The Global Gag Rule: Another Form of Medical Care Under Fire: by Jason Cone, MSF USA General Director

The 2017 IGA will discuss the issue of internal barriers to providing safe abortion care in MSF projects. This is a contribution to the debate by Jason Cone, MSF USA General Director

The Expansion of a policy that denies U.S. global health funding to organizations that counsel women on abortion, comes as MSF struggles to provide lifesaving service through safe abortion services

A new and vast front in the war against women's health was opened on January 25, 2017, with the U.S. government's reinstatement and expansion of a decades-old policy known as the so-called "Global Gag Rule" (GGR).

The GGR, officially known as the Mexico City Policy, prohibits nongovernmental organizations from receiving US funding for performing or providing counseling or information about abortion. Under previous administrations, the policy was limited to organizations providing family planning services.

In early May, the worst fears of women's health advocates were realized when this policy was expanded to include all U.S. government foreign aid for global health. This means that an organization that receives US funding for HIV or malaria prevention, for example, will lose funding if it provides pregnant women with any counseling or information that even mentions abortion.

Studies have shown the devastating impact of the GGR when it was solely "limited" to the roughly $600-$700 million of family planning funds from the U.S. government between the Clinton Administration, when the policy was revoked, and the Bush Administration, when it was reinstated. The consequences included decreases in the use of contraceptives at the peak of the HIV pandemic and increases abortion, many of them unsafe.

With the radical expansion of the policy to cover at least $9.5 billion for global health assistance, government-wide, we can expect dire repercussions across many of our fields. The decision of Marie Stopes International alone to forgo U.S. funding, to comply with its operational principles, will result in 6.5 million, unintended pregnancies, 2.2 million abortions, 2.1 million unsafe abortions, and 21,700 maternal deaths. Marie Stopes projects that the related health-care costs will exceed $400 million. International Planned Parenthood Federation, which will turn down $100 million in U.S. support, estimates that the withdrawal in funding from the Federation will lead to an additional 20,000 maternal deaths, 4.8 million unintended pregnancies and 1.7 million unsafe abortions. The latest global figures from the WHO estimate that 46 million abortions are requested per year, with roughly 20 million considered unsafe.

A History of Falling Short

This reinstatement and expansion of the GGR comes against the backdrop of 13 years of MSF's failure to provide lifesaving abortion care. While we have talked a good game at the highest level of the association with the passage of an International Council resolution in 2004 affirming MSF's commitment to the, "provision of termination of pregnancy, based on the medical and human needs of our patients", we have struggled to meet the needs of our patients in the field.

Provision of safe abortion services, as evidenced by the analysis and reflection of the Reproductive Health and Sexual Violence Care Working Group, has been reduced to personal, operational choice even though it strikes at the heart of our identity as a medical humanitarian organization. According to the debate paper for the IGA, "At times, MSF staff members may personally support safe abortion care but are reluctant to implement it in their project due to concerns about its potential impact on MSF's operations and security."

This is a damning statement. Effectively, our operations are deciding to deny access to a medical procedure because the provision of lifesaving care might endanger a field program. Viewing the delivery of a much-needed medical procedure to our patients through a threat matrix is a dangerous compromise of our principles. Yet this is an unsurprising state-of-affairs given MSF's aversion to addressing the topic of abortion in our internal and external communication. The lead up to the IGA and recent publications by Catrin Shulte-Hillen, working group leader, and Severine Caluwaerts are a break from the past in this regard.

The consequences have been devastating and the numbers don't lie. Data from the past three years, according to the working group, reflects that 25 to 35% of the projects which provided either obstetric care or sexual violence care or both report having ensured provision of safe abortion care in MSF services or having referred patients in need to an alternative quality provider.

While we've seen improvements in 2015, the latest figures from the working group remain far below the need: "In 2015 only 50 projects reported having provided termination of pregnancy or having referred women/girls in need for safe abortion care; a total of 517 women/girls received medical care for termination of pregnancy – few directly from MSF; most via referral." At the same time, teams treated 12,000 women for complications associated with unsafe abortions.

De facto, MSF is denying a lifesaving and morbidity reducing form of medical care to our patients in breach of meeting the needs of our patients. Simply put, our institutional and operational inertia is putting women's lives at risk. This is an unacceptable compromise that we would never accept from State or Non-State actors if it were imposed on us in terms of limiting access to our facilities. This reality has laid bare the limits of top-down approaches to concrete operational challenges.

