


## Slowing progress: the US Global Gag Rule undermines access to contraception in Madagascar

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**Abstract:** *Madagascar's health system is highly dependent on donor funding, especially from the United States (US), and relies on a few nongovernmental organisations (NGOs) to provide contraceptive services in remote areas of the country. The Trump administration reinstated and expanded the Global Gag Rule (GGR) in 2017; this policy requires non-US NGOs receiving US global health funding to certify that neither they nor their sub-grantees will provide, counsel or refer for abortion as a method of family planning. Evidence of the impact of the GGR in a country with restrictive abortion laws, like Madagascar – which has no explicit exception to save the woman's life – is limited. Researchers conducted semi-structured interviews with 259 representatives of the Ministry of Health and NGOs, public and private health providers, community health workers and contraceptive clients in Antananarivo and eight districts between May 2019 and March 2020. Interviews highlighted the impact of the GGR on NGOs that did not certify the policy and lost their US funding. This reduction in funding led to fewer contraceptive service delivery points, including mobile outreach services, a critical component of care in rural areas. Public and private health providers reported increased contraceptive stockouts and fees charged to clients. Although the GGR is ostensibly about abortion, it has reduced access to contraception for the Malagasy population. This is one of few studies to directly document the impact on women who themselves described their increased difficulties obtaining contraception ultimately resulting in discontinuation of contraceptive use, unintended pregnancies and unsafe abortions.*  
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## Introduction

While to most foreigners the country of Madagascar conjures up images of exotic flora and fauna, Madagascar is among the poorest countries in the world.<sup>1</sup> Since its independence in 1960, the country's economic growth has not kept pace with its population growth. In 2019, an estimated 75% of the population was living on less than US\$1.90 per day.<sup>1</sup> The health system is correspondingly weak, failing to meet the needs of the Malagasy population, especially the poorest who are most dependent on the public sector.<sup>2</sup> Madagascar relies heavily on foreign aid for its health services, although the country experienced a severe reduction in donor support from 2008 to 2014 as a result of a 2009 coup.<sup>3</sup> The main donors to the country's health system are the United Nations (UN), including WHO, UNICEF and UNFPA, and United States Agency for International Development (USAID). The UN agencies mainly provide support directly to the Ministry of Health (MOH) while USAID funds non-governmental organisations (NGOs) that provide services to communities, strengthen MOH capacity and support the private sector.

In addition to Madagascar's high dependence on foreign donors, health access is inequitable across regions, with 20% of the country considered to be highly isolated due to extremely inadequate transportation infrastructure, particularly in marshy or mountainous areas. Only 53% of the country's health facilities are accessible year-round from the district capital because seasonal flooding blocks roads, and 40% of the population lives more than 5 km from the nearest health facility.<sup>4</sup> In addition, health workers are concentrated in cities, leaving rural areas with fewer providers. In some areas, insecurity due to criminal banditry poses a barrier to access to health care, as people cannot travel safely in isolated areas.

Sexual and reproductive health (SRH) remains a major challenge and barrier to the wellbeing of women in Madagascar. The maternal mortality ratio of 426 per 100,000 live births clearly depicts the gravity of this issue.<sup>5</sup> Improving maternal and child health is one of the six strategic pillars of the MOH 2015–2019 Health Sector Development Plan. In 2015, Madagascar committed to Family Planning 2020 (FP2020) to increase contraceptive prevalence to 50% by 2020,<sup>6</sup> a goal they are unlikely to meet, with contraceptive prevalence in 2018 of 40%.<sup>5</sup> Unmet need for contraception is 18.4%,<sup>5</sup> well above their Sustainable Development

Goal commitment of 9.5%.<sup>7</sup> The national total fertility rate is 4.6 children per woman, although the rate for rural areas is 1.5 times that of the capital (5.0 as compared to 3.4).<sup>5</sup> Adolescent pregnancy is high with 34.7% of girls aged 15–19 having begun childbearing; this is much higher among those in the poorest quintile (49.3%) compared to the wealthiest quintile (15.8%).<sup>5</sup>

UNFPA and USAID are the major donors for SRH, including contraception. In 2017, the United States government (USG) provided 59.4% of Madagascar's official development assistance (ODA) for population and reproductive health overall, and 88.4% of ODA for family planning.<sup>8</sup> UNFPA supplies contraceptive products to public sector health facilities and its NGO partners, trains health workers, and funds activities linked to the improvement of maternal health. Similarly, USAID supplies contraceptive products to both public and private health facilities via NGOs and provides skills-based training for health workers. The MOH reported that in 2014, 85% of funding for SRH and contraceptive commodities came from USAID, followed by UNFPA (11%), with less than 1% coming from the Madagascar government.<sup>9</sup> In 2015, the MOH committed to increasing their annual financial contributions to contraceptive commodities by 5% annually and ensuring security of contraceptive commodities by 2020.<sup>6,9</sup> The government is not on track to meet either of these commitments.<sup>10</sup> The MOH convenes an SRH technical working group that includes UNFPA, USAID and partner NGOs to ensure coordination, in particular related to contraceptive supplies, and to promote common advocacy strategies, such as the registration of misoprostol for prevention of post-partum haemorrhage. In addition, the MOH coordinates with NGOs to ensure equitable access to services in areas located far from health facilities via mobile clinics. NGOs also support health facilities with training health workers to provide long-acting reversible contraceptives (LARC). While community health workers (CHWs) in Madagascar provide education, information about mobile team visits and referrals for contraception, they mostly do not provide contraceptives directly.

