In order to achieve gender justice, the International Women’s Health Coalition advances the sexual and reproductive health and rights of women and adolescent girls, by:

- Funding and supporting feminist leaders, organizations, and movements, primarily in the Global South.
- Advocating for international and US policies, programs, and funding, and holding governments to their commitments.
- Generating knowledge and leading dialogues on critical and emergent issues.

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Executive Summary

In its third year, the expanded Mexico City Policy, also known as the Global Gag Rule, continued to cause immense harm around the world. Issued on January 23, 2017, US President Donald Trump’s presidential memorandum reinstated and expanded the policy. The implementation plan for the expanded policy, called “Protecting Life in Global Health Assistance,” (“the policy” or “the Global Gag Rule”) was announced in May 2017. Under the terms of the policy, any foreign nongovernmental organization that accepts US global health funds must certify that it does not provide abortion services, information, counseling and referrals, nor does it advocate to expand access to safe abortion services. The Global Gag Rule applies to what organizations do with their own, non-US government funds, in many cases forcing health care providers to choose between providing a comprehensive spectrum of reproductive health care and receiving critical US funding.

Since the enactment of the policy, the International Women’s Health Coalition (IWHC) has sought to document its profound impacts across communities, including its effects on health care, access to services, civil society activity, and the political climate. Throughout the application of the policy, IWHC has worked alongside grantee partners in Kenya, Nepal, Nigeria, and South Africa to investigate and document the policy’s effects through interviews with civil society organizations, health service providers, anti-abortion groups, and government agencies across the four documentation project countries.

The previous two phases of the project, which included over 160 interviews, found widespread misinterpretation and began to show how the policy was limiting access to critical health services and causing the fragmentation of health systems. In this third phase of the project, 104 interviews from stakeholders revealed the following impacts:

- **The policy continues to exacerbate existing barriers to health care access.** Services including comprehensive abortion care, contraceptive services, and HIV/AIDS testing and treatment have become less accessible. The Global Gag Rule continues to be harmful to the health and well-being of women and marginalized groups such as young people, people living in rural areas, and poor communities.

- **The policy creates funding gaps, and continues to fragment health services, and halt critical health programs, including those supporting government health services.** The policy leaves gaps in nongovernmental organizations’ work in strengthening health systems through direct health service provision, technical and financial assistance to governments, as well as capacity-building of health workers. These gaps can be difficult, time-intensive, and sometimes impossible to fill.

- **The policy is shrinking civil society spaces, silencing voices, and creating distrust amongst collaborators and partners.** Partnerships and coalitions are becoming fractured due to the policy, thereby limiting civil society’s ability to work effectively and hold their governments accountable.
• Implementing and monitoring the requirements of the policy burdens organizations who have to reduce or shut down programs, restructure, retrench staff, and closely monitor compliance.

• Lack of clarity about the policy is still common among key stakeholders, including leaders of organizations receiving US global health funding. This confusion often resulted in over-interpretation of the policy. In particular, key stakeholders did not know that the policy exempted the provision of post-abortion care or referrals for services in cases of rape and incest.

• The policy continues to embolden regressive actors and is creating new opportunities for such players to expand their influence. It has also been providing an excuse to hinder progress on sexual and reproductive health for individuals who do not support comprehensive sexual and reproductive health and rights within their professional capacities. Governments of countries receiving large amounts of US global health funds have remained largely silent regarding the consequences of the policy on the health of their own people and have failed to take significant steps to mitigate its effects.

Based on the findings of this research, **IWHC strongly urges the US government to prioritize legislative action to permanently end the Global Gag Rule, and to prevent future presidential administrations from unilaterally reinstating it.** The research conclusively shows that the policy has implications even when it is not in place and, while Presidential action to end it is important, congressional action remains critical. IWHC urges the US Congress to pass the Global HER Act and to finally end this policy permanently.

IWHC further urges congressional action to repeal other abortion restrictions in US law, including the Helms Amendment and similar restrictions on the use of US foreign assistance funds. These policies, similar to the Global Gag Rule, erect needless barriers to abortion care around the world and increase stigma around abortion services.

Finally, IWHC urges donors and national governments to continue to act to mitigate the impacts of the Global Gag Rule, including by increasing funding commitments for sexual and reproductive health, filling the gaps left by US policy, and by supporting organizations and communities most impacted by the policy.
I. Background

On January 23, 2017, United States President Donald Trump signed a presidential memorandum reinstating and expanding the Mexico City Policy, also known as the Global Gag Rule. The policy prohibits foreign (non-US) nongovernmental organizations that receive US foreign health assistance funding from using their private, non-US government funds to provide comprehensive abortion services, information, counseling, or referrals, or to advocate to expand access to safe abortion services. The policy is an additional barrier on top of the already restrictive Helms Amendment, which prohibits the use of US foreign assistance funds to pay for the performance of abortion as a method of family planning and has been in place since 1973. (See Appendix 1 for complete definitions of the Helms and Siljander policies.) President Trump’s implementation plan for the expanded policy, called “Protecting Life in Global Health Assistance”, was announced in May 2017.

A version of this policy has been enacted by every Republican president since Ronald Reagan, and rescinded by each incoming Democratic administration. While previous versions of the policy only applied to reproductive health and family planning funding, representing about $600 million a year, the Trump version of the Global Gag Rule was applied to all US global health funding, implicating more than $9 billion. Research into the effects of previous versions of the policy has found wide-ranging disruptions to sexual and reproductive health services, including contraception and HIV prevention. Previous research also shows that earlier versions of the Global Gag Rule led to increased abortion rates in countries in sub-Saharan Africa and Latin America.

In March 2019, US Secretary of State Mike Pompeo announced new enforcement criteria for the standard provision that guides implementation of the policy,amounting to a further expansion. The standard provision states that an organization receiving US funding cannot “provide financial support to any other foreign organization that conducts such activities,” referring to the abortion work prohibited by the policy. Pompeo announced that this clause would be interpreted to mean that compliant foreign nongovernmental organizations cannot provide any funding, from any donor, to another foreign nongovernmental organization for any purpose—even for activities outside of global health—if that other organization works on abortion.

While previous versions of the policy only applied to reproductive health and family planning funding, representing about $600 million a year, the Trump version of the Global Gag Rule was applied to all US global health funding, implicating more than $9 billion.
The United States is by far the world’s largest global health donor, contributing approximately half of all official development assistance for health provided by Organization for Economic Cooperation and Development (OECD) donor countries. For fiscal year 2020, the US congress appropriated $608 million for reproductive health and family planning as part of a $9.1 billion global health programs budget. While other donors have increased funding for sexual and reproductive health services in response, these efforts have not been able to fully compensate for the funding gaps caused by the Global Gag Rule, nor are they able to address many of the policy’s other impacts.

Upon taking office in January 2021, US President Joe Biden revoked the policy, directing agencies not to enforce the provision on current grants and to remove it from future funding agreements.

**PRESIDENT TRUMP’S ANTI-ABORTION AGENDA**

The Global Gag Rule prohibits foreign (non-US) nongovernmental organizations from using their private, non-US government funds to provide comprehensive abortion services, information, counseling, or referrals, or to advocate to expand access to safe abortion services as a condition for receiving US global health assistance.

The policy was part of a broader effort by the Trump administration to undermine global sexual and reproductive health and rights. Throughout its term, the Trump administration blocked funding for the United Nations Population Fund (UNFPA), the largest purchaser and distributor of contraceptives worldwide, and cut funding to other entities, like the Inter-American Commission on Human Rights and the Inter-American Commission on Women. The Trump administration also worked to reverse international human rights standards that recognize sexual and reproductive rights as human rights and removed mentions of reproductive rights from the US State Department’s annual Country Reports on Human Rights Practices in 2018. Pompeo took further aim at sexual and reproductive rights through the Commission on Unalienable Rights, a US State Department panel whose 2020 report sought to undermine global human rights laws and norms and instead to create a hierarchy of rights with freedom of religion paramount. In its waning days, the Trump Administration touted its so-called Geneva Consensus Declaration, a non-binding statement by anti-abortion governments committed to opposing abortion access globally.
II. Project Description


The first report from this documentation project was published in May 2018, and a second report was published in June 2019.

This third report presents findings from 104 additional in-depth interviews conducted during 2019, with civil society organizations, health service providers, anti-abortion groups, and government agencies across Kenya, Nepal, Nigeria, and South Africa. Further details about the characteristics of interviewees and the methods used can be found in Appendix 2.

Data collection for this phase of the project ended in November 2019. Therefore, the findings of this report do not account for the significant events of 2020, including COVID-19, the US withdrawal from the World Health Organization, and US elections.
NIGERIA
Abortion is permitted only in a medical emergency or to save the life of the woman.

KENYA
Abortion is permitted if, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.

SOUTH AFRICA
Abortion is legal without restrictions in the first 12 weeks of pregnancy, up to 20 weeks for socio-economic hardship, rape, incest, fetal abnormality, and to protect the health of the woman, and after 20 weeks in cases of severe fetal malformation and risk to the life of the woman or fetus.

NEPAL
Abortion is legal without restrictions in the first 12 weeks of pregnancy, up to 28 weeks in cases of rape or incest, or in situations where the woman suffers from HIV or other similar types of incurable diseases, and at any time if the pregnancy endangers a woman’s physical or mental health or life, or in cases of fetal anomaly.
III. Findings

Health Impacts

ACCESS TO SAFE ABORTION SERVICES AND INFORMATION

The policy increased barriers to safe, comprehensive abortion services, impacting both access to abortion services and to information, with detrimental effects. In all four countries, the policy exacerbated existing barriers to and disparities in access to abortion by shrinking and sometimes nullifying the awareness, availability, and provision of safe abortion services. These include magnifying the already-widespread stigma and discrimination around seeking abortions.

“[A]bortion on itself is a very sensitive issue for both male and female and this is very personal. There is stigma; social, cultural and religious values are attached as well. It is not necessary that people would like to talk about it publicly. Despite being legal there are still many barriers related to abortion. Many people may not have been supporting this policy. Some people might be against abortion as well.” – Program Officer, sexual and reproductive health NGO, Nepal

The loss of funding as a result of the policy compounded local silence on abortion and resulted in sexual and reproductive health organizations no longer being able to counsel and support women facing unwanted pregnancies in Kenya:

“Some of our partners in other organizations that have been offering the actual services of abortion are closing down their shops. Those who used to receive the US funding... FHOK [Family Health Options Kenya] and Marie Stopes have been affected. Those are the two key [organizations] that we worked with and as partners sexual and reproductive health “ – Technical Advisor, HIV and sexual and reproductive health organization, Kenya

Several sexual and reproductive health organizations across the four countries made the difficult decision to sign on to the policy. By signing, some organizations had to change their areas of focus and not offer abortion services, while others had to alter public-facing health information by removing all mention of abortion from manuals, posters, websites and other materials. As a result, both the service itself and information about abortion care became harder to access. Representatives from sexual and reproductive health organizations explained:

“We have products, we have programs that focus on sexual reproductive health, for example in the Rift Valley. The impact has been to revise the package of service to ensure that it excludes advocacy and also delivery of services around abortion. So that means, women who may have been interested in procuring an abortion then have not been able to receive those services.” – Manager, HIV-focused international NGO, Kenya
“It really affected us then as an adolescent health organization since we were advocating or working on sexual reproduction health and rights. We were actually told to stop advocating for abortion. So we were told to discontinue with that kind of information. We were also instructed to remove any part that talks about the TOP [Termination of Pregnancy] from our curriculum. Our curriculum development team then worked on that. We have a curriculum that we have developed and designed for different age groups. We have a specific curriculum … which is focusing only on girls. In that curriculum, there was that part that talks about TOP. So we had to also remove that part as well from our curriculum as a result of the policy. And we were invited to come and, you know, talk to learners about the benefits of TOP and things like that. But unfortunately, we couldn’t do that for them because we know that we are not allowed to take them through that process. It [the policy] has sort of like disempowered us to provide information to participants.” – Program Manager, adolescent health organization, South Africa

These kinds of compliance measures create inconsistencies in the sexual and reproductive health information provided, particularly to young people and women. Beyond the strict requirements of the policy, organizations often over implement, effectively self-gagging and amplifying the negative effects. For example, in South Africa, even in situations where organizations and the government are allowed to provide or refer for abortion services, they are becoming silent or removing language from training materials. Two participants described this as:

“I think that even in situations where organizations are empowered to continue to do the counselling and referring work that they are required to do by South African law, it still means that they might be removing some of the language of TOP [Termination of Pregnancy] from their training materials or from other things just to not appear like ‘troublemakers’” – Policy Associate, private foundation with work in South Africa

“It almost feels like there’s an insidious self-policing and self-gagging that’s taken place. So, they are centering themselves and positioning themselves with our new Minister of Health, but then what happens? We are still waiting for our abortion guidelines. There’s no South African group that is funded to hold our government accountable and to be on top of it. I mean we are...currently, our legal group is writing to our Minister of Health to say ‘What is happening to the guidelines?’. It’s been a year since they’ve been developed and we’re not hearing a word” – Representative, reproductive justice organization, South Africa

“Some of our partners in other organizations that have been offering the actual services of abortion are closing down their shops.”

