



APPROPRIATE USE OF GLOVES

- PUT ON THE RIGHT SIZE
- ONE PAIR PER PATIENT / PROCEDURE
- REMOVE BEFORE OPENING DOOR, RECEIVING CALLS, DOCUMENTATION OF RESULTS AND MICROSCOPY
- REMOVE GLOVES BEFORE LEAVING LABORATORY
- WASH HANDS AFTER REMOVING GLOVES

REALITY CHECK:

YEAR ONE IMPACT OF TRUMP'S
GLOBAL GAG RULE

The International Women's Health Coalition advances the sexual and reproductive health and rights of women and young people, particularly adolescent girls, in Africa, Asia, Latin America, and the Middle East. IWHC furthers this agenda by supporting and strengthening leaders and organizations working at the community, national, regional, and global levels, and by advocating for international and US policies, programs, and funding.

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EXECUTIVE SUMMARY

On January 23, 2017, President Trump issued a Presidential Memorandum reinstating and expanding the Mexico City Policy, also known as the “Global Gag Rule.” President Trump’s implementation plan for the expanded policy, called “Protecting Life in Global Health Assistance,” was announced in May 2017. The policy states that any foreign nongovernmental organization that takes US global health funds must certify that they do not engage in certain abortion-related activities, including providing abortion services, information, counseling and referrals, and advocating to expand access to safe abortion services. The Global Gag Rule applies to what organizations do with their own non-US government funds and forces health care providers to choose between providing a comprehensive spectrum of reproductive health care and receiving critical US funding. Trump’s Global Gag Rule expands a bad policy enacted by previous Republican presidents since Ronald Reagan, but now implicating almost \$9 billion in US foreign assistance and affecting many organizations that had not previously had to comply with it.

The International Women’s Health Coalition (IWHC) is documenting the effects of the Protecting Life in Global Health Assistance (“the Policy” or “the Global Gag Rule”) restrictions on civil society, the political climate, and women and girls, alongside grantee partners in Kenya, Nigeria, and South Africa. To date, IWHC and partners have conducted 59 interviews with civil society organizations, health service providers, anti-abortion groups, and government agencies across the three project countries. Although the Policy is still rolling out, some clear effects have emerged across the three very different country contexts in our first-year assessment:

- **Confusion and lack of information about the Policy exists at all levels and among all stakeholders.** Interviews with directors of civil society organizations, as well as with program managers and health providers, demonstrated mixed levels of knowledge about the Policy. Nearly all interviewees expressed some lack of clarity or confusion about the Policy, suggesting potentially damaging effects on organizational decision making, as well as on the ability of individuals to serve their clients and save lives.

These findings were not isolated to local nongovernmental organizations: interviewees discussed a lack of clear guidance from in-country US officials and from prime recipients of US global health funding.¹ Confusion, coupled with fear of crossing the unclear boundaries, leads organizations to overinterpret the Policy and to restrict themselves from carrying out even those activities permitted by the Policy.

- **The Policy is harming the most vulnerable populations in society.** Interviews with service providers revealed that the Policy is already putting services further out of reach for marginalized women, women living in rural areas, and poorer women—populations that already have the least access to health services and information.

In South Africa, where one in five women of reproductive age is living with HIV, many interviewees raised concerns that women living with HIV and poorer women would be disproportionately harmed by the Global Gag Rule. Across the three countries, interviewees from service delivery organizations, civil society organizations, and universities agreed that the Global Gag Rule would also disproportionately threaten the health of young people who are most in need of health information and services, but face the greatest barriers accessing them.

- **The Policy threatens progress towards integrated health systems, often made with US investments.** Both national governments and the US government have heavily prioritized integration of health care services in recent years because it makes health systems more efficient and health services more accessible to patients that need care, especially in rural or hard-to-reach areas where health care options are limited. Now, the Global Gag Rule is forcing organizations to make a choice between continuing to provide life-saving services or to forego significant funding, an untenable choice that threatens to topple the advances in integrated healthcare previously supported by US global health funding.
- **The Policy has sparked anger at the US and national governments.** Over half of the countries that receive US global health assistance allow abortion in at least one instance not permitted under the Global Gag Rule, putting the Policy at direct odds with local laws. Across the project countries, interviewees active in the health sphere found the Policy to be a form of neo-imperialism and described the Policy as “racist,” “unfair,” and “a bullying tactic.”

The Global Gag Rule is more restrictive than abortion laws in many of the countries that receive US global health funding: a good number of these countries allow abortion to preserve the health of the woman, for example, while the Global Gag Rule does not. Many interviewees were outraged that the Policy uses health assistance as a tool to undermine their countries’ laws. Frustrations with the Global Gag Rule often coincided with calls for national governments to take ownership and accountability for the health of their own people.

- **The Policy, even when not in force, has long-lasting effects on civil society.** Civil society organizations reported that critical partnerships and consortia are being lost as organizations that receive US funding stop collaborating with those who continue to work on abortion—creating gaps and inefficiencies that will be hard to remedy. Some organizations expressed growing distrust, deepening fissures, and increased competition for funding within civil society. The Policy causes funding fluctuations that destabilize civil society organizations.

Interviewees from civil society, particularly in South Africa, felt that they were just beginning to recover from the earlier iteration of the Policy under the Bush Administration. The gag imposed by the Policy prevents civil society organizations that sign the Policy from expressing themselves freely and weakens their capacity to hold their own governments accountable.

Based on the findings, IWHC makes the following recommendations to US policymakers:

Permanently repeal the Global Gag Rule through legislation.

Develop and share clear guidelines for implementation with all recipients of US global health funding, including sub-award recipients and local organizations.

As long as the Global Gag Rule is in effect, any US government review process must be a consultative, transparent, comprehensive, and action-oriented analysis of the Policy and its impacts. Any review must pay particular attention to the effects of the Policy on marginalized populations.

Document and record instances of misapplication, over-application, and chilling effects of the Policy.

Other recommendations:

Prime recipients of US global health funding must ensure that their staff, partners, and sub-award recipients understand the Global Gag Rule, especially those areas of work that are not covered by the Policy.

All international nongovernmental organizations, including prime recipients of US global health funding, donor governments and governments receiving US global health assistance should document the impact of the Global Gag Rule on their work, including misapplication, over-application, and the chilling effects, paying particular attention to marginalized populations. All stakeholders should publish their documentation and submit comments to any State Department reviews.

All stakeholders should continue to resist this harmful policy and work towards ending it. US-based nongovernmental organizations should continue to build support among members of the US Congress to repeal the Policy, and both donor governments and governments in countries that receive US global health assistance should actively advocate with the US government to end the Policy.

For a full list of recommendations, see page 19.

I. BACKGROUND

On January 23, 2017, US President Trump reinstated and expanded the Mexico City Policy. Also known as the “Global Gag Rule,”² the policy requires foreign nongovernmental organizations to certify that they will not “perform or actively promote abortion as a method of family planning,” as a condition of US government or global health assistance.³ The Global Gag Rule prevents organizations from providing abortion services, information, counseling, referrals, and advocating to expand access to safe abortion services. The policy even applies to activities that organizations carry out with their own funds not provided by the US government.

While every Republican president since Ronald Reagan has enacted some version of this policy, Trump’s Global Gag Rule represents a huge expansion. Previous versions applied to family planning funding, representing about \$500 million a year in US foreign assistance. Expanding the policy to all recipients of US global health funding means that approximately \$9 billion is implicated, including funding for HIV/AIDS, malaria, tuberculosis, nutrition, maternal health, and a range of other health programs designed to benefit millions of people. Estimates have determined that Trump’s Global Gag Rule will affect more than 1,000 organizations around the world, many of which have never had to comply with the Policy before.⁴

Previous iterations of the Global Gag Rule have proven harmful by making it more difficult for people to access critical reproductive health care information and services. Research has found that the Bush administration’s Global Gag Rule did not have its intended effect of reducing the incidence of abortion. Instead, it restricted access to sexual and reproductive health care—in particular contraceptive services—leading to increases in unplanned pregnancy and maternal mortality.⁵ In addition, the Global Gag Rule has caused a chilling effect on civil society, as organizations constrained themselves and stopped providing even permitted services out of fear and misunderstanding.⁶

In May 2017, the Trump administration approved the full implementation plan for the Policy, called “Protecting Life in Global Health Assistance” (“the Policy” or “the Global Gag Rule”). The standard provision outlining the contractual obligations for recipients of US global health funding is inserted into agreements when a foreign nongovernmental organization faces a new funding action, such as a contract revision, new contract, or new funding disbursement. As a result, there is no single date by which all implementing partners are required to sign, and some partners are encountering the Policy long before others.⁷ The standard provision describes key areas of work that are not covered under the Policy:

It explicitly does not apply to abortion services or counseling and referral for abortion in cases of rape, incest, or life endangerment.

