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The Global Gag Rule: An Ideological Policy's Consequences for Reproductive and Global Health

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**The Global Gag Rule: An Ideological Policy's
Consequences for Reproductive and Global Health**

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A senior thesis submitted in partial fulfillment of the requirements of the
International Political Economy major

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EXECUTIVE SUMMARY

The Global Gag Rule (GGR) is a U.S. policy first instituted by the Reagan administration in 1984 that aims to reduce the amount of abortions that occur globally. The GGR attempts to accomplish this by revoking all U.S. foreign aid to NGOs which provide any abortion counseling or services, or that advocate for abortion rights in their own country (Crane and Dusenberry 2004, 128). The only exceptions made to the policy are in cases of rape, incest, or if the mother's life is in direct danger (Crane and Dusenberry 2004, 128). The vagueness of the policy can often lead to over interpretation by providers, which is known as the chilling effect that it has on both care and advocacy efforts (Crane and Dusenberry 2004, 132). The GGR greatly disrupts integrated care in countries that depend on U.S. health aid, as all U.S. funding is revoked even if the organization in question also provides non-abortion related services and uses alternate sources of funding for anything that is abortion related (Rodgers 2018).

The effects of the GGR are sweeping and consequential, with ripple effects that stretch far beyond the scope of women's rights and reproductive health. It is statistically clear that the policy achieves the opposite of its intended effect of decreasing abortion rates, and burdens women and healthcare systems in countries that are highly exposed to the policy by reducing funding for family planning and reproductive health services (Bendavid, Avila, and Miller 2011, 873). Importantly, the U.S. is the largest global health donor in the world, with their total contribution to family planning and reproductive health in 2019 being \$608 million USD per year (Kaiser Family Foundation, 2019). The overall amount of funding that the U.S. provides for global health is many times this amount, reaching about \$10.8 billion USD per year in 2018 (Schaaf et al. 2019, 5). The scope of the GGR has wide reaching implications for global health, as funding is lost from the U.S. that would normally contribute to diseases and public health efforts completely unrelated to abortion (Singh and Karim 2017, 387).

This thesis project consists of three parts—a context paper, a case study of Kenya, and a case study of Nepal. The context paper aims to explore the implementation and global impact of the GGR since its initial implementation in 1984, to the most expanded version, the Protecting Life in Global Health Assistance Act (PLGHA) in 2017. Part two explores the effects of the policy in Kenya. The case of the GGR in Kenya illustrates that in developing countries where resources to respond to public health issues are urgently needed, the policy causes critical losses to funding. The negative effects of the GGR on Kenyan politics, NGO abilities, social stigma, and health outcomes are abundantly clear, making it a prime case study in which to examine the outcomes of the policy. Part three focuses on Nepal, where the timing of the policy's institution under multiple U.S. presidents has slowed the implementation of the country's reformed 2002 abortion law. The GGR's institution in Nepal has violated the sovereignty of the Nepalese government and organizations to improve reproductive health indicators at a critical time, and in doing so has harmed reproductive and public health. Each of these papers culminates to the finding that the GGR has never functioned as an effective policy to reduce abortion, and instead has had numerous negative health effects in countries that rely on U.S. health funding. The GGR not only causes harm to women but to global health outcomes in general, signaling that it is an ideologically based policy which goals would be better realized by increasing funding to family planning and global health efforts.

Part I: Context

The Global Gag Rule: How does it affect reproductive and public health?

Women's reproductive health and rights have long been a topic of debate, both domestically in the United States and globally. The topics of family planning resources and abortion continue to spark great controversy today, and women globally do not have a guarantee that they will have access to vital reproductive health services. The Global Gag Rule (GGR), is a policy that greatly affects this issue, and has been since it was first implemented by President Reagan in 1984. The GGR is also known as the Mexico City Policy, which is where it was first introduced by Reagan (Crane and Dusenberry 2004, 128). In essence, the GGR revokes all U.S. foreign aid to NGOs which provide any abortion counseling or services, or that lobby for abortion rights in their country (Crane and Dusenberry 2004, 128). The only exceptions made to the policy are in cases of rape, incest, or if the mother's life is in direct danger (Crane and Dusenberry 2004, 128). Over the last 37 years, the policy has been rescinded and reinstated strictly along political party lines, with each republican president reinstating it, and each democratic president rescinding it, usually within their first few days in office (Bendavid, Avila, and Miller 2011, 873).

