U.S. FUNDING FOR ABORTION:

HOW THE HELMS AND HYDE AMENDMENTS HARM WOMEN AND PROVIDERS

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Ibis Reproductive Health is an international nonprofit organization with a mission to improve women's reproductive autonomy, choices, and health worldwide. Our core activity is clinical and social science research on issues receiving inadequate attention in other research settings and where gaps in the evidence exist. Our agenda is driven by women's priorities and focuses on increasing access to safe abortion, expanding contraceptive access and choices, and integrating HIV and comprehensive sexual and reproductive health services. We partner with advocates and other stakeholders who use our research to improve policies and delivery of services in countries around the world.

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INTRODUCTION

More than 40 years ago, the Helms Amendment became the first abortion funding restriction enacted by the U.S. Congress. Three years after its enactment, in 1976, the Hyde Amendment, which also restricts abortion funding, was put into place through the annual appropriations process. Both restrictions make it difficult for the most vulnerable women to access safe abortion. And while the Helms Amendment prohibits funding for abortion through U.S. foreign aid, the Hyde Amendment prohibits coverage of abortion in the United States through federally funded health insurance programs like Medicaid. The Helms and Hyde restrictions disproportionately affect young, poor, women of color across the globe.

U.S. abortion restrictions are out of step with international standards and the recognition of abortion as a human right. Abortion is referenced in several intergovernmental consensus documents and international and regional human rights documents including United Nations conference consensus documents, United Nations Treaty Monitoring Committees' guidance to governments, African regional conference consensus documents and a regional human rights treaty. In 2005, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, also known as the Maputo Protocol, became the first human rights treaty to explicitly address women's right to safe abortion.[1] And notably in 2011, abortion was recognized in the report of the United Nations Special Rapporteur on the right to health, which called on states to rescind criminal and restrictive laws related to abortion, comprehensive sexuality education, contraception, and conduct during pregnancy; and to ensure that abortion is safe, accessible, and of good quality.[2] The World Health Organization asserts that laws, policies, and practices that restrict access to abortion deter women from seeking safe services and instigate a "chilling effect" among reproductive health-care providers.[3]

This report, produced by Ipas and Ibis Reproductive Health, is the first inclusive report on how the Helms and Hyde Amendments harm access to abortion. It highlights the ways in which the Amendments violate human rights, impose barriers on access to safe abortion for women and young women, and tie the hands of the health-care providers who serve them.

U.S. FUNDING FOR ABORTION OVERSEAS

The Helms Amendment is a decades-old, draconian policy that has imposed barriers on access to abortion for poor women and girls in the developing world. Appended to the U.S. Foreign Assistance Act in 1973, it prohibits the use of foreign assistance for the performance of abortion "as a method of family planning or to motivate or coerce any person to practice abortions."[4] Written as a mere limitation on the use of funds, the Amendment does not preclude U.S. foreign assistance funds for abortion to a woman in a dire situation, such as when she is experiencing a life-threatening pregnancy or has become pregnant as the result of rape or incest. Abortions offered under these circumstances are not provided as family planning.[5] Support for abortion in the cases of life, rape and incest is in line with almost all other funding restrictions currently applied to abortion coverage for American women.

Despite the limited scope of the Helms Amendment language, the U.S. government has applied it as a total ban on abortion-related services and information. It should be noted that the U.S. government does support the treatment of complications and injuries that result from unsafe abortion, also known as postabortion care. Ipas's Helms Amendment impact assessments over the span of several years found that, due to this restrictive application, U.S. government agencies administering foreign assistance programs (namely the U.S. Agency for International Development (USAID) and the State Department), do not support abortion care even in narrow cases of life, rape, and incest.* Additionally, abortion-related information is censored and women do not receive information and counseling on where to get a safe abortion even though the provision of information is explicitly permitted under the Leahy Amendment in U.S. law.†[6] Finally, the Helms Amendment denies providers support for critical maternal health supplies like misoprostol and manual vacuum aspirators, which are needed to treat post-partum hemmorhage, miscarriage, and provide postabortion care, just because they could be used to induce an abortion.

Restricting access to abortion beyond the legal requirement only serves to further compound the global problem of unsafe abortion. Of the 22 million unsafe abortions worldwide each year, 98% occur in the developing world.[7] These unsafe abortions cause the deaths of 47,000 women every year, and millions more experience needless injuries. By implementing the Helms Amendment in a way that, at a minimum, allows abortion in cases of rape, incest and life endangerment, the U.S. government could help save the lives of tens of thousands of women, while also ensuring access to reproductive health services through its programs. The United States is the single largest bilateral donor of international family planning and reproductive health programs. It is not only efficient and effective for the United States to use foreign assistance to support access to abortion, but it is also a moral imperative.

Impact of the Helms Amendment on Health-Care Providers

The Helms Amendment has tied the hands of government officials, U.S.-funded grantees, and reproductive health providers working to ensure access to comprehensive reproductive health care for women overseas. The blanket ban application of the law by U.S. government officials has led to the avoidance of abortion-related service provision, information and counseling; censorship; and reduced access to life-saving equipment and supplies.

* Ipas has sponsored three separate fact-finding projects that include interviews with NGOs, government officials, USAID staff, and other stakeholders, as well as with USAID cooperating agencies—a total of over 200 interviews—to document how restrictions on USAID funding for abortion are applied and continues to gather information from recipients of U.S. foreign assistance

† The Leahy Amendment applies to all acts authorizing or appropriating funds for foreign operations, export financing, and related programs. It clarifies the definition of the word "motivate" in the Helms Amendment: "That for purposes of this or any other Act authorizing appropriating funds for foreign operations, export financing, and related programs, *the term 'motivate', as it relates to family planning assistance, shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options.*" Emphasis added.

