





# Foreign assistance or attack? Impact of the expanded Global Gag Rule on sexual and reproductive health and rights in Kenya

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**Abstract:** *In 2017, the Trump Administration reinstated and expanded the Global Gag Rule (GGR). This policy requires non-governmental organisations (NGOs) not based in the US to certify that they will not provide, counsel, refer, or advocate for abortion as a method of family planning in order to receive most categories of US global health assistance. Robust empirical evidence demonstrating the policy's impacts is acutely lacking. This paper describes the effects of the expanded GGR policy in Kenya eighteen months after its reinstatement. We conducted semi-structured interviews with purposively selected representatives of US- and non-US-based NGOs, as well as managers and health providers at public and private health facilities, between September 2018 and March 2019. Organisations reported critical funding loss as they were forced to choose between US government-funded projects and projects supporting safe abortion. This resulted in the fragmentation of sexual and reproductive health and HIV services, and closure of some service delivery programmes. At public and private health facilities, participants reported staffing shortages and increased stock-outs of family planning and safe abortion commodities. The expanded GGR's effects transcended abortion care by also disrupting collaboration and health promotion activities, strengthening opposition to sexual and reproductive health and rights in some segments of Kenyan civil society and government. Our findings indicate that the GGR exposes and exacerbates the weaknesses and vulnerabilities of the Kenyan health system, and illuminates the need for action to mitigate these harms.* DOI: 10.1080/26410397.2020.1794412

**Keywords:** abortion, sexual and reproductive health, HIV, Global Gag Rule, Kenya

## Introduction

Kenya has achieved moderate improvements in sexual and reproductive health (SRH) outcomes in recent decades, but significant gaps and inequities remain.<sup>1</sup> While modern contraceptive use has increased steadily to 53%, 17.5% of married women have an unmet need for contraceptives.<sup>2</sup> Unmet need is significantly higher among adolescents and young women<sup>3,4</sup> who experience additional barriers to accessing contraceptives

and high levels of contraceptive stigma.<sup>5,6</sup> Although the Kenyan maternal mortality ratio decreased from 513 deaths per 100,000 live births in 2008 to 342 in 2017, the number of deaths is still unacceptably high, with significant variation across regions and socio-economic status.<sup>2,7</sup>

Unsafe abortion is among the leading causes of maternal death in Kenya,<sup>8</sup> despite being largely preventable through increased use of modern contraceptives and the provision of safe abortion.

While the Kenyan Constitution permits abortion to protect the health or life of a pregnant woman,<sup>9</sup> the circumstances under which abortion is criminalised in the Kenyan penal code are less clearly specified.<sup>10</sup> This inconsistency creates confusion among clients and providers regarding the legal status of abortion,<sup>11</sup> which, combined with widespread abortion stigma,<sup>12–14</sup> engenders significant barriers to safe and legal abortion<sup>15</sup> – especially for young women and girls.<sup>16</sup> Unsafe abortion, meanwhile, is common: of the 464,690 reported induced abortions (48 per 1000 women of reproductive age) that took place in Kenya in 2012, the majority were unsafe.<sup>17</sup> Approximately 37% resulted in severe complications requiring treatment at a health facility.<sup>18</sup> These data reflect only abortions documented in healthcare facilities; the true numbers are likely much higher.

In addition to these legal and policy barriers, SRH service delivery in Kenya is plagued by health systems challenges (e.g. supply chain disruption, stock-outs, and staff shortages) and funding deficiencies.<sup>19–21</sup> Kenya relies heavily on foreign aid to finance its SRH services, the vast majority of which (nearly 99% in 2017) comes from the United States Government (USG).<sup>22,23</sup> This reliance on foreign aid suggests that a disruption in assistance will cause a significant impact on the short and long term health and well-being of the population, especially the marginalised.

In January 2017, the Trump Administration reinstated and expanded the Mexico City Policy or Global Gag Rule (GGR), renaming it “Protecting Life in Global Health Assistance.”<sup>24</sup> Prior iterations of this policy (in place from 1985 to 1993, 1999 to 2000, 2001 to 2009) applied only to US family planning assistance (US\$575 million for the fiscal year 2016). However, the new version extends the restrictions to nearly all US global health assistance – an estimated US\$9.5 billion – which includes funding for HIV/AIDS, malaria, and maternal and child health, among others.<sup>25</sup> This policy requires non-US-based non-governmental organisations (NGOs) that receive US global health assistance to certify that they will not provide, refer for, counsel on, or advocate for abortion as a method of family planning. The GGR includes exceptions for cases of rape, incest, and to save the life of the woman; however, these are rarely applied in practice.

Research on past iterations of the GGR found that it did not reduce the number of abortions performed in countries that receive USG funding.<sup>26</sup> Rather, the GGR was associated with an overall

decrease in contraceptive use and an increase in abortion rates in highly impacted countries.<sup>27–29</sup> In Kenya, previous versions of the GGR resulted in damage to civil society and sexual and reproductive health and rights (SRHR) advocacy and reduced access to family planning (FP) services.<sup>30</sup> By cutting off funding to organisations that offer a full spectrum of SRH services, including FP and safe abortion, the policy ended crucial programmes and shuttered facilities, leaving some poor and vulnerable communities with no SRH services.<sup>31–34</sup>

Given the evidence of damage done by past versions of the GGR, as well as the dramatically increased scope of the current version, it is likely that the Trump Administration’s expanded GGR will have widespread deleterious effects. Kenya may be particularly vulnerable to these effects because of the large proportion of its health system that is supported by USG funding, and because of its complex national abortion context. This study analyses data collected from NGO representatives, health providers, and managers at health facilities to investigate the impact of the expanded GGR at multiple levels of the health system. It explores changes in funding, policy, advocacy and service provision related to abortion, FP, and other SRH services in Kenya.

