What about Rose? Tying international aid to U.S. abortion policy: Tying international aid to U.S. abortion policy

by Debra Bendis in the September 8, 2009 issue

In 1984 Ronald Reagan declared that no U.S. foreign aid money would be sent to organizations that perform abortions, provide counseling and referral for abortions, or lobby to make abortions legal or more available. This policy, often referred to as the gag rule, was rescinded by Bill Clinton when he became president, but reinstated eight years later under President George W. Bush. In the early weeks of his presidency, Barack Obama canceled the policy. As it's swung back and forth for the last 25 years, this pendulum of U.S. policy on international family planning and women's health has resulted in unnecessary tragedy.

The unevenness of U.S. policy has caused many health clinics to close and health care to be denied, with women and children as the first to lose. Some organizations are committed to providing safe abortions and see this goal as inseparable from overall family medical care in the Third World. When these organizations lost funding, all of the work they did was affected—which included services like HIV testing, baby checkups and cataract surgeries. In many cases, removing funding for abortion-related services means ending funding for every other aspect of medical care.

What's worse, the gag rule has been counterproductive when it comes to reducing abortions. "Contrary to its stated intentions," says Eunice Brookman-Amissah of the Center for Reproductive Rights, "the global gag rule results in more unwanted pregnancies, more unsafe abortions, and more deaths of women and girls."

In their new book, *Half the Sky*, Nicholas D. Kristof and Sheryl WuDunn describe Rose Wanjera, a 26-year-old woman who showed up at a maternity clinic in rural

Kenya with her small child. She was pregnant and sick, and told staff that wild dogs had recently mauled her husband to death. A doctor examined her and found she had an infection that threatened both her life and that of the unborn child. He persuaded Rose to come regularly for prenatal and delivery help. But when she returned the clinic was closed. It had been an unusual outpost of a consortium formed by several aid organizations in an effort to care for the poorest of refugees, and its U.S. funding was cut off because one of the organizations (Marie Stopes Inter national) helps provide abortions—in China.

The funding cut forced Marie Stopes to drop a planned outreach program to help Somali and Rwandan refugees. It had to close two clinics in Kenya and to lay off 80 doctors and nurses—just the staff who were looking after Rose. She became one of the untold victims of American abortion politics that effectively eliminated her only source of health care. “These were clinics focusing on the poorest, the marginalized, in the slums,” said Cyprian Awiti, the head of Marie Stopes in Kenya.

Over a lifetime, Rose and other sub-Saharan women have a one-in-16 chance of dying during childbirth. For each birth in which the mother dies, there are many more in which the mother experiences serious medical complications, for a total of approximately 10 million each year, according to the World Health Organi zation. Imagine all of the ways that a clinic gives Rose and her unborn child a better chance of surviving and of being healthy—clean conditions, better nutrition, medicines for infection, the support and sympathy of medical personnel, education in child care.

A woman is in even greater danger if she’s HIV-positive (many African women contract the virus from their husbands), in which case there is a 15 to 40 percent chance that her baby will be infected during pregnancy, childbirth or breastfeeding. A Benedictine sister serving in the ghetto of Nairobi explains the extent of the AIDS crisis in Kenya. “Imagine a camp as far as your eye can see. Then imagine grandparents raising grandchildren, with few or no parents in sight. This is the reality we work with.” The middle generation—the parents—have died from AIDS. Medical clinics routinely test for AIDS and offer medicine and care for these patients—but they can’t if they don’t have funds to operate.

Some women contract infections from self-administered abortions. Of the estimated 4.2 million abortions that take place each year in Africa, 95 percent are illegal and therefore unsafe. Those who are witnesses to this clandestine epidemic and see these women suffering and dying cannot separate their care of the women from

their conviction that safe, legal abortions must be available in such cases.

Ipas, a nonprofit organization working to reduce deaths and injuries from abortion, states that “given low contraceptive availability and use rates in Africa, unwanted pregnancies are inevitable for the foreseeable future. Until they have the ability to make their own childbearing decisions, African women will continue to die from unsafe abortions.” The World Health Organization reports that homemade methods of abortion—drinking turpentine, bleach or tea made with livestock manure; inserting a stick, chicken bone or wire into the uterus; jumping from a roof—kill 33,000 African women and girls each year. A woman who survives an abortion attempt, says Paul F. A. Van Look of WHO’s Department of Repro ductive Health and Research, may join 5 million women worldwide who suffer temporary or permanent disability from their attempts—ailments include “incomplete abortion, sepsis, hemorrhage, and injury, such as puncturing or tearing of the uterus, . . . chronic pelvic pain, pelvic inflammatory disease, tubal blockage, and secondary infertility.”

Another result of a lack of medical care in childbirth is an epidemic of fistula cases—an issue brought to the awareness of the industrialized world by the film *A Walk to Beautiful*. During childbirth women may suffer a tear in vaginal tissues that results in the leaking of urine and feces, and may lead to shunning and exclusion from family and neighbors. The condition can be repaired—if medical help is available.

It is the impetus to save women’s lives that is behind nonprofit international organizations’ advocacy for safe instead of unsafe abortions. If we don’t care for the girls and women at risk—dying, maimed, abused and undervalued—what is the future for their children? While U.S. citizens dictate restrictions on aid, women and families in poor countries continue to suffer. Clinc closures and staff reductions intensify the suffering.

Evidence from the Reagan era (it’s too soon to evaluate data from the George W. Bush years) suggests that the gag rule slowed the work of agencies and organizations that were *decreasing* the number of abortions through the distribution of contraceptives. There are statistics that confirm a link between reduction in abortions and use of condoms. In Turkey, for example, the use of safe and effective contraceptives went up 20 percent from 1988 to 1998. At the same time the ratio of abortions per 100 live births dropped by one-third, from 24 to 15.

According to the Guttmacher Insti tute, 500 million women in the developing world are using some form of family planning, thereby preventing 187 million unintended pregnancies, 60 million unplanned births, 105 million induced abortions, 2.7 million infant deaths and 215,000 maternal deaths. But another 200 million women throughout the developing world lack access to contraceptives. Meeting this need would further reduce global rates of maternal mortality by 35 percent and would lower the overall number of abortions, many of which would have been unsafe, by 64 percent.

Data suggest that when a woman in Rose's situation has confidence that her children will survive birth and be healthy, she is more likely to consider having fewer children (United Nations Popula tion Fund). This confidence comes about through access to immunizations; screening for blindness, anemia and other problems; AIDS education; and development of trusting relationships between women and their doctors. When clinics are closed these relationships are broken, and the checkups come to an end. Without medical care, mothers are likely to have a higher number of children, and this leads to higher infant and child mortality rates, in creased anemia in mothers and less time to breastfeed. Interrupted care also means less prevention and treatment of AIDS and blindness among infants—key factors in children's welfare.

Tying medical aid abroad to the antiabortion idealism at home has not reduced the number of abortions. But it has further endangered women and children whose lives are already marked by violence, oppression, disease and hunger.