

## Call in the lawyers: mitigating the Global Gag Rule

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The Global Gag Rule (GGR), previously formally titled the “Mexico City Policy”, now declared “Protecting Life in Global Health Assistance” by the Trump administration, is a presidentially enacted policy restricting who can receive US global health assistance to those foreign organisations who agree not to provide, refer, counsel, or advocate for abortion as a method of family planning.<sup>1</sup> Data on the policy’s negative impacts, including that published within this special issue, show that among other things the GGR increases rates of abortion, impedes access to contraception, and harms HIV and AIDS prevention, treatment, and care.<sup>2–15</sup>

With the expansion of the GGR in May 2017 to all of US global health assistance (GHA), the Policy encompasses nearly US\$8.5 billion in new funding, and attaches for the first time to some of the largest funding sources in all of global health – the President’s Emergency Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative (PMI).

In March 2019, US Secretary of State Mike Pompeo expanded the Policy further by unilaterally declaring that “foreign NGOs that receive U.S. global health assistance should take steps to ensure that they are not providing financial support, *with any source of funds and for any purpose*, to another foreign NGO that performs, or actively promotes, abortion as a method of family planning”.<sup>16,17</sup> Accomplished through a vague provision in the contracting terms of the Policy, this effectively requires foreign NGOs bound by the GGR to attach US funding restrictions to their subrecipients, even if those subrecipients receive no US funding of any kind.

More than this, the Policy imposes potentially enormous cost burdens, auditing requirements, and risk assessments not only on the NGOs that accept GHA funding, but ultimately imposes costs on other funders’ projects that must be assessed for potential noncompliance. The mechanisms of the Pompeo expansion are discussed more fully elsewhere.<sup>18</sup> This is an extraordinary notion in law – to be imposing US policy on organisations that have no legal or financial relationship with GHA, because of their mere partnership with another organisation that does.

While the tortured rhetoric of the Policy and Pompeo expansion *can* need lawyers to parse, the extraordinary reach of this iteration of the GGR has also reignited questions about legal challenges. Because of the limited nature of US law (evidence of global health or human rights harm are unlikely to be successful in US courts), the challenges to previous iterations of the policy have been unsuccessful, and the expansions have not dramatically changed that likelihood of success in US courts.<sup>19–21</sup>

This does not mean that the expansive reach has not created myriad legal issues in the 65 countries where GHA is invested, universally met by the US government with a single defence, “It’s a contract. If you don’t like it, if you can’t legally comply with it, don’t sign it”. That response masks – or wilfully ignores – the deep legal and ethical problems the GGR opens up for recipients of GHA.

The Policy drives a wedge between NGOs that work on comprehensive sexual and reproductive health and rights (SRHR) and those that accept GHA, and also interferes with the relationship between domestic governments and the civil society organisations necessary to support

democratic processes and good governance.<sup>22</sup> This is an *intended* effect of the Policy.

For example, in 2014, Mozambique legalised abortion in the country for the first time, overturning the colonial-era penal code. That legalisation is part of an effort to reduce maternal mortality, where unsafe abortion accounted for 10-18% of maternal deaths.<sup>23–25</sup> However, the Mozambique government's endeavours to expand access to safe abortion services, particularly through public awareness of the change in law and availability of access to services, have been undermined by the GGR. Mozambique is a major PEPFAR country, receiving more than US\$300 million per year in HIV programming support.<sup>26</sup> Among other services, PEPFAR in 2018 funded 68% of HIV clinical care, treatment, and support, 75% of prevention of mother-to-child transmission (PMTCT) programming, and 75% of HIV laboratory services in Mozambique.<sup>27</sup>

Such funding levels, while critical for the HIV response, carry crippling implications when combined with the GGR, particularly under the Pompeo expansion. How this affects the Mozambican Government is that these foreign NGOs implementing PEPFAR programmes and their employees are prohibited – by a US government policy – from working with their own government to engage communities and conduct educational campaigns about the changes in abortion law and access. Moreover, the health care workers employed by PEPFAR-funded programmes – the nurses, doctors, and clinical officers who are leading experts in HIV treatment and management, PMTCT and maternal health for women living with HIV – may be prohibited from engaging with the Mozambican Ministry of Health to develop clinical guidelines on issues like HIV care and management if the *Ministry* chooses to include provisions in those guidelines about appropriate counselling on the legal options available to pregnant women or women seeking family planning services. This is not only an affront to the speech rights of the organisations and health care workers, it is direct – and intended – interference with democratic and good governance practices.

