



Prescribing Chaos in Global Health

The Global Gag Rule from 1984-2018



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Letter from the President

The global gag rule (GGR)—officially known as the Mexico City Policy and, under the Donald Trump administration, Protecting Life in Global Health Assistance (PLGHA)—is a failed, outdated, and deadly policy. The GGR prohibits foreign non-governmental organizations (NGOs) that receive certain categories of U.S. foreign assistance from using their own, non-U.S. funds to provide abortion services, counseling or referrals, or to advocate for the liberalization of abortion laws, except in cases of rape, incest, and life endangerment of the pregnant woman. This report maps the policy's development and implementation from 1984 to the present, and outlines the policy's impact both on organizations and programs that receive U.S. foreign assistance and on those that do not. The report also traces the politics that drive the policy, the human rights implications, and overall health systems impacts. CHANGE developed this report based on a scoping review, stakeholder interviews, in-country fieldwork, and additional research carried out in partnership with other organizations.

Throughout this report, CHANGE seeks to document the breadth of the GGR's impacts on civil society and health systems. For example, CHANGE provides evidence that the GGR under President George W. Bush had consequences outside family planning programs, and that it adversely impacted a wider range of health services provided by foreign NGOs.¹ Some of these impacts were mitigated when President Barack Obama rescinded the policy, but the harmful effects have been shown to linger, particularly as each iteration has become more oppressive, culminating now with the Trump GGR.

In this report, CHANGE contributes valuable research on the impact of the expanded Trump GGR—the most sweeping version of the policy yet—which has had immediate, direct, and potentially devastating ramifications, not only for women's health, but for all health services for women, men, and children. The report details the loss of services directly caused by the Trump GGR around the world, which is already inhibiting in-country programs from managing critical health issues including: sexual and reproductive health; HIV; the health of adolescent girls and young women; maternal, newborn and child health; nutrition; water, sanitation, and hygiene (WASH); Zika; and more. In addition to outlining the specific health impacts, CHANGE explores the uncertainty and confusion created by the Trump GGR, its impact on funding and partnerships, and the chilling effect on health provider–patient dialogue as well as on local NGO advocacy.

CHANGE concludes with recommendations for organizations, funders, researchers, and policymakers, including a decisive appeal to abolish the GGR forever because of its destructive impact on health and human rights around the world.



Serra Sippel
President

Background

I. THE GLOBAL GAG RULE (GGR): AN OVERVIEW

First announced by the administration of President Ronald Reagan at the International Conference on Population and Development (ICPD) in Mexico City in August 1984, the GGR is a destructive policy that endangers lives and violates human rights around the world. The GGR mandates that for foreign NGOs to receive U.S. foreign assistance for family planning, they cannot perform or actively promote abortion as a method of family planning, *even if they paid for such activities with their own, non-U.S. funds.*² Foreign NGOs include both foreign nonprofit and for-profit organizations.³

Abortion is considered a method of family planning “when it is for the purpose of spacing births,” including for the physical or mental health of the woman or in cases of fetal abnormalities.⁴ Activities that are prohibited under the GGR include:

- Provision of abortion as a method of family planning;
- Counseling and referrals for abortion as a method of family planning;
- Conducting public information campaigns on the benefits or availability of abortion; and
- Advocating for the liberalization of abortion laws or lobbying for the continued legality of abortion.⁵

The policy includes exemptions in cases of rape or incest, or if the life of the pregnant woman is at risk.⁶ It does not apply to foreign governments or directly to U.S.-based NGOs.⁷

“For me, the problem with explaining the global gag rule, whether in its original or expanded form, has always been that it comes across as counterintuitive. That is, you are essentially being asked to explain to a country partner that, not only can you not use the U.S. government funding that we are providing to you under this award to offer these services, but that in order to receive these U.S. government funds, you cannot use your own money from any other donor or internal resource to offer these services. That just doesn’t make sense.”

—Representative of a health research organization

The untenable choice foreign NGOs face—either to stop conducting abortion-related work or lose their U.S. funding—is only the beginning of the GGR’s far-reaching impacts. Both paths lead to actual cuts to health services and information, often resulting in irreparable damage for people and entire communities. There are countless points of confusion and instances of harm caused by this U.S. government intrusion into the provider–patient interaction. Historically, the GGR has targeted NGOs that receive U.S. funding for family planning because safe and legal abortion services are often included in comprehensive family planning programs.

What's in a name?

The Mexico City Policy came to be known among human rights and global health advocates as the “global gag rule” because it uses fiscal pressure⁸ to stifle, or “gag,” health providers, counselors, advocates, and NGOs that provide abortion services.

In this report, CHANGE uses the term “global gag rule” (GGR) to refer to the Mexico City Policy. Although the Trump administration has renamed the GGR “Protecting Life in Global Health Assistance,” most of those interviewed for this report will not call the policy by its current moniker, finding the mere mention of it objectionable.

“The name is not a minor thing—symbolically, the framing and the message that that sends,” one interviewee said.⁹ “The name, Protecting Life, already sends a message. Because if you think that the global gag rule, in the expression of the money, is a way to censor the ability of folks like ours to do the work we need to do, it’s also a wink to those who are opposing it.”

A. Policy compliance

When the GGR is in effect, organizations must decide whether to comply with the policy—and curb their abortion-related work in exchange for receiving U.S. funding assistance—or not comply and consequently lose their U.S. funding. When an NGO accepts a funding award from the U.S. government, a set of requirements and conditions known as Standard Provisions are attached to the award. These provisions include the GGR when the policy is in effect.

Once an organization certifies an award that attaches the GGR as a Standard Provision, it automatically agrees to comply with the policy as part of the funding conditions. This can create confusion, because the policy is included as one of many terms mandated by the donor, so NGOs may not even know it is included as part of their award when they certify it. To illustrate, the Trump GGR appears on page 83 of United States Agency for International Development (USAID) Standard Provisions.¹⁰ Much

like the “fine print” in any agreement, organizations may not be fully aware of all terms included in the agreement when they sign. Many simply believe they are agreeing to accept funding when, in fact, they are agreeing to adhere to the GGR at the same time.

The NGO that certifies the funding agreement, the “prime partner,” has the direct fiscal relationship with the U.S. government. Both foreign NGOs and U.S.-based NGOs can be prime partners. Although the GGR does not apply directly to U.S.-based NGOs, they are required to pass down the policy to any foreign organizations with which they work on a U.S.-funded project. These foreign NGOs, which are known as “sub-grantees,” “sub-recipients,” or “sub-primes,” often have no direct contact with the U.S. government and rely on the prime partner to explain and monitor their compliance with the policy. This indirect relationship often hinders their understanding of the GGR.

About prime partners and sub-grantees

A “prime partner” is an organization that receives U.S. funding directly from the U.S. government. Both U.S.-based NGOs and foreign NGOs can be prime partners. All U.S. funding and policy requirements are passed down from prime partners to their sub-grantees.

A “sub-grantee,” “sub-recipient,” or “sub-prime” is an organization that receives U.S. funding from a prime partner, rather than directly from the U.S. government. Sub-grantees are one step removed from a direct relationship with the U.S. government, and communications about their funding are filtered through the prime partner.

Because the GGR is embedded in funding agreements, many organizations do not realize that the policy applies to their work. NGOs are expected to alter activities, services, information, and even interactions with patients to be in compliance with the GGR. This becomes painfully clear, one respondent said, when “the individual provider... who isn’t involved in any of the policy conversations... is then put in the awful position of having to deliver health care but basically has his or her hands tied the whole time by an entity in another country that s/he doesn’t know or can’t see.”¹¹

B. Politics of the policy

The GGR is a presidential memorandum, and not legislation, and as such the president alone has the power to revoke and reinstate the policy at will. Since the Reagan administration, the policy has been tossed from one president to the next like a political football: Republican presidents reinstate it as one of their first acts in office and Democrats rescind it.

Even once the policy is reversed, its impact lingers in communities that were forced to discontinue health services, dissolve NGO partnerships, and halt advocacy efforts. These activities—and the funding for them—do not automatically resume

after a four- or eight-year hiatus. Even once the GGR is rescinded, organizations that seek to rebuild or recover what was fractured or destroyed while the policy was in effect may find their efforts met with an even more damaging version when the next administration comes to power.

The reality of the GGR is that its harmful effects last well beyond a particular administration, and the policy has gotten successively worse and more expansive with each iteration. After the Reagan administration, it was expanded under George W. Bush to apply to State Department funding. In 2017, Donald Trump took the unprecedented measure of applying the policy to all global health assistance, rather than only family planning funding. One former U.S. government official noted that USAID is a vital funding source for local NGOs, as not many other donors fund local organizations on a comparable scale. As a result, the GGR “makes life very uncertain for these NGOs.”¹² With the drastic expansion to all of global health under Trump, many organizations are now grappling for the first time with whether to comply with the policy, no matter how tangential abortion may be to their work. The expansion is so broad that “I don’t think it’s clear yet what the implications really are,” the former official remarked.¹³

C. Human rights impact of the GGR

The United Nations (UN) enshrined a right to life and a right to health in the 1948 Universal Declaration of Human Rights,¹⁴ which was followed by many international treaties and other legal instruments that support a woman's right to health care, including access to safe abortion.¹⁵ In 2015, the world adopted 17 Sustainable Development Goals (SDGs), among them a specific goal to achieve gender equality and empowerment of all women and girls that includes a target to achieve universal access to sexual and reproductive health and rights (SRHR).¹⁶

Donor governments including the U.S. play a critical role in ensuring this goal is achieved. The GGR violates the U.S. government's commitment to upholding SRHR by denying women the full range of reproductive health options and significantly impairing their control over their reproductive lives.¹⁷ This is crippling for broader social and economic development, as it limits women's ability to decide the timing and spacing

of their pregnancies, thereby adversely impacting maternal health and child development.¹⁸

While foreign governments and parastatal entities¹⁹ are exempt from the GGR, the policy still seriously infringes on national sovereignty and priorities. "At the end of the day, if this is a rule that's impacting who gets to be at the table for a national health strategy meeting, it's directly impacting national sovereignty," one informant argued.²⁰

By enacting the GGR the U.S. is exporting a policy that would likely be found unconstitutional if it were applied in the U.S., because it would force U.S.-based NGOs to relinquish their rights to free speech, association, and participation in the political process in order to be eligible for federal funding.²¹ As one interviewee said, the GGR is "viewed with pretty serious and valid concern by people who care about the empowerment of women and girls, [and] who have seen firsthand the negative and chilling effects of previous implementations of the global gag rule."²²

How the GGR obstructs NGOs and health care providers

The GGR hinders the work of foreign NGOs and health care providers by:

- Placing providers in an ethically dubious position that could violate the medical ethics of their country by controlling what they can or cannot say in a provider–client interaction, which may not be consistent with the national standards of care or informed consent;
- Weakening crucial coalition-building efforts, as NGOs may fear engaging with groups that are not complying;
- Perpetuating one-sided political debate by preventing organizations from advocating for the liberalization of abortion laws, while allowing work towards the criminalization of abortion; and
- Stifling organizations' right to advocate before their own governments, violating the rights to free speech, association, and democratic participation.

D. Health systems impact of the GGR

The GGR disrupts health systems and impacts the most vulnerable populations. As one respondent said, “In regards to global health, there can be the perception that ... things are getting better and better and better. Well it’s not just an inevitable incline. It’s because people are *pushing* at every level and every step of government and every local organization, and if some of those scaffolding

pieces here are pulled out, will the arc of things keep improving in global health or will it stall or drop? Things can definitely get worse: diseases are getting smarter, Zika, HIV, and AIDS. And if we’re pulling out the infrastructure, it’s not just pregnancy rates that we need to worry about. The impact is [on] all those pieces of global health.”²³

Table I: GGR impact on health systems building blocks

Health system building block	Disruptions created by the GGR
Financing	Loss of global health assistance Splitting of funding for integrated programs
Service delivery	Shutting down health centers and services Insufficient resources to conduct outreach programs Dissociation of integrated programs Weakening of post-abortion care services
Medical products, vaccines, and technologies	Debilitated antiretroviral therapy (ART) distribution and delivery to clients Reducing or cutting off condom distribution Disrupting pre-exposure prophylaxis (PrEP) accessibility
Health workforce	A confused, overcautious health workforce Over-interpretation of the policy A gagged workforce Professional migration of health workers to “better” NGOs Loss of health worker jobs
Health information systems	Undermining collection of abortion data Gagging of health information
Leadership and governance	Loss of U.S. leading technical assistance provision Loss of funding for leading NGOs (e.g. MSI & IPPF) Lack of local leadership, which is lost to professional migration Dismantling of key & powerful collaborative partnerships & coalitions



Health care workers from Mozambican Association for Family Development (AMODEFA) clinic in Xai-Xai district, Mozambique.

The “six building blocks” framework is often used to understand complex global health systems.²⁴ The six building blocks are:

- Financing
- Service delivery
- Medical products, vaccines, and technologies
- Health workforce
- Health information systems
- Leadership and governance²⁵

The framework establishes that health systems rely on these building blocks, which are interconnected and interdependent.²⁶ Framing the GGR using the health systems narrative in Table I shows that the policy exacerbates already fragile health systems, and an interruption in one block of the health system, such as a loss of funding, has detrimental ripple effects on other health system elements across health programs. This disruption weakens health systems to the extent that they cannot serve populations fully and effectively and impedes universal health coverage²⁷ and the realization of the SDGs.²⁸

II: THE GGR THROUGH SIX U.S. ADMINISTRATIONS

Each iteration of the GGR has had a devastating impact on health care delivery and civil society, with the level of harm increasing every time it is reinstated. This section details the policy’s trajectory from its establishment through May 2018, over the course of six U.S. presidential administrations.

A. Ronald Reagan (1981-1989)

At the 1984 ICPD in Mexico City, President Ronald Reagan announced the Mexico City Policy, issued by presidential memorandum, to restrict U.S. funding for international family planning by targeting foreign organizations that provide abortion services and information.²⁹ Under the Reagan administration, USAID was the largest funder of NGOs that worked in family planning, with oversight of financial assistance for family planning and reproductive health.³⁰ From the government side, “the first Mexico City Policy was very hard to roll out,” one respondent recalled, because it was difficult to determine the extent to which it would apply and how it would be applied.³¹ As a result, the implementation of the Reagan GGR was mired in confusion and was susceptible to misinterpretation by foreign NGOs that received funding from USAID’s Office of Population and Reproductive Health (PRH).³²

The Reagan GGR’s impact on IPPF

Founded in 1952, International Planned Parenthood Federation (IPPF) is an international federation of autonomous organizations, known as member associations, that provides and promotes health services and advocates for sexual and reproductive health and rights for all, particularly underserved groups.³³ As one of the largest, most visible SRHR NGOs in the world, IPPF cannot comply with the GGR.³⁴ During the Reagan administration, IPPF spent approximately one percent of its annual budget, totaling around \$400,000, on abortion-related work. Not certifying the policy resulted in a loss of approximately 25 percent of IPPF’s total funding from USAID, amounting to \$11–12 million.³⁵

Under Reagan, the U.S. government said it would maintain the availability of family planning funding in its budget and that it would not reduce those funds, but rather would reallocate them to organizations that had certified the GGR.³⁶ However, the government never produced documentation from this time period demonstrating how these funds were reallocated.³⁷ In addition, some prime partners intentionally began to avoid working with or soliciting proposals from NGOs that were unlikely to certify the GGR, because identifying who was or was not complying became complicated.³⁸

A study conducted in 1987 by the Population Crisis Committee, now called PAI, revealed that organizations were over-restricting their activities in their implementation of the GGR. For example, one USAID-funded family planning organization in Asia would not sell sterilization equipment to another organization that *legally* provided abortions in fear of contravening the GGR.³⁹

Another aspect of the Reagan GGR that lacked clarity was regarding post-abortion care.⁴⁰ There was concern on the part of government officials that because of this, providers would be reluctant to provide such lifesaving care to women who arrived at health facilities presenting with complications from abortion.

B. George H.W. Bush (1989-1993)

President George H.W. Bush kept the policy in force when he took office. During his tenure, the U.S. government faced a series of legal challenges that sought to permanently end the GGR. (See Annex.)

Although none of these challenges proved successful, the first, brought by DKT Memorial Fund, helped lead USAID to commission a study on GGR implementation in 1990.⁴¹ The results showed that, while prime partners had a robust understanding of the policy, this comprehensive knowledge did not extend to sub-grantees. They were found to be overcautious and generally over-restrictive in their interpretation for fear of violating the policy and losing their funding.⁴²

C. Bill Clinton (1993-2001)

President Bill Clinton rescinded the GGR on January 22, 1993, on his second full day in office, stating that the policy contained “excessively broad anti-

abortion conditions” that “undermined efforts to promote safe and efficacious family planning programs in foreign nations.”⁴³

But throughout much of his presidency—beginning in 1994, when Republicans took control of Congress—anti-choice lawmakers led a continuous and concerted effort to legislate the GGR. When they were not able to legislate the restrictions as such, they added funding restrictions to foreign aid appropriations bills and to State Department reauthorization acts.⁴⁴

As retaliation for President Clinton’s refusal to re-impose the GGR, Republicans succeeded in cutting U.S. international family planning assistance by 35 percent for the 1996 fiscal year.⁴⁵ They then instituted a process called “metering,” which involved Congress delaying the availability of family planning funding to PRH and only releasing one-twelfth of the funds each month.⁴⁶ USAID had to scramble to figure out how to continue funding programs with severely depleted resources and to make sure that the grants and contracts that needed funds immediately got funded first. It also meant that instead of just one incremental funding action for each project, most projects needed two or three funding actions over 12 months. This also strained the resources of the Office of Procurement.⁴⁷

“And this went on for *four years*—different versions of this,” one former government official told CHANGE.⁴⁸

When Republicans found that they could not cripple family planning programs through these tactics, they shifted their focus to U.S. government dues to the UN.⁴⁹ In 1998, facing a \$900 million debt to the UN—incurred because Congress kept attaching the GGR to bills that would have authorized payment

of the U.S. government's dues—President Clinton vetoed a bill that would have repaid the debt because members of Congress had again included the GGR in the bill.⁵⁰

By 1999, the debt to the UN placed the U.S. at risk of losing its vote in the UN General Assembly.⁵¹ As a trade-off for including the UN debt repayment in the fiscal year 2000 foreign aid appropriations bill, the Clinton administration added a modified version of the GGR as a one-year "rider."⁵² "It was not something that the Clinton administration wanted to do *at all* and it had contributed to the government shutdown—because this was one of the things that he wouldn't agree to," one interviewee said. "So it was not by choice, obviously, that it was ultimately instituted."⁵³

D. George W. Bush (2001-2009)

On January 22, 2001, George W. Bush reinstated "in full all of the requirements of the Mexico City Policy" that were in effect prior to the Clinton administration.⁵⁴ One former U.S. government official told CHANGE that she was asked to field a call from a reporter about the policy when it came out. "And I said, 'No, because you don't want me talking to a reporter about what I think of this policy and what it's going to do. My views won't reflect what this administration wants me to say.' And that was the first time in my career I felt like I couldn't do my job, and that was an indication for me to start thinking about leaving."⁵⁵

President Bush issued another presidential memorandum on March 28, 2001, directing USAID to incorporate the GGR Standard Provision into new grants and cooperative agreements as well as grants and cooperative agreements that are amended to add new funding.⁵⁶ The Standard Provision added an

explicit exemption for post-abortion care, a "minor but significant adjustment"⁵⁷ that one former government official said was made "to clarify something that had been a question prior to that date."⁵⁸ Another noted that this exemption actually was not controversial: "There was an understanding and an agreement with even those that are against abortion that you do not *not* treat people who are suffering from an unsafe or illegal abortion."⁵⁹

1. EXPANSION OF THE GGR TO THE STATE DEPARTMENT

On August 29, 2003, President Bush issued a memorandum extending the GGR for the first time to family planning assistance from the State Department.⁶⁰ Humanitarian aid was not specifically included in the scope of the GGR.⁶¹ However, areas of conflict and refugee settings have enormous need for family planning and sexual and reproductive health services.⁶² Recognizing this, PRM for several years had funded NGOs to provide such services in humanitarian settings. The Reproductive Health Response in Conflict (RHRC) Consortium,⁶³ founded in the mid-1990s, coordinated efforts for providing services and for conducting assessments, research, and training, as well as for advocating for quality sexual and reproductive health services for women in conflict settings.⁶⁴ Through PRM, the U.S. became the primary donor to this consortium in 2002,⁶⁵ with grants approximating \$1 million each year.⁶⁶

In 2003, however, PRM refused to renew the group's funding as a consequence of the newly expanded George W. Bush GGR because the consortium included the organization Marie Stopes International (MSI) as a member.⁶⁷ As one informant explained, "[RHRC was] basically told, 'We'll give you funding for another year, but Marie Stopes can't

be on your coalition because they're subject to the gag rule.' ...The coalition said, 'That's not right. This is refugee assistance funding and we are a seven-member consortium, and we work together.'⁶⁸ The consortium refused to cave to the State Department's demand and lost its funding.⁶⁹

The George W. Bush GGR instilled a climate of fear, paranoia, and misinformation within the U.S. government as well as among organizations. "They know how to make it onerous," said one former U.S. government official who worked under the Bush administration.⁷⁰ This iteration of the GGR created an environment that fostered increased scrutiny and stigma related to family planning, thereby reducing the effectiveness of U.S. programs abroad. One former U.S. official said she received more information about the policy impact from NGOs than from within the government.⁷¹



Entrance to the International Centre for Reproductive Health (ICRH-M) in Maputo, Mozambique.

How Bush policies silenced officials

One former U.S. government official described "constant" policing of behavior within the government around the GGR and reproductive health during the George W. Bush administration, which drove staff to self-censor emails and calls.⁷² Throughout the Bush administration, clearance for materials that PRH released went through political appointees, who buried evidence that family planning saves lives. At the International AIDS Conference one year, a one-government approach to development was adopted; political appointees did not allow information on integrated family planning and HIV services in the U.S. government booth.

External meetings, panels, and conferences were closely reviewed as well. "If somebody from IPPF or MSI was on that forum, we couldn't appear," one former government official recalled.⁷³ Another added: "It wasn't until G.W. Bush that we were restricted in meetings attended and, at one point, if abortion was on the program we could not speak and then we could not even attend the meeting."⁷⁴ Still, "some of us went to meetings and conferences and were careful about not getting into discussions related to abortion."

2. THE COST OF NON-COMPLIANCE

Under the George W. Bush GGR, the U.S. government restricted family planning assistance from any foreign NGO that would not comply with the policy. Just as it had under the Reagan and George H.W. Bush GGRs, IPPF lost its U.S. funding, totaling more than \$100 million for family planning and sexual and reproductive health programs over the eight-year Bush administration.⁷⁵ The IPPF director general at the time noted that this translated to an estimated 36 million unintended pregnancies and 15 million induced abortions.⁷⁶

Because it lost its U.S. funding, IPPF was forced to cut funding from its member associations it supported with U.S. money. For example, Planned Parenthood Association of Ghana (PPAG), which was running a USAID-funded community-based services program, certified the policy to keep the program running, but still suffered significant budget cuts when it lost its IPPF funding.⁷⁷ Planned Parenthood Association of Zambia terminated 40 percent of its staff to mitigate some of the harm caused by the GGR.⁷⁸

3. IMPACT ON FREE SPEECH

The George W. Bush GGR gagged foreign NGOs from speaking about abortion in advocacy, lobbying, legislative and public arenas, and even at UN conferences.⁷⁹ The policy's chilling effect and de facto implementation went beyond foreign NGOs to U.S.-based ones as well. In 2004, the Bush administration revoked \$360,000 in funding from a Global Health Council conference that it had previously supported for 30 years. It did so mere weeks before the event because it learned IPPF, the United Nations Population Fund (UNFPA), and other organizations opposed to the GGR would be discussing abortion.⁸⁰ One informant pointed out that the U.S. government donated money to the conference "but didn't

anywhere in writing have control over the agenda and should not have been able to dictate who the speakers were and what they said, especially if they were funded by other sources."⁸¹ The U.S. government's attempts to control organizations by withdrawing funding debilitated the spaces in which organizations typically exercised their rights to free speech, expression, and association.

Organizations CHANGE spoke with discussed the widespread overreach that manifested under the George W. Bush GGR. One interviewee recalled "people having to sign in their contract that they would not talk about abortion, research on abortion. The rule didn't say that. But somehow in the implementation of things ... no one wants to be held accountable and it's very unclear and it's highly political."⁸² Multiple interviewees remembered how afraid people were to even speak about abortion. One reflected, "in my review of anecdotal research on prior iterations of the global gag rule I was surprised to uncover, over and over again, how aid workers and providers were afraid to even use the word 'abortion' in their work for fear of being reported and penalized ... as if that alone was a violation of the rule that could lead to loss of funding."⁸³

4. IMPACT ON ADVOCACY

USAID missions' strategic plans seek to improve democracy and governance around the world, including protecting the work of civil society groups.⁸⁴ The role of civil society is to make the law accessible, understandable, and clear to citizens, but also to provide a space to challenge provisions in restrictive laws.⁸⁵ The GGR's "chilling effect" strips civil society groups of their ability to act on issues related to abortion and negates U.S. foreign policy objectives on foreign democracy and governance.⁸⁶

The "chilling effect" refers to organizations or health

care providers over-restricting their activities to avoid being found out of compliance with the GGR. This manifests in a multitude of ways, including organizations self-censoring their speech, ending activities or programs unnecessarily, and avoiding participation in meetings or coalitions. The speech restriction, in particular, is a major component of the chilling effect experienced by NGOs under the GGR.