## Methods

The African Population and Health Research Center (APHRC), in collaboration with the Heilbrunn Department of Population and Family Health, Columbia University, conducted a cross-sectional qualitative study to assess the impact of the expanded GGR in Kenya. We conducted semi-structured in-depth interviews with three categories of purposively selected study participants: representatives of local and international NGOs ( $n = 18$ ), managers of health facilities that provide SRH services ( $n = 12$ ), and SRH service providers ( $n = 25$ ). Interviews took place in Nairobi, Kisumu, and Busia counties from September 2018 to March 2019.

The purposive sampling involved compiling a list of 40 local and international NGOs that were engaged in service delivery, advocacy, and/or research in SRHR, HIV, or related health issues in Kenya. The NGOs had various priorities and funding streams; the majority were based in Nairobi, though many implemented programmes throughout Kenya. Researchers contacted these organisations via email or phone to request interviews; interviews were completed with representatives from 18 NGOs.

We identified and recruited participants from health facilities that received SRH support from two NGOs in our sample. We visited a total of twelve health facilities, consisting of two public and two private facilities in Kisumu, and eight public facilities in Busia. In each facility, we interviewed one facility manager and two to three providers of FP or abortion services.

A team of eight male and female research assistants received five days of training on the study protocol, the expanded GGR, interview guides (in English and Swahili), and informed consent procedure. We piloted the study tools and adjusted as needed. All interviews were conducted in a private location, using the participant's preferred language. Before the interview, research assistants provided participants with information about the study from an informed consent script and answered their questions. Participants provided verbal consent; interviews were audio-recorded. We obtained ethical approval from the institutional review boards of Amref Health Africa (P524/2018) and Columbia University (IRB-AAAR6802).

Interview recordings were transcribed and translated into English when necessary. All transcripts were de-identified before coding in NVivo 12 (QSR International). Using an inductive approach, we developed a codebook through a collaborative, iterative process. After the initial codebook was created, two researchers each read and coded the same subset of the transcripts, then met to discuss codes applied, identify emerging codes, and reach consensus where there were disagreements. If an additional code emerged, one coder applied the new code to all previously coded transcripts. Once inter-coder reliability was established, the coders divided the remaining transcripts and coded them independently.

During data analysis, researchers conducted short follow-up interviews with several NGO participants to clarify emerging themes and better determine the extent to which changes experienced by NGOs and at facilities related to the GGR.

## Results

The results of the study are presented separately at NGO level, and at facility level.

### NGO-level

Half of the 18 NGOs implemented HIV projects or research. While participants' knowledge of the expanded GGR varied, all NGO participants had

heard of the policy and understood that it was a USG policy concerning abortion. Five NGOs were US-based, and 13 were not based in the US. At the time of the interview, four of the NGOs not based in the US had certified the GGR, two had declined to certify, and seven had not been asked to certify because they had not received or applied for USG funding since the policy was reinstated (Table 1). Participants from three of the seven non-US-based NGOs that did not receive USG funding reported that their organisations had never received USG funding, while four said that their organisation had received USG grants in the past. US-based NGOs are not subject to the policy, but those that receive USG funding must ensure that any of their local NGO subgrantees comply with the policy.

Our findings indicate that the expanded GGR has impacted the Kenyan health system through multiple pathways. The policy exacerbated preexisting anti-SRHR sentiment in Kenya and disrupted collaboration and partnerships around SRH. While organisations that declined to certify the GGR reported the most significant funding loss, NGOs in all categories experienced GGR-related disruptions in their partnerships, referral networks, and the ability to deliver integrated health services. These disruptions, in turn, affected community-based organisations (CBOs), as well as public and private health facilities receiving support from NGOs, and ultimately damaged the ability of facilities to provide good quality care.

### *GGR compounded anti-abortion context*

Results indicated that the expanded GGR exacerbated existing hostility towards abortion in Kenya by emboldening anti-SRHR actors and silencing

**Table 1. NGO participants\* in Kenya**

US-based NGOs	5
Non-US-based NGOs	13
Certified GGR	(4)
Did not certify GGR	(2)
Had no USG funding (USG\$) at time of interview	(7)
<b>Total</b>	<b>18</b>

\*One individual from each NGO was interviewed.

advocates. Although this hostility was independent of and preceded GGR implementation, there was broad consensus among participants that the SRHR and abortion climate had worsened since its reinstatement. Interviewees described intensification of anti-abortion activities in the private and public sectors, and identified faith-based organisations and government actors at national and county levels, including the Ministry of Health, as common voices of this anti-abortion sentiment.

Interviewees described the government of Kenya as largely hostile to safe abortion. Interviewees from SRH organisations that did and did not work on abortion explained how they had to “keep very quiet” and were “very silent” about their SRH work in fora supported by the government. For one organisation that provided safe, legal abortion services, this caution stemmed from prior experience:

*“Yeah, so we have to do things clandestinely so we can’t go out and speak about these things because we risk being branded. At one point, the Ministry of Health raided this place and tried to search for whether we had any abortion commodities.”* (Non-US NGO)

Some interviewees perceived a connection between the expanded GGR and specific anti-abortion actions taken by the government of Kenya. For example, several participants mentioned recent national controversies, including a 2018 government ruling banning Marie Stopes Kenya from providing safe abortion and post-abortion care, and the ongoing reluctance of the government to fully operationalise the standards and guidelines on abortion provision.<sup>35,36</sup> Some interviewees believed the GGR provided international cover and support for the national government’s actions to restrict and retaliate against safe abortion providers and advocates. One interviewee stated simply: *“the government of Kenya has bought into GGR for their own political reasons.”* Another said:

*“So I feel like the GGR is giving our government more impetus to be ... indecisive. And I think since the GGR was implemented, last year we’ve just now been seeing an ... increase in the morality policing, by film classification board or now the Ministry of Health allegedly so we are just seeing an increase of unwillingness to meaningfully engage in [the constitutional right to safe abortion].”* (Non-US NGO)