It does not prohibit postabortion care, including “treatment of injuries or illness caused by legal or illegal abortions.”

It does not apply to humanitarian assistance.

It does not apply to US nongovernmental organizations (though US organizations must enforce the Policy on their local subgrantees).

It does not apply to funds given to foreign governments or multilateral institutions.

It includes a new “affirmative duty” provision: in cases where there is an “affirmative duty of a healthcare provider required under local law to provide counseling about and referrals for abortion,” the provider will not violate the Policy by complying with local law.

II. PROJECT DESCRIPTION

IWHC works to connect local voices to international policy debates, and this ethos of partnership is a guiding force behind this documentation project. IWHC is working with Trust for Indigenous Culture and Health (TICAH) in Kenya, Education as a Vaccine (EVA) in Nigeria, and the Critical Studies in Sexuality 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 key informant interviews to document the Policy’s effects on civil society and the political climate, and its perceived effects on women and girls. To date, IWHC and grantee partners have conducted 59 in-depth interviews with civil society organizations, health service providers, anti-abortion groups, and government agencies across the three project countries. In-depth interviews are a key way to obtain nuanced information on the initial and long-term effects of the Global Gag Rule and are well suited for understanding how complex factors, such as the social and political context of a country, interact with the Policy. Using qualitative methods also allows for documentation of the Global Gag Rule now, before effects on population-level health are observable, so that the global community of donors, health providers and advocates understand and can make informed decisions about the Policy.

Although affected agencies began rolling out implementation in May 2017, it is still too early to assess the full impact of the Policy. The first year of this documentation project is an opportunity to gauge the initial effects and to establish a baseline for future research. IWHC and partners plan to continue documenting the effects of the Policy in Kenya, Nigeria, South Africa, and additional countries annually, as long as it is in force.

III. 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.”⁸ 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.⁹ These contradictions have created confusion about the legal status of abortion in Kenya, and efforts to clarify the situation have been stymied. For example, in 2013 the Ministry of Health withdrew the newly drafted 2012 Standards and

Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion, which remain in limbo today.¹⁰ Many providers in public health facilities are afraid to provide comprehensive abortion care, due to stigma and fear of arrest or other criminal consequences, further restricting access and driving women to unsafe alternatives.

This environment contributes to higher maternal mortality in Kenya, where 25 percent of all maternal deaths are due to unsafe abortion.¹¹ In 2012 alone, nearly 120 thousand women and girls received care for complications resulting from unsafe abortions; almost half of these were young women under 25 years old.¹² Each day seven women die needlessly due to unsafe abortion in Kenya.¹³

Kenya allocates approximately 7 percent of its total budget to health, the equivalent of about \$1.36 billion. In 2016, Kenya received \$327 million—approximately 26 percent of its total health budget—in US global health assistance. Civil society and faith-based health care facilities provide about 60 percent of all health care services.

NIGERIA

Abortion is severely restricted in Nigeria according to both the penal code, which generally applies in the country's northern states, and the criminal code, which generally applies in the southern states.¹⁴ The criminal and penal codes allow an exception only to save a woman's life, with the permission of a physician and a gynecologist. Despite the restrictions, pregnancy terminations are quite common. In 2012 alone, 1.25 million Nigerian women had an abortion; of those, an estimated 456,000 were unsafe.¹⁵

Some women can access safe abortion through a small number of private clinics, but the majority cannot afford this option. As a result, many abortions are performed clandestinely, often by unskilled providers.¹⁶ Unsafe abortion is a major contributor to Nigeria's high levels of maternal morbidity and mortality—some of the highest ratios in the world, with little improvement in recent years.¹⁷ One Nigerian woman dies every 13 minutes from preventable causes related to pregnancy and childbirth, accounting for 14 percent of the global total of maternal deaths.¹⁸ Abortion providers are rarely prosecuted, unless there are severe complications or death, but police sometimes extort providers for money.

In May 2015, the Violence against Persons Prohibition (VAPP) Act was adopted and signed into law at the national level. The VAPP Act states that “comprehensive medical care” should be provided to survivors of rape and incest. Subsequently published “Standards and Guidelines for the Medical Management of Victims of Violence in Nigeria” included therapeutic abortion as a comprehensive medical service, essentially creating a rape and incest exception within the current restrictive abortion law.

However, as a federal law, the VAPP Act applies only in the Federal Capital Territory (FCT) of Abuja and federal health institutions across the country. To be applicable at the state level, state legislatures must pass their own versions. Pushback by Catholic Bishops against the passage of the VAPP Act at the state level has been swift. While the VAPP Act passed in Ogun, Oyo and Anambra states, among others, and advocates are working to get it passed in Kano state, it was shot down in Edo and Imo states, because those versions explicitly mentioned the rape and incest exception.

Nigeria allocates about 4 percent of its total budget to health, approximately \$943 million annually. In 2016, Nigeria received \$495 million in US global health assistance, or

approximately 53 percent of the country's total health budget. For-profit and faith-based health care facilities in Nigeria provide about 80 percent of all health care services. Nongovernmental organizations disseminate health information to engage communities and generate demand for health services.¹⁹

SOUTH AFRICA

South Africa has one of the most progressive abortion laws in the world, with abortion permitted on demand in the first 12 weeks of pregnancy. Between 12 and 20 weeks, the law allows 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.²⁰

Maternal mortality and morbidity dropped significantly (91 percent)²¹ after the passage of the Choice on Termination of Pregnancy (CTOP) Act in 1996. However, abortion is still a contested issue—with morality and stigma on one side, and extreme need on the other, due to lack of sexuality education, lack of contraception, and high rates of sexual and gender-based violence, all resulting in unwanted and unplanned pregnancies. The CTOP Act stipulates that abortions may take place only in designated and approved health facilities that meet certain criteria.

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.²² 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. Maternal mortality in South Africa remains high at 141 deaths per 100 thousand live births, with unsafe abortion a significant contributing factor. It is estimated that approximately 50 percent of the abortions in the country are performed illegally.²³

In spite of this situation, the current Health Minister, Dr. Aaron Motsoaledi, has taken little action to expand access to safe and legal abortion or protect the rights of women to reproductive decision making once pregnant. The government does not provide any official training or continuing professional development on abortion for health care providers. More than 20 years after the CTOP Act was adopted, the Department of Health is only now in the process of developing comprehensive implementation protocols or guidelines on abortion care. Draft guidelines focus on providing patient-centered care, ensuring access to safe and legal abortion care through the health system and including referrals within the system, if necessary.

South Africa allocates about 14 percent of its total budget to health, approximately \$14.5 billion annually. In 2016, South Africa received \$256 million in US global health assistance, or approximately 2 percent of the country's total health budget. The proportion of health services provided by nongovernmental organizations in South Africa is not known; however, nongovernmental providers play an important role in the health system, particularly in more rural areas of the country.

IV. FINDINGS

A. MISINFORMATION, CONFUSION, OVERINTERPRETATION, AND FEAR

You can't talk about abortion. You can't counsel on abortion. You can't provide abortion. You can't refer for abortion.

— Public health researcher, South Africa

While levels of knowledge about the Policy were mixed, most interviewees across all three countries described the Global Gag Rule as prohibiting organizations from doing any work related to abortion as a condition of receiving US government funding. Understanding beyond this overall explanation was generally limited. Only one out of 59 the interviewees specifically and correctly mentioned areas of work that are not included in the Policy (e.g. postabortion care).