Creates Confusion for Providers

Because U.S. abortion-related restrictions are generally not well understood, there is a lack of clarity about prohibited activities. When Ipas researchers interviewed USAID grantees, most of them mistakenly understood the restrictions to be a complete ban on activities and speech around induced abortion. USAID grantees and local governments are largely unfamiliar with the Leahy Amendment; hence, information and counseling on abortion is either incorrectly understood as being prohibited or is otherwise avoided. At times, Ipas staff found knowledge of U.S. foreign policy on abortion to be unbalanced, even within a single grantee organization. This was particularly evident in Ghana with none of the 75 respondents able to provide a clear and accurate description of the Helms Amendment. Most interviewees wrongly believed the law to be a complete ban on abortion provision, as well as any discussion of abortion. The vast majority of respondents were also unsure whether abortion counseling or information was allowed, but assumed not—particularly harmful in a country with a liberal abortion law and government will to address unsafe abortion and maternal mortality. Oftentimes, U.S.-funded trainers on reproductive health deliberately avoid any mention of abortion in their work even in contexts where it would be relevant. We found no evidence of counseling on abortion provided by U.S.-funded reproductive health providers.

Interferes with Providers' Abilities to Provide Care

The U.S. government has also prohibited the sharing of abortion-related information in print and in meetings under the Helms Amendment. Abortion-related information is consistently omitted in U.S.-funded training and communications materials. Key training and guidance manuals supported by USAID to train foreign officials exclude information about abortion, inhibiting officials' ability to then provide health care providers with accurate information about abortion in accordance with local law. During Ipas interviews, several USAID grantees expressed uncertainty about whether U.S. funding can be used for project staff to attend abortion-related meetings, although participation in meetings is permitted under the plain language of the Helms Amendment. One particular example cited by a respondent highlighted a situation where USAID advised a grantee to omit information on the magnitude of unsafe abortion in a publication.[8] USAID and grantees also made decisions to cancel presentations by a high-level official in Malawi because of abortion content.[9]

In Kenya, staff of U.S.-funded family planning and reproductive health organizations were directed by USAID-Kenya not to attend a meeting by the Ministry of Health during which abortion could be discussed in the context of reproductive rights. The next day, the policy standards and guidelines and training curricula for safe abortion were withdrawn by the Ministry of Health. The withdrawal of the documents weakened the process to approve the standards and guidelines and since then, U.S.-funded stakeholders have been cautious about participating in discussions around reducing maternal mortality and morbidity that may also involve access to safe abortion in the country. U.S.-funded organizations that address gender-based violence also generally omit information about abortion as an option for a woman who is pregnant as a result of rape.

Contributes to Medical Equipment Shortage

Implementing the Helms Amendment as a complete ban contributes to a shortage of equipment and medicines used to save the health and lives of women who suffer pregnancy complications, complications of unsafe abortion and post-partum hemorrhage. Evidence-based care for complications related to miscarriage and unsafe abortion require manual vacuum aspiration instruments for postabortion care and misoprostol for both post-partum hemorrhage and postabortion care. Because both the manual vacuum aspirator and misoprostol can be used for induced abortion, the U.S. government has not allowed the purchase of either with U.S. funds. This contributes to shortages in U.S.-funded programs for organizations that are providing postabortion care services. Indeed, a 2007 training document states that while the purchase of manual vacuum aspirator equipment is permitted under the Helms Amendment (and under the now-rescinded Mexico City Policy), "it is USAID's **policy** that the Agency does not finance the purchase or distribution of MVA equipment for any purpose, in order to avoid any appearance of supporting abortion activities."[10]

> "We ran out of [an essential MVA equipment part] last week. A woman came here bleeding after inserting a cassava stick in her uterus. Because we couldn't treat her, she had to walk eight hours to the nearest hospital."
>
> — Nurse midwife in Malawi

Impact of the Helms Amendment on Women

There is an established consensus among those in the international and public health communities that the respect, protection and fulfillment of human rights requires access to safe abortion and that this access is necessary to prevent unsafe abortion and save women's lives.[‡3] U.S. foreign policy is increasingly at odds with this consensus and local discourse deeming safe abortion services vital to women's health and empowerment. Despite efforts by some country governments and other stakeholders to ensure access to comprehensive abortion care, the implementation of abortion restrictions in U.S. foreign policy remains an obstacle to reproductive health throughout the world.

It should be noted that stories of the impact of U.S. abortion policy on women's experiences undergoing unsafe abortion are limited. The unique position of abortion as a highly stigmatized reproductive health care service[11] pressures women to remain silent about their experiences accessing abortion services.

Because the Helms Amendment restricts foreign assistance funds, it prevents the most vulnerable women in some of the poorest countries from accessing the care that they need. Women who are poor, young, or victims of sexual violence suffer the most under Helms restrictions.

‡ Human rights include "the right of all persons to the highest attainable standard of health; the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; the right of women to have control over, and decide freely and responsibly on, matters related to their sexuality, including sexual and reproductive health – free of coercion, discrimination and violence … the right of access to relevant health information; and the right of every person to enjoy the benefits of scientific progress and its applications."

Poor women are disproportionately affected by the Helms Amendment because they often lack the resources to obtain a safe abortion. Young women are particularly vulnerable to both violence and unintended pregnancy, which can result in their leaving school and becoming mothers before they are ready. Additionally, young women face an increased risk of death and disability due to early pregnancy. Young women often must navigate considerable social, economic, logistic, policy and health-system barriers to access safe abortion services—barriers that lead many women to resort to unsafe abortions. Indeed, young women aged 15–24 account for half of the 22 million unsafe abortions that occur annually.[12] Thus, the Helms Amendment remains a significant policy challenge that denies girls and young women their sexual and reproductive health and rights.