Some interviewees discussed the complicated legal status of abortion in Kenya, and the

widespread confusion caused by the contradiction between the abortion framework in the 2010 Constitution and the penal code. They believed that most Kenyans do not understand the constitutionality of abortion, and think that it is “illegal.” One interviewee believed that the expanded GGR added to this confusion:

*“It’s not that it’s confusing about the GGR, it’s that abortion in Kenya is confusing to start with ... and it’s a very contentious issue so the GGR just adds on that because already people who provide the services do so almost on the periphery of the law or thinking that maybe they’ve been. So, [not] understanding what is allowed and what is not allowed within our context.”* (Non-US NGO)

A few participants highlighted the large amount of funding that Kenya received from the USG and suggested it made the Kenyan government unwilling to speak about the expanded GGR. One participant said that the Kenyan government was being particularly cautious to avoid upsetting USAID because (at the time of the interview), the USG was threatening funding cuts due to allegations of misappropriation.

*“US government gives a lot of aid to Kenya, so they have a lot of say. So I think in terms of even the top leadership of the Kenyan government, they would not speak boldly about the Global Gag Rule because they know what is at stake.”* (Non-US NGO)

Several interviewees mentioned increased activity from anti-choice churches and civil society organisations. While participants could not say whether these organisations were the beneficiaries of funding from the USG, they believed that anti-abortion USG policies provided validation to these organisations and amplified their voices.

*“It’s created divisions, so the biggest effect we’ve seen now is increase in what we call opposition to abortion access. So the groups that are anti-choice are invigorated now, by this gag rule. It’s given them momentum ... there is new vigor in the opposition groups.”* (US-based NGO)

#### *Impacts of GGR on civil society*

According to participants from both certifying and non-certifying NGOs, the expanded GGR fractured the civil society landscape and engendered mistrust between organisations that had previously collaborated on shared SRH issues. We found evidence of a “chilling effect,” meaning an effect

causing NGOs that had certified the expanded GGR to self-censor and unnecessarily restrict their participation in coalitions and meetings out of confusion about the scope of the policy or fear of drawing unwanted scrutiny from USAID.

Interviewees reported that USG-funded organisations were unwilling to attend meetings with organisations that do safe abortion-related work, even when meeting agendas were unrelated to abortion. Similarly, NGOs that had not certified the expanded GGR said they were not invited to meetings hosted by certifying NGOs. One interviewee explained that, before the expanded GGR, organisations with different priorities and funding streams came together in coalitions “for the good of women and girls’ health.” The reinstatement of the policy disrupted these coalitions.

*“But now what I’m seeing ... it’s impossible to partner with a US-funded organisation ... we are working in silos. We are all working on SRH, but we cannot work in the same space. Even in terms of being invited in meetings, you would feel like you are being stigmatized, in fact not invited in those places, yeah, because you do not believe in the Global Gag Rule, and you are pro-choice.”* (Non-US NGO)

Participants from some certifying NGOs explained that adhering to the policy forced their organisation to alter how they communicated in coalition spaces and with the public. An interviewee described this difference, comparing to before the GGR was in place:

*“It was relatively easy; you were not too constrained. Right now, you have to be careful what you say to whom because [the organisation has] signed those agreements and rules.”* (Non-US NGO)

When asked about their organisation’s involvement in advocacy, this interviewee explained how fear of losing USG funding had effectively “muted” the voice of their organisation, along with several other organisations that had previously been strong advocates for SRH.

Conversely, many participants described strengthened coalitions and invigorated advocacy among SRH organisations, especially among those that worked on SRH and had not been recipients of USG funding when the policy was reinstated. These participants explained that the expanded GGR led them to re-ignite collaborative advocacy efforts in response to the policy:

*“What the gag rule has done is ... forced pro-choice groups like us and other partners to come together, something that we had sort of neglected to do, but now because of these challenges we are facing, we’ve been forced to come together.”* (US-based NGO)

#### *Impacts of GGR on organisations and the health system*

##### **Loss of funding**

Several participants reported that the expanded GGR forced their organisations to sacrifice one source of funding in order to maintain another. One interviewee framed this choice as a decision “between the lesser of two evils,” as both outcomes resulted in a loss of funding and subsequent organisational and service delivery-level impacts. For some organisations, this choice was required to renew a USG grant; for others, it came up during the final stages of a grant proposal process. Representatives from two local NGOs reported spending time and resources applying for USG grants, only to be informed at the last minute that their work on safe abortion made them ineligible to receive this funding. These organisations had submitted proposals, been selected as grant recipients, and begun the orientation process before being told that they had to choose between projects.

*“They [US prime] just told me if you want our [USG] money, forget about your grant from [donor funding FP and abortion program]. So I had to make a conscious choice, which one do I drop off. So that’s how it affects my work because ... we are so torn in between.”* (Non-US NGO)

Some participants suggested that the expanded GGR diverted funding from organisations that are highly qualified to implement programmes. The two organisations described above had previously benefited from USG grants intended to strengthen their capacity to become prime recipients of large US President’s Emergency Plan for AIDS Relief (PEPFAR) grants. Interviewees from these organisations expressed frustration that, having improved their infrastructure to enhance their competitiveness for PEPFAR grants, they suddenly found themselves disqualified.