Madagascar has extremely restrictive laws on induced abortion with no explicit exception to save the woman's life.<sup>11</sup> Article 317 of the Madagascar penal code punishes women who voluntarily terminate their pregnancy and all persons (medical or not) who help them.<sup>12</sup> Post-abortion care, a life-saving package of services to manage complications of spontaneous or induced abortion,

is, however, permitted in Madagascar.<sup>4,13</sup> Evidence shows that abortion rates are generally similar across countries with varying legal restrictions.<sup>14</sup> Thus, despite the restricted legal situation of abortion in Madagascar, many women still seek abortions<sup>15–17</sup> and in 2015, the MOH estimated that 11.8% of maternal deaths were due to complications of abortion.<sup>4</sup> A 2016 study in 10 districts found that 11% of sexually active women aged 18–49 had had at least one induced abortion in the previous 10 years; 27.7% of these women sought care for complications after the abortion, indicating that the abortions were unsafe.<sup>16</sup> In 2007, several UN agencies raised the issue of decriminalisation of abortion; this recommendation engendered significant backlash from the Catholic Church and the President.<sup>18</sup> The MOH proposed articles permitting abortion to save a woman's life to a 2017 law on reproductive health and family planning, but these articles were removed during debate.<sup>18</sup> A December 2019 African Union delegation visit to Madagascar advocated for Madagascar's ratification of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol); resistance to its looser abortion restrictions (which requires that states authorise abortion in cases of rape, incest, fetal impairment and to preserve the mental or physical health or life of the woman) were among the main objections in the National Assembly to ratification.<sup>19,20</sup>

In January 2017, the Trump administration introduced the expanded Global Gag Rule (GGR), which requires non-US-based NGOs receiving US global health assistance to certify that neither they nor their sub-grantees will provide, refer for, counsel on, or advocate for abortion as a method of family planning with US and non-US funding.<sup>21</sup> Post-abortion care may be provided with US funding and is supported by USAID.<sup>22,23</sup> The GGR includes exceptions in cases of rape, incest or to save the woman's life. Although prior iterations of the GGR applied only to US family planning assistance (US\$575 million globally in 2016), the current policy, renamed "Protecting Life in Global Health Assistance", applies these restrictions to most US global health assistance, an estimated US\$9.5 billion in 2016.<sup>24</sup> US-based NGOs are not gagged by the policy; however, if they receive US global health funding, they must enforce the GGR when providing funds to non-US-based NGOs. The GGR was introduced as part of a larger anti-abortion policy that includes the Helms Amendment which bans US funding for

abortion<sup>25</sup> and the defunding of UNFPA on the pretext that it supports coercive abortions in China.<sup>26,27</sup>

The Madagascar MOH's main NGO partners for contraception are two international non-US NGOs; a US NGO (not subject to the GGR because it is US-based); and two small local faith-based NGOs. Both of the non-US international NGOs declined to certify GGR: although they do not provide abortion care in Madagascar due to the legal restrictions on abortion, they have a global presence supporting a woman's right to comprehensive SRH services and provide safe abortion in other countries where abortion is legal. One of these non-US NGOs is the largest MOH partner providing contraception in Madagascar, and received substantial USAID funding prior to the imposition of the GGR; the other was not receiving US funding when the GGR was introduced. When this NGO declined to certify GGR, their USAID funding to increase access to and use of high-quality, affordable contraceptive services (US\$3.5 million in fiscal year 2017 for Madagascar) abruptly ended in August 2017. This NGO provides contraceptive services in selected districts in all 22 regions, with a focus on remote rural areas, and poor or young populations, through a network of private providers and support to public health facilities (Box 1). All provide short-acting and LARC methods, while outreach teams and clinics also provide permanent methods (tubal ligation and vasectomy). The NGO also supports trained CHWs to provide education, counselling and referrals.

### Box 1. Service provision modalities of non-certifying NGO

- Mobile outreach teams visit areas with few or no other contraceptive providers.
- Community-based midwives receive training, supplies, a stipend and supervision from the NGO to provide contraception in their homes and through home visits.
- Social franchises with private providers receive training, supplies, a stipend, supervision and accreditation from the NGO.
- Public health facilities receive training and supervision from the NGO. Although these public sector facilities are supplied by the national supply chain, the NGO provided a buffer stock in case of shortages.
- NGO-run clinics: 20 clinics in 14 regions (in 2016)

*\*All provide high quality short-acting and LARC methods. Outreach teams and clinics also provide permanent methods.*

The high proportion of health sector funding coming from the USG and the sizeable contribution of non-certifying NGOs in contraceptive service provision in Madagascar suggest that the GGR would have substantial impact in the country. This study assesses the effects of the GGR on public and private contraceptive service provision and on women's ability to access contraception.

### Methodology

The Institut National de Santé Publique et Communautaire (INSPC, National Institute for Public and Community Health), in collaboration with the Heilbrunn Department of Population and Family Health, Columbia University, conducted a qualitative descriptive study to explore the impact of the expanded Global Gag Rule on SRH programmes and services in Madagascar. The study was conducted at both central and regional levels of the health system. We selected eight regions in which USAID-funded NGOs provided SRH services in 2016: Androy, Atsimo Andrefana, Atsimo Atsinana, Betsiboka, Bongolava, Diana, Itasy, and Vatovavy Fitovinany. In each region, two districts were selected: the regional capital and one within a half day's travel. In each district, we selected public and private health facilities providing SRH services, which were currently or previously supported by USAID's NGO partners.