> "After receiving support from a gender-based violence prevention and response project after being raped, a young woman [about 16] came in to one of our supported clinics nine months later to deliver, and the staff of our project were talking about how difficult it would be for her in her community due to the stigma of having a child from rape. Our post-rape kits only contain emergency contraception, which must be taken within five days, so evidently she did not come to seek help from our program in time."
>
> — Health-care worker, U.S.-funded project in the DRC

Abortions performed as a result of life endangerment, rape or incest are legally eligible for U.S. support. While these exceptions are already dangerous barriers to comprehensive abortion care, the misapplication of Helms as a ban on all abortion-related activities prevents women in heinous circumstances from accessing the care they need from U.S.-funded programs. Sexual violence, including rape and incest, is prevalent around the world,[13] including in countries where USAID and State Department-funded programs operate. One in three women in the world will experience sexual violence, and many before the age of 18. In conflict-affected or fragile states, rape is often used as a tool of war to destabilize communities and impregnate women. High rates of violence contribute directly or indirectly to unintended pregnancy, pregnancy complications, unsafe abortion, and maternal deaths in countries where women lack access to quality reproductive health care. In addition to dealing with the degradation of sexual violence, women may be abandoned by their families, expelled from their communities and forced to suffer from permanent disabilities and sexually transmitted infections, including HIV. U.S. foreign policy further victimizes these women by denying organizations the ability to treat women humanely.

The Helms Amendment harms women seeking care from U.S.-funded programs by severing the full range of reproductive health services, undermining the quality of reproductive health services, and reinforcing abortion stigma.

Fragments Services

The exclusion of abortion-related programming under U.S. foreign policy results in the division of reproductive health care into two segments—comprehensive abortion services and family planning. Due to U.S. funding for a range of reproductive health care services and exclusion of safe abortion care, services are fragmented. Separation of services serves to entrench a lack of service integration in public health care systems.

In Nepal, at the time of our research, the application of restrictions led to perverse situations where abortion services either had to be forgone or be provided out of maternity delivery rooms, because USAID did not permit the use of the postabortion care rooms to be used for safe abortion services. USAID-funded program officers explained the strict separation requirements this way: "Need to separate instruments, and if possible the providers should be separated. So the instrument and the facility cannot be used for abortion. Not in the same room, on the same table."[14] In Ghana, the distinct separation of services forced women to visit two separate locations for comprehensive abortion care and for family planning.

> "This one client [first came to get comprehensive abortion care and I had to refer her to the hospital which is very far]. She came back after two weeks to seek postabortion care. She was bleeding and had an infection. She had inserted sticks inside her. She was 23 years old, married and had two children. She had no money and she couldn't travel. Her husband was in India, she was illiterate, a housewife…[If we cannot provide comprehensive abortion care and only postabortion care then] it will lead to more unsafe abortions and maternal deaths."
>
> — A provider in Nepal

The artificial separation of the full range of reproductive and sexual health services, including abortion, impairs access to services vital in women's health and lives. Because no induced abortions are provided at USAID-funded facilities, providers have had to turn away women seeking safe services. One USAID-funded organization had experienced a number of maternal mortality cases in villages where the full range of reproductive health services remained unavailable and inaccessible to women who needed them the most.[15] Community-level public health centers in Nepal have had to send women, who are often unable to afford services at closer private or NGO facilities, to zonal public hospitals that could be hours or days away when traveled to by foot, bus or ox-pulled cart. Indeed, one provider in a remote primary health center in which USAID had initiated postabortion care but prohibited any abortion services reported that the closest comprehensive abortion care site was a zonal hospital 90 kilometers away.[16] He told several stories of women who, lacking the funding to travel, resorted to dangerous methods to induce an abortion and returned to the facility for emergency abortion care.

Reduces Quality of Care

For women, the omission of abortion-related information and counseling means that the quality of the services available to them varies depending on clinic location. The Helms Amendment has been applied in a way that prevents providers from offering comprehensive counseling on the full range of reproductive health services, including for women who suffer contraceptive failure by no fault of their own.[17] As women are frequently unable to get the information they need from providers, they are often faced with a delay in services.[18]

USAID-funded training of providers and outreach workers is censored and at times based on the assumption that those outside of the USAID-funded NGO network can provide abortion care. This further contributes to discontinuity of care for women. For example, one U.S.-funded NGO decided to omit all abortion-related information and care from its work. Instead its staff was instructed to refer any abortion-related inquiries to Ghana Health Service staff during trainings. The NGO has instituted a similar technique for its referrals. Thus, the NGO is actually providing referrals for referrals. Leadership within the U.S.-funded NGO recognized possible weaknesses and harmful implications of this referral system, such as the possibility that Ghana Health Service staff would not have correct information with which to provide a woman, but weighed their funding and image vis-à-vis USAID against that.[18]

> "It would be great to have a holistic family planning and reproductive health process. So that when we do family planning and reproductive health work we can bring all players together on how that works so then when concerns arise, can have coordinated efforts to help reduce the complications, and increase transparency and accurate information and ensure life-saving strategies for women. Ideally we would like that… to speak openly about issues concerning women to prevent complications, especially from unsafe abortions."[19]
>
> — Clinic staff member in Nepal

Reinforces Stigma

Abortion stigma is global. Women in every country—regardless of the legal status of abortion—are shamed for seeking or having an abortion. The Helms Amendment heightens the stigma surrounding abortion by singling out abortion care as the only restricted health care service. This stigma creates a chill around abortion amongst providers and health system managers who worry that merely associating with abortion services—even where clearly permissible—will jeopardize the ability to be awarded with U.S. funding. This in turn forces inefficiencies in resource-constrained settings, imposing an artificial separation of services that should be available as a continuum of care. Ultimately, women are endangered by this vicious cycle. In fact, the stigma surrounding abortion plays a critical role in silencing and punishing women who seek abortion care. When women feel shame about abortion and are unable to access accurate information, they often delay care or turn to untrained, unsafe providers, increasing the severity of complications, injuries and likelihood of death.

Case Studies: Countries Working to Reduce Unsafe Abortion Under the Helms Amendment

Women in more than 40 countries are reached through U.S.-funded family planning and reproductive health programs.[20] All of these countries legally permit abortion to save a woman's life and about half permit abortion in cases of rape and incest.[21] Additionally, in the last decade, several of these countries have liberalized their abortion laws to promote women's human rights and reduce unsafe abortion.