Of the interviewees with deeper knowledge about the Policy, most had long-term experience in the sexual and reproductive health (SRH) field and knew about the Global Gag Rule because of this prior experience. Even so, there was very little understanding about how the Trump administration's iteration of the Policy differed specifically from earlier versions. Additionally, there were several instances where organizations affected by the Policy thought it was never rescinded, but instead believed that different US administrations placed more or less emphasis on its implementation. Interviewees also expressed confusion about how the Policy differs from other restrictions on US funding, such as the Helms Amendment²⁴ and the Anti-Prostitution Loyalty Oath.²⁵

Confusion and lack of information about the Policy occurred at all levels within organizations, from decision makers at the director level to frontline staff, providers, and desk officers. Nearly all interviewees (including those receiving US global health funding), stated that “[its] boundaries are not clear.” Some interviewees from organizations receiving US global health assistance responded, “I have heard, but I don't understand the details” and “I have heard about it, but I don't know what it means.” Interviewees across the three countries asked questions about which activities were affected by the Policy and demonstrated a lack of awareness about areas explicitly excluded from the Policy, including whether the Policy also applied in cases of rape, incest, or when the health or life of the woman is at risk. Lack of clarity about the Policy at different levels could affect organizational decision making and strategy, and impair the way individual health workers do their work.

In South Africa, many interviewees questioned how the Policy would apply, since it conflicts with local laws. In Nigeria, an organization affected by the Global Gag Rule asked the interviewer whether they would be in conflict with the Global Gag Rule if a staff member took a young girl complaining of stomach pain to the hospital in case she ended up needing postabortion care. If people working directly with clients do not know that offering help and referrals for postabortion care or emergency services complies with the Global Gag Rule, then the lives of women and girls are at risk.

In addition to confusion about which activities are affected by the Global Gag Rule, interviewees also asked questions about the timeline for roll out and who was responsible for providing them with information. In particular, knowledge about the Global Gag Rule had yet to reach some organizations newly affected by the expansion of the Policy.

Confusion and lack of understanding create a chilling effect around abortion. In many cases, this leads organizations to over-implement the Policy, stopping even those activities permitted by the Policy out of fear of losing US government funding.

In Kenya, one interviewee shared, “Some of our partners have been told to hang signs that say: we don’t provide abortion services...there is uncertainty regarding the full implications [of the Global Gag Rule].” Some of these health care providers falsely believed that these signs were a requirement imposed by the Global Gag Rule. They expressed concerns that these signs would lead to increased stigma around safe and legal abortion services or make women think the providers who hung the signs would also not provide emergency or postabortion care services, ultimately putting women’s lives at risk.

In Nigeria, a community-based organization that was far along in the proposal development process with a US-based NGO prime partner shared their frustrations. Having heard about the Global Gag Rule through peer organizations, they reached out to the prime partner repeatedly to ask for clarification on how the Global Gag Rule would affect their work if they were approved for funding, but received no substantive response. This lack of clarity forced the organization to stop moving forward with the proposal process for a grant that would have provided funding to dramatically scale up their adolescent girls programming. After learning more about the boundaries of the Global Gag Rule through this project, the interviewee remarked that if the prime partner had answered their questions, the organization would have likely moved forward with the application for funding. Because of the confusion around the Policy and the lack of information shared by the prime partner, this organization was not able to make an informed decision about whether to pursue USG funding.

Misunderstanding and confusion about the Global Gag Rule do not only affect local NGOs or community based organizations. Interviewees discussed a lack of clear instruction or guidelines from US officials in-country, and many said that US contracting officers were not able to answer their questions about the Policy and its implementation. In the words of one President’s Emergency Plan for AIDS Relief (PEPFAR) funding recipient:²⁶

Up to now, it has seemed like the South African PEPFAR people don’t really know, to be honest. They feel uncomfortable about it themselves, and they don’t really know. So they’ve spoken about it but haven’t got into any detail.

— Executive director, HIV/AIDS and sexual and reproductive health and rights (SRHR) organization, South Africa

Other respondents from South Africa also felt that USAID staff in country might be confused themselves since it was difficult to get further guidance from them. In Nigeria, the US mission has shared limited information with local organizations. Nigerian civil society organizations attributed this to the legally restrictive context of abortion in their country. In Kenya, Nigeria, and South Africa, the chilling effect also made organizations fearful to bring up questions about the Global Gag Rule with their prime organizations or with the local US missions, increasing the likelihood of confusion and misinformation.

The confusion and lack of information caused by the Global Gag Rule also applies to national governments. While the Global Gag Rule does not apply to government agencies, their nongovernmental partners who develop and implement projects that will necessarily intersect with issues of abortion (e.g. life skills education in schools, implementation of health outreach

programs, and developing clinical guidelines) may be affected if they receive US funding separately. In general, interviewees remarked that they had not received any response from their government agencies about the Global Gag Rule. Interviewees from the Department of Basic Education and the Department of Social Development in South Africa did not know much about the Global Gag Rule or how it might affect the civil society organizations they work with to implement programs. The representative from the Ministry of Health in Kenya did not directly address the Global Gag Rule but commented that they themselves were not affected by the Policy. Government representatives in Nigeria were not available for an interview.

B. DIFFERENTIAL HEALTH IMPACTS HARMING THE MOST VULNERABLE

The Global Gag Rule is already jeopardizing women's and girls' health, exacerbating existing barriers to health care, and threatening to set back progress made towards integrated health systems. These impacts will disproportionately affect the most vulnerable populations in society while also undermining previous US investments in health systems.

Despite the different legal and social contexts of abortion in Kenya, Nigeria, and South Africa, interviews have documented deep concerns, grounded in both research and experience, about increases in unsafe abortion in each country. Many interviewees were familiar with the research studies that have found that previous iterations of the Global Gag Rule have caused increases in unintended pregnancies, abortions, and maternal deaths in sub-Saharan African countries.²⁷ An interviewee from a Nigerian civil society organization explains:

*Research [has found] an increase in induced abortion in some countries where the US government restricted their funding...People are very concerned that [the reinstatement and expansion of the Global Gag Rule will] lead to more problems for women and their families by affecting their right to get information and to access referral services. And that it will affect the rights of women's organizations to be able to impart information and to be able to influence policies...If organizations that rely on US funding who have been supporting family planning information are restrained from [supporting women's groups] to provide information in the grassroots community, **there is a likelihood that more women will die. There is a likelihood that there will be more unsafe abortion. There is a likelihood that induced abortion will be higher, which is a bane for women and their families in Nigeria.***

— Executive director, women's rights organization, Nigeria

Other interviewees in Nigeria shared these concerns. They also predicted that the Policy would push clandestine abortion services further underground and force women to go to less safe providers. Several of the US-funded global health organizations interviewed were not certain whether assisting someone presenting with complications from unsafe abortion was in conflict with the Policy (it is not), raising concerns about effects on the accessibility of emergency and postabortion care. A reproductive health care provider in Nigeria who had witnessed the impact of the last Global Gag Rule told us:

It's an unfair provision and it does directly the opposite of what it's intended to do. It denies life-saving services to a lot of women. It ends up being really anti-life.

— Executive director, sexual and reproductive health (SRH) organization, Nigeria

In South Africa, where abortion access remains a persistent problem despite its legal status, increased rates of unsafe abortion were the primary concern among interviewees. Many women are unaware of their rights under the CTOP Act and abortion remains highly stigmatized. Despite this, advertisements for illegal services are widespread. These services are often unsafe; in 2014 there were 47 recorded deaths from unsafe abortion.²⁸ By restricting organizations' ability to provide information, counseling, and referrals relating to safe and legal abortion services, the Policy has the potential to increase levels of unsafe abortion in South Africa.

*Even in terms of publications that we're printing for women—posters in the clinics, little pamphlets that you can hand out on outreach or to women who visit the clinic—you can't say anything about a comprehensive response to somebody who might be pregnant or is wondering what her next steps are or is requiring family planning services. You can't include anything about [termination of pregnancy] as an option, which allows these illegal providers to flourish. Because you can't respond, you can't say 'This is the safe way. These are the safe providers. Don't believe this kind of information.' **I think it puts women's lives in danger. You don't have access to information, but countering information [about illegal providers] is prolific. How are you supposed to respond?***

— Sexual and reproductive health and rights (SRHR) activist, South Africa

In Kenya, county-level health facilities are already starting to see a resurgence of women needing treatment for complications from unsafe abortion, explained IWHC grantee partner Monica Oguttu, Executive Director of Kisumu Medical and Educational Trust (KMET). KMET provides comprehensive health services, including HIV, malaria, TB, maternal health, and reproductive healthcare services at the community level in remote and hard to reach areas in western Kenya. KMET supports 122 community clinics throughout the 15 western Kenyan counties that contribute to 98 percent of the country's maternal mortality.