### Sampling and recruitment of participants

At the central level in Antananarivo, key informants were recruited from the MOH department responsible for SRH programmes, the parastatal responsible for logistics and commodity management, and NGOs that provided SRH services. At the regional and district levels, respondents were selected from the following groups: MOH managerial teams including directors of various family health programmes (SRH, HIV, malaria, community health); contraceptive service providers from both public and private health facilities and regional representatives of NGOs supporting SRH service delivery. At the community level, we recruited participants from areas previously served by a non-certifying NGO's outreach teams: CHWs who provided contraceptive education and referrals, and current or previous contraceptive clients. CHWs reached out to their own clients asking if they would be willing to speak to an interviewer, and then introduced those who agreed to an interviewer. In total, 219 in-depth interviews were

**Table 1. Number of interviews, by type of participant**

Category	Number
NGO providing SRH – central level	8
NGO providing SRH – district level	33
MOH – central level	2
MOH – regional or district level	38
Service providers – public	41
Service providers – private	20
Community health workers (CHWs)	33
Contraceptive clients	44
Total	219

conducted with 259 participants (Table 1). Some MOH teams were interviewed as a small group.

### Study procedures

INSPC and Columbia researchers developed semi-structured interview guides for four categories of participants: MOH representatives, NGO representatives, health providers, and clients. Guides were developed based on the hypothesised impact of the GGR, informed in part by research on previous iterations of the policy.<sup>28</sup> The guides addressed potential changes in funding, technical support, supplies and service utilisation with respect to contraception, post-abortion care and other health services. Clients were asked about changes in the access, availability and cost of contraceptive methods and services. The interview guides were piloted in a district that was not included in the study, and subsequently modified for clarification. Four teams of three trained interviewers experienced in SRH research conducted the interviews in local languages or French, according to the respondent's preference. Before each interview, interviewers provided an explanation of the study from an information sheet, stated that participation would have no effect on their job status or access to health services, and obtained verbal consent to participate in an audio-recorded interview. The interviews took place at three time periods: central level interviews in May–June

2019, regional and district level interviews in July–August 2019 and February–March 2020.

### Data analysis

Interviews were transcribed, translated into French, checked for accuracy and de-identified before being uploaded into NVivo 12 (QSR International) for coding. Researchers from INSPC and Columbia University (fluent in French and English) read a sample of transcripts to develop a draft codebook based on the themes in the interview guides and then coded several transcripts together. A team of three INSPC researchers independently coded a sub-set of transcripts, met to establish inter-coder reliability, and identified additional codes if needed. They then coded the remaining transcripts independently. After coding, researchers conducted thematic content analysis to identify emerging themes related to how the GGR impacted NGOs, providers and clients. Authors fluent in English and French wrote the final analysis in this paper in English.

We obtained ethical approval from the National Ethical Committee for Biomedical Research of Madagascar (007-MSANP/CERBM) and the Institutional Review Board of Columbia University (AAAR6802).

### Results

Our findings revealed the causal pathway of the GGR's impact in Madagascar (Figure 1), similar to

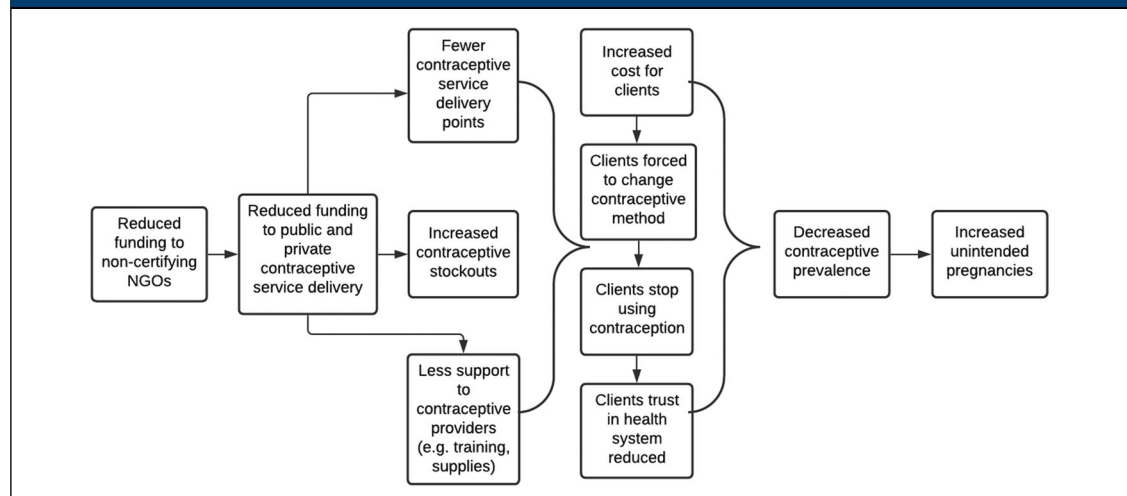
that hypothesised and detected elsewhere.<sup>28–32</sup> Reduced funding to NGOs who do not certify the GGR resulted in the closure of and reduced support to contraceptive service delivery points, leading to stockouts and increased costs for clients. This ultimately resulted in women discontinuing contraceptive use and experiencing unintended pregnancies. In Madagascar, the primary impact of the GGR was through the defunding of the MOH's primary partner NGO for contraception. We present results below by level of impact, beginning with a brief summary from affected NGOs, followed by the health system and health workers, and finally the impact on clients.

### Impacts on NGOs

We interviewed Antananarivo-based representatives of eight non-governmental or international organisations involved in SRH service delivery in Madagascar. Most of the representatives had limited knowledge of the GGR; however, the major MOH partners for contraception were more familiar with the GGR and its impact.

