

# Operational reality: the Global Gag Rule impacts sexual and reproductive health in humanitarian settings

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The impacts of the Global Gag Rule (GGR) are less widely discussed in humanitarian contexts, given that US humanitarian assistance is, in theory, exempt per the May 2017 State Department Standard Provisions for the implementation of the policy.<sup>1</sup> However, reverberations from the GGR's impact on nongovernmental organisations (NGOs) lead to notable policy and practice constraints and implications in the context of humanitarian emergencies. The GGR negatively impacts humanitarian best practices: namely, working effectively across the humanitarian-development nexus, localisation, and the overall integration of health services, including sexual and reproductive health (SRH), in addition to negative health impacts for women, girls, and their communities.<sup>2</sup>

The Trump administration's expanded GGR forces non-US-based NGOs to choose between receiving US global health assistance, including for HIV/AIDS, nutrition, and malaria, among others, and providing comprehensive SRH. To comply with the policy, non-US-based NGOs must agree not to provide information, referrals or services for legal abortion or to advocate for the legalisation of abortion in their country with their own, non-US funds. There are exceptions though. Under the GGR, non-US-based NGOs may provide a safe abortion in cases of life endangerment, rape, and incest. Additionally, US policy explicitly permits the provision of treatment for injuries or illnesses caused by legal or unsafe abortions, which includes post-abortion care (PAC). In countries where abortion is legal for reasons beyond those GGR exceptions, non-US-based NGOs can make referrals for

abortion under the GGR only if: the person is already pregnant; that person clearly states they have decided to have an abortion; they specifically ask where they can obtain a safe, legal abortion; and the provider believes the country's medical ethics require them to provide the referral. While US-based NGOs are not gagged by the policy, they are responsible for enforcing the GGR when furnishing financial support to non-US-based NGOs.

It is important to remember that the US government's humanitarian assistance is separate from its global health assistance. Therefore, non-US-based NGO recipients of US humanitarian assistance, including for activities related to refugees and migrants as well as disaster and humanitarian response, are exempt from implementing the GGR, so long as they do not also receive US global health funding. Though seemingly straightforward, the operational realities of humanitarian work do not align so neatly. For instance, the strengthening of the humanitarian-development nexus is an identified global priority and best practice that requires effective collaboration between local and international NGOs, governments and donors along the humanitarian continuum.<sup>3</sup> The humanitarian-development nexus focuses on addressing needs before, during, and after crises: a commitment to action was made at the World Humanitarian Summit and signed by eight United Nations agencies, the International Organization for Migration and World Bank with the goal of transcending the humanitarian-development divide. Thus, humanitarian and development actors must work together to ensure that the overall

health needs of a population are met throughout the stages of preparedness, emergency response, and recovery. In addition, given the fluidity of humanitarian settings which may fluctuate between emergency and stability, many non-US-based NGOs who receive humanitarian funding also receive US global health funding.

The effects of the GGR on health service provision have been notable throughout the years when the policy has been active. For GGR-compliant organisations, the integration of comprehensive SRH services is not feasible. While abortion services or counselling are permissible under the GGR under the above exceptions, providers are often so fearful of violating the policy that they are not providing any services, even clearly permissible PAC. The self-censorship of either providing or referring women and girls to safe abortion services can lead to increased unsafe abortion, maternal morbidity, and mortality.<sup>4–6</sup> In Cox's Bazar, Bangladesh, the minimum package of essential health services for primary health care in the Rohingya camps, established by the Health Sector, includes menstrual regulation (MR) which is first trimester abortion; this means that GGR-compliant organisations are not providing the mandated minimum package in supported health facilities. More notably, the GGR-compliant organisations are not counselling, referring or providing rape survivors with safe abortion services due to fear of violating the GGR, which is an example of over-implementation of the policy.<sup>7</sup> This breakdown in service delivery and referrals for MR has had outsized impacts beyond safe abortion, also impacting response to gender-based violence.