Between 2009 and 2015, Ipas commissioned fact-finding trips to three countries receiving U.S. foreign assistance funds—Nepal, Ghana, and Kenya—to document the impact of U.S. foreign policy, particularly the Helms Amendment, as it relates to access to safe abortion care within those countries.

Status of the abortion law in countries receiving U.S. family planning and reproductive health assistance							
Country	**Early abortion legal for any reason**	**Legal on social grounds**	**Legal on health grounds**	**Legal in cases of rape**	**Legal in cases of incest**	**Legal in cases of fetal impairment**	**Legal when the life of the woman is at risk**
Azerbaijan	x	x	x	x	x	x	x
Cambodia	x	x	x	x	x	x	x
Georgia	x	x	x	x	x	x	x
Nepal	x	x	x	x	x	x	x
Ukraine	x	x	x	x	x	x	x
India		x	x	x	x	x	x
Zambia		x	x			x	x
Benin			x	x	x	x	x
Burkina Faso			x	x	x	x	x
Ethiopia			x	x	x	x	x
Ghana			x	x	x	x	x
Guinea			x	x	x	x	x
Liberia			x	x	x	x	x
Zimbabwe			x	x	x	x	x
Togo*			x*	x	x	x	x
Jordan			x			x	x
Niger			x			x	x
Burundi			x				x
Kenya			x				x
Mozambique			x				x
Nigeria			x				x
Pakistan			x				x
Rwanda			x				x
Tanzania			x				x

* Togo permits abortion in the case of physical health, but not mental health.

Country	Early abortion legal for any reason	Legal on social grounds	Legal on health grounds	Legal in cases of rape	Legal in cases of incest	Legal in cases of fetal impairment	Legal when the life of the woman is at risk
Uganda			x				x
Indonesia				x	x		x
Mali				x	x		x
Afghanistan							x
Angola							x
Bangladesh							x
Cote d'Ivoire							x
Democratic Republic of Congo							x
Guatemala							x
Haiti							x
Honduras							x
Madagascar							x
Malawi							x
Mauritania							x
Senegal							x
Yemen							x
South Sudan	Data not available for post-secession South Sudan						

Source of Laws: Pew Research Center "How Abortion is Regulated Around the World," 2015, http://www.pewresearch.org/fact-tank/2015/10/06/how-abortion-is-regulated-around-the-world/. Note: Pew's data is from the UN Population Division as of 2013.

Source for funding data: USAID "Family Planning and Reproductive Health," 2015, https://www.usaid.gov/what-we-do/global-health/family-planning.

NEPAL

Nepal has long experienced some of the highest maternal mortality rates in the world. With no safe abortion services available prior to legal reform in 2002, Nepali women turned to unsafe and clandestine abortion providers with devastating results. In the late 1990s, for example, more than half of the gynecological and obstetric hospital admissions were due to complications from unsafe abortions.[22]

Since 2002, abortion has been legal for any reason for up to 12 weeks' gestation; in the cases of rape or incest for up to 18 weeks; at any time if the mental or physical health or life of the pregnant woman is at risk; and at any time during pregnancy if there is a fetal abnormality.[§23] Following the liberalization of its abortion law, the Nepali government introduced a comprehensive abortion care plan in 2004. By 2009, when Ipas conducted Helms research in Nepal, safe abortion services were available in all 75 districts, despite lingering barriers to women's access.

USAID has been involved in the delivery of reproductive health care in Nepal for many years, reaching more than 14 million men and women of reproductive age.[24] In 2009, USAID signed a bilateral agreement with the Nepali government to provide $205 million over five years. $82.5 million of that amount was budgeted to assist the government in providing quality health services, particularly to the poor and to support the government in its pursuance of the 2015 Millennium Development Goals (MDGs) for health.[25] The USAID-funded Nepal Family Health Program (NFHP) was the major family planning and maternal, neonatal and child health bilateral project with the Nepali government.

The implementation of the Helms Amendment impeded government efforts to improve access to care for women and train providers. It also led to fragmentation of basic health services, and unnecessary censorship at all levels.

Ipas interviewed respondents in Nepal shortly after President Obama rescinded the Mexico City Policy.[¶26] Perceptions after the policy was rescinded ranged from a misunderstanding of a complete lift of U.S. funding restrictions on abortion-related activities to the belief that

§ To obtain a legal abortion under the latter three exceptions, a woman must seek approval from a medical practitioner.

¶ The Mexico City Policy restricts foreign NGOs that receive U.S. family planning assistance from advocating for or providing abortion-related services, even with their own, non-U.S. resources. This policy is also known as the Global Gag Rule (GGR).

organizations were still bound by the policy. Additionally, many interviewed conflated the Helms Amendment and the Mexico City Policy. It was reported that USAID did little to explain U.S. restrictions on funding for abortion services. The implementation of U.S. restrictions contributed to a lack of health-care service integration in Nepal.

GHANA

Women in Ghana have among the best access to reproductive health care in sub-Saharan Africa. Recent maternal mortality figures are 350 deaths per 100, 000 live births, which mark a decrease from the last decade.[27] Nonetheless, unsafe abortion is the second leading cause of maternal mortality in Ghana, contributing to 11% of maternal deaths in the country.[28]

Since 1985, Ghana has had one of the most liberal abortion laws in Africa. Abortion is legal in Ghana in cases of rape, incest, fetal impairment, and to protect the life, and mental and physical health of a woman. The Ghana Health Service and Ministry of Health established protocols for the provision comprehensive abortion care, including safe abortion services, which were adopted in 2006.[29] Comprehensive abortion care** and postabortion care†† are available at all district and regional hospitals and even smaller health centers. Several barriers to access remain including conscientious objection, the mobility of trained providers, and the minimal knowledge of the abortion law among providers and women.[30]

Since 1966, USAID has provided health sector assistance in Ghana, focusing on family planning, maternal and child health. Between 2009 and 2013, USAID's Health Sector Strategy (HSS) focused on family planning, ante- and post-natal care, safe delivery, and newborn and child survival.[31] Funding for maternal and child health is $4.5 million per year, while reproductive health and family planning receives $12 million per year.[7]

Ipas found evidence of censorship and a chilling effect due to U.S. abortion policy in Ghana, which undermines progress in reproductive health access. Ipas research found that U.S. abortion policy harmed the continuum of reproductive health care, and contributed to fragmented funding schemes and fear around abortion for grantees. Reproductive health professionals expressed their conviction that the continued implementation of the Helms

** Comprehensive abortion care includes contraception and family-planning services, postabortion care and pain management.