A similar situation in reverse is under way in Malawi. Abortion is currently illegal in Malawi and punishable in the Penal Code, with only an unclear exception based on “preserving life”.<sup>28</sup> Due to the absence of clear exceptions to the offence in the law, even young people pregnant as a result of rape cannot access a safe abortion.

Because of the lack of access to safe and legal abortion services, about 13% of maternal deaths are attributable to unsafe abortions. There is a great need for law reform, and a comprehensive Termination of Pregnancy Bill has been drafted. Due to opposition from conservatives and fundamentalist religious leaders emboldened by the Policy's silencing of bill proponents, progress on reforming the law has stalled. The GGR has stifled the concerted advocacy and collaborations between and among civil society organisations and government departments needed to overcome opposition and reform the law.<sup>29</sup>

Such intrusions into the democratic process of governance can and should be understood, guarded against, and countered through creative lawyering in countries receiving US GHA, but this engagement with national legal remedies is hampered by organisations' fear of seeking legal assistance and pushing back on the Policy.<sup>30</sup> Governments themselves fear US retribution for acting in any way that would counter the Policy. In addition, the human rights and legal institutions needed to safeguard against this neo-colonial intrusion are often not aware of the invasive nature of the Policy and how it can interfere with Constitutional processes.

The Policy also creates conflicts with domestic laws in completely unrelated areas – labour laws, for instance, where organisations are forced to close down projects because the organisation is not capable of being compliant with the Policy. In some countries, such as South Africa,<sup>31</sup> workers are entitled to a minimum notice and severance pay for being retrenched, yet the US government will not fund such costs despite being the cause of such retrenchments. Likewise, medical ethical standards related to patients' rights to informed consent, access to information, and non-discriminatory services may come into conflict with the Policy. While limited exceptions in the Policy account for some potential conflicts<sup>32</sup>,<sup>†</sup> these

<sup>†</sup>USAID, Standard Provisions RAA28(a)(II)(6)(A)(iii) (stating that “passively responding to a question regarding where a safe, legal abortion may be obtained is not considered active promotion if a woman who is already pregnant specifically asks the question, she clearly states that she has already decided to have a legal abortion, and the healthcare provider reasonably believes that the ethics of the medical profession in the host country requires a response regarding where it may be obtained safely and legally”) and RAA28(a)(II)(9) (stating,

exceptions are narrowly defined and limited. As such, they may be distinct from the ethical standards in place under professional councils regulating health care workers and rights of patients that are not clearly established in statute or regulation. Moreover, the lack of clarity and training on these exceptions – combined with the level of fear of being found not in compliance with the Policy – means they are often left unimplemented.

The expansive and invasive nature of the GGR requires diplomatic, advocacy, and legal responses, many of which are hindered by the political volatility and financial power of the United States. The threat is not just to public health; the Policy, by design, threatens sovereignty and democratic processes upheld by law. The Policy would not be so powerful if it did not. While many of these threats existed in prior implementations, the scale did not.<sup>3, ‡</sup> The world cannot respond in the same ways or on the same scale either. More is required.

As stated earlier, it is unlikely that legal challenges in US courts can play any significant part of the response, but legal challenges and responses through domestic legal systems are not as restricted. While a full analysis of legal claims in 65 countries is well beyond the scope of this commentary, one important guardrail on the Policy is where governments have clearly established the legal rights of patients. The US government has tended to avoid requiring an open violation of domestic laws, even while they encourage imprecision and tacit prioritisation of US policy over

national laws and priorities. This is one opportunity for advocates and lawyers in countries receiving GHA to effectively engage in mitigation, while continuing the vital work of protecting the health and rights of their people. There are also underutilised litigation opportunities to protect the rigour of informed consent and standards of medical care.

While advocates all over the world mitigate the harms of the Policy, and work in Washington DC to permanently end it, response to the GGR by national governments and advocates cannot be predicated on a change in US leadership and policy in January 2021, nor on a hope that this will be the Policy's last imposition. Systems, clinical guidelines, and laws need to be made resilient to US government interference. Law reform advocates, lawyers' associations, law schools and student lawyers, labour and employment lawyers, and impact litigators can all be conscripted in reducing the harm of the GGR, and leaving patients, medical providers, and advocates to address the national and global health priorities not manufactured by American ideologies.

#### Disclosure statement

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<sup>14</sup>For the avoidance of doubt, in the event of a conflict between a term of this paragraph (a) and an affirmative duty of a health-care provider required under local law to provide counseling about and referrals for abortion as a method of family planning, compliance with such law shall not trigger a violation of this paragraph (a").

<sup>‡</sup>For a thorough overview of the policy and its impacts from 1984 to 2018, see CHANGE, *Prescribing Chaos in Global Health: The Global Gag Rule from 1984–2018 (2018)*.

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