“Women who may have been interested in procuring an abortion then have not been able to receive those services.”
In South Africa, the so-called “affirmative duty” exemption included in the Global Gag Rule raised specific questions and challenges. Abortion is legal in South Africa through the Choice on Termination of Pregnancy Act. Participants noted that the “affirmative duty” exemption, a provision in the policy that exempts health providers from complying with the policy if national law specifically requires them to provide counseling and referral for abortion, should apply. However, one respondent reported that at least one organization applied for this exemption and was rejected by the US government, with no reason provided for the rejection.

In addition, one sexual and reproductive health and rights practitioner noted that there has been an erosion of abortion services and increase in so-called “conscientious objection” by health care providers who may view the policy as validation for their own beliefs against abortion.

“First, it doesn’t do what it’s intended to do. We’ve seen time and time again research come out that the policy increases abortion rates as opposed to decreases abortions as major providers of contraception in countries lose access to funds and women have to rely more heavily on abortion to prevent unintended birth.” – Policy Associate, Private foundation with work in South Africa
ACCESS TO CONTRACEPTIVE SERVICES

In previous iterations of the Global Gag Rule, decreased access to contraceptive information and services has been one of the most direct and well documented impacts of the policy. As a result, some of the most salient effects of the Global Gag Rule include increases in unwanted pregnancies, clandestine abortions, maternal mortality, and child abandonment*. Three years into the Trump version of the policy, this continues to be true. In all four countries, there was reduced access to sexual and reproductive health information and services as organizations lost funding and stopped providing contraceptive services. As was true previously, these impacts continue to have the greatest consequences for marginalized populations.

“[T]here will be more unwanted pregnancies because the service providers that provide other reproductive health services such as information about from menstruation to how your reproductive system works, to reproductive health to screening for a range of diseases and conditions, providing contraceptive services, providing antenatal and maternal health services, providing support to survivors of violence. All of these organizations are already losing funding. So, it’s not just seeing more deaths due to unsafe abortion but more unplanned pregnancies as well.” – Advocacy Manager, regional development organization, South Africa

The advent of the Global Gag Rule has had layered effects. In all four countries, the reduction or loss of funding culminated in decreased ability of nongovernmental organizations to support government initiatives, especially in building capacity of health providers on family planning. In Nepal, two US-funded organizations promoting safe abortion and family planning stopped providing family planning support to the government in 22 districts due to Global-Gag-Rule-related funding cuts. They had to close programs in districts, halting many services and trainings related to family planning, because they refused to sign the policy.

NEPAL: THE SUPPORT TO INTERNATIONAL FAMILY PLANNING ORGANIZATION (SIFPO-2 PROJECT)

SIFPO-2 was a four-year USAID-funded project to support the government in increasing access to and use of quality family planning services in Nepal. The project focused on capacity building and systems strengthening in provision of family planning services in districts with hard-to-reach-areas. International NGOs with substantial experience promoting safe abortion services in Nepal were tasked with implementing the project. The project would have extended until the end of 2018 but due to the Global Gag Rule, the implementing organizations started constricting activities in early 2018 and were eventually compelled to end the project entirely before the scheduled completion date.

* child abandonment: this refers to a parent, guardian or caregiver deserting him/her; or if he/she has, for no apparent reason, had no contact with the parent, guardian, or caregiver for at least three months. In the case of SRH, this can refer to dumping children right after birth.
The SIFPO-2 project in Nepal was particularly impacted and was forced to lay off staff, with impacts on service and commodity supply. A member of one of the affected organizations mentioned:

“[W]e had to lay off 150 staff and sacrifice 4 districts just because there was no other support coming to us after the project phased out 6 months earlier than its due date... Around 60% of our funding has been reduced.” – Senior Advisor, sexual and reproductive health and rights service delivery organization, Nepal

According to one respondent who worked on the project, the policy coming into effect shortened the SIFPO-2 project’s lifespan and the Nepali government lacked adequate resources to conduct family planning training for providers. This resulted in a shortage of providers trained in family planning and subsequent poor quality of sexual and reproductive health care.

POST-ABORTION CARE

Post-abortion care is allowed under the Global Gag Rule regulations. However, due to miscommunication, lack of awareness, and the overall misunderstanding and overinterpretation of the policy, the Global Gag Rule reduces the availability and accessibility of post-abortion care. One respondent in Nigeria articulated why this might be the case:

“People just don’t want to have anything to do with it [post-abortion care]. ‘I don’t want trouble,’ so to say. And the orientation isn’t always that out there. I understand that every US government supported facility must have a compliance folder that has that entire rule. But they are what they are, folders. The knowledge is actually what really matters. Because by the time the information gets transmitted from the AOR [Agreement Officer Representative], the COR [Contracting Officer Representative], the chief of party to the provider, it gets watered down and then at some point, the message is just, ‘when you see abortion, just run away.’ So, there is that tendency not to have anything to do with it as long as the word is involved, whether post [abortion] or whether incomplete [abortion]. So, I would say that it still affects the operations of the facilities that are supported by the US funds because everybody just wants to be careful and not know where the monitoring can come from.” – Representative, sexual and reproductive health and HIV&AIDS organization, Nigeria

EXACERBATING EXISTING BARRIERS TO HEALTH CARE ACCESS

As in the previous phases of this project, the Global Gag Rule continues to reduce access to comprehensive health services. There is a higher impact on disadvantaged communities, young people, women, the LGBTI community, as well as marginalized members of society, such as sex workers and people with disabilities. Though abortion and family planning services are most impacted, the implementation of Trump’s expanded version of the policy has created additional effects on other sexual and reproductive health and related services, such as the HIV/AIDS cascade services, maternal health services, and gender-based violence support. One sexual and reproductive health organization in Nigeria described what the Global Gag Rule implications entail:

“If we don’t have such funds anymore, advocacy also will literally stop. Interventions of what we have been doing before will also literally stop. So, it will be a tough time for sexual and reproductive health.” – Representative, sexual and reproductive organization, Nigeria
In Kenya, the integration of health care services increases access for patients. For example, patients may come to a clinic seeking treatment for one medical issue and, at the same time, request counseling, information, or services on sexual and reproductive care, including abortion care. In one such case, a woman being treated in-clinic for a malaria infection requested a pregnancy test, which came back positive. The director of a local HIV and reproductive health organization described her circumstances:

“She told us she cannot carry the pregnancy to term because she had three children already and is no longer with the husband. She is taking care of three children alone. She says, 'I have decided I cannot carry the pregnancy to term. Please assist me, doctor.' The providers gave her options [for ending the pregnancy] and she opted for the tablets [Mifepristone and Misoprostol medication, to be taken at home] because the children were home alone and she was going home after a full day of malaria treatment in the recovery room. The following day, she gives us the good news that it was successful. We reconfirmed later and she was okay.”

In this case, the woman who originally presented at the clinic for malaria treatment was able to receive information on her options, make an informed choice on her treatment, and receive medication and follow-up consultation from trained health care providers. Under the Global Gag Rule, a provider in a similar circumstance where the clinic received US government funding would not be able to even provide information on abortion options or refer the patient to another trained health care provider who could effectively support their needs. This might lead to the patient seeking out untrained providers, unsafe abortion methods, or continuing a pregnancy that carries higher risk of miscarriage and maternal mortality due to malaria infection.

The director reflected on the intersection of malaria treatment and abortion care, applying the lens of the Global Gag Rule restrictions:

“Who is murdering who? Because we are now talking of preventing maternal mortality as a global movement and you are not giving the women services based on their needs […] I don’t know what the Global Gag Rule is intending to do. Say if this lady died, why did she die? Let’s say she went to a quack and went to an unsafe provider and she died. Who would have caused her death? Is it the provider or the policy? That is the situation where we are.”

### IMPACTS ON HEALTH SYSTEMS

The impacts are felt beyond reproductive health care: the policy is dismantling comprehensive and integrated health services and paralyzing nongovernmental organizations that provide technical, implementation, and financial support to health systems. The most immediate effect of the policy is the funding cuts to US-government-funded organizations that do not sign onto the policy. In all four countries, organizations revealed how these funding cuts directly resulted in clinic closures, halted rural outreach work, and forced the retrenchment of employees.
In South Africa and Kenya, there was a sense of desperation as organizations prioritized keeping fixed-location clinics open at the expense of stopping mobile and outreach services—some had already halted outreach, while others reported the expectation that mobile services would imminently be eliminated. An abortion service provider from South Africa described a sequence of events:

“Only when we decided to receive other funding from another funder did we start to open up other clinics. But once we shut down from 44 clinics to 12 that we now had, it has stayed as the 12 clinics.”

– Marketing Manager, abortion service provider, South Africa

Additionally, when organizations that lost US funding were forced to shrink their operations or service provision, organizations with other sources of funding reported increased pressure to expand health service provision to meet the demand and to close the gap left by the others that were closing down clinics or services. These entities were not necessarily getting the same level of resources to fill these gaps.

“We have one of our programs that is dealing with sexual and reproductive health work and it’s purely focusing on abortion. It is funded by a private donor who came in after the Mexico camp who gave some money to partner [with] us especially to support the youth access safe abortion. What the program does is to work with private pharmacies to have safe abortion [medicines available] at a subsidized rate and we also work with youth groups to sensitize them on abortion, where to get care, a helpline where you can call when you have issues. So, the program is a little bit low key because in Kenya we have the rule of abortion being illegal. However, there is some big need for it. There are so many youth who are getting pregnant and they do not know where to go to because I think Marie Stopes was key in the market and since most of the funding from Marie Stopes was from the USAID that gap is crazy and huge.”

– Senior Program Manager, global health consultancy organization, Kenya

The policy also impacted human resources for health in all four countries. Retrenchments in Nepal and South Africa, where abortion is legal, resulted in a reduction in the number of qualified abortion providers practicing in the country, increasing supply-side barriers to quality and safe abortion. Across multiple countries, highly qualified providers faced unemployment, underemployment, and under-skilling. One provider described the cycle of abortion provider unemployment saying:

“Reduced funding means they [pro-choice organizations] then have to reduce their workforce and that means job losses for some of the folks particularly those who are in the whole field of provision of abortion services and by losing jobs, most of them are usually the bread winners and so that eventually affects not just their families but eventually the communities that they come from”

– Representative, HIV organization, Kenya

At the time of data collection, some of the health system impacts were not yet fully visible on the ground, but the longer-term effects were anticipated by the organizations who implemented programs and worked in the health system. A skilled workforce does not immediately bounce back when the Global Gag Rule is revoked, thus the impacts of a weakened health workforce are long-lasting as the pipeline shrinks due to resignations, retrenchments, or lack of training. As a participant who participated in both year 1 and 2 of this project noted:

“A quick realization after year 2 findings, is that the Global Gag Rule policy implications will outlive the policy itself. I wish more people would understand that.”

– Representative, sexual and reproductive health organization, Kenya
Fragmentation of Integrated and Collaborative Health Services

Integrated health systems are an established strategy for effectively and efficiently improving access to multiple necessary health services in one visit. Donors, including the US government, have made substantial investments in creating and funding integrated systems of care. The Global Gag Rule directly targets only one part of the system, but can unravel and dismantle the rest of the integration model. In just one example, as a result of the policy, HIV projects in Kenya were separated from other sexual and reproductive health activities as some organizations decided to only offer some sexual and reproductive health services, and not others. One respondent noted:

“We promote integrated services where you get into a facility and you get everything like a mini supermarket but with the Global Gag Rule everything is in pieces. It is not because even referral is already affected leave alone the integrated, with the expanded [policy] you are not even supposed to refer. We were able to refer that time and you could get cases that you needed to refer. Even with this situation we thought you can still stop offering abortion services in the network clinics but you refer to even the obstetrician or gynecologist but it [the policy] has affected the integration of services so it has all been disintegrated. It has affected the referral is from the community to the clinics and from clinic to clinics so all that system it’s distorted.” – Representative, sexual and reproductive health coalition organization, South Africa

Before the policy, organizations providing an array of health services could partner together to create an integrated service or referral model. Across all four countries, as a result of the policy, US-government-funded organizations pulled out from such models, affecting the availability of services that a client would ordinarily find under one roof or through referral. Robust partnerships and coalitions disintegrated, which affected service provision, referral systems, utilization, and information.