†† Postabortion care, a term originated by Ipas in the early 1990s, is an approach for reducing deaths and injuries from incomplete and unsafe abortions and their related complications. Postabortion care is an integral component of comprehensive abortion care.

Amendment was a result of U.S. policymakers' lack of understanding of the lived experiences of Ghanaian women as well as the realities on the ground.

KENYA

Unsafe abortion is a leading cause of maternal morbidity and mortality in Kenya.[32] In 2012, an estimated 464,690 women in Kenya underwent abortions, virtually all of which were clandestine and unsafe procedures. More than 75% of women who needed postabortion care were treated for moderately severe or severe complications. The rate of fatality from unsafe abortions is high in Kenya with an estimated 266 women dying per 100,000 unsafe abortions.[33]

Kenya's new Constitution, adopted in 2010, sought to address the devastating toll of unsafe abortion in Kenya. Abortion is now permitted if performed by trained medical professionals in cases of emergency, to save the health or life of a pregnant woman, or if allowed by any other written law.[‡‡34] The lack of national standards and guidelines for safe and legal abortion, which has been linked to the censoring of U.S.-funded family planning and reproductive health organizations by USAID-Kenya, remains a significant barrier to safe abortion access.[§§]

In 2014, USAID spent $11.4 million on family planning and reproductive health, down from $25.5 million the previous year.[35]

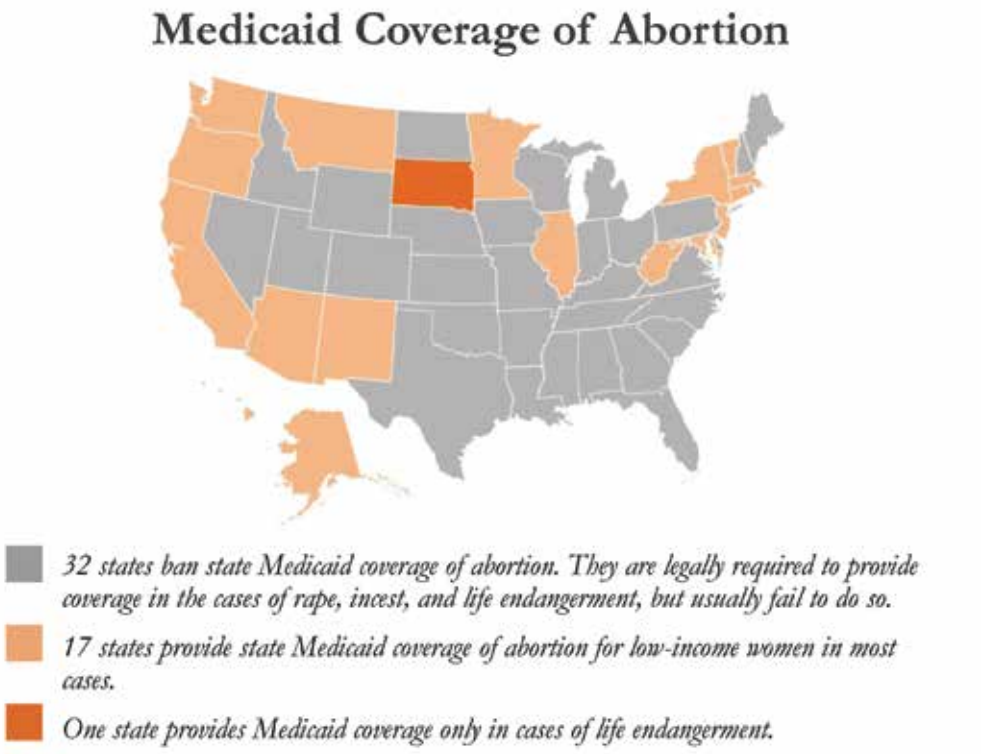
‡‡ A trained medical professional must analyze the mental or physical health of a pregnant woman when determining whether a woman's health is in danger. Abortions are also permitted in the cases of rape or sexual assault.

§§ In 2012, the Ministry of Health launched the "National Standards and Guidelines for the Reduction of Morbidity and Mortality from Unsafe Abortion," which clarified the legal grounds under which abortion could be performed and was a critical step in addressing the high rates of injuries and death due to unsafe abortions. In October 2013, the MOH withdrew the guidelines after alleging the document had been misused.

FUNDING FOR ABORTION IN THE UNITED STATES

Though abortion is a legal, common and safe procedure in the United States, there are numerous laws at the state and federal levels that restrict access to abortion services. Among the most longstanding and widespread of these restrictions are bans on funding for abortion services. These bans exist in both private and public health insurance programs, as well as in block grants for family planning programs. This report focuses on U.S. restrictions that largely prohibit the use of funds for abortion for people enrolled in Medicaid, which is a nationwide public health insurance program for low-income people who meet certain eligibility criteria.[36]