The GGR has built on the Helms Amendment and Hyde Amendment, both of which were policies passed by congress in 1973 and 1976 respectively that restricted abortion funding. The Hyde Amendment prevents federal funds from being used to provide abortions domestically, while the Helms Amendment limits U.S. funds from being used internationally to perform abortion, both with the same few exceptions as the GGR (Ernst, Katzive, and Smock 2004, 16). The GGR expanded the Helms Amendment by not only preventing U.S. aid from being used to fund abortion services internationally, but by restricting NGOs from providing abortion services at all if they wanted to receive funding from the U.S. (Rodgers 2018). This means that if an NGO also provides non-abortion related services and uses sources of funding other than the U.S. for anything that is abortion related, under the GGR all U.S. funding from that organization is still revoked (Rodgers 2018).

The effects of the GGR are sweeping and consequential, with ripple effects that stretch far beyond the scope of women's rights and reproductive health. The scope of the policy has wide reaching implications for global health, as funding is lost from the U.S. that would normally contribute to diseases such as "Zika virus, Ebola virus, tuberculosis, and AIDS" (Singh and Karim 2017, 387) if the same NGOs also provide any abortion and family planning related services. I argue that the GGR is empirically ineffective in reducing abortion, and not only causes harm to women but to global health outcomes in general, signaling that it is an ideologically based policy which goals would be better realized by increasing funding to family planning. Because there are a limited amount of quantitative studies on the effects of the GGR throughout its implementation, it is difficult to assess the exact and comprehensive effects of it globally. However, from the studies that do exist, it is clear that the policy does not achieve its desired outcome and instead negatively affects both women's and public health. In the sections that follow, I first examine the international political economy of the GGR, in order to better understand the unique effects that economic and political policies have on women, and to place the GGR in the context of the political economy of health. The greatly influential role of the U.S. in women's global reproductive health is outlined, and I discuss the greatly expanded GGR under the Trump administration in order to examine the implications of this much broader policy.

Finally, the last two sections focus on women's reproductive and public health outcomes under the GGR, which empirically show that the policy accomplishes the opposite of its intended effect, and has negative public health repercussions which fall under a far wider scope than abortion access.

The international political economy of the GGR and women's reproductive health

The political economy of health, and specifically women's health, tends to be an underdeveloped field of research within the field of international political economy. There are relatively few articles that develop understandings of the linkages between global political and economic structures and women's reproductive health outcomes. Primary frameworks which can be used to view the GGR through the lens of include the effect of neoliberalism and capitalism on health outcomes and economic and political policies' specific effects on women. This section is devoted to examining these unique effects of economic and political policies on women's health, and examines the political economy of health in the context of the GGR.

Capitalism and neoliberalism have unique effects on health outcomes for the world's population, and are relevant as the world becomes highly interconnected and globalized. This relationship continues to be under researched, while "political and international studies increasingly have paid attention to the political and policy dynamics of health, yet the global political economy of health remains piecemeal and largely underdeveloped" (Sell and Williams 2020, 2). From the time of the industrial revolution, working class individuals and the poor consistently face a lack of access to health resources, and as a result on average have worse health outcomes and shortened life expectancies than their economically better off peers (Sell and Williams 2020, 3). Multinational Corporations in the capitalist system also play a role in this issue, with workers, especially women, often facing working conditions that adversely affect their health (Hippert 2003, 861). Multinational corporations can have intense effects on women's health, particularly as they participate in the "race to the bottom," meaning that they move from country to country in search of the most relaxed labor standards and regulations while maximizing their own profits at the expense of the individuals who they employ (Schrecker 2020, 31). Inequality to some extent is inevitable in a capitalist system, but the growing income inequalities globally in combination with factors such as gender and race result in the subjugation of many people's health, particularly women. Sell and Williams argue that "the populations affected by many diseases are simply too poor to constitute effective market demand that would supply a pull mechanism for their health needs to be met" (2020, 13). This perspective is certainly relevant to the GGR, as the women most affected by it are often poor and live in mainly rural areas, in countries that many of the presidents who have reinstated it will never step foot in. For this reason, market systems which further exacerbate inequalities can have profound health effects.