Over the past five years, by training community healthcare providers to “prevent unwanted pregnancies with contraception, prevent unsafe abortion by providing safe abortion within the law, and prevent maternal mortality by treating complications of unsafe abortion,” KMET had seen serious complications from unsafe abortion all but disappear in the counties where it operates. Now, even as KMET itself faces the imminent decision of whether or not to sign the Global Gag Rule, Oguttu is seeing community-based providers preemptively reducing their provision of safe abortion services for fear of losing the USAID funding that supports their clinics. Particularly in rural and hard-to-reach communities, where the next nearest clinic may be more than 40 miles away, loss of essential reproductive health services puts women's lives at risk.

1. Harming the Most Vulnerable

People from marginalized or remote communities and those who cannot afford to pay out of pocket for services are the first affected when organizations are forced to cut outreach and subsidized services in response to the Global Gag Rule. Interviews with service providers in Kenya and Nigeria documented how these changes are already affecting women living in marginalized communities and poorer women.

For example, a health care organization in Kenya that has decided not to sign the Global Gag Rule reported that they had to stop their community outreach services in anticipation of losing funding. Without community-based services, people are unlikely to access healthcare services

unless it is an acute emergency, and are less likely to access preventative healthcare, such as contraception. A representative from the organization told us:

It has impacted how we service the community, so currently we do not do any outreach; our clients now have to come to see us physically at their own cost. This limits our reach as our clients cannot afford to come and see us.

— Program manager, sexual and reproductive health (SRH) organization, Kenya

In Nigeria, an organization that works to educate communities about contraceptive methods to generate demand and increase contraceptive uptake, is facing a dilemma because service providers are increasing fees as funding is lost.

Before now, it was entirely free. Not now. The women have to pay for commodities. It was entirely free, but now they pay N1000 for commodities.

— Frontline staff member, HIV/AIDS and global health organization, Nigeria

Charging N1000 (approximately \$2.78 USD) for contraceptive commodities can create a barrier to access when more than half of Nigerians live below the income poverty line (or under \$1.90 a day).²⁹

In South Africa, where one in five (21.2 percent)³⁰ women of reproductive age is living with HIV and more than \$300 million in US global health funding supports HIV/AIDS programming, many interviewees expressed concerns about how the expanded Global Gag Rule would affect this population.

*It's absolutely appalling. Countries like ours depend on PEPFAR, and CDC, and USG funding for a lot of our essential health services.³¹ **Women are disproportionately affected by HIV [and] this program will disproportionately affect women who are HIV positive and poorer women who need public health services...** Many of these people are people who desperately need birth control, they need access to family planning services, and they do need abortions...Increasing the Global Gag Rule to cover HIV services is going to be extremely damaging.*

— Sexual and reproductive health and rights (SRHR) activist, South Africa

Across the three countries, interviewees agreed that the Global Gag Rule would disproportionately affect young people.

We would be losing over \$250,000 if that grant had to be withdrawn because of our stand on safe abortion. What is also most dear to our heart is actually the fact that we are also going to be losing young girls and women who are supposed to contribute to the growth and development of this country for not being allowed to make a choice that would save their lives.

— Executive director, women's rights organization, Nigeria

In South Africa, a young girl would prefer going to an NGO more than to a government facility. As you know, our clinics sometimes are unfriendly, judgmental. So I think [the

Global Gag Rule] will have definite implications, especially with HIV amongst our young population as well.

— Staff person, Department of Social Development, South Africa

By putting health care further out of reach for the same women and girls who already have the hardest time accessing health care and information, the Global Gag Rule will disproportionately affect the most vulnerable populations: women in rural and underserved areas, women living with HIV, poor women, and young people.

C. FRAGMENTATION OF HEALTH SERVICES

The documentation in Kenya and South Africa has found that the Policy is threatening progress towards integrated health systems, often made with substantial US investments.

The effect goes right down to the village. The integration of services is breaking down—malaria, HIV, and so forth.

— Executive director, sexual and reproductive health and rights (SRHR) organization, Kenya

In Kenya, people living in rural areas often need to travel long distances to access health services. With investments from USAID, IWHC-grantee partner KMET's *Huduma Poa* Health Network grew incrementally from 50 to 122 clinics over the course of five years, based on the success of its integrated health care model.

KMET's US funding contract is coming up for renewal in November 2018 and the organization will be forced to make an impossible choice: sign a contract including the Global Gag Rule provision and stop providing life-saving information and services to the communities they serve, or refuse to sign and forego the funding that supports 122 clinics, many of which are the sole healthcare providers in their communities. This successful network of clinics providing integrated services, built with USAID support, is now at risk as a result of the Global Gag Rule.

Like KMET, organizations that work with marginalized populations in South Africa are often community-based and may be the only organization serving that community. The Global Gag Rule will force them to decide between abandoning abortion-related work or foregoing significant amounts of funding for a range of services. Particularly because the law in South Africa protects the right to abortion, interviewees working in global health and HIV in that country found this an immoral dilemma.

*It will obviously be a very difficult trade-off for organizations to make. **Do we make a decision on principle to say if we can't continue doing these services then we don't want your money? But then you will ultimately affect people that were reliant on other services. They will obviously be the victims of that decision...**It's terrible to be having to make such a trade-off. You have to basically cut your work on abortion which does not even include the actual physical clinical procedure. It's even just counseling women on their right or referring women to other services. If you do that then you don't get any funding for your other work. It's very unethical.*

— Director, health advocacy organization, South Africa

By forcing these choices, the Policy threatens recent US government investments through PEPFAR to integrate HIV/AIDS and sexual and reproductive health services in the South African health care system. Integration of health care services makes health systems more efficient and increases the likelihood that patients will receive the comprehensive care they need. The Global Gag Rule threatens to undermine evidence-based practice:

The other thing that the US government has been supporting for a long time because of the AIDS epidemic is services...and to give credit to the US government, they've really helped roll out antiretroviral treatment throughout the country. Now, they are trying to integrate different services, and this is not easy. With the Gag Rule, I can see that affecting the integration. Instead of integrating AIDS services with sexual and reproductive health and rights, there may be problems there.

— Director, HIV/AIDS and global health organization, South Africa

Beyond threats to the integration of health services, the Policy has the potential to affect guidelines and training for health care providers and educators by removing all mention of abortion. In South Africa, civil society organizations often lead the development of government guidelines (e.g. for HIV treatment or life skills education). The same civil society organizations that are contracted by the South African government are often also recipients of US global health funding, with USAID, government ministries, and civil society organizations working together closely. Several representatives from civil society organizations were concerned about this effect, including one that has signed the Global Gag Rule.

We spend a lot of time with experts going through the evidence to put guidelines together...and we had a whole range of options: you need to counsel around family planning options, and at one point we even had something in terms of termination of pregnancy, and one of the participants to the guideline, said we couldn't use that term "termination of pregnancy..." so I don't know what that's going to mean going forward. So if termination of pregnancy is the right response, or is an option that you offer in a guideline, I think we would need to continue to do that.

— Executive director, HIV/AIDS and sexual and reproductive health and rights (SRHR) organization, South Africa

In Nigeria, where abortion is more restricted, health service integration did not come up as frequently. Some interviewees did speak about the absurdity of a policy aimed at separating out one specific health service from all others:

For want of words, I think I would just say that the whole thing is stifling development. The world is full of sick people, so if you are saying because of one particular kind of issue, others suffer; you are trying to solve a problem by creating multiple problems. That's what the Trump's version of the Gag Rule would definitely do.

— Representative, global health and rights organization, Nigeria

D. ANGER AT US AND NATIONAL GOVERNMENTS

The Global Gag Rule has sparked anger at the US government and frustration over African countries' dependency on foreign aid. Across the project countries, interviewees active in the health sphere found the Policy to be an imposition of US political ideology, and a form of neo-

imperialism. They described the Policy as “racist,” “unfair,” and “a bullying tactic.” Participants emphasized that the Policy may lead to increased maternal mortality in their countries, and as such, worsens their image of the United States.