“We didn’t have a choice because they were major partners, they pull you out. It is not you to decide, it is them...Seriously, the Global Gag Rule has affected our network. It was one of the best...Now everything is in pieces, referrals affected intervention of services.” – Manager, major sexual and reproductive health organization, Kenya

Collaborative relationships between Global Gag Rule-compliant organizations and those that work on abortion-related activities ended. This division impacted women and girls’ access to services:

“We are actually putting programs that are at war with each other. It’s sad because on one hand the sexual and reproductive health and rights programming one of the deliverables is to advance the right to safe abortion in order to save lives. On the other hand, our deliverables under the US funding are around empowering young women and making sure that they have knowledge and access to services so that they can prevent on HIV, STIs, and unwanted pregnancies. But, organizations through which we do that are already starting to get their funding taken away.” – Advocacy Manager, regional development organization, South Africa
“It affects nongovernmental organizations that are working with us as they are not ready to work with us further because, obviously in comparison to US government support, our support [financial volume] is less, therefore, knowing all these things they have been compelled to discontinue their partnership with organizations like ours. They cannot say no to US fund, since 80s it is taking care of their projects and number of staffs. That’s way the impact is seen here. In case of our organization, previously three organizations worked with us and now they withdraw working with us.” – Project Coordinator, international nongovernmental organization, Nepal

In Nepal, prime recipients (organizations that directly receive foreign assistance funds) of US funding were particularly disgruntled by the fracturing of collaborative partnerships due to the Global Gag Rule. One prime recipient involved in increasing family planning coverage in numerous districts shared that they had to disassociate with some of their sub-prime service centers who wanted to continue providing abortion services. Another prime recipient reported that a collaborative relationship was destroyed because their sub-prime partner would not comply and the sub-prime threatened to sue the prime if they cut funds because of the policy. A representative of this prime told a story further illustrating both the breakdown of a longstanding partnership and the ongoing lack of clarity and confusion that surrounds the policy and all of its expansions:

“We had an organization with whom we were working since many years. Through some sources we heard that they were going to receive funds from another organization that works in post abortion. We then, had to sit down and walk through the policy and said if you do receive that fund, we won’t be able to work with you. So, then the organization said that it’s not fair, we want to work in that area because it has nothing to do with your program. It got really complicated that the organization threatened to sue us if we pull a flag on that. They were saying that they don’t have a freedom and it’s going to be another team to work. But we said we cannot work with the same organization that work on abortion or receive funds for abortion. Because it’s a same management and same organization and they wanted to just draw a line. But it’s so grey area that the best thing for us is just to withdraw and not to work with organizations like that. They literally threatened to sue us” – Deputy Country Director, sexual and reproductive health and rights organization working on maternal and child health, Nepal

Additionally, the fragmentation of networks and coordination between organizations in Nepal has resulted in replication of partnership processes - a time consuming activity that may deter from ready service implementation.

“Nongovernmental organizations working with us are not ready to work with us further because, obviously in comparison to US Government support our financial support is less. Knowing all these, they are compelled to discontinue their partnership with our organization...Three organizations have withdrawn partnership and working with us... we need to repeat the nongovernmental organization selection process which is very difficult. There is rigorous process for getting social welfare council’s approval and it consumes a lot of time to get the approval.” – Project Manager, humanitarian international nongovernmental organization, Nepal

In Nigeria, a local organization described the breakdown of a partnership with an international organization with significant funding for abortion care. The local organization signed the Global Gag Rule and felt it could no longer work with the international organization. The two parties described it
“We didn't have a choice because [the US government] were major partners, they pull you out. It is not you to decide, it is them . . . Seriously, the Global Gag Rule has affected our network. It was one of the best . . . Now everything is in pieces, referrals affected intervention of services.”

as a “divorce” and had to separate the staff and offices that they previously shared. The international organization re-registered in Nigeria as a separate organization, and continues to provide abortion care. The local organization described:

“We were receiving the money from [an international nongovernmental organization], but when this Gag rule came and we signed the new certification, [the funding organization] actually had to break out from [us], and now started a [separate] project in Nigeria as at January 1, 2018. This has really damaged the partnership completely. It’s gone beyond any salvaging now. So, [the international nongovernmental organization] now has its own office, [our organization] has its own office. And of course, you know it’s never going to be the same thing. So that’s another huge impact of this Global Gag Rule on programming in Nigeria. Because it’s like losing those strengths, the experience, the expertise already built in [with the other organization] the to cater for the private sector. And they were the major player in family planning in the private sector. That now has been eroded.” – Representative, local sexual and reproductive health and HIV/AIDS organization, Nigeria

In this example in Nigeria, the local organization ultimately did not receive USAID funding despite signing the policy, and, facing both the loss of funding and the loss of their partnership with the international organization, was forced to make cuts to programming. While working in partnership with the international nongovernmental organization, they had been the largest provider of contraceptive commodities to the private sector; the fallout from Global-Gag-Rule-related decisions reduced their ability to do that work, as well as their family planning social marketing.

Additionally, in Nigeria, the number of organizations that feel they can work with entities that continue to provide safe abortion access has shrunk, with ripple effects across health systems capacity. One former partner noted:

“But just to note that in the past, before the Gag Rule, we were supporting a safe abortion organization in conducting training. Basically, our role has been training of providers to prevent unsafe abortion, and complications, managing complications from abortion. I know as a country, we are a recipient of the USAID grant, so for us as an organization, we have signed into the Gag Rule.”

– Representative, sexual and reproductive health organization, Nigeria
Impacts on marginalized or hard to reach groups

The loss of funding because of the Global Gag Rule, and the subsequent closure or reduction of health programs, decreased access to sexual and reproductive health and rights information and services, particularly affecting marginalized or hard to reach groups. One on-the-ground provider in South Africa noted how compliance to the policy is in tension with other US programming and negatively impacts adolescent girls and young women:

“PEPFAR supports the DREAMS programme to try to address that specifically which is great on the one hand but on the other hand you have this Global Gag Rule which if you really want to engage an adolescent girl or young women to care about their health overall, their sexual reproductive health and their health overall you need to provide a wide and comprehensive range of activities. On one hand they are supporting HIV prevention efforts through DREAMS and other things but at the same time imperiling those same adolescent girls and young women in terms of restricting their access to all of the services.” – Field Manager, health-focused international nongovernmental organization, South Africa

This gap in service provision for marginalized groups widened since the last phase of this project (between 2018 and 2019) in Nepal. Several organizations reported increased vulnerability of women
and children. Participants believed that the Global Gag Rule contributed to increasing the incidence of unsafe abortion and the associated mortality and morbidity especially amongst young girls. The policy influenced the shortened timeline of the SIFPO-2 USAID program and it was mostly marginalized groups, communities in remote areas, and young people who were impacted by the service shifts and closures of the program. There was not only a decrease in access to contraceptives services, but access to safe abortion and prevention of mother-to-child transmission (PMTCT) services were also limited.

The policy was also reported to limit young people’s access to adolescent-friendly sexual and reproductive health services like outreach services. Outreach is critical for hard-to-reach populations like young people or rural cohorts who otherwise lack access to services—and in many cases these programs were among the first to be shut down with the loss of funds under the policy. A participant noted:

“Young population especially in marginalized community and hard-to-reach area will be impacted. Young population needs knowledge and information on family planning. The information and services on this were being provided by us through SIFPO project in hard-to-reach areas. They also are the most fertile age group and are likely to get engaged in sexual activities. Such groups will be under risk zone. The risk of unwanted pregnancy and HIV/AIDS might be prone to such groups.”
– Branch Manager, sexual and reproductive health service providing organization, Nepal

In Nigeria, the effects of the humanitarian crisis in the Northeast were potentially intensified by the Global Gag Rule. In this region, Boko Haram constantly target and rape young women, many of whom also sell sex for food. For survivors of Boko Haram’s violence, there is stigma and isolation associated with bearing a child as a result of rape. Consequently, these young women often resort to unsafe abortion—a situation that is exacerbated when the social environment is gagged by religion and tradition. The Global Gag Rule only compounds these challenges by imposing additional restrictions on the health care system.

“And then with the high rate of rape that we have now, especially in the northern part of Nigeria, not even the northern part of Nigeria alone, big men are raping small girls all over the place, and then because of gender based violence we have this. Even at the community level, some of the women, because of poverty or ignorance, they don’t know how to do family planning, the best thing they can do is to abort. And the process of abortion becomes complicated, and here we are at the community level, we cannot talk about it, we cannot do this, we cannot give you service we can’t, we have to refer you to the hospital, because it is not part of what we are being permitted to do. So, a lot of lives is sometimes lost in the process, or infections.” – Representative, local Sexual and Reproductive Health & HIV organization, Nigeria

When providing sexual and reproductive health services, trust between clients and providers can take time to develop due to the sensitivity of the issue. When providers are gagged and cannot speak on current or certain issues, it has implications for their ability to build trusting provider/client relationships—especially with young people, LGBTI people, people with disabilities, and sex workers—cohorts of the population that are already high risk, face discrimination, and are hard to reach.
Institutional Impacts

Across multiple countries, respondents in this project felt that in general there has been reduced funding for sexual and reproductive health and HIV/AIDS programming. Some multi-country organizations in this project also reported seeing impacts in other countries that were not part of the project. Organizations experienced fear and anxiety when deciding whether or not to comply to the Global Gag Rule. In 2017, when the Global Gag Rule came into effect, many programs did not experience immediate budget cuts, but with time observed more restrictions in available US government funds for sexual and reproductive health programs. In Nepal for example, there was less US government funds being distributed with no clear indication of where the rest of the funds were going, and 64% of funding from the Global Fund in Nepal was gagged.

MORAL DILEMMA

The decision to comply (or not) to the Global Gag Rule was, for many organizations, determined by a spectrum of factors. In Kenya, Nigeria, and South Africa, several organizations reported that they made the difficult decision to sign onto the policy to keep providing some vital, necessary sexual and reproductive health services. For some of these complying organizations, US government funding made up a substantial amount of the institution’s budgets. They felt compelled to sign the policy by the lack of alternative funding to cover the gap if they were to let go of US government funding. One organization described this dilemma by noting:

“it’s for the organization to make a decision, do you want to go for the US funding or you leave it entirely and go for other sources of funding and if you are a huge organization that has a huge budget, then that is a hard decision to make but if you are receiving say 10% funding from US government, you can make that decision easily to drop and continue with other, it is a hard decision to make.”
– Technical Advisor, HIV and sexual and reproductive health organization, Kenya

Many complying organizations argued that the population at stake would suffer more consequences if they opted to forgo funding and were willing to sign despite their ideological opposition. A sexual and reproductive health coalition in South Africa was opposed to the policy, but in order to keep providing critical services and remain functioning, organizations in the coalition had no choice but to comply to the Global Gag Rule. These kinds of decisions create a moral dilemma forcing organizations to compromise their principles for survival; and in some cases, at the potential expense of lost partnerships and collaborations.
“Well, we’re concerned about reputation. I mean we’re a human rights organization that have called government to task many, many times. And we are concerned about how we will save face with our peers, you know? At the same time in [another country], we’re also the lead organization in taking government to court for legalizing same-sex partnership and abolishing the sodomy law that still exists in [another country]. Yes, we’re taking US money. We luckily don’t do any abortion work, so we are not too concerned about that because we are not working in that space at all. But we are concerned around how our peers will view us... but it [signing the Global Gag Rule and taking US government funds] helps us to sustain the population and the groups we’ve committed to support. I guess there is a bit of tension... And I think over time, a lot of people’s views have changed to become more balanced truly based on the fact that there’s diminishing resources for everyone. And there isn’t as much choice” – Representative, rights-based organization, South Africa

COST OF IMPLEMENTATION AND COMPLIANCE

There were associated hard and soft costs to a compliance or non-compliance decision. Organizations with flexibility in their mandates that chose to sign the Global Gag Rule had to shoulder the burden of adapting their work to meet the compliance requirements. In many cases, this went well beyond altering programs or reporting requirements, and included shifts in personnel. One example of this adaptation was provided by a Kenyan sexual and reproductive health organization who explained:

“Same case if you are having a new employee, when you advertise you have to let them know from the interview, what their view is around that and whether they subscribe to that policy, if they don’t, we will not take them because it has become a part of the organization” – Technical Advisor, HIV and sexual and reproductive health organization, Kenya

In addition, compliant organizations mentioned that they experienced an additional burden to train staff and monitor Global Gag Rule compliance. Referring to some of the efforts that went into maintaining compliance, one organization described:

“It made us have to rethink the trajectory of our support and the type of support that we could provide. I mean, just very frankly speaking we did not get clarity when we spoke to [the US government] locally about what we could or could not spend for [XXX-a partner organization in another country], so we had to err on the side of caution and make sure none of the money went directly to [XXX]. So for example, if they were hosting a workshop, we would have to pay for the caterers ourselves, we would have to print and take care of the materials ourselves, do the things that [XXX] had the capacity to do, but because we didn’t want to be subject to an investigation in terms of violating the Global Gag Rule we had to tread very carefully with regard to spending directly to [XXX], we were able to work with the US experts to bring them in, to pay for their travel and other costs and help them to develop the intervention for adolescent disclosure, but the lack of clarity as regards to the implementation of the Global Gag Rule actually just caused a lot of confusion for us in terms of what and what not we could materially support for [XXX]. Even though our programme had nothing to do with supporting XXX’s ability to provide abortion services, as part of their complete array of their sexual and reproductive health services.” – Field Manager, health-focused NPO, South Africa

In Nigeria, the effects of the policy were acutely felt by sub-prime level organizations. Respondents noted that most prime recipients of funds complied with the policy, but many sub-primes faced consequences
of their decisions to either sign or not sign the policy. In many instances, instead of sub-granting to local organizations, large international organizations began implementing programs themselves. As they were not established implementors in the communities they normally sub-granted into, the programming was reported to be substandard and, in many instances, more expensive than what a local organization would have implemented.

