EDITORIAL

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Exporting bad policy: an introduction to the special issue on the Global Gag Rule's impact

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This special issue is dedicated to illuminating the harm done by the Trump administration's expanded Global Gag Rule which tramples on national sovereignty, sound healthcare policy, and women and girls' sexual and reproductive health and rights (SRHR).

On 23 January 2017, President Trump issued an expansion of the Mexico City Policy, or "Global Gag Rule" (GGR), last implemented under George W. Bush. The GGR blocks US global health assistance to any non-governmental organisations (NGOs) which are not based in the US, that: perform abortions, except in cases of rape, incest, or threat to the life of the woman; provide counselling on, or referrals for, abortion; or lobby for the liberalisation of abortion law. Earlier iterations of the rule (1985–1993, 1999–2000, 2001–2009) applied only to US family planning assistance, while the current GGR applies to all US global health assistance. The GGR was further expanded in March 2019, when US Secretary of State Mike Pompeo announced the policy would also apply to non-US NGO sub-grantees, even if the organisations themselves do not receive any US global health assistance. This expansion limits what these sub-grantees can do with their own, non-US government funds. According to Secretary Pompeo's office, the expansion will ensure the policy is "enforced to the broadest extent possible".[1]

In the past, researchers have found three crucial areas of the GGR's impact: decreased stakeholder coordination and a "chilling" (i.e. deterrence, suppression) of discussion related to SRHR; reduced access to contraception, with attendant increases in unintended pregnancy and induced abortion; and negative outcomes beyond SRHR, including weakening of overall health system functioning. These consequences are all associated with adverse maternal health outcomes.[2]

Based on a partnership between the Global Health Justice and Governance Program (GHJG) at Columbia University's Mailman School of Public Health and researchers, advocates, and healthcare providers in three countries – Kenya, Madagascar and Nepal – the research and commentaries in this special issue document the impact of the current version of the GGR on a varied set of actors and health systems. In selecting countries and partners, we sought diversity in the following areas: legal context for abortion; level of development aid and US global health assistance; and regional representation. Our objective was to document and mitigate harm caused by the GGR.

The GGR has multi-level impacts

Our research was designed to capture multi-level impact on civil society, on facilities and providers, and on clients. It turns out that each of the country papers is weighted a little more toward one of these levels, articulating distinct parts of a causal pathway that links the policy to health outcomes. Overall, the policy imposes enormous logistical challenges. Roose-Snyder et al. address the enormous cost burdens, auditing requirements, and risk assessments caused by the policy. They note the extraordinary legal context of imposing US policy on organisations that have no legal or financial relationship with US global health assistance because of their mere partnership with another organisation that does.[3] Skuster et al. describe how the US government limits abortion in the global South, against the will of governments and civil society. They describe how the 1973 Helms Amendment, which bans foreign assistance for abortion,

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and the Global Gag Rule compound harm against people who need abortion in Kenya and Nepal. In both countries, abortion laws were liberalised, and the governments took steps to increase access to abortion, but US foreign policy interfered.[4]

Even systems that are supposedly exempt from the GGR are affected. Gallagher et al. show how the GGR negatively impacts humanitarian best practices: the ability to work effectively across the humanitarian-development nexus; localisation; and the overall integration of health services, including sexual and reproductive health.[5]

The GGR caused critical funding losses for health systems and civil society partners

The GGR caused a critical loss of funding to organisations and health systems in Kenya, Madagascar, and Nepal. NGO participants discussed how organisations that both do and do not certify the policy are experiencing financial and partnership losses due to the choices forced by the GGR, which in turn affects their sustainability and roles in the health system.[6] In some cases, non-certifying NGOs have closed clinics, laid off health workers, and discontinued training and material support to public facilities. This has a particularly devastating impact on women in rural and remote areas where there may be only one clinic offering a wide array of services. At public and private health facilities, participants reported staffing shortages, stockouts of family planning and safe abortion commodities, and a disruption of referral networks.[6–8] The GGR also exacerbated existing contraceptive supply problems in all three countries.

The GGR tears apart fragile health systems through disruption of partnerships and referral networks

Many NGO and facility-level participants at certifying NGO facilities stopped referring women to non-certifying NGO facilities for SRH services permitted under the policy.[6,7] Often, the forced choice between sources of funding meant organisations had to narrow their areas of focus; many had to halt either HIV or other SRH projects and discontinue partnerships with health facilities or community-based organisations that conduct outreach and connect rural populations with the health system.