Medicaid is an essential health insurance program for the 71.5 million people in the U.S. who are enrolled in it.[37] Medicaid coverage helps to ensure that people of limited means have access to affordable medical services and leads to documented improvements in health and well-being.[38–40] One striking limitation of the health insurance program, however, is that abortion is generally not covered. The Hyde Amendment, passed in 1976 and renewed annually as part of the federal appropriations process, prohibits federal funding for Medicaid coverage of abortion care except when a woman is pregnant as a result of rape or incest, or when her pregnancy endangers her life. States have the option to use their own funds to provide Medicaid abortion care coverage in a wider range of cases, but few do (see map); most states follow the federal example and restrict Medicaid coverage of abortion to the limited cases allowed under the Hyde Amendment.[41] Further, research shows that in states that restrict Medicaid coverage of abortion to instances of rape, incest, or life endangerment of the pregnant woman, abortion coverage is frequently not available even in these circumstances.[42]



This report reviews research on the experiences of abortion providers and women seeking abortion services while navigating the funding restrictions imposed by Medicaid. This body of research reveals that the Hyde Amendment often impedes providers from their commitment to provide timely abortion care to the women they see and erodes their ability to provide care for all women who need it. For women, this decreased access to abortion services causes many covered by Medicaid to continue a pregnancy they do not want despite having health insurance. For the women who do still obtain abortion care, evidence shows that they are confronted with delayed and costly care, at great expense to their health and well-being.

Impact of the Hyde Amendment on Health-Care Providers

Medicaid is a key health care payer for many health-care providers, including those who perform abortions. However, many health-care providers face challenges participating in Medicaid, navigating the Medicaid bureaucracy, and obtaining adequate reimbursement rates for services.[43, 44]

Creates Confusion for Providers

Funding restrictions on abortion exacerbate healthcare providers' challenges working with Medicaid. These funding restrictions promote lack of clarity about when abortion care is covered, making it difficult for providers to give their patients up-to-date information about the potential for insurance coverage.[44] One study found that 64% of claims providers believed qualified for coverage were rejected in states where restrictions on Medicaid coverage are in place.[45] The complex billing procedures that the restrictions create make it difficult to file Medicaid claims, particularly for abortions in cases of rape, incest, and life endangerment when extra paperwork is often required and claims are often rejected; in one study, providers described billing Medicaid for abortion as "futile," "a big runaround."[46]

> "Essentially … you fill out the form, and you explain the circumstances, and you provide all of the information, and then … submit it and then wait for the rejection. And when they tell you what the reason for rejection is, then you resubmit it and continue to do so until it just is no longer worth pursuing, and then you quit!"
>
> — Executive director, abortion clinic[47]

Interferes with Providers' Abilities to Provide Care

Funding restrictions can interfere with a provider's ability to provide health care when Medicaid staff—instead of a woman's clinician—decide when a condition is life-endangering "enough" to merit coverage, or when a woman has experienced rape or incest. A clinic administrator reflected that there are times when a provider may determine an abortion is necessary to save the life of a pregnant woman but Medicaid does not agree with that assessment, saying, "When you have a woman who needs to have an abortion right away, you can't sit and wait for a week for Medicaid to decide what to do."[44]

Imposes a Financial Burden on Providers

The Hyde Amendment is a drain on resources at facilities that provide abortion care because they often have to spend large amounts of time filing and responding to incorrectly rejected claims.

As a result, many providers have to take on more financial burden due to these restrictions when they have to cut back on staff or cut staff salaries to continue to keep their doors open.[44] In the words of a clinic administrator, "We have never been reimbursed by Medicaid for an abortion. We have trouble with gynecology getting reimbursed appropriately. And a number of times we have to turn things back in, the average is three times that we have to do paperwork before it's all accepted.... And for abortion, we may try seven different things and then we give up because it's not worth the staff time anymore. It's just at some point—how damaged is your head from that brick wall?"

Providers reported "eating the costs" of abortion care that should be covered by Medicaid. Some providers said this cost them around $100,000 a year, which is unsustainable.

Impact of the Hyde Amendment on Women

Restrictions on Medicaid funding mean that women with very limited incomes are forced to come up with a substantial amount of money to pay out-of-pocket for their abortion care. For most women, this care will cost approximately $500,[48] though in some situations—particularly for later abortions or when a woman has a significant medical issue—a woman may need to pay upwards of $1,500 or more.[49] This denial of Medicaid coverage has deleterious impacts on access to abortion services, creating unnecessary delays and distress for women who are already struggling to make ends meet, and even putting abortion care out of reach for some.

Creates Confusion for Women

The Hyde Amendment creates confusion for women about when abortion is appropriately covered by Medicaid, and how women can obtain those services. In secret shopper research of Medicaid information lines, 36% of calls about abortion coverage were answered incorrectly and 52% of Medicaid information line staff discouraged callers from seeking Medicaid coverage for abortion because of the difficulty of securing coverage.[50] This confusion and

misinformation contributes to a de facto ban on coverage for any reason, making Medicaid coverage for abortion care inaccessible even in cases of rape, incest and life endangerment. One study found that states that restrict abortion coverage to the federal exceptions only covered 36% of the abortions that should have been eligible for coverage.[44, 51]

Promotes Physical Harms

The Hyde Amendment puts women's health and well-being at risk when they go without food, shelter, or other necessities in order to put money towards an abortion.[52, 53] Restricting insurance coverage for abortion also results in women obtaining abortion services later in pregnancy than they wanted. Denying Medicaid coverage delays their care while they search for the financial resources to pay for an abortion out-of-pocket,[54, 55] which is concerning as delays increase the costs of abortion. Furthermore, though abortion is among the safest medical procedures performed, the risks of complication are higher later in pregnancy,[56] and the Hyde Amendment forces some women to unnecessarily obtain an abortion later in pregnancy than was intended.[49, 53]

> "I saved as much money as I could with still paying my rent and water and electric and car payment and child support and everything else that I have to pay. I ended up being late on my electric bill…. You can't have groceries when you don't have electricity…. Hot water heaters are electric. Little things like that that you take for granted until you don't have electricity, [you have] ice cold showers and no groceries in the fridge."[52]
>
> — 21-year-old low-income woman