It is rude for you to say you are actually saving lives, to say that you are helping the Africans. For me, I still see it as modern day slavery. I see it as we are still in the colonial age. Because if you are helping me, I know my issues, I should be able to deal with my issues...If I am going to be given money to do work, I should be able to work based on participatory methods and not work on rules that can only work in the US and not in Nigeria.

— Representative, faith-based global health organization, Nigeria

An advocate from a sexual and reproductive health and rights organization in Nigeria exclaimed:

It is not American women dying, it is Nigerian women that are dying.

Participants from South Africa often highlighted that abortion is legal in both the United States and in South Africa, making conditions of the Global Gag Rule out of line with the law in both countries.

I don't understand why the US thinks they can just dictate policies to other countries when abortion is legal in the US, and it's legal in South Africa. I would also say it's a racist policy. It's based on a problematic view of developing countries, and women in developing countries. It's a colonial view of women in developing countries.

— Sexual and reproductive rights and health (SRHR) activist, South Africa

Many also considered the Global Gag Rule to be part of a larger attack on reproductive rights exported by the US. Several interviewees from civil society mentioned that the anti-choice groups in their countries have adopted US-developed anti-choice tactics. For example, in South Africa, right-wing groups have proposed laws similar to the Targeted Regulation of Abortion Provider (TRAP) laws that have passed in several states in the US in an effort to restrict access to abortion.³²

Often, outcry over the harmful US policy coincided with calls for national governments to take ownership and accountability for the health of their own people. Interviewees pointed out that if their governments were fulfilling obligations to their own constituents, nongovernmental organizations would not need to fill the gaps. Funding given directly to governments is not subject to the restrictions of the Global Gag Rule, yet, in many cases, it is nongovernmental organizations—not national or local governments—ensuring the essential health needs of individuals are met.

Some of those interviewed felt that the Global Gag Rule might spur their own governments to take more responsibility for funding health care. In Kenya, for example, some commented that there is goodwill in the health system at the county level and noted the need for education at different levels of government. Others, across the three countries, hoped that a policy as offensive and harmful as the Global Gag Rule might inspire governments to position themselves to better counter external influence and called for increased mobilization of local resources.

*We are a sovereign nation. We can decide to do away with any kind of grant from anybody. We can decide to depend on our own income to handle those health related issues. We can depend on ourselves; develop our inner strength, build our capacity. After all, I believe that we have enough to be able to meet our needs without depending on anybody from anywhere...**When is Nigeria going to wake up to take up their own responsibility and not say because this America did not bring, we cannot do? We need to wake up and say that Nigeria knows how to take responsibility.***

— Sexual and reproductive rights and health (SRHR) organization, Nigeria

E. WEAKENING OF CIVIL SOCIETY AND EMBOLDENING OF ANTI-CHOICE GROUPS

1. Silencing Voices

The Global Gag Rule affects the ability of civil society organizations to do their work effectively. Across the three countries, civil society organizations reported that critical partnerships and consortia are being lost, creating gaps and inefficiencies. Interviewees also reported that the Policy silences civil society organizations, making them less able to hold their governments accountable. These effects were documented in South Africa and Kenya, and to a lesser extent in Nigeria.

In all three countries, some organizations that were approached to participate in the research ignored requests for interviews or declined, referencing their need to adhere to the Global Gag Rule. Those who chose to participate reported they were adjusting their ways of working and censoring themselves.

We are not sure about how to proceed and are therefore hesitant to voice our opinions. So some of us are self-censoring ourselves.

— Sexual and reproductive rights and health (SRHR) organization, Kenya

I think it is pushing everybody away. People don't want to discuss it because that would have impact on your general funding...the intention is actually to gag people so they are very careful. Because they are likely going to lose funds, they don't want the risk of discussing it.

— Executive director, women's rights organization, Nigeria

2. Fracturing Relationships and Fomenting Distrust

The threat of losing funding often leads organizations to stop activities that are allowed under the Global Gag Rule when their work may in any way touch the issue of abortion. In South Africa, IWHC's grantee-partner, Ibis Reproductive Health, an organization known for its work on sexual and reproductive health, including abortion, shared that they had encountered increasing challenges finding project partners after the reinstatement of the Global Gag Rule.

At that time, Ibis was in the final stages of securing funding from a European donor to implement a project in partnership with a local organization. At the last moment, the local organization dropped out of the partnership, even though the project did not include any work that would conflict with the Global Gag Rule. At the time of the interview, Ibis had found it impossible to find another local partner to work on the project. They attributed this experience to

the Global Gag Rule and local partners' fear of being associated with an organization known for working on abortion.

In addition to the loss of partnerships, some civil society organizations expressed growing distrust among civil society organizations and described increased competition for funding. The result is a weakened and fractured civil society, with sexual and reproductive health and rights groups distancing themselves from other health service delivery and advocacy organizations. From the perspective of the civil society leader of an organization that does not receive USG funding in South Africa:

This Gag Rule has affected most organizations. I think that it has weakened, slowed the growth of [civil society organizations]... We'll go to a meeting with the Department of Health or with government officials, and because we're not getting money from anybody, we are free to say "No! You are not doing right. We are not happy about this. You cannot do this." Other civil society organizations will be there with us, but they won't comment, they won't say anything. When we are out of the meeting, they'll say "You comrades raised an important point. Continue to do this. You have our support."

How can I have your support when we are in the meeting and you are not saying anything? Now, I understand better why they can't say anything: because the very same government officials are the ones who are making you get this [USAID] money, and if you break this [gag] rule, then it means you won't get any funding.

— National chairperson, HIV/AIDS and global health organization, South Africa

The same sentiment was echoed by an interviewee from a South African organization that has signed the Global Gag Rule:

It makes it difficult for us to work together, like in consortia and partnerships, because they think we're morally corrupt and sort of woozy for not standing up. And part of me really strongly agrees, and part of me is just like... We're stuck. What can we do? But I think it's going to be devastating, like I think the consequences are going to be devastating.

— Executive director, HIV/AIDS and sexual and reproductive rights and health (SRHR) organization, South Africa

Interviewees also expressed fears that the Global Gag Rule would deepen the fissures between the HIV/AIDS and sexual and reproductive health and rights communities.

3. Creating Gaps

The gaps created by the Global Gag Rule can be hard to fill. In Nigeria, some interviewees expressed frustration at losing the ability to collaborate with an organization known to do work on abortion, since it was the only organization operating in particular geographic areas. In South Africa, the representative of an organization grappling with its existing relationships spoke about a current project that might be in jeopardy:

*It's a very successful, very unique project. It would be huge pity. It could be handed over to someone else but it would be a massive loss for our organization... **I'm also not sure***

that any of the other organizations have the capacity to run it... That would be the biggest loss.

— Executive director, HIV/AIDS and sexual and reproductive rights and health (SRHR) organization, South Africa

Interviewees from civil society and service delivery organizations spoke about how previous iterations of the Global Gag Rule similarly decimated civil society groups, particularly smaller, community-based organizations working with specialized populations. They explained how the fluctuations in funding due to the repeated revocation and reinstatement of the policy with different US administrations served to destabilize organizations and reduced their potential for sustainability over time. Particularly in South Africa, many civil society members felt that the Bush-era policy had set them back significantly and that civil society was just beginning to recover.

*In the previous era, the George Bush one... Oh my goodness, the number of organizations that were closed! **The progressive advocacy vibe that was in this country almost went quiet for some time, literally.***

— Public health researcher, South Africa

They predicted that the Policy would again cause organizations, particularly those working on women's rights and sexual and reproductive health and rights, to close.

4. Emboldening the Foes of Sexual and Reproductive Rights

The Global Gag Rule emboldens anti-choice groups while leaving fewer voices to counter their efforts. While they did not generally expect their national laws to change, interviewees felt that the Policy has the potential to reinforce existing legislation and practices that restrict access to abortion. Interviewees, particularly in South Africa, also noted that the Policy emboldens anti-abortion activists to push increasingly extreme legislation. Even if these efforts do not result in policy change, they require time and effort to fight.

I don't think [the legal status of abortion] can change. Our constitution is tight... However, with the Global Gag Rule, that foolish political party called the ACDP³³, they tried it. They tried it and they put a motion in government so that we must talk about the right to termination of pregnancy again. So it gives space for crap. You get what I'm saying? It gives space for nonsense.

