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REVIEW ARTICLE

Impacts of the Global Gag Rule on sexual and reproductive health and rights in the Global South: A scoping review

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ABSTRACT

The Global Gag Rule is a United States policy that blocks global health funding to foreign non-governmental organisations if they engage in abortion-related activities. It has been implemented by every Republican administration since 1984 and remains in operation at the time of writing in its most stringent and extensive form. It has been criticised for its implications for women's bodily autonomy, its censorship of non-governmental organisations and health professionals, and for its impact on the health of populations in affected countries. To capture the effects of the policy to date, we conducted a scoping review in April 2020. Forty-eight articles met our eligibility criteria, and were analysed thematically, noting the effects on: the operations of non-governmental organisations; maternal health; sexually transmitted infections; marginalised groups; reproductive rights. We found that the policy increased the abortion rate and had a negative impact on maternal health, STIs, and the health of marginalised groups. We conclude that the policy amounts to the neocolonial co-optation of sexual and reproductive health in the Global South to advance an ideological agenda in the Global North. We urge that the policy be repealed as part of the broader project of protecting and decolonising sexual and reproductive health globally.

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Global Gag Rule; global health; health policy; human rights; sexual and reproductive health

1. Introduction

The Global Gag Rule (GGR) has become a hallmark of Republican administrations. Initially implemented by Reagan in 1984, the policy has been reinstated by every subsequent Republican president, and its scope was significantly expanded by Trump in 2017 (Bingenheimer & Skuster, 2017; Starrs, 2017; The Lancet, 2019). Given the contested status of these policies in the electoral politics of the United States (U.S.), it is important to review and critique their impact on global health.

The GGR blocks U.S. global health assistance to overseas non-governmental organisations (NGOs) if they use funds – obtained from any source – to carry out abortion-related activities. This forces NGOs to choose between discontinuing their abortion services or forgoing U.S funding, which in turn affects the provision of other services (Bogecho & Upreti, 2006; Starrs, 2017). Under the policy, abortion is prohibited in all cases except for rape, incest or where the life of the pregnant woman is at risk. An NGO is considered to be actively promoting abortion if it provides counselling

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or advice to patients regarding abortion as a method of family planning, conducts public health campaigns regarding the benefits or availability of abortion, or lobbies the government of the host country to legalise or liberalise abortion laws (United States Agency for International Development [USAID], 2020).

The policy has been dubbed the 'Global Gag Rule' by its critics due to this limitation on the freedom of speech of those working within NGOs. Its official name was previously the 'Mexico City Policy' and in its most recent, extended, incarnation it is entitled: 'Protecting Life in Global Health Assistance' (Bogecho & Upreti, 2006; The Lancet, 2019). Under iterations of the policy implemented by Presidents Reagan and Bush, the restrictions applied to bilateral family planning funding, which in fiscal year 2016 totalled US$575 million (Kaiser Family Foundation [KFF], 2016; Starrs, 2017). However, under the Trump administration the requirements have been extended to all '*global health assistance furnished by all departments or agencies*', thereby jeopardising an estimated US$9.5 billion in global health aid (Salaa-Blyther, 2018; Starrs, 2017; The White House, 2017, para. 2). Foreign NGOs that receive U.S health assistance work in approximately 60 low- and middle-income countries, providing a broad range of health services—including for HIV/AIDS, malaria, tuberculosis, Zika virus, maternal and child health, neglected tropical diseases, nutrition and global health security—now face critical risks to their funding and new moral dilemmas. As the primary source of global health funding worldwide, the U.S. has enormous influence over the agenda of global health and sexual and reproductive health and rights (SRHR) (Institute for Health Metrics and Evaluation, 2017; Starrs, 2017), and the GGR should be seen as a deliberate exercise of this influence.

The election of Trump must be contextualised against a broader, global rise in conservative right-wing populism that has emboldened opponents of SRHR and normalised anti-choice attitudes towards abortion (Golder, 2016; Moghadam & Kaftan, 2019). This is demonstrated through the emergence of movements across Europe and in the U.S. and Latin America which oppose women's rights, LGBT rights, and the destabilisation of gender norms. Policies aiming to restrict access to abortion have recently been proposed and/or implemented in several countries, including but not limited to, Hungary, Poland, Turkey and Russia (Berer, 2017; Moghadam & Kaftan, 2019; Stockemer, 2017; Vida, 2019). Even within the U.S., access to abortion in some states has been severely limited, and 2019 saw a wave of restrictive legislation which threatened to overturn Roe v. Wade (Guenther, 2018; Minkoff & Gibbs, 2019). However, significantly, the GGR imposes restrictions *not* on the electorate of the U.S., but on women living in Global South countries, who have no input or involvement in the elections or policies of the U.S. Further, the GGR in its current form would be unlawful if implemented in the U.S, and would be deemed unconstitutional due to its infringement on key democratic principles (Crimm, 2007; Legal information Institute, 2020; The Lancet, 2019).

Despite the policy's intended focus on abortions, its impacts on sexual and reproductive health have always been extensive and wide-ranging. The integrated nature of healthcare, particularly in low- and middle-income settings, makes it difficult to target one specific area without unintended consequence. Existing literature on the policy suggests broadly negative impacts on the health of those in affected countries, with long-term detrimental effects to social and economic infrastructure (Crane et al., 2017; Singh & Karim, 2017; Starrs, 2017). There have been many predictions about the negative implications of the new, extended policy, and much condemnation from professional organisations of the effects on health and wellbeing, bodily autonomy, and freedom of speech (Bingenheimer & Skuster, 2017; Singh & Karim, 2017; Starrs, 2017). Mavodza et al. (2019) found that the GGR under Bush and Reagan resulted in decreased levels of funding and impaired access to family planning. It is vital to continue to monitor and report the ongoing consequences due to the significant changes and expansions made under Trump's policy. This study comprehensively reviews the available literature on the GGR to date with the aim of better understanding its impacts on the SRHR of people and organisations living and working in Global South settings.