Related to this, there are numerous unexpected effects that policies related to globalization and capitalism can have on health outcomes. Income inequality greatly contributes to this, as do austerity measures and structural adjustment policies. The "poverty trap" (Schrecker 2020, 27) of global health is a persistent issue, and affects vulnerable populations with the greatest force and consequences. Economic and political policies related to health often have disproportionate effects on the most vulnerable populations of a country, making it important to consider the actual versus intended effects of policies related to public health. Multiple authors in this field agree that there is a gap in the literature of the political economy of health, and a need for more

research on this topic in order to be able to better theorize and create further frameworks through which to discuss it (Schrecker 2020; Sell and Williams 2020).

The everyday political economy of health, written about by Nunes (2020) is another helpful framework from which to conceptualize the GGR. Writing about the Zika outbreak in Brazil from this framework, she described the Zika crisis as an “epidemic of the poor,” which relates back to the idea of vulnerable populations' health being greatly impacted by political and economic policies, often in ways that are not considered before implementing the policy in question (Nunes 2020, 148). The everyday political economy of health is focused on four different components; “an understanding of power as the production of unequal life conditions and chances; a nuanced view of agency; the value of intersectional analysis to unpack the effects of power and the possibilities for agency; and the recognition of the mutual constitution of the local and the global” (Nunes 2020, 152). This framework takes into account the different identities and lived experiences which cause political, economic, and social policies to have varying effects on individuals. Intersectionality plays an important role in the political economy of health, as different populations are more adversely and differently affected than others. Women are often marginalized in society and face economic and social disadvantages, which increases when women or women identifying individuals have multiple identities that put them at even greater risk of getting the care and rights that they need (Nunes 2020, 160). For this reason, women are constantly forced to negotiate for their rights and bodily autonomy (Petchesky 1998, 188). It also lends itself to examining the GGR, as women are a population that tend to face more barriers to accessing health resources, and are burdened by restrictions to family planning, reproductive health, and abortion access. Policies such as the GGR cannot be properly examined or critiqued without first acknowledging the unequal ways in which they interact with different populations.

Turning to frameworks that take into account economic policies' unique effects on women, economists contend that women's empowerment has the potential to increase development and create better health and societal outcomes not only for women, but for all of society (Duflo 2012, 1052). Duflo argues that women's empowerment may not be a “magic ticket” to development, but that by prioritizing the specific needs of women this can lead to greater development and highly benefit women's health and economic standing (2012, 1053). Economic policies and social norms such as education, financial autonomy, a later age at first marriage, and access to family planning are all incredibly important to women's health outcomes and have the power to increase maternal mortality and other valuable health indicators (Duflo 2012, 1059). Neoliberal policies can have unforeseen effects on women's health specifically—“Some have viewed Eastern Europe and Central Asia as 'test regions' for judging the impact of neoliberal policies. Rather than revealing positive effects of market reform, almost all the countries in these regions have exhibited regressions in women's economic and social status” (True 2010, 51). These arguments make it evident that it is highly important to examine the political economy of health from a perspective that takes into account unique effects of policies on women, while also judging the effects of capitalism and neoliberalism. For these reasons, it is vital to craft and evaluate health policies such as the GGR from this standpoint.