— National chairperson, HIV/AIDS and global health organization, South Africa

Interviewees included three anti-choice organizations in Nigeria and one in Kenya. These interviewees saw the Global Gag Rule as a validation of continued restrictions to abortion access and were hopeful about the Policy's potential to influence their governments' opinions. These responses underscored the concern among sexual and reproductive health and rights advocates that the Global Gag Rule provides an excuse for unsupportive government leaders to continue their inaction. Furthermore, proponents of sexual and reproductive health and rights who had lived through previous implementations of the Global Gag Rule expected that more funding would go to anti-choice and anti-sexual and reproductive health and rights groups as the result of the Policy, as happened during the George W. Bush administration.

The American government's position fuels the anti-choice campaign. And as you do know very clearly, that anti-choice campaign is a strong community of mixed faith and conservatives. So how we navigate that terrain will be very interesting to watch in the coming days.

— Executive director, sexual and reproductive health and rights (SRHR) organization, Nigeria

V. RECOMMENDATIONS

A. US GOVERNMENT

- **Permanently repeal the Global Gag Rule through legislation.** Congress must pass legislation not only to terminate the current incarnation of the gag rule, but also to permanently end the President's ability to reinstate this harmful policy in the future.

Congressional legislation that explicitly states that organizations will not be deemed ineligible for US funding for providing legal health or medical services—including abortion—has already gained bipartisan support. Such legislation would ensure that eligible foreign NGOs could continue to provide critical health services with US funds, and continue to work on abortion-related work with their non-US funding.

- As long as the Global Gag Rule is in effect, **develop and share clear guidelines for implementation with all recipients of US global health funding, including sub-award recipients and local organizations.** Until the Global Gag Rule is repealed, the State Department, USAID, and other agencies must provide better, clearer, and more consistent guidance for organizations faced with signing the Global Gag Rule and should create a mechanism for addressing questions and confusion.

Ensuring that people working at all levels of an organization, including frontline staff, understand the content and limits of the Policy is imperative and could be lifesaving. In particular, the State Department should clarify the areas of work that are explicitly excluded from the Policy. They also should make clear that organizations that receive funding will not be punished for collaborating with organizations that do work on abortion or for attending meetings or conferences where access to safe abortion is on the agenda.

- As long as the Global Gag Rule is in effect, **any US government review process must be a consultative, transparent, comprehensive, and action-oriented analysis of the Policy and its impacts.** The initial review of the Policy, undertaken at six months, was not a legitimate effort to understand its effects and implications. Not only was it extremely premature, not allowing sufficient time with the Policy in place to truly evaluate it, it made no effort to look at the Policy's initial impacts on organizations and the people they serve; it was merely a bureaucratic checklist on the process of implementation.
- To be credible, any future review must create a process of evaluating the impact of the Policy and understanding both its short and long-term implications. The process should allow for both local and US civil society input with adequate response time, and all submissions should be made public.

- Any process of review must **pay particular attention to the effects of the Policy on marginalized populations.** To be comprehensive, a review must take particular note of the ways that the Policy affects different communities, with particular emphasis on adolescents and young women, LGBTQ individuals, women and girls living in rural and hard to reach areas, women and girls living with HIV, economically disadvantaged women and girls, indigenous women, and women of ethnic and racial minorities. A review should also examine the impacts of the Policy on local and community-led organizations, which often are best placed to meet specific needs within a community.
- **Document and record instances of misapplication, over-application, and chilling effects of the Policy.** Any US government review of this policy must look at the ways the Policy is being misapplied and the impacts of this chilling effect on the delivery of legal and permissible services like contraceptives, postabortion care, and referrals for abortion services in cases of rape, incest, or a life-endangering pregnancy.

B. PRIME RECIPIENTS OF US GLOBAL HEALTH FUNDING

- **Ensure that staff and sub-award recipients understand the Global Gag Rule, especially those areas of work that are excluded from the Policy.** Prime recipients of US global health funding, both foreign and US-based, have the responsibility to educate themselves and their sub-award recipients so that organizations can make well-informed decisions and mitigate harmful impacts.

Prime recipients of US global health funding who must ask their sub-recipients to sign the Policy should continue to provide all services and information allowed under the Policy and must clearly convey to their sub-award recipients what activities are still permissible under the Global Gag Rule. This includes, for example, understanding that they can refer a client for safe abortion if she states that she wants one, continuing to receive training and supplies for postabortion care, and other critical services. Prime recipients have a responsibility to make every effort not to over-implement the Policy, either in their own work or in that of their sub-recipients, out of fear or misinformation.

C. ALL INTERNATIONAL NGOS, BOTH PRIME RECIPIENTS OF US GLOBAL HEALTH ASSISTANCE AND OTHERS

- **Document the impact of the Global Gag Rule on their organization's work, including misapplication, over-application, and the chilling effects of the Policy.** International NGOs, both US-based and non-US-based, should document the impact of the Global Gag Rule on their ability to do their own work and make impact assessments publicly available whenever possible. Organizations should also submit comments to any State Department reviews to ensure the US government understands the full effects of the Policy.
- **Continue to resist this harmful policy and work towards ending it.** US-based NGOs should continue to build support among members of Congress and the general public to repeal the Policy.

D. DONOR GOVERNMENTS AND INTERNATIONAL AND REGIONAL ORGANIZATIONS

- **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 other than those commonly funded 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 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,** make the documentation publicly available, and submit it to the US State Department as part of any review process.
- **Engage in diplomacy** with the US Government to reverse the Policy.

E. UN AGENCIES

- **Publicly speak out against the Global Gag Rule and other conditionalities on development assistance** that undermine the autonomy of countries and organizations and their ability to meet people's needs.
- **Include information about the impacts of the Global Gag Rule in reports** and other materials that address gender equality, sexual and reproductive health and rights, HIV, and other health issues.

F. GOVERNMENTS IN COUNTRIES THAT RECEIVE US GLOBAL HEALTH ASSISTANCE

- **Increase 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 population.** Governments should make the results of this documentation publicly available whenever possible and should submit comments to any State Department reviews.
- **Actively advocate with the US government to end this harmful policy.** Governments should push back on US foreign policies that negatively affect the health of their people, especially when those policies are in conflict with local laws.

G. AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS

- **Consider issuing a statement on the Global Gag Rule as a violation of the human rights of women and girls in Africa.** National government to include statements on the effects of the Global Gag Rule in their countries as part of the country reporting process.
- Continue efforts through the Campaign for the Decriminalization of Abortion in Africa to encourage governments to **decriminalize abortion** and take active measures to increase the acceptability, accessibility, availability, and quality of safe abortion services.
- **Encourage national governments to increase their funding for comprehensive sexual and reproductive health services**, including safe abortion, in order to meet their obligations under the African Charter on Human and Peoples' Rights and the Protocol on the Rights of Women in Africa.
- **Document the effects of the Global Gag Rule and its impact on the human rights of people in Africa through special mechanisms**, including the Special Rapporteur on the Rights of Women in Africa, the Special Rapporteur on Freedom of Expression and Access to Information, and the Commission on the Protection of the Rights of People Living with HIV and Those at Risk, Vulnerable to and Affected by HIV.

VI. CONCLUSIONS

This report documents the early effects of the Global Gag Rule in its first year of implementation and presents a baseline for the future. Across three countries with very different legal and social contexts, the findings are strikingly similar:

Lack of information and confusion about the Policy is common among affected stakeholders.

The Global Gag Rule hurts women and girls, especially affecting the most marginalized populations and young women.

The Policy threatens to roll back progress towards effective and integrated health systems, often made with US investments.

Even when not in place, the Policy does long-lasting harm to civil society.

The Policy sparks anger at the US and national governments.

The consistency in these findings underscores their validity and suggests that similar effects may be occurring worldwide.

In this initial phase of our research, IWHC partners and interviewees emphasized that implementation of the Policy is just beginning and that it will be months, if not years, before we can see its full impact. Because the Policy now applies to sectors beyond family planning—like HIV/AIDS treatment and prevention, malaria, and infectious diseases—many organizations are being asked to grapple with the Global Gag Rule for the first time. Many are still in the process of deciding whether to meet the conditions and certify under the Policy, or to forgo future US funding. Either decision will have consequences for the women and communities they serve.