When the large non-certifying NGO mentioned previously lost its USAID funding in mid-2017, it was forced to end support to over 100 public and 90 private health facilities, return 12 vehicles used for mobile outreach teams, and end its contraceptive voucher programme for adolescents. In addition, the NGO no longer received contraceptive commodities from USAID. When USAID recalled the 12 vehicles used for outreach, it transferred

Figure 1. Causal pathway of GGR impact in Madagascar





them to a US NGO. Although the non-certifying NGO returned the vehicles to USAID in mid-2017, the US NGO reported receiving them and additional USAID funding only in January 2019, leaving a gap of well over a year. The non-certifying NGO's outreach services served an average of 200,000 clients and the voucher programme reached 25,000 young people annually.

Although the non-certifying NGO was able to replace some of the vehicles via a private donation, they lacked funding to cover training, salaries, and maintenance for the mobile clinics. The \$3.5 million they received from USAID represented nearly half of their total funding in 2017; they managed to replace about \$1 million of this lost funding in 2018. The imposition of the GGR also entailed significant transaction costs to this NGO. When they lost their USAID funding, their leadership spent around 50% of their time – 80% of the country director's time – trying to fill the funding gap created by the GGR. These transaction costs were incurred by other NGOs as well. For example, a US NGO also described time spent on administrative efforts to create a clear separation between their USG and other funding streams, so that the GGR would not impact those funded activities, even though US NGOs are not subject to the GGR. To fully separate financial management, they had to increase the number of staff and duplicate some roles.

Respondents from non-certifying NGOs described that they continued to participate in a contraceptive task force convened by the MOH that included USG-funded NGOs. However, one also commented that national contraception workshops at which all partners presented their commodity needs to the MOH and donors had now split into separate events for USG partner NGOs and other NGOs.

### Impacts on providers in the health system

We conducted 165 interviews with providers in 8 regions, including regional and district MOH ( $n = 38$ ) and NGO representatives ( $n = 33$ ), public and private/NGO providers ( $n = 61$ ) and CHWs ( $n = 33$ ) (Table 1). Many participants described ways in which the defunding of a major non-certifying NGO partner affected their work (Figure 1). Few major differences were noted between public versus private providers. Thus, in the following paragraphs, references to “providers” includes those from both public and private health facilities unless otherwise specified.

Several respondents mentioned the reduction in outreach visits provided by the large non-certifying NGO. For example, in one region the non-certifying NGO reduced the number of outreach teams from two to one; this team now had to cover six districts, resulting in fewer visits to each. These outreach teams served clients in some of the poorest and hardest-to-reach areas of Madagascar, and were often the only providers of LARC or permanent methods. The end of outreach services from the non-certifying NGO meant women living in these areas no longer had access to contraception, unless they travelled further and spent more money to obtain it. A regional MOH representative remarked that this NGO's outreach services reached very isolated communities, areas that the MOH could not reach, and represented a substantial loss when they ended.

In addition to the end of the outreach services, district and regional MOH representatives lamented the reduction in the number of public health centres that received support from the NGO for contraception from “many” to four in one district and by half in another district due to the funding reduction. Another regional representative commented on reduced outreach services and the impact on contraceptive prevalence and increased numbers of women coming to antenatal care with unintended pregnancies as a result.

*“The [non-certifying NGO] can reach isolated areas with its outreach teams... And we at the regional level, we work with the health system at the health facility level, but not in the fokontany [collection of villages] through the advanced [outreach] strategy like the [non-certifying NGO] did... [Women] asked about the failure of the outreach vehicle to come through because people don't always have the time to reach the health facility. So, if you are in the bush, you always hear these questions, especially complaints from clients following the end of these outreach visits these days, especially where the health center and hospital is several kilometers away.”* (Regional MOH representative 20, Betsiboka)

As mentioned earlier, although USAID reportedly transferred 12 vehicles from the non-certifying NGO to a US NGO, there were substantial delays before the US NGO launched the outreach teams. Some of the new outreach teams were deployed to different areas, abandoning those served by the non-certifying NGO. We do not know if the number of beneficiaries remained the same as participants did not share this detail.

In addition, some providers expressed frustration that the US NGO imposed different practices, such as not providing stipends to CHWs for community mobilisation prior to the outreach team's arrival. One public provider also noted that, in addition to hosting outreach team visits, they had also received contraceptive supplies from the non-certifying NGO, something the US NGO did not provide. A CHW who educated the community about contraception and the timing of the NGO mobile outreach team visits said they had not done any community mobilisation in the past year due to the departure of the non-certifying NGO.

*“Then, there were still the outreach teams that came here and this causes us problems because the CHWs are already used to receiving motivation [stipend] from them, and if there is no motivation, ... financial, I mean, they do their job badly ... Since the [US NGO] announced that there will be certain changes, and in particular with respect to the question of motivation, CHWs have lost their diligence.”* (Public provider 32, Atsimo-Atsinanana)

*“I didn't do any awareness raising in 2019 because the [NGO outreach team] didn't come this year.”* (Community health worker 14, Betsiboka)

Public and private providers supported by the non-certifying NGO described reductions in staff stipends, training, supplies and supervision resulting from the loss of US funding. Some NGO-supported facilities reduced the number of health workers providing contraception. Providers expressed concern about decreases in the quality of care they provided. One community-based midwife previously affiliated with the non-certifying NGO said the funding cuts forced her to reduce the number of sites she visited by half. The loss of training from the non-certifying NGO meant that providers no longer received updates to clinical practice. In addition, new staff hired to replace those who left did not receive training, inhibiting their ability to provide LARCs to clients.