There are also significant effects on women's reproductive health from political policies, which similarly to economic policies affect women in unique ways. There is often not adequate funding and political commitment to women's health resources, and more marginalized groups such as

indigenous and rural women suffer greatly, bearing the greatest cost of this issue (Mills 2006, 512). Mills also discusses the importance of global networking in order to build international norms and coalitions regarding women's health (2006, 492). Without unequivocal political commitment to protect women's reproductive rights, their health is at stake and critical needs are often left unmet. The very existence of the GGR signals the fragility of women's rights globally, as it can either be rescinded or reinstated every four to eight years with drastic effects for NGOs' funding and women's health outcomes. This is further evidenced by women's reproductive rights not being sufficiently protected by international law, and prominent states such as the U.S. not signing on to conventions that do attempt to enumerate them. The Convention on the Elimination of All Forms of Discrimination (CEDAW), is a prime example of this, which the U.S. has not ratified partly due to its language surrounding reproductive rights (McGovern et al. 2020, 55).

The role of the United States in women's global reproductive health

The amount of funding that is contributed to global health by the United States is unmatched by any other donor, and thus policies such as the GGR that cause interruptions to that funding have wide reaching impacts. In addition to funding, the U.S. has considerable influence over international norm building and sentiment regarding women's right to abortion and reproductive health services. This makes the growing anti-choice sentiment in the U.S. and the partisan tradition of the GGR increasingly impactful and alarming for women's global reproductive health.

The U.S. plays an integral role in women's reproductive health and the domestic policy of the U.S. on reproductive rights is consequential not only to women domestically, but globally as well. The United States contributes the most foreign aid to family planning and global health initiatives, with their total contribution to family planning and reproductive health in 2019 being \$608 million USD per year (Kaiser Family Foundation, 2019). The overall amount of funding that the U.S. provides for global health is many times this amount, reaching about \$10.8 billion USD per year in 2018 (Schaaf et al. 2019, 5). Consequently, funding from the U.S. in this sector provides a significant amount of public health resources to the international community. For example, in Sub-Saharan Africa, one of the most vulnerable regions to a lack of family planning and reproductive health resources, the U.S. is the main source of funding, "providing an average of 30% of all FPRH aid between 1995 and 2014" (Brooks, Bendavid, and Miller 2019, 1050). The U.S. contributes such a large amount of funding for global health that it is difficult to replace the same amount through other donors and channels during periods of time in which the GGR is in effect (Brooks, Bendavid, and Miller 2019, 1050). During the Bush administration the United Nations Population Fund (UNFPA), which is only one aspect of global health funding that the U.S. contributes to, lost more than \$244 million in funding because of the reinstatement of the GGR (Singh and Karim 2017, 387).

Looking back at the complicated history of family planning and abortion ideology in U.S. politics, a landmark moment is the 1973 *Roe v. Wade* decision. The *Roe* decision was a significant statement of a woman's right to abortion and to have autonomy over her own body, and worked internationally to advance the idea of women's equality (Ernst, Katzive, and Smock 2004, 1). However, as Ernst, Katzive, and Smock argue, from the moment that the *Roe* decision was handed down, attacks on women's right to abortion both domestically and globally have greatly increased and in many ways have led to regression in the U.S. on this issue (Ernst,

Katzive, and Smock 2004, 2). In 1992, almost 20 years after *Roe*, the *Planned Parenthood v. Casey* decision weakened the *Roe* precedent by upholding restrictive provisions such as a 24 hour waiting period that the state of Pennsylvania had implemented (Ernst, Katzive, and Smock 2004, 14). This growing anti-choice sentiment has proliferated every republican administration since Reagan and led to the most recent and vastly expanded iteration of the GGR—Trump’s *Protecting Life in Global Health Assistance*. There are also a growing number of highly conservative abortion laws in U.S. states, such as the Texas law which prohibits abortion after six weeks, notably with no exceptions made for pregnancies that are a result of rape or incest (McCammon 2021). These domestic policies have extreme ramifications for women’s reproductive health globally, as other countries often depend on the U.S. for funding on this issue and are influenced by domestic political decisions. Other countries are influenced by U.S. actions on this issue because “Foreign governments and nongovernmental organizations who depend upon U.S. assistance for survival have every incentive to implement policies within their own countries that will not offend the U.S. government and jeopardize their funding” (Ernst, Katzive, and Smock 2004, 25). As a result of the GGR, NGOs are forced between choosing to lose funding that allows them to carry out their intended mission, or to attempt to continue with their original mission of providing full reproductive health services while losing key funding from the U.S. to do so.