CHANGES IN AND LIMITATIONS TO WORKING AREAS/SECTORS

When abortion was included in the mandate of an organization, and/or the organization had significant, non-US funding for comprehensive sexual and reproductive health programs, such organizations reported that the policy was restrictive and not in support of safeguarding women’s rights, and they did not sign, at the cost of losing funding.

To ensure sexual and reproductive health program sustainability, organizations that did not sign the Global Gag Rule were forced to find alternative sources of funding, which was time consuming and not always successful. This limited the organizations’ effectiveness and reach. Organizations that did not sign the Global Gag Rule reported significant reversal of gains on sexual and reproductive health and rights indicators, including the coverage of family planning, cancer screening, and HIV counselling and testing. In Kenya, a major sexual and reproductive health partner reported that their reach had almost halved:

“Yes there has been significant impacts because you will find in terms of our statistics, in a year we tell you we see this number of clients so the numbers have gone down because most of the people don’t want to come to the facility but they would wait for us to come to their community for the outreaches to get the services...what we can disseminate is the figures you could see our reports has declined in terms of service statistics probably if we served 200,000 at the end of the year currently right now, we are looking at 100,000.” – Manager, sexual and reproductive health organization, Kenya

Some non-compliant entities that lost US government funding had to reduce operations, restructure, and reorganize resources like infrastructure, trained human resources, coordination mechanisms, and coalitions.

“This last year, we have had maybe fifty percent of our team in Cross River. We are closing totally on September 30th” – Representative, sexual and reproductive health organization, Nigeria

REPERCUSSIONS OF NON-COMPLIANCE

In Nigeria, during the early years of this iteration of the policy, sub-grantee organizations on the ground hypothesized that the US government would not have the time and resources to monitor compliance. By the third year of implementation, however, organizations reported the implementation of oversight practices from the US.

Additionally, some primes reported stepping up the compliance protocols in place to ensure that sub-grantees were abiding by the policy:
“We did a modification of their grants or rather their contracts to include the PLGHA provisions. We developed a checklist to help them understand what was the scope and the breadth of the principles and we instituted a supervision program that now allows compliance teams to do routine support supervision visits, to be able to check whether partners that we implemented are actually complying.”

– Manager, HIV-focused international nongovernmental organization, Kenya

Participants noted increased fear and anxiety around the possible consequences of non-compliance as the US government has demonstrated the capacity to monitor and focus on compliance. As one organization in South Africa noted about two meetings they conducted:

“And I’ll tell you that we had 2 different meetings. We had one meeting for recipients of US funds, from implementers. And one for the activist community outside of US funds. And the activists showed up, the room was full. We had a great day of discussion. And of the implementing orgs, we had like 5. And we heard that it was because people were really scared, like they didn’t want to be in a room where the policy was being discussed in case that might trigger a violation of the policy. There was just so much fear around it. The airs in those 2 rooms is really what, for me, highlighted how it was impacted the advocacy community because you do have sort of a group of orgs which are perhaps less well-funded but have freedom of speech. And you have ones that have more funding, but are gagged in this way that makes it difficult for them to talk about the actual services, but then also beyond that also talk about the impacts of the policy on their organizations because that also could be seen as a violation.”

– Policy Associate, private foundation with work in South Africa

Nigerian stakeholders reported increased scrutiny of sexual and reproductive health and rights organizations. This hyper-scrutiny induced fear and anxiety and has possibly created a feedback loop of over-interpretation or over-application of the Global Gag Rule at the expense of quality sexual and reproductive health service provision. Organizations receiving US funding over-applied the policy so that they would not be found in non-compliance and lose the already overcompetitive funding. For HIV-specific organizations, the Trump Global Gag Rule was the first experience of the policy. Compliant sexual and reproductive health organizations like maternal health organizations in Nigeria were taking extra and unnecessary steps to avoid getting tagged as non-compliant. On respondent presented a case experience of this:

“So, you can imagine, this is people [working on maternal health] that are not affected by the Global Gag Rule, yet they are, you know...We belong to the reproductive health technical working group. Whenever there are events and partners are pulling resources together so we could support the Federal Ministry of Health organize events, and people are bringing their logos and all that, some will not want to have their logo together with ours, you know....”

– Representative, International sexual and reproductive health and rights organization, Nigeria
Effects on Civil Society

FRAGMENTATION OF CIVIL SOCIETY AND REDUCTIONS IN COALITION SPACE.

Implementing the policy disrupted collaborations and partnerships in civil society. When some members of a coalition comply and others do not, it creates compromising and difficult scenarios. Two respondents described:

“What it continues to do is create division between those that are pro and against abortion, but also divides civil society on who should take the US money and who has not.” – Director, Research Institution, South Africa

“I was in a meeting that might as well gone into a partnership, one of the partners was a recipient of the US government funding. That means they signed that policy. Because we are pro-abortion, they dealt with children so they felt that we are contradicting, we are pro-abortion, they on the other hand dealt with children, we on the other hand kind of promoted abortion so they felt we are contradicting so we eventually realized that it just wasn’t going to work so that arrangement didn’t continue. So that is how it happened very recently.” – Representative, sexual and reproductive health organization, Nigeria

In all four countries, respondents felt strongly that civil society coalitions have been broken and weakened because of the Global Gag Rule. The policy creates divisions and reduces the power of coalitions that work together to advocate for or provide sexual and reproductive health services. In South Africa, the process of drafting a comprehensive sexuality education curriculum was negatively impacted by the advent of the Global Gag Rule. Because of the status of abortion under the constitution, it was expected to be part of the discussion; however, the policy has interrupted the ability of organizations to discuss abortion as part of this package. Coalitions, partners, and organizations would need to meet to discuss the content of the comprehensive sexuality education package but, due to the Global Gag Rule, US-funded organizations felt they could not show up to the conversations and/or talk about abortion. This hindered the ability of the coalition to meet to comprehensively discuss the content of the comprehensive sexuality education package, running the risk of producing a sexuality education package that is not comprehensive.

The typical alliances of organizations that would ordinarily have held governments accountable to their health commitments were broken.
In 2016, several United Nations agencies co-published updated international standards for comprehensive sexuality education. Following this guidance, South Africa’s Department of Basic Education set out to update and expand the national curriculum for “Life Orientation” education to align with international best practices. This project was funded in part by the US government via the US Agency for International Development (USAID). Interviews with representatives from sexual and reproductive health organizations in South Africa revealed their concern that, even though the project began before the Global Gag Rule was reinstated and expanded in 2017, the multi-year process would be stripped of abortion-related material due to the influence of US funding.

In South Africa, abortion rights are outlined in the country’s Choice on Termination of Pregnancy (CTOP) Act, passed in 1996. Reproductive health advocates pushed for this information to be included in the updated national lesson plans.

A representative of a sexual and reproductive health organization in South Africa shared their interactions with the Department of Basic Education: “One of the questions that I asked [about the new life curriculum lesson plans] was whether abortion would be mentioned and particularly people’s rights under CTOP [the Choice on Termination of Pregnancy Act]. I asked that question because our research has shown that young people don’t have sufficient information about their rights.”

Later, the same advocate noted how the influence of the Global Gag Rule reached project consultants, suggesting that project leads may have steered away from abortion content because USAID was a funder. “One of the people who had initially been commissioned to do these scripted lesson plans [...] indicated to me that she thought that if it was funded by the US government that, you know, abortion would be off the table.”

Before the project’s completion, at meetings of the taskforce on the National Adolescent Sexual and Reproductive Health and Rights Strategy Framework, “there was a fear that the funding from the US government would result in abortion not being dealt with substantively,” according to the respondent.

Of the new guidelines, published in 2019, they stated, “abortion – yes, it is mentioned – but it is very much in passing. It’s never dealt with substantively on its own. And where it is dealt with, it’s to say, for example, […] to reassure learners that emergency contraception is not abortion. Is this a direct effect from USAID? And that I don’t know. I just know that this is not the outcome we had anticipated it would be.”
SILENCING OF VOICES

The silencing of civil society has been a persistent occurrence for as long as the policy has been in effect. Civil society organizations are gagged and find the policy to be restrictive and controlling. In all four countries, complying organizations stopped attending conferences or workshops where abortion would be discussed; or if they did attend, then abortion was unlikely to be discussed—even by non-complying organizations. Sexual and reproductive health leaders in Kenya described the silencing by saying:

“If there is a conference or a workshop that promotes or advocates for abortion or what has been excluded you are limited. You cannot go. You cannot use US funds. Then if there are some other opportunities that are rising, the first question you ask before you apply for that grant is, do they subscribe to the gag rule? So, it affects how we make decisions and the effectiveness of making a decision and following up.” – Technical advisor, sexual and reproductive health organization, Kenya

In Nigeria, the policy led to fewer organizations working on sexual and reproductive health. One representative of a national sexual and reproductive health organization noted, “A lot of people want to go to where money is, so we don’t have a lot of nongovernmental organizations working on sexual reproductive health and rights.”

In Nepal, abortion is permitted by law, but organizations reported that they stopped talking about abortion as a result of the policy. Grassroots and community level organizations stopped advertising or showcasing their abortion advocacy work, which means their clients and audiences received incomplete sexual and reproductive health information and services. A Kenyan civil society respondent noted:

“Local civil society know what it means, and cascade it down to local partners which make it very difficult or punitive. I know of organizations that have been ordered to cool down social media on sexual and reproductive health and rights.” – Representative, civil society organization, Kenya

In South Africa, partner organizations self-gagged and self-silenced. A respondent, who is a director of a South African SRH coalition, noted that “some [organizations] are very, very aware of how some partners are gagging themselves.”

In Kenya and Nigeria, the Global Gag Rule threatens progress on the Journey to Self-Reliance, the US-imposed plan whereby the US government reduces donor assistance and country governments increase national contributions. The abrupt funding cuts and subsequent service delivery effects that are triggered by the Global Gag Rule make it challenging for these countries to advance towards self-reliance. In Nigeria, for example, the principles of the Journey to Self-Reliance were aligned with respondents’ recommendations calling for the government to increase financial investment in the health sector. However, it remains unclear how this new development aid framework is going to operate when other policies (like the Global Gag Rule) from the US government undermine the same systems that self-reliance seeks to strengthen. In Kenya a respondent said:
“I don’t know whether you have been following what is going on in Kenya right now. Something new has emerged which the US government is calling journey to self-reliance. Journey to self-reliance is now the other monster in the house it has affected most of the international nongovernmental organizations that came together to form the [XXX]s there was the [ABC], [DEF], [GHI], [JKL] there were many [XXX]s. Now their funding has been cut, our funding specifically as [health and education organization] we have lost it because of compliance issues and all that. When you interviewed us last time, we were waiting, we hoped that they would renew it and I think as we understand the Global Gag Rule does not affect the running budget because our budget was funded and it was already running so that is why we were not affected. When it came to renewal, we have not renewed it so we have lost the funding.” – Executive Director, health and education organization, Kenya

EMBOLDENING REGRESSIVE ACTORS

Participants reported that the silencing of pro-abortion advocacy voices, fracturing of civil society coalitions, and gagging of service providers has, in turn, uplifted existing conservative actors and emboldened anti-choice groups. Many of the anti-choice groups that were approached declined to participate or contribute to this project.