*“Then [the GGR] limits ... organisations who would otherwise have the capacity to be able to play in the league of the ones who are benefiting from PEPFAR or USG grants ... For example, [NGO A] might*

*have a better capacity than [NGO B] who is not doing abortion ... [NGO B] is not able to implement the programs adequately the way [NGO A] would have done. Just because [NGO B] are more favorable to attract funding while they don't have the capacity.” (Non-US NGO)*

For many organisations, the policy resulted in a narrowing of funding options. Interviewees from organisations that were ineligible for USG funding because they did not certify the expanded GGR were subsequently forced to increase the amount of time and effort dedicated to fundraising. This put a strain on individuals and organisations, and detracted from other duties and priorities. One interviewee from an organisation that had previously attracted funding based on their reputation as experts in SRH service delivery described struggling to find replacement funding after declining to certify the policy:

*“Actually, partners are the ones who used to come to us, and I would be able to choose who we want to work with. Now it has shifted. Nobody wants to come to us; it's us who are trying to reach out. So [I] am always on the computer prospecting ... and in forums in Nairobi trying to look for where are the resources.” (Non-US NGO)*

NGOs that chose to certify the GGR and continued to receive (or remained eligible to receive) USG funding were also at risk of losing funding for activities prohibited by the expanded GGR. As one participant pointed out, many NGOs would choose to protect their USG funding because USG grants were typically larger than non-USG grants. However, the loss of smaller grants for work on safe abortion could still be damaging for organisations and harmful to the populations they serve. An interviewee from one organisation that asked subgrantees to comply with the expanded GGR was aware of the painful choice this policy forced on smaller organisations that they support:

*“Now we are making them [decide whether to certify the GGR]. So then they have to weigh which funding they lose ... And it's not just about funding, because when you lose funding it means the beneficiaries, the people you were supporting, you can no longer support them. If you are providing services, you can no longer do that; and this particular organisation I am giving as an example ... supports mainly young people, adolescent girls and young women, supports life skills education, comprehensive sexuality education in schools. So they are clearly filling*

*a gap that nobody [else is] filling. So if they have to sign [the GGR], it means they have to lose funding somewhere ... .” (US-based NGO)*

Whereas the majority of participants discussed decreases in SRH funding caused by the expanded GGR, a handful mentioned increased funding from non-USG donors to support SRH programmes, including efforts by certain European governments and private foundations to provide replacement funding for organisations impacted by the policy.

*“I've also seen a very robust donor society where they understand that the Global Gag Rule has an impact on the community ... Global Gag Rule will scale back any gains that we have made, and so they are coming up with new funds or new funding facilities to be able to cushion people from that.” (Non-US NGO)*

However, the majority of participants described these new sources of funding as insufficient to fill the funding gap created by the expanded GRR.

#### Changes in service delivery

##### *Fragmentation of SRH and HIV service delivery*

Interviewees frequently discussed the negative impact of the expanded GGR on integrated health service delivery. Choosing between USG and other funders caused some NGOs to narrow their organisational priorities. Groups with reputations for delivering good quality programmes across technical areas, including HIV, child health, maternal health, and SRH, reported closure of programming in at least one area, reducing clients' access to comprehensive, integrated care.

Many participants reported that the expanded GGR effectively forced organisations to choose between implementing HIV or other SRH programmes. Two NGOs in our sample that were denied funding after declining to certify the GGR reported that they were no longer able to implement USG-funded HIV activities. One interviewee described how this loss rolled back the gains made by their organisation in reaching communities with HIV testing and linkage to care.

*“HIV is being affected because previously we ... [did] a splendid job in the regions we are covering and we've been able to reach out to many people either to test them, to offer ART [antiretroviral therapy] and other services linked to HIV care. But right now we cannot ... get [USG] funding because we*

*are being supported by [donor funding FP and abortion].” (Non-US NGO)*

At the same time, participants from certifying and US-based organisations reported including fewer SRH activities in their USG-funded integrated programmes. They attributed this shift both to the expanded GGR and broader changing priorities of USG funders. An interviewee from an organisation that previously provided integrated HIV and SRH services stated that USAID was “pushing [them] towards HIV treatment and care.” Another explained that, while their organisation previously implemented integrated FP, HIV, maternal health, and STI services to young women, girls and individuals engaging in transactional sex, they were directed to drop other SRH activities and focus exclusively on HIV testing, treatment, and care.

*“We are not doing integrated service delivery in Kenya anymore ... We no longer offer RH, FP services in our program ... I do not know what factors have led to those changes at USAID, but what has happened is that USAID now has separate RH, FP programs and not [integrated] ones for the entire country.” (US-based NGO)*

Several participants expressed frustration at the inefficiency and potential harm to clients caused by the fragmentation of HIV and other SRH services. Interviewees from both certifying and non-certifying NGOs emphasised their belief that “HIV is a sexual and reproductive health problem” and should not be siloed. As an interviewee from a certifying organisation described, fragmented care leaves clients with unmet needs for information and services:

*“So yes, women are complaining the services are not very comprehensive right now ... currently we are only talking about HIV and the complaint is that even for people who have HIV, it is not HIV that is harming them, it is other conditions, STIs, unwanted pregnancies, this is what is disturbing other people. Yet donors, because of the American gag rule, would want to focus [only] on the condition of HIV.” (Non-US NGO)*

#### *Disruptions in referral networks*

Many NGO participants described disruptions in referral networks for FP, abortion, and post-abortion care (PAC). Several said that a shrinking network of SRH providers made it increasingly difficult to refer clients for good quality care.

Others observed that some USG-supported NGOs had stopped making referrals to non-certifying organisations, including for services permitted by the expanded GGR.

Interviewees discussed closures of health facilities offering SRH services, or the reduction of SRH services provided by organisations within their referral networks. For organisations that had not certified the expanded GGR and could refer clients for comprehensive SRH, including abortion care, it became challenging to find appropriate referral points as fewer facilities were offering this care. Organisations that had certified the expanded GGR but referred clients for FP and non-abortion SRH services faced the same shortage of referral options. Participants in both categories noted the inadequacy of government facilities as a replacement for lost referral points.