During the George W. Bush GGR, Ethiopia, Kenya, Mozambique, Nigeria, and Uganda received significant U.S. family planning assistance and also had grassroots initiatives attempting to reform restrictive abortion laws, which the GGR inhibits.⁸⁷ In Kenya, advocates were unable to support efforts to repeal restrictive abortion laws with the policy in place.⁸⁸ In Nepal, NGOs were prohibited from participating in the government's efforts to implement a more liberal abortion law.⁸⁹

Under the GGR, civil society organizations' political and reproductive advocacy voices are effectively gagged.⁹⁰ The policy discriminates against pro-choice NGOs, because they cannot advocate politically for abortion as a reproductive choice.⁹¹ Meanwhile, anti-choice NGOs and advocacy groups can continue to speak and express themselves freely.⁹² Through this imbalance created by the GGR, the U.S. is projecting its ethical and moral values on foreign advocates, despite the consensus forged at the 1994 ICPD that countries could create customized, context-specific abortion policies.⁹³

5. IMPACT ON CONTRACEPTION

As a core component of SRHR, the availability and accessibility of voluntary, high-quality contraception gives people the freedom to make decisions about their own reproductive lives.⁹⁴ Family planning programs are directly linked to increased use of modern contraceptives.⁹⁵ The increased use of

modern contraceptives, which include male and female condoms, has been linked to reductions in new HIV infections, unintended pregnancies, and subsequent reductions in unsafe abortions.⁹⁶ Family planning has positive ripple effects for HIV prevention and treatment efforts,⁹⁷ rates of unintended pregnancies,⁹⁸ and maternal and child health.⁹⁹ It saves women's and girls' lives, protects their health, and fosters social and economic development.¹⁰⁰ As developing countries' health systems often have insufficient resources to provide the full range of health care services, family planning clinics typically are where women receive comprehensive primary health care, including prenatal care, contraceptive counseling and distribution, birth spacing, and information on sexually transmitted infections (STIs).¹⁰¹

The George W. Bush GGR hit family planning programs especially hard. Two leading family planning providers in Kenya, Family Planning Association of Kenya (FPAK) and Marie Stopes Kenya, did not comply with the policy, lost funding, and were forced to close five clinics total.¹⁰² To avoid having to close seven additional clinics and a nursing home, Marie Stopes Kenya reorganized its clinics' structures and raised service fees, terminated about 20 percent of its staff, reduced the salaries of remaining staff, and cut back on the services they offered.¹⁰³ The resulting diminished service delivery impacted more than 300,000 clients and left one of the poorest urban communities without a clinic to provide health services.¹⁰⁴ In addition, FPAK¹⁰⁵ closed down three clinics that were providing comprehensive care, beyond abortion services, to more than 19,000 people.¹⁰⁶

By not complying with the GGR, MSI local affiliate Marie Stopes Tanzania lost 65 percent of its annual budget and had to eliminate capacity-building

programs that were run in conjunction with the local family planning NGO Chama Cha Uzazi na Malezi Bora Tanzania (UMATI).¹⁰⁷ These capacity-building programs provided technical support to private providers and trained government facilities on family planning provisions. In opposition to the GGR, UMATI did not renew its USAID contract in 2003 and had to terminate 13 percent of its staff, including many highly skilled technical support staff necessary to sustain family planning services within government facilities.¹⁰⁸

Many community-based distribution (CBD) programs—which use community-trained workers to distribute family planning information and services to hard-to-reach rural and impoverished urban communities—were also terminated due to the George W. Bush iteration of the GGR.¹⁰⁹ For example, in Ethiopia, where 45 percent of the population lives in rural areas, CBD programs were shut down, which for many, eliminated their only interaction with the health system.¹¹⁰ Rural communities in Ghana,¹¹¹ Kenya,¹¹² Nepal,¹¹³ Zambia,¹¹⁴ and Zimbabwe¹¹⁵ also felt the effects of the GGR. In rural Zambia, USAID stopped sending contraceptives to CBD programs, and their capacity to train and support their workers suffered.¹¹⁶

Family Guidance Association of Ethiopia (FGAE) lost more than \$500,000 in U.S. funding when it did not certify the George W. Bush GGR.¹¹⁷ FGAE was impacted by the “advocacy on abortion” restriction of the policy¹¹⁸ because it raised awareness that unsafe abortions were responsible for more than 50 percent of Ethiopia’s 20,000 annual maternal deaths.¹¹⁹ The FGAE funding cuts left 301,054 women and 229,947 men in urban areas in Ethiopia without health services.¹²⁰ In the case of FGAE, the policy curtailed activities that would have otherwise

reduced maternal deaths.¹²¹

This loss of funding also forced FGAE to shut down “condom corners,” where they provided free and readily available condoms, and close rural programs that provided contraceptives.¹²² Clinic closures and disruption of outreach programs reduces access to reproductive health services, which can have negative effects on the use of modern contraceptives for women in rural areas,¹²³ further exposing them to risk of HIV infection, unintended pregnancies, and possibly unsafe abortions.

During the George W. Bush GGR, the policy resulted in USAID either reducing or cutting off shipments of contraceptives, which were already limited in quantity, to 16 countries in sub-Saharan Africa, Asia, and the Middle East.¹²⁴ Under Bush, the condom distribution for Lesotho was suspended in 2001 as a consequence of the Lesotho Planned Parenthood Association (LPPA) not complying with the GGR.¹²⁵ During this time, one in four women in Lesotho were living with HIV¹²⁶ and LPPA had received 426,000 condoms from USAID over two years during the Clinton administration.¹²⁷ LPPA was the only organization that distributed condoms provided by the U.S. government, and this relationship stopped when the GGR came into effect.¹²⁸

6. IMPACT ON EMERGENCY CONTRACEPTION

Emergency contraception is a method of birth control that prevents pregnancy after sexual intercourse.¹²⁹ The World Health Organization (WHO) affirms that, “Emergency contraception cannot interrupt an established pregnancy or harm a developing embryo.”¹³⁰ It is unequivocally accepted by the medical community that emergency contraception does not cause abortion, but rather is a pregnancy prevention method because it acts

before implantation.¹³¹ However, anti-abortion proponents, who believe a pregnancy begins at the moment of fertilization, equate contraceptive methods that prevent implantation of a fertilized egg with abortion.¹³² Anti-choice advocates often erroneously categorize emergency contraception as an abortifacient. When the GGR is in place, U.S. government officials and NGOs have been confused and misinformed about the applicability of the policy to emergency contraception.

During the George W. Bush administration, USAID did not include emergency contraception in its commodity (contraceptive) distribution program.¹³³ This means that foreign NGOs were not receiving emergency contraception from the U.S. government along with other contraceptive methods that it funded and distributed. Typically, pro-choice advocates would advocate for the U.S. government to procure and distribute a comprehensive range of commodities, including emergency contraception. However, because of the GGR, pro-choice advocates actually fought to keep emergency contraception out of USAID's commodity distribution program so that it was not subject to GGR restrictions like other contraceptives were.

Although emergency contraception was expressly excluded from George W. Bush's GGR, interviewees reported that throughout the Bush years, misconceptions about emergency contraception persisted. A former U.S. government employee recalled having to explain to colleagues that emergency contraception is not the same thing as mifepristone, also known as RU486, which is a medication used to help induce an abortion,¹³⁴ because they confused the two regularly.¹³⁵ One organization recounted that it was questioned for working on expanding access to emergency

contraception because "that gets conflated with abortion."¹³⁶ In Zambia, a media organization removed a chapter on emergency contraception from a brochure it produced on contraceptive options.¹³⁷

7. IMPACT ON HIV AND AIDS

In 2007, sub-Saharan Africa accounted for approximately 67 percent of the global burden of HIV.¹³⁸ Within sub-Saharan Africa, women accounted for about 60 percent of people living with HIV,¹³⁹ and globally, HIV and AIDS remains the number-one cause of death for women of reproductive age (15–44 years).¹⁴⁰ Efforts to reduce the HIV burden are heavily supported by the U.S. government, with U.S. foreign assistance for HIV and AIDS channeled through the President's Emergency Plan for AIDS Relief (PEPFAR).¹⁴¹ PEPFAR was created in 2003 as part of a five-year, \$15 billion "emergency" investment to address the global HIV and AIDS epidemic.¹⁴² It has since been reauthorized twice, in 2008¹⁴³ and 2013.¹⁴⁴ With significant pressure from advocates, PEPFAR was not included in the George W. Bush GGR,¹⁴⁵ which meant that NGOs remained eligible to receive funding for all HIV services, even if they conducted abortion-related activities that would cost them family planning funding.

Still, because of the policy, programmatic, and service delivery synergies between SRHR and HIV,¹⁴⁶ the Bush GGR did affect organizations working on HIV. For example, in Ethiopia, before PEPFAR existed, there was widespread misinformation and confusion about restrictions of the policy on HIV and AIDS activities, with many NGOs incorrectly believing the GGR also applied to their HIV work.¹⁴⁷ This prompted a chilling effect on NGOs' work, as they became excluded from HIV and AIDS projects by other partner NGOs, thus weakening overall efforts to curb the HIV epidemic. In one instance,

PPAG partnered with Africa Youth Alliance (AYA) to promote and incorporate adolescent-friendly sexual and reproductive health services in PPAG's rural and remote sites, but the scope of this outreach and partnership diminished when PPAG lost its funding and could no longer support some of its rural and remote communities.¹⁴⁸ The GGR fractured this partnership that sought to provide comprehensive HIV prevention and treatment as well as reproductive health services to marginalized communities in Ghana.

8. IMPACT ON MATERNAL, NEWBORN AND CHILD HEALTH

The continuum of maternal, newborn and child health (MNCH) is fundamental to the health of both the woman and the child.¹⁴⁹ When a pregnant person's health is threatened, it can have negative consequences for the child's health. Jones' (2011) estimations for the George W. Bush GGR showed that children born from unintended pregnancies related to the imposition of the policy had poor nutritional status on height- and weight-for-age indicators relative to their siblings.¹⁵⁰ A Public Policy Master's thesis from a Georgetown University student also found that in Ghana, access to prenatal care models experienced significant negative effects due to high GGR exposure during the Bush administration.¹⁵¹ The policy had a negative effect on access to prenatal care in rural and urban areas, particularly as large service providers like MSI had to shut down facilities.¹⁵²

9. IMPACT ON POST-ABORTION CARE

Unsafe abortion remains a major cause of maternal death, complications, and hospitalizations.¹⁵³ During the Bush GGR, unsafe abortions accounted for up to 13 percent of pregnancy-related deaths

worldwide.¹⁵⁴ USAID started funding post-abortion care in 1994, when the GGR was not in effect,¹⁵⁵ as a response to evidence that showed unsafe abortion complications were a major cause of maternal deaths.¹⁵⁶ When the Bush GGR was implemented, post-abortion care programs were exempted from the policy and USAID continued to fund such care.¹⁵⁷ However, explicit exemption of post-abortion care programs did not diminish the confusion that surrounded the policy in this regard.¹⁵⁸ One organization said USAID missions suggested that they could not work on post-abortion care. In response, "we made sure we were completely familiar with what the policy did and did not allow, and were accordingly able to take it as far as we could in working on what was permissible to ensure reproductive health and wellbeing. Post-abortion care *was* permissible."¹⁵⁹

Providers felt that if USAID could provide post-abortion care, then they should be funding programs and activities that prevent unsafe abortion from happening in the first place.¹⁶⁰ However activities such as advocacy and counseling on safe abortion are prohibited under the GGR, undermining providers' abilities to respond to women's reproductive health needs.

10. IMPACT ON ABORTION

When abortions are conducted safely and legally, and are accessible, available, affordable, and acceptable as a reproductive health option, they provide women with a wider range of choices to plan their families.¹⁶¹ Abortions are considered safe if they are done by a trained provider with a method recommended by the WHO that is appropriate to the woman's stage of pregnancy.¹⁶² In fact, abortion is actually one of the safest medical procedures in the world when done correctly,¹⁶³ and it can be provided

at the primary care level or by a health worker who is not a doctor.¹⁶⁴ Abortion is a key component of comprehensive family planning, and undermining access to comprehensive family planning services hurts women by denying them the tools they need to make decisions that are best for them, including preventing unintended and unwanted pregnancies.

The GGR removes abortion from reproductive health and family planning services, causing health organizations to fear that any ties to abortion, no matter how remote, will make them susceptible to loss of funding.¹⁶⁵ Under George W. Bush, a former U.S. government official recalled that in the field, the U.S. government was “constantly having to halt programs.”¹⁶⁶ One program, they said, was stopped because its office happened to be in the same building as an abortion provider, which was located on another floor. “You have that kind of harassment that doesn’t have anything to do with the Mexico City Policy but has everything to do with how easy it is to deliver programs and to serve people,” they said.

Data from countries with restrictive abortion laws show that limiting access to abortions does not stop them from happening.¹⁶⁷ Imposing legal barriers on women’s reproductive health needs and desires, including access to safe abortion services, does not eliminate women’s need for abortions¹⁶⁸ and, in fact, perpetuates unsafe abortion.¹⁶⁹

While supporters of the GGR assert that the policy reduces the number of abortions, this is demonstrably false.¹⁷⁰ In 2011, two rigorous studies used quantitative data analysis to evaluate the relationship between the GGR and abortion rates.¹⁷¹

In one of these studies, Jones evaluated the effects of the George W. Bush GGR on Ghanaian women’s reproductive and child health outcomes,¹⁷²

estimating the likelihood of inducing abortion during two periods when the policy was in effect compared to two periods when it was not.¹⁷³ Jones found that during the years the policy was in place, **abortion rates did not decrease** for any demographic, and in fact there was a 50–60 percent increase in the likelihood of abortion for women in rural areas of Ghana. In addition, there was an estimated 12 percent increase in pregnancies in rural areas and 500,000 to 750,000 additional unintended births that could be attributed to the termination of community based distribution of contraceptive supplies—a consequence of GGR-related loss of funding.¹⁷⁴

The other study, by Bendavid *et al.*, focused on sub-Saharan Africa.¹⁷⁵ It examined the association between sub-Saharan African countries’ exposure to the George W. Bush GGR and induced abortion in women of reproductive age between 1994 and 2008.¹⁷⁶ The authors defined high exposure to the GGR as women who lived in countries that received U.S. financial assistance above a calculated median level. The study found that women in high GGR-exposed countries had **two and a half times** the odds of experiencing an induced abortion once the policy was reinstated, compared to their counterparts in low GGR-exposed countries.¹⁷⁷

More recently, a third study by Rodgers, a researcher from Rutgers University, applied the methodology from the Bendavid study to a global analysis of the association between the George W. Bush GGR exposure and induced abortion rates.¹⁷⁸ The analysis found that women in Latin America and the Caribbean countries highly exposed to the GGR had **three times** the odds of receiving an induced abortion after the policy was reinstated compared to their low-exposed counterparts. For sub-Saharan African women, Rodgers’s finding was

similar to Bendavid's study: the abortion odds in high-exposed countries were two times more than in low-exposed ones.¹⁷⁹ The evidence from these quantitative studies demonstrates that the GGR's impact on abortion rates runs directly counter to the policy's implied aim to limit abortion.

E. Barack Obama (2009-2017)

On his third day in office, President Obama rescinded the George W. Bush GGR on January 23, 2009. Obama used similar language to President Clinton's revocation, citing "excessively broad conditions on grants and assistance" that "undermined efforts to promote safe and effective voluntary family planning programs in foreign nations."¹⁸⁰ He directed USAID and the State Department to immediately waive GGR provisions in awards with foreign NGOs.¹⁸¹

Despite this, interviewees reported that the residual stigma and misunderstanding carried over from the previous administration, affecting the way the U.S. government and organizations functioned for years after the policy was revoked.

One former U.S. government employee emphasized that, "you still had missions being very, very cautious, and you can understand it because of just the pressure that was being put on them."¹⁸² They were reluctant to begin working with organizations to which the GGR had applied during the George W. Bush administration. "They kept saying, 'what's in it for us? Because we get four or eight years, and then it's back to where we were.' It took about a year or two for us to *really* convince the missions that it was okay to come into the water."¹⁸³ They said government employees also gravitated towards maternal and child health and PEPFAR because the Bush administration increased funding to these areas—

while simultaneously making sizable cuts to family planning funding. Therefore, work in these areas was not viewed as under threat by the GGR like family planning was at the time. "So the policy, combined with shifts in funding priorities, started scaring people away from coming in to work on family planning."¹⁸⁴

Organizations also had the legacy of the GGR embedded in their understanding of what was and was not permissible in their work. According to Ipas Ethiopia, USAID did not provide sufficiently clear guidance on implementing the reversal of the GGR after Obama rescinded the policy, nor did the agency sufficiently address the wide-ranging effects of the George W. Bush iteration.¹⁸⁵ The lack of clarity created ongoing confusion about permitted safe abortion practices in Ethiopia's reproductive health spaces.¹⁸⁶ In Kenya, an NGO told CHANGE that some organizations may not have been aware that the policy was lifted by Obama, because they saw women whose lives were at risk be refused health care by organizations that were continuing to apply the policy in error.¹⁸⁷

According to IPPF/Western Hemisphere Region (IPPF/WHR), the policy coincided with a proliferation of vocal anti-choice groups in the region. Even once the policy was rescinded, organizations continued to operate in an overly cautious manner out of fear of being attacked. "You restrain much, much more," one respondent said.¹⁸⁸ "So the legacy is way longer than one can imagine," another added.¹⁸⁹

After the Bush administration, USAID assistance has become more decentralized, a move that, while well-intentioned, has resulted in making more local NGOs susceptible to the GGR. The Obama administration implemented USAID Forward from 2010 to 2016,¹⁹⁰ which emphasized strengthening

missions' partnerships and investments at the local level. In FY2015, 27 percent of USAID funding was obligated to local actors,¹⁹¹ and a larger proportion of funding shifted to missions to disburse themselves. Now, of the foreign NGOs that receive U.S. global health assistance, about half are prime partners.¹⁹² As primes, these foreign NGOs will now be subject to the GGR, unlike U.S.-based primes.

F. Donald Trump (2017-present)

On January 23, 2017, President Trump issued a presidential memorandum reinstating the GGR that was last in effect during the George W. Bush administration—and paving the way for unprecedented expansion of the policy.¹⁹³ The memorandum directed the Secretary of State and the Secretary of Health and Human Services (HHS) to extend the policy, to the extent allowable by law, “to global health assistance furnished by all departments or agencies.” On March 2, 2017, USAID released the George W. Bush Standard Provision as the first phase of implementation, which applied *only* to international family planning assistance.¹⁹⁴ On May 15, 2017, then-Secretary of State Rex Tillerson released the new and revised GGR Standard Provision, which included the expansion of the policy to *all* global health assistance.¹⁹⁵

The expanded Trump GGR applies to \$8.8 billion in global health funding, including:

- Family planning and reproductive health
- Global health security
- Health systems strengthening
- HIV and AIDS
- Infectious diseases
- Malaria, including the President's Malaria Initiative

- Maternal and child health
- Non-communicable diseases
- Nutrition
- Tuberculosis (TB)
- Water, sanitation, and hygiene (WASH) at the household and community levels¹⁹⁶

The reinstatement of the GGR was on the list of rules, regulations, and executive orders that the Freedom Caucus, a group of the most conservative House Republicans, sought from the new administration in Trump's first 100 days in office.¹⁹⁷ “When Trump came into office, it was assumed he would sign a version of global gag because this is just a ping-pong policy, a policy that flips every administration,” one former U.S. government official said. “What was a surprise was the massive GGR expansion. And how quickly it was done was an indicator that Trump signed the memorandum before any kind of review, before any kind of even real parsing of the potential impact or legal analysis...of what this was going to do.”¹⁹⁸

Trump's Expansion of the GGR

The Trump GGR is more far-reaching and restrictive than any previous iteration of the policy, impacting not only reproductive health programs but every single area of global health care service delivery funded by the U.S. government. Countries are already feeling the devastating impact of the GGR as they are forced to curtail essential services for everything from HIV prevention and maternal health to gender-based violence (GBV) and nutrition.

To document the impact of Trump's expanded GGR, CHANGE conducted interviews with NGOs and current and former U.S. government officials in the United States, as well as with civil society organizations across sub-Saharan Africa. Interviews and site visits in Mozambique and Zimbabwe reveal the damaging impact of the Trump administration's expanded GGR.

The fear surrounding the Trump GGR cannot be overstated. In interviews, CHANGE observed a general reluctance to speak on record about the policy; local NGOs and large U.S.-based primes alike expressed trepidation.

This level of discretion and fear is unique to the GGR. In part, this can be attributed to just how much organizations rely on U.S. funding: many NGOs that CHANGE spoke with had more than 50 percent of their budgets financed with U.S. global health funding; some were closer to 100 percent. They did not want to compromise that fiscal relationship by speaking out against a policy of one of their main donors. One director from an NGO that has endured both the George W. Bush and Trump GGRs noted that the GGR "ends up being so restrictive and so stigmatizing—much more than any rule."¹⁹⁹

I. ROLLOUT

The development and rollout of Trump's GGR did not seem to adhere to the broad consultative process and commitment to transparency that are considered best practice for U.S. policy formulation. This includes engaging a broad set of stakeholders, convening working groups, analyzing and debating the pros and cons, and consulting with civil society organizations as well as those who would be directly affected, such as patients or clients. However, "that was not the rollout of GGR or the development of GGR," in the Trump administration, one former U.S. government official said.²⁰⁰ "The development of the policy was behind closed doors...with a pretty pre-determined outcome...written in a way that could be interpreted as expansively as possible. ...I think there was a lot of confusion when it came out about what each paragraph actually means."

Organizations working on SRHR, many of which had experience with previous iterations, expected the policy to be reinstated once Trump was elected. For one, "we passed a resolution globally about our position in November, right after the election. So we were expecting for it to take place and therefore we prepared for it, politically speaking."²⁰¹ Others began "scenario-planning" immediately after the election to analyze how the policy was going to affect their work.²⁰² One global organization employs a team specifically to understand and address the implication of policies like the GGR, and was able to communicate with its partner in Zimbabwe in January 2017.²⁰³

Many interviewees expressed concern about the expansion to new funding areas under the Trump administration, both for U.S. government entities that have previously been exempt from the policy and for NGO implementers. “The family planning community understands how to implement the GGR. They’ve managed it before; they know how to manage it again,” one informant said.²⁰⁴ “But the others, such as our maternal health and the HIV colleagues, and even including those within USAID, are struggling with providing clarity and guidance on the expanded—and now more complex—policy.” Another interviewee who used to work on SRHR was the person who flagged that this would impact their NGO: “I had enough background to read it and go...this is global health programs writ large. We get money from them. So I actually started the process of elevating it, like, January 20.”²⁰⁵

A. Application across agencies and funding streams

The global health areas impacted by the Trump GGR fall under several funding streams, including Global Health Programs, PEPFAR, the Economic Support Fund, and Assistance to Europe, Eurasia, and Central Asia, among others.²⁰⁶ The funding streams are managed by multiple government agencies, most prominently USAID and the State Department. A number of new agencies are now impacted, including the Department of Defense (DoD), HHS—which includes Centers for Disease Control and Prevention (CDC), and the Peace Corps.

Of the \$8.8 billion in global health funding to which the Trump GGR applies, almost \$6 billion is dedicated to PEPFAR.²⁰⁷ In FY2017, PEPFAR comprised 62 percent of U.S. global health assistance,²⁰⁸ funding HIV and AIDS programs in the

Global South, particularly in sub-Saharan Africa.²⁰⁹ In Zimbabwe, the PEPFAR budget was \$127 million;²¹⁰ in Mozambique it was more than \$330 million.²¹¹

The U.S. government is the largest contributor of global health assistance²¹² and sustains critical programs that improve the health and lives of people and health systems worldwide.²¹³ Eighty-six percent of Zimbabwe’s HIV funding comes from donor assistance,²¹⁴ and in an increasingly shrinking donor funds atmosphere,²¹⁵ U.S. contributions are critical. Along with financial assistance, the U.S. provides technical assistance that many other donor countries have limited capacity to provide.²¹⁶ The unprecedented expansion of the policy to apply to **15 times** the amount of funding compared to previous GGR iterations threatens to derail decades of progress in advancing health care service delivery and systems, especially in the Global South.