Throughout all four countries, there remains a general fear that emboldened regressive organizations are interfering with young people and women’s access to information. One respondent noted that:

“[W]ith the Global Gag Rule, one serious effect is the anti-choice movement is thriving. Anti-choice movement is everywhere even in [ABC] and you can be stopped and abused and in the African culture there is nothing as abusive as somebody calling you a murderer. What we have been receiving are messages, like in our organization’s info, I can share with you those communication, you get somebody abusing you, like you killers in this organizations', there are some that will abuse there are some that will ask you whether you offer that I’m distressed and having a lot of problems and I need abortion services, can you offer abortion services? You get those mystery emails that you don’t who it is…” – Executive Director, health and education organization, Kenya

In the wake of the Global Gag Rule, respondents reported that the anti-choice advocacy space ballooned and increased in volume. Anti-choice advocates pushed forward anti-abortion agendas, and, in South Africa, managed to embed themselves within the Ministry of Education, hindering plans to introduce CSE in schools (see Case II example). According to respondents, the US government, through embassy personnel, publicly praised the work of one pro-life organization on international platforms. In South Africa, sexual and reproductive health organizations reported a belief that US funding previously reserved for nongovernmental organizations and community-based organizations working on HIV prevention and adolescent and women’s health was now been increasingly channeled towards funding churches and anti-abortion faith-based organizations. One gave an example:

“Organizations that focus on the family are receiving funding from PEPFAR to do abstinence education in schools in South Africa. And they are definitely part of the development of CSE with the Department of Basic Education. So that is a direct consequence. Do you know about Focus on the Family?... they are the most frightening right-wing group. So, they’re like based in the US, but they’ve got a chapter that is gaining strength in South Africa” – Director, reproductive justice organization, South Africa
In Nigeria, regressive religious fundamentalists were already active in the sexual and reproductive health space, and the presence of the Global Gag Rule allowed these actors to thrive. One regressive actor coordinated a sting targeting a prominent safe-abortion organization in Nigeria. They sent a mystery client to the safe-abortion organization in Lagos, who was asked to come back the next day. The client returned the next day, with police. The safe-abortion clinic had to be shut down as a result of this sting, but it was eventually re-opened after extensive negotiations. Whilst active regressive actors in Nigeria are not a new phenomenon, a respondent felt that this particular sting was a result of the emboldening of these actors due to the Global Gag Rule.

Respondents also noted targeted work by regressive players to restrict access as they tried to expose underground networks that are facilitating life-saving access, and get those networks completely wiped out. Referring to this specific story, a sexual and reproductive health respondent mentioned:

“We have had reported cases in some organizations who provide sexual and reproductive health and rights services. They have been attacked; their brand has been attacked to the media publications against them. There have been reported cases of physically going to their service point to disrupt services and protest, even in-country. We have increasingly seen some organizations that have not worked in this part of the world coming in to do this, also claiming to be non-profit, targeting sexual and reproductive health organizations.” – Director, sexual and reproductive health organization, Nigeria
Impacts on government policy objectives and programs

While the Global Gag Rule is a foreign policy enacted by the US on bilateral global health funds given directly to nongovernmental organizations, it interacts with other local and national policies and programs. US global health funds provided directly to foreign governments are explicitly exempted from the policy, yet these funds—and the programs they support—are affected by it. For example, some government agencies refused for their logos to be placed together with non-compliant sexual and reproductive health organizations when doing collaborative work. These unspoken cues are visible on the ground and felt by respondents in multiple countries.

In South Africa, respondents noted that the Global Gag Rule will not change abortion service provision because it is protected by law. However, it was reported that parliamentarians and government health programs have self-gagged because they fear losing US funding and it also became an opportunity to not confront their own anti-abortion biases. A coalition member provided examples of this self-gagging stating:

“If you look at their maternal health programs like Mumconnect and the youth program like BeWise, they themselves have gagged themselves on abortion messages, so they’ve got maternal health messaging, and they themselves have taken out those messages on abortion.” – Chairperson, sexual and reproductive health and rights coalition, South Africa

Organizations interviewed in Nepal posited that the Global Gag Rule does not have an impact on the status of abortion because it was already legalized. A US-funded organization in Nepal also expressed dissatisfaction over not being able to support the government in safe abortion, particularly when the government desires this, because they are gagged. They noted:

“Our project is to strengthen the government system. When the project isn’t there, how can we strengthen the government system? That has been the biggest question mark for us. We have bought equipment and also have trained human resources. There will be a biggest loss for everyone.”
– Director, sexual and reproductive health service delivery organization, Nepal

IMPACTS ON GOVERNMENT COMMITMENTS

The Global Gag Rule alters government decision-making. Some respondents felt that US pressure was driving government positions and actions, leading to government failure to meet existing commitments. Despite the Nepali government’s commitments on universal quality health care, for example, this commitment was not fully reflected in resource allocation. Respondents reported that the Nepali government had no mitigation strategies for the effects of the policy on the country’s health system, pointing to donor dependency and the ties and conditionalities that come with that reliance. One government official referred to possible impacts of the Global Gag Rule on sexual and reproductive health progress:
“There will be a slow progress. If the external funding sexual and reproductive health and rights is reduced then government may give priority in the areas where there is US funding. In such situation, the process for making new strategies and expansion of services will be slower since the government has their own constraints.” – Parliamentarian, Nepal

In South Africa, Kenya, and Nepal, several organizations expressed frustration and anger with their country’s government. In Kenya and South Africa, there was anger at the government for allowing itself to get coerced by the US, and for not standing up for its people or pushing back against harmful US policies. It was perceived that some parliamentarians in South Africa avoided addressing sexual and reproductive health issues as a result of their personal beliefs and used the Global Gag Rule as an excuse for their silences. One respondent from a reproductive justice organization mentioned:

“They don’t want us to be vocal and to hold government accountable. And I think it’s easier to, you know, say ‘he doesn’t get sexual and reproductive health.’ There are no champions for sexual and reproductive health in the Department of Health. You can see how the Department of Social Development have really tried, and they are pretty much the custodians of our concerns in government.” – Director, reproductive justice organization, South Africa

Alternatively, in Kenya, some organizations felt that the Kenyan government was attempting to become self-reliant and not necessarily be dictated to by a foreign policy:

“I applaud what the government is doing, we self-sustain our health and also just to be an advocate of science at the individual level in terms of the research and what it tells us. What does the science tell us, irrespective of any policy then that we can be able to advise our local policies on what does that mean and we stick to that no matter the effect.” – Technical Advisor, Sexual and Reproductive health organization, Kenya

At the time of data collection, Nepal was operationalizing a strategy to decentralize its health system with major administrative and structural changes as well as the relocation of staff. In this strategy, district level government health providers shared that activities from civil society organizations and international nongovernmental organizations were a driving factor for them to provide services, and that nongovernmental organizations’ activities were supportive of government in various ways. In most cases, however, civil society and international nongovernmental organizations’ activities were strongly negatively impacted by the Global Gag Rule, with consequences on government health providers’ service provision. Partners felt that the Global Gag Rule was contributing to a loss in momentum of the country’s health sector. Because Nepal was in the midst of a transition, the Global Gag Rule threatened the progress made in the health sector in the last decade and added challenges to achieving national goals. Referring to Global Gag Rule-induced loss of nongovernmental organizations’ support, one government officer noted:

“It was like; they were very supportive when we had some crisis in our organization. But later they were gone with their organization. We felt some difficulties after they left but the work is still continuing in the absence of such nongovernmental organizations and international nongovernmental organizations. However, this could leave us not achieving the goals and targets that we have set for the country.” – Government Officer, government, Nepal
IN SOUTH AFRICA: INCREASING ANGER TOWARDS PRIVATE FOUNDATIONS

Respondents in South Africa noted that the Global Gag Rule has forced civil society to become increasingly dependent on private foundation support, which has in turn increased concerns about the impact that foundations’ restrictions and other forms of pressure have on programs and advocacy. For example, respondents reported concerns about some private foundations’ prioritization of technological approaches to increasing contraceptive use, and expressed beliefs that foundations are looking to fund long-term methods for the purposes of population control. When civil society would ordinarily be advocating for access to spectrum of contraceptive products to accommodate a diverse population, they expressed that, as a result of the Global Gag Rule, civil society voices are gagged and the strategies advanced by private foundations take precedence.

“So, I’m interested in how the Gag Rule has also facilitated a culture of nongovernmental organizations and the Department of Health to gag themselves. Not necessarily with US funding, but also US private foundation funding. …And so, for me, what the gagging is the...almost co-option of government into these private foundation-initiated ideas around sexual and reproductive health that seem insidiously good, but actually are quite detrimental to our autonomy and independence as South Africa. And our commitment to human rights and to bodily autonomy.” – Director, reproductive justice organization, South Africa

Respondents felt that the increased influence of private donors revealed how this US policy has unprecedented ripple effects. In this case, the prioritization of long-acting reversible contraceptives means that people seeking sexual and reproductive health services do not receive comprehensive information about the full range of available contraceptive methods and are directed towards injections or other long-acting methods, thereby reducing choice and increasing the risk of coercion. In effect, because nongovernmental organizations are gagged and the power of Departments of Health is undermined, other voices and agendas have the opportunity to rise to the top.
Awareness, Understanding and Perceptions of the Global Gag Rule

Across the four countries, stakeholders demonstrated awareness of the policy, but knowledge of the policy’s complexity lacked depth, and confusion and misinterpretation continue to be widespread.

When compared to the past two phases of this project, more stakeholders demonstrated that they are aware of the policy and were able to describe it:

“It’s basically targeting national and international nongovernmental organizations and preventing them from access to US funding if they are involved in the provision of abortion services regardless of whether or not it is from US funding. So, even if they’re being funded from other sources that they are using it for supporting safe abortion services then they do not have access to US funding. Previously under the Gag rule, it was limited to family planning programs to see whether the family planning programs that nongovernmental organizations were managing were included elements of safe abortion services or not. But under the Trump administration, that has expanded to the health programs.”
– Manager, HIV-focused international nongovernmental organization, Kenya

In South Africa, respondents were aware that the Global Gag Rule exists, but noted that the specifics were not clear, especially with regards to affirmation duty clause in the policy. One lawyer explained the vagueness in the interplay between the Global Gag Rule and South African law:

“But then the questions become, okay how does that work in a country like South Africa where, abortion is a right - you have a right to have abortion services so how do those two conflicting, foreign policy and a national law, how do we navigate it. For me, that is the area that is vague. It is not the policy itself that is vague. It is not what it seeks to do that is vague.”
– Lawyer, Public Interest legal Organization, South Africa

SECRETARY OF STATE MIKE POMPEO: NEW EXPANDED ENFORCEMENT CRITERIA, MARCH 2019

The standard provision states that an organization receiving US funding cannot “provide financial support to any other foreign organization that conducts such activities,” referring to the abortion work prohibited by the policy. In March 2019, Secretary Pompeo announced that this would be interpreted to mean that compliant foreign NGOs cannot provide any funding, from any donor, to another foreign NGO for any purpose—even for activities outside of global health—if that other NGO works on abortion.

There was particular lack of knowledge around the March 2019 announcement by Secretary Pompeo around expanded implementation of the policy. In Kenya, all of the respondents were unfamiliar with the additional rules. When the expanded version was explained during data collection, respondents felt it was more restrictive and extreme and would continue to limit space for sexual and reproductive health and rights organizations. A respondent in Kenya described the expansion:
“It is terrible, it is very, very bad and it will drastically reduce US assistance. They are sieving out organizations. What about advocacy, like what you are doing, like you are advocating against it?” – Director, women’s nongovernmental organization, Kenya

Another participant, describing what would happen to an organization that receives a large amount of US government funds, was completely unaware and shockingly stated, “Oh my God! If [US funded organization] have money from [European country1] or [European country2], they cannot use that money from [European country] to fund another organization that’s working on abortion?!” – Human rights worker, health organization, Kenya

In Nepal and Nigeria, stakeholders reported that there was poor knowledge and lack of discussions on the effects of the Global Gag Rule within government and parliament. A respondent in Nigeria noted:

“…but, if legislators don’t even know that the gag rule exists, or this policy expansion exists, then they would not understand what you need to do to get the gap filled so that women can be attended to.” – Representative, non-compliant sexual and reproductive health organization, Nigeria

In Nepal, interviews with government officials, including those directing working in health, revealed that they did not know or had not heard about the policy until they were contributing to this project.