*“And then we also tried to work with the government institutions to refer the young people so that they can access the services from the government institutions. But [we] know that the government institutions are almost, you know ... there are no commodities, the young people don't go to the facilities, and they do not get any friendly services.” (Non-US NGO)*

Interviews surfaced evidence that over-interpretation of the expanded GGR led some USG-funded NGOs to curtail referrals beyond the requirements of the policy. Interviewees from two non-certifying organisations reported that their organisations no longer received referrals from USG-supported NGOs, including for services permitted by the expanded GGR; both attributed this change to the policy. According to a representative of an organisation that hosts a hotline providing confidential information regarding abortion and PAC, USG-supported NGOs that had previously referred patients to the hotline believed they could no longer do so, even though the GGR does not restrict organisations from referring clients to a source of information. A few participants mentioned cases of USG-funded organisations failing to refer clients for PAC, and expressed concern about the safety of clients in these instances:

*“So for now, they do not do [referrals]. So my question is, when these women come to their facilities or clinics and request for this service, where do they go? Because the ones I talked to believe they cannot*

*refer. So if a woman comes with even post-abortion complications, what do they do with this woman? How do they treat this woman? What happens to this woman?"* (Non-US NGO)

#### *Disruption of partnerships*

Results indicated that the harmful impacts of the expanded GGR trickled down through the Kenyan health system via sub-grants and partnerships. Many participant organisations supported health facilities – either directly or through partnerships with local NGOs – by providing supplies, equipment, and staff training. Participants drew attention to negative impacts that occurred at the health facility and community level when these supportive partnerships were disrupted. Organisations that were denied USG funding after declining to certify the expanded GGR reduced operations to what a smaller budget could accommodate. Other measures they described to cope with lost USG funding included laying off staff, closing facilities, and reducing the amount of funding sub-granted to CBOs or health facilities. For sub-grantees of these organisations, the downstream effects of this funding loss could be severe.

*"We used to support around 30 healthcare health service centers, like hospitals. Now we are just left with one. So you can imagine we had to do away with those twenty-nine, so that's a big gap."* (Non-US NGO)

Conversely, organisations that do work related to safe abortion reported losing crucial community partnerships when their partners chose to certify the policy. The expanded GGR thus restricted the choice of partners for these organisations and influenced their ability to carry out work at the community level. An interviewee from an organisation that works on strengthening SRH services in the public sector reported losing half of its community partners when they certified the expanded GGR to maintain other sources of funding. Without these partners, community health volunteer (CHV) training, information campaigns, and service referrals were reduced or halted in some areas. Moreover, the futures of all of their community partners were jeopardised due to lost funding streams.

*"It's either they accept to lose the funding from the US government or they accept to lose our funding. So for some, [because] we provide the majority of their funds, they have elected to lose the American*

**Table 2. Facility-level participants**

County	Facility type	Number of facilities	Facility managers	Service providers
Busia	Public	8	8	17
Kisumu	Public	2	2	4
	Private	2	2	4
Total participants			12	25

*funding. That is not fair to them because it means that they are not able to undertake the full scope of their activities. ... you can't survive on either/or. They need both [sources of] funding. So it makes them very unsustainable."* (US-based NGO)

#### **Facility-level**

We interviewed 12 health facility managers and 25 service providers at 10 public and 2 private health facilities in Kisumu and Busia counties that currently or recently received NGO support for their SRH services (Table 2). All selected facilities offered FP and PAC services, and most offered safe abortion. Four health facilities in Kisumu were supported by an NGO that was denied USG funding after declining to certify the GGR. This NGO continued to receive funding for SRH programming from a non-USG partner, and provided facilities with supplementary income for providers, stipends for CHVs, training, and FP and abortion commodities that allowed the facilities to provide SRH services free of charge. The eight public health facilities were staffed by the county health department and provided with FP commodities through the parastatal supply chain. A US-based NGO currently, or had previously supported these facilities with CHV stipends, staff training, commodities, and outreach efforts. FP was provided free of charge at these facilities, while the cost of abortion and PAC varied.

Facility managers and providers at public and private health facilities described changes in staffing and the availability of commodities in the year preceding data collection. Interviewees at health facilities in Kisumu linked these changes to a reduction in NGO support. Results from public facilities in Busia suggested that many of the staffing and commodities shortages that facilities faced



were the result of shortfalls and inefficiencies in the county health infrastructure, which were unrelated to the expanded GGR. However, participants in Busia also described the crucial role that NGOs played in supporting their capacity to provide services to the community, and noted that recent reductions in this support exacerbated existing challenges.

#### *Changes in staffing*

Participants at public and private facilities described a decrease in the number of trained staff at the facilities where they worked. Interviewees at public facilities in Busia County frequently mentioned staff shortages and their impact on the well-being of remaining staff, as well as on service delivery. They attributed these shortages to staff transfers initiated by the County Health Department and a county-wide shortage of health personnel. Although these shortages were considered normal, and not a recent phenomenon, interviewees believed that the disruption caused by routine staff transfers was compounded by a recent reduction in staff training opportunities offered by NGO partners.

Participants emphasised the essential role that NGOs played in helping to train providers when they arrived at a given facility without requisite knowledge and skills and described the difficulty of replacing skilled staff who left. One provider described the impact of these training opportunities on the ability of staff to provide good quality care:

*“Our donors really help us ... [When] they are not there, [we lack] updates, training ... For instance, ... when you are newly employed you need some updates, you need some training ... Yes, there is [on the job training], but sometimes it’s good when these donors are there and are able to train. It makes service delivery effective, and the quality of the job becomes perfect ... but for those ones who the donors didn’t train ... They lack some knowledge; there is knowledge gap.”* (Service provider, Busia)

Staff transfers, combined with a decrease in NGO-supported training, reportedly reduced the number of staff trained to provide abortion services at these facilities. In some facilities, this meant that “the number of clients sometimes overwhelms the [trained] staff,” which resulted in increased waiting time for clients, and meant

that some clients were denied services or had to be referred to another facility for care.

