U.S.-funded entities, while also hampering the delivery of vital reproductive health care to women and girls who need it the most. Although the power for each of these policies rests within different branches of the U.S. government, full repeal of both through the legislative action of Congress is the best mechanism for ensuring the rollout of comprehensive global reproductive health programs that include access to safe abortion services. Along with access to family planning, the provision of safe abortion care is key to reducing maternal deaths and injuries, which have major implications for meeting MDG 5. Without a full repeal of the Mexico City Policy, executive orders may be used to play political games with women’s lives and further confuse USAID grantees. Without a repeal of the Helms Amendment, women will be denied access to vital reproductive health services and U.S. global health programs will lack the resources needed to provide them with comprehensive care.

Disproportionate funding for U.S. global health, with the lion’s share being allocated for HIV/AIDS, has caused the U.S. to fall behind in contributing its fair share of the global need for maternal and child health and family planning/reproductive health. The U.S. government must evaluate its priority and commitment to addressing maternal and child health and family planning as part of the GHI beyond the rhetorical value of statements at international gatherings. Along with the inclusion of reproductive health in an integrated model for global health, increased funding must also be a part of the plan in order to ensure that adequate resources are available to help meet the growing reproductive needs of women and girls in the developing world. It is recommended that at least $1 billion in U.S. funds be allocated for both maternal and child health and family planning/reproductive health to adequately help meet the global need for reproductive health, which is tantamount to meeting the MDGs.

– Ildiko Hrubos and Sarah Mine served as lead editors of this article.

NOTES

4 Fidler, “Health and Foreign Policy,” 179.
6 Ibid.
7 Ibid.


The World Health Organization defines unsafe abortion as any procedure for terminating an unwanted pregnancy done by persons who lack the necessary skills or that which is conducted in an environment that lacks the minimal medical standards, or both. Such abortions may be performed by the woman herself, or by non-medical personnel or health workers.


According to Ipas, postabortion care includes three critical elements: emergency treatment of complications of spontaneous or induced abortion, family planning counseling and services, and linkages between emergency care and other reproductive health services.

According to Ipas, safe abortion care services include three elements that will contribute to reductions in maternal mortality: contraception and safe abortion to prevent and manage unwanted pregnancies; and prompt and appropriate treatment of pregnancy-related complications.

Taylor and Skuster, U.S. Foreign Policy and Abortion, 1.


According to Population Council, unmet need for family planning is used to describe women of reproductive age in the developing world who wish to delay childbearing, space births or want no more children but are not using a modern method of contraception.


Ibid., 4.