As the U.S. has become increasingly unreliable for stable funding for family planning and abortion services since the first instatement of the GGR in 1984, other countries and actors have attempted to make up for the resulting gaps in funding. Following Trump’s PLGHA implementation, “357 world leaders issued a high-level statement which asserted that the global gag rule would “reverse decades of progress on reproductive, maternal and child health by putting critical health and family planning services and supplies out of reach for those who most need them” (Bingenheimer and Skuster 2017, 280). Because the GGR violates many country’s domestic policies involving abortion, including the U.S. itself, the global reaction to its reinstatement under Trump was one of condemnation (Singh and Karim 2017, 387). Countering the GGR, other countries and organizations have stepped in such as the Netherlands, Sweden, and the organization *SheDecides* (Opondo 2020, 66). Although efforts have been made to counter the loss of funding from the GGR, because of the magnitude of funding that the U.S. normally provides, the impact of the policy is still greatly felt by women globally, and is not fully compensated for by other actors.

The GGR has been referred to by many authors as a “partisan tradition” (Bendavid, Avila, and Miller 2011, 873; Greer and Rominski 2017, 1), as Reagan, Bush, and Trump have each reinstated it, while Obama, Clinton, and Biden have each rescinded it. This speaks to the origins of domestic abortion policy and debate in the U.S., which came into increasing political focus in the 1970s under Reagan and the Christian Right, which was a central force in originally passing the GGR and lobbying for abortion restrictions globally (Gezinski 2012, 839). This makes it clear that the anti-choice sentiment in the U.S. has been growing from the time that *Roe v. Wade* was first decided, and remains a contentious issue between the right and left today. While Biden has not been in office long enough to accurately or quantitatively observe the effects of the latest rescindment of the GGR, under both the Clinton and Obama administrations it was clear that abortion rates decreased in highly exposed countries when the policy was rescinded, and increased when it was in effect (Brooks, Bendavid, and Miller 2019, 1051). Further corroborating this trend, “quantitative evidence suggests that country-level abortion rates

increased when the Bush administration’s GGR was in effect in countries that received large amounts of U.S. foreign aid, and these rates subsequently decreased during the Obama administration” (Giorgio et al. 2020, 2). In the following sections of this paper, I will discuss the effects of the GGR for both women and general public health in greater depth, as these findings and history make it clear the great influence that the GGR and U.S. ideology have on the global stage.

Trump’s Protecting Life in Global Health Assistance (PLGHA) and the increasing fragility of women’s rights and health security

The extreme expansion of the GGR to the Protecting Life in Global Health Assistance (PLGHA) under the Trump administration greatly increased the amount of global health funding effected under the policy, and caused more widespread health effects as a result—including public health threats such as HIV. This expanded policy is indicative of the growing polarization and extremity of U.S. domestic politics, and their negative effect on the international community and women globally.