2. Methods and materials

A scoping review is apt as it allows exploration of a topic with undefined conceptual boundaries and data of a varied and heterogenous nature (Arksey & O'Malley, 2005; Tricco et al., 2016). This study will be conducted using a framework developed by Arksey and O'Malley (2005), consisting of five stages: identifying the research questions; identifying relevant studies; selecting studies; charting the data; collating, summarising, and reporting the results. Our research question is as follows: *What is the impact of the Global Gag Rule on the sexual and reproductive health of people living in low- and middle-income countries across the three periods that is has been in effect?*

There were three stages to the search strategy. First, a limited search was carried out on the databases Global Health and MEDLINE using the terms 'Global Gag Rule', 'Mexico City policy' and 'USAID funding.' Key words and MeSH terms were extracted from relevant articles. The original research question was dissected, and synonyms and similar terms were added to the search strategy, facilitated by the extracted terms from the initial search (The Joanna Briggs Institute, 2015). The relevant search terms were then modified into a completed search strategy through the addition of Boolean operators. The term 'low- and middle-income countries' and its synonyms were ultimately excluded to minimise redundancy and to optimise relevance, since the GGR in any case affects those regions exclusively (Starrs, 2017). The final search strategy was adjusted for each database according to the relevant key words (see Table 1). The search was conducted on 1st April 2020 in the original databases and Embase, Web of Science, Psychoinfo and CINAHL. No limits on date, language or type of research were placed on the database search. Finally, the reference lists of collected articles was reviewed to identify additional resources that may not have been retrieved from the database searches.

Additional sources and unpublished literature were retrieved by a Google search using the terms 'Global Gag Rule', 'Mexico City Policy' and 'USAID funding'. Websites of key stakeholders were then hand-searched, including Marie Stopes International, International Planned Parenthood Federation, Kaiser Family Foundation, Guttmacher Institute, Human Rights Watch, CHANGE and Population Action International. A Google Scholar Search was also carried out using the key terms 'Global Gag Rule' and 'Mexico City Policy', providing approximately 5910 results. The first 20 pages of Google Scholar results were reviewed, and appropriate articles extracted.

The study selection included peer-reviewed journal articles and grey literature. Qualitative, quantitative, mixed method and review journal articles were included in the interest of comprehensiveness (Levac et al., 2010). We included only those articles that referred to the policy in question and gave insight as to the actual or expected impacts on sexual and reproductive health. Only those articles in English to which we had full access were retained, and only those published after 1984 (when the first version of the GGR was implemented) (Crane & Dusenberry, 2004). Opinion pieces, news articles, and mass media articles were excluded, as many were sensationalist in nature and of poor quality. We also excluded articles that did not contribute any new information, or merely cited findings from articles already included within the review. Once the full list of references had been retrieved and duplicates excluded, the abstracts and then the articles themselves were screened for relevance and adherence to the inclusion criteria (see Table 2).

Of the 308 articles retrieved from the searches, 48 were deemed eligible for inclusion in this review (Figure 1). Each article was thematically analysed, and relevant data extracted and inputted into a table (see supplementary material).

Table 1. Database search strategy including Boolean operators.

Database search terms	(global gag rule) OR (Mexico City policy) OR (protecting life in global health assistance) OR (USAID funding) OR (united states policy) AND (sexual health) OR (reproductive health) OR (maternal health) OR (induced abortion) OR termination OR contraception OR (family planning) OR (human rights) OR advocacy)

Table 2. Inclusion and exclusion criteria.

Inclusion Criteria	Exclusion Criteria
Journal article, government document, grey literature, book chapter	News article, mass media article, opinion piece
Discusses actual or expected impact of GGR on SRHR or access to sexual and reproductive health services of people in LMIC	Discusses impact on people in U.S. No new information added.
English language	Other languages
Published between 1984 and present	Published prior to 1984

The results were structured according to the five major themes identified: the operations of non-governmental organisations, maternal health, sexually transmitted infections, specific social groups, and reproductive rights. Some of the major themes were then divided into sub-themes, as depicted in Table 3. (See supplementary material for a complete reference, theme and sub-theme overview). The interpretation of the results and the broader implications of the study findings are considered in the discussion.

3. Results

In the following subsections, we summarise the results along the five themes that emerged from the content of the articles. Key sub-themes are italicised to assist with signposting.

