Global Justice Center
Human Rights Through Rule of Law

Oral Evidence to the UK APPG on Population, Development and Reproductive Health inquiry on "Abortion in the Developing World and in the UK"

November 22, 2017

(as prepared)

Thank you for the opportunity to present oral evidence to the APPG on Population, Development and Reproductive Heath today on the topic of Abortion Globally and in War Zones. I'm Akila Radhakrishnan, the Vice-President and Legal Director of the Global Justice Center, an international human rights organization focused on using international law to ensure women's equality. Today, I would like to speak with you about how the UK can continue its excellent leadership in protecting abortion as a matter of women's rights under international law, including through the funding of abortion services with its development and humanitarian aid. My presentation is divided into two sections.

First, I will address the implications for the global sexual and reproductive rights landscape resulting from the reinstatement and expansion of the Global Gag Rule by US President Trump and why leadership by the UK and likeminded donors is even more critical today.

Second, will I discuss how the UK can better ensure that girls and women affected by conflict—including those raped in war zones—receive the medical care they need and are entitled to, including abortion services.

A major current barrier to the provision of abortion services around the world are US abortion restrictions on foreign assistance—not only the recently reinstated and expanded Global Gag Rule, but also the long-standing Helms and Siljander amendments which directly restrict how US funds—and indirectly funds from other donors—may be used.

The Helms amendment restricts the provision of abortion services, with no exceptions for rape, life endangerment and incest, as well as nearly all abortion-related speech with US foreign assistance funds. The Helms amendment has been imposed on the US foreign aid continuously since 1973. The Siljander amendment prevents US grantees from engaging in speech that could be considered "lobbying for or against abortion" with their US funds. This speech censorship is not only broad, but it is also rigorously enforced by the US government, even under Democratic leadership and has impeded the ability of governmental and civil society actors to advocate for, or pursue policies, that could improve access to safe abortion in their own countries. This restriction, like the Helms amendment, is also long-standing—it has been imposed on US foreign aid since 1981.

Together, these restrictions, which apply to all recipients of US foreign assistance regardless of the type of organization, constitute an absolute ban on abortion related service provision and speech with US foreign funds, which in 2017 totaled approximately $36 billion dollars. Furthermore, where grantees do not segregate their US funds from funds of other donors, these restrictions can also censor funds from other donors as well. The application of these restrictions

has resulted in severe harm to women and girls around the world for decades, including through the denial of abortion services for female war rape victims in humanitarian settings.

Exacerbating the impact of these restrictions is President Trump's reinstatement and expansion of the Global Gag Rule ("GGR"), now termed the "Protecting Life in Global Health Assistance" policy in January 2017. The Global Gag Rule in essence extends the provisions of the Helms and Siljander amendments on non-US based NGOs to cover the entirety of their activities, including those funded by other donors.

President Trump not only reinstated the rule as it had been imposed by previous Republican presidents, but also expanded it to cover all US global health assistance funds, which amounts to approximately $8 billion in 2017. Previous iterations of the Gag Rule only applied to US family planning assistance. As a result, funding for a whole range of health services is impacted, including maternal and child health, malaria, nutrition, Zika and HIV. This unprecedented expansion of GGR's scope will no doubt narrow the number of providers around the world who are willing and able to provide information about abortion and provide abortion services.

As the expanded Gag Rule has only recently started to be implemented since it only applies to new or modified funding agreements, the negative impacts of this new Gag Rule remain unknown. However, studies on the impacts in previous times when the Gag Rule was in place have shown that abortion rates have actually increased due to the decreased availability of family planning and contraceptive services, and that providers have had to fire staff, reduce available services, and charge higher fees or close altogether. It is likely that these impacts will be exacerbated under the expansion. One recent study of the early impacts of the expanded Gag Rule in Kenya and Uganda has already found that there is widespread lack of information about the policy and overreach in its implementation; reductions in key sexual and reproductive health services due to anticipated funding losses; a loss in training and technical support to government clinics providing abortion in circumstances legal under the GGR; and concerns over increased unsafe abortion and maternal deaths.

The challenges posed by US abortion restrictions, in particular in today's landscape with the expanded Global Gag Rule in place, requires that other international donors take proactive measures to ensure that the ideologies of anti-choice politicians in the United States do not dictate the care that is available to women and girls around the world. The UK has long taken leadership on this issue—including by instituting a development policy that commits to funding abortion services and engaging in conversations with the US government on the Helms amendment—and its continued leadership is needed more than ever.

Proactive steps that can be taken have already emerged: the Dutch She Decides fund is an important start to filling the funding gap caused by the GRR, as are the UK's increased funding commitments for SRHR over the next 5 years. While these steps are laudable, it is essential that they be sustained and extend beyond 2017 and the initial outrage around the Global Gag Rule. We urge the UK to take leadership in doing so.

Furthermore, beyond funding, there are other steps the UK can take to help eliminate the cloud of confusion and censorship imposed by US abortion restrictions on foreign assistance. First, states like

the UK must use their voice to reinforce the importance and centrality of abortion to women's human rights and equality. When the Global Gag Rule has been in place in the past, we saw a marginalization of abortion in order to focus on the "less controversial" aspects of family planning, which in effect feeds the "success" of the US's abortion censorship. As a result, it is essential that measures to combat the Global Gag Rule are grounded in women's rights, including to abortion. Second, even with the GGR in place, those subject to it may continue to engage in certain activities, including the provision of abortion and information about abortion in cases of rape, threat to life and incest, as well as "passive referrals" where a woman clearly states her intention to have an abortion and asks for information as to where to obtain one. All donors should ensure that where they fund organizations who have signed the Gag Rule, they continue to, at a minimum, provide permitted information and services.