During the Trump administration, the GGR was significantly expanded to encompass all global health funding rather than only family planning, and was renamed Protecting Life in Global Health Assistance (PLGHA). This greatly increased the amount of organizations that were mandated to comply with the policy or lose their U.S. funding, and consequently the amount of funding that was vulnerable to being lost under the policy also greatly increased (Starrs 2017, 486). The PLGHA, instituted in 2017, affected approximately \$10 billion USD in funding each year that contributed to global health assistance, while family planning funding made up only approximately \$600 million of that annual budget (Starrs 2017, 485; Rodgers 2018; Greer and Rominski 2017, 1). This means that a higher number of global health NGOs than ever before were forced to decide between signing the PLGHA or losing their U.S. funding, even if their main focus was for example malaria, tuberculosis, maternal health, or HIV/AIDS—not abortion services (Starrs 2017, 485). This was a departure from earlier versions of the GGR that existed under the Reagan and Bush administrations, as it had a vastly more widespread effect in terms of the NGOs that it effected and the total amount of funding involved. Another key aspect of the PLGHA is that its restrictions also applied to foreign NGO subgrantees, meaning that if funding that at any point came from the U.S. went to an NGO even indirectly, they were also bound under the restrictions of the policy (McGovern et al. 2020, 54). This addition to the policy occurred in 2019, which expanded the PLGHA to “both prime and sub-awardees...any NGO receiving US global health assistance is prohibited from providing financial support to another NGO that fails to meet the strict guidelines regarding abortion” (Hunter, Hubner, and Kuczura 2021, 351). As is made clear from these expansions of the rule, the movement of the U.S. to anti-choice and the far right on matters of reproductive health and women’s rights advanced under the Trump administration but was the culmination of decades of anti-choice sentiment. This is clear from the existence of the Helms Amendment and Hyde Amendment discussed earlier, the *Planned Parenthood v. Casey* decision, and the ideological divide between presidents reinstating and rescinding the GGR.

By widening the scope of the GGR, Trump’s PLGHA consequently has even more varied public health repercussions than the policies which preceded it. A prime example of this is the President’s Emergency Plan for AIDs Relief (PEPFAR), which was created under the Bush

administration to combat the HIV/AIDS crisis internationally (Bingenheimer and Skuster 2017, 285). Because the GGR has impacted health care beyond abortion services in the past such as family planning, it is highly likely that the PLGHA will impact other health services and programs such as PEPFAR (Bingenheimer and Skuster 2017, 285). If PEPFAR were to lose funding and resources, this would mean that “new HIV infections and AIDS-related deaths that could have been averted will occur, and potential declines in the incidence and prevalence of HIV will not take place” (Bingenheimer and Skuster 2017, 285). It becomes abundantly clear that when funding is lost because of the PLGHA, funding for abortion services is rarely the only thing effected, and many other aspects of NGOs’ operations can be negatively impacted as a result. Because the U.S. contributes such a large amount to global health assistance, “loss of income resulting from a foreign NGO’s decision not to certify PLGHA can result in funding as well as referral disruptions beyond the funding stream/activities subject to the policy” (Schaaf et al. 2019, 5). These disruptions are personally felt by individuals globally, for whom a loss of services in health care creates great disadvantages.

The expanded GGR under Trump, and his very election, are indicative of the growing polarization in U.S. politics that has created a far right and a far left, with little room left to negotiate ideological differences in the middle. This polarization and growing conservatism has real impacts for women’s reproductive rights as well as general public health resources, which is made clear by the huge scope of the PLGHA. The Trump administration’s mercantilist and nationalist view of foreign aid is an example of this, and makes clear the fragility of women’s reproductive rights—which without sufficient protections are left vulnerable on the ballot every four years (Starrs 2017, 486). There continues to be a growing disconnect between the values that the U.S. espouses to the rest of the world, particularly to developing countries, and what the U.S. government’s actual actions involve. “The US government’s assault on human rights, particularly in sexual reproductive health and rights (SRHR), is not new with the Trump administration, but his administration has demystified the U.S. human rights and democracy myth to levels never seen before” (Opondo 2020, 65). The PLGHA makes evident the divide between the human rights, global health, and development commitments that the U.S. has long promoted, and the effects of U.S. policy in action. For example, both the GGR and PLGHA undermine international goals and norms, such as the Sustainable Development Goals, Millennium Development Goals, and CEDAW (Bingenheimer and Skuster 2017, 287). However, it is important to note that the right to abortion is not explicitly protected in international agreements or goals, including the Sustainable Development Goals or Millennium Development goals (McGovern et al. 2020), 56). They both mention improving maternal and reproductive health, but do not explicitly promote the right to abortion, which is extremely problematic as many maternal deaths are caused by unsafe abortions (McGovern et al. 2020), 56). The refusal of the international community to enshrine the right to abortion in official discourse is important to discuss as it allows the fragility of women’s reproductive health to continue on a global scale.