VII. NEXT STEPS

IWHC is committed to continuing to monitor and document the impacts of the Global Gag Rule as it continues to be rolled out. In 2018, IWHC will continue to work with TICAH in Kenya, EVA in Nigeria, and CSSR in South Africa and expand the documentation project to Nepal, with the Center for Research on Environment, Health, and Population Activities (CREHPA).

As an advocacy and grantmaking organization, IWHC understands how essential civil society organizations are, especially those that work to strengthen the sexual and reproductive health and rights of women and girls worldwide. While policies such as the Global Gag Rule may aim to silence voices and fracture coalitions and partnerships, they also serve to highlight the importance of organizations that continue to defend the health and rights of the most vulnerable members of society. Through advocacy, documentation, and evidence, IWHC commits to the global fight to call for the permanent repeal of this harmful policy.

APPENDIX 1. METHODOLOGY

IWHC'S APPROACH:

IWHC is working with Trust for Indigenous Culture and Health (TICAH) in Kenya, Education as a Vaccine (EVA) in Nigeria, and the Critical Studies in Sexuality 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 key informant interviews with civil society organizations, health service providers, anti-choice groups, academics and government agencies to document the Policy's effects on civil society and the political climate, and its perceived effects on women and girls. This first year represents the projects baseline and the project will continue while the Policy continues to be in effect.

To leverage its organizational strengths and relationships, IWHC chose to work with existing grantee partners. IWHC recognizes that its partners have a greater familiarity with the local contexts, a better understanding of what is happening on the ground, and a greater proximity to the direct effects of the Policy. Focus countries were determined based on three criteria: volume of US global health funding, active social and political conversations about abortion, and IWHC's relationship with local civil society organizations.

For the first year of the project, IWHC worked with long-term grantee partners TICAH in Kenya and Education as a Vaccine (EVA) in Nigeria. IWHC identified the third partner, CSSR at Rhodes University, through interviews conducted in South Africa; CSSR is associated with another current grantee partner in South Africa, the Sexual and Reproductive Justice Coalition (SRJC). IWHC sees this project as one component of its broader work with current grantee partners, with the expectation that it can help to build capacity for research and documentation projects and strengthen connections among grantee partners.

IWHC's grantee partners participated in each step of the process, from determining which research questions were most important to answer, to designing the methods, and to analyzing the data.

IWHC's project complements the work of other US-based organizations conducting research and documentation projects about the Global Gag Rule. Larger research and service delivery organizations are better placed to gather data on service provision and health outcomes, IWHC's strengths are its approach to partnership and its ability to document the broader social and political effects of policies, such as the Global Gag Rule.

GUIDING QUESTIONS AND METHODS:

IWHC and partners determined the project's research questions and methods collaboratively, with the goal of maximizing the usefulness of the project's data. The following questions guide the documentation project:

1. How are USG policies on SRHR, particularly the Global Gag Rule, perceived, understood, and interpreted by key stakeholders (civil society organizations, abortion service providers, anti-abortion groups, government officials and policymakers)?
2. How do key stakeholders see USG policies on SRHR, particularly the Global Gag Rule, affecting SRHR in their country?

3. What effect do USG policies on SRHR, particularly the Global Gag Rule, have on civil society organizations?
4. What effect do USG policies on SRHR, particularly the Global Gag Rule, have on the political discourse about SRHR?
5. How are organizations that work to defend and expand access to SRHR mitigating these effects?
6. How does the media reference USG policies and the Global Gag Rule with respect to SRHR, abortion, and women's rights?

To answer the above questions, the documentation project used qualitative interviews with key informants. In-depth interviews are a key way to obtain nuanced information on the initial and long-term effects of the Global Gag Rule and well suited for understanding how complex factors, such as the social and political context of a country, interact with the Policy. Using qualitative methods also allows for documentation of the Global Gag Rule now, before effects on population-level health are observable, so that the global community of donors, health providers and advocates understand and can make informed decisions about the Policy.

IWHC developed the data collection tools (e.g. interview guides) and then partner organizations made adjustments for the country context. Partners identified key informants representing civil society organizations, abortion service providers, anti-abortion groups, academics, and government based on an initial analysis of the SRHR 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.

Overall, 59 interviews were conducted across the three countries (including interviews conducted by IWHC in South Africa). Cases where more than one person from an organization was present were counted as one interview. There were three cases in which two people from the same organization were interviewed separately in South Africa because they offered different perspectives. Those interviews were counted as two separate interviews.

Table 1 below describes the breakdown of interviews conducted in each country by key informant type. While there is some overlap among these categories, interviewees were grouped into the general category with which they most strongly identified.

Table 1. Key Informant Interviews by Type, Country, and Organization Conducting Interviews					
Key Informant Type	Kenya / TICAH	Nigeria / EVA	South Africa / CSSR	South Africa / IWHC	Total
CSOs focused on SRHR and Women's Rights	9	7	4	5	25
CSOs working on HIV/AIDS and other global health issues	1	8	3	8	20
Researchers/Academic	1		3	2	6
Faith-Based Organizations	1	3			4
Government Agencies	1		1	1	3
Journalist		1			1
Total	13	19	11	16	59

Of the 49 interviews with civil society and faith-based organizations, ten interviews were with affiliates of international nongovernmental organizations and 39 were with local or indigenous organizations. Table 2 describes the breakdown by country.

Table 2. Key Informant Interviews with CSOs and FBOs by International or Local Organization and Country				
Country/CSO Type	Kenya	Nigeria	South Africa	Grand Total
INGO	4	2	4	10
Local	7	16	16	39
Grand Total	11	18	20	49

Seven interviews (four in Kenya, one in Nigeria, and two in South Africa) were with individuals from organizations that directly provide abortion-related services. Two interviews were with individuals who represented anti-choice groups (one in Kenya and one in Nigeria).

ANALYSIS:

Interviews from Nigeria and South Africa were recorded and transcribed verbatim. Due to privacy concerns, interviews from Kenya were not recorded. Instead, the researcher took detailed notes throughout the interviews.

Data analysis was conducted in two phases. First, each partner organization conducted a thematic analysis of their own interview data. Two individuals from each organization worked in a pair to devise a coding scheme for analyzing their country's data. Before analyzing the data across the project 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 the three grantee partners came together to analyze the data across the project 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. Findings were verified iteratively in the group to identify similarities, differences, and gaps in the data across the three countries.

APPENDIX 2. 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. 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, LGBTI 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.

EDUCATION AS A VACCINE (EVA) — NIGERIA

Education as a Vaccine is a non-profit organization founded in 2000, registered in Nigeria with the CAC in 2001 and in the United States as a 501(c)(3) organization to improve the health and development of children, 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 mechanism for improved quality of life for vulnerable children and young people. In line with our vision, EVA works in partnership with children, adolescents, 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.

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

CRITICAL STUDIES IN SEXUALITY AND REPRODUCTION (CSSR) RESEARCH UNIT, RHODES UNIVERSITY — SOUTH AFRICA

The Critical Studies in Sexualities and Reproduction 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/NGOs in South Africa and across the world.

Overarching Goals

Despite the introduction of enabling sexual and reproductive health legislation, and the implementation of a range of public health, nongovernmental and educational interventions, South Africa is faced with multiple challenges surrounding sexuality and reproduction, including: high levels of forced sexual debut, sexual coercion and violence; transactional sex; HIV infection; rape (including child rape); hate crimes against lesbian women and gay men (including 'corrective' rape); unwanted and unsupportable pregnancies; and a high maternal mortality rate. Barriers to sexual and reproductive health service provision include structural factors (e.g. traveling distances and cost incursion in reaching a facility) and a range of social dynamics (e.g. abortion is seen in some areas as destructive of cultural values and traditions). The above-mentioned challenges and barriers are simultaneously rooted in, and serve to perpetuate, a range of social inequities centered on race, class, ability, sexual orientation, age and gender. The overarching goal of the *Critical Studies in Sexualities and Reproduction* (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.

Areas

Research activities fall under the following broad interconnected areas: (1) sexualities; (2) reproduction; and (3) unsupportable pregnancies/abortion. Within each of these broad areas, a number of related themes of inquiry are conducted.

Recent systematic literature reviews point to certain cross-cutting issues in sexualities and reproduction (e.g. gender stereotypes underpin young people's sexual behavior; intimate partner violence is associated with unintended pregnancies; cultural beliefs concerning pregnancy affect antenatal usage). Within this, the socio-spatial specificity of discourses, narratives and practices relating to sexualities and reproduction is increasingly recognized. 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.