3.1. Impact on organisations: funding, services, and resource allocation

Of the included articles, 25 reported that the GGR had an impact on *funding* during at least one of the implementation periods. Under the Reagan GGR, International Planned Parenthood Federation

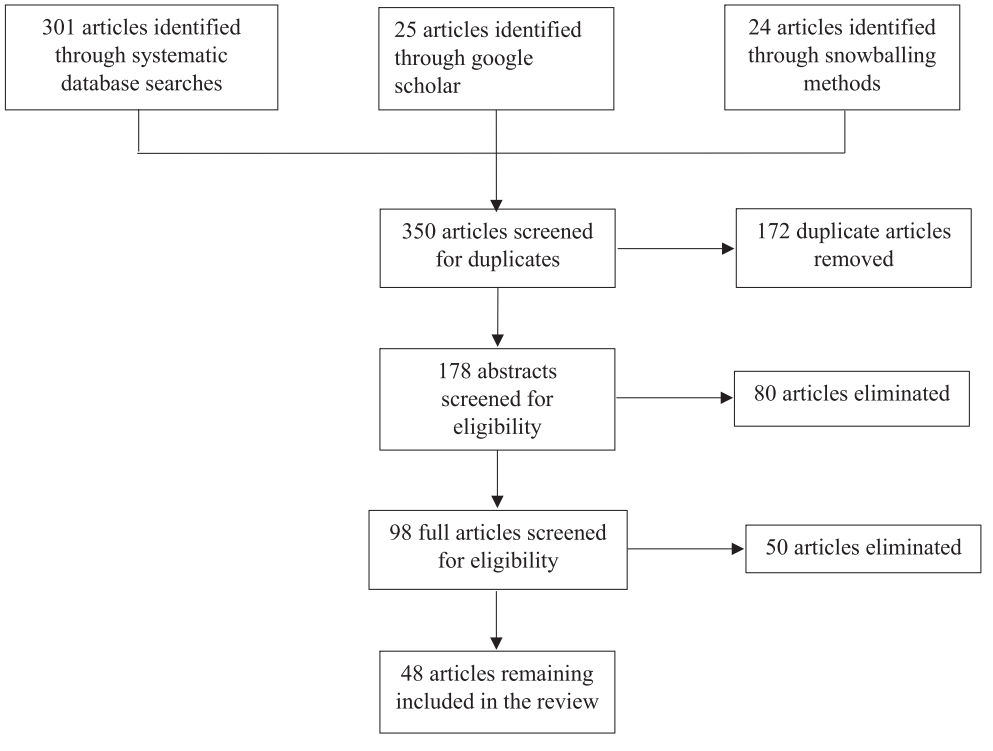

Figure 1. Flow chart of included publications.

Table 3. Major themes identified in the review.

Theme	Sub-theme
Impact on organisations	Funding
	Health services
	Burden of compliance
Maternal health	
Sexually transmitted infections	
Impact on specific groups	Rural communities
	Sexual minorities
	Religious minorities
	Refugees and migrants
Reproductive rights	Censorship
	The right to an abortion
	Galvanising advocates

(IPPF) lost 25% of their funding, totalling $11–12 million (Centre For Health and Gender Equality [CHANGE], 2018). Under the Bush GGR, family planning assistance decreased by 3–6% and 11 organisations reported a loss of U.S. funding (Asiedu et al., 2013; CHANGE, 2018; Jones, 2011; Population Action International [PAI], 2005; Sagala, 2005). IPPF lost more than $100 million over the 8-year administration, and at least four member associates lost funding (CHANGE, 2018; Gezinski, 2012). Member firms of Marie Stopes International (MSI) also lost a proportion of their budget due to non-compliance with the GGR; MSI Ethiopia lost 10%, MSI Kenya lost 40% and MSI Tanzania lost 65% (PAI, 2005). Increased donations from other sources were not sufficient to fully compensate for the lost U.S. funds (Brooks et al., 2019; Gezinski, 2012; Grollman et al., 2018).

The literature emphasised the severity of Trump's expanded GGR and the additional impact it would have on funding and services. IPPF and MSI have identified a combined funding gap of $160 million by the end of the 2017–2020 Trump administration (Planned Parenthood Global [PPG], 2019). Across sub-Saharan Africa, South Asia and Central and South America, 31 IPPF member associates have lost up to 70% of their annual income, and one reported being required to return all assets received from the U.S. over the past seven years, including medical equipment and vehicles (IPPF, 2017; PAI, 2018). MSI estimates that approximately $62.2 million in direct costs will be transferred on to governments, families and women between 2017 and 2020 (MSI, 2017, 2018). The She Decides movement was initiated to replace the lost funds and had raised $450 million by March 2018. However, this is not sufficient to compensate for the impacts of the expanded GGR (Brooks et al., 2019; CHANGE, 2018; Grollman et al., 2018).

During the Bush GGR, *health services* were severely impacted and 59 clinics across four countries were forced to close (Bogecho & Upreti, 2006; CHANGE, 2018; Jones, 2004; Jones, 2015; PAI, 2005). Four key NGOs reported cutting staff and two introduced or raised client fees. Termination of clinics and outreach programmes left 28,000 people in Kenya and 531,000 people in Ethiopia without alternative affordable sources of healthcare (Bogecho & Upreti, 2006; Gezinski, 2012; PAI, 2005). Similar outcomes were reported under Trump's expanded GGR with at least five organisations being forced to reduce their services, retrench staff members and close clinics (Adhikari, 2019; CHANGE, 2018; PAI, 2018; PPG, 2019; Rios, 2019). Family Planning Association of Nepal (FPAN) estimates that 10 million people, one third of the Nepali population, will be affected by the funding cuts (Adhikari, 2019). Even if non-complying organisations mobilise new funding, there is, on average, an interval of 3–6 months where clients are left without health services, affecting health and trust in NGOs (PPG, 2019).