B. Policy exceptions

The Trump GGR contains exceptions for abortion advocacy, services, and counseling and referral for abortion in cases of rape, incest, and if the woman’s life is at risk.²¹⁷ The policy also excludes any aspect of the “treatment of injuries or illnesses caused by legal or illegal abortions,” such as post-abortion care.²¹⁸ The policy does not restrict the provision of information on or distribution of contraception, including emergency contraception.²¹⁹

The policy also does not apply to individuals acting in their own personal capacities who are not on duty or on their organization’s premises. Foreign national or local governments remain eligible for U.S. global health assistance even if they perform abortion-related activities, as long as they keep U.S. funds in a separate account from

the funds that support such activities.²²⁰ Public international and other multilateral organizations are also exempt from the GGR, including the UN and its related agencies, international financial institutions like the World Bank Group or UN regional banks (e.g., African Development Bank), regional organizations like the African Union, and other international organizations like the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund),²²¹ the International Committee of the Red Cross (ICRC), and the Global Alliance for Vaccines and Immunization.²²²

Organizations can conduct “descriptive” research on the subject of abortion, such as the incidence or causes of abortion, as long as they do not use the research to advocate for the liberalization of abortion laws or the continuation of laws more permissive than the three exceptions mandated by the GGR. NGOs that conduct “implementation-science research, operational or programmatic research, surveys, needs assessments and related capacity-building” must certify the policy in their funding agreements with the U.S. government.²²³ Biomedical research on abortion may also be interpreted as subject to the policy.²²⁴

The “passive referral” exception

The policy includes an exception for what it calls “passive referrals” for abortion—in countries where abortion is legal—for reasons broader than life endangerment, rape, or incest. Four criteria must be met to constitute a passive referral, which permits a health care provider to tell a woman where she can obtain an abortion:

- A woman is already pregnant;
- She clearly states that she has already decided to have a legal abortion;
- She asks where a safe and legal abortion can be obtained;
- The provider believes that the ethics of the medical profession in the country require a response regarding where an abortion may be safely and legally obtained.²²⁵

“If you’re a provider and medical ethics require you to serve the best interests of the patient to protect their health, fulfilling each of these criteria for ‘passive referral’ places an undue burden on both the women and providers to keep track of the exchange. Moreover, it means that a skilled provider in the context of a brief consultation has to deny information to their patient that would protect their health and wellbeing. This is a difficult ethical position to put physicians and health care providers in,” a representative of a health research organization underscored.²²⁶

The “affirmative defense”: South Africa

The Standard Provision for the Trump GGR stipulates that if health care providers have an “affirmative duty” under local law to provide counseling and referral for abortion as a method of family planning, “compliance with such law shall not trigger a violation of [the policy].”²²⁷ This affirmative defense likely has some application in over a dozen countries impacted by the GGR. In South Africa, a country that received over \$450 million in newly impacted PEPFAR funding in 2017, this is indeed the case.²²⁸

South Africa’s abortion laws permit abortion far beyond the scope of the three GGR exceptions, including for any reason during the first 12 weeks of pregnancy, and for a range of circumstances up to 20 weeks.²²⁹

The South African Constitution ensures the right to bodily and psychological integrity, and guarantees the right to access “health care services, including reproductive health care.”²³⁰ The National Health Act of 2003 requires health care providers to ensure that patients have “full knowledge,” including on “the range of diagnostic procedures and treatment options generally available to the user,” and “the benefits, risks, costs, and consequences generally associated with each option.”²³¹

South African case law further reflects precedent that health care providers are under an affirmative duty to counsel and refer women for legal abortion services. This includes case law establishing liability of health providers for failing to provide information pertaining to a decision around pregnancy termination.²³² In *H v. Fetal*

Assessment Centre (2014), the Constitutional Court recognized that health care providers can be liable for negligent failure to provide “medical advice during pregnancy to ascertain whether their child will be born in good health,” in order for the woman to make an informed decision on whether to continue with a pregnancy.²³³ In *AB and Another v. Minister of Social Development* (2016), the Constitutional Court found that “Section 12(2)(a) protects the right ‘to make decisions concerning reproduction’. Conspicuously, it is the decision that is protected, rather than any particular choice. Consequently, a person relying on this right need only show that their inability to make the decision – resultant upon some law or conduct – has caused (at least) psychological harm.” The court recommended that this provision be “interpreted generously to cover all instances where the bodily or psychological integrity of a person is harmed.”²³⁴

South African ethical guidelines also dictate how health care professionals should handle counseling and referral for abortion services.²³⁵ Patients in South Africa have the right to relevant information regarding their health care options, and health care providers are legally required to provide full information on services, including counseling and referrals for abortion services. Providers are thus legally entitled to invoke an affirmative defense, and doing so will “not trigger a violation of” the Trump GGR. However, because of the general knowledge gap and misunderstanding that often comes with the GGR, providers are unaware of this exception and their conflicting duties.²³⁶

Humanitarian assistance, “including State Department migration and refugee-assistance activities, USAID disaster and humanitarian-relief activities, and DoD disaster and humanitarian relief,” is not included under the policy.²³⁷ However, as CHANGE demonstrates throughout this report, even areas that seem to be excluded on paper—such as humanitarian settings—can be impacted by the policy in practice.

Importantly, the expanded policy permits requests for case-by-case exemptions, which the Secretary of State, in consultation with the Secretary of Health and Human Services, can authorize.²³⁸ This is a new inclusion and both the process and grounds for exemption are unclear. First-hand accounts from those who have requested exemptions suggest that the State Department did not apprise USAID headquarters or missions of this “case-by-case exemption” clause.

C. Certification

CHANGE spoke with both U.S.-based and foreign NGOs that had anywhere from a couple of small U.S.-funded projects to more than half their budgets comprised of U.S. funding. Most received their funding from USAID, a number received State Department funding, and fewer received funds from the CDC, the National Institutes of Health (NIH), or other agencies. Many received PEPFAR funding, which can be channeled through multiple agencies, including USAID and the CDC. Their funding covered global health areas such as maternal and child health, HIV and AIDS, family planning and reproductive health, Zika virus, malaria, biomedical, and WASH, among other areas. Although they cited various reasons for their decisions around certification of the policy, all described careful

calculations that weighed the amount of funding and implicated programs, the integrity of their work, and their institutional ability to mitigate harm. One SRHR organization in Zimbabwe rejected the GGR, stating, “if we speak SRHR for all, it has to be inclusive, and there is no exception.”²³⁹

For WaterAid America, whose implementing offices are mostly foreign NGOs, the decision to reject U.S. funding due to the GGR was “surprisingly easy.”²⁴⁰ It has a small number of grants and contracts with the U.S. government. Of those, it is only currently implementing those funded by Development Assistance, not Global Health Programs. A representative explained that, “even though we are not an SRHR organization, we do a lot of work with maternal health and safe delivery and gender-based violence, and a lot of things that result in women being at clinics that would potentially be providing services that are prohibited under [the] gag [rule].” They were concerned about losing integrity in their advocacy for universal health coverage if they could not talk about sexual and reproductive health, or if their partnerships with SRHR organizations were compromised. And so, their ability to continue to advocate and partner effectively outweighed the funding that may have been at stake. “Our sense is that because nobody expects a WASH organization to oppose the gag rule, that our power is in opposing it publicly,” they added.²⁴¹

At IPPF, “unlike in the past, there is a much more clear and unified position in terms of not signing,” according to a representative.²⁴² “[W]e have done a lot of work to ensure that there is a base of support. That’s why the decision to reject the global gag rule and not abide by it was done quickly and ahead of time.” While IPPF/WHR’s funding is less affected since USAID phased out much of its funding to Latin America and the Caribbean over

the past several years, Giselle Carino, CEO and IPPF Regional Director, noted that, “40 percent of some of our global organizations’ budgets come from U.S. money. So there’s no way to prepare for that.”²⁴³

One of those affiliate organizations is the Mozambican Association for Family Development (AMODEFA). AMODEFA is a leading SRHR organization in Mozambique that also works on

HIV prevention and care, TB, malaria, and support for orphans and vulnerable children (OVCs), among other areas, and operates clinics throughout the country. As AMODEFA does not intend to re-sign any of its agreements that contain U.S. funding, it stands to lose **two-thirds** of its budget because of the Trump GGR.²⁴⁴



Staff from CHANGE and AMODEFA in Maputo, Mozambique.

II. IMPACT OF TRUMP'S EXPANDED GGR

A. Implementation

1. COMMUNICATION WITH THE U.S. GOVERNMENT

Organizations reported varying degrees of communication with the U.S. government about the rollout of the policy under the Trump administration. Jonathan Rucks, Senior Director of Advocacy at PAI, which does not take U.S. funding, explained, “the U.S. government has a fiscal and legal relationship with the prime implementing partner. In the case of the global gag rule, the U.S. government, or U.S. global health agencies should be having conversations with these prime partners about what compliance with the policy means.”²⁴⁵ The prime partner is then responsible for flowing the policy down to its sub-grantees that receive global health funding.

A senior USAID official reported that the agency has conducted “extensive outreach to, and training for,” field-based and headquarters staff. This outreach encouraged staff “to discuss the PLGHA conditions with funding recipients, particularly before the point of incremental funding when the partner is asked to agree to the standard provision.”²⁴⁶ They said staff that oversee funding agreements “use routine project calls or meetings with their implementing partners to discuss implementation of the policy and to share compliance best practices,” and that USAID also “conducts compliance trainings for implementing partners regarding the PLGHA policy and the other legal and policy requirements that guide our health programs.”²⁴⁷

Some organizations observed positive interactions

with the U.S. government around the rollout of the Trump GGR. A representative of the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) in the U.S., for example, reported that they often receive information from their grant manager that helps contextualize the policy’s in-country implementation.²⁴⁸ Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), an HIV and SRHR organization in Zimbabwe, did not comply with the GGR, but they still worked closely with U.S. mission teams to ensure that their projects were transitioned to organizations that were complying.²⁴⁹

Others CHANGE spoke with said the U.S. government did not inform them about the reinstated GGR. One respondent whose organization works closely with NGOs affected by the GGR described their partners’ communications with the U.S. government as “really chaotic.”²⁵⁰ They said some organizations only received an email from their U.S. government contact as a heads-up that the policy will be included in their future award. “And sometimes,” the respondent continued, “they don’t get any notice at all, and just get sent an email saying, ‘You need to sign this and get it back to us in a week.’ So it really puts them in a tough position of trying to get advice in a timeframe that works for an informed response.”²⁵¹

In Mozambique, most of the organizations CHANGE spoke with—including direct recipients of U.S. government funding—have had no contact with the U.S. government about the policy, but instead learned about it from the media or through their networks. A representative from one organization that receives almost all of its funding directly from

the U.S. government said that they typically learn about changes to their agreements in meetings with the U.S. government throughout the year. But when asked what communication on the Trump GGR they have received from the government, they said, “None.”²⁵²

2. COMMUNICATION AMONG NGOS

Because many organizations were not getting the communication they needed from the U.S. government, they were forced to rely on each other. Organizations reported that they learned more about the GGR from civil society partners than they did from the U.S. government. Many people CHANGE spoke with cited PAI’s work as being integral to their understanding of the Trump GGR and their ability to explain it to others. One interviewee credited “a lot of NGO information-sharing; a lot from women’s health groups who knew they would be directly affected in any version of it.”²⁵³ One organization said that it has cultivated new relationships with NGOs in the process of navigating the GGR.²⁵⁴ “I think that’s what happens where there’s adversity, and there’s a threat. There is a sort of unification that kind of emerges,” another organization said.²⁵⁵

Multiple organizations CHANGE spoke with who were sub-grantees received information on the policy from their prime partners as expected, but one year after the Trump GGR had been announced, an organization in Zimbabwe that has three global health-funded projects—comprising 85 percent of its budget—had not yet received any correspondence about the Trump GGR from its prime partners.²⁵⁶ Many interviewees spoke about the confusion that can permeate this prime–sub-grantee relationship.

A director at a U.S.-based prime partner witnessed this disconnect when giving a presentation to

“This is a really complex policy, so it requires a lot of work by organizations to ensure they understand it. It also requires a lot of work on the part of the mission staff to make sure that they understand it well enough to help implementing partners navigate it.”

—Jonathan Rucks, Senior Director of Advocacy, PAI

local affiliates on the Trump GGR. “Halfway through our presentation, I looked at their faces, and asked, ‘Do you all realize that this is talking about a patient-level interaction? You cannot have a *patient-level* conversation about legally available abortion options,’ and the people I was talking to, they seemed pretty taken aback by this realization. I could tell that up to this point they thought this was about some high-level political issue, not individual patient discussions.”²⁵⁷ That the GGR requires ground-level implementation—and is not simply language that goes into funding agreements—is often overshadowed by talk of funding streams and contract jargon.

These challenges are evident when speaking with local NGOs. “So I do not think that the conversation has actually gotten to a level where people then get to understand the policy and its implications. I think the kind of information that’s available around it is probably, as a requirement to fulfilling a grant agreement...you just get that section where it talks about the policy and you need to sign,” one respondent in Zimbabwe told CHANGE.²⁵⁸ “The policy is confusing.”

Lost in translation

Cultural and language barriers complicate GGR communication and implementation, especially at the provider–client level. For example, in the Shona language, one of the official languages of Zimbabwe, there is no direct translation for the “passive referral” aspect of the GGR, which requires a pregnant woman to verbally demonstrate to a health provider that she has already decided to have an abortion and would like a referral, in cases where it is legally permissible to have one. A health provider cannot prompt a woman to ask for an abortion.

How a woman says, “I am pregnant, I want to get an abortion, and I am going to have an abortion,” to their provider is going to be culturally and linguistically influenced. The language to say, “I am pregnant” in Shona is usually embedded in cultural undertones. One of the phrases loosely translates to “I am carrying myself.” There is no direct word in Shona for “abortion,” either. As a result, “I want an abortion” is not a direct translation. This means that there may be situations when the woman is saying that she wants to have an abortion without using those exact words. In these instances, the provider’s interpretation is vitally important because it will determine if this constitutes a “passive referral” and is therefore in compliance with the Trump GGR.

A representative of EGPAF-Zimbabwe told CHANGE, “it gets lost in translation because a lot of our women, they’re not going to go to their local health care worker and speak in English, and say, ‘I want an abortion. I am going to get an abortion.’ They will say it in Shona, for example, which then gets translated, which means what the patient says depends on who is translating what they said. It can then mean exactly what the policy permits, or if it’s not translated properly, it now sounds like a violation. I’m already thinking of many words in Shona that can, in fact, be used for both sides.”²⁵⁹

Organizations are now spending time and resources on making sure they and their civil society partners understand this single policy. They are conducting trainings and webinars, producing and disseminating written guides, creating working groups and listservs, and consulting lawyers—whatever is needed to make the complexities of the GGR understandable. One NGO CHANGE spoke with is now conducting field visits nearly every two months for *one* project until it ends, because “we don’t want to put the organizations themselves at any risk—many of

them are small and vulnerable. We are providing very detailed, detailed monitoring.”²⁶⁰

3. UNCERTAINTY AND MISINFORMATION ON APPLICABILITY

CHANGE’s interviews revealed that the chaos that has accompanied each iteration of the GGR has now been magnified by Trump’s expanded version. With a host of new funding channels affected and previously exempt organizations now subject to the rule, questions, confusion, and misinformation are prevalent about what funding is impacted.

Funding for WASH is one example. An interviewee explained that in the U.S. government, “because the Water Office actually sits in the [Bureau for Economic Growth, Education, and Environment] (E3)²⁶¹—not in the Global Health bureau—my colleagues at the Water Office were not even informed that the gag rule was attached to their program, because it was the Global Health bureau that made the decision. / told them, and they investigated.”²⁶² Even though this took place a month *after* the expanded Trump GGR went into effect in May 2017, she understood that the E3 bureau had not been provided any guidance on the policy at that time.

She attributes this, in part, to WASH funding often being “co-mingled,” meaning multiple accounts fund one project. “People don’t think of WASH as health. People think of WASH as infrastructure,” she continued. And in relation to the GGR, “It’s like the *farthest* thing from abortion—you’re digging a toilet. So it’s interesting because we’ve had to do so much work over the past decade trying to position ourselves as a health issue, and now we’re in a, like, ‘all right, now you’re ready to listen. Let me tell you why,’ kind of place. But it’s because of gag, which is very odd.”²⁶³

CHANGE found instances of the Trump GGR being attached to awards where it did not belong. For example, one respondent said some prime partners were inserting policy language into all of their agreements, regardless of whether they applied to global health assistance funding. “It has been showing up in places where it should not and [we are] having to work with partners to push back against these errors and instances of over-implementation by primes.”²⁶⁴

Excessive application of the Trump GGR

CHANGE found examples of over-interpretation of the policy. In one instance, a consortium of organizations had been awaiting a decision for years on a multi-year, multi-million dollar U.S. grant for a WASH program. It was finally awarded in June 2017. The grant had a mix of programmatic areas that would have been exempt from the Trump GGR under HL.8,²⁶⁵ which covers mostly water and sanitation infrastructure, while others would have been subject to the policy under HL.6.7,²⁶⁶ which is the maternal and child health program area and typically includes hygiene, most sanitation, and behavior change related to WASH.

When the award came through, it indicated that the funding source would be “Development Assistance”—which is exempt from the policy—but the GGR was attached anyway. “So I looked at the documentation that we had and I said, ‘This is wrong. It doesn’t indicate any [Global Health Programs] funding despite the fact that there’s hygiene included in the scope of work. ...[The U.S. government is] interpreting the policy too broadly,’”²⁶⁷ one of the consortium members told CHANGE.

After much back-and-forth, the U.S. government informed the consortium partners that the reason the policy was attached was due to an anticipated addition of Global Health Programs funding *in the future*. “Which, we suspect, is because the president is trying to eliminate the [Development Assistance] account entirely. And so it’s the mission trying to cover its bases so that the program doesn’t die if Congress...eliminate[s] Development Assistance.” Regardless of reason, the policy clearly stipulates that it can only be attached to awards that contain global health assistance—which this particular award did not. Including the GGR provisions to preempt future, hypothetical changes to an award is not part

of the policy.

The consortium was able to obtain confirmation that the source of the funds would be Development Assistance; however, USAID warned that in 2018 Global Health Programs funding might be added to the grant's funds, a move that would invoke the GGR. The group was in the midst of fighting this development when CHANGE interviewed the NGO. If their efforts prove unsuccessful, "we'll have to drop out, a year into a five-year program," the member said.

The entire episode points to a "massive internal communication fail within USAID" and an incredible amount of global coordination and staff time required to sort through the issue, this person said. "All of us had to tap our best relationships to get as much confidential information as possible. ...It took us almost four weeks exactly to resolve, and it took six [of our] staff from four teams in three countries. In one week, I alone worked on this 30 hours. In one week. The transaction costs are huge. Huge."²⁶⁸

Other areas that have caused confusion or uncertainty with regards to the applicability of the GGR are as follows:

- **Research.** Biomedical research has proven to be a point of confusion. Exactly which research is impacted by the GGR is unclear, and organizations are uncertain of what, if any, exceptions might apply.²⁶⁹ Additionally, many medical research protocols require abortion counseling and referral in the case of pregnancy in the course of clinical trials, and this conflict with the GGR is not clearly resolved.
- **National governments.** Due to sovereignty considerations, national governments are not included in the policy. One organization representative said, "anecdotally, we've heard

about government officials saying, 'We won't be able to give you commodities again in the future because of Mexico City,'...that would be very worrying if governments thought that they were required to adhere to Mexico City, given that it clearly states that it doesn't include governments."²⁷⁰ That said, this person added, national governments generally seem to be informed about the provisions of the policy.

- **Government-operated entities** are also exempt, but one interviewee reported at least one instance of government-funded universities being erroneously presented with the policy language.²⁷¹ Sometimes, CHANGE was told, state universities "have private clinics within them where they provide a range of women's health services. And so, it gets complicated with university health research centers."²⁷² For organizations in Mozambique, who often partner with government entities to deliver health services, it was not clear whether the policy applied to them. One interviewee flagged that this is an issue for PEPFAR funding.
- **Consultants.** Some organizations said they knew of consultants that were asked to certify the GGR.²⁷³ Individuals working in their own capacities, that are neither representing an organization nor working on an organization's premises, are not subject to the policy.

The uncertainty surrounding the Trump GGR extends to U.S. government officials, and to USAID missions in particular. A few interviewees attributed the missions' overreach to fear and self-censorship. "They don't want to somehow be sanctioned by the administration or their supervisors," one remarked. "Anyone associated with global health having to implement the policy will have challenges in both its interpretation

and compliance. I suspect most stakeholders would have major challenges trying to document potential impacts of the policy because its rollout has been quite cumbersome.”²⁷⁴

Some organizations have had success in challenging over-interpretation of the GGR. As one interviewee noted, “Pushing back on whether or not the funds are actually subject to the gag rule, we’ve seen a couple of successes in challenging the application of the rule and in a couple of cases have gotten the [U.S. government representative] to agree that the grant wasn’t subject to the rule,” one said.²⁷⁵ Another added, “You may invite increased scrutiny by pointing out instances in which the policy is inappropriately interpreted by government staff, but it’s important to speak up.”²⁷⁶

4. RESTRICTIONS ON ABILITY OR WILLINGNESS TO PARTNER

The Trump GGR fuels uncertainty about whether an NGO can enter into new partnerships or maintain existing relationships. “We’re definitely starting to see the impacts on the partnering and future business side of things,” one interviewee, whose organization cannot comply, said.²⁷⁷ In some cases, organizations said they walked away from opportunities they would have otherwise pursued because of uncertainty around applicability of the policy. A representative from WaterAid America, which cannot comply with the GGR, described three different funding opportunities in three different countries in sub-Saharan Africa that the policy has compromised. “What I’m doing is keeping track of the number of USAID opportunities we don’t go for, and trying to keep track of the amount of time that it takes to answer the source of funds question before deciding whether something is eligible for us,”

she said.²⁷⁸ It’s a shame, she continued, because “the number of [USAID] opportunities that fit our strategy now are more than there ever have been before and the really cool new ones on health integration, now we can’t go for.”

One opportunity was for a food security and agriculture project, which she says should fall under Development Assistance, rather than Global Health Programs. “But it’s been months and no one’s confirmed the source of funding, and meanwhile the deadline to submit just keeps ticking by.” They fear the prime will choose to partner with another organization while they await USAID’s response. “And it really shouldn’t be hard. It’s a food security and agriculture program. That’s Development Assistance—that’s not Global Health Programs—but I want it in writing before people spend months writing a proposal.”²⁷⁹

In Mozambique, one of the organizations CHANGE interviewed was Pathfinder International, a U.S.-based NGO that receives USAID and CDC funds for family planning and HIV prevention for key populations. As a U.S.-based organization, it is able to work on abortion issues with non-U.S. funding, but its local partners do not have the same luxury. Mahomed Riaz Mobaracaly, Senior Country Director for the Mozambique office, told CHANGE that Pathfinder can no longer partner with certain local organizations there that work on SRHR because of the GGR. “It’s narrowed down the number of organizations with whom you can work,” he said.²⁸⁰

For this reason, the policy effectively eliminates opportunities for local NGOs in Mozambique. For example, a U.S.-based NGO that works on family planning was asked to fill a gap in a project where the local organization decided not to comply with

the GGR.²⁸¹ In another instance, AMODEFA had to end its partnership with its prime, FHI 360, a U.S.-based human development organization, and transfer some work in two projects to a GGR-compliant organization that was to minimize the disruption to beneficiaries.²⁸²

In Zimbabwe, an SRHR organization that is certifying the policy lost out on a partnership opportunity, with one representative noting: “But we also have partners that are really adamant and concerned that if they continue to partner with us [it] will also affect their work.”²⁸³ One such partner lost funding because of the GGR and had wanted to directly partner with the SRHR organization, so their question was, “So how is it going to work out if we partner with you and we are affected by this policy? You guys are safe, your name is okay, and you are doing much of this work and we’ve already had to choose,” they told CHANGE.²⁸⁴ For prime partners in particular, because of the policy, “People have become a bit more jumpy about signing up sub-recipients” because they want to make sure they are eligible, a representative of CARE International in Mozambique said.²⁸⁵

One NGO has also had “a number of organizations” ask if they are eligible to partner with it because it cannot comply with the policy. In one instance, an organization that was considering such a partnership began asking questions about the GGR and pulled out of the opportunity soon after. “An interesting thing to monitor over the next 12 months is whether we think we’re losing out on funding opportunities with non-U.S. government money as a result of this,” the respondent added.²⁸⁶

Another NGO, which is not certifying, recounted a similar experience. A partner organization of theirs certified the GGR, and then told them they

would no longer be able to partner with them on other, non-U.S. funded projects. “So it is really disrupting, because these are partners that we have been working [with] for many years, and we know that the source of funding is definitely not USAID.”²⁸⁷

Quantifying these severed partnerships puts into perspective the scope of services that will be lost and, as a result, the lives that will be impacted. One organization told CHANGE they “had to withdraw from at least five sub-relationships with primes, which would have carried on, because of [GGR].” In addition, they said, “there are two other countries where we believe we would have been the most likely candidate to win follow-on funding from USAID, so that’s seven countries, and those have already happened. We are now having to shut down our operations in our global award countries because we can’t request any further funding from USAID. **So in total, by the time we close everything out – we were operating last year in 17 countries, and by the end of or by sometime next year, those will all be shut down—all those [USAID-funded] projects**” [*emphasis added*].²⁸⁸

5. THE CHILLING EFFECT

Because of confusion surrounding the GGR, organizations tend to over-interpret it for fear of being found non-compliant. One organization noted that, “organizations are very nervous about Mexico City, especially when they are signing up to it. And so the tendency is for them to err on the side of caution and to over-interpret it, rather than to interpret it to the letter and/or be a bit brave in interpreting it.”²⁸⁹ It was apparent in CHANGE’s interviews that, under the current iteration of the GGR, the chilling effect is now

compounded by the political climate surrounding the Trump administration and SRHR, namely its broader efforts to defund women’s and global health programs.

“The chilling effect is there already, but given the expanded rule, and because Trump is not a usual president, I think there is a greater fear now of possibilities of retaliation and having to pay back the money if for some reason they’re found not to be complying. So I think that the chilling effect compounded by the broad scope and fear makes the impacts worse this time.”

—Rebecca Brown, Director of Global Advocacy, Center for Reproductive Rights

The International Centre for Reproductive Health (ICRH-M), a local SRHR organization in Mozambique, has already observed self-censoring among key coalition groups that comply with the GGR—including some partners declining participation in meetings—and contends this has weakened their coalition network that advocates for SRHR.²⁹⁰ For example, some members of the Mozambican Sexual and Reproductive Rights Network²⁹¹ have mostly stopped participating on abortion issues, while remaining engaged around other activities including GBV and early marriage. As Ivone Zilhão, of the network’s steering committee, told CHANGE, “People, they don’t know what is the future.”²⁹²

One organization described changes in the dynamic of a technical working group that has supported the rollout of safe abortion services

in Mozambique. “Now...there’s a much stricter interpretation of being in the room and being a part of the conversation. I do think in a less measurable term, it’s caused a bit of anxiety and friction and extra thought energy.”²⁹³

By March 2017, one NGO had already discontinued adolescent pregnancy consultations and taken all its written materials on abortion out of circulation.²⁹⁴ Another respondent described NGOs that are no longer administering emergency contraception or post-abortion care: “things that are so clearly outside of the strictures of the rule. And I think that it’s an exacerbated chilling effect because there’s the understanding of the very conservative ideology of this government, and not wanting to have *any* situation that could potentially be misconstrued, and putting the organization’s financial viability at stake.”²⁹⁵

Interviewees from IPPF/WHR echoed that the chilling effect is tied to the larger political ideology of the Trump administration. “It’s not just the money you lose, it’s not just the stigma that it creates, it’s not just the confusion. It’s highly ideological and political,” one said.²⁹⁶

The disruptive impact on coalitions has also been seen in Zimbabwe, where an organization told CHANGE that it has seen confusion about the policy lead coalition members to stop participating. “There’s a lot of confusion among these coalitions... whereby [some] partners have signed the Mexico City Policy while others haven’t signed the Mexico City Policy. ...Others will say ‘we won’t do this’ while others will say ‘we will do this.’”²⁹⁷ Another organization observed that in technical working groups it co-chairs, and of which USAID is also a member in some countries, some groups are no longer participating and are “trying to stay below

“If you’re in a country that’s heavily reliant on another government for underwriting your health system, you’re likely used to answering to that country in many ways. For example, donors check and approve budgets, and at the facility level, supplies are counted and services are tracked to ensure that donor-set targets are met. At every check along your path to delivering health care, there is at some level another government making sure you’re doing what they think is appropriate. That does not leave much room for debate or pushback, or silent or individual protest on the part of providers, even though they have the contextual knowledge about health systems and service demand that politicians do not.”