We fight for the right to treat the enemy, yet leave women behind. It is a harsh conclusion but a valid one to reach in the face of hard facts.

One Patient at a Time

The creation of the "Safe Abortion Task Force in DRC" is a major step forward in engaging operations. But it is wholly insufficient to the scale of neglect and the operational reality that we are now confronted with given the expansion of the GGR.

We need both an operational and advocacy strategy if we are going to be serious about addressing the shortcomings of our own operations and able to step up to the challenge of filling that gap in care that is on the horizon with the impending loss of reproductive health services from other organizations in many of our fields of operation.

The provision of safe abortion care is a complex challenge with many different barriers to overcome. There is no one-size-fits-all approach to ensuring the service is available. In some contexts, we may be forced to be more low profile, integrating care within larger medical programs, while in others a more vertical approach may be the solution. The development of the tool kit, videos, and other trainings initiated by the task force are welcome initiatives, but we must combine political will with intelligent and well-resourced strategies to overcome the obstacles to care.

Defending Humanitarian Space

For too long, the issue of safe abortion care has been viewed solely as a matter of women's health. But so much more is at stake. Denying access to this service, whether through our own neglect or external laws and policies, is a form of violence against women. As an organization and association that professes to ease the suffering of victims of violence, we are falling horribly short of our mission.

Part of creating the safe space for the provision of abortion services is ensuring the institution is ready to back up our teams on the field, knowing that the stakes can be very high for our colleagues. Hiding an aspect of our work because it may generate controversy or not be accepted in the societies where we raise funds or recruit staff is not the answer.

Over the past three years, for our small part at MSF USA, we have gone through a deliberate process, working hand in hand with the women's health working group, to publicly address that MSF provides safe abortion services. This was done through the "Because Tomorrow Needs Her" multimedia project (womenshealth.msf.org) and denouncing the reinstitution and expansion of the Global Gag Rule. We have addressed these issues with our major donors, a group that provides more than $100 million towards MSF's programs worldwide. The result has been largely resounding support with only a few donors walking away.

While these efforts in the US have been framed through the lens of health rather than rights, these actions are grounded in taking the sides of our patients and fighting back against policies and practices that essentially attack the safe space for our clinicians to counsel our patients.

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From Rhetoric to Action

Women cannot afford further MSF institutional and operational stagnation on this issue. The fact of the matter is that our patients face tremendous hurdles ranging from economic to legal, to ethical and cultural obstacles to get the care they desperately need. And because of the stigma attached to having an abortion, many women remain in the shadows, often physically scarred for life from being forced to have an unsafe termination of pregnancy. The loss of fertility in many societies in which we operate is at best a path to being ostracized, at worst a death sentence through abandonment or violence.

There is a role to be played at all levels of MSF:

- The International Board must again reaffirm its commitment to the provision of safe abortion care and hold the Executive accountable;
- National Boards must challenge their executives and push us beyond a risk-averse position on safe abortion care;
- General Directors must be willing to confront the perceived controversy that may arise in our home societies when talking about our policy and the political dimensions of what it means to deny this service to our patients;
- Operational Directors need to push desks for inclusion of abortion care in our services, potentially envisaging the establishment of vertical programs and operational research to document the internal and external barriers to care for our patients;
- Medical Directors need to ensure the safety and efficacy of methods while also pursuing innovation in reproductive health care;
- Epicentre, the Manson Unit, SAMU, BRAMU, and other operational research entities should be conceiving a research agenda to fill the gap in knowledge on the mortality and morbidity associated with unsafe abortion in our catchment areas;
- The HART network and Communications Directors should support the development of communications to speak out and advocacy strategies to engage governments and multilateral institutions;
- HR directors must ensure our field staff are willing to support the provision of this care even if they hold ethical concerns about directly conducting the procedure themselves and that our staff are trained to create a workplace environment that accepts and protects;
- Communications and Fundraising Director must not shy away from hard discussions with donors and the public.

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While we take time at the IGA to look in the collective mirror, let's raise the level of ambition in this fight for our patients. Because unlike so many issues we face today – whether lack of medical innovation or attacks on our hospitals – the fate of our patients is squarely in our hands.

Today, we are confronting another form of violence against our patients in the GGR expansion – medical care under fire by other means. It is a phenomenon made all-the-more sinister by our organizational complicity in denying lifesaving care.