Restricting Medicaid coverage of abortion also risks the health and lives of women who are denied abortion coverage when carrying pregnancies that threaten their lives.[44, 52] One abortion provider shared the story of a woman who needed an abortion to undergo life-saving cancer treatment: "She had a reoccurrence of throat cancer, and had to undergo chemo, and they had to withhold the chemo because they found out she was pregnant, so she had to terminate the pregnancy in order to have chemo, in order to treat the reoccurring throat cancer." Medicaid would not cover the abortion.[44]

Increases Emotional Harms

Research has found that the Hyde Amendment increases trauma for women who have experienced rape or incest and have to "prove" they have been sexually assaulted to qualify for Medicaid coverage.[57] For example, in previous research one abortion clinic administrator reflected on the hoops women have to go through to prove their abortions should qualify for Medicaid coverage under the limited exceptions of the Hyde Amendment and said, "In these particular cases [I wish] they didn't have to go through these extra steps and burden of thinking about one more thing in addition to being raped, or being concerned about their medical condition threatening their life."[57] The Hyde Amendment also interferes with women's personal medical decisions and undermines their autonomy by putting care out of financial reach.[52, 54, 58]

> "It's not enough just to make it legal to have an abortion. If it's not cost available, then it's practically the same thing as keeping it illegal because…if you can't afford something that you need, it might as well be illegal to you."
>
> — 21-year-old low-income woman

Poses Financial Harms

The Hyde Amendment forces women and their families to endure financial hardships to afford abortion care, such as forgoing food or schooling, taking out payday or other loans, delaying bills or rent, putting large amounts on credit cards, and pawning belongings—because they are denied abortion coverage despite being eligible for health insurance that is otherwise comprehensive.[54, 55] It is not surprising that women eligible for Medicaid—those already struggling to makes ends meet—rarely have in hand the hundreds of dollars needed to pay for abortion care out-of-pocket. Explaining what it took for her to gather the money for her abortion, one 27-year old, low-income, Black woman said, "It was hard, it took me three weeks…. I don't have a strong family support where I could borrow money from…. The payday loan [I took out for my abortion] wiped out my entire account…. I got a three-day notice on my apartment door, and things started to spiral out of control and then when I became evicted I lived in a shelter temporarily."[54]

The Hyde Amendment also forces one in four women who qualify for Medicaid to continue unwanted pregnancies[55] which are associated with poorer maternal and child health outcomes compared to planned births.[59] A recent study found that women who obtained the abortion they wanted were more likely to have aspirational one-year plans, like employment, schooling, and emotional well-being, compared with women who were unable to obtain the abortion they wanted.[60] An abortion clinic counselor reported, "There are certainly women who have an unwanted pregnancy, and wish to terminate, and don't have the funds to. They may, out of necessity, continue the pregnancy because they don't even have $340 dollars to do the termination."[44]

Contributes to Inequities

The Hyde Amendment hinders access to abortion through discrimination, because it denies women insurance coverage for safe, legal, and necessary abortion services because of their income level. Restrictions on Medicaid coverage of abortion are also discriminatory against women of color, and in particular Black and Latina women, as they are more likely than White women to be poor and qualify for Medicaid, and are more likely to face financial barriers paying for abortion care. Additionally, because of broader social and economic disparities, and existing gender, income, racial, and ethnic inequalities in the United States, unintended pregnancy and abortion are disproportionately experienced by poor women and women of color.

Case Studies: A Look at Medicaid Coverage of Abortion in Four States

Medicaid coverage of abortion varies significantly across states. In states that limit coverage to the exceptions under the Hyde Amendment, women may not be able to access coverage even in allowable circumstances, while in states that use their own funds to cover abortion broadly, Medicaid coverage of abortion may be available and accessible to women and providers in most or all circumstances. The following examples show the variance across states of Medicaid coverage of abortion.

FLORIDA

In Florida, the number of abortions covered through Medicaid has been reported at very low numbers (0–1) every year.[42, 61] In interviews, providers reported seeing a large number of women who should have been able to have an abortion covered by Medicaid but were denied or unable to get coverage. Providers discussed inadequate financial compensation from Medicaid and problems with a complex Medicaid reimbursement process that is so cumbersome that many providers consider the process futile. In addition, providers reported that even in cases of life endangerment of the woman, the Medicaid insurance plans interpreted the clause so strictly that few, if any, cases qualified for reimbursement, further endangering the health of the woman.[62]

> "They're so sick, but they're in the hospital because Medicaid will pay for them to be sick in the hospital while they're pregnant and they won't pay for them to have a safe, legal abortion so they can be healthy."
>
> — Florida provider

PENNSYLVANIA

In Pennsylvania, public funding for abortion is only available in the limited circumstances outlined by the Hyde Amendment; however, due to advocacy efforts beginning in 2001, the number of abortions covered by Medicaid increased drastically according to providers interviewed in 2007 and 2008. The advocacy efforts resulted in a medical assistance bulletin outlined by the Pennsylvania Department of Public Welfare for providers and state Medical Care Organizations (MCOs) detailing the appropriate procedures for obtaining Medicaid coverage for an abortion and the circumstances under which an abortion can be covered. These improvements built on a legal victory from 1995, which removed two requirements for receiving Medicaid funding for abortion. First, a woman is no longer required to report a rape to the police to obtain Medicaid coverage for an abortion if a physician indicates that she was psychologically or physically unable to file a report. Second, in cases of life endangerment, only one physician (instead of two) is required to certify that an abortion is necessary to avert the death of a woman.[63]

In interviews, providers reported that there were still barriers to receiving reimbursements, including inconsistent reporting required by the different state MCOs. Though providers came up against barriers and complicated systems for reimbursement, many providers also attributed the high number of Medicaid reimbursements (equal to some states who have expanded Medicaid coverage for abortion beyond Hyde) to the advocacy efforts in 2001.[63]