By targeting non-US-based NGOs, the GGR affects efforts to localise, or support local actors at the centre of, humanitarian response and service delivery. Localisation of global health assistance is a recognised best practice in both the development and humanitarian sectors, and was a priority of the US Agency for International Development under the Obama administration. However, the GGR has moved funds back towards larger US NGOs as trusted and qualified local service delivery NGOs choose not to comply with the policy. Globally, non-US-based NGOs that do not comply with the GGR also work across the humanitarian-development nexus, providing SRH services in emergency settings. For organisations that choose not to comply with GGR, the loss of US funding has forced them to shift funds and programme activities at an operational cost or end

activities, including those in fragile contexts and humanitarian settings where they had previously been the sole providers of SRH services. For example, in Burkina Faso, non-US-based NGOs who lost US global health funding are critical government SRH partners in the response to the needs of over 800,000 internally displaced persons. Their SRH expertise and experience in mobile outreach is critical to meet the needs of populations who are unable to access public health services in the best of times, let alone during the ongoing displacement crisis stemming from conflict and drought in 2019. The International Planned Parenthood Federation affiliate in Uganda, which operates throughout the country and is the main organisation providing SRH services in some refugee camps, chose not to comply with the GGR. As a result of loss of US funding because of the GGR, the organisation had to divert US\$100,000 away from work in refugee settlements to support their existing clinics.<sup>8</sup> Similarly, in Bangladesh, local non-US-based NGOs which no longer receive US global health assistance work across the country providing integrated services in perceived traditional development settings as well as in the Rohingya camps. As a result of choosing not to comply with the GGR, they no longer receive US global health assistance, impacting their work throughout Bangladesh and in the camps.

The GGR's chilling effect, including self-censorship leading to over-implementation of the policy, has a notable impact on humanitarian populations, given that high quality development work and humanitarian work are inherently linked. Organisations often over-implement the policy where it does not apply in order to avoid any risk to their US funding. For example, in Cox's Bazar, the United Nations Population Fund contracted with a US-based NGO to provide training to other NGOs on long-acting reversible contraception, PAC, and MR. Several GGR-compliant organisations did not participate in their contraceptive and PAC trainings, even though these essential services are permissible under the GGR, because the NGO providing them also provided a separate MR training. Coordination in a humanitarian emergency is critical and is the first objective of the Minimal Initial Service Package (MISP) for Sexual and Reproductive Health.<sup>9</sup> The GGR hinders this coordination when GGR-compliant NGOs stop participating in activities that involve NGOs that do not comply with the GGR. In Peru, Uganda, and the Democratic Republic of Congo, US country

missions reached out to NGOs (including a US-based, a global non-US-based and a local women's rights NGO) to verify their global position on abortion before they would be invited to respond to a humanitarian funding call. Thus, organisations were prematurely screened out of the chance to apply for humanitarian funding, despite it not being subject to the GGR. It remains unclear if these actions were at the direction of headquarters in Washington, DC or if local US missions wanted to pre-empt possible missteps and created an unnecessary and improper screening process.

Humanitarian actors focused on SRH have worked to mitigate over-implementation of the GGR in fragile settings. The Inter-Agency Working Group on Reproductive Health in Crises created GGR-compliant versions of the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*<sup>10</sup> and the *Quick Reference for the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH)*<sup>9</sup> to help GGR-compliant NGOs provide SRH services to the full extent of the policy and avoid over-interpretation of the GGR.<sup>11</sup>

Further, work has been done to ensure that the GGR is not impacting SRH service provision in settings and legal contexts where it is not relevant.

Although the GGR does not purport to apply to humanitarian settings, the reality on the ground is that both GGR-compliant and non-compliant humanitarian NGOs are affected and have scaled back SRH work, even contraceptive and PAC services that are not restricted under the GGR. The chilling effect is notable and impacts the women, girls, and communities who have been forced from their homes due to violence, persecution, and disasters.

#### Disclosure statement

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