*“[Regarding training] We don't know any more what has changed in terms of new recommendations on prescription, reception of clients, contraception. In medicine, there is always new knowledge, changes ... Therefore, your knowledge is outdated, we no longer receive knowledge updates.”* (Public provider 25, Betsiboka)

*“A comment on contraception in terms of training, because we have a new additional provider who is*

*trained neither on long-acting methods, nor on Depo Provera, nor on the management of adverse side effects ... So, she should be trained. In addition, at the time of our collaboration with [non-certifying NGO], we had CHWs who approached women about contraception.”* (Public provider 27, Betsiboka)

Participants described problems with the contraceptive commodity supply chain across Madagascar that were a persistent national issue, further exacerbated by the GGR. They reported periodic stockouts of contraceptive injectables, pills and implants. Several public providers said that the non-certifying NGO supplemented their MOH supplies by providing buffer stock to avoid stockouts. However, once that support ended, they too experienced stockouts of multiple methods.

*“There were no pills, no injectables, no Implanon [implant]. The MOH district office did not provide us with any products, all the more [important] since [non-certifying NGO] doesn't collaborate with us anymore.”* (Public provider 27, Betsiboka)

*“In addition, we were in cooperation with [non-certifying NGO] so they provided us with products. When our stocks ran out, [non-certifying NGO] gave us the products so there was no shortage. But currently, we are no longer in collaboration with [non-certifying NGO], so they no longer visit us.”* (Public provider 40, Anosy)

Providers reported that when they were stocked out of a woman's preferred method, they offered her a different method that was in stock, or sent her to a pharmacy to purchase it and bring it back so they could administer it (in the case of injectables). In addition, health workers in different regions described providing contraceptive commodities and services free or at low cost when they received support from the non-certifying NGO, especially for lower income and young women who received vouchers. However, with the loss of support, clients were now asked to pay for their method, and sometimes also the necessary supplies needed to safely inject or insert the contraceptive method. Several providers commented that while purchasing the method was feasible for some, women coming from rural areas and adolescent women were often unable to pay the cost. Health workers, CHWs and regional and district MOH representatives described a drastic and noticeable decrease in contraceptive utilisation in

the population as result of the stockouts and increased costs.

*“The impacts are really tangible concerning FP [family planning]. Because people are already used to free FP services. Then, when they were asked to buy them, the numbers lost to follow-up increased. Many women are lost to follow-up. And even our coverage rate has decreased, decreased, decreased. We can even say that the impacts in our district were catastrophic because of this disruption of products.”* (District MOH representative 34, Androy)

Many providers described elevated frustration and disappointment amongst their contraceptive clients about the cost of services that were once provided for free, as well as the unavailability of their preferred methods. Multiple providers talked about the ways in which this situation resulted in decreased client trust in them and the health facilities. One private provider referred to deceptive and unsafe practices among some drug sellers which would further erode women’s trust in contraception.

*“Yes, we have monthly meetings ... with the CHWs. We took the initiative to educate people to continue to come pick up methods at the health center despite the frequent stockouts. And these situations lead the community to lose confidence in us. To avoid this, we try and try to explain the reality to the community ... What is sad is that it’s us who come into conflict with the community. This is one of the major problems with our health system.”* (Public provider 32, Atsimo-Atsinanana)

*“At a certain point, both we and the public health center had a stockout. At that time, those who had methods sold them at very high prices. And then some of them divided one vial of Depo into two doses for sale ... Women complained that they got pregnant even while using Depo.”* (Private provider 1, Itasy)

Several providers reported seeing an increase in the number of unintended pregnancies, including among adolescents, demonstrated by an increase in the number of antenatal care visits. They also described seeing increasing numbers of post-abortion care clients after unsafe abortions; one provider noted that the majority of these cases were adolescents.

*“What is happening is that ... the fact that people who are used to free care must now pay affects them a lot. Since after the free care ended, users*

*had two choices: either they change methods or they decide to stop. And we can assess the effects by the increase in the number of ANC [antenatal care] visits. Especially among the under 18 year olds. High risk pregnancies are on the rise. This weighs on our health facility since there are complications to prevent.”* (Public provider 32, Atsimo-Atsinanana)

### Impact on contraceptive clients

We interviewed 44 current or previous contraceptive users in eight regions. Consistent with reports from providers, the vast majority of clients interviewed reported increased difficulties obtaining their preferred method while a few reported no change in their access to contraception.

Many clients described multiple obstacles when attempting to procure contraceptive methods and services in the past year. Women reported looking in multiple pharmacies and health facilities when their regular provider was stocked out of their preferred method, often the injectable. Some were able to purchase the method in a pharmacy, but sometimes the pharmacy too was stocked out. In some cases, women had to purchase methods at local grocery stores or from unqualified providers. While a black market for contraceptives always existed, the sale of these products by unregulated informal suppliers appeared to increase in some locations with the advent of GGR. Others reported a different experience each time they came for their next dose, making it difficult to continue uninterrupted method use: sometimes it was available, sometimes they had to go buy it in a pharmacy, and sometimes they just had to stop using contraception or switch methods because they couldn’t find it at all.

*“Since 2018, I started to use the [injectable] irregularly following the stockouts. As usual, at each stockout, we had to go to the pharmacy, but sometimes the pharmacy didn’t have it either.”* (Contraceptive client 36, Atsimo-Atsinanana)

*“I used the injectable and when I came here, there was none and they told me to go buy it in the pharmacy. I bought it at the pharmacy and I came back here for the injection. After 3 months, I came back and the method was available, and after that, there was none, so I stopped the injectable.”* (Contraceptive client 42, Androy)

*“I didn’t change health centers, but I changed services because I was using the injectable, so I changed*



*to the method in the arm [implant] because they had no more injectables.*" (Contraceptive client 17, Menabe)

Increased cost was a common barrier described, an insurmountable one for many. Most clients reported receiving their method previously at no or a very low cost. Many women reported current prices that were two to five times the original price, up to 5000 Malagasy Ariary (~US\$1.35), placing them out of reach (average daily wage is 3000 Ariary).