—Emily Maistrellis, Senior Program Officer, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University

the radar,” a trend it worried could compromise progress made on integrated primary health care.²⁹⁸

One organization that does SRHR advocacy around the world has received reports that there have been fewer people showing up to events and signing on to written materials under the Trump GGR.²⁹⁹ At a 2017 annual gathering to discuss sexual and reproductive health services, some groups were unable to attend abortion workshops relevant to their work as a response to the GGR.³⁰⁰ Another organization mentioned, “At some point we realized we shouldn’t post our

work around abortion on social [media] of what’s really happening on the ground, in particular with [the GGR].”³⁰¹

6. SIX-MONTH REVIEW: EARLY FINDINGS

The State Department announced on May 15, 2017 that it would conduct a “thorough and comprehensive review” of the GGR over the next six months, with particular attention to newly covered global health programs.³⁰²

The State Department released its findings from the six-month review on February 6, 2018.³⁰³ The review did provide several limiting clarifications including a definition of financial assistance.³⁰⁴ It is a woefully incomplete assessment of implementation with no measure of impact, despite several NGOs having provided submissions detailing early harmful impacts of the policy. Disregarding evidence to the contrary, the review paints an overly simplistic and positive picture of the Trump GGR. It mentions “the full range of benefits and challenges” of the policy and highlights that, of 31 groups that provided submissions, “several submitted comments in support of the policy.” In fact, the *only* quoted submission is from the United States Conference of Catholic Bishops praising the Trump GGR.

In addition to being incomplete, the review process lacked transparency and, therefore, accountability. There was no indication of timing of the review’s release, and submissions have not been made public, despite requests from civil society groups that the State Department do so.

Lastly, the review was conducted too early and thus missed important inputs; for example, the information collected through September 30,

Measuring the toll of Trump's GGR

The Kaiser Family Foundation quantified how many organizations received U.S. global health assistance from FY2013 to FY2015 to illustrate how much funding could be affected under the Trump GGR. Their report found that, had the policy been in force during this period, at least **1,275 foreign NGOs** and an estimated **\$2.2 billion** in U.S. global health assistance would have been impacted. Additionally, **469 U.S.-based NGOs** would have been required to pass down the policy to their sub-grantees.³⁰⁵ Had Trump simply reinstated the George W. Bush administration's version of the policy, without the expansion to all global health assistance, 92 percent of foreign prime NGOs (587 of 639 organizations) would not have been affected. Of these 587 foreign NGOs, 557 received no family planning assistance.³⁰⁶ Eighty-eight percent of funding received by foreign prime NGOs, or \$1.2 billion, would also not have been subject under the terms of the Bush iteration.³⁰⁷ Among U.S.-based primes, 82 percent would have had to ask their sub-grantees to sign for the first time because of Trump's GGR expansion.³⁰⁸

2017 would not have included any CDC grants and agreements because their new and renewed awards were disbursed after that date. CDC distributes global health assistance as USAID does, yet foreign NGOs receiving CDC funding are not reflected in the review. These NGOs, some of which spoke with CHANGE for this report, are now feeling the effects of the policy.

B. How the Trump GGR harms health and service delivery

1. LOSS OF HEALTH SERVICES

MSI estimates that, due to the loss of funding and related discontinuation of services it will see under the Trump GGR, 1.6 million fewer women will have access to contraceptives from a trained MSI provider annually.³⁰⁹ In addition, from 2017 to 2020, it anticipates that the cuts to its programs—and the impact on its clients alone—will result in:

- 6.5 million unintended pregnancies
- 2.2 million abortions
- 2.1 million *unsafe* abortions
- 21,700 maternal deaths
- \$400 million in direct health care costs³¹⁰

MSI's program in Zimbabwe, Population Services Zimbabwe (PSZ), is an NGO specialized in providing sexual and reproductive health services.³¹¹ Through USAID's five-year Improving Family Planning Services (IFPS) project, PSZ was able to provide family planning services to 650,000 Zimbabweans, in turn preventing 814 maternal and 3,100 child deaths.³¹² The grant supported nine outreach teams in all 10 provinces at 1,200 service points, reaching marginalized, hard-to-reach populations in mostly rural locations. The grant also supported 50 social franchise (SF) clinics under the Blue Star Healthcare Network, a public-private partnership delivering provincial-level family planning services.³¹³ With the grant scheduled to end in September 2017, PSZ had anticipated it would be renewed. Yet because the GGR was reinstated and MSI cannot comply with the policy, PSZ was not able to reapply for this grant.

The loss of U.S. foreign assistance, which accounted for 56 percent of PSZ's overall budget,³¹⁴ has

resulted in a 50 percent scale-back of the outreach programs and a decrease in the SF partners with whom PSZ can work. A PSZ representative said, “In Zimbabwe, outreach is covering 1,200 sites—that’s the local health facilities that we are covering and outreach. And we had to cut it by 50 percent to 600. ...We had 50 partners in the southern region, but currently, we’re left with 20.”³¹⁵ The reduction of facilities and SF partners has hindered severely the provision of comprehensive family planning and sexual and reproductive health services in hard-to-reach communities.

IPPF estimated it would lose \$100 million in U.S. funding during the Trump administration, a loss that would hamper IPPF’s ability to prevent 20,000 maternal deaths, 4.8 million unintended pregnancies, and 1.7 million unsafe abortions. This funding would have paid for:

- 70 million condoms
- 725,000 HIV tests
- Treatment for 275,000 pregnant women living with HIV
- Treatment for 525,000 STIs³¹⁶

IPPF’s local Mozambique affiliate AMODEFA is a long-time recipient of direct USAID/PEPFAR funding and a sub-grantee of FHI 360, N’weti, and the American International Health Alliance, among others. The PEPFAR funding supports a research program in Beira focusing on the lesbian, gay, bisexual, transgender (LGBT) community, including examining the incidence of HIV and STIs—just one aspect of the important work that is in jeopardy. AMODEFA will lose **60 percent** of its budget because it cannot comply with the Trump GGR.

AMODEFA has had to close clinics across the country and let go of approximately **30 percent** of its staff. This is weighing on staff morale, as no one knows who might lose their job next. “But I think that we will lose more people because as [a] consequence of this cut, we have to restructure the organization this year,” a representative told CHANGE.³¹⁷ “We don’t have resource[s] for activities. How can we be paying so many people when we are not providing service[s]?”

2. IMPACT ON HIV AND AIDS

The Trump GGR is the first iteration of the policy in which HIV funding is subject to the policy restrictions. Organizations that are heavily reliant on PEPFAR funding are bracing for GGR impacts. One Ethiopian NGO that provides ART in all 52 of its

The power of PEPFAR in reducing HIV and AIDS worldwide

Data indicate that PEPFAR has been instrumental in combating HIV and AIDS around the world. As of September 2017, PEPFAR was supporting antiretroviral therapy (ART) for 13.3 million men, women, and children living with HIV.³¹⁸ It has supported HIV testing services for 85.5 million people, including more than 11.2 million pregnant women in FY2017 alone, and prevented 2.2 million babies from being born with HIV.³¹⁹ PEPFAR also supported 6.4 million orphans, vulnerable children, and their caregivers and trained 250,000 new health workers on HIV and other health service delivery.³²⁰ As a result, PEPFAR has helped avert more than 11 million AIDS-related deaths and almost 16 million new HIV infections around the world.³²¹

clinics, particularly to highly vulnerable groups and in regions with a dearth of health service providers, fears disruptions in care because it expects to lose U.S. funding.³²² Some of these impacts have already materialized. Another NGO spoke to CHANGE about two programs for youth—one in Uganda that provides vouchers for HIV and STI screening and family planning services, the other in Malawi for HIV testing and counseling—that will be shut down if the organization cannot obtain alternative funding.³²³

Given Mozambique's high HIV prevalence, organizations there are concerned about the impact of the Trump GGR. "I think that really creates a fear that HIV rates will go up because there's no longer this availability of funding," a representative of WaterAid said.³²⁴ Pathfinder International noted that community-based organizations "are doing the household visits and the community-based care for HIV, and they are the ones that are very well-penetrated at the community level. We want to take advantage of that penetration at the community level to offer services, but they will not be able to because now of this extension of [the global] gag rule."³²⁵

In Mozambique, many young people who are born with HIV are unaware that they are living with HIV. AMODEFA was implementing a pilot program on parental disclosure of HIV to children, which was so successful that they expected to expand it nationwide. But they have already stopped the program because of the Trump GGR. They are planning to train other organizations to take over the work so they can revive the program, "but the other organizations don't have experience in these areas," said Santos Simione, AMODEFA's Executive Director.³²⁶ In the meantime, children with HIV in Mozambique are growing up unaware of their status.

a. Impact on adolescent girls and young women

Adolescent girls and young women (AGYW) account for 74 percent of new HIV infections among adolescents in sub-Saharan Africa.³²⁷ Gaza province, in Mozambique, has the highest HIV rate in the country—24.4 percent of the population in Gaza is living with HIV³²⁸—and the highest HIV prevalence among AGYW.³²⁹ Organizations CHANGE spoke with fear that the GGR will curtail their ability to decrease the HIV rate among youth.

The drastic reduction in HIV service provision for AGYW at AMODEFA's clinic in Xai-Xai district, Gaza province, as a result of funding cuts from the Trump GGR shows how quickly the policy can destroy HIV prevention efforts. In just the last three months of 2017—after they lost their U.S. funding—there is a marked decrease in HIV services provided to AGYW, compared with the months leading up to September 2017.³³⁰

The clinic also closed its U.S.-funded program, Tua Cena, in September 2017 because of the GGR.³³¹ The program aimed to increase access to quality sexual and reproductive health services for adolescents and young people in three districts in Gaza province, including testing and counseling for HIV, testing and treatment for STIs, and family planning services.

Through Tua Cena, AMODEFA was able to identify particularly vulnerable adolescents, such as orphans and adolescents living with HIV, and start them on ART. From September 1-22 of 2017, Tua Cena tested 1,099 people for HIV, including 923 girls and young women; distributed nearly 15,000 male condoms and 476 female condoms; and provided family planning services for 1,237 people, including 32 intra-uterine device (IUD) insertions, 106 contraceptive implant insertions,

Table 2: HIV services at AMODEFA’s Xai-Xai clinic for girls and young women under 24 years of age, July-December 2017

Service	July-Sept. 2017	Oct.-Dec. 2017
Consultation	6,799	833
Pre-counseling	6,799	833
Rapid test	5,621	833
Pre-test counseling	5,621	833
Counseling to reduce risk	6,799	833
Psychosocial support	896	253
Clients tested	5,981	671

348 contraceptive pills, and 684 Depo-Provera injections.³³² The discontinuation of these services leaves already-vulnerable youth at greater risk of HIV, STIs, and unintended pregnancies.

One NGO has been forced to discontinue a project that reached 14,000 AGYW in Uganda with information and services on HIV and economic empowerment because the prime partner could not comply with the GGR. As a result, it was unable to scale up or transition the work in order to provide AGYW with continuity. “It means that the women, the young women and girls, will not be able to have the skills or the economic empowerment that they had been accessing, and therefore it will have a long-term impact in terms of access, in terms of information and knowledge, and then in terms of their ability to prevent HIV,” the NGO’s executive director said.³³³

b. Impact on DREAMS

The DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) Partnership, launched by PEPFAR in December 2014,³³⁴ is a \$385-million initiative to reduce new HIV infections among AGYW in 10 sub-Saharan African countries; new infections in these countries accounted for more than half of all new HIV infections among AGYW globally in 2016.³³⁵ Data on DREAMS demonstrate that the initiative is succeeding: 2017 estimates showed that new HIV infections significantly declined in nearly every DREAMS district, with two-thirds of the highest HIV-burden communities reaching a 25–40 percent reduction in new HIV infections.³³⁶ In nearly all DREAMS districts, new HIV diagnoses decreased.³³⁷

i. DREAMS Mozambique: Immediate impact of the GGR

In Mozambique, DREAMS has programming in six high-prevalence districts located in Gaza, Zambézia, and Sofala provinces.³³⁸ The U.S. contributed \$20.4 million for DREAMS programs in the country in FY2016–2017.³³⁹ In Mozambique, where child marriage, early sexual debut, and adolescent pregnancy are common—and put girls at increased risk of HIV—programs such as DREAMS are critical. Without them, CHANGE was told, the futures of young women would be bleak.

The staff at AMODEFA's clinic in Xai Xai district, Gaza province, have a very stark view of the future under the Trump administration's GGR. "By the time you get the policy repealed, many people will have died," one person told CHANGE.³⁴⁰ The clinic's U.S. funding through the DREAMS Partnership has helped them reduce the incidence of HIV in the province, a trend they expect to see reversed now.

The clinic began a five-year DREAMS initiative in April 2017 that would have continued until 2022. The program trained and supported 600 community health workers, called *activistas*, to provide SRHR information, referrals, and services to rural communities, including HIV testing and counseling, STI testing and treatment, and family planning, particularly for AGYW. In addition, *activistas* served as community leaders. AMODEFA's clinic discontinued much of these activities in September 2017 because of the Trump GGR.

Without funds to pay them, the clinic was forced to lay off both nurses and *activistas*; they now have only 64 *activistas* left out of an original 600. "Now people in the communities where we can't go still call me, but there are no resources to reach those communities," one *activista* said.³⁴¹ "So it affects

our name and our integrity."

The remaining sources of information for the community, radio and the internet, cannot replace the in-person, evidence-based, community-centered care provided by *activistas* and nurses. The clinic staff is very concerned about the impact this reduction in services will have in Gaza. "We cannot achieve our goals," one staff member said.³⁴²

ii. DREAMS Zimbabwe: Immediate impact of the GGR

In FY2016, \$20,621,571 in U.S. funding was allocated for DREAMS interventions in six districts (Bulawayo, Chipinge, Gweru, Makoni, Mazowe, and Mutare) in Zimbabwe.³⁴³ From inception until mid-2017, about 110,000 AGYW between the ages of 10 and 24 had received DREAMS services.³⁴⁴ Additionally, in 2017, pre-exposure prophylaxis (PrEP) provision was extended from four to all six DREAMS districts in the country.³⁴⁵

The Trump GGR is impacting DREAMS activities in Zimbabwe by diminishing implementing organizations' abilities to educate adolescent girls about family planning and pregnancy prevention as strategies for HIV prevention. "I don't even understand how the DREAMS will be worked out without mentioning abortion because we are talking about adolescents, young women, and so forth," a representative of the Women's Action Group (WAG) said.³⁴⁶

CHANGE met with DREAMS-implementing organizations that are providing interventions addressing a range of issues including education, community mobilization, girls' empowerment, and family planning. "We used to be part of the DREAMS Partnership...doing the family planning in that DREAMS Partnership," a representative of PSZ told CHANGE.³⁴⁷ "We are no longer part of DREAMS or

any DREAMS activities. We are no longer taking part.” The PSZ funding for DREAMS family planning was transferred to a U.S.-based organization, Population Services International (PSI).³⁴⁸ PSZ pointed out that PSI does not offer the full range of comprehensive family planning and sexual and reproductive health services that PSZ does.

One organization explained the duality of HIV and SRHR, noting that HIV acquisition is the result of SRHR challenges that young people face.³⁴⁹ Nearly half of SAfAIDS’ budget was from USAID, the bulk of which was used for DREAMS programming. As a DREAMS prime partner, SAfAIDS would have

continued accepting U.S. funding if it were not for the Trump GGR.³⁵⁰

Another NGO, Roots (Real Open Opportunities for Transformation Support), had a five-year sub-grant with SAfAIDS that made up 60 percent of their budget. Roots—a pro-choice NGO that promotes social and economic justice for young people in rural, peri-urban, and mining communities³⁵¹—also declined U.S. funding. Roots’ funding was being used for DREAMS initiatives in Mazowe and Glendale,³⁵² rural, agricultural, mining towns, where AGYW are particularly vulnerable to HIV acquisition.



Staff from CHANGE, Real Open Opportunities for Transformation Support (Roots), and adolescent girls and young women from DREAMS programs in Mazowe, Zimbabwe.

Roots' DREAMS interventions, which centered on strategies for keeping girls in school or getting them back into school, was targeting 5,000 young women ages 20–24 and 2,500 girls and young women ages 15–19.³⁵³ The initiative included education and providing safe spaces, as well as training in income-generating activities such as manufacturing detergent and floor polish. They also anticipated undertaking some agricultural projects, designed to foster both economic and SRHR empowerment. At the time of CHANGE's interviews with DREAMS beneficiaries, these activities had been inactive since October 2017 because of the Trump GGR.³⁵⁴ "I am a young mother," one beneficiary said, "[DREAMS] had these groups and clubs, and we would come together for some form of economic empowerment so we could support our children. Even that stopped."³⁵⁵ Another DREAMS beneficiary told CHANGE that, without these savings clubs, they face barriers to earning money. "You hear a young girl saying, 'For me to buy one [menstrual] pad, I need to sleep with two men.'"³⁵⁶

In the communities where Roots was active, DREAMS strategies were working for HIV prevention. DREAMS beneficiaries consistently reiterated that with Roots no longer conducting DREAMS activities, young women were neither accessing SRHR information nor participating in economic or enrichment activities, and this would eventually result in unintended pregnancies. DREAMS was impacting areas beyond HIV, but "[GGR] will derail the progress that has already been made," one Roots representative told CHANGE.³⁵⁷ "The disruption of the DREAMS program is [having] this negative effect on the experiences of adolescent girls and young women." The Trump GGR's conditions mean organizations like Roots cannot continue with progressive empowerment initiatives for AGYW.

3. IMPACT ON POPULATIONS OF SPECIFIC CONCERN

a. LGBT people

Organizations interviewed by CHANGE anticipate, and have already started to see, the future impact of the Trump GGR on LGBT communities. One organization, which was a sub-grantee on an HIV prevention project working with populations at high risk of HIV infection, including men who have sex with men (MSM), can no longer participate in the grant now that it has been renewed because it cannot comply with the GGR. The work spanned four countries in Central America.³⁵⁸

In Zimbabwe, national government and civil society organizations have invested substantial effort in collaboration to increase funds in country operational plans (COPs) for key populations' access to health services.³⁵⁹ Under the Trump GGR, key populations are extremely vulnerable. "Many key populations are already disadvantaged, although they're not helpless. However, the system has already placed them in a very unsafe space as they struggle with access to services. Now if this one SRH service *might* have been available to them, even that will be taken away," SAfAIDS told CHANGE.³⁶⁰

The LGBT community in Mozambique also faces barriers to health services. One organization CHANGE spoke with works on HIV prevention. Organizational representatives worried about the detrimental impact of the GGR on the NGO's partnerships, and the resulting implications for its ability to deliver care to key populations. "So if for example in one province, [there is] not anymore shared space like in the past, we cannot for instance have Pathfinder as intermediaries, so it means that our capacity in terms of providing services on the HIV area will reduce, and it will

have an impact on the provision of services in terms of HIV.”³⁶¹ They further explained, “Many organizations are not solely working on HIV prevention. Sometimes they bring together services—like HIV prevention and safe abortion, so all of these are going to be impacted, meaning that [in] the situation of HIV, most organizations won’t have funds to carry on their work.”

According to another interviewee who works on LGBT issues globally, “In many countries, it is the reproductive health community that is often one of the biggest allies of LGBT issues. And also in many countries, although this may be less true, the health community...is very frequently the first sector that will start to attend to the needs of LGBT people.”³⁶² Because reproductive health communities are impacted negatively by the Trump GGR, by extension LGBT needs and issues will suffer as well.

One organization partnered with AMODEFA clinics to serve LGBT populations in Mozambique, but that work has been affected adversely with the closure of many of AMODEFA’s clinics. “AMODEFA clinics were a unique space where we could refer our beneficiaries, who are [transgender] women, who are lesbian, who are gays, who are MSM, expecting if you are referred to AMODEFA’s clinics, they were going to receive friendly attendance,” a representative told CHANGE.³⁶³ For example, they recently found out that AMODEFA will be closing a clinic the organization works with in Manica province. “In the Manica province, we do not have a lot of choices or clinics that we have in Maputo. So we can feel the impact. It will be different.”

As the GGR curtails access to health care and to youth-friendly programs, lesbians will be particularly impacted. Andrew Park, former

Director of International Programs at The Williams Institute at UCLA School of Law, explained, “Contrary to common belief, lesbians and bisexual women get pregnant. Research shows that adolescent-age lesbians can face higher rates of unplanned pregnancy than heterosexual women. One possible reason is that condom use is lower amongst lesbian and bisexual women. There is a general belief that sexuality education programs are only meant for women who identify as straight. So there is often a self-selection or an exclusion of lesbians and bisexual women from mainstream youth programs that deal with family planning issues. Many reproductive health organizations fill a very important need by running youth programs that address the needs of lesbians and bisexual women. When funding is cut, these programs will be impacted.”³⁶⁴

Transgender people are also expected to face barriers to care as a result of the Trump GGR. “When the general health infrastructure is damaged, I worry that marginalized groups will be among the first to be hurt. Transgender people need transition-related health care, but also appropriate care in general to respond to unique health needs. For instance, transgender women may still need prostate care and transgender men and lesbians may still face unique risks for breast cancer. Health providers need to know what questions to ask and what to look for,” Park noted.³⁶⁵ Closures of adolescent- and LGBT-friendly spaces—such as AMODEFA’s clinics in Mozambique—could mean that providers who remain are not going to be asking these types of questions, and as a result will not be providing the care that LGBT communities need.

b. Sex workers

Informants said the Trump GGR will impact key populations' programming and service delivery by disrupting comprehensive access, information, and services, especially where providers are forced to choose how they communicate sexual and reproductive health information, and specifically what they will not say.³⁶⁶ This may constrain the health services delivered to vulnerable groups, such as sex workers. One NGO representative argued that, "There's no way you can work with sex workers and then you don't talk about abortion. So some people may choose to take the easy road, in terms of what they work on, in terms of their target groups, and that is definitely going to impact groups that are already more vulnerable."³⁶⁷

In Mozambique, ICRH-M, a sub-grantee of FHI 360 receiving PEPFAR/USAID funding, works with

key populations, including sub-granting to local district health services. They operate the Moatize Night Clinic in Tete province as well as community-based services that serve more than 2,000 sex workers. The organization is one year into a five-year contract, but they cannot comply with the Trump GGR. Sexual and reproductive health "is a core part of who we are," a representative told CHANGE.³⁶⁸ "There's no way we could, with any credibility, stop doing that work."

When CHANGE met with ICRH-M in January 2018, the GGR had not yet been added to their funding agreement, but they knew it was only a matter of time before they would have to give up their U.S. funding. In late February 2018, FHI 360 told ICRH-M that they would lose their funding and have to cease all of their U.S.-funded activities within one month. With one month to



Staff from CHANGE and ICRH-M in Maputo, Mozambique.

grapple with a 40 percent budget cut and shut down essential health services, Sally Griffin, director of ICRH-M, called the policy “something you’re completely powerless about.”³⁶⁹

Among the services to be discontinued is ICRH-M’s night clinic, which is a very important space for sex workers who face barriers to accessing public health services. It provides an integrated package of HIV and STI services, family planning, and screening and referral for cervical cancer, GBV, and TB, “so if they go for an HIV test they’re supposed to get these other services that they recognize are important for key populations,” Griffin said.³⁷⁰

Griffin told CHANGE it has “taken us a very long time to build up trust of the sex worker population” over the course of 15 years operating the clinic and community services. Now that ICRH-M must stop this work, a vital relationship will be lost. “We treat them with respect, and we don’t see that in all organizations that work with sex workers.”³⁷¹ ICRH-M noted that they do not know of any organization that could take up the work in their place.

Many organizations that work with sex workers have “HIV blinders,” meaning they treat sex work as solely an HIV issue rather than seeking to meet the complete range of SRHR needs of sex workers. With the vacuum left by ICRH-M comes a significant loss of expertise in this regard. Further, even though the U.S. is a strong supporter of integrated health services for key populations, Griffin noted that the organizations that comply with the Trump GGR “will not include safe abortion in that package of services and will not refer sex workers, young women, drug users, whoever it is, to those services.”³⁷²

c. People living with disabilities

PSZ’s IFPS activity grant improved access to family planning and sexual and reproductive educational materials for people living with disabilities, especially for those who have physical, auditory, speech, and visual impairments.³⁷³ Without U.S. funding, PSZ cannot continue to support access to family planning services for people living with disabilities. “We used to have a disability project that USAID funded...[it] requires a lot of resources. And without adequate funding, we have sort of scaled down. ...So I think the disability sector suffered the most broadly. It was an abrupt termination of the relationship. We had initiated some activities with people with disabilities, and all of a sudden, we couldn’t continue,” PSZ said.³⁷⁴ “It is expensive.”