“No, sir. I haven’t come across such news and articles related to the Global Gag Rule. I heard about this policy only from you.” – Medical Superintendent, government, Nepal

“We never have had any meeting and discussion of the Global Gag Rule. We haven’t heard this from other organizations. This is a very new thing to us.” – Chief District Officer and Family Planning Supervisor, government, Nepal

In all four countries, the policy was better understood by respondents from organizations that were prime recipients of US funds, when compared to respondent from sub-grantees or organizations that did not receive US funds. The poor understanding and shallow awareness of the policy was in part driven by the lack of communications and information about the Global Gag Rule, particularly for non-prime organizations. In many instances, staff from both prime grantees and sub-grantees were unclear of the pathways, personnel, or procedures to turn to if they had key questions or needed clarification on the policy. In South Africa, stakeholders noted that it was difficult to find readily available and accessible information about the policy. One respondent noted that they were asked to seek clarity from a US government department in the US, and the organization’s headquarters (US-based) followed this directive. However, the organization (both the US headquarters and South Africa country office) still did not receive clear information on how to implement the policy.

Despite receiving updates on the policy, in some instances, the prime recipients were confused about the policy and were not able to explain it well to their sub-recipients. One prime-recipient executive noted:
“We were trying to seek clarification I think specifically from USAID and [another country] on the implementation of the previous iteration of the Gag Rule. And frankly, they never got back to us. We just had to maneuver how we solved this, which unfortunately was to err on the side of caution, which was really to the detriment of our local partner because we could not sub-grant them because of the Gag Rule. So that’s one example. And of course, we were not quite sure if what we decided to do was truly in violation of the Gag Rule, but as I said earlier, I think organizations are trying to stay out of the line of fire”. – Growth Executive, Global health organization, South Africa

Confusion and misinformation were also manifest within US government implementing agencies and US government representatives themselves, who were meant to inform and educate on the policy. In one case, a US government representative called an organization in Nigeria asking them to apply to a request for proposal even though the organization has a known pro-choice mandate and would have to be subjected to the Global Gag Rule.

In general, knowledge about the policy’s limits and exceptions was particularly weak, and even though respondents who had Global Gag Rule knowledge could explain what cannot be done when the policy is in effect, they could not explain what can be done. While most of the respondents knew that US funding could not be used to promote abortion as a method of family planning, for example, they did not know about the exemptions on post-abortion care, or whether they were allowed to collaborate with other nongovernmental organizations offering sexual and reproductive health services. This impacted sexual and reproductive health providers’ ability to make informed decisions during consultations with patients. One provider articulated:

“Right now, it is a patient centered approach but with a condition so when they present this it is so hard to make a decision on whether to refer and previously sometimes back, we used to refer. It is hard to stand with the policy in terms of decision making and when your staff, the people that you are supervising come to you and say, we are working with bigger key populations that do a lot of abortions. So how do you supervise and balance between the policy of human rights personal values and the referral around that? It is so hard to make a decision based on that.” – Technical Advisor, Sexual and Reproductive Health organization, Kenya

Across the countries, respondents repeatedly pointed to the need for additional policy training, information dissemination, and communication, especially for grassroots organizations. A responder articulated that training should be targeted towards:

“One in particular is in the local civil societies, to know what it means and to know the implication but also to people who are first line recipient of US money, who have to cascade it down to local partners and who make it very difficult or who will be very punitive when they engage with partners. I think the education and information you remember we were just doing a brief to civil society on what is it, its application? What are the implications and I am saying those kinds of forums are very critical for so many civil societies because there is completely huge misunderstanding and lack of knowledge sometimes.” – Program Manager, adolescent health organization, Kenya
Perceptions of the Policy

There was general anger at the US government as US officials talk about women’s and human rights but US policies continue to infringe on the rights of women.

“A lot of countries receive US government funding or funding from the Europeans countries. In my opinion if you want to help people don’t help them according to the way you think they should be helped. People should be the ones to choose how they want to be helped” – Program Manager, alliance of civil society organizations, South Africa

There was also anger toward national governments’ disinterest in the Global Gag Rule’s effects and dependency on donor funding that is largely US based. In all countries, almost all the stakeholders considered the policy to be ‘regressive,’ ‘weird,’ ‘unfair,’ ‘restrictive,’ ‘controlling,’ ‘extreme,’ and a rule ‘against human rights.’

The policy was seen as not doing what it is intended to do (lower abortion rates), and not responding to needs of people on the ground. There was confusion about why it was still in place. Respondents in Kenya thought that the Global Gag Rule interfered with their constitution, including the right to access and provision of comprehensive health services which includes abortion services and referrals:

“The reality is also it infringes on some of the fundamental rights of the users because I think if you look at the constitution, it talks about chapter 4 of the Kenyan constitution, has a whole chapter has a whole section of provision in terms of the rights and it actually borders the infringement of some of those basic principles and rights enjoyment of and the entitlement of the rights of the users of the service because then they are denied a service that they should be able to decide because I think the Kenyan constitution says that if you are over 18 years and over then you are free to make certain decisions and choices in life” – Manager, HIV-focused international nongovernmental organization, Kenya

“A lot of countries receive US government funding or funding from European countries. In my opinion, if you want to help people don’t help them according to the way you think they should be helped. People should be the ones to choose how they want to be helped.”
Solutions and Resistance

Stakeholders in all four countries reported that the impacts of the Global Gag Rule made it clear how necessary it is for national governments to be accountable for and have ownership of sexual and reproductive health services. Civil society identified the need and called for national governments to reduce donor dependency and allocate more resources for sexual and reproductive health services to mitigate the impact of the policy on these services. For example, one representative of an HIV and sexual and reproductive health organization in Kenya noted that they needed to “reach a place where we can stand on our own completely” in order to avoid the disruptive nature of the fluctuations in the application of the policy.

Stakeholders also began to place more pressure on the government to commit and allocate resources towards ordinarily donor-funded health sectors. One of these stakeholders referred to this by saying:

“We need to put more emphasis on policy and advocacy work to mobilize government and political commitment to reproductive health and family planning. And to mobilize domestic resources so that these programs are sustainable and they are not dependent on external financial support.”
– Technical Advisor, health-systems focused international nongovernmental organization, Nepal

Some organizations saw the effects of the Global Gag Rule as an opportunity to build financial resilience and diversified their financing, donor, and operational models. In all four countries, organizations sought alternative sources of funding where ever possible. In some cases, alternative sources of funding were found, including in Nigeria and Nepal. Other organizations transitioned from being fully non-profit to adopting a business model. For example, one organization in Kenya was able to reopen clinics by using revenue from their hotel and rental suites. However, despite their efforts to make up for lost funding, they were forced to make substantial changes, including requiring payment for previously free-of-charge services and operating facilities with fewer staff. These changes potentially compromised both access to and quality of the health services there.

In Kenya and Nigeria, some organizations decided to split up and register as independent organizations. One organization in Kenya became two entities, one that provides safe abortion access and did not apply for US government funds, and one that provides other non-abortion sexual and reproductive health services and applies for US government funding.

“I know ABC had differences because ABC-Sweden did not sign and therefore made a shift from ABC-International that had had signed. The reason was that ABC-Sweden said the source of its funding was quite liberal and therefore could not take up, whereas ABC-International had taken up quite a huge chunk of USAID money so that conflict created two different entities out of one, same in Bungoma where we have been doing work.” – Representative, civil society advocacy organization, Kenya
IV. Media

As in previous phases of this project, across all four countries, there was extremely little engagement by the media to educate decision-makers and the general public about the policy. Some participants surmised that this was due in part to the media’s limited (if any) understanding of Global Gag Rule’s effects:

“If you look at our media as well, there hasn’t been much. I can count the number of times I’ve seen the Gag Rule mentioned in the media. So there has been not much understanding of what it means and the impact. And the media and how most of them are not trained on reporting on sexual reproductive health issues and even HIV. So, there’s a gap there to reach a lot more people through media” – Director, HIV/AIDS-focused international nongovernmental organization, South Africa

“The media’s inadequacy could be stemming from other Medias limited knowledge about the dynamics around the global gag rule. They cover issues on SRH but not from the Global Gag Rule point of view but of course we have seen international press make some progressive coverage on the effects of global gag rule, Aljazeera had quite prolific programmers and I think other agencies have done some work around on that we are, I’m yet to see national media houses focusing on what are the consequences of this policy as a country now.” – Executive Director, Adolescent sexual and reproductive health organization, Kenya

In an 18-month period between 2017-2018, only 6 Nepali media articles covered the Global Gag Rule, and mainly described the policy and the organizations in Nepal that will be affected. The media identified Family Planning Association of Nepal (FPAN) and Marie Stopes International (MSI) as the two main organizations that would be impacted by the Global Gag Rule. Most of the media mentions portrayed the US policy in a negative light and emphasized its negative impact on women’s health. One member of the media in Nepal noted that there may be a direct link between reduced funding for abortion advocacy and lack of media engagement:

“If advocacy on abortion from organization reduces, we will not be able to cover the news on abortion advocacy.” – Journalist, Nepal

Stakeholders in this project believed that there is a role for the media to play in advocating for sexual and reproductive health, including, on the harmful impacts of the Global Gag Rule.

“I think the media has not been doing enough. I know there are some opinions that I read around it sometimes back, but the media can do a lot more, they can support the advocacy, they can cover health-related news, and they need to bring it to the front burner and the subconsciousness of our national assembly as well as other policymakers.” – Director, Government agency, Nigeria
V. Policy Recommendations

US Government, Legislative Branch

Permanently end the Global Gag Rule through passage of the Global HER Act. Congress must pass legislation to take away end the president’s ability to reinstate this harmful policy. Although, at the time of printing, President Biden has utilized executive action to rescind the policy and it is no longer in place, a future US President opposed to abortion access could act unilaterally to reinstate the policy. As has been made clear by the evidence, the Global Gag Rule has negative impacts even when it is not in place, and even the threat of future implementation of the policy could impact programming by both nongovernmental organizations and governments.

- The Global HER Act, introduced by Senator Jeanne Shaheen (D-NH) and Representative Barbara Lee (D-CA), explicitly states that organizations will not be deemed ineligible for US funding because they provide legal health or medical services—including abortion. It has already gained bipartisan support. Passage of such legislation, either as a stand-alone bill or as part of an appropriations package, would ensure that eligible foreign nongovernmental organizations could continue to provide critical health services with US funds or continue to work on abortion-related work with their non-US funding.

Repeal the Helms Amendment and remove other policy barriers to abortion programming. The Helms Amendment – the statutory prohibition on the use of US foreign assistance funds to pay for abortion activities – remains a substantial barrier to sexual and reproductive health services globally. As long as this policy, and similar US policy restrictions on use of US funds for abortion, remain in place, US foreign policy erects unnecessary barriers to abortion accessibility around the world. Instead of doubling down on stigma and seeking to place abortion further out of reach of the most marginalized communities globally, US policy should proactively support access to comprehensive sexual and reproductive health care, including abortion.

- The Abortion is Healthcare Everywhere Act, introduced by Rep. Jan Schakowsky (D-IL) would not only remove the Helms Amendment from federal statute, it would replace it with a firm commitment to use US foreign assistance funds to fully support access to comprehensive sexual and reproductive health care globally, specifically including abortion services.

Use all available mechanisms to conduct oversight of US foreign assistance programs, global health spending, and the impacts of US policies and restrictions. Congress should continue to seek answers about the effects of Trump Administration policies, urging agencies to continue to collect data and analyze trends around the Global Gag Rule and related policies, even when the Global Gag Rule is not in place.

- Congress should continue to use hearings, investigations, and other oversight tools to seek, and publicly release, more information about the allocation of US foreign assistance dollars, including information about the redirection of funds while the Global Gag Rule was in place. Congress should call for increased transparency about funding, as well as greater analysis and understanding around the ongoing impacts of US policies.
US Government- Executive Branch

Clearly communicate out to missions, partners, and other stakeholders that the policy is no longer in place. Proactively share information about current US policy, making it clear to both current and prospective recipients of US funding that the policy will not be attached to future awards.

Halt implementation of the policy while new standard provisions are being drafted and added to contract language. Clearly convey this to partners, and develop and disseminate guidance to missions – make sure that mission staff responsible for overseeing US global health funds are able to answer questions on the status of the policy.

Make a clear statement that the US government will support comprehensive sexual and reproductive health services, including abortion, to the fullest extent of the law. Take action to ensure that the Helms amendment is correctly and narrowly interpreted, clarifying that current law allows for the use of US funds for abortions that are not conducted “as a method of family planning,” including in cases of rape, life endangerment, and incest.

Put forward budget proposals clear of restrictions on abortion.

Donor Governments and other Global Health Funders

Increase funding for comprehensive sexual and reproductive health services, including in particular safe abortion services, to help close funding gaps.