- ¹ A prime partner is “the entity which receive[s] funding directly from, and has a contractual relationship (contract, cooperative agreement, grant, etc.) with, the US government agency.
- ² The policy is formally called the Mexico City Policy and Trump’s plan to implement the policy, extending it to all US global health assistance, is called “Protecting Life in Global Health Assistance.”
- ³ “The Mexico City Policy: An Explainer,” *The Henry J. Kaiser Family Foundation* (blog), June 1, 2017, <https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/>.
- ⁴ Kellie Moss and 2017, “How Many Foreign NGOs Are Subject to the Expanded Mexico City Policy? - Issue Brief,” *The Henry J. Kaiser Family Foundation* (blog), December 4, 2017, <https://www.kff.org/report-section/how-many-foreign-ngos-are-subject-to-the-expanded-mexico-city-policy-issue-brief/>.
- ⁵ Eran Bendavid, Patrick Avila, and Grant Miller, “United States Aid Policy and Induced Abortion in Sub-Saharan Africa,” *Bulletin of the World Health Organization* 89, no. 12 (December 1, 2011): 873–80, <https://doi.org/10.2471/BLT.11.091660>.
- ⁶ PAI, IPAS, and Planned Parenthood Federation of America (PPFA), “Access Denied: US Restrictions on International Family Planning,” accessed May 2, 2018, <http://trumpglobalgagrule.pai.org/wp-content/uploads/2017/04/Access-Denied-Executive-Summary.pdf>. PAI Access Denied
- ⁷ “U.S. NGOs are responsible for flowing-down *the policy* to foreign NGO partners that receive U.S. global health assistance from them, and for monitoring partners’ compliance with *the policy*. Foreign NGOs are responsible for ensuring their own compliance when receiving U.S. global health assistance directly from the USG, for flowing-down *the policy* on other foreign NGO partners who receive U.S. global health assistance from them as sub-recipients, and for monitoring those partners’ compliance with *the policy*.” PAI What You Need to Know Guide. PAI, “What You Need to Know About the Protecting Life in Global Health Assistance Restrictions on US global health Assistance: An Unofficial Guide,” September 30, 2017.
- ⁸ The Constitution of Kenya. Article 43(1)(a).
- ⁹ Center for Reproductive Rights (CRR), “Kenya’s Abortion Provisions,” *The World’s Abortion Laws 2018*, February 20, 2014, https://www.reproductiverights.org/node/2747/map_popup.
- ¹⁰ In addition to other factors, the Kenyan MOH withdrew the S&Gs and halted their safe abortion training program when USAID warned recipients of U.S. family planning funding that they could not attend a meeting because it was on abortion. This warning was due to a grave misinterpretation of the Helms Amendment. “This Map Shows the State Of Abortion Laws Worldwide,” accessed May 2, 2018, <https://www.refinery29.com/2016/04/108037/abortion-laws-global-restrictions-illegal>.
- ¹¹ Network for Adolescent and Youth of Africa (NAYA), “Ministry of Health Should Adopt Standard Guidelines for Reducing Morbidity and Mortality for Unsafe Abortion,” March 6, 2018, <http://nayakenya.org/ministry-of-health-should-adopt-standard-guidelines-for-reducing-morbidity-and-mortality-for-unsafe-abortion/>.
- ¹² African Population and Health Research Center et al., “Women’s Lives Matter: Preventing Unsafe Abortion in Kenya. Key Findings of a National Study: Incidence and Complications of Unsafe Abortion in Kenya” (Nairobi, Kenya, 2013), <https://www.gutmacher.org/sites/default/files/factsheet/fb-abortion-in-kenya-2013.pdf>.
- ¹³ Network for Adolescent and Youth of Africa (NAYA), “Ministry of Health Should Adopt Standard Guidelines for Reducing Morbidity and Mortality for Unsafe Abortion.”
- ¹⁴ Penal Code Federal Provisions Act, Chapter 345 of the Laws of the Federation of Nigeria, Articles 232-236; Criminal Code Act, Chapter 77 of the Laws of the Federation of Nigeria, Articles 228-230, 297, 309, 328.
- ¹⁵ Akinrinola Bankole et al., “The Incidence of Abortion in Nigeria,” *International Perspectives on Sexual and Reproductive Health* 41, no. 04 (December 2015): 170–81, <https://doi.org/10.1363/4117015>.
- ¹⁶ Marc Worrell, “Nigeria: Abortion Law,” *Women on Waves*, accessed May 1, 2018, <http://www.womenonwaves.org/en/page/5015/nigeria--abortion-law>.
- ¹⁷ Bankole et al., “The Incidence of Abortion in Nigeria.”
- ¹⁸ Frederick Wekesah and Chimaraoke Izugbara, “Maternal Health in Nigeria: Facts and Figures” (African Population and Health Research Center, June 2017), <http://aphrc.org/wp-content/uploads/2017/06/APHRC-2017-fact-sheet-Maternal-Health-in-Nigeria-Facts-and-Figures.pdf>.
- ¹⁹ “Nigeria Health System Assessment 2008,” *HFG* (blog), June 1, 2009, <https://www.hfgproject.org/nigeria-health-system-assessment-2008/>.
- ²⁰ Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996)
- ²¹ A. M. Mbele, L. Snyman, and R. C. Pattison, “Impact of the Choice on Termination of Pregnancy Act on Maternal Morbidity and Mortality in the West of Pretoria,” *South African Medical Journal = Suid-Afrikaanse Tydskrif Vir Geneeskunde* 96, no. 11 (November 2006): 1196–98.
- ²² Karen A. Trueman and Makgoale Magwentshu, “Abortion in a Progressive Legal Environment: The Need for Vigilance in Protecting and Promoting Access to Safe Abortion Services in South Africa,” *American Journal of Public Health* 103, no. 3 (March 2013): 397–99, <https://doi.org/10.2105/AJPH.2012.301194>.
- ²³ Statistics South Africa, “Millennium Development Goals 5: Improve Maternal Health 2015” (Pretoria, South Africa), accessed May 7, 2018, http://www.statssa.gov.za/MDG/MDG_Goal5_report_2015_.pdf.
- ²⁴ The Helms Amendment (1973) Prohibits the use of foreign assistance to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortion.
- ²⁵ The anti-prostitution loyalty oath (APLO) is a provision in the US Leadership Act of 2003 which requires all foreign NGOs receiving PEPFAR funding to “have a policy explicitly opposing prostitution” and makes it so that no funds “may be used to promote or advocate the legalization or practice of prostitution or sex trafficking” or “to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking.”
- ²⁶ The President’s Emergency Plan for AIDS Relief (PEPFAR) is a US government initiative to address the global HIV/AIDS epidemic.
- ²⁷ Bendavid, Avila, and Miller, “United States Aid Policy and Induced Abortion in Sub-Saharan Africa.”
- ²⁸ Department of Health, South Africa, “Saving Mothers: Annual Report and Detailed Analysis of Maternal Deaths Due to Non-Pregnancy Related Infections” (Pretoria: Department of Health, South Africa, 2014).

²⁹ United Nations Development Programme (UNDP), “United Nations Development Programme: Human Development Reports - Nigeria,” accessed May 1, 2018, <http://hdr.undp.org/en/countries/profiles/NGA>.

³⁰ Statistics South Africa, “Mid-Year Population Estimates” (Pretoria, South Africa: Statistics South Africa, July 31, 2017), <http://www.statssa.gov.za/publications/P0302/P03022017.pdf>.

³¹ The Centers for Disease Control and Prevention (CDC) is a federal agency that “protect[s] America from health, safety and security threats, both foreign and in the US.” “CDC Organization | About | CDC,” February 15, 2018, <https://www.cdc.gov/about/organization/cio.htm>.

³² “TRAP” (Targeted Regulation of Abortion Providers) laws single out the medical practices of doctors who provide abortions and impose on them requirements that are different and more burdensome than those imposed on other medical practices. “Targeted Regulation of Abortion Providers (TRAP),” Center for Reproductive Rights, February 29, 2012, <https://www.reproductiverights.org/project/targeted-regulation-of-abortion-providers-trap>.

³³ The African Christian Democratic Party (ACDP) is a conservative Christian political party in South Africa.



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