In the private facilities in Kisumu, changes in staffing resulted directly from decreased NGO support. Participants described facility-level measures taken in response to funding changes, including salary reductions, job loss, and “lean staffing” (reductions in the number of staff who perform the same job function). While these measures were intended to mitigate the harm caused by funding cuts, participants explained that salary cuts sometimes led to staff attrition, and that “lean staffing” created additional burdens for remaining staff who were already stretched thin:

*“We reduced the number of staff which [NGO 1] were supporting and also [NGO 2] did the same, and in fact, that has made workload very difficult. As the facility-in-charge, I have now to work because of the reduced number of clinical staff ... so now I am doing both the clinical work and the managerial.”* (Service provider, Kisumu)

#### *Changes in commodities*

Participants at public facilities in Busia revealed frequent stock-outs of FP commodities. Short-acting methods (pills and injectables) were most commonly reported stocked-out, although several participants also mentioned decreased supply of IUDs and implants. Like staffing shortages, these stock-outs were described as routine and mainly attributed to inefficiencies in the supply chain and delays in receiving supplies from the County Health Department. However, many facility managers and providers pointed to a recent reduction in commodity support from the NGO sector that exacerbated the problem. Participants described the vital role that NGOs served in supporting public facilities with additional commodities when the public sector supply chain was not able to meet facility demand. They explained that, without support from NGOs, these gaps in supplies went unfilled, and public facilities were unable to meet client demand. While these facility managers and providers had limited knowledge of the expanded GGR and its impact on NGOs, some respondents mentioned a decrease in support for FP from NGOs that had certified the expanded GGR.

When commodities were unavailable at public facilities, interviewees reported turning patients away or instructing them to seek supplies at

private facilities or pharmacies. One provider described the impact of reduced NGO support for commodities on clients:

*“We used to get some supplies from donors, and now that the donors are not there, and also sometimes the county government is not able to avail those commodities, the number of clients has reduced. And, at our service delivery point, you may find that you will send a client back home because there is no drug. For instance, ... we have not seen Depo [Provera] ... and you know there are those clients who believe in Depo, you cannot even counsel them, and they cannot even think about any other method. So they come and go and get unwanted pregnancies.”* (Service provider, Busia)

At private facilities, nearly all participants reported reductions in the supply of FP and abortion commodities provided by an NGO that was denied funding after declining to certify the GGR. To cope with these commodity shortages, interviewees described borrowing commodities from nearby facilities or seeking them through the government supply chain, but both of these solutions were described as unsustainable. One provider explained that the county was not able to provide all of the commodities formerly supplied by the NGO:

*“We were being provided with commodities in the facilities, but right now there is a reduction, we don’t have commodities. We have to get them from KEMSA [parastatal supplier], but we used to get them from our donors ... [NGO] used to bring us [implants], misoprostol and mifepristone, and even the equipment ... we used in family planning ... KEMSA does not provide all the commodities.”* (Service provider, Kisumu)

Interviewees were keenly aware of how stock-outs and shortages of commodities impacted clients. Two facilities in Kisumu were forced to begin charging clients a fee for FP services after experiencing a reduction in support from an NGO for these services. Multiple respondents noted that these fees deterred women from seeking FP services. One expressed concern about attendant SRH impacts, including an increase in unintended pregnancies:

*“The service provision has reduced because the client used to get the services for free, but now when you start telling them we charge, they go without the service. Most of them have pregnancies that they didn’t*

*want to have. So it has really affected much of the reproductive health side.”* (Service provider, Kisumu)

In both counties, interviewees worried about shortages of other commodities provided by NGOs, such as disinfectants, antibiotics, and painkillers. One participant in each county expressed concern about their ability to provide safe, good quality care when this support is reduced:

*“Every quarter they [NGOs] would bring in commodities, but now it’s a bit challenging ... I mentioned something like [disinfectant products]; when we are brought the commodities from KEMSA [parastatal supplier], and maybe we run out of stock ... now the moment we don’t have the booster from [NGO]; definitely we are going to have a problem because this client comes in, you don’t have [disinfectant products] ... so definitely the quality of service you are going to offer to this client is not up to standard.”* (Facility manager, Kisumu)

## Discussion

Overall, our findings show a loss of critical funding to NGOs and the disruption of partnerships, with a concomitant negative impact on health service delivery and the health system. The expanded GGR exposes and exacerbates the weaknesses and vulnerabilities of the Kenyan health system. Other donors have made efforts to provide replacement funding to fill the gap left by GGR.<sup>37</sup> However, the amounts provided are insufficient to alleviate the GGR-induced financial blow to many NGOs in Kenya, given that the US is Kenya’s largest bilateral health donor.<sup>22</sup> Kenya had 71 active US global health awards that were subject to the expanded GGR between May 2017 and September 2018. Four non-US-based NGO subgrantees had declined to certify the GGR by September 2018, leaving an estimated \$8 million in unobligated US global health assistance.<sup>38</sup>

Impacts on both certifying and non-certifying NGOs have significant adverse effects on the Kenyan health system, which relies on NGOs to provide services, training for health workers, and commodities. While anecdotal research on previous iterations of the GGR suggest similar impacts on service-providing NGOs,<sup>26,39–43</sup> little empirical research has shown its impact at the facility level to date. Our study identifies pathways through which GGR-related funding cuts and changes in service provision affect both private and public health

facilities in Kenya. Private facilities experienced staff reductions, salary cuts, and shortages of abortion and FP commodities due to GGR-related funding cuts to the NGO that supported them. This results in private facilities referring FP clients to public facilities and requesting FP commodities from the public sector, thereby putting increased strain on the already stressed public system. At the same time, public facilities also lose support from NGO partners. The disruption in partnerships as organisations choose between USG and other funding results in a reduction of CHVs working with public facilities to provide and refer for SRH services. These service delivery challenges, combined with inadequate financing for FP at the national and county-level, threaten Kenya's ability to achieve its national SRH goals and FP2020 commitment of expanding equitable access to FP to marginalised populations and throughout the country.<sup>44</sup>