Effects on reproductive health and abortions from the GGR: Does it accomplish its goal?

When examining the effects of the GGR on induced abortion rates and reproductive health outcomes, the results are clear—abortion rates increase under the policy in countries that lose substantial funding, and other reproductive health metrics are worsened as well. In this section, I will outline the reasons for this contradiction with the intent of the policy, and examine what other unintended effects arise as well such as increased HIV/AIDS risk and maternal mortality.

Contrary to the stated intention of the GGR, the policy has been shown to actually increase the prevalence of abortions in effected countries rather than reduce it, thereby making it both an ineffective and dangerous policy. There have been a limited amount of quantitative studies published on the effects of the GGR on abortion rates and reproductive health, however the studies that have been done do not show a decrease in abortions when the policy is in effect. In a 2011 study by Bendavid, Avila, and Miller, the authors measured the likelihood between 1994 and 2008 of women in Sub-Saharan Africa getting an abortion and found that the abortion rate rose after the policy was reinstated by the Bush administration in 2001 (873). The study concluded that “the induced abortion rate increased significantly from 10.4 per 10 000 woman–years for the period from 1994 to 2001 to 14.5 per 10 000 woman–years for the period from 2001 to 2008 (P=0.01). Although the trend changed gradually, the timing of the rise is consistent with the reinstatement of the Mexico City Policy in early 2001” (Bendavid, Avila, and Miller 2011, 876). Furthermore, this effect was found to be more pronounced in countries that were highly exposed to the GGR, meaning that they received a large amount of funding from the U.S., rather than in countries that did not receive as much funding and were subsequently less affected by the reinstatement of the policy (Bendavid, Avila, and Miller 2011, 873).

Other studies and research on this topic corroborate these findings, with Schaaf writing that “Women living in countries defined as heavily exposed to the Mexico City policy had 2.55 times the odds of self-reported abortion compared with women living in less exposed countries” (2019, 3). Furthermore, in research by Rodgers in which she examined Demographic and Health Survey data from 1994 to 2008 in 51 developing countries, she found that the policy increased the likelihood of abortion in Latin America and the Carribean by three times for women who were in highly exposed countries when compared to women “in less exposed countries before the policy was reinstated” in 2001, as well as in Sub-Saharan Africa by two times (Rodgers 2018). She also researched Eastern Europe, Central Asia, and South and Southeast Asia. Her findings here were mixed, in that abortion rates did fall after the 2001 reinstatement of the policy in these places, but there were other factors such as increased funding from other donors which led to difficulty establishing direct causation from the GGR (Rodgers 2018). In another study on the effect of the GGR in 26 Sub-Saharan African countries by Brooks, Bendavid, and Miller, the authors found that abortions increased while the policy was in effect, as contraception declined by 13.5% and pregnancies increased by 12% during these same time periods (Brooks, Bendavid, and Miller 2019, 1052). Importantly, they also found that this trend reversed during administrations in which the policy was no longer in effect, which points to a strong relationship between these effects and the GGR itself (Brooks, Bendavid, and Miller 2019, 1052). With all of this in mind, it is clear that the GGR does not achieve its goal of consistently reducing the prevalence of abortion internationally, and in fact appears to increase the likelihood of induced abortions.

The reason that has been discussed by many authors for this reverse effect of the GGR is that often many of the same NGOs that provide abortion services or counselling also provide family planning resources. This means that when the GGR is in effect, women end up losing access to contraceptives and family planning education because the same NGOs that provide those services have lost funding that not only goes to abortion services, but to family planning tools as well (Schaaf et al. 2019, 8). Examples of effects that occurred during the PLGHA were clinic closures, staff layoffs, decreases in HIV testing, and reduced numbers of community health workers (Schaaf et al. 2019, 9). Kenya is another example of the effects on overall reproductive health services from the GGR. Their largest sexual and reproductive health provider, Family