*"I was using the injectable but then they started charging for it, but I still made an effort to continue because I already have too many children. I am mostly used to injectables, they were free before. Now, they are no longer free, so I changed and use oral pills now."* (Contraceptive client 44, Anosy)

The high cost created problems for many women who described having to choose between using contraceptives and buying food for their families. These choices often resulted in an unintended pregnancy. Women explained that they had to find additional work to earn money to purchase their contraceptive method.

*"[Buying the method has been a] problem because the money is needed to buy food for the family, but you have to take some out to buy the method."* (Contraceptive client 18, Betsiboka)

*"And now, there are none at the public health center, so the injectable is so expensive. It costs 3000 Ariary at the pharmacy. And because we are poor, we didn't go to school, we can't find a job with a good income. So, we work as a launderer, we look for jobs that require heavy labor during the day to find money for the injectable. We sell wood to get money for the injectable. For this purpose, we have no more to survive on. And now, I'm pregnant when I didn't want to be. You know, with the difficulty of life, the lack of money, you can't find the money, and suddenly, I'm pregnant."* (Contraceptive client 39, Androy)

*"Life is hard here. During times of cultivation, when it's not raining, there is no income generating activity you can do. To have money, you have to sell your plates [a sign of severe poverty in Madagascar] and buy new ones only when the harvest is good."* (Contraceptive client 42, Androy)

Overall, clients reported inconsistent contraceptive use because of the stockouts and increased cost. In some cases, clients purchased their method

at the pharmacy until they could no longer afford to, then obtained condoms from the CHW until those too were stocked out, ultimately attempting the calendar method, switching methods or stopping altogether. Some clients reported switching methods again because the calendar method was just too difficult to implement with their partner. Others complained of side effects after switching methods, especially to pills, which led them to stop use. Some women resorted to using traditional but ineffective or dangerous methods to prevent pregnancy and ended up pregnant.

*"Some make a decoction, they go to the midwife and make a decoction whereas there are side effects; they think it may work but are then disappointed when after 6 months they end up pregnant. This happens."* (Contraceptive client 22, Bongolava)

Women also described frustration with the health workers who could not explain why they did not have the methods as expected, nor when they expected to have them or why they had to pay more for them.

*"They [health workers] said that they already ordered the contraceptive products but that we have to wait. But up to now, women are tired of looking everywhere for the products because sometimes we can find them and sometimes we can't. Some changed their method and chose Implanon [implant], others accepted pills unwillingly. But me, I only want the injectable."* (Contraceptive client 15, Atsimo-Atsinanana)

As also mentioned by the providers, many women described that they themselves, and other women they knew, ended up with an unintended pregnancy because they had to stop using contraception.

*"But this one is the daughter of my husband's brother, and I asked her why did you do that? You already have many children and you know that life is hard. She told me that she couldn't get the injectable at the hospital and tried the thing in the arm [implant], but removed it because she couldn't tolerate it and suddenly, she got pregnant."* (Contraceptive client 18, Betsiboka)

*"Some were not careful, and they got pregnant like my sister – she got pregnant."* (Contraceptive client 35, Vatovavy Fitovinany)

*“To be honest, I’m not ready yet to have another child, not ready yet but ... here it is, it’s like that now.”* (Contraceptive client 24, Bongolava)

Women reported additional consequences of their unintended pregnancy, including increased economic difficulties and hardship. One young woman said that she had to quit school because she became pregnant.

*“I am sad [because of my pregnancy] especially because I had to quit my studies.”* (Contraceptive client 41, Androy)

*“As a result, I got pregnant since the method wasn’t there. Food is already difficult to find, and we aren’t able to buy medicines because there are none in this health center. The truth is that I didn’t choose to get pregnant; it’s because of the stockout.”* (Contraceptive client 43, Androy)

A few clients also described that they or other women they knew terminated their unintended pregnancy. One woman said she had too many children already, and described her efforts to continue her preferred method (injectable). She became pregnant and induced abortion by drinking some concoction. She ended up seeking post-abortion care at a health facility after – another cost she could not afford.

**Interviewer:** *And if everything had a fee in the end, why not buy the method that you prefer?*

**Respondent:** *Because I didn’t have enough money ... I got pregnant, but I had an abortion.* (Contraceptive client 44, Anosy)

## Discussion

Our results clearly demonstrate substantial impact on contraceptive service delivery, and ultimately on women and girls, in Madagascar. When a major MOH partner declined to certify the GGR and lost their USAID funding, they closed multiple contraceptive service delivery points, causing disruptions in women’s access to contraception and resulting in an increase in unintended pregnancies and subsequent abortions – purportedly the opposite of GGR’s intended objective. During an initial visit to Madagascar by two authors to discuss the proposed study, several stakeholders wondered why we would bother conducting a study on the GGR in Madagascar where abortion is highly restricted and therefore the GGR would presumably have little effect. Our findings plainly show that it is incorrect to assume the GGR has no impact in countries with restrictive abortion laws.

The GGR exacerbated existing problems with contraceptive commodities in Madagascar, including delayed fulfilment of the government’s contraceptive order by international suppliers in late 2017. As described earlier, UNFPA and USAID are the major sources of funding for contraceptives in Madagascar. The imposition of the GGR and the Trump administration’s defunding of UNFPA<sup>26</sup> coincided with the end of a United Kingdom-funded grant in 2017 with which UNFPA provided contraceptives in Madagascar. The confluence of these events resulted in greater demand on UNFPA for contraceptives as non-certifying NGOs lost USAID funding at a time when UNFPA had less funding to meet these higher needs. UNFPA increased their support for contraceptives to non-certifying NGOs in late 2017, but was unable to fully meet the need previously funded by USAID. In fact, Madagascar’s update on its FP2020 commitments specifically referenced USAID’s defunding of the non-certifying NGO as a threat to the resilience of their contraceptive programming.<sup>10</sup> Moreover, multiple key informants mentioned that administrative delays at the USG mission during a shift of funding from the non-certifying NGO to a US NGO further exacerbated supply problems in the country.