OREGON

Oregon is one of the few states that allow the use of state funds for abortion both in policy and in practice. Since 1984, Oregon has been under court order to provide state Medicaid funds to cover medically necessary abortions. Both women and providers described a Medicaid system that largely meets the abortion care needs of women eligible for Oregon's Medicaid program, the Oregon Health Plan (OHP). Participants reported that most eligible women are able to enroll in the insurance program and obtain timely abortion care. Providers reported the electronic claims process, combined with knowledgeable and helpful OHP staff, make for a streamlined and user-friendly billing process for abortion care. One provider said, "Most of the time we are very certain that the patient has that coverage and that they [OHP] will cover the visit. I don't think [any cases get denied] because we rely on that database very heavily." It was also reported that immigrants, minors, and women from out of state continue to need support paying for abortion care.[64]

CONCLUSIONS AND RECOMMENDATIONS

While the Helms Amendment is statute and applies to grants awarded by the State Department and USAID for health and humanitarian programs overseas, Hyde restrictions are renewed annually by the federal appropriations process and apply to coverage of abortion in a publicly funded health insurance program, Medicaid. The Helms Amendment prevents foreign programs receiving U.S. funds from using those funds to support abortions except in the cases of life, rape, and incest. The Hyde Amendment prevents health-care providers from receiving reimbursement for abortion services except those administered in the cases of life, rape, and incest. Although these federal abortion restrictions operate and impact women differently, by creating numerous barriers to abortion access, the Helms and Hyde Amendments have harmed and violated the rights of millions of women for decades.

The implementation of the Helms Amendment has resulted in the failure of many U.S.-funded organizations to adequately address the needs of women in the developing world. Several countries have sought to mitigate the horror of unsafe abortion by liberalizing their laws and taking significant steps to make abortion care safe and accessible. Yet, the implementation of anti-abortion U.S. policy in other parts of the world stubbornly hinders progress in reproductive health access. The Helms Amendment causes the separation of the full range of reproductive health services; the censorship of abortion information, counseling, referrals and training and guidance materials for foreign officials; and a shortage of life-saving equipment in other countries. All of these barriers force women to resort to dangerous methods of abortion. Women who already lack resources, face substantial social, economic and health barriers, and contend with the aftermath of sexual violence suffer the most under an export of U.S. reproductive oppression—the Helms Amendment.

In the U.S., abortion is legal and constitutionally protected. Yet, the implementation of the Hyde Amendment has destroyed this right for millions of low-income women. Similar to the impact of the Helms Amendment, the Hyde Amendment has had negative effects on the well-being of women and their families that go beyond just denying some women abortion care. Restrictions that impede access to abortion interfere with women's autonomy, denying women the ability to make their own decisions about their life and health, derailing their life plans, and eroding their economic well-being.[49, 68, 69] Even among low-income women who are able to obtain abortions, such restrictions can lead to emotional, financial, and physical harms, including poor emotional well-being, physical health impairments, and intimate partner violence.[57, 68, 70–74] The Hyde Amendment hijacks one the most successful public health advancements in the United States—the Medicaid program—to make a political anti-abortion point, and it does so at the direct expense of those who are already struggling to make ends meet and are least able to overcome unnecessary roadblocks to healthcare.

Restrictions on funding of abortion send a message that abortion is wrong and thus generate and reinforce the stigma surrounding abortion. In countries where the U.S. funds global health programming, the stigma generated by the Helms Amendment leads to the enactment of the restrictions as a total abortion ban, precluding even women who would fall under the life, rape, and incest exceptions from care that they desperately need. Similarly, though the Hyde Amendment allows for abortion coverage in cases of rape, incest, and life endangerment of the

pregnant woman, women often do not receive coverage even in these circumstances, leading to a de facto ban in many states for women who are entitled to abortion coverage. In the U.S., Hyde restrictions on the use of public funds for abortion coverage explicitly shame low-income women for both their poverty and their abortion.[54]

Despite overwhelming evidence of the harms done to women by restrictions on abortion coverage and funding, anti-abortion rhetoric and policies in the U.S. have only increased since the introduction of the Helms and Hyde Amendments decades ago. Nonetheless, short-term solutions can be implemented to provide women here and abroad with some relief from these deleterious policies. The Administration can act now to help reduce the burden of the Helms Amendment and to help reduce unsafe abortion in the developing world by allowing support for abortion in the cases of life, rape, and incest under U.S. foreign assistance. States can provide Medicaid staff with guidance about abortion coverage policies and appropriate implementation. However, in order to fully protect the health and guarantee the full human rights of women in the U.S. and abroad, the U.S. must lift all its restrictions on U.S. abortion funding and insurance coverage. A comprehensive approach to reproductive health care anywhere in the world must include funding for, coverage of and access to safe abortion.

DATA & METHODS APPENDIX

Helms Amendment

Ipas has sponsored three separate fact-finding projects in Ghana, Nepal and Kenya and consulted with partner organizations in the United States and eight countries to document how U.S. restrictions on U.S. funding for abortion are applied. Ipas has conducted over 200 interviews with the staff of reproductive health organizations, health care providers, government officials, multilateral agencies, bilateral donors, and opinion leaders. All interviews were conducted in confidentiality, and the names of the interviewees are withheld by mutual agreement.

In 2009, Ipas conducted research in Nepal from November 15 – December 1. Ipas interviewed stakeholders in Ghana from March 22 – April 8 during 2011. Finally, in 2015, Ipas began a third fact-finding project in Kenya in December of 2015. Research in Kenya is ongoing and is set to complete in 2016.

Hyde Amendment

Results from several studies that Ibis Reproductive Health conducted on the experiences of abortion providers and women seeking abortion services under Medicaid abortion funding bans are included in this report.

Between 2007 and 2012, Ibis Reproductive Health investigated the impact of the Hyde Amendment through: 1) In-depth interviews with abortion providers at 70 facilities in 15 states; 2) In-depth interviews with more than 70 low-income women in four states; and 3) A "mystery caller" survey of Medicaid staff in 17 states. The methodological details and detailed results of these studies are published elsewhere. This brief also references additional research conducted by other institutions examining the impact of the Hyde Amendment on access to abortion services.

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