Across all three policy periods, the GGR impacted integration of services and partnerships between organisations, leading to fragmented and inefficient health systems (Camp, 1987; CHANGE, 2018; PAI, 2005; Schaaf et al., 2019). Efforts to integrate HIV care into existing reproductive health services have in many cases been halted and reversed to protect HIV funding from

the GGR. Non-compliant organisations have been forced to withdraw from important projects as they are no longer eligible for U.S. funding. Consequently, projects suffer the loss of the expertise and facilities of the largest and most established NGOs (CHANGE, 2018; PAI, 2005, 2018; Rios, 2019). However, several stakeholders suggested that decreased reliance on U.S. funding could increase stability for future years and may encourage governments to take greater responsibility of health services. An NGO worker mused that: 'It's a hard lesson, but good if the policy creates other funding channels and we can say to the U.S. "we can do without you"' (PAI, 2018, p. 9; Rios, 2019).

The *administrative burden* involved in complying with the GGR absorbs valuable funding and resources. One organisation in Uganda reported being 4–6 months behind implementing projects because of diverting efforts to comply with the policy. Across all three implementation periods, widespread confusion around the details of the policy has been reported and, in some cases, has led to over-implementation through fear of losing funding (Camp, 1987; CHANGE, 2018; du Plessis et al., 2019; PAI, 2018; PPG, 2019). The confusion surrounding the policy has affected provision of post-abortion care and emergency contraception, including for rape victims, whose care is supposed to be exempt from the restrictions of the GGR (CHANGE, 2018; Mavodza et al., 2019; Rios, 2019). Confusion around the policy has been particularly pronounced among newly affected organisations as a result of the expanded GGR (PPG, 2019). Organisations in Uganda, Ethiopia, Nigeria, Nepal, Kenya and Mozambique reported little or no communication with the U.S. regarding the policy and some organisations were not aware of their compliant status due to the voluminous and inscrutable nature of the U.S. assistance documents. Where guidance on the policy has been provided, documents were only available in English, serving as an additional barrier to small and non-English speaking organisations (CHANGE, 2018; Mavodza et al., 2019; PAI, 2018; PPG, 2019; Puri et al., 2019; Rios, 2019).

3.2. Maternal health and abortion access

Under the Bush GGR, funding cuts forced reductions in maternal health services, including the closure of pre- and postnatal care clinics in Kenya which served over 300,000 clients (Bogecho & Upreti, 2006; Gezinski, 2012). The number of unsafe abortions rose as a result of funding cuts to non-compliant organisations and discontinuation of abortion services and referrals from compliant organisations (Crane & Dusenberry, 2004). IPPF estimates that the funding lost during the Bush era GGR led to an additional 36 million unintended pregnancies and 15 million induced abortions (CHANGE, 2018). Of the six studies investigating the effect of the GGR on the rate of abortion, four found a significant increase in the likelihood of abortion across sub-Saharan Africa and specifically in Ghana, one found a substantial increase in the likelihood of abortion in Latin America and sub-Saharan Africa but a decrease in Eastern Europe and in Asia, and the final study found a decrease in the likelihood of abortion in Ethiopia (Bendavid et al., 2011; Brooks et al., 2019; Jones, 2011, 2015; Tibone, 2013; Van der Meulen Rodgers, 2018). Several articles indicated that the abortion rate increased under the GGR due to reduced access to contraceptive services.

During this time, USAID reduced or suspended contraceptive shipments to 16 countries in sub-Saharan Africa, Asia and the Middle East (CHANGE, 2018). The Planned Parenthood Association of Zimbabwe and FPAN lost $137,092 and $400,000 respectively in USAID-funded contraceptive supplies, and condom distribution to Lesotho was terminated since the sole recipient of USAID contraception in the country did not comply with the GGR (Mavodza et al., 2019; PAI, 2005; Sagala, 2005). Across sub-Saharan Africa, total modern contraceptive use decreased by 13.5% and in Ghana, the Planned Parenthood Association of Ghana (PPAG) saw a 40% reduction in family planning use in their clinics (Brooks et al., 2019; Jones, 2015; PAI, 2005).

Organisations expect that the Trump GGR will increase maternal mortality at a rate equal to if not greater than the Bush GGR (Crane et al., 2017). The current GGR has disrupted obstetric and gynaecological services including cervical cancer screening, provision of nutritional supplements to

reduce anaemia, Zika prevention and training, and misoprostol adminstration for the treatment of post-partum haemorrhage (CHANGE, 2018; IPPF, 2019; PAI, 2018; PPG, 2019). Services and centres for survivors of gender-based violence have been disrupted, and several discontinued, after refusing to comply with the GGR due to their dedication to providing integrated, woman-centred care which includes safe abortion (CHANGE, 2018; Rios, 2019).

MSI estimates that between the years 2017 and 2020, cuts to their contraceptive services will result in an additional 6.5 million unintended pregnancies, 2.1 million unsafe abortions and 21,700 maternal deaths (MSI, 2017). Loss of U.S. funding has forced termination of family planning programmes serving 650,000 people in Zambia, 6,000 adolescent girls in Uganda, 40,000 adolescent girls in Kenya, and 11 remote districts in Nepal (Adhikari, 2019; CHANGE, 2018; IPPF, 2019; Puri et al., 2019; Rios, 2019). Non-compliant organisations are seeing fewer women accessing safe abortion due to the lack of education and referrals from compliant organisations. A stakeholder in Kenya reported that: 'Our gynae wards were empty … today we are getting unsafe abortion cases back in our wards, septic, with complications' (PPG, 2019, p. 21).

3.3. Sexually transmitted infections

Funding cuts to non-compliant NGOs affect the prevention, detection, and treatment of STIs, including HIV. Even though they were ostensibly protected from the effects of the Bush GGR, confusion and fear amongst NGOs led to disruption of HIV services, including exclusion of key partners in HIV prevention projects and avoidance of discussing legal abortion as an option for pregnant women living with HIV (PAI, 2005; Philpott et al., 2010).