- Make funding available to organizations in countries impacted by the Global Gag Rule, especially local and community-based organizations, in order to ensure alternative funding reaches those most in need. Involve local and community-based organizations in the design of funding channels and processes.
- Avoid applying conditionalities on development funding for health, including counter-conditionalities intended to respond to the Global Gag Rule. Trusting local organizations to set their own strategies and respond to the needs of the communities they serve is imperative; counter-conditionalities can undermine the well-being of organizations, and ultimately the communities they serve, by forcing them to make the extremely difficult choice of whether to forgo one funding stream or another.
- Donors should document the impact of the Global Gag Rule on their partners’ and their own work, including when the policy is not in place, and make the documentation publicly available.

National Governments in countries that receive US foreign assistance

Increase national funding for health to fill gaps in services and information caused by the Global Gag Rule.

Document the effects of the policy on population health and health systems, paying particular attention to the effects on marginalized populations. Governments should make the results of this documentation publicly available.
VI. Conclusion

This report documents the continued impacts of the Global Gag Rule three years into the policy’s implementation. Despite differences in legal and social contexts, the policy had a number of common impacts across the four countries, including:

• The Global Gag Rule makes health services less accessible, harming the health of individuals and communities. This includes, but is not limited to, sexual and reproductive health care, including abortion, contraception, and HIV prevention and treatment. These effects are particularly felt by marginalized communities and other individuals already facing barriers to care.

• The policy creates funding gaps, for which organizations are often not able to compensate, leading to the closure of clinics and programs, retrenchment of staff, and causing the fragmentation of integrated health services.

• The policy divides and dismantles civil society spaces and coalitions, and silences voices diminishing government accountability. It makes it harder for organizations to collaborate, with tangible effects on both programming and the more intangible impact of stifling debate and preventing constructive engagement.

• The policy endangers government policy objectives and programs. The Global Gag Rule threatens public sector health programs that are supported by civil society and nongovernmental organizations, as well as the sovereignty and autonomy of governments.

• Lack of clarity about the policy, its provisions, expansion and exemptions remain common among key stakeholders.
Appendix 1: What is the Policy

HISTORY OF THE POLICY

On January 23, 2017, President Donald Trump issued a presidential memorandum reinstating the Mexico City Policy, also known as the Global Gag Rule. As imposed by President Trump, the policy requires all foreign nongovernmental organizations to certify that they will not “perform or actively promote abortion as a method of family planning” as a condition for receiving US government global health assistance. This policy applies to what organizations do with their own non-US government funding, and it applies irrespective of national laws dictating the local legality of abortion services.

While every Republican president since Ronald Reagan has implemented a version of this policy (and every Democratic president has rescinded it), Trump’s version represents a massive expansion over any previous iteration. While previous Republican administrations have applied the policy to funding specifically designated for family planning and reproductive health services (or about $600 million per year), Trump’s version applies to all global health spending (roughly $9 billion annually). For the first time, under this administration, the policy applies to funding for programs including maternal and child health, nutrition, HIV, tuberculosis, malaria, and other areas of health funding.

After the January 2017 announcement, USAID began to implement the policy on March 2, 2017, rolling out a standard provision attaching the policy to family planning and reproductive health funding. Subsequently, on May 15th of the same year, the State Department announced a plan, called “Protecting Life in Global Health Assistance” to apply the policy to all global health assistance.

The Trump administration initially committed to reviewing the roll-out of the policy at the six-month mark. That review was substantially delayed and finally released in February 2018.

WHAT ACTIVITIES ARE PROHIBITED?

The policy prohibits recipients of bilateral global health assistance from using non-US funds to “perform or actively promote abortion as a method of family planning.” Specifically, they cannot provide abortions in most instances; they cannot counsel patients on available abortion options, nor can they refer patients for abortion services. They cannot organize or lobby to liberalize abortion laws in their country and cannot conduct public information campaigns about abortion.

Under the policy, foreign nongovernmental organizations are not prohibited from performing, counseling, or referring for abortion in cases of rape, incest, of where the life of the mother is at risk. It does not prohibit the provision of postabortion care. The policy also does not prevent a provider from responding to a question about where safe and legal abortion services can be obtained if a pregnant woman clearly states her intention to have a legal abortion. The Trump policy also contains an exception stating it does not apply to providers who have an “affirmative duty” under local law to provide counselling and referrals for abortions.
MARCH 2019 ANNOUNCEMENT

In late March 2019, Secretary of State Mike Pompeo announced new enforcement criteria surrounding a legal phrase in the standard provision implementing the policy. The standard provision states that an organization receiving US funding cannot “provide financial support to any other foreign organization that conducts such activities,” referring to the abortion work prohibited by the policy. While compliant foreign nongovernmental organizations have always been prohibited from providing funding from other donors to conduct abortion-related work, the new interpretation goes even further. Now, they cannot provide any funding, from any donor, to another foreign nongovernmental organization for any purpose if that other organization works on abortion – even funding for activities outside of global health.

This new interpretation is an unprecedented step to isolate, stigmatize, and even effectively blacklist foreign organizations that continue to work on abortion.

HELMS AMENDMENT

The Helms Amendment was signed into law as part of the Foreign Assistance Act on December 17, 1973 after being authored by then Sen. Jesse Helms (R-NC). Since 1973, the Helms Amendment has prohibited the use of any US foreign assistance for ‘the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortion.’ In effect, it is implemented as a ban on funding for abortion.

SILJANDER AMENDMENT.

The Siljander Amendment was introduced in 1981 as an amendment to the FY1982 Foreign Assistance and Related Programs Appropriations Act by then Representative Mark Siljander. It prohibits the use of funds to lobby for or against abortion. When initially introduced, the amendment prohibited only lobbying for abortion, but in subsequent years Congress modified the language to include lobbying against abortion as well. It has rarely been invoked, and a 2011 Government Accountability Office Report found that neither State nor USAID has clear guidance for compliance with the policy, and neither specifies what specifically is prohibited by the amendment.

Concurrent with the March 2019 expansion of the Global Gag Rule policy, Secretary of State Mike Pompeo announced that the US would be using the terms of the Siljander Amendment to reduce US funding for the Organization of American States by $210,000. This decision came after nine anti-abortion US-Senators expressed concerns about statements on abortion by the Inter-American Commission on Human Rights (IACHR) and the Inter-American Commission of Women (CIM)—the OAS organs responsible for upholding human rights and women’s rights in the region. The senators accused IACHR and CIM of lobbying for the legalization of abortion, in what they called a “direct contravention of US law.”
Appendix 2. Methodology

IWHC’S APPROACH

IWHC is working with Trust for Indigenous Culture and Health (TICAH) in Kenya, Center for Research on Environment, Health and Population Activities (CREHPA) in Nepal, Education as a Vaccine (EVA) in Nigeria, and the Critical Studies in Sexualities and Reproduction (CSSR) research unit at Rhodes University in South Africa to document the effects of Trump’s Global Gag Rule. IWHC’s project relies on in-depth interviews with civil society organizations, health service providers, anti-abortion groups, academics, journalists, government agencies, and parliamentarians to document the policy’s effects on civil society, the political climate, and the health and well-being of women, girls, and other marginalized populations.

This report is from the third phase of a multi-year documentation project. The first report was published in May 2018 and focused on the policy’s impacts in Kenya, Nigeria, and South Africa. In the second phase, the project expanded its geographic scope to include Nepal. Focus countries were determined based on the volume of US global health assistance, the presence of active social and political conversations about abortion, IWHC’s relationship with local civil society organizations, and geographic diversity. In this third phase, the report focuses on the in-depth Global Gag Rule impacts in all four countries, expanding the stakeholders interviewed but also going in-depth on the impacts that had been emerging in phase one and phase two.

IWHC considers this documentation project to be one component of our trust-based relationships with our grantee partners. We take a feminist approach to our work, using inclusive and participatory methods throughout the project. IWHC has worked in partnership with our colleagues at TICAH, CREHPA, EVA, and CSSR to define our research questions, design our data collection tools, and analyze the data.

GUIDING QUESTIONS AND METHODS

The following objectives guide the documentation project:

• To understand how US Government policies on sexual and reproductive health and rights, particularly the Global Gag Rule, are perceived, understood, and interpreted by key stakeholders (civil society organizations, abortion service providers, opposition groups, government officials, and policymakers).

• To determine what effect US government policies on sexual and reproductive health and rights, particularly the Global Gag Rule, have on civil society organizations, including those working in sexual and reproductive health and rights, HIV/AIDS, global health, women’s rights, and opposition groups.

• To document the effect of US government policies, particularly the Global Gag Rule, on the political discourse about sexual and reproductive health and rights

• To understand how organizations that work to defend and expand access to sexual and reproductive health and rights are mitigating the effects of the Global Gag Rule

• To look at the impact of the Global Gag Rule over time

To achieve the above objectives, the documentation project used in-depth interviews with key informants.
and media tracking. IWHC developed the data collection tools (e.g. interview guides) and then partner organizations made adjustments for the country context.

**IN-DEPTH INTERVIEWS**

Partners identified potential interview participants who represented civil society organizations, abortion service providers, anti-abortion groups, academics, and government based on an initial analysis of the sexual and reproductive health and rights landscape in their countries. Interviews included questions to assess the interviewee’s knowledge and understanding of Trump’s Global Gag Rule, their experience with the Global Gag Rule in the past and present, and their perspectives on the current and potential effects of the Global Gag Rule.

All interviewees were informed about the purpose of the interview and its voluntary nature. Information about the Global Gag Rule and sources of additional materials were shared with all participants after the interviews.

In order to continue to fill gaps in knowledge about the impacts of the policy, IWHC and partners collectively decided to focus on including a broader range of interviewees in the second project phase. Therefore, a greater number of organizations that receive funding from the US government, organizations that have forgone US funding as a result of the Global Gag Rule, and government representatives were purposively selected for interviews in the second-project phase. For interviewees who were interviewed in the previous-project phase, interviewers followed up on specific effects of the policy that the interviewee felt were imminent in the earlier interview. The same phase two approach was taken in this phase three report- focusing on expanded stakeholder pool and deep-dive into emerging impacts and findings from the previous phases.

Overall, 104 in-depth interviews with civil society organizations, health service providers, anti-abortion groups, and government agencies were conducted across Kenya, Nepal, Nigeria, and South Africa. Table 1 Below describes the breakdown of interviews conducted in each country by the area of work for each interviewee. While there is some overlap among these categories, interviewees were grouped into the category with which they most strongly identified.

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</tbody>
</table>
TABLE 2. INTERVIEWEES FROM CIVIL SOCIETY ORGANIZATIONS BY INTERNATIONAL NONGOVERNMENTAL ORGANIZATION (NGO) OR LOCAL/INDIGENOUS

<table>
<thead>
<tr>
<th>Country</th>
<th>International NGO</th>
<th>Local/Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Nepal</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Nigeria</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>South Africa</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

Of the 80 interviews with civil society and faith-based organizations, 37 interviews were with affiliates of international NGOs and 43 were with local or indigenous organizations. Table 2 describes this breakdown by country.

MEDIA TRACKING

Media tracking and analysis focused on how information about the Global Gag Rule was represented to the public in print and online newspaper media. In Nepal, only print media was included in the analysis. To access the relevant articles, key search terms such as “Global Gag Rule,” “Protecting Life in Global Health Assistance,” and “Mexico City Policy” were used. A discourse analysis was conducted on relevant articles to see how journalists were talking about the policy and representing it to the general public in the respective countries.

ANALYSIS

Interviews were recorded and transcribed verbatim. Interviews that were conducted in other languages were then translated into English. Transcripts were then uploaded and analyzed in Dedoose, a cloud-based mixed-methods analysis software.

Data analysis was conducted in two phases. First, each partner organization conducted a thematic analysis of their own interview data. Before analyzing the data across the documentation countries, each grantee partner wrote a report that they shared with the researchers from IWHC and the other grantee partner organizations.

During an in-person, three-day, data co-interpretation meeting, IWHC and grantee partners came together to analyze the data across the documentation countries. The data co-interpretation session began with a presentation of each country’s context and major findings. Then, participants grouped the major findings from each country thematically to determine common themes across the three countries. Once the common themes were identified, all participants used their raw data to extract illustrative quotes and to provide examples of how a theme was present in their own country context. IWHC and grantee partners also developed a coding frame for the qualitative data that was used for subsequent analysis in Dedoose. Findings were verified iteratively in the group to identify similarities, differences, and gaps in the data across the three countries.
Appendix 3: Country Contexts

KENYA

In 2010, Kenya adopted a new constitution that affirms that “every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.” Article 26(4) states that abortion may be granted to a pregnant woman or girl when a trained health professional determines that emergency treatment is needed, her life or health is in danger, or it would be permitted by any other written law. The constitution further authorized abortion services to be provided by any trained health professional.