Although the GGR specifically restricts most abortion-related activities, our findings depict far-reaching effects on the Kenyan health system, including on HIV programming. Non-certifying organisations that once offered both SRH and HIV services to vulnerable populations reported ending HIV programming after being denied PEPFAR funding. Certifying organisations reported reducing SRH services, in part as a result of the expanded GGR. This fragmentation of HIV and SRH services contradicts global and national guidelines that promote integrated service delivery to improve health outcomes<sup>45</sup> and contradicts USAID's own guidance promoting the integration of family planning and HIV.<sup>46</sup> In Kenya, a high proportion of HIV programmes have been integrated with SRH, which has resulted in increased HIV testing among women and higher patient satisfaction with services, but which leaves the country more susceptible to the impacts of the expanded GGR.<sup>47,48</sup> Because the expanded GGR applies to all US global health assistance, including PEPFAR, which makes up 58% of HIV funding in Kenya,<sup>48</sup> this iteration of the policy brings newfound impact on HIV services. A recent survey of PEPFAR prime implementing partners across 45 countries found that Kenya was among the four countries with the highest number of PEPFAR prime recipient organisations affected by the policy.<sup>49</sup>

Our findings suggest that over-interpretation of the expanded GGR led some organisations to curtail permitted services, including referrals for PAC, or referrals to organisations that provide

information about safe abortion (permitted under GGR) and PAC. These findings reflect the “chilling effect” that occurs when organisations restrict their activities beyond the provisions of the policy, either due to fear of reprisal from USG actors or misunderstanding of the policy's restrictions.<sup>26</sup> This can result in clients being denied life-saving services, as happened in a previously documented case in which two women died from unsafe abortions after being denied PAC.<sup>33</sup> National service delivery guidelines recognise the provision of PAC as essential to protecting maternal health,<sup>50</sup> yet PAC service delivery in Kenya is limited in availability and quality.<sup>51</sup> By fostering confusion and fear around PAC, the expanded GGR contradicts Ministry of Health guidelines and impedes progress towards improving access to PAC.

Another element of this chilling effect is the reluctance of certifying organisations to participate in meetings with non-certifying NGOs. The expanded GGR undermines Kenyan civil society and SRHR advocacy by reducing collaboration between certifying and non-certifying NGOs, and stifling the advocacy efforts of organisations receiving USG funding. Although the 2010 Kenyan Constitution protects the right to abortion when the life or health of a pregnant woman is in danger, our results reflect ongoing challenges to the implementation of legal safe abortion, including unclear guidance from the Ministry of Health.<sup>35,36</sup> While the controversy surrounding the Kenyan abortion law predates the Trump administration, our findings suggest that the expanded GGR influences debate over national abortion policy by obstructing SRHR advocacy and fostering opposition to abortion and SRHR among conservative actors and government officials eager to avoid the ire of Kenya's most significant bilateral donor. This is despite the fact that the GGR permits abortion in some of the same circumstances as Kenyan law – including when the woman's life is in danger.<sup>52</sup> Similar effects of the expanded GGR on abortion advocacy and policy change have been reported in other countries.<sup>53,54</sup>

Notably, in spite of the chilling effect and suppression of advocacy among certifying NGOs, we found some evidence of resilience to the expanded GGR in Kenyan civil society. Several NGOs have responded to the policy's reinstatement and expansion with amplified advocacy efforts and strengthened collaboration. These organisations demonstrate that a robust civil society can foster

strong GGR resistance and act as a conduit for harm mitigation.

### Limitations

This study has several limitations. First, this study does not represent the experiences of all NGOs and SRH service providers in Kenya under the expanded GGR policy. We experienced challenges in our efforts to recruit a diverse sample of NGO respondents. Despite contacting 40 NGOs working in SRH service provision, research, and advocacy, we ultimately completed interviews with representatives from only 18 NGOs. Over half of the organisations in our sample were not directly impacted by the GGR – either because they were US-based, or because they were not recipients of USG funding when GGR was introduced. While data from these organisations shed light on the many indirect impacts of GGR, the comparatively small number of non-US NGOs in our sample that received USG funding limited our ability to reflect the experiences of organisations that are forced to choose between USG funding and abortion-related work. Notably, few NGOs that certified the GGR agreed to be interviewed. This may be indicative of a chilling effect, as representatives from certifying NGOs may be concerned about attracting scrutiny from USG donors by participating in research on the expanded GGR.

As participants were not always knowledgeable about the GGR, and because many dynamic factors influence changes in the Kenyan health sector, we faced some difficulty attributing reported changes to the expanded GGR policy. This was especially true of interviews at the facility level, where most participants had no knowledge of the GGR, and facilities were often supported by multiple NGOs. Furthermore, the reinstatement and expansion of the GGR coincided with other significant changes to global health funding<sup>55,56</sup> as well as a complex national SRHR context.<sup>35,36</sup> While NGO participants were typically able to distinguish between changes due to the expanded GGR and those due to other national and global factors, the confluence of these events at times obscured the root cause of a reported change. To correctly attribute changes to the GGR in Kenya, our team engaged in a lengthy process of data triangulation which included conducting follow-up interviews with participants to clarify comments, speaking with experts on the GGR and the Kenyan SRHR context, and comparing results obtained from health facilities and the NGOs that supported them.