Disruption of these partnerships led to negative impacts on health facilities and communities at large. In all three countries, the number of health service delivery points decreased as outreach has scaled down or ceased entirely. Financial support for community health workers has been reduced, resulting in less community mobilisation and community-based distribution.[6–8]

For many years, global and national guidelines promoted integrated service delivery to improve health outcomes,[9] including USAID's own guidance promoting integration of family planning and HIV.[10] Studies have demonstrated that integrated service delivery can improve quality of care and patient satisfaction, and increase cost-effectiveness of both SRH and HIV service delivery.[9,11] While Kenya had made great strides in integrating family planning and HIV services,[12,13] the GGR has torn this work asunder, as Ushie et al. describe, with participants frequently discussing the negative impact of the expanded GGR on integrated health service delivery.[6]

GGR emboldens hostility to SRHR and breeds mistrust/self-censure

The expanded GGR also creates a chilling effect that transcends abortion care by disrupting collaboration and health promotion activities, and strengthens opposition to SRHR. According to participants from NGOs that both have and have not certified compliance with the policy in Nepal and Kenya (organisations must certify, or agree to the terms and conditions of the expanded GGR in a section of any grant or sub-grant agreement involving US global health assistance), the expanded GGR promoted mistrust among organisations that had previously collaborated on shared SRHR issues. In both countries, some NGOs who certified the GGR were unnecessarily restricting their participation in coalitions that also involved NGOs who provided abortion.[6,7]

Women and girls are harmed

While providers are significantly affected by GGR-induced cutbacks in funding, supplies, training, and supervision, it is women and girls who ultimately bear the brunt of this reduced support. Family planning methods that were previously free or subsidised now cost more, forcing women to switch methods or stop using contraception altogether. Stockouts further limited accessibility of certain family planning methods.[6–8] In Madagascar, women described being put in difficult

situations where they had to choose between buying food for their families and paying for their contraceptive method. Providers discussed seeing increases in unintended pregnancies, a claim substantiated by multiple women who reported ending up with an unintended pregnancy.[8]

The GGR impedes science

Unfortunately, the GGR is worsening already-glaring gaps in abortion-related data. The US government has significantly curtailed data collection related to SRHR, and there are signs that reporting on reproductive rights and abortion may be further restricted. As McGovern et al. found, the GGR's chilling effect on abortion-related research is particularly devastating, given the overall scarcity of data in this area.[14] Global estimates of abortion are largely inaccurate, as empirical data are limited even in settings where abortion is legal. Data are least available for adolescents, populations who are criminalised, and forced migrants. Stigma leads to underreporting across legal contexts, and the availability of medical abortion outside the formal health system has further complicated tracking. Unsurprisingly, global estimates of unsafe abortion are especially inaccurate.

The path forward and mitigation of harm

In September 2019, GHJG held a meeting in Istanbul, Turkey, with advocates, researchers, and activists from the three countries to map out a mitigation strategy and explore pathways to ending this policy. Partners discussed how our findings could help mitigate the harm caused by the GGR. For example, the research in Nepal showed that the government's unfamiliarity with and indifference to over-interpretation of the GGR by compliant organisations has resulted in exclusion of abortion-related information from government documents. In response to this and other findings, advocates in Nepal created educational materials and messages tailored for specific actors within the health system – NGOs, providers, community gate-keepers, and local governance bodies – not only to remedy impacts caused by the chilling effect and confusion about the GGR, but also to fortify national SRHR priorities.

The commentaries in this special issue further explore intersecting impacts of the GGR, mitigation strategies, and specific country-level impacts. Opondo describes how the Trump administration's intensified attacks on SRHR inspired Kenyan anti-choice groups to target and intimidate policy makers who were in support of safe abortion guidelines. Advocates prevailed in the Kenyan High Court.[15] Bajracharya describes how youth movements in Nepal have utilised social media campaigns to challenge US rhetoric that emboldens anti-abortion extremists and propagates stigma. She describes how her own grassroots network YoSHAN is joining forces with national, regional, and international networks like Asia Safe Abortion Partnership (ASAP), International Network for the Reduction of Abortion Discrimination and Stigma (inroads), and Women's Global Network for Reproductive Rights (WGNRR) to amplify knowledge of the GGR's adverse effect on adolescents and youth in Nepal.[16]

Conclusion

Our findings show substantial impact across all three countries, regardless of the legal context of abortion. Ultimately, the changes driven by the GGR mean that fewer women have access to good quality contraceptive and other health services, resulting in unintended pregnancies and increased unsafe abortions. Our partners in this work ask: when will this harmful policy end? It is our hope that the evidence presented in this special issue will hasten its demise.

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