Nevertheless, the country’s penal code still criminalizes “unlawful” abortion, both for providers and people seeking abortion services, with punishments of imprisonment for up to fourteen years for those who are found guilty. Recent court rulings, however, have sided in favor of wider abortion access. For example, in 2019 Kenya’s High Court ruled in favor of the right to abortion for women who had been raped. This decision came after a mother filed a petition in 2015 on behalf of her daughter who had died due to a clandestine abortion after she had been raped. In 2013, the Ministry of Health withdrew the newly drafted 2012 Standards and Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion. The Center for Reproductive Rights filed a case against the Director of Medical Services and the Ministry of Health about this arbitrary withdrawal of the guidelines and the High Court of Kenya ruled in their favor, stating that these two parties had violated the rights of Kenyan women and children by creating uncertainty around the legal status of abortion. The High Court confirmed that abortion is legal in cases of sexual violence and women and girls have the right to the highest attainable standard of health.

Many providers are afraid to provide comprehensive abortion care due to stigma and fear of arrest or other criminal consequences, which further restricts access and drives women to unsafe alternatives. In 2016, policy reform led to medical abortion drugs misoprostol and mifepristone becoming classified as essential drugs for OB/GYN care.

Kenya has one of the highest maternal mortality rates in the world, with 510 deaths per 100,000 live births. Unsafe abortion (defined by the World Health Organization as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both) is a major driver of this high mortality rate—25 percent of all maternal deaths in Kenya are due to unsafe abortion. Each day, seven women die due to unsafe abortion in Kenya. In comparison, in the US, fewer than one woman per 100,000 dies from complications of a legal abortion, while the maternal mortality ratio is 18 deaths per 100,000 live births. In 2012 alone, nearly 120,000 Kenyan women and girls received care for complications resulting from unsafe abortions. Stigma, legal challenges, fear of repercussions, cost, and limited facility capacity result in women delaying care and prevent them from seeking timely, potentially life-saving postabortion care services.

In 2019, the US obligated $405.22 million in global health assistance to Kenya overall, with $37.18 million going to family planning and maternal and child health, and $307.32 million to HIV/AIDS programming.
NEPAL

Abortion was legalized in Nepal in 2002, with an amendment to the National Country Code (Muluki Ain) which guaranteed and improved reproductive rights. This law permits abortion without restrictions for the first 12 weeks of gestation. In 2009, the Supreme Court case Lakshmi Dhikta v. Nepal reiterated the 2002 amendment and protected abortion as a human right. More recently, in 2018, Nepal’s House of Representatives passed the Safe Motherhood and Reproductive Health Rights Act (RH Act), which reinforced reproductive rights as human rights, and defined these rights as including: maternal and newborn health, family planning, safe abortion, and adolescent health. The law also increased gestational age limits on abortion in cases of rape or incest until 28 weeks or in situations where the pregnant person suffers from HIV or other similar types of incurable diseases and at any time in cases where the pregnancy poses risks to the physical or mental health or life of the woman, or in case of fetal abnormality. Despite the progress made with these substantial policy reforms, abortion access remains difficult and highly stigmatized.

The legalization of abortion contributed to a sharp decline in Nepal’s maternal mortality rate, from 539 per 100,000 live births in 1996 to 239 in 2016. Nevertheless, unsafe abortion remains a concern. An estimated 323,000 abortions were performed in Nepal in 2014, 58 percent of which were considered illegal. The same year, an estimated 80,000 women were treated in health facilities for complications relating to abortion and miscarriage, 68 percent of which had complications resulting from a clandestine abortion.

In 2019, the US obligated $46.14 million in global health assistance to Nepal overall, with $29.86 million going to family planning and maternal and child health, and $3.45 million in funding towards HIV/AIDS programming.

NIGERIA

Nigeria has one of the more restrictive abortion policies globally. Abortion is regulated by both the penal code and criminal code, which provide that the procurer and supplier of surgical and medical abortions can face up to 14 years of imprisonment. The only exceptions are in a medical emergency or to save the life of the woman. The 1981 Termination of Pregnancy Bill and the 2015 Violence against Persons Prohibition (VAPP) Bill were two recent attempts to reform abortion law and increase access to services. The Termination of Pregnancy Bill, sponsored by the Nigerian Society for Gynecology and Obstetrics, would have legalized abortion when two registered doctors agreed that it could save the life of a pregnant woman, or that the child would be born with a severe disability. Similarly, the VAPP Bill would have ensured the right to comprehensive reproductive services, including medical abortion. These two reforms were challenged and ultimately struck down under pressure from conservative, anti-abortion organizations, and religious leaders.

The annual incidence of abortions in Nigeria was reported in 2017 to be 41.1 per 1,000 women aged 15-49 years old, which is approximately 1.8 million abortions. However, there is evidence to suggest that this estimate should be as high as 2.7 million abortions annually. The World Health Organization reports that Nigeria has a high maternal mortality rate of 814 per 100,000 live births. Unsafe abortions are responsible for an estimated 11 percent of these deaths.

In 2019, the US obligated $293.75 million in global health assistance to Nigeria overall, with $85.39 million going to family planning and maternal and child health, and $129.05 million to HIV/AIDS programming.
SOUTH AFRICA

The 1996 Choice on Termination of Pregnancy (CTOP) Act legalized abortion in South Africa upon request for up to 12 weeks of gestation. Between 12 and 20 weeks, the law allows for abortion in case of risk to the woman’s physical or mental health, severe fetal abnormality, rape, incest, or for social or economic reasons. After 20 weeks, the law allows abortion if the pregnancy endangers the woman’s life, would result in a severe malformation of the fetus, or would pose a risk of injury to the fetus. While the CTOP Act is one of the most liberal abortion laws globally, stigma, regional and economic disparities, and refusals to provide services on the grounds of religious or moral objections reduce access and lead to unsafe abortions.

In South Africa, the affirmative duty exemption in the global Gag rule has attracted particular interest, due to the national abortion laws. This is a provision in the Global Gag Rule that exempts health providers from complying with the policy if national law specifically requires them to provide counseling and referral for abortion.

South Africa’s maternal mortality rate is 138 per 100,000 live births, with unsafe abortion considered a significant contributing factor. Between 2016 and 2017 approximately 74.2 percent of abortions were considered safe (performed in the private and public sectors by trained professionals), while 25.8 percent were considered unsafe. Significant barriers to accessing legal abortion services remain, including under-resourced health systems (especially outside of urban centers), lack of awareness, stigma, and the refusal of care by providers using a claim of “conscience.” A 2010 study found that fewer than 50 percent of designated public health facilities actually provided abortion services. Private services tend to be extremely expensive and are therefore not an option for poor women. Even accurate information about public providers and services is largely unavailable. As a result, women often turn to untrained providers, whose services are widely advertised and easily accessible.

In 2019, the US obligated $277.87 million in global health assistance to South Africa overall, with no funding going to family planning and maternal and child health, and $268.54 million to HIV/AIDS programming.
Appendix 4: Partner Profiles

Trust for Indigenous Health and Culture (TICAH)—Kenya

Trust for Indigenous Culture and Health (TICAH) is a feminist organization whose main aim is to promote health, equitable relationships, healthy households, and community action. We seek to enhance the positive links between health and cultural knowledge, practices, beliefs, and artistic expression. Over the years, we have evolved from an organization focused on alternative therapies and empowerment for women living with HIV to one that focuses on sexual and reproductive health and rights more comprehensively. We know how widespread patriarchal beliefs, sexual violence, and unsafe abortions are in Kenya and understand firsthand the needs of young people, especially adolescent girls.

We believe that culture shapes health, that beauty is powerful, that expression is activism, and that stories have something to teach. Our work includes training and research in women’s rights to comprehensive sexual and reproductive health, publication and documentation to stimulate attention to grassroots solutions, advocacy on sexual and reproductive health and creative projects to raise our communal voices to affect national policy and programs.

TICAH is a pioneer in brave, progressive work in the field of sexual and reproductive health in Kenya. Our work has seen us produce informative yet provocative sexuality facilitation guides and theatre pieces for all ages. We facilitate peer discussions reaching communities that include in-school and out-of-school girls and boys, HIV-positive women and men, female sex workers, LGBTQI people, and women with disabilities. We run a hotline that provides information on sexuality and reproductive health, including information on safe abortion and referrals to health care providers. TICAH is a member of the Africa Network on Medical Abortion (ANMA), the Reproductive Health and Rights Alliance (RHRA), FEMNET and the WGNRR Alliance Kenya.

Learn more about TICAH at www.ticahealth.org or find them on Twitter @TICAH_KE

Center for Research on Environmental Health and Population Activities (CREHPA) – Nepal

Center for Research on Environment Health and Population Activities (CREHPA) is a not-for-profit nongovernmental organization based in Lalitpur, (Kathmandu valley), Nepal. CREHPA’s mission is to “contribute towards improving environment, health including reproductive health and welfare of Nepalese citizens by responding to key policy and programmatic issues through education, training, research, alliances, partnerships, and policy advocacy initiatives”.

The organization has substantial research and programmatic experience in the topic of abortion. In 1996, CREHPA conducted the first national public opinion poll on abortion in Nepal and used the poll results to lobby for abortion law reform. CREHPA carried out subsequent groundbreaking hospital-based studies on abortion, as well as a study on women imprisoned for abortion. Women’s right activists used the results of CREHPA’s research extensively in the fight to decriminalize abortion in Nepal. Additionally, CREHPA was one of the first organizations globally that refused to sign the Mexico City Policy (Global Gag Rule) when it was reinstated by the George W. Bush Administration in 2000.

CREHPA is a member of the National Safe Abortion Advisory Committee, the Technical Committee for Implementation of Comprehensive Abortion Care (TCIC) formed by the Health Ministry, and a Core Committee Member for drafting the Safe Abortion Bill 2012 formed by the National Women’s
Commission. As a lead research organization in abortion matters and as a core member of TCIC, CREHPA's research findings are highly regarded by national policy makers and program planners. As a result, it exerts policy influence and musters government support on abortion related policy matters.

Learn more about CREHPA at crehpa.org.np or find them on Twitter at @CREHPA_Nepal

**Education as a Vaccine (EVA)—Nigeria**

Education as a Vaccine (EVA) is a non-profit organization founded in 2000, registered in Nigeria with the Corporate Affairs Commission in 2001 and in the United States as a 501c3 organization to improve the health and development of children as well as adolescent and young people. EVA envisions a Nigeria where children and young people reach their full potentials and work to build and implement innovative and sustainable mechanisms for improved quality of life for vulnerable children and young people. In line with our vision, EVA works in partnership with children as well as adolescent and young people to advance their rights to health and protection from all forms of violence by strengthening capacities providing direct services and influencing policies for improved quality of life.

Using child- and youth-friendly approaches, the organization strengthens the capacities of children, young people, and other stakeholders to facilitate and sustain social change in the area of health, protection, and education through integrated programming.

EVA is an active member of several networks, such as the Civil Society Health Reform Coalition, Association of Positive Youth Living with HIV and AIDS in Nigeria, Association of Women Living with HIV in Nigeria and the National Youth Network on HIV and AIDS.

Learn more about EVA at www.evanigeria.org or find them on Twitter @EVA_Nigeria

**Critical Studies in Sexualities and Reproduction (CSSR) Research Unit, Rhodes University – South Africa**

The Critical Studies in Sexualities and Reproduction (CSSR) research program is a multi-disciplinary program funded by the National Research Foundation South African Research Chair Initiative (SARChI), Rhodes University, Eastern Cape Liquor Board, and the International Women’s Health Coalition. It draws on the expertise of a number of researchers, both within Rhodes University and at universities and nongovernmental organizations in South Africa and across the world.

The overarching goal of the CSSR research program is to conduct critical research that addresses the social and human dynamics underpinning our slow progress towards full sexual and reproductive citizenship for all. CSSR’s research activities fall under the following broad interconnected areas: sexualities; (2) reproduction; and (3) unsupportable pregnancies/abortion. Within each of these broad areas, a number of related themes of inquiry are conducted.

A strategic aim of the CSSR research program is to conduct comparative research where feasible and appropriate (the United Kingdom, Poland, India, Zimbabwe, the Philippines, Kenya, and Nigeria). This research highlights commonalities and differences in the human and social dynamics underpinning reproduction across these sites and allows for greater depth of analysis of the South African data.

Learn more about CSSR at www.ru.ac.za/criticalstudies or find them on Twitter @CSSR15
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