Our data collection for this study occurred 12–18 months after the reinstatement and expansion of the GGR. Because organisations are asked to certify the policy at the beginning of a new funding cycle, it is possible that some USG recipient organisations in our sample had not yet been required to choose between USG funding and abortion-related programmes. Even among organisations whose decision to certify or not had been made at the time of the interview, data collection may have occurred before the full effects of the policy were felt. Lastly, our data collection does not take into account the additional policy expansion announced in March 2019 by US Secretary of State Mike Pompeo.<sup>57</sup> Further research is needed to understand how the impacts of the GGR in Kenya change or compound over several years.

### Conclusion

Our findings demonstrate the multi-layered, harmful effects of the expanded GGR on the Kenyan health system and civil society. In the first 18 months since its reinstatement and expansion, the policy has disrupted national SRHR advocacy efforts and resulted in critical funding losses and disruptions to health service delivery and partnerships. These losses weaken NGO support to the Kenyan health system, and likely have a substantial impact on clients seeking SRH services. Our findings call for harm mitigation interventions by advocates, funders, and policymakers in Kenya and the United States. The Government of Kenya can play a leading role in mitigating harm associated with the expanded GGR by developing and disseminating the standards and guidelines for comprehensive SRH, including abortion. Such guidelines will offer clarity on legal abortion service provision in Kenya to providers, advocates, and service delivery organisations. National and county governments should review and increase their budgetary allocation for SRH services, including for FP commodities and supplies at the county-level, to plug the gaps that are exacerbated by the expanded GGR. Similarly, other donors should expand their funding to help fill the gap caused by the expanded GGR. To inform effective interventions, researchers should continue monitoring the effects of the policy for as long as it remains in place and work with national stakeholders to strengthen data collection and monitoring systems. At the same time, policymakers in the United

States should work to permanently repeal the policy to prevent further harm.


### Acknowledgements

*The research team would like to acknowledge the hard work and dedication of the interviewers (Kevin Ochieng, Everlyne Otteng, Valleria Obure, Diana Mombo, and Glenda Otieno), as well as the time the participants spent with our team. The team also thanks Columbia University MPH student Naomi Gaspard for her assistance with data analysis.*

### Funding

*This work was supported by William and Flora Hewlett Foundation [grant number 2017-5966].*

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## Résumé

En 2017, l'administration Trump a rétabli et élargi la « Global Gag Rule » (ou règle du bâillon mondial). Cette politique oblige les organisations non gouvernementales (ONG) non basées aux États-Unis à s'engager à ne pas pratiquer ou conseiller des avortements, à ne pas adresser de femmes

## Resumen

En el año 2017, el Gobierno de Trump restableció y amplió la Ley Mordaza. Esta política exige que organizaciones no gubernamentales (ONG) con sede fuera de EE. UU. certifiquen que no proporcionarán servicios, consejería o referencias de aborto, ni abogarán por el aborto

vers des services d'avortement et à ne pas promouvoir l'avortement comme méthode de planification familiale si elles souhaitent recevoir la plupart des catégories d'aide sanitaire mondiale des États-Unis. Des données empiriques solides démontrant les conséquences de cette politique font cruellement défaut. Cet article décrit les effets de l'élargissement de la politique au Kenya, 18 mois après son rétablissement. Nous avons conduit des entretiens semi-structurés avec des représentants d'ONG, américaines ou non, sélectionnés de manière délibérée, ainsi que des gestionnaires et prestataires de santé dans des centres de santé publics et privés, de septembre 2018 à mars 2019. Les organisations ont fait état d'une perte de financements essentiels puisqu'elles étaient forcées de choisir entre des projets financés par le Gouvernement américain et des projets soutenant l'avortement sûr. Cela a entraîné une fragmentation des services de santé sexuelle et reproductive (SSR) et de prise en charge du VIH, et la fermeture de certains programmes de prestation de services. Dans les centres de santé publics et privés, les participants ont signalé des pénuries de personnel et de plus fréquentes ruptures de stocks de produits de planification familiale et d'avortement sûr. Les répercussions de l'élargissement de la politique dépassaient les soins en cas d'avortement puisque cette mesure a aussi compromis la collaboration et les activités de promotion de la santé, en renforçant l'opposition à la santé et aux droits sexuels et reproductifs dans certains segments de la société civile et des autorités kényanes. Nos conclusions indiquent que la politique expose et exacerbe les faiblesses et les vulnérabilités du système de santé kényan et met en lumière la nécessité de mesures pour atténuer ces effets néfastes.

como método de planificación familiar, para poder recibir la mayoría de las categorías de asistencia sanitaria mundial brindada por EE. UU. Falta evidencia empírica robusta que demuestre los impactos de esta política. Este artículo describe los efectos de la política ampliada de la Ley Mordaza en Kenia dieciocho meses después de su restablecimiento. Realizamos entrevistas semiestructuradas con representantes de ONG con sede en EE. UU. y fuera de EE. UU. seleccionados deliberadamente, así como con administradores y prestadores de servicios de salud en unidades de salud públicas y privadas, entre septiembre de 2018 y marzo de 2019. Las organizaciones informaron una pérdida crítica de fondos por ser obligadas a elegir entre los proyectos financiados por el gobierno de EE. UU. y proyectos que apoyan el aborto seguro. Esto produjo la fragmentación de servicios de salud sexual y reproductiva (SSR) y de VIH, y el cierre de algunos programas de prestación de servicios. En las unidades de salud públicas y privadas, los participantes informaron escasez de personal y un aumento en desabastecimientos de insumos de planificación familiar y aborto seguro. Los efectos de la ampliación de la Ley Mordaza trascendieron los servicios de aborto al trastocar la colaboración y las actividades de promoción de salud, fortalecer la oposición a la salud y los derechos sexuales y reproductivos en algunos segmentos de la sociedad civil y del gobierno de Kenia. Nuestros hallazgos indican que la Ley Mordaza expone y exacerba las debilidades y vulnerabilidades del sistema de salud keniano, y destacan la necesidad de tomar acción para mitigar estos daños.