People living with disabilities in Mozambique struggle to access health services and are at greater risk of abuse. Robert Burny of Handicap International told CHANGE, “What we have observed is that those people with disabilities, particularly the women and the young women and teenagers with disabilities, are much more exposed than their neighbors without disabilities.”³⁷⁵ They are more likely to be HIV positive and be targets of sexual abuse, exploitation, and rape. “So my concern is that that would close some doors for them to be referred” to services, including for SRHR, protection, and abortion. He feared the GGR would “create an additional bottleneck” and a barrier to accessing those services.

d. People living in rural areas

The Trump GGR is particularly threatening to service delivery in rural areas. As one respondent explained, “A mobile community health worker that goes village to village...is often the only health worker

those people see, and they don't really have the opportunity to cherry pick. The health worker can't really say, 'Let me refer you to another community health worker from a different organization that doesn't have to worry about this [policy].' That's where I think it gets to be a little challenging, is that there isn't just a whole range of actors out there that you can just refer them to someone else or [say], 'Let me get someone who can talk about this with you.' You kind of have the health worker you have—oftentimes they're the only one."³⁷⁶

Organizations described the vital role community health workers play in encouraging pregnant women to go to a clinic and in helping women make decisions about their health. A representative of CARE International in Mozambique is worried about their community health workers, who regularly conduct home visits and give referrals for a list of health interventions, "not being able to say anything to pregnant women or women who [find] themselves in distress."³⁷⁷

Respondents fear rural areas of Mozambique will likely be hardest hit by the Trump GGR, since community health workers, peer educators, and community activists will not be able to reach those communities without funds. "I feel this fear more at the provincial level and district levels," a member of the Sexual and Reproductive Rights Network told CHANGE.³⁷⁸

AMODEFA predicts the number of STIs will increase in communities as well. "If you want to work on prevention, it's not in the hospitals—it's at the community level," a representative told CHANGE.³⁷⁹ AMODEFA's rural Xai-Xai clinic has reduced dramatically the services it provides in-house. The level of services it provided in the three months leading up to October 2017—when it lost

its U.S. funding—compared with the three months after concretely illustrate how the Trump GGR is already harming people's access to health care.³⁸⁰

In Zimbabwe, PSZ specializes in contraceptive implant insertion and removal, using outreach programs to provide this service to hard-to-reach communities.³⁸¹ Implants are long-acting contraceptives that can last up to three years without requiring a return clinic visit.³⁸² Since scaling down due to the loss of U.S. funding, "the family planning methods that are expired, like the implants, you'll find maybe we're not able to reach some areas we already have provided the service, and they will be overdue. And even now, [women] may want to have the implant removed, but we have no means to go there. So it's not only for after [it's] expired, but [women] may opt to remove for family planning if they want to have more children. So we're not able to do that," a representative told CHANGE.³⁸³ Some of these hard-to-reach areas do have access to government facilities, but government health workers are not specialized in long-acting and permanent methods (LAPM) and have competing priorities and resource setbacks. "So it's actually a pity when someone has to buy their own razor blade for implant removal. And it's not the proper surgical blade."³⁸⁴

The organizations CHANGE met with in Gaza province, Mozambique, were particularly concerned about the impact of the policy on AGYW living in rural areas, who already lack access to information about SRHR and face high rates of early pregnancy and early marriage. They fear girls as young as 12 who become pregnant will likely never return to school, and that the lack of family planning services will likely lead to a higher rate of unintended pregnancies.

Table 3: Services provided at AMODEFA's Xai-Xai clinic, July–December 2017

Family Planning (Women)	July–Sept. 2017	Oct.–Dec. 2017
General counseling	12,258	2,728
Pills - consultation	1,780	460
Male condom - consultation	71,582	6,708
Female condom - consultation	3,464	694
Injectable - consultation	3,445	688
IUD insertion - consultation	225	73
Implant insertion - consultation	664	232
Implant removal - consultation	52	1
EC - counseling	848	0
Family Planning (Men)		
General counseling	2,063	426
Male condom - consultation	22,635	4,490
STI		
Consultation	414	40
Pre-test counseling	229	40
Post-test counseling	229	39
Counseling to reduce risk	414	40
Syndromic treatment	364	13
Gynecology		
Consultation	2,789	0
Counseling for cancer prevention	2,789	0
Pre-test counseling for cervical cancer	1,249	0
Manual examination - breast palpation	2,789	934
Bimanual investigation - internal and external	1,705	0
Menstrual regulation	58	0
Syndromic treatment	18	0

According to the Community-based Association for Health and Development (ACOSADE), a community-based organization in Chicumbane, Xai-Xai district, the Trump GGR “will be a drawback for the engagement of the girls.”³⁸⁵ In communities where child marriage and early pregnancy are common, SRHR education can be life-changing. “When we started this kind of sexual and reproductive health education, then girls started understanding who they are,” a representative explained.³⁸⁶ For example, “Before it was difficult to find a young girl who stands up and talks about sex and HIV, but nowadays...you can find a woman who tells men, ‘If you don’t wear a condom, there’s no sex.’” For communities where ACOSADE is beginning to see results, they said, “this policy is like giving a sweet to someone and while they are starting to taste it, you take it back out of their mouth.”³⁸⁷

4. IMPACT ON INTEGRATED SERVICES

Over the past decade, the U.S. has been a strong proponent for integrated health systems—for example, having HIV, AIDS, and family planning services provided at the same clinic—as an effective and efficient strategy for improved health outcomes.³⁸⁸ As a result, the U.S. has increased co-mingled funding in its awards. For example, AMODEFA ran an integrated clinic in the Nampula province of Mozambique—where the distance to the nearest health facility can be as far as 50 kilometers for some people. Because of the loss of funding from the GGR, AMODEFA has already stopped its integrated TB, malaria, HIV, and family planning program. They had used motorbikes to reach and test people, because “people cannot really afford to go that distance.”³⁸⁹

One interviewee compared integrated services to a supermarket, “where I get into a supermarket, I get a fruit, I get a juice, I get a meal. Literally, I get everything within one shop. I reach into this hospital, I expect to get HIV testing, counseling, treatment; STI screened; family planning service, which is not going now to be available. Why? Because there is a condition [the GGR].”³⁹⁰

The DREAMS Partnership is an example of a U.S. government program that has successfully implemented integrated services. As one respondent said, “Before the DREAMS initiative, which provides a package, we had been implementing piecemeal interventions, where it has not been like you come to a facility and it’s a one-stop shop, where you come and you get everything. But now, because of [the] DREAMS initiative, when it comes to the integration, it’s one of the core components that have a package being provided in health facilities.”³⁹¹

Many people who seek HIV care may also seek contraceptive services as part of their regimen. In Zimbabwe, for example, about 30–40 percent of women who sought family planning care in 2003 were thought to be living with HIV.³⁹² To effectively address the epidemic, HIV prevention services, testing, and counseling are usually integrated with other service delivery channels like family planning services. CHANGE observed that the Trump GGR is dismantling this type of response to the HIV epidemic. “Because we know for HIV/AIDS, Zimbabwe is mainly FHI [360], PSI. ...We used to cooperate with these organizations. When we would do service integration, we would do some joined operations, especially with the outreach. ...While we were providing family planning, they would also come ride on our back and provide HIV services and so forth. ...They are being affected.

What it means now is that they have only their own mobilizations and self-provision,” one family planning organization said.³⁹³

Because HIV programs would be less likely to be subject to the GGR without a family planning component, health services that provide HIV and family planning integrated services could be forced to decouple the services to protect HIV funding.³⁹⁴ AMODEFA, which was operating **20 youth clinics** within government health facilities throughout Mozambique, all supported by U.S. funding, has had to close **half** of them. These clinics provided integrated services, including family planning, HIV prevention, information on drug use, and referrals to public facilities for HIV treatment. “If you close them, you are not closing only one service. It’s the package, including HIV,” they told CHANGE.³⁹⁵ Youth prefer their clinics “because these services are designed to this specific age group.” So by closing them, “the impact will be big,” AMODEFA’s Santos Simione said.³⁹⁶

Many anticipate that by siloing health services under the Trump GGR, people are going to make tradeoffs between which services they seek and which services they give up, since they may no longer be located in one place. “If you can’t bring your child to get vaccinated and get your contraception at the same time anymore,” one interviewee told CHANGE, “well probably you’re still going to make the effort to get your child to that clinic to be vaccinated, but you’re not necessarily going to make the additional effort to get *your* needs taken care of.”³⁹⁷

5. IMPACT ON WATER, SANITATION, AND HYGIENE (WASH)

There has been a concerted effort by USAID’s Maternal and Child Survival Program to make WASH a normative part of MNCH.³⁹⁸ This effort has spurred the integration of services across USAID, WASH, and/or SRHR and maternal health-implementing partners. As one respondent said, WASH is considered a “nice-to-have” rather than a core health intervention.³⁹⁹ Because of this, even though it is a key component of preventing maternal and infant deaths, the respondent worried that the work to integrate WASH in health facilities is “either going to be put on hold indefinitely or is going to start to be walked back.”⁴⁰⁰

WASH tends to be viewed as an outlier among impacted areas of the GGR. Still, one interviewee from a large WASH-implementing partner that will not certify the Trump GGR mentioned that they anticipate their advocacy leverage will be weakened.⁴⁰¹ One of their partners is MSI, which is discontinuing programs around the world because of the GGR. So “it’s definitely going to create a barrier to us achieving our strategy.”⁴⁰²

WaterAid America expressed concern about the impact of the GGR on maternal health services, as it has been working to integrate WASH into primary health systems, maternity units, and clinics that provide antenatal care (ANC) services to reduce deaths from sepsis. “We’ve been doing an increasing amount of work on WASH in health facilities, focusing specifically on maternity wards and in places where there isn’t a tertiary facility that has a dedicated maternity ward with whatever facility would be providing that care. And again, it’s going to usually be a facility that’s also providing prohibited services [under the GGR],” one informant said.⁴⁰³

6. IMPACT ON NUTRITION

In Mozambique, programs that serve vulnerable populations experiencing food insecurity and lack of nutrition are particularly imperiled by the GGR. “It’s very clear that the issues around early marriage, premature pregnancy or teen pregnancy...and nutrition are all linked,” CARE’s representative told CHANGE.⁴⁰⁴ “So for us if our focus is nutrition, working backwards, we could and should be thinking about issues around the rights of adolescent girls.”

Because of these linkages, there will be a negative impact on nutrition programs if access to family planning and services for pregnant adolescents must be scaled back. This would undermine Concern Worldwide’s recommendation that adolescent girls in Mozambique receive special attention to make sure their nutrition needs are being adequately addressed, which includes reducing the rate of adolescent pregnancy and prevention of early marriage.⁴⁰⁵

Many people with chronic diseases, including children with HIV, need “access to...additional food baskets to compensate or to boost not only their endurance to treatment but strengthen their whole body so they can take ARVs [ART] and progress properly,” one organization told CHANGE.⁴⁰⁶ In response to this issue, AMODEFA runs a program in Boane that provides nutritional supplements to OVCs. Because of the GGR, it now must find a partner to take over the program.⁴⁰⁷

WaterAid America told CHANGE that it gave up two opportunities to work on nutrition issues because the funding was subject to the GGR, and the organization was not going to comply.⁴⁰⁸ One project was supported with U.S. global health funding; the specific source of funding for the other project was not able to be confirmed, except that it was part

of an embassy special fund. “And nutrition—50 percent of malnutrition is attributed to lack of access to WASH. So a nutrition program without WASH is not a great program. So we walked away,” a representative said.⁴⁰⁹

7. IMPACT ON ZIKA

Zika is an issue that will require more research and monitoring to determine the broader impact of the Trump GGR. An organization that is not complying with the Trump GGR received global health assistance to respond to the Zika virus epidemic. This assistance was specifically to train providers working at the community level on counseling and information about Zika, to position it as a sexual and reproductive health issue—not just a vector-borne disease—and to increase access to contraception. The organization must now figure out how to continue the work without USAID money, because the initiative began in 2016 and runs for five years.⁴¹⁰ They vow to carry on the work. “We cannot continue to do serious work around Zika without making sure that the women we see [know] that Zika is transmitted sexually *and* [they] can protect themselves, so we will continue doing that. We might have to shift resources from the other pieces of the work...but I don’t think it’s on the table to stop doing the core of what we do,” one interviewee said.⁴¹¹

8. IMPACT ON INFECTIOUS DISEASES

Interview respondents said infectious diseases like TB and malaria would see impacts similar to HIV, since these larger global health assistance programs are integrated and at times led by implementing partners that cannot comply with the Trump GGR. “Where’s the next major HIV outbreak going to be? Where’s a new infectious disease not going to be

contained because the people who were doing all the work aren't there? Literally, which epidemic did we cause because we stopped handing out condoms in Lesotho?" one U.S.-based interviewee asked.⁴¹²

A representative of AMODEFA questioned whether the U.S. government truly understands the full scope of the GGR's global health impact on beneficiaries. "I believe that the work we are doing, it will bring difference...bring change. ...People with tuberculosis. People with malaria. People with no water. Those are the problem[s] affected. Is that what you want? No."⁴¹³

An area of particular concern is malaria. The global burden of malaria transmission has been significantly reduced in recent years, in part due to the contributions of the President's Malaria Initiative (PMI).⁴¹⁴ The Trump GGR's application across all global health assistance, including PMI, threatens the progress that has been made in combating this infectious disease.

On the surface, PMI funding and related services might seem to be immunized against the GGR, but malaria infection in pregnant women is a public health concern.⁴¹⁵ Every year, an estimated 125.2 million women living in countries where malaria is prevalent—30 million in Africa alone—become pregnant, with up to 10,000 maternal and 200,000 infant deaths resulting from malaria in pregnancy.⁴¹⁶ In moderate- to high-level malaria transmission countries, PMI intervenes using WHO guidelines, which include integration into ANC services that are sometimes bolstered by community-based programming.⁴¹⁷ In integrated and comprehensive primary care services in Global South countries, ANC service provision incorporates family planning and reproductive health services.⁴¹⁸ The GGR would therefore apply to malaria programming that is

About the President's Malaria Initiative

The President's Malaria Initiative (PMI) is an interagency partnership that is USAID-led with implementing contributions from the CDC.⁴¹⁹ Since its inception in 2005, the funding allocated to PMI has increased from \$30 million in 2006 for operations in three high-burden countries in sub-Saharan Africa, to \$723 million in 2017 in 24 focus countries and three programs in the Greater Mekong Subregion.⁴²⁰ PMI's contribution to the global budget for malaria has averted an estimated 185 million malaria cases and saved approximately 940,000 lives.⁴²¹

integrated with ANC services that incorporate family planning and reproductive health care. For PMI services to remain untouched by the policy, they would have to be divorced from ANC—thus undermining effective health services.

9. IMPACT ON MATERNAL, NEWBORN AND CHILD HEALTH

The Trump GGR is disrupting symbiotic NGO relationships in MNCH and undermining effective partnerships. A representative of one U.S.-based NGO explained how they intended to partner with an organization in Kenya for a USAID-funded maternal and neonatal health project. The Kenyan NGO would have been the prime partner and this organization a sub-grantee. However, as the Kenyan NGO did not certify the GGR, it was therefore ineligible to receive funding. "The NGO that we were going to work with had the expertise and on-the-ground presence to successfully carry forth the project and deliver

results to USAID, but was excluded from doing so under the expanded GGR,” a representative said.⁴²²

One interviewee explained the challenge of both getting women to attend the clinic, and of making sure they follow through on services such as HIV testing and check-ups for themselves and their children.

“I think from a clinical standpoint, health providers are really strong, but they don’t always encourage health-seeking behavior,” the representative told CHANGE.⁴²³ “So we rely a lot on community elements...to really be out there and encouraging people to come to the clinic, to access services.” These community groups are most likely the people women turn to when seeking information on pregnancy-related health-seeking behavior; and this information is not always GGR-compliant.

10. IMPACT ON CONTRACEPTION

In interviews, respondents said they expected to see contraceptive impact in instances where the main service providers were organizations that would not comply, such as MSI and IPPF, although the onus is on the U.S. government for implementing a policy that forces organizations to curtail the delivery of certain health care services due to lack of funding or specific restrictions. “I think you’re going to find that a small country or, again, a rural area that only has a limited number of partners in it—I think *that’s* where you’re going really to find contraceptive access heavily impacted,” one interviewee told CHANGE.⁴²⁴

In Madagascar, for example, 40 percent of women using modern contraceptives access them from MSI-Madagascar, which also provides 60 percent of all long-term contraceptive methods.⁴²⁵ Before the



A contraceptive kit from an NGO in Maputo, Mozambique.

Trump GGR was implemented, USAID had funded MSI's work in rural areas, and in many instances MSI's outreach was the only way that these areas were able to access contraceptives, including long-term methods.⁴²⁶ Because MSI did not certify the Trump GGR, it has lost funding in Madagascar and has already felt the impact on its programming. For example, the organization closed down a voucher program that provided contraceptives to poor young women in and around urban areas, and is planning to scale back its outreach.⁴²⁷ This will seriously undermine access to family planning in the country and risks increasing unintended pregnancy rates and STIs—or both—as a result.⁴²⁸

In Uganda, another respondent said, “in my country, abortion is illegal, but we also know that [the GGR has] limited access to reproductive health information and services.”⁴²⁹ This person noted that MSI is “the biggest family planning service provider in the country, and that means quite a lot in terms of access to information, access to services. ...And the impact does not stop at the organizational level; it translates to the service beneficiaries, the majority of whom are women, but also importantly, young people.”

In 2015, USAID provided 90 percent of Senegal's contraceptives, distributed in part through MSI-Senegal.⁴³⁰ GGR restrictions under the Trump administration have the potential to fracture contraceptive distribution, worsening the country's unmet contraceptive need, which is 25 percent, and unsafe abortion rate, which is currently 63 percent.⁴³¹

Two other organizations that were interviewed linked their concerns about contraceptives not only to this policy, but also to the U.S. government's defunding of UNFPA, also a large supplier of contraceptives worldwide.⁴³²

11. IMPACT ON GENDER-BASED VIOLENCE

GBV is a known risk factor for HIV, as women exposed to GBV are 1.5 times more likely to acquire HIV or an STI.⁴³³ Women who have experienced physical or sexual abuse are also more than twice as likely to have an abortion compared to non-abused women.⁴³⁴ WHO guidelines require that health providers offer women-centered care⁴³⁵ when a client presents with a GBV-related abortion case.⁴³⁶ Women-centered care involves private and confidential first-line support that is non-judgmental, non-intrusive, and provides supportive access to resources, information, and practical care.⁴³⁷ Yet the GGR's restrictions on counseling and referrals for abortion prohibit women-centered care.

A representative from a Mozambican organization added, “We just fund gender-based violence activities, GBV training, GBV registrations, monitoring and evaluations, psychosocial support to victims. ...So we cannot put aside the possibility of some young women or mothers of children to ask for pregnancy interruption or end pregnancies that resulted from sexual abuse.”⁴³⁸

One NGO that CHANGE interviewed revealed that their partner organization was approached by USAID about a program on GBV in Belize, but that the organization could not participate because it did not certify the GGR.⁴³⁹ More study of the impact of the Trump GGR on GBV interventions is needed.

12. IMPACT ON ABORTION

As of 2016, 43 percent of the 206 million pregnancies in developing countries were unintended, and 84 percent of those unintended pregnancies were due to unmet contraceptive needs.⁴⁴⁰ Globally, from these unintended pregnancies, an estimated 25 million unsafe abortions occur annually, 97 percent of them in developing countries in Africa, Asia, and

Latin America.⁴⁴¹ As established from the research on the impact of the George W. Bush GGR,⁴⁴² the GGR does not reduce abortions, and the expanded Trump GGR could exacerbate these figures.

In interviews, a few respondents said they expect to see the most impact in countries with progressive abortion laws—those that permit abortion beyond the three exceptions stipulated by the GGR: rape, incest, and risk to a woman's life. There has been a global trend toward the liberalization of abortion laws since the George W. Bush GGR was in place. Thirty-seven of the 64 countries receiving U.S. bilateral assistance for global health programs in 2016 had laws allowing abortion beyond the scope provided in the GGR.⁴⁴³ As a result, close to 880 million women of reproductive age currently live in countries where the policy would prohibit otherwise legal abortion services.⁴⁴⁴ Mozambique and Zimbabwe are two such countries.

To reduce the country's high maternal mortality rate, often due to unsafe abortion, in 2014 Mozambique liberalized the abortion provision in its penal code.⁴⁴⁵ Abortion is now permitted on request in the first 12 weeks of pregnancy, in cases of rape or incest in the first 16 weeks, and in cases of fetal anomaly in the first 24 weeks. Abortions must be performed at officially designated facilities by qualified practitioners. Mozambique's abortion provision is far more liberal than the three exceptions allowed by the GGR.

Clinical guidelines for providers on the 2014 abortion provision were issued by the Ministry of Health as recently as September 2017,⁴⁴⁶ so implementation is still in an early phase. The Trump GGR could create significant barriers to health facilities that are now legally able to offer and promote abortion services. "Why a country like us decided that we need a provision that decriminalizes abortion in

certain circumstances [is] because we know that it's important. ...Safe abortion will save lives," a representative from Oxfam said.⁴⁴⁷

The U.S. funds a robust network of community health workers in Mozambique, some of whom will now be restricted in what they can say to clients, despite the 2014 abortion article in the penal code. "The national strategy is...widening services. It's intended to save lives by the national government," a representative from one U.S.-based organization explained.⁴⁴⁸ "And you need to make sure that women know services are available, where they're available, how they're available, and you want responsible organizations doing that. And I do think that we're now missing some that were a key part to that puzzle of making sure that the national health strategy was communicated well to communities that have grown to trust certain partners and have connections to partners. Information related to abortion will not flow as freely."

For example, Oxfam in Mozambique has been working with partners to distribute information on access to safe abortion services at the community level since 2014. Some of these partners receive as much as 75 percent of their funds from USAID and are complying with the GGR, prohibiting them from continuing to conduct these activities. The organization considers this "a loss" for Oxfam, and damaging to efforts to inform people across the country who generally don't know about the new abortion provision and are operating as though abortion were still illegal.⁴⁴⁹

Pathfinder International agreed that many providers and communities still don't know abortion has been decriminalized, and the Trump GGR hinders the law's implementation. "Now, after almost 20 years, you have a good legal framework to offer services—

free of charge,” Mahomed Riaz Mobaracaly told CHANGE. “And then you don’t have promotion or information given at all level of communities for the population.”⁴⁵⁰

The GGR is also expected to diminish the reach of NGO-run youth facilities that provide information for girls to make informed decisions, potentially endangering the lives of young women who do not feel they have anywhere else to turn. One organization explained that hospitals are not always friendly environments for youth. By contrast, at civil society organizations, “the way the information is transmitted, is relayed to the girls, it’s...more open. ... Because people will still [get] abortion, so it’s important to pass along information so they know they can do it in a safe way. So one of the impacts would be not decreasing the number of girls who die [due] to unsafe abortion,” Helena Chiquele of Oxfam in Mozambique said.⁴⁵¹

Among AMODEFA’s clinics, only one provides abortion, while the rest provide information and referrals to clinics where abortion is provided. But the organization is working to increase the number of clinics that provide legal abortion from one to three. This move is a direct response to the GGR, which the organization says will lead to an increase in “unsafe abortions.”⁴⁵²

Ipas Mozambique works with 40 government facilities in two provinces to train safe abortion providers, equip facilities to provide services, and raise awareness of integrated services that include abortion for women and girls living in rural areas. Clemence Langa, Country Director for Ipas Mozambique, said, “As long as [AMODEFA] pull themselves from those communities, it means those women living in those communities won’t be having access to information which they used to have.”⁴⁵³

Unsafe abortion and the importance of post-abortion care programs

One interviewee, whose organization provides services for key and vulnerable populations, talked about the reality of abortion and post-abortion care on the ground. She said that approaching a health worker to ask for a safe abortion in their country is complicated: health workers are often reluctant to perform abortions, try to discourage women from having them, or charge exorbitant prices. As a result, women often self-induce with unsafe methods that lead them to seek medical care afterward, as described by one person interviewed by CHANGE.⁴⁵⁴

“Either use the stick, like to pierce my uterus so that blood starts getting out, or I would try miso[prostol], in a very wrong way because there’s no medical worker to actually guide me on how it works, or I would use a hanger—anything,” she said.⁴⁵⁵ “Because for me, my mind is ready; I don’t want this. And [then] I would come to you [a health worker]. ...I can’t even tell you that, ‘Actually, I was attempting to [induce an abortion].’ ...Why should I? You won’t touch me. You would let me die, as a health worker. I don’t want to die, but I want to be safe, but you wouldn’t listen to me if I had come before doing this. Now you struggle to save my life, but in reality you would have done it more safer if you had listened to me as a doctor.”

“I believe that with less access to information, and less information to health services, the maternal mortality rate also can go up,” Langa added.⁴⁵⁶ Many echoed the assertion that more women and girls will die due to unsafe abortion because of the policy.

Oxfam’s representative said, “The country already has a legal instrument that decriminalizes abortion, and then you come with your money saying only certain people can do this work. It is taking away from what we’ve already achieved.”⁴⁵⁷

In Zimbabwe, under the 1977 Termination of Pregnancy Act, pregnancies can be terminated under three circumstances: (1) where there is a reasonable possibility that the fetus was conceived as a result of rape and incest, described in the law as “unlawful intercourse;” (2) when there is a serious risk that the child will suffer permanent physical or mental defects; and (3) endangerment of the life or physical health of the woman.⁴⁵⁸ The law deviates from the GGR by permitting abortion in cases of fetal anomaly and risk to the health of the woman, thus going beyond the rape, incest, and maternal life exceptions stipulated in the Trump GGR.

The Zimbabwean Ministry of Health and Child Care (MoHCC) grapples with the high rate of unsafe abortions, which account for about 10 percent of maternal mortality.⁴⁵⁹ “The Ministry’s actually working on trying to reduce unsafe abortions because they are happening illegally, and they now have to deal with that,” one organization said.⁴⁶⁰ “Quite clearly if the organizations that the MOH is depending on to help stop unsafe abortions are also the organizations impacted by the policy, then the country’s ability to stop unsafe abortions would definitely be affected.” Some of these organizations are worried about an increase in unsafe abortions under the Trump GGR, in both rural

and urban areas. Intertwined with unsafe abortion, the maternal mortality rate—which is already high in Zimbabwe—is expected to rise as a result of an increase in unsafe abortions in communities.

An informant from another organization underscored that, “The theory that I think some proponents of GGR push is that by giving family planning funding to organizations like [ours], it frees up money for them to spend on abortion. If you therefore take away funding, they’ll have less money to spend on abortion. I don’t think that’s true.”⁴⁶¹ In fact, U.S. funds are never permitted to be allocated towards abortion services. The Helms Amendment already bars U.S. foreign assistance funds from being used for abortion-related activities—even during periods when the policy is not in effect. The informant continued, “I think that we will carry on providing our safe abortion services in the same way as we have done previously because, as I say, U.S. government money has never touched on those.”

