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

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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

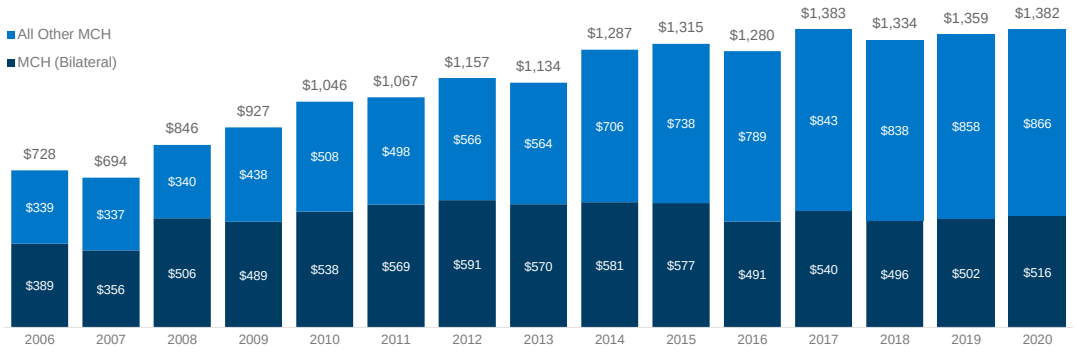
Funding[25]

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

U.S. Funding for Maternal & Child Health (MCH) and Nutrition, FY 2006 – FY 2020



NOTES: Overall totals include MCH and nutrition funding provided through USAID and CDC as well as U.S. contributions to UNICEF. "All Other MCH" includes funding for nutrition and polio at USAID, global immunization programs at CDC, and U.S. contributions to Gavi and UNICEF. Prior to FY09, nutrition funding was included as part of MCH. Does not include funding provided through Food for Peace (FFP) due to the unique nature of the program. 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 MCH and nutrition funding is determined at the agency level and is not yet known for FY19 and FY20; for comparison purposes, these amounts are 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.

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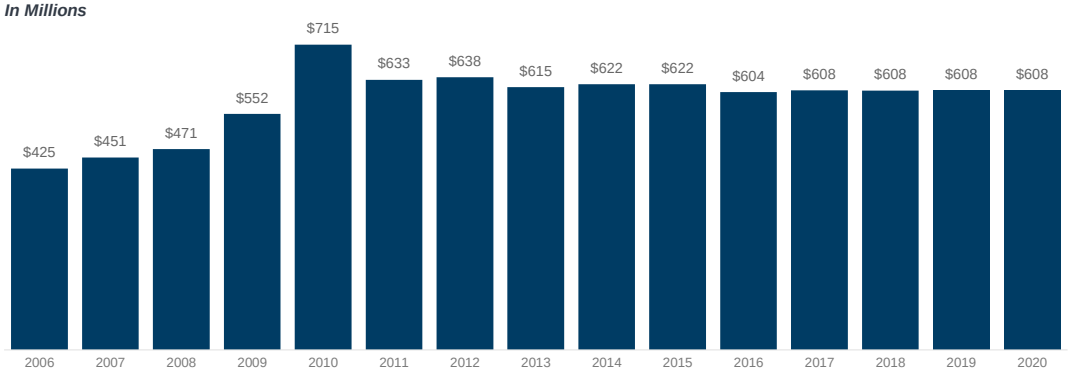
FP/RH: The majority of U.S. FP/RH funding is provided to USAID for bilateral activities, with additional funding provided for the U.S. contribution to the United Nations Population Fund (UNFPA). Funding for FP/RH rose steadily over its first two decades of U.S. support but has since fluctuated over time 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

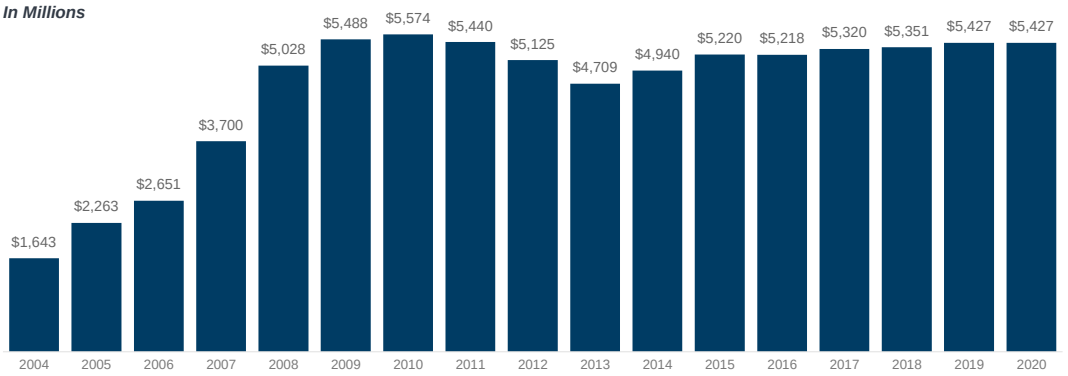


NOTES: Includes FP/RH funding through USAID as well as U.S. contributions to UNFPA. Includes base and supplemental funding. FY13 includes the effects of sequestration. FY20 is based on funding provided in the "Consolidated Appropriations Act, 2020" (P.L. 116-94) and is a preliminary estimate.
SOURCE: 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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