Under the Trump GGR, IPPF and MSI have predicted a decrease in the number of STI treatments they can provide by 525,000 and 30%, respectively (IPPF, 2017; PAI, 2018). The inclusion of the President's Emergency Fund for AIDS Relief (PEPFAR) in Trump's expanded GGR is likely to result in decreased funding to and de-integration of HIV services, increasing the number of avoidable HIV infections and AIDS-related deaths (Bingenheimer & Skuster, 2017; Rios, 2019). In at least 10 PEPFAR-funded countries, over 90% of HIV sites are integrated with family planning services (Sherwood et al., 2018). A representative from a legal organisation in Kenya describe the impact of de-integration of services: ' … we are going to ignore a huge part of what makes them susceptible to HIV infection, like limited information around their bodies, their health, their rights, and their right to access safe abortion' (Rios, 2019, p. 19). IPPF estimates that the expanded GGR will prevent them from providing 725,000 HIV tests and anti-retroviral therapy to 275,000 pregnant women living with HIV (PPG, 2019). Organisations in Uganda, Malawi and Zimbabwe have reported that their HIV prevention programmes have closed or will face closure without alternative sources of funding (CHANGE, 2018). An NGO in Uganda has been forced to discontinue an HIV project that reached 14,000 adolescent girls because their prime funder could not comply with the GGR, and a clinic in Mozambique reported a decrease in the number of clients tested for HIV from 5,981 to 671 (CHANGE, 2018; Mavodza et al., 2019).

3.4. Impact on marginalised groups

The literature emphasised the impact on *rural and isolated communities* due to their dependence on NGOs for healthcare and lack of alternative options if services were cut (CHANGE, 2018; du Plessis et al., 2019; PAI, 2005; PPG, 2019; Puri et al., 2019). During the Bush GGR, rural communities in Ethiopia, Ghana, Nepal, Tanzania, Kenya, Zambia, Zimbabwe and Bolivia faced a reduction or termination of services due to a loss in U.S. funding, leaving many communities with no access to affordable healthcare (Barot & Cohen, 2015; CHANGE, 2018; Jones, 2004; Jones, 2015; PAI, 2005). In Ghana, PPAG were compelled to suspend their community-based distribution projects and close 28 rural clinics, resulting in a 45% drop in contraceptive provision and a 20–40% increase

in unwanted fertility. The burden of additional unplanned pregnancies fell disproportionately on the poorest women, who were unable to access abortion services (Jones, 2015).

Under Trump's GGR, NGOs in Uganda, Ethiopia, Senegal, Swaziland, Mozambique, Zimbabwe, Madagascar and Botswana have had to reduce or scale back services that serve marginalised populations (CHANGE, 2018; IPPF, 2019; MSI, 2019; PAI, 2018; PPG, 2019). In Zimbabwe, the number of contraceptive implants provided to rural women by the IPPF member associate has reduced from 664 to 232 in a 3-month period. Women requiring implant removal, either due to expiration of the implant or wanting to have more children, may no longer be served by community outreach teams (CHANGE, 2018). A report by Population Action International noted that even where funding from other sources is secured, it is rarely diverted to health initiatives for rural populations as most donors consider this work to be too cost inefficient (PAI, 2018).

The GGR has led to the defunding of organisations that provide sexual and reproductive health services to *sexual minorities* (CHANGE, 2018; Rios, 2019; Sastrawidjaja, 2004). Under Trump's GGR, projects in Kenya, Mozambique, Zambia and across four countries in Central America that provided HIV prevention services to high-risk populations, such as sex workers, men who have sex with men and transgender people, have shut down (CHANGE, 2018; IPPF, 2019; Rios, 2019). Services for sex workers have also been significantly reduced; a night clinic in Mozambique providing integrated healthcare to sex workers could not comply with the GGR and has closed due to inadequate funding (CHANGE, 2018; IPPF, 2019).

As organisations providing comprehensive sexual and reproductive health services are less likely to sign the GGR, PEPFAR funding has been redirected to conservative organisations such as Focus on the Family; an anti-LGBT, abstinence-only organisation in South Africa. A member of the SRHR coalition stated: 'They have got funding from the US government to do [comprehensive sexuality education] that is just abstinence … they want to cure homosexuals, it's just shocking. They've got money from the US government to do this work' (Rios, 2019, p. 27).

Organisations have expressed concern about the effects of the expanded GGR on *religious minorities,* particularly Muslim women, who in some contexts face additional stigma and social barriers in accessing family planning (CHANGE, 2018; PAI, 2018). Dedicated programmes serving Muslim women in Nepal and Kenya have been forced to close due to funding cuts (PAI, 2018; Rios, 2019). A former local health worker described the impact of the loss of services:

> The people [in the community where the clinic closed] are mainly the Muslim community. There are women who use family planning but do not want it to be known. They also cannot leave home without the husband's permission … It has been difficult for women in our area as they want to use family planning, but they can't access them … We used to visit them at home and deliver the contraceptives there (Rios, 2019, p. 16).

A civil service organisation in Senegal, which had previously worked with Muslim organisations, agreed to comply with GGR and was therefore required to withdraw from an abortion advocacy task force. As a result, the task force has lost vital links to religious groups in Senegal and their expertise in guiding sensitive service-delivery (PAI, 2018).