Interviewees were adamant that this policy fosters stigmatization of abortion around the world. “There is going to be stigma related to people who speak about it, but also the girls who choose to have an abortion,” one respondent said.⁴⁶² “The U.S. government is sending a message to the world that abortion is something unfavorable or shameful, that it’s not health care, that it’s not anything that the U.S. government is going to support *and* it doesn’t want anybody else to support either. That’s a *huge* message, and it stigmatizes abortion,” said Lourdes Rivera, Senior Vice President of U.S. Programs at the Center for Reproductive Rights.⁴⁶³

13. IMPACT ON OTHER FUNDING OPPORTUNITIES

With the Trump GGR in effect, many organizations that cannot comply are in a position of attempting

to broaden their funding sources in order to avoid major reductions in programming or services. In some countries, for example in Zimbabwe and Mozambique, organizations are under the impression they have to choose between accepting U.S. funding or European funding, and that they cannot apply for both.⁴⁶⁴ As one interviewee put it, “if you’re getting funding from the U.S. government, then you’re going to be penalized by other development partners, by other bilateral government bodies that are giving out funding.”⁴⁶⁵

The Swedish International Development Cooperation Agency (Sida), for example, prioritizes SRHR “as a key issue” in its development work, and explicitly includes “safe abortion services as an integral part” in SRHR-integrated services.⁴⁶⁶ Its guidance on the Trump GGR stipulates that if a partner receives Sida funding for SRHR activities *and* complies with the GGR, “it is the partner’s responsibility to ensure that the Sida-funded program can continue.”⁴⁶⁷ If the partner is unable to continue providing comprehensive SRHR—which includes safe abortion—Sida “may see it fit to phase out the programme, end certain components or terminate the agreement.”⁴⁶⁸ So while Sida does not have a hardline policy on not funding anyone who complies with the GGR, it cites as a clear priority ensuring that SRHR obligations under its agreements with its partners are fulfilled.

NGOs in the field are operating as if they can only take funding from one or the other. Multiple organizations have said that Sida is reluctant to fund organizations that comply with the policy. This is demonstrated by their increased scrutiny around receipt of U.S. government funding during the application process: when applying for Sida funding, one NGO said that it received “a series of questions”

on “how the expanded GGR would affect the work to be conducted under their pending award from the Swedish government.”⁴⁶⁹ This can exacerbate uncertainty at a time when many are still trying to unravel the implications of the Trump GGR. Some organizations told CHANGE that they are reluctant to pursue U.S. funding in the future because of this chilling effect on other funding sources.

In addition to European donors, impacted organizations are turning to foundations for alternative funding to mitigate harm. However, the urgency with which NGOs must implement the policy, coupled with the sheer volume of affected funding, has outpaced many donors’ ability to fill the gap. “Foundations, in general, don’t change that quickly, even though the *whole* scenario changed. ...You would think this would be the moment in which they put much more money into women’s rights programs globally, but we are not seeing that, from any of them” as of yet, one said.⁴⁷⁰

SheDecides is a global movement started by the Dutch Minister of Foreign Trade and International Development, Lilianne Ploumen, shortly after President Trump signed the executive order instating the expanded GGR. It aims to galvanize non-U.S. donors to fund organizations that stand to be impacted by the policy, and to present a united front in the face of the U.S. stepping back from its support of SRHR work. As of March 2018, it had raised \$450 million.⁴⁷¹ While commendable, the funding raised so far pales in comparison to the \$8.8 billion restricted by the GGR. For some, this funding would likely only be able to delay funding cuts in the short-term. Many of CHANGE’s conversations on mitigating harm recognized the uphill battle that organizations face to make up lost U.S. funding in an effort to preserve programs and services.

Conclusion

The Trump GGR is the most extreme and sweeping iteration of a policy that has fomented confusion, fear, and harm for NGOs and health care providers around the world since 1984—over the course of six U.S. presidential administrations. When the GGR is in effect, it creates and exploits inefficiencies in health care delivery and causes harm to beneficiaries, who may not be aware that their fate is being determined by what is essentially a political football in Washington, D.C. For a community to be stripped of its access to HIV and TB testing, as is the case with the discontinuation of AMODEFA's outreach program in Nampula, or for sex workers to lose the only space that meets their health needs, as has occurred with ICRH-M, demonstrates the extent of the cruelty of this policy and the callousness of its proponents.

As CHANGE has detailed throughout this report, the evidence is robust and stories abound: the GGR, both in previous versions and its current expanded form, curtails adults and children's access to health care. It stretches far beyond abortion and family planning, impacting HIV, MNCH, and now nutrition, GBV, WASH, infectious diseases, and more. It has unique, disproportionate ramifications for AGYW; key and vulnerable populations; and communities living in rural areas. It gags providers in their patient-level conversations and NGOs who seek to change their local political landscape. In so doing, it fractures health care and advocacy, creating parallel systems within countries of organizations that sink or swim based on their relationship to U.S. funding. Because it effectively tramples on rights to free speech, association, and participation in the political

process, it would likely be deemed unconstitutional if applied to U.S.-based NGOs.

Permanently ending this broken and pernicious policy—and beginning to heal its corrosive effects—will require decisive legislative action. The Global Health, Empowerment and Rights (HER) Act, introduced by Representative Nita M. Lowey (D-NY) and Senator Jeanne Shaheen (D-NH) on January 24, 2017, would allow foreign NGOs receiving U.S. funding to use their non-U.S. funds for medical services, including safe abortion, that are legal both in their country and in the U.S. This legislation also seeks to nullify any U.S. policy that contravenes it.⁴⁷² Stoked by President Trump's unprecedented expansion of the GGR to all global health assistance and the general political and social climate following his election, the Global HER Act quickly amassed far more co-sponsors than previous versions of the bill.

A legislative solution such as the Global HER Act would send a strong signal that women's health must never again be subject to the ideological posturing of a new administration, or used as a political pawn to appease anti-choice activists in the U.S. Passing the Global HER Act and relegating the GGR to the past is a critical first step towards halting the pervasive effects of this policy—and beginning the process of mending the fractured global health infrastructure it has left in its wake.

Recommendations

Simply put, the GGR creates inefficiencies in health care delivery and causes irreparable harm to people's health and lives. The following recommendations seek to minimize damage, preserve advocacy communities, and ultimately restore strength and resilience to global health and human rights movements.

While the responsibility for this destructive policy lies squarely with President Trump's White House, CHANGE recognizes that a number of actors can make valuable contributions to addressing its impact.

Recommendations for the Administration:

Unless and until the GGR is repealed, CHANGE makes the following recommendations to the executive branch of the U.S. government to mitigate harm caused by the policy:

- Create an accountability mechanism for prime partners to communicate to sub-grantees what activities and communications are allowable under the GGR;
- Standardize mission communications with in-country grantees and ensure communications and guidance are translated into local languages, are culturally relevant, and are comprehensible (see example on passive referrals in Zimbabwe on pg. 32);
- Create, implement, and communicate a transparent process for case-by-case exemptions;
- Implement site-level monitoring visits by

PEPFAR using the Sustainability Index and Dashboard (SID) that clearly communicate to providers what services they can and should continue to provide under the GGR;

- Provide mandatory training for U.S. government officials (working in global health assistance) on the GGR to educate them on what is and is not permitted, with clear guidance on how to avoid service disruptions and unwarranted severance of organizational relationships; and
- Conduct annual, transparent, comprehensive reviews of the implementation and the impact of the GGR, with public access to the methodology and submissions.

Recommendations for Congress:

- End the GGR permanently through legislative action; and
- Use the oversight power of Congress to monitor both the implementation and impact of the expanded GGR, including calling hearings and requesting Government Accountability Office reports as relevant;

Recommendations for prime partners:

- Clearly communicate affirmative opportunities and obligations for sub-grantees to continue to provide services; and
- Monitor, document, and report changes in relationships with sub-grantees to missions and implementing agency headquarters, as well as changes in secondary outcomes such as decreased referrals from non-complying organizations.

Recommendations for funders:

- Fund GGR research and advocacy;
- Provide clear support and resources for both certifying and non-certifying grantee organizations on exemptions, exceptions, and resilience; and
- For SheDecides and other endeavors that seek to mitigate the GGR's harm, disclose how funds are allocated and distributed with the aim of modeling transparency and informing advocates' priorities.

Recommendations for researchers:

- Document the impact of GGR on all streams of funding and all populations including but not limited to: HIV and AIDS; family planning and reproductive health; MNCH; key populations; AGYW; people living with disabilities; people living in rural areas; integrated services; WASH; nutrition; Zika; infectious diseases; non-communicable diseases; contraception; GBV; PrEP, Post-exposure prophylaxis, and prevention of mother-to-child transmission; and abortion advocacy, services, and stigma;
- Monitor redirection of funds that would otherwise have been given to non-certifying NGOs;
- Monitor and evaluate how the GGR is impacting integrated services that include family planning/reproductive health services interacting with newly affected health areas, such as cervical cancer, malaria, TB, and HIV; and
- Work with partners to collect abortion data for longitudinal studies investigating the association between the Trump GGR and abortion rates.

Methodology

The report is based on a three-part data collection model.

1. CHANGE conducted a scoping review of peer-reviewed articles and grey literature, which explored the impact of the GGR from 1984 to December 1, 2017. CHANGE also interviewed a range of stakeholders, including: current and former U.S. government officials; representatives from civil society organizations; service providers; country-level program implementers; and researchers.

2. CHANGE, in partnership with the Walter Leitner International Human Rights Clinic at the Leitner Center for International Law and Justice at Fordham Law School, collected information from 17 civil society organizations in sub-Saharan Africa on the immediate impacts of the policy. Interviews were conducted between February and April of 2017.

3. CHANGE conducted a 12-day fact-finding mission in late January and early February 2018 to Mozambique and Zimbabwe to document and analyze the policy's implementation and impacts.

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Annex

I. PRIOR LEGAL AND LEGISLATIVE CHALLENGES TO THE GGR

A. Legal Challenges

There have been four legal challenges to the GGR since its instatement, all of which were unsuccessful. In 1989, DKT Memorial Fund first took USAID to court, claiming that the GGR violated U.S.-based NGOs' right to free speech. The court found that the policy did not infringe upon the First Amendment free speech provision of the U.S. Constitution because it did not prohibit domestic NGOs from using their private funds for abortion-related activities, nor were these NGOs required to promote the GGR with their own funding.⁴⁷³

In a subsequent case in 1990, Planned Parenthood Federation of America argued before the U.S. Second Circuit Court of Appeals that the policy violated its First Amendment rights to freely associate and collaborate with non-U.S. based NGOs, such as the organization's foreign affiliates. But the court found "no constitutional rights implicated," arguing that U.S.-based NGOs could use their own private funds to conduct abortion-related activities in other countries and that it was their choice to take USAID money, which comes with conditions.⁴⁷⁴

Pathfinder Fund also challenged USAID in 1990 on similar grounds: that the GGR infringed on the First Amendment right of expressive association. The court found that the policy did not place a "substantial burden" on the NGO plaintiffs, and argued that the policy was "rationally related" to the interests of the government and, as such, its

application was constitutional.⁴⁷⁵

The fourth legal challenge to the GGR was brought in 2001 by the Center for Reproductive Law and Policy (CRLP), now the Center for Reproductive Rights. It argued that the policy impeded CRLP's ability to work with non-U.S. based NGOs around abortion law reform and expanding access to abortion, and in so doing, it violated their First Amendment rights to free speech, association, and peaceable assembly, as well as their Fifth Amendment rights to due process and equal protection. The court rejected these claims.⁴⁷⁶

Without the demonstrated harm to constitutional rights, many groups have looked to policy changes. The Center for Reproductive Rights argues that, "Although the courts have stated that the constitutional protections guaranteed to domestic NGOs do not apply equally to foreign NGOs, as a matter of policy, U.S. legislators should extend to overseas NGOs and multilateral organizations the same principles of freedom of speech and association that apply under the U.S. Constitution to U.S.-based NGOs."⁴⁷⁷

B. Legislative Challenges

Congress also has attempted to supersede the policy through legislative action. Soon after President George W. Bush reinstated the GGR, Rep. Nita M. Lowey (D-NY) and Sen. Barbara Boxer (D-CA) introduced the Global Democracy Promotion Act (GDPA) to eliminate the policy.⁴⁷⁸ The GDPA, an amendment to the Foreign Relations Authorization Act, would have mandated that U.S. assistance to overseas groups could not be conditioned on the provision of medical services that are legal in their own country and in the U.S. It also would have kept them from being disqualified for using their own funds to engage in free speech activities that are permissible for U.S.-based groups participating in USAID programs.⁴⁷⁹ In May 2001, the House

International Relations Committee passed the bill with a 26-22 vote. Two weeks later, after heavy lobbying by the Bush administration and the prospect of a presidential veto, the full House of Representatives voted 218-210 to retain the GGR.⁴⁸⁰

Months later, the Senate Foreign Relations Committee approved the proposed GDPA with a vote of 12-7, and the Senate Appropriations Committee signed off on the FY2002 foreign aid appropriations bill with the GDPA incorporated.⁴⁸¹ The language was ultimately removed from the bill in conference committee because of “pressure from anti-choice members.”⁴⁸² While provisions from the GDPA were repeatedly added to legislation or introduced on their own in subsequent years, they have yet to pass.

II. MOZAMBIQUE CASE STUDY

A. Executive Summary

As a U.S.-based women's rights organization that advocates for SRHR globally, CHANGE has addressed the harmful impact of the GGR on the health of women, girls, and communities across U.S. administrations. The current policy under President Donald Trump has broader, more dangerous implications than any previous iteration.

The Trump GGR is a U.S. foreign policy that, when enacted, prohibits foreign NGOs that receive U.S. global health assistance funds from advocating for abortion, or providing, counseling, or referring for abortion services as a method of family planning.⁴⁸³

About Mozambique and U.S. funding

Mozambique sits on the coast of the Indian Ocean in Southern Africa and has a population of nearly 30 million people.⁴⁸⁴ The country is young and rural: 45 percent of the population is under 15 years old⁴⁸⁵ and 19 million people live in rural areas.⁴⁸⁶ Mozambique has one of the lowest development indicators in the world: it ranks 181 out of 188 countries on the United Nations Development Program's Human Development Index, which measures progress in life expectancy, access to education, and standard of living.⁴⁸⁷

While some of Mozambique's health indicators have improved over time,⁴⁸⁸ its health system faces severe constraints. More than 90 percent of Mozambicans must walk more than an hour to reach a primary health care center,⁴⁸⁹ and there are fewer than 10 doctors for every 100,000 people.⁴⁹⁰ The burden of HIV and AIDS, and malaria (the top two causes of death in the country),⁴⁹¹ along with other communicable diseases and high maternal and neonatal mortality rates, puts pressure on a health system that is already stretched thin.⁴⁹²

The U.S. is the largest bilateral donor to Mozambique,⁴⁹³ and Mozambique is the 11th largest recipient of U.S. foreign assistance in sub-Saharan Africa.⁴⁹⁴ In FY2017, the U.S. government allocated nearly **\$407 million** in global health funding to Mozambique for HIV and AIDS; malaria; maternal and child health; family planning and reproductive health; WASH; nutrition; and TB.⁴⁹⁵ The Trump GGR is applicable to all of these health areas, putting critical services that depend on U.S. funding at risk.

Of the \$407 million, funding for HIV and AIDS from PEPFAR alone accounted for more than **\$330 million**.⁴⁹⁶ As of September 2017, PEPFAR funding supported HIV testing for more than 6.5 million people, ART for almost 1 million people, and care and support for 379,747 OVCs affected by HIV and AIDS.⁴⁹⁷

To analyze the impact of President Trump’s GGR in Mozambique, CHANGE conducted an independent five-day fact-finding mission in January 2018. CHANGE learned that the Trump GGR causes grave harm by creating new barriers to HIV prevention in a country with a high HIV prevalence, and putting girls who live in rural communities at increased risk of early marriage and early pregnancy. Consequently, the policy will inflict far-reaching damage, not only on reproductive health, but also on many other aspects of health including MNCH, nutrition, HIV prevention, and health service provision for vulnerable and marginalized populations. The expanded reach of the GGR has the potential to increase rates of illness and even death.

This case study outlines the immediate impact of the Trump GGR on organizations, coalitions, programs, and individuals in Mozambique. For a country like Mozambique that has decriminalized abortion and then built on that momentum to address other local public health issues, the Trump GGR represents a major reversal of progress—not only in providing care to communities across the country, but also in protecting the ability of Mozambican civil society to freely speak, associate, and advocate.

B. Snapshot of the impact of President Trump’s expanded GGR

In Mozambique, the severe effects of the GGR were most apparent at one organization in particular—AMODEFA⁴⁹⁸—due to its work across nearly every health domain. AMODEFA is a leading SRHR organization and a member association of IPPF. Aside from SRHR, it provides services for HIV prevention and care, TB, malaria, and support for OVCs, among other areas. AMODEFA cannot re-sign its agreements that contain U.S. funding—

accounting for **two-thirds** of its budget—because the Trump GGR would require them to end the provision of information, referrals, and services for abortion that they provide with non-U.S. funding.

AMODEFA is a long-time recipient of direct USAID/PEPFAR funding, and a sub-grantee of funding from FHI 360, N’weti, and the American International Health Alliance, among others. The PEPFAR funding supports a research program in the city of Beira that focuses on the LGBT community, including the incidence of HIV and STIs—this is just one aspect of AMODEFA’s important work that is in jeopardy due to loss of U.S. funding.

Because AMODEFA has publicly refused to comply with the policy, its staff was more forthcoming with information than many of the organizations CHANGE interviewed. The full weight of the Trump GGR has not yet manifested across Mozambique, but AMODEFA is a harbinger of the harms that the country can expect.

When the GGR was announced, AMODEFA was operating **20 youth clinics** within government health facilities throughout the country, supported by U.S. funding. Since then, it has had to close **half** of them. AMODEFA provides integrated services at these clinics, including family planning, HIV prevention, information on drug use, and referrals to public facilities for HIV treatment. “If you close them, you are not closing only one service. It’s the package, including HIV,” Santos Simione, the Executive Director, told CHANGE.⁴⁹⁹ Youth prefer their clinics “because these services are designed to this specific age group.” So by closing them, “the impact will be big,” he affirmed.

AMODEFA has also had to let go of approximately **30 percent** of its staff as a result of the GGR. This

is weighing on staff morale, because no one knows who might lose their job next. “But I think that we will lose more people because as [a] consequence of this cut, we have to restructure the organization this year. ...We don’t have resource[s] for activities. How can we be paying so many people when we are not providing service[s]?”⁵⁰⁰

C. Impacts

1. IMPACT ON COMMUNICATION WITH U.S. GOVERNMENT AND PRIME PARTNERS

The Trump GGR causes widespread confusion and misunderstanding for NGOs, often stemming from a communication breakdown between the U.S. government and prime partners and their grantees. Most of the organizations CHANGE spoke with had no contact with the U.S. government about the policy—including direct recipients of U.S. government funding—but first learned about it from the media or through their networks. Representatives from one organization that receives almost all of its funding directly from the U.S. government said they typically learn about changes to their funding agreements in meetings with the U.S. government throughout the year. However, regarding the Trump GGR, they have received no communication whatsoever.⁵⁰¹

Some organizations told CHANGE they are unsure how the GGR affects them and if they could continue their U.S.-funded work without violating the policy. Others did not know which services were exempt, such as post-abortion care counseling, and many conflated the Helms Amendment and the Trump GGR. There is no differentiation in the policy language between safe and unsafe abortion, which further confuses matters—especially in

A “prime partner” is an organization that receives U.S. funding directly from the U.S. government. Both U.S. NGOs and foreign NGOs can be prime partners. Prime partners are responsible for passing down all U.S. funding and policy requirements to their sub-grantees.

A “sub-grantee” or “sub-recipient” is an organization that receives U.S. funding from a prime partner, rather than directly from the U.S. government. Sub-grantees are one step removed from a direct relationship with the U.S. government, and communications about their funding go through the prime partner.

Mozambique, where abortion is decriminalized. Organizations were unclear that the Trump GGR does not apply to government entities, which often partner with NGOs to deliver health services. On top of this, as U.S. government contracts are written in English, this poses a language barrier for local organizations that are complying with the policy but have limited—if any—in-house English language capacity.

2. IMPACT ON COALITION SPACES AND PARTNERSHIPS

CHANGE found many instances of organizations in Mozambique having already discontinued partnerships because of the GGR. Some organizations can no longer participate or have decreased their level of engagement in coalitions. “If for some reason, we start talking about abortion, we have colleagues who just leave the room,” one local NGO representative said.⁵⁰²

ICRH-M, a local SRHR organization, reported already observing self-censoring by key coalition groups, with some of their partners not attending meetings anymore, thus weakening their coalition network that advocates for sexual and reproductive rights.⁵⁰³ Some members of the Sexual and Reproductive Rights Network⁵⁰⁴ that will comply with the Trump GGR have mostly stopped participating in abortion-related work, such as advocacy around the decriminalization of abortion. They continue to address other issues such as GBV and early marriage. Ivone Zilhão, of the Network's steering committee, underscored the impact of the resulting uncertainty several times in her conversation with CHANGE: "People, they don't know what is the future," she said.⁵⁰⁵

One organization observed changes in participation in a technical working group that has supported the rollout of safe abortion services in the country. "Now...there's a much stricter interpretation of being in the room and being a part of the conversation," a representative noted.⁵⁰⁶

Mahomed Riaz Mobaracaly, Senior Country Director at Pathfinder International, noted the impact of the Trump GGR on coalition spaces. As a U.S.-based organization, they are able to work on abortion with non-U.S. funding, but its local partners do not have the same liberty. Mobaracaly told CHANGE that Pathfinder can no longer partner with key local organizations that work on SRHR because of the GGR. "It's narrowed down the number of organizations with whom you can work," he said.⁵⁰⁷

3. IMPACT ON HIV AND AIDS

Currently, 13.2 percent of Mozambique's adult population is living with HIV,⁵⁰⁸ a rate that has increased from 11.5 percent in 2009.⁵⁰⁹ Women

have a higher HIV prevalence rate at 15.4 percent compared to 10.1 percent of men.⁵¹⁰ Nearly 10 percent of all AGYW aged 15-24 are living with HIV, a number that is **three times higher** than their male counterparts, whose HIV prevalence rate is 3.2 percent.⁵¹¹ An additional 200,000 children are living with HIV, and there are 1.2 million orphans in the country due to the AIDS epidemic.⁵¹² In 2016, an estimated 83,000 people were newly infected with HIV, 13,000 of which were children.⁵¹³

Of the 47 percent of people living with HIV aged 15-49 who know their status, 40 percent are on ART.⁵¹⁴ Only 30 percent of 15- to 24-year-olds have comprehensive knowledge of HIV prevention, indicating a dearth of information on HIV among youth despite the country's high HIV prevalence.⁵¹⁵ This figure is even lower in rural areas.⁵¹⁶

Given Mozambique's high HIV prevalence, organizations were concerned about the impact of the Trump GGR on HIV, while noting that the full implications will take time to emerge. Rui Maquene, from Handicap International, noted that because this is "the first generation of this policy on HIV," it's still too early to know the impact.⁵¹⁷ A representative of WaterAid, a WASH organization, said, "I think that really creates a fear that HIV rates will go up because there's no longer this availability of funding."⁵¹⁸

Pathfinder International, which receives USAID and CDC funding for family planning and HIV prevention for key populations, noted that community-based organizations "are doing the household visits and the community-based care for HIV, and they are the ones that are very well-penetrated at the community level. We want to take advantage of that penetration at the community level to offer services, but they will not be able to now because of this extension of [the GGR]."⁵¹⁹

One organization CHANGE spoke with that works on HIV prevention worried about the impact of the GGR on its partnerships, which would hinder its ability to deliver care to key populations. “So if for example in one province, [there is] not anymore shared space like in the past, we cannot for instance have Pathfinder as intermediaries, so it means that our capacity in terms of providing services on the HIV area will reduce, and it will have an impact on the provision of services in terms of HIV.”⁵²⁰ Moreover, they explained, “Many organizations are not solely working on HIV prevention. Sometimes they bring together services—like HIV prevention and safe abortion—so all of these are going to be impacted, meaning that the situation of HIV, most organizations won’t have funds to carry on their work.”

In Mozambique, many young people are born with HIV and often don’t know that they have it. Prior to the Trump GGR, AMODEFA was implementing a pilot program on parental disclosure of HIV to children, which they looked forward to expanding across the country because of how successful it was. They are now planning to train other organizations to take over the work so that they can revive the program, “but the other organizations don’t have experience in these areas,” Simone said.⁵²¹ And in the meantime, children with HIV are growing up unaware of their status.

There’s also grave concern about HIV in Gaza province, where the HIV prevalence is the highest in Mozambique at 24.4 percent.⁵²² Gaza also has the highest prevalence of HIV among AGYW in the country.⁵²³ Organizations CHANGE spoke with fear that the Trump GGR will impact their ability to reduce the rate of HIV among youth.

Some of the organizations CHANGE spoke with are part of the PEPFAR DREAMS Partnership, which aims to dramatically reduce new HIV infections among AGYW in 10 sub-Saharan African countries. Since its inception in 2015, DREAMS has reduced new HIV infections in young women by 25–40 percent in 41 of the 63 districts in all DREAMS countries. These target countries, including Mozambique, accounted for more than half of all new HIV infections among AGYW globally in 2016.⁵²⁴

In Mozambique, DREAMS programming is active in six high-prevalence districts located in Gaza, Zambézia, and Sofala provinces.⁵²⁵ The U.S. contributed \$20.4 million for DREAMS programs in the country in FY2016–2017.⁵²⁶ In Mozambique, where child marriage, early sexual debut, and adolescent pregnancy—all risk factors for HIV—are common, programs such as DREAMS are critical. Without them, informants said, young women’s futures would be bleak.

CHANGE visited the AMODEFA clinic in Xai-Xai, a rural district in Gaza province. The staff CHANGE spoke with had a very stark view of the future under the Trump GGR. “By the time you get the policy repealed, many people will have died,” one person said.⁵²⁷ U.S. funding that the clinic has received through the DREAMS Partnership has helped them reduce the incidence of HIV in the province, a trend they now expect to see reversed.