In addition to exacerbating contraceptive supply problems in Madagascar, the GGR increased stress on an already fragile health system. As described earlier, the country relies heavily on donor funding for the health sector: 72% of the health sector is funded by external resources, meaning that funding is not always best aligned with MOH priorities.<sup>3</sup> Given that the USG provides a majority of SRH funding in Madagascar, any changes in USG health funding would have outsized impacts in the country. Several USAID-funded projects implemented by US NGOs (which are not gagged) also provide support to the MOH on related topics such as training, post-partum contraception, and the SRH supply chain.<sup>33</sup> In its planning, the MOH aims for an equitable distribution of support by designating areas of intervention among their partners. When the USG abruptly removed funding from a key partner, it was highly probable that it would destabilise the health system. The MOH considers this NGO a critical partner to reduce inequity by working in remote and rural areas of the country underserved by the public sector, where few other partners invested, and targeting key marginalised populations including the poor and youth. The GGR thus threatens the government’s

ability to choose and maintain partnerships as well as ensure that health services are distributed equitably around the country. Unlike in other countries where the GGR has negatively impacted national coordination,<sup>34–36</sup> we found limited evidence of reduced participation of certifying or non-certifying NGOs in national contraceptive task force meetings, perhaps due to the small number of SRH partners and sizeable role of the non-certifying NGOs in contraceptive provision.

The GGR ostensibly does not reduce the amount of global health funding given, but only changes the partners that receive the funding for programme implementation. Unfortunately, we were unable to find accurate data on USG allocation and expenditures in Madagascar, making it difficult to determine whether the full funding removed from the non-certifying NGO was given to other NGOs. However, even if the amount of money remains constant, it takes time for a new funding recipient to complete administrative requirements for a grant and then to fully engage and train needed staff, obtain supplies and equipment, and establish appropriate partnerships, especially if the new NGO is entering an area of the country where it did not previously work, as was the case in Madagascar.<sup>28</sup> For example, NGOs reported a gap of over a year between the time vehicles for mobile outreach services were recalled from the non-certifying NGO and when they were given to a US NGO with funding. It took additional time to staff, train and equip the mobile clinics before they could be used. As mentioned above, multiple key informants, from both NGOs and MOH, commented on severe and noticeable gaps in service delivery during USAID's transfer of funding from the non-certifying NGO to other NGOs. The US Department of State's second review of GGR implementation released in 2020 confirmed these impressions, finding that the USAID Mission in Madagascar needed additional time to identify new partners to implement contraceptive programming that the non-certifying NGO was providing with its USAID funding, which targeted poor and rural populations through mobile outreach to communities.<sup>37</sup> It is unsurprising that highly skilled SRH NGOs with unique SRH expertise may not be easy to replace, particularly in a country like Madagascar which has few specialised NGO partners, and where the non-certifying NGO worked at a large scale, providing contraceptives to a significant proportion of Malagasy contraceptive users.

The strain placed by the GGR on an already weak health system and the closing of or reduced support to contraceptive service delivery points ultimately contributed to negative impacts on Malagasy women's use of contraception and unsafe abortion. The vast majority of the clients interviewed described difficulties in obtaining contraception since 2017. Many women described increased cost as a major barrier. Studies have found that the removal or reduction of service fees has been associated with increased SRH service utilisation,<sup>38</sup> suggesting that fees deter utilisation. Research with adolescents in particular suggests that cost impacts the decision to use SRH services and where to seek them.<sup>39,40</sup> An important programme that was cut by USAID's defunding of the non-certifying NGO provided vouchers via CHWs that young people and low-income clients used to receive free contraceptive and STI services; over 18 months in 2013–2014, clients redeemed 43,352 vouchers, 78.5% of these for LARCs.<sup>41</sup> Voucher programmes have been shown to increase SRH access and utilisation among women for whom cost is a barrier.<sup>42</sup>

Our findings demonstrated an increased sense of frustration amongst contraceptive clients, which may result in increased mistrust of the health system over the long term. Some women blamed health facilities or providers for the stockouts and increased cost of their methods, similar to findings in Uganda where women misinterpreted stockouts as health workers' refusal to administer services.<sup>43</sup> When the preferred method was not available, providers encouraged women to change contraceptive methods, a move that impacts women's autonomy and further contributes to mistrust of health workers/facilities.<sup>44</sup> Stockouts and women's inability to obtain their method of choice are among the issues of service quality that are associated with contraceptive discontinuation.<sup>45–48</sup> Stockouts are an important problem in countries like Madagascar where short-acting methods are popular. As supported by our research, inconsistency in the availability and cost of supplies can result in an overall reluctance to continue engaging with the health system.<sup>49,50</sup> This mistrust may be long-lasting and may continue past any future improvements in the availability of contraceptives.

### Limitations

This study has several limitations. While we were able to interview many of the main NGOs working

on SRH, we were unable to secure interviews with several non-US NGOs working on other health issues that received USG global health funding and may have been impacted by the GGR. A few NGOs working on SRH were only interviewed at district or regional level where knowledge of the GGR was lower. Many respondents had limited knowledge of the GGR, which contributed to difficulties in attribution. As mentioned above, multiple factors affected stockouts in Madagascar, further complicating attribution. However, we conducted interviews in districts previously served by a major NGO that lost USG funding when it declined to certify GGR. The provider transcripts were scrutinised for references to affected NGOs or service providers supported by them to ensure that quotes referred to GGR impacts. The contraceptive clients were largely unaware of the GGR, and also less likely to mention an NGO. However, we recruited clients in areas served by providers supported by the affected NGOs and therefore believe that many of the difficulties they referred to were the result of, or at least exacerbated by, the GGR.