Although humanitarian aid is excluded from the GGR, in practice the policy has significant implications for the health of *refugees and migrants*. The Reproductive Health Response in Conflict Consortium coordinates efforts for providing sexual and reproductive healthcare to women living in conflict settings. However, since MSI was a constituent member, the Consortium was forced to relinquish U.S. funding in 2003 (CHANGE, 2018; PPG, 2019). Under the expanded GGR, organisations in Uganda and Nepal working with refugees and migrants have funding shortfalls and have had to reduce or withdraw support. In Uganda, 1.3 million people live in refugee camps, half of which were previously served by Reproductive Health Uganda. Under the Trump GGR, the organisation has been forced to divert $100,000 of funding away from refugee camps to cover other areas of their work. They emphasised the importance of their presence within the camps: 'When it comes to issues of family planning, adolescents [and] post-abortion care, the demand [in the camps] is

huge. When someone has HIV and is on drugs and comes here as a refugee, they are lost. We've gone in and introduced services as public health facilities are overstretched' (PAI, 2018, p. 6).

3.5. Reproductive rights

Compliant NGOs in Mozambique, South Africa, Bolivia, Nepal, Senegal, Uganda, Peru, Ethiopia and Zimbabwe have stated that they feel *censored* by the GGR and are reluctant to engage in discussion around their work for fear of losing U.S. funding (Baird, 2019; Centre for Reproductive Rights, 2000; CHANGE, 2018; du Plessis et al., 2019; Gezinski, 2012; Jones, 2004; PAI, 2005, 2018; Puri et al., 2019; Rios, 2019). In both Nepal and Ethiopia, compliant NGOs have been prevented from engaging in government-initiated discussions on abortion law reform in their countries (PAI, 2005; Mavodza et al., 2019). As opponents of abortion are still able to speak freely and advocate their views, public discussion of abortion has become skewed, which may lead to long-term changes in local and national discourses around abortion (CHANGE, 2018; Petroni & Skuster, 2008; Rios, 2019). Under the expanded GGR, fewer organisations have been attending SRHR advocacy events. At an annual conference in 2017, several groups were unable to participate in relevant workshops as abortion would likely be discussed. In South Africa, civil society organisations are fearful that abortion issues will be side-lined at national sexual and reproductive health gatherings. Stakeholders from South Africa and Nepal expressed frustration and anger at the power imbalance between the Global North and the Global South, and regarded the GGR as interference from a powerful nation openly abusing its position of economic dominance (CHANGE, 2018; Cohen, 2003; du Plessis et al., 2019; Puri et al., 2019; Rios, 2019).

In 2016, 37 out of 64 countries receiving U.S. global health assistance had *laws* which allowed for abortion in circumstances not permitted by the GGR. Therefore 880 million women of reproductive age lived in a jurisdiction in which the GGR prohibits abortions that are in fact lawful (CHANGE, 2018). Many women are not aware of their legal right to an abortion, and the GGR prevents health workers from distributing information and raising awareness (CHANGE, 2018, PPG, 2019). In an HIV prevention trial in South Africa, staff avoided offering pregnancy options to women living with HIV, despite this being required by South African law, as they felt confused and fearful of the GGR (du Plessis et al., 2019; Philpott et al., 2010). This is particularly concerning since even where abortion has been decriminalised, governments are invariably slow to implement the new legislation and ensure access to services. The GGR produces additional barriers, as many governments fear losing U.S. support, and represent populations that are reliant on NGOs for the provision of health services. Stakeholders are concerned that economic constraints, coupled with censorship of abortion advocates, may shift policy away from a focus on human rights, health and wellbeing, towards one on moralism or religious values, or on raw economic pragmatism (Adhikari, 2019; Bogecho & Upreti, 2006; PPG, 2019; Rios, 2019).

The GGR has *mobilised advocates* for and against abortion. SRHR organisations in Uganda, Nepal, Senegal, Peru and South Africa have expressed concerns that the GGR emboldens political opponents and fuels an anti-choice rhetoric (PAI, 2018; du Plessis et al., 2019; Mollmann, 2004; Rios, 2019). Some stakeholders have witnessed a stall in progress made by governments in reproductive health policies since the implementation of the GGR. Recent laws in Tanzania include banning pregnant girls from attending school and suspending family planning advertisements in the media (du Plessis et al., 2019; Mollmann, 2004; PAI, 2018; PPG, 2019). A representative from a SRHR organisation in Senegal stated:

> Opponents have always said that what we promote – safe abortion and women's rights – are Western ideas. They always accused us of 'following the United States.' But now, with Trump, they are asking us why we work on these issues if even the United States doesn't believe in them anymore (PAI, 2018, p. 7).

However, a number of NGOs and organisations have been motivated to increase advocacy efforts for safe, legal abortion. Several movements have formed in opposition to the policy including the

SheDecides movement and the Global Health, Empowerment and Rights Act. The latter is a legal challenge to the GGR, introduced by a bipartisan group of policy makers in the U.S., and, if successful, would revoke and prevent reinstatement of the policy (CHANGE, 2018; du Plessis et al., 2019; PPG, 2019; Rios, 2019).