AMODEFA's Xai-Xai clinic began a five-year DREAMS initiative in April 2017 that would have continued until 2022 had it not been for the Trump GGR. The program trained and supported 600 community health workers, called *activistas*, to provide SRHR information, referrals, and services to rural communities, including HIV testing and counseling, STI testing and treatment, and family planning, particularly for AGYW. In addition, *activistas* served as community leaders.

The clinic was forced to lay off both nurses and *activistas* because it no longer had the funds to pay them. Of **600** *activistas*, only **64** remain. "Now

people in the communities where we can't go still call me, but there are no resources to reach those communities," one *activista* said.⁵²⁸ "So it affects our name and our integrity."

The only sources of information for the community now are the radio and the internet, but these channels cannot replace the in-person, evidence-based, community-centered care provided by *activistas* and nurses. The clinic staff are very concerned about the impact this reduction in services will have in Gaza. "We cannot achieve our goals," one concluded.⁵²⁹

Child marriage and adolescent pregnancy in Mozambique

In Mozambique, only 26 percent of women aged 15–49 use a modern contraceptive method,⁵³⁰ a reality that contributes to a national fertility rate of 5.3 children per woman.⁵³¹ Adolescent pregnancy rates in Mozambique are high: 14 percent of adolescent girls become pregnant before age 15, and 57 percent have been pregnant by age 18.⁵³² Adolescent pregnancy significantly increases the risk of maternal mortality, and complications from pregnancy and childbirth are the leading cause of death in 15- to 19-year-old girls globally.⁵³³

Mozambique has the world's 10th highest rate of child marriage,⁵³⁴ which is a determinant of adolescent pregnancy.⁵³⁵ From 2010–2016, 14 percent of girls were married by 15 years of age, and 48 percent were married by age 18.⁵³⁶ According to the 2011 Demographic and Health Survey (DHS), of girls who married before 15 years of age, 39 percent had their first child before age 15, compared to less than 3 percent of girls who married after age 15.⁵³⁷ Additionally, the probability that a girl or young woman in Mozambique had three or more children was seven times higher among those who were married by age 15.⁵³⁸

In 2015, Mozambique faced a maternal mortality rate of 489 deaths per 100,000 live births, which is higher than the regional average and more than double the global maternal mortality rate.⁵³⁹ Reducing unsafe abortions is one way to reduce the maternal mortality rate (see "Impact on abortion" section on page 79), and the Trump GGR will make it much harder to provide not only safe and legal abortion services, but also the contraceptive information and services and education that girls and young women need to control their health and their futures.

4. IMPACT ON ADOLESCENT GIRLS AND YOUNG WOMEN

The organizations CHANGE met with in Gaza province were particularly concerned about the impact of the Trump GGR on AGYW in rural communities. This population, which lacks access to SRHR information and services, faces high rates of early pregnancy and early marriage, often resulting in girls having to drop out of school.

ACOSADE,⁵⁴⁰ a community-based organization in Chicumbane, Xai-Xai district, felt that Trump’s GGR “will be a drawback for the engagement of the girls.” In communities where child marriage and early pregnancy are common, SRHR education can be life-changing. “When we started this kind of sexual and reproductive health education, then girls started understanding who they are,” a representative explained.⁵⁴¹ “Before it was difficult to find a young girl who stands up and talks about sex and HIV, but nowadays...you can find a woman who tells men, ‘If you don’t wear a condom, there’s no sex.’” In

communities where ACOSADE was beginning to see results, they said, “this policy is like giving a sweet to someone and while they are starting to taste it, you take it back out of their mouth.”⁵⁴²

The drastic reduction in HIV service provision for AGYW at AMODEFA’s clinic in Xai-Xai illustrates how quickly Trump’s GGR can destroy HIV prevention efforts. In just the last three months of 2017—after they lost their U.S. funding—a marked difference was seen in the number of HIV services AMODEFA provided to girls and young women, compared with the months prior to September 2017.⁵⁴³

The clinic also closed its U.S.-funded program, Tua Cena, in September 2017 because of the Trump GGR. The program aimed to increase access to quality sexual and reproductive health services for adolescents and young people in three districts in Gaza province, including testing and counseling for HIV, testing and treatment for STIs, and family planning services.

Table 1: HIV services at AMODEFA’s Xai-Xai clinic for girls and young women under 24 years of age, July-December 2017

Service	July–Sept. 2017	Oct.–Dec. 2017
Consultation	6,799	833
Pre-counseling	6,799	833
Rapid test	5,621	833
Pre-test counseling	5,621	833
Counseling to reduce risk	6,799	833
Psychosocial support	896	253
Clients tested	5,981	671

Through Tua Cena, AMODEFA was able to identify particularly vulnerable adolescents, such as orphans and adolescents living with HIV, and start them on ART. From September 1–22, 2017 alone, AMODEFA tested 1,099 people for HIV, of which 923 were girls and young women; distributed nearly 15,000 male condoms and 476 female condoms; and provided family planning services for 1,237 people, including 32 IUD insertions, 106 implant insertions, 348 contraceptive pills, and 684 Depo-Provera injections.⁵⁴⁴ The discontinuation of these services leaves already-vulnerable youth at greater risk of HIV, STIs, and unintended pregnancies.

5. IMPACT ON SEX WORKERS

Key populations,⁵⁴⁵ vulnerable populations, and populations of specific concern⁵⁴⁶ are disproportionately affected by HIV and other sexual and reproductive health issues.⁵⁴⁷ ICRH-M, a sub-grantee of FHI 360 that receives PEPFAR/USAID funding, works with key populations. They sub-grant to local district health services and operate the Moatize Night Clinic in Tete province as well as community-based services that serve over 2,000 sex workers. The organization is one year into a five-year contract, but they cannot comply with the Trump GGR. Sexual and reproductive health “is a core part of who we are,” they told CHANGE.⁵⁴⁸ “There’s no way we could, with any credibility, stop doing that work.”

When CHANGE met with ICRH-M in January 2018, the Trump GGR had not yet been added to their funding agreement, but they knew it was only a matter of time before they would have to give up their U.S. funding. In late February 2018, FHI 360 told ICRH-M that they would lose their funding and have to cease all of their U.S.-funded activities—with one month’s notice. With just a month to grapple with a

40 percent budget cut and shutting down essential health services, Sally Griffin, director of ICRH-M, called the policy “something you’re completely powerless about.”⁵⁴⁹

The services that will be discontinued include ICRH-M’s night clinic, which is a very important space for sex workers who face barriers to accessing public health services. The clinic provides an integrated package of HIV and STI services, family planning, and screening and referral for cervical cancer, GBV, and TB, “so if they go for an HIV test they’re supposed to get these other services that they recognize are important for key populations,” Griffin said.⁵⁵⁰

Griffin told CHANGE that it has “taken us a very long time to build up trust of the sex worker population.”⁵⁵¹ ICRH-M has been operating the clinic and community services for 15 years, forming a vital relationship with the community that will be lost now that ICRH-M must end these services. “We treat them with respect, and we don’t see that in all organizations that work with sex workers.” ICRH-M noted that they do not know of any organization that could take up the work in their place.

Many organizations that work with sex workers have “HIV blinders,” meaning they treat sex work as solely an HIV issue rather than seeking to meet the full range of SRHR needs of sex workers. Without ICRH-M, there will be a loss of expertise. Even though the U.S. is a strong supporter of integrated health services for key populations, Griffin noted that the organizations that will be implementing the Trump GGR “will not include safe abortion in that package of services, and will not refer sex workers, young women, people who use drugs, whoever it is, to those services.”⁵⁵²

6. IMPACT ON LGBT POPULATIONS

The LGBT community also faces barriers to health services. One organization partnered with AMODEFA clinics to serve LGBT populations, but that work has been affected because AMODEFA is closing many of its clinics. “AMODEFA clinics were a unique space where we could refer our beneficiaries, who are [transgender] women, who are lesbian, who are gay, who are MSM, expecting if you are referred to AMODEFA’s clinics, they were going to receive friendly attendance,” a representative told CHANGE.⁵⁵³ For example, they just found out that AMODEFA would be closing their clinic in Manica province that the organization works with. “In the Manica province, we do not have a lot of choices or clinics that we have in Maputo. So we can feel the impact. It will be different.”

7. IMPACT ON VULNERABLE POPULATIONS

Programs that serve vulnerable populations experiencing food insecurity and lack of nutrition are particularly imperiled in Mozambique. “It’s very clear that the issues around early marriage, premature pregnancy, or teen pregnancy...and nutrition are all linked,” a representative of CARE International in Mozambique, an anti-poverty organization that aims to improve food and nutrition security through women and girls’ empowerment, told CHANGE.⁵⁵⁴ “So for us if our focus is nutrition, working backwards, we could and should be thinking about issues around the rights of adolescent girls.”

Because of these linkages, there will be a negative impact on nutrition programs if access to family planning and services for pregnant adolescents are scaled back. This contradicts Concern Worldwide’s recommendation that adolescent girls in Mozambique require special attention to make sure their nutrition needs are being adequately

addressed, which includes reducing the rate of adolescent pregnancy and prevention of early marriage.⁵⁵⁵

Many people with chronic diseases, including children with HIV, need “access to...additional food baskets to compensate or to boost not only their endurance to treatment but strengthen their whole body so they can take ARVs and progress properly,” one organization said.⁵⁵⁶ In response to this issue, AMODEFA runs a program in Boane that provides nutritional supplements to OVCs.⁵⁵⁷ But because of Trump’s GGR, they now must find a partner that is equipped with the knowledge and resources to take over the program.

8. IMPACT ON PEOPLE LIVING WITH DISABILITIES

People living with disabilities in Mozambique face difficulty accessing health services and are at greater risk of abuse. Robert Burny of Handicap International told CHANGE that, “what we have observed is that persons with disabilities, particularly the women and the young women and teenagers with disabilities, are much more exposed than their neighbors without disabilities.”⁵⁵⁸ They are more likely to suffer from HIV and be targets of sexual abuse, exploitation, and rape. He fears that the Trump GGR will “create an additional bottleneck and a barrier to access to those services.”

9. IMPACT ON COMMUNITIES LIVING IN RURAL AREAS

Communities living in rural areas of Mozambique will likely be hardest hit by the Trump GGR. “I feel this fear more at the provincial level and district levels,” because community health workers, peer educators, and community activists will not be able to reach communities living in rural areas without

Table 2: Services provided at AMODEFA's Xai-Xai clinic, July–December 2017

Family Planning (Women)	July–Sept. 2017	Oct.–Dec. 2017
General counseling	12,258	2,728
Pills - consultation	1,780	460
Male condom - consultation	71,582	6,708
Female condom - consultation	3,464	694
Injectable - consultation	3,445	688
IUD insertion - consultation	225	73
Implant insertion - consultation	664	232
Implant removal - consultation	52	1
EC - counseling	848	0
Family Planning (Men)		
General counseling	2,063	426
Male condom - consultation	22,635	4,490
STI		
Consultation	414	40
Pre-test counseling	229	40
Post-test counseling	229	39
Counseling to reduce risk	414	40
Syndromic treatment	364	13
Gynecology		
Consultation	2,789	0
Counseling for cancer prevention	2,789	0
Pre-test counseling for cervical cancer	1,249	0
Manual examination - breast palpation	2,789	934
Bimanual investigation - internal and external	1,705	0
Menstrual regulation	58	0
Syndromic treatment	18	0

funds, a member of the Sexual and Reproductive Rights Network told CHANGE.⁵⁵⁹ For example, in Nampula province, the distance to health facilities can be as far as 50 kilometers (31 miles). Needing to scale back activities due to the GGR, AMODEFA has already ended its integrated TB, malaria, HIV, and family planning program in Nampula, where they delivered services directly to communities using motorbikes.⁵⁶⁰

AMODEFA predicts the incidence of STIs will increase in communities.⁵⁶¹ Besides suspending the outreach of almost all of their 600 *activistas* because of the GGR, AMODEFA's Xai-Xai clinic has dramatically reduced the services it provides in-house. The disparity in services they provided in the three months leading up to October 2017 (Table 2)—when they lost their U.S. funding—compared with the three months after concretely illustrates how the Trump GGR is already harming people's access to health care.⁵⁶²

10. IMPACT ON RESEARCH

The Trump GGR also adversely affects the ability of local NGOs to conduct research that is used to influence domestic policy in the Global South. In one instance, AMODEFA said it explained to the government that, "Normally public facilities, they close at 3:00 pm every day. And we're saying to work with sex workers, to work with LGBTI [people], maybe we should not close at that time. [We] should continue during the evening to work with them."⁵⁶³ They then piloted this hypothesis in health facilities, using the results as recommendations for the government to keep their own facilities open longer. With resources now dramatically reduced because of the Trump GGR, Simone said, "we'll not be able to provide evidence for the government to take decision[s]. Also for us to influence change."

11. IMPACT ON ABORTION

Abortion-related deaths in Mozambique were highly common among adolescents prior to the decriminalization of abortion, accounting for somewhere between 10–18 percent of maternal deaths in hospitals.⁵⁶⁴ To curb the country's high maternal mortality rate, Mozambique liberalized the abortion provision in its penal code in 2014.⁵⁶⁵ Abortion is now permitted on request at designated facilities by qualified practitioners in the first 12 weeks of pregnancy, in cases of rape or incest in the first 16 weeks, and in cases of fetal anomaly in the first 24 weeks. Mozambique's abortion provision is far more permissive than the three exceptions allowed by the Trump GGR.⁵⁶⁶

Clinical guidelines for providers on the 2014 abortion provision were issued by the Ministry of Health as recently as September 2017,⁵⁶⁷ so implementation is still in an early phase. Trump's GGR could create significant barriers to health facilities in offering and promoting safe and legal abortion services. "Why a country like us decided that we need a provision that decriminalizes abortion in certain circumstances [is] because we know that it's important because abortion will save lives. Safe abortion will save lives," said a representative from Oxfam, an NGO that focuses on advocacy, sustainable development, and supporting civil society organizations in Mozambique.⁵⁶⁸

The U.S. funds a robust network of community health workers in Mozambique, some of which will now be restricted in what they can say to clients, thus contradicting the 2014 abortion provision that is now being implemented. "The national strategy is to—I think it's called the decriminalization of abortion, but really it's also widening services. It's intended to save lives by the national government,"

a representative from one U.S.-based organization explained.⁵⁶⁹ “And you need to make sure that women know services are available, where they’re available, how they’re available, and you want responsible organizations doing that. And I do think that we’re now missing some that were a key part to that puzzle of making sure that the national health strategy was communicated well to communities that have grown to trust certain partners and have connections to partners. Information related to abortion will not flow as freely.”⁵⁷⁰

For example, Oxfam has been working with partners to distribute information about access to safe abortion services at the community level since 2014. Some of these partners receive as much as 75 percent of their funds from USAID and are complying with the Trump GGR. The organization considers this “a loss” for Oxfam, and particularly for efforts to inform people throughout the country who generally are unaware of the new abortion provision and are operating as though abortion is still illegal.⁵⁷¹

Pathfinder International agreed that the Trump GGR hinders implementation of the provision. “Now, after almost 20 years, you have a good legal framework to offer services—free of charge,” Mobaracaly told CHANGE. “And then you don’t have promotion or information given at all level of communities for the population.”⁵⁷²

The Trump GGR will also diminish the reach of NGO-run youth facilities that provide information for girls to make informed decisions. One organization explained that hospitals are not always friendly environments for youth. By contrast, at civil society organizations, “the way the information is transmitted, is relayed to the girls, it’s...more open. ...Because people will still [get] abortion, so it’s

important to pass along information so they know they can do it in a safe way. So one of the impacts would be not decreasing the number of girls who die [due] to unsafe abortion,” Helena Chiquele of Oxfam in Mozambique noted.⁵⁷³

Among AMODEFA’s clinics, one provides abortion care while other clinics provide information and referrals for abortion services. But the organization is trying to increase the number of clinics that provide legal abortion services from one to three—to counter the effects of the Trump GGR, which AMODEFA says it expects will increase the incidence of “unsafe abortions.”⁵⁷⁴

Ipas Mozambique works with 40 government facilities in two provinces to train safe abortion providers, equip facilities to provide services, and raise awareness of integrated services that include abortion for women and girls living in rural areas. Clemence Langa, the Country Director, said that if AMODEFA “pull themselves from those communities, it means those women living in those communities won’t be having access to information which they used to have.”⁵⁷⁵

Many interviewees felt that more women and girls will die due to complications from unsafe abortion because of the Trump GGR.

“The country already has a legal instrument that decriminalizes abortion, and then you come with your money saying only certain people can do this work,” a representative from Oxfam said.⁵⁷⁶ “It is taking away from what we’ve already achieved.”

D. Conclusion: Widespread harms of Trump's GGR in Mozambique

Time and again, stakeholders in Mozambique emphasized that the Trump GGR would be a step back.

It forces local organizations that are dependent on U.S. funding to make the nearly impossible choice between maintaining their integrity and credibility—by providing the full range of health services they have promised to their communities and non-U.S. donors—and accepting U.S. funding that is vital to maintaining some service provision.

Many organizations in Mozambique felt they were facing a tradeoff between U.S. funding and support from European donors, who have indicated they will prioritize funding NGOs that cannot comply with the Trump GGR. Some organizations told CHANGE they are wary of pursuing U.S. funding in the future because of the complications—and harms—the GGR triggers when it is in effect.

This means organizations may struggle to preserve enough funding to maintain the programs they offer now—many of which appear to have nothing to do with abortion. Florencio Marerua, of WaterAid, remarked, “it’s about primary health care. It’s not even relevant to speak about abortion only.”⁵⁷⁷

One organization fears a “grassroots gap” and a loss of capacity, echoing concerns CHANGE heard numerous times from interviewees. As funding is cut off, organizations have fewer resources to reach out to communities and provide access to rural populations, leaving them vulnerable to disease, unintended pregnancy, unsafe abortion, HIV, and other significant harms. Simone, of AMODEFA, added, “This policy is going back, means that all the fight we’ve been doing the last eight years, thanks

to the great support of USAID to Mozambique and to AMODEFA/IPPF, will go down. We’ve been doing a lot in these last years. And then, the [Trump GGR] come[s]. And everything go[es] to zero.”⁵⁷⁸

From the decriminalization of abortion to combat high maternal mortality rates, to gearing SRHR education toward AGYW in rural communities, to providing integrated services tailored for key populations, NGOs in Mozambique are committed to shaping their country’s future. The Trump GGR goes beyond undercutting their work; it threatens to fracture the health system—and reverse decades of progress—in a country that has made monumental gains in addressing the health needs of its population.

III. ZIMBABWE CASE STUDY

A. Executive summary

As a U.S.-based women's rights organization that advocates for SRHR globally, CHANGE has assessed and documented the harmful effects of the GGR on the health of women, girls, and communities across U.S. administrations. The current policy under President Trump has broader, more dangerous implications than any previous iteration.

To analyze the impact of the Trump GGR in Zimbabwe, CHANGE conducted an independent eight-day fact-finding mission in January and February 2018. CHANGE learned how the GGR causes grave harm by not taking into consideration language translation, blocking access to contraceptive implant removal, and putting girls at increased risk of sexual violence and exploitation. The policy will have far-reaching consequences on not only reproductive health systems, but also on aspects of health ranging from maternal, newborn and child health, to nutrition, to HIV prevention, to health service provision for vulnerable and marginalized populations. The expanded reach of the GGR has the potential to increase the rates of illness and even death.

This case study outlines the immediate impact of the Trump GGR on individuals, programs, organizations, and coalitions in Zimbabwe. It shows how life-changing programs that have been supported by U.S. global health assistance in Zimbabwe are quickly unraveling under the Trump GGR, and that beneficiaries are the hardest hit. The policy is forcing organizations to take giant steps backward in their efforts to protect community health and to empower AGYW who seek opportunities to make decisions about their own lives.

The Trump GGR is a U.S. foreign policy that, when enacted, prohibits foreign NGOs that receive U.S. global health assistance funds from advocating for abortion, or providing, counseling, or referring for abortion services as a method of family planning.⁵⁷⁹

B. Impacts

1. IMPACT ON COMMUNICATION WITH U.S. GOVERNMENT AND PRIME PARTNERS

Miscommunication by the U.S. government and prime partners has led to confusion about the policy among organizations. If an NGO receives funding from a prime partner, it is the prime's responsibility to pass down the GGR and make sure the sub-grantee understands the policy. CHANGE found that organizations are unclear about the conditions of the policy and the implications of complying with or violating the policy.

Many organizations CHANGE met with noted that they have received no communication from the U.S. government or their prime partners. When they did receive communication, it was not specific, incomplete, and left little opening for further communication. Pangaea Zimbabwe AIDS

About Zimbabwe and U.S. funding

Zimbabwe has an estimated population of 16.1 million,⁵⁸⁰ approximately 68 percent of which live in rural areas.⁵⁸¹ The country once had a robust health system that has suffered nearly two decades' worth of economic shocks and downturns. The now-corroded health delivery system is reflected in high mortality and morbidity rates, and is made more vulnerable by high burdens of maternal and child-related illnesses, HIV, and TB, among other issues.⁵⁸² The functions of the health delivery system have become largely dependent on donor assistance.

Zimbabwe is currently the 16th largest recipient of U.S. foreign assistance in sub-Saharan Africa.⁵⁸³ U.S. foreign assistance to Zimbabwe was \$187,246,019 in FY2017; over \$186 million of which came through USAID for services including HIV and AIDS, primary health, maternal and child health, family planning, water supply and sanitation, OVCs, TB, and malaria.⁵⁸⁴ U.S. global health assistance comes into the country through the Ministry of Health and Child Care (MoHCC) as well as through partner organizations. The latter funding dynamic makes the country's health system particularly sensitive to the impacts of the Trump GGR.

Currently, 86 percent of HIV funding in Zimbabwe comes from donor assistance.⁵⁸⁵ In FY2017, the PEPFAR budget for Zimbabwe was nearly **\$127 million**.⁵⁸⁶ As of September 2017, PEPFAR Zimbabwe has provided almost 2.5 million people with HIV testing services, 848,120 people with ART, and care and support for 470,705 OVCs as well as their caregivers.⁵⁸⁷

Trust (PZAT),⁵⁸⁸ a sub-prime partner, told CHANGE that they have not received any direct memo or communication about the Trump GGR from their prime partners. PZAT has three U.S.-funded projects that make up over 80 percent of the organization's overall budget.

One organization received a detailed questionnaire on the policy from their prime partner that they had to complete in order to determine whether or not they would comply.⁵⁸⁹ They simply checked boxes on the questionnaire and their responses were taken to reflect compliance. It was not until meeting with CHANGE that they understood that some of their work might be in conflict with the policy. "So I do not think that the conversation has actually gotten

to a level where people then get to understand the policy and its implications," representatives from the organization concluded.⁵⁹⁰ "The policy is confusing."

CHANGE found the best communication to be issued by organizations that cannot comply. MSI, one of the largest international family planning organizations, directly communicated with their partner organization, Population Services Zimbabwe (PSZ), on January 23, 2017, the same day that the Trump GGR was enacted. MSI employs a team that is specifically responsible for digesting and communicating the implications of policies like the Trump GGR. Beneficiaries of PSZ services were told that services would be scaled down because of funding cuts.⁵⁹¹

2. IMPACT ON ABILITY OR WILLINGNESS TO PARTNER

Organizations in Zimbabwe rely on coalitions and partnerships to maximize their resources and to deliver a broad range of services to communities. In almost every interview, CHANGE heard concerns about how the Trump GGR could damage or even dismantle coalitions and referral networks.

One respondent now mistrusts referral networks they once participated in, as some of those organizations are complying with the policy.⁵⁹² Additionally, some organizations that cannot comply are experiencing stigmatization from other partners within coalitions; some are labeled, “*ndimi munosvatora*,” a discriminatory insult that loosely translates from Shona to “you are the organization that aborts.”⁵⁹³

The fact that coalition spaces are occupied by both complying and non-complying organizations is itself generating confusion. The Trump GGR is “creating a space of conflict within the coalition itself.”⁵⁹⁴ Some U.S.-based organizations have become “silent” on certain issues they should be speaking on in order to protect their funding.⁵⁹⁵ On the other hand, other organizations are faced with potentially renegotiating their place in a coalition that is ultimately beneficial to their mission and goals. “It has taken us a long time. ...We’ve been building strong networks and this policy would affect that. Because civil society also has its own politics...we do not want to be that organization that considers itself a human rights organization and then takes [U.S.] money,” one interviewee said.⁵⁹⁶

At the country level, the partnerships between the U.S. government and organizations have been fruitful and productive. These partnerships and collaborations may become “anti-USA instead

of anti-global gag rule. ...So it is never about the institution we worked with. We completely enjoyed working with USAID and FHI. It was great learning for us. It was a good opportunity to add value in a complementary fashion. We liked their systems,” a concerned SAfAIDS representative stated.⁵⁹⁷ Organizations have had to adjust and adapt accordingly.

DREAMS: Zimbabwe⁵⁹⁸

Zimbabwe has an HIV prevalence of 13.8 percent,⁵⁹⁹ with 40,000 new HIV infections reported in 2016.⁶⁰⁰ Of the 1.3 million people living with HIV, 75 percent are on ART.⁶⁰¹ Among young people aged 15–24, young women have a 5.7 percent HIV prevalence compared to 2.8 percent in young men.⁶⁰²

The PEPFAR DREAMS⁶⁰³ Partnership aims to dramatically reduce new HIV infections among AGYW in 10 sub-Saharan African countries,⁶⁰⁴ including Zimbabwe.⁶⁰⁵ Since its inception in 2015, DREAMS has reduced new HIV infections in young women by 25–40 percent in 41 of the 63 districts across all DREAMS countries.⁶⁰⁶

In FY2016, \$20,621,571 in U.S. funding was allocated for DREAMS interventions in six districts in Zimbabwe (Bulawayo, Chipinge, Gweru, Makoni, Mazowe, and Mutare).⁶⁰⁷ Until mid-2017, about 110,000 AGYW, aged 10–24 years, had received DREAMS services.⁶⁰⁸ Additionally, in 2017, provision of PrEP, a medication to reduce the risk of HIV infection, was extended from four to all six DREAMS districts in the country.⁶⁰⁹

3. IMPACT ON HIV AND AIDS

The DREAMS Partnership, which provides essential services to AGYW, is losing prime partners and their sub-grantees due to the Trump GGR. Organizations had been providing interventions that addressed a range of issues, including education, community mobilization, girls' empowerment, and family planning. Under the GGR, PSZ is no longer able to take part in these activities, a PSZ representative told CHANGE.⁶¹⁰ This funding was transferred to PSI, an organization that is complying with the GGR.⁶¹¹ However, PSZ pointed out that PSI does not offer the same full range of comprehensive family planning and sexual and reproductive health services that PSZ does.