### Conclusion

In a country like Madagascar that is highly dependent on donor funding for its health system, and on the USG specifically for SRH, the impact of the GGR has been devastating despite the fact that the country has a more restrictive abortion law than that of the policy itself. These findings could be used to advocate for the government to reduce its dependence on foreign donors. Although the GGR is ostensibly about abortion, it has reduced access to contraception and increased inequities in the Malagasy population. Removal of funding

for a primary MOH partner for contraception substantially reduced access to contraception, particularly among groups prioritised by the MOH, including youth and those living in remote areas, likely increasing inequity. The cessation of funding to this NGO has slowed the country's momentum towards achieving its global health goals, including Sustainable Development Goals, ICPD25<sup>51</sup> and FP2020 commitments. This is one of few studies to directly document the impact on women who themselves described their increased difficulties obtaining contraception ultimately resulting in discontinuation of contraceptive use, unintended pregnancies and unsafe abortions. The GGR clearly violates widely shared norms related to country driven development, equity, and aid efficiency. It is imperative that the USG stop hindering Madagascar's, and other countries', ability to promote women's rights and health.

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*No potential conflict of interest was reported by the authors.*

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## Résumé

Le système de santé malgache est extrêmement dépendant du financement des donateurs, en particulier des États-Unis d'Amérique, et compte sur quelques organisations non gouvernementales (ONG) pour assurer des services de contraception dans les zones écartées du pays. L'administration Trump a

## Resumen

El sistema de salud de Madagascar depende mucho del financiamiento de donantes, especialmente de Estados Unidos (EE. UU.) y depende de unas pocas organizaciones no gubernamentales (ONG) para proporcionar servicios de anticoncepción en regiones remotas del país. El gobierno de

rétabli et élargi la « Global Gag Rule » (ou règle du bâillon mondial) en 2017 ; cette règle oblige les ONG non américaines recevant des fonds internationaux pour la santé de la part des États-Unis à certifier que ni elles-mêmes ni leurs bénéficiaires ne pratiqueront l'avortement, ne donneront de conseils en matière d'avortement ni ne feront la promotion de l'avortement comme méthode de planification familiale. Les données sur les répercussions de la règle dans un pays avec des lois restrictives sur l'avortement, comme Madagascar qui n'a pas d'exception explicite pour sauver la vie de la femme, sont limitées. De mai 2019 à mars 2020, les chercheurs ont réalisé des entretiens semi-structurés avec 259 représentants du Ministère de la santé et d'ONG, des prestataires publics et privés de services de santé, des agents de santé communautaires et des clients de services de contraception à Antananarivo et dans huit districts. Les entretiens ont mis en lumière les conséquences de la règle du bâillon mondial sur les ONG qui n'avaient pas présenté de certificat et avaient perdu leur financement américain. Cette réduction des fonds a abouti à une diminution des points de prestation de services contraceptifs, notamment les services mobiles avancés, un volet essentiel des soins dans les zones rurales. Les prestataires publics et privés ont signalé une multiplication des ruptures de stock de contraceptifs et une hausse des frais facturés aux clients. Même si la règle du bâillon mondial concerne ostensiblement l'avortement, elle a aussi réduit l'accès de la population malgache à la contraception. C'est l'une des rares études à documenter directement l'impact sur les femmes qui ont-elles-mêmes décrit leurs difficultés grandissantes pour obtenir une contraception, ce qui aboutit en fin de compte à l'interruption de l'emploi de contraceptifs, des grossesses non désirées et des avortements à risque.

Trump restableció y amplió la Ley Mordaza en 2017; esta política exige que las ONG con sede fuera de EE. UU. que reciben financiamiento de EE. UU. para la salud mundial certifiquen que ni ellas ni sus sub-beneficiarios proporcionarán servicios de aborto ni brindarán consejería ni referencias relacionadas con el aborto como método de planificación familiar. Existe limitada evidencia del impacto de la Ley Mordaza en un país con leyes restrictivas relativas al aborto, como Madagascar, que no tiene ninguna excepción explícita para salvar la vida de la mujer. Entre mayo de 2019 y marzo de 2020, los investigadores realizaron entrevistas semiestructuradas con 259 representantes del Ministerio de Salud y ONG, prestadores de servicios de salud de los sectores público y privado, agentes de salud comunitaria y usuarias de anticonceptivos en Antananarivo y en ocho distritos. Las entrevistas destacaron el impacto de la Ley Mordaza en las ONG que no certificaron la política y perdieron su financiamiento de Estados Unidos. Debido a esta reducción de fondos, disminuyeron los puntos de entrega de servicios anticonceptivos, entre ellos los servicios de extensión móvil, un componente esencial de los servicios en las zonas rurales. Los prestadores de servicios de salud, tanto públicos como privados, informaron un aumento en los desabastecimientos de anticonceptivos y en las tarifas cobradas a las usuarias. Aunque la Ley Mordaza aparentemente está relacionada con el aborto, ha reducido el acceso de la población malgache a la anticoncepción. Este estudio es uno de los pocos que documentan directamente el impacto en las mujeres, quienes describieron mayores dificultades para obtener anticoncepción, lo cual causó el abandono del uso de anticonceptivos, embarazos no deseados y abortos inseguros.