4. Discussion

The findings of this study clearly demonstrate that the GGR has a negative impact on the SRHR of people in the Global South. Across all three policy periods there have been funding cuts to key organisations, leading to significant reductions in health services, including clinics, community-based distribution of commodities, and outreach teams (Camp, 1987; Jones, 2011, 2015; Moss, 2017; PAI, 2005). Reductions in funding to key organisations has not only affected abortion access but has led to an increase in maternal mortality and morbidity through diminished access to contraception and peri-natal care, resulting in higher fertility rates, unsafe abortions, and pregnancy and birth complications (Brooks et al., 2019; CHANGE, 2018; Crane et al., 2017; Gezinski, 2012; MSI, 2017). The decimation of funding to organisations providing comprehensive sexual health care and the de-integration of HIV from basic reproductive health services has resulted in a deterioration of STI prevention and treatment efforts. This has led to an increased number of people with an untreated STI, including HIV, resulting in avoidable deaths and disability (Bingenheimer & Skuster, 2017; IPPF, 2017; Rios, 2019; Sherwood et al., 2018). The policy has disproportionately affected the limited services directed towards marginalised groups, including sex workers, LGBT people, religious minorities, refugees and migrants. Without specialised services, these groups face further barriers to accessing quality healthcare and will suffer the consequences of continued poor health outcomes and associated stigma (CHANGE, 2018; PAI, 2005; Rios, 2019; Sastrawidjaja, 2004).

The 'gagging' of health professionals and NGOs has created a chilling effect on free speech, silencing discussion and advocacy around abortions, as organisations and governments fear the repercussions of opposing the U.S. government's position (Baird, 2019; PPG, 2019; Philpott et al., 2010). This has allowed anti-choice groups and politicians to voice their views without challenge and dominate the SRHR discourse, and has prevented women from accessing abortion-related services even in countries where it is their legal right (CHANGE, 2018; Moss, 2017; PAI, 2018). The epistemic effects of the GGR will likely be transformative of the moral discourse and public understanding of abortion in affected countries, which could have long-term effects on how abortion is conceived of as a moral, political, and legal matter.

The GGR does not fulfil its aim of reducing the number of abortions, and therefore does not realise the purported aim of the Trump policy of 'protecting life.' There is significant evidence that the policy has the opposite effect, while introducing devastating consequences for the health and wellbeing of affected populations (Bendavid et al., 2011; Brooks et al., 2019; Jones, 2011, 2015; Van der Meulen Rodgers, 2018). Organisations involved in abortion-related activities are key suppliers of contraceptives, therefore withdrawing funding results in decreased availability and accessibility of family planning options, leaving women without the means to control their fertility (Brooks et al., 2019; PAI, 2005; Sagala, 2005). The policy not only increases the number of abortions but tends to increase the proportion of unsafe abortions. By forcing cessation of abortion provision by compliant organisations and necessitating cuts to the services of non-compliant organisations, many women are left with no alternative but to seek clandestine abortions (Crane & Dusenberry, 2004; PPG, 2019; Rios, 2019). Even in countries with broad legal provisions for abortion, the censorship of healthcare professionals impedes women's awareness of their legal entitlements and their ability to access information about services (Barot, 2017; Miller & Billings, 2005). Women suffering the health consequences of unsafe abortion may be denied life-saving care, because although such care is permitted under the terms of the policy, its provision has deteriorated under the GGR (Rios, 2019).

Despite an abundance of evidence as to the negative impacts on women's health, the U.S. government continues to uphold this policy. This raises questions as to whether the policy was ever intended to decrease the number of abortions and 'protect lives', or whether its aim is simply to appease the anti-abortion lobby in the U.S., guaranteeing their support for Republican administrations (Abramovitz, 2014; Crane & Dusenberry, 2004). Yet even then, there is a question as to *which* lives the policy is supposed to protect. Contrary to its titular claim, the GGR protects neither women nor foetuses (Brooks et al., 2019; Jones, 2015; MSI, 2017). Perhaps it is best interpreted as a political 'dogwhistle' whose intention is to signal commitment to particular values, regardless of its actual effects and the devastation it causes elsewhere.

The connected and interlinked nature of healthcare, particularly in Global South settings, mean that defunding or reduction in one area has wide-ranging and unpredictable effects on other areas of healthcare. Although it ostensibly sets out to decrease the number of abortions, the policy has far-reaching consequences for global health through its impacts on HIV care, access to contraception, and the disproportionate effects on marginalised groups. Separating HIV from other basic reproductive health services harms both efforts, particularly in the care of women of reproductive age and in preventing mother-to-child transmission (PPG, 2019; Rios, 2019). Further, the inclusion of PEPFAR funding in Trump's expanded GGR undermines the commitment that the United States has made to eliminating HIV and the unprecedented levels of funding put towards this effort (Emanuel, 2012; Webster, 2018).

Access to contraception and abortion allows families to choose the number and spacing of children, enabling greater investment in each child and increasing health and future prospects. It also allows increased participation in the workforce, particularly for women, increasing household income and improving the opportunities and status of women (Bingenheimer & Skuster, 2017; Schultz, 2007). Through these mechanisms, the GGR threatens the health and economic security of whole populations, as well as progression towards gender equality. Determinants such as poverty, social exclusion and ethnicity are all inextricably linked to health and wellbeing, whose global distribution is vastly uneven (Ruger, 2006). The GGR has led to an even greater disparity in the access and utilisation of health services and will continue to widen health inequity globally by disproportionately affecting those most vulnerable to disease and ill-health.