A “prime partner” is an organization that receives U.S. funding directly from the U.S. government. Both U.S. NGOs and foreign NGOs can be prime partners.

A “sub-grantee” or “sub-recipient” is an organization that receives U.S. funding from a prime partner, rather than directly from the U.S. government. Sub-grantees are one step removed from a direct relationship with the U.S. government, and communications around their funding go through the prime partner. All U.S. funding requirements are passed down through prime partners to their sub-grantees.

CHANGE met with a prime partner that is a foreign NGO and their sub-grantee, both of which cannot comply with the Trump GGR. SAfAIDS is a regional NGO that promotes effective and ethical development responses to SRHR, TB,

“The story is that, the work that was being done by Roots was helping a lot of people. ...The people in the urban area, they have access to information, where we stay—we do not have access to such information. But what Roots used to do, is that they used to come to our rural communities. They would use their funds to come to see us. They would employ facilitators who would come give us information. ...The issue of sex work, some of us were sex workers only because we come from poverty—we had no money. ...When DREAMS came, it [helped] us do projects so that we could become empowered. Now all of that has stopped. Girls were benefitting from the savings club, but now that has stopped—they don’t have money anymore. We were anticipating starting agricultural projects—but DREAMS stopped, so that isn’t going to happen anymore. We no longer have that support.”

—DREAMS beneficiary supported by
Roots

and HIV (including prevention of mother-to-child transmission) through advocacy, communication, and social mobilization.⁶¹² Until the Trump GGR went into effect, nearly half of SAfAIDS' budget was from USAID, and the bulk of that went to support DREAMS programming. Of its inability to comply with the GGR, SAfAIDS explained, “If we speak SRHR for all, it has to be inclusive, and there is no exception.”⁶¹³

One of SAfAIDS' sub-grantees—Roots— had a five-year agreement with SAfAIDS that made up 60 percent of their budget. Roots, a pro-choice NGO,⁶¹⁴ will not comply with the Trump GGR. Roots' funding was being used for DREAMS interventions that were focused on keeping girls in school or getting them back in school, targeting 5,000 young women aged 20–24 and 2,500 girls and young women aged 15–19.⁶¹⁵ The initiative included providing education, safe spaces, and training in income-generating activities—all designed to foster economic and SRHR empowerment. At the time of CHANGE's interview with Roots, this initiative had come to an abrupt stop due to loss of funding.

Roots was informed that another organization would be taking over the implementation of DREAMS, but representatives of Roots and the participants in Roots' DREAMS programming told CHANGE that nobody has stepped in to fill the gap and DREAMS activities had stopped as of September 2017.⁶¹⁶

"I am a young mother," one DREAMS beneficiary told CHANGE. "[DREAMS] had these groups and clubs, and we would come together for some form of economic empowerment so we could support our children. Even that stopped."⁶¹⁷

4. IMPACT ON KEY POPULATIONS

Key populations,⁶¹⁸ vulnerable populations, and populations of specific concern⁶¹⁹ are disproportionately affected by HIV.⁶²⁰ In Zimbabwe, substantial efforts have included collaboration among national government and community-level service providers to increase funds in COPs for key populations' access to health services.⁶²¹

Key and vulnerable populations already face barriers within the health system, including social exclusion, discrimination, stigma, barriers with health service

providers, and criminalization.⁶²² These challenges impact their ability to access relevant, needed, and appropriate health services, and the Trump GGR is only going to make these issues more acute. Under the policy, key populations are disproportionately vulnerable, and the services they have struggled to access will be further diminished, SAfAIDS said.⁶²³

Organizations anticipate a stark impact on HIV prevention, including the ability to provide PrEP, a daily HIV preventative medication⁶²⁴ that can significantly reduce HIV incidence in at-risk populations.⁶²⁵ In Zimbabwe, PrEP is rolled out as part of an integrated service at facilities, some of which are U.S.-funded. The Trump GGR threatens this funding, which may directly impact PrEP provision for HIV high-risk groups.

5. IMPACT ON LGBT POPULATIONS

There were fears that the Trump GGR will result in further discrimination and stigmatization of LGBT communities. "When you're looking at the kind of work that we're doing—removal of barriers of access to services and abortion as a service—we cannot then say to our community, 'No we cannot provide this particular service.' It will then mean that probably we are also then marginalizing the lesbian community so to speak, or the [female sex worker] community," one organization said.⁶²⁶

6. IMPACT ON PEOPLE LIVING WITH DISABILITIES

PSZ's Improving Family Planning Services (IFPS) activity grant improved access to family planning and sexual and reproductive health educational materials for people living with disabilities, especially for those with physical, auditory, speech, and visual impairments.⁶²⁷ These programs require substantial funding. Without U.S. funding, PSZ cannot continue

to support access to family planning services for people with disabilities. “We used to have a disability project that USAID funded. ...[It] requires a lot of resources. And without adequate funding, we have sort of scaled down. ...So I think the disability sector suffered the most broadly. It was an abrupt termination of the relationship. We had initiated some activities with people with disabilities, and all of the sudden we couldn’t continue,” PSZ told CHANGE.⁶²⁸

7. IMPACT ON INTEGRATED SERVICES

Zimbabwe started providing integrated services as a health system strategy in 2016.⁶²⁹ The Trump GGR is “creating divisions that are not necessary right now. Instead of having an integrated system, which benefits people in a more comprehensive manner, [we] are now having small pockets, and it’s bringing up stigma, hate, some attitude,” according to a Roots representative.⁶³⁰ “In a country where 70 percent of maternal deaths are related to HIV issues, there are serious fears about the policy’s impact on integrated services,” a representative of WAG told CHANGE.⁶³¹ One organization has a GBV project whose success is dependent on integrated services via referral networks to organizations that are complying with the GGR; this makes referrals difficult because the organization cannot comply.⁶³²

8. IMPACT ON CONTRACEPTION AND MATERNAL HEALTH

Access to contraceptives is vital to protecting the health of women and children by ensuring that pregnancies occur safely and are wanted.

Among married women, Zimbabwe has the lowest unmet need for family planning in sub-Saharan Africa at 13 percent,⁶³³ and the contraceptive prevalence rate is 67 percent.⁶³⁴ Among women

aged 15–49, about one in four has experienced sexual violence after the age of 15, and one in three has experienced physical violence.⁶³⁵ Child mortality rates are high, with one in 15 children not surviving beyond their fifth birthday.⁶³⁶ The maternal mortality rate is staggering—at 651 deaths per 100,000 live births⁶³⁷—and unsafe abortions account for roughly 10 percent of maternal deaths.⁶³⁸

Organizations in Zimbabwe face unique challenges under the Trump GGR, but PSZ serves as an example of the shared impacts of the policy across health sectors and communities. PSZ specializes in providing sexual and reproductive health services.⁶³⁹ Over USAID’s five-year IFPS activity, PSZ was able to provide family planning services to 650,000 Zimbabweans, preventing 814 maternal and 3,100 child deaths in total.⁶⁴⁰ The grant supported nine outreach teams in all 10 provinces at 1,200 service points, accessing marginalized, hard-to-reach populations in mostly rural locations. The grant also supported 50 social franchise clinics under the Blue Star Healthcare Network, a public-private partnership that delivers family planning services at the provincial level.⁶⁴¹ The grant ended in September 2017. Although PSZ anticipated a renewal, because the GGR was reinstated and MSI cannot comply, PSZ did not reapply for this grant.

For PSZ, the loss of U.S. foreign assistance, which accounted for 56 percent of its overall budget,⁶⁴² has resulted in a 50 percent scale-back of the outreach programs and a stark decline in the number of partners it can work with. “In Zimbabwe, outreach is covering 1,200 sites. That’s the local health facilities that we are covering and outreach. And we had to cut it by 50 percent to 600. ...We had 50 partners in the southern region, but currently, we’re left with 20.” The reduction in facilities and social

franchise partnerships has gutted the provision of comprehensive family planning and sexual and reproductive health services across the board.

“Using the USAID fund[s], we reached about 150,000 women with services,” a PSZ representative told CHANGE.⁶⁴³ “So if you are to work with that 50 percent scale-down, we might be able to reach about half of that, and that will be due to the budget deficit.”

For improved family planning and maternal health, the U.S. government funded the provision of mixed-method family planning in Zimbabwe and “was really strong on promoting the LAPM—the long acting and the permanent methods,” PSZ said.⁶⁴⁴ LAPM are

the most effective types of contraceptives.⁶⁴⁵ Long-acting methods are reversible and include IUDs and the progesterone implant.⁶⁴⁶ PSZ’s outreach teams halted their provision of LAPM to hard-to-reach communities. With these communities, particularly within rural areas, now having diminished access to the highly effective family planning services they need and want, PSZ is fielding questions from people in the communities they used to serve. “You know we are receiving those calls, especially from the rural areas. They may be calling and saying you are no longer coming to the site and so forth. And I think that’s an indication to show that there’s already an impact,” PSZ told CHANGE.⁶⁴⁷

Impact on removal of contraceptive implants

Implants are a long-acting method of family planning that can last up to three years without a clinic visit.⁶⁴⁸ For rural or hard-to-reach communities that do not have ready access to health facilities, it can be an ideal contraceptive choice. In Zimbabwe, PSZ is specialized in implant insertion and removal, and prior to the Trump GGR, used outreach programs to provide this service. Due to the loss of funds, PSZ has been unable to reach women who may be due for implant removal. As a result, women with expired implants have no access to trained professionals to remove them. While some of these hard-to-reach areas do have access to government facilities, government health workers are not specialized in LAPM, and lack the proper surgical tools. Women have to buy their own razor blades and bring them to government facilities. “So it’s actually a pity when someone has to buy their own razor blade for implant removal,” PSZ noted, adding that it is often not even the correct surgical blade needed for the procedure.⁶⁴⁹ The inability for women to have their implants removed properly is just one example of many of how the Trump GGR is negatively impacting health.

PSZ also explained that contraceptive research—and therefore the body of evidence around best practices—is expected to be hindered because of the Trump GGR. They previously conducted research as they rolled out services, such as implantation of long-acting birth control, with USAID funding. “When we had USAID funding, we had the resources to conduct research. ...When we provide family planning, there are papers that you are doing the implant removal with our studies,” they told us.⁶⁵⁰ “But you find going forward, we might be forced to scale down some of these issues due to resource constraints.”

9. IMPACT ON ABORTION

Modern contraceptive use as a method of family planning is fairly high in Zimbabwe.⁶⁵¹ However, abortion as a method of family planning is restricted by Zimbabwe's Termination of Pregnancy Act.⁶⁵² Under this 1977 law, pregnancies can be terminated under three circumstances: (1) where there is a reasonable possibility that the fetus was conceived as a result of rape and incest, described in the law as "unlawful intercourse;" (2) where there is a serious risk that the child to be born will suffer physical or mental defects such that they'd be permanently handicapped; and (3) endangerment of the life or physical health of the woman.⁶⁵³ Legal and, in some cases, medical documentation is required for the pregnancy to be terminated.⁶⁵⁴

Technically, the Termination of Pregnancy Act is less

restrictive than the Trump GGR because it permits abortion in cases of fetal anomaly and risk to the health of the woman—two reasons beyond the rape, life, and incest exceptions in the policy.

Organizations CHANGE spoke with conveyed that stigma around abortion—and barriers to providing adequate education about it—will only get worse under the Trump GGR. "I think that there's going to be deprivation of information to the most vulnerable groups," the programs officer at Roots said,⁶⁵⁵ adding that young women will be disproportionately impacted. "There is going to be stigma related to people who speak about it, but also the girls who choose to have an abortion."⁶⁵⁶ The stigma and silence associated with abortion will only push the practice further underground, where evidence shows it will become less safe.

Lost in translation

Cultural and language barriers complicate communication around and implementation of the Trump GGR, especially at the provider–client level.

For example, in the Shona language, which is an official language of Zimbabwe, there is no direct translation for the “passive referral” exception to the GGR, which allows a provider to refer a patient for an abortion under certain circumstances. It requires a pregnant woman to verbally demonstrate to a health provider that she has already decided to have an abortion and would like a referral, in cases where it is legally permissible to have one and the provider believes the medical ethics of the country require that a referral be provided. A health provider cannot prompt a woman to ask for an abortion.

How a woman says, “I am pregnant, I want to get an abortion, and I am going to have an abortion” to her provider will be culturally and linguistically influenced. The language to say “I am pregnant” in Shona is typically shaped by the circumstances of the pregnancy, such as if the pregnancy was unplanned or unwanted. One of the phrases loosely translates to “I am carrying myself.” There is no direct word in Shona for “abortion.” As a result, “I am pregnant and I want an abortion” is not a direct translation. This means there may be situations when the woman is saying that she wants to have an abortion without using those exact words, and the provider’s interpretation is vitally important because it will determine if this constitutes a “passive referral” and is therefore in compliance with the GGR.

A representative of EGPAF Zimbabwe told CHANGE, “It gets lost in translation because a lot of our women [are] not going to go to their local health care worker and speak in English, and say, ‘I want an abortion. I am going to get an abortion.’ They will say it in Shona, for example, which then gets translated, which means what the patient says depends on who is translating what they said. It can then mean exactly what the policy permits or, if it’s not translated properly, it now sounds like a violation. I’m already thinking of many words in Shona that can, in fact, be used for both sides.”⁶⁵⁷

C. Conclusion: Expansive harms of the Trump GGR in Zimbabwe

Nearly every organization CHANGE spoke with shared grave concerns about the impact the Trump GGR will have on their ability to execute their work, extending far beyond abortion care to include family planning, HIV, MNCH, GBV prevention, and much more. The policy is causing a ripple effect among coalitions, where some organizations are accepting U.S. funding and others are not. Conflict and distrust within coalitions break down the ability to collaborate for the good of communities. There is also a great deal of confusion, which poses its own set of challenges in terms of which collaborative or integrated services can be provided under the GGR, and which are forbidden.

In countries like Zimbabwe, where resources are already spread thin, losing U.S. funding could prove devastating to programs that are showing positive results in improving the health of people across all demographics, in both urban and rural communities, and to young women in particular. Without funding, these programs will be scaled back or eliminated altogether, which will escalate rates of HIV, unintended pregnancy, and unsafe abortion.

When CHANGE asked DREAMS beneficiaries what message they wanted to send to the U.S.

government, they responded: “We are DREAMS, and we are trying to reduce HIV infections. But now you will have a girl who will get pregnant. Some men are so violent and will say ‘I didn’t say you could get pregnant,’ and will divorce this girl. Now you have a girl who is left alone with children to take care of. ...There used to be Roots. Roots would help her become financially self-sufficient—now she doesn’t have Roots. This girl will be forced to go do sex work. But we are DREAMS, and we are trying to reduce HIV infections—now these are just going to increase.”

“This is going to affect a lot of girls. Because right now I am thinking, I am a girl and if I need airtime or to buy sanitary pads, I am going to go to a boy. But this boy will tell me nothing is for free [and] I have to sleep with him. So I will sleep with him and maybe he is HIV positive. Now I will become a burden to my parents or I will get HIV infected myself.”⁶⁵⁸

Life-changing programs that U.S. funding has supported in Zimbabwe—like DREAMS—are quickly unraveling under the Trump GGR, and beneficiaries are the hardest hit. The policy is forcing organizations to take giant steps backward in their efforts to protect community health and to empower young women seeking opportunities to make decisions about their own lives.

IV. ACRONYMS

ACOSADE	Community-based Association for Health and Development
AGYW	Adolescent girls and young women
AIDS	Acquired Immune Deficiency Syndrome
AMODEFA	Mozambican Association for Family Development
ANC	Antenatal care
ART	Antiretroviral therapy
AYA	African Youth Alliance
DHS	Demographic and Health Survey
DoD	Department of Defense
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
CBD	Community-based distribution
CDC	Centers for Disease Control and Prevention
COP	Country Operational Plan
CRLP	Center for Reproductive Law and Policy
EC	Emergency contraception
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
E3	Economic Growth, Education, and Environment
FGAE	Family Guidance Association of Ethiopia
FPAK	Family Planning Association of Kenya
FY	Fiscal year
GBV	Gender-based violence
GDPA	Global Democracy Promotion Act
GGR	Global gag rule
HER Act	Health, Empowerment and Rights Act
HHS	Health and Human Services
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICRC	International Committee of the Red Cross
ICRH-M	International Centre for Reproductive Health - Mozambique
IFPS	Improving Family Planning Services
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine device
LAPM	Long-acting and permanent methods

LGBT	Lesbian, gay, bisexual, transgender
LGBTI	Lesbian, gay, bisexual, transgender, intersex
LPPA	Lesotho Planned Parenthood Association
MNCH	Maternal, newborn and child health
MoHCC	Ministry of Health and Child Care
MSI	Marie Stopes International
MSM	Men who have sex with men
NGO	Non-governmental organization
NIH	National Institutes of Health
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PLGHA	Protecting Life in Global Health Assistance
PMI	President's Malaria Initiative
PPAG	Planned Parenthood Association of Ghana
PRH	Population and Reproductive Health
PSI	Population Services International
PSZ	Population Services Zimbabwe
PZAT	Pangaea Zimbabwe AIDS Trust
Roots	Real Open Opportunities for Transformation Support
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SF	Social franchise
SID	Sustainability Index and Dashboard
Sida	Swedish International Development Cooperation Agency
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TB	Tuberculosis
UMATI	Chama Cha Uzazi na Malezi Bora Tanzania
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WAG	Women's Action Group
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

V. PRESIDENTIAL MEMORANDUM ISSUED BY PRESIDENT DONALD TRUMP ON JANUARY 23, 2017⁶⁵⁹

MEMORANDUM FOR THE SECRETARY OF STATE

THE SECRETARY OF HEALTH AND HUMAN SERVICES

THE ADMINISTRATOR OF THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

SUBJECT: The Mexico City Policy

I hereby revoke the Presidential Memorandum of January 23, 2009, for the Secretary of State and the Administrator of the United States Agency for International Development (Mexico City Policy and Assistance for Voluntary Population Planning), and reinstate the Presidential Memorandum of January 22, 2001, for the Administrator of the United States Agency for International Development (Restoration of the Mexico City Policy).

I direct the Secretary of State, in coordination with the Secretary of Health and Human Services, to the extent allowable by law, to implement a plan to extend the requirements of the reinstated Memorandum to global health assistance furnished by all departments or agencies.

I further direct the Secretary of State to take all necessary actions, to the extent permitted by law, to ensure that U.S. taxpayer dollars do not fund organizations or programs that support or participate in the management of a program of coercive abortion or involuntary sterilization.

This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

The Secretary of State is authorized and directed to publish this memorandum in the Federal Register.

DONALD J. TRUMP

Endnotes

- 1 See Nina J. Crimm, *The Global Gag Rule: Undermining National Interests by Doing unto Foreign Women and NGOs What Cannot Be Done at Home*, 40 CORNELL INT'L L.J. 587 (2007) [hereinafter Crimm, *The Global Gag Rule: Undermining National Interests*]; see also Sneha Barot, *When Antiabortion Ideology Turns into Foreign Policy: How the Global Gag Rule Erodes Health, Ethics and Democracy*, 20 GUTTMACHER POLICY REVIEW 73 (2017) [hereinafter Barot, *When Antiabortion Ideology Turns into Foreign Policy*].
- 2 Policy Statement of the United States of America at the United Nations International Conference on Population (Second Session) (Aug. 6-14, 1984), available at http://www.uib.no/sites/w3.uib.no/files/attachments/mexico-city_policy_1984.pdf [hereinafter 1984 Policy Statement of the United States of America at the United Nations International Conference on Population].
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- 4 *Id.* at 86.
- 5 *Id.* at 87.
- 6 *Id.* at 86. See also CONGRESSIONAL RESEARCH SERVICE, INTERNATIONAL FAMILY PLANNING: THE "MEXICO CITY" POLICY 2 (2001), available at https://www.everycrsreport.com/files/20010402_RL30830_c36ae9159587c6ca12d4da8edacc125b1394ce6c.pdf [hereinafter CRS, INTERNATIONAL FAMILY PLANNING: THE "MEXICO CITY" POLICY].
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- 8 See Aryeh Neier, *The right to free expression under international law: implications of the Mexico City Policy*, 20 NYU J. INT'L L. & POL. 229 (1987).
- 9 Interview with Giselle Carino, CEO and IPPF Regional Director, Alejandra Meglioli, Director of Programs, and Kelly Castagnaro, Director, Content & Media, International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR), in New York, NY (Oct. 2017) [hereinafter Interview with IPPF/WHR].
- 10 USAID, STANDARD PROVISIONS, *supra* note 3, at 83.
- 11 Interview with Emily Maistrellis, Senior Program Officer, Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University, in New York, NY (Oct. 2017) [hereinafter Interview with Emily Maistrellis].
- 12 Telephone interview with Margaret Neuse, International Family Planning Consultant (Dec. 2017) [hereinafter Interview with Margaret Neuse].
- 13 *Id.*
- 14 Universal Declaration of Human Rights, arts. 3, 25, G.A. Res. 217A, at 71, U.N. GAOR, 3rd Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948).
- 15 See, e.g., Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, arts. 12, 16(e), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (entered into force Sept. 3, 1981); International Covenant on Economic, Social and Cultural Rights, adopted Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (entered into force Jan. 3, 1976); Committee on Economic, Social and Cultural Rights (ESCR Committee), *Gen. Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), paras. 12, 14, 21, U.N. Doc. E/C.12/2000/4; ESCR Committee, *Gen. Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social, and Cultural Rights)*, para. 28, U.N. Doc. E/C.12/GC/22 (2016); K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); L.M.R. v. Argentina, Human Rights Committee, Commc'n No. 1608/2007, U.N. Doc. CCPR/C/101/D/1608/2007 (2011); L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).
- 16 Transforming our world: the 2030 Agenda for Sustainable Development, G.A. Res. 70/1, Goal 5.6, at 18, U.N. Doc. A/RES/70/1 (Sept. 25, 2015).
- 17 See CENTER FOR REPRODUCTIVE RIGHTS, BREAKING THE SILENCE: THE GLOBAL GAG RULE'S IMPACT ON UNSAFE ABORTION (2003), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/bo_ggr.pdf [hereinafter CRR, BREAKING THE SILENCE]; Sylvia A. Law & Lisa F. Rackner, *Gender Equality and the Mexico City*

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25 *Id.* See also ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH & WHO, HEALTH POLICY AND SYSTEMS RESEARCH: A METHODOLOGY READER (2012), available at http://www.who.int/alliance-hpsr/alliancehpsr_reader.pdf.

26 See Taghreed Adam & Don de Savigny, *Systems thinking for strengthening health systems in LMICs: need for a paradigm shift*, 27 HEALTH POLICY AND PLANNING iv1 (2012).

27 The WHO defines universal health coverage as "receiving health services you need, when and where you need them, without facing financial hardship." See WHO, What is Universal Health Coverage?, http://www.who.int/universal_health_coverage/what-is-uhc.gif?ua=1 (last visited Apr. 12, 2018).

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41 MEXICO CITY POLICY IMPLEMENTATION STUDY, *supra* note 32.

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43 Memorandum on the Mexico City Policy, 29 WEEKLY COMP. PRES. DOC. 88 (Jan. 22, 1993).

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45 Susan A. Cohen, *The Broad Benefits of Investing in Sexual and Reproductive Health*, THE GUTTMACHER REPORT ON PUBLIC POLICY 5 (Mar. 2004); CENTER FOR REPRODUCTIVE RIGHTS, INTERNATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH PROGRAMS: WHEN WILL THE U.S. GOVERNMENT FULFILL ITS COMMITMENTS? 17 (2001), available at https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_familyplanning.pdf [hereinafter CRR, INTERNATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH PROGRAMS].

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48 Interview with Margaret Neuse, *supra* note 12.

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51 Cohen, *Global Gag Rule Threatens International Family Planning Programs*, *supra* note 44, at 1; CRR, THE BUSH GLOBAL GAG RULE, *supra* note 44, at 2.

52 Sneha Barot & Susan A. Cohen, *The Global Gag Rule and Fights over Funding UNFPA: The Issues That Won't Go Away*, 18 GUTTMACHER POLICY REVIEW 27, 28 (2015) [hereinafter Barot & Cohen, *The Global Gag Rule and Fights over Funding UNFPA*]; Cohen, *Global Gag Rule Threatens International Family Planning Programs*, *supra* note 44, at 1.

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63 The consortium was originally called the Reproductive Health for Refugees Consortium. Its name was changed in 2003 “to reflect the work of the Consortium, whose programs provide services to a variety of conflict-affected populations, not just refugees.” REPRODUCTIVE HEALTH RESPONSE IN CONFLICT CONSORTIUM, RENEWING INTERNATIONAL COMMITMENT TO REPRODUCTIVE HEALTH FOR CONFLICT-AFFECTED POPULATIONS 1 (2003), available at https://www.womensrefugeecommission.org/joomla-tools-files/docman-files/rh_eval.pdf.

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About CHANGE

The Center for Health and Gender Equity (CHANGE) is a U.S.-based nongovernmental organization that promotes sexual and reproductive health and rights as a means to achieve gender equality and empowerment of all women and girls, by shaping public discourse, elevating women's voices, and influencing U.S. and global policies. We are guided by our vision of a world that respects, protects, and honors sexual and reproductive rights for all. Our four-pronged impact model—advocacy, research, partnerships, and communications—is grounded in and driven by a human rights framework at the intersection of multiple sectors including women's rights, human rights, family planning, maternal health, HIV/AIDS, and gender-based violence.



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