Third, the UK should ensure that those who are not subject to the GGR segregate their US funds from UK funds in order to ensure that the Helms and Siljander restrictions are not applied to UK money.

Now I would like to turn to the issue of access to abortion for women in war zones.

In recent years, in large part due to increased attention at international levels to sexual violence in situations of conflict, access to sexual and reproductive health services, including abortion has become an increasing priority in humanitarian action. This has been paralleled and supported by a growing global consensus that abortion is protected and necessary medical care for women under international human rights and humanitarian law. However, while precise data points on this issue are not available, we know that access to abortion services on the ground remains limited, if not totally absent, in the majority of humanitarian settings.

While there are a multitude of reasons why safe abortion services are not currently available in the majority of humanitarian settings (including abortion stigma, attitudes amongst humanitarian actors, and restrictive donor policies), perhaps the most frequently cited reason is restrictive abortion laws. However, relegating abortion services to the confines of national law fails to take into account the full framework of laws governing the provision of care to those affected by armed conflict, including international humanitarian and human rights laws.

These treaties set forth a variety of individual rights that support access to abortion including: the right to life; right to non-discrimination; right to information; right to health and medical care; the right to be free from torture and cruel, inhuman and degrading treatment.

In the in the context of armed conflict, it is international humanitarian law (IHL), that is the *lex specialis*, or in other words, the law that specifically governs situations of armed conflict. IHL, in order to achieve its aim of limiting the suffering of those affected by conflict, provides essential protections to them—including pregnant persons or survivors of sexual violence. Specifically, they are to be provided "to the fullest extent practicable and with the least possible delay the medical care and attention required by their condition," without discrimination, including on the basis of sex. In other words, women and girls impregnated in war are entitled to any and all of the medical care that they may need, whether that be safe and quality maternal care or, for those who wish to terminate their pregnancy, safe abortion services.

While IHL is the *lex specialis* of armed conflict, obligations and rights under international human rights law run concurrently and help to define IHL rights. This is particularly important as IHL does not define the specific care to be provided, rather it establishes broad based protections that can be adapted to the needs of modern conflict. Accordingly, the protection of abortion services under IHL is bolstered by rand must be interpreted in light of parallel protections under human rights law, including under the International Covenant on Civil and Political Rights, the Convention on the Elimination of all Forms of Discrimination against Women, and the Convention against Torture, and Other Forms of Cruel, Inhuman and Degrading Treatment.

As a first step, recognition of abortion as protected medical care under international humanitarian law (IHL) is essential to ensuring that women and girls receive the full extent of services they need in conflict situations. The UK has, laudably, taken steps to recognize abortion services as protected medical care under IHL. In 2014, the UK amended its abortion policy to acknowledge safe abortion services as part of IHL's protections. This leadership from DFID has proven influential on the global stage, as the Netherlands, France, and the European Commission have all subsequently expressed similar policies.

Furthermore, it is not enough to just have good policies and laws, they must be translated into practice.

As I mentioned, abortion services are rarely, if ever, provided on the ground in humanitarian settings. The situation is only getting worse—owing to a resurgence of restrictive policies and a lack of clear guidance on the ground. However, when effectively implemented, policies such at the UK's which are grounded in the rights based protections of IHL and human rights can help transform norms and ensure that care saves lives and respects the rights of women and girls.
Thus, it is critical for the UK Government to: reaffirm its policy to its humanitarian partners; monitor those partners' implementation of the policy; and require its partners to segregate UK funds from other donors' to ensure effectiveness and coherence with law.

Finally, while the UK's recognition of abortion as protected medical care is a fundamental and laudable step, it is important to understand the barriers that continue to stand in the way of implementing these policies and turning them into practice. Significant impediments to the performance of abortions are uncertainties regarding legal status of abortion and negative healthcare provider attitudes.

Confusing policies like GGR cause providers' concerns about whether they will lose funding if they offer advice on or perform abortions, even where those activities are permitted. As a result, providers may censor themselves and restrict the information they offer to patients. Consequently, women who seek information on or have decided to obtain an abortion are wrongly turned away—leading them to pursue unsafe alternatives on their own.

Providers' hesitancy to perform abortions has also been shown to stem from moral and religious reservations as well as stigmatization by colleagues and communities. In some circumstances these negative associations of disinclined providers have resulted in patients receiving inadequate care.

More work remains to be done on changing providers attitudes regarding abortion and the need to provide them. For one, provider training is needed so that IHL's legal obligations are clearly understood. This includes the important principle that regardless of national law, abortion is protected medical care for victims of armed conflict under IHL. Additionally, utilizing a rights-based approach could be more beneficial in shifting provider attitudes if it is understood that abortion is necessary medical care that women and girls are entitled to under international human rights and humanitarian law.

As a result, the UK should engage in proactive measures with its grantees to help shift provider attitudes towards the provision of abortion and ensure that it is understood as medical care that is required for women as a matter of right.

It is commonly understood that unsafe abortion is a leading cause of maternal mortality, but it is the only one that can be fully preventable. Leadership from states like the UK can help make this a reality. I thank again for this opportunity and I look forward to your questions.