The restrictions imposed by the GGR are not implemented by a democratically elected government but are imposed by the U.S. onto those in the Global South (Crimm, 2007). Despite being challenged legally, the policy undermines the abortion legislation of an estimated 37 countries where abortion is permissible in at least one circumstance prohibited by the policy, while in a further 27 countries, opportunities for abortion law reform are inhibited (Moss, 2017). By prohibiting NGOs and healthcare professionals from speaking openly about abortion, the GGR violates several international covenants which guarantee the rights to freedom of speech, to seek and share information and to enjoy the benefits of scientific progress (United Nations General Assembly, 1966a, 1966b). This contradicts the principles of U.S. foreign policy and the mission of USAID to 'promote and demonstrate democratic values abroad' (USAID, 2018, para. 1). The GGR, alongside similarly justified policies such as the defunding of UNFPA and the promotion of abstinence-only HIV prevention programmes, has undermined the rights-based approach to global health and set a dangerous precedent for funding restrictions (Bogecho & Upreti, 2006; Crane & Dusenberry, 2004). It is important to acknowledge that the values reproduced by the GGR around race and gender are not new. These power dynamics bear worrying similarities to the imposition of norms and values when much of the Global South was under direct colonial rule, and are reminiscent of the post-colonial power relations that have been critically analysed by scholars in other contexts (Ayeb-Karlsson, 2020; Said, 1978). The GGR exports the limits posed by the values of a vocal political minority in the U.S. onto the SRHR of women across the Global South. It does so in the name of serving the political interests of a powerful foreign state, and with no regard to the consequences for the health and lives of millions of women. This is a form of neo-colonialism and is yet another

force that serves to perpetuate growing disparities of wealth and health between the Global North and the Global South.

One positive outcome of the expanded GGR is the decreased reliance on U.S. funding. Its most recent iteration has encouraged the governments of affected nations to take action in relation to the provision of quality healthcare (PPG, 2019; Rios, 2019). Currently, a worryingly large proportion of healthcare in the Global South is delivered by NGOs in order to the address the gaps in weak, under-funded health systems (Wadge et al., 2017), the end-result of the economic exploitation of colonialism and the effects of structural adjustment and political instability in the post-colonial period (Alubo, 1990; Bruhn & Gallego, 2012; Turshen, 1977). Dependence on NGOs for healthcare provision results in unsustainable health systems that are subject to troubling power dynamics, as funding is assigned in accordance with the decisions of external operators and therefore may be discontinued, reallocated, or conditional. Further, the difficulties in coordinating between NGOs and country governments can result in unequal health coverage across states and unevenness in relation to different areas of care (Hearn, 1998; Reddy et al., 2018; Wadge et al., 2017). The dependence of the Global South on international aid to meet the basic health needs of the population leaves countries vulnerable to the questionable political and ideological whims of the Global North (Shahvisi, 2019), creating a cycle of intensifying dependence and control.

Finally, several limitations of this study must be noted. First, although many articles have been published discussing the impacts of the GGR on health, there is little primary data, and much of the available primary data is grey literature, which proved invaluable in this review for its first-hand accounts and practical overviews. However, the dearth of peer-reviewed articles poses a limit to the quality of the data reviewed. No formal quality appraisal was carried out, as it was decided that inclusion of a broad range of studies, including grey literature, was imperative to fulfilling the research aims (Levac et al., 2010).

Second, some countries and regions are not represented in the study, while others are proportionally overrepresented. For example, countries in Asia and Latin America were underrepresented while the Africa region was overrepresented (see supplementary material). This is an artefact of the openness of the methodology, yet it is likely that important consequences have accordingly been overlooked, and that the sensitivity of this issue, as well as the limited resources required to provide reports on outcomes, have posed barriers to information gathering. This may also be a result the inherent struggle in academia (and review studies in particular) where former British colonies, or country contexts that may more frequently provide reports and research in English, are overrepresented. Meanwhile, there is a relatively unexplored body of literature in Spanish and Portuguese, for example.

Finally, it is difficult to decisively attribute changes in health outcomes to the GGR, due to the many overlapping social, political, and economic determinants of health. The diversity of affected populations and health systems also makes it difficult to compare the policy's effects across different regions (Navarro & Shi, 2001).

5. Conclusion

The purpose of the GGR is not to protect lives but rather weaponise U.S. global health assistance in order to advance a conservative ideology and respond to domestic political divisions. At the end of a complete presidential term with the extended policy in operation, and with the prospect of it being extended to 2024, it is vital to fully comprehend its damaging effects.

This review has identified several aspects of sexual and reproductive health that have been harmed by the GGR. First, the policy does not reduce abortions but rather decreases access to family planning, resulting in a higher number of unintended pregnancies and a subsequent increase in the number of unsafe abortions. Through its impacts on services, the GGR leads to an increase in maternal morbidity and mortality, and higher rates of STIs, including HIV. These consequences have implications for the health of populations as a whole, with the greatest impact on the most

marginalised. Censorship of health professionals and organisations has created an atmosphere of fear, in which the conversation on abortion and SRHR is severely constrained and nudged towards the ideological right. The net result is the stalling and reversing of global progress in advancing and protecting SRHR.

Imposed on the Global South by the U.S. government, the GGR limits the autonomy of affected populations to determine their own systems and principles in realising sexual and reproductive justice. We remain hopeful that organisations will find alternative sources of funding, decreasing their reliance on the U.S. and therefore their vulnerability in the case of similar policies in the future. Further, the withdrawal of services by NGOs may encourage country governments to develop more comprehensive health systems to address the lacunae opened by the policy. The disruption caused by the GGR should be taken as an opportunity to review the global health arena and make amendments to increase the sustainability of Global South health systems and the autonomy of individual countries and populations therein. Further research in this area, including first-hand accounts of the impact of the GGR on vulnerable populations, is urgently needed to substantiate our findings. Extended local evidence from diverse geographical contexts and social groups would provide important additional detail and nuance as to the effects of the policy, helping to direct efforts to mitigate its harms. In the meantime, the policy must be vocally opposed by all those whose speech is not constrained by it, and this should be seen as a central component of the broader priority of decolonising global health.

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