Health Options Kenya, lost 60% of their funding under the PLGHA (Opondo 2020, 66). In Uganda under the PLGHA, the main effect that was found to be statistically significant was a reduction in community health workers (Giorgio et al. 2020, 1). The authors predicted that this was because they studied the effects of the policy less than a year into its implementation, and that further effects were likely to develop if the policy stayed in place. They also noted that the decrease in the number of community health workers was important to note, as this had high potential to “reduce contraceptive use and increase unintended pregnancies in Uganda” (Giorgio et al. 2020, 1). In a 2015 quantitative study on the effects of the GGR in Ghana, Jones found that rural and economically disadvantaged women were the most adversely affected by the policy, revealing the intersectionality of the issue as well (41). Similarly to Opondo and Giorgio, Jones found that “the primary impact of the policy was to close clinic locations and force cutbacks in outreach services, reducing access to contraceptives primarily in rural areas” (Jones 2015, 41). Contraceptive access issues already commonly exist in developing countries, such as supply chain bottlenecks and cultural issues of what method women will use in different areas versus what is actually available to them (Mukasa et al. 2017, 384). The GGR worsens these already existing issues by further reducing vital funding and resources. The loss of family planning resources that result from the GGR helps to explain the effect of increasing abortions, as well as other negative health effects for women such as declining maternal health.

Maternal health is another important reproductive health outcome to consider, as much of the funding lost from the GGR and subsequent clinic closures, staff layoffs, and unexpected pregnancies can also lead to poor maternal health. An increase in abortion under the GGR because of a lack of contraception can cause a “greater risk of unsafe procedures and long-lasting complications, in a setting that already has very high maternal mortality” (Jones 2015, 66). On average, women also have healthier pregnancies and children when their births can be spaced farther apart (Gates 2019, 73). Thus, the GGR can also cause higher birth intervals by resulting in decreased access to contraception and more frequent pregnancies (Greer and Rominski 2017, 1). This can also lead to worsened maternal health, as well as higher rates of child malnutrition due to families not being able to adequately care for unplanned children (Greer and Rominski 2017, 1). Furthermore, one of the most common causes of maternal mortality is unsafe abortions, which increase under the GGR in highly exposed countries as they become more difficult to obtain safely (Rodgers 2018).

The chilling effect of the GGR is another common reproductive health issue that is discussed in much of the literature on this topic, meaning that organizations face ambiguity and confusion over what actions do or do not violate the policy. Organizations are often concerned about losing their funding from the U.S. by unintentionally violating the policy after signing it (Crane and Dusenberry 2004, 132). This can result in NGOs going beyond the scope of the GGR out of an abundance of caution, and therefore cutting even more services and actions than necessary. Common effects of this include NGOs to be “less likely to engage in outreach activities, pursue partnerships with other organizations, or provide certain kinds of SRH services, such as post-abortion care” (Giorgio et al. 2020, 6). This means that more services, outreach, and education are lost because of the GGR’s unclear scope to many NGOs. The chilling effect may also be referred to as “self-censorship” (McGovern et al. 2020, 58), and some NGO leaders have stated that they feel as though the language of the policy is purposely ambiguous, so as to cause organizations to self restrict out of fear of losing funding even when they are already technically compliant with the policy (McGovern et al. 2020, 58). The GGR and PLGHA have also caused a

chilling effect for abortion related research, which is one of the reasons that there are so few quantitative studies about it. In turn, this also causes the data concerning the number of abortions, both safe and unsafe, to likely be inaccurate and underreported (McGovern et al. 2020, 59). The chilling effect is another example of the GGR's wide reaching ramifications in women's reproductive health outcomes, both for research on this topic as well as actual care.

Public health and the GGR: Ripple effects beyond reproductive health

The GGR's wide reaching impacts create effects that stretch far beyond women's reproductive health and abortion access. When examining the effects of the policy, it becomes clear that many other public health risks including HIV/AIDS, Zika, Ebola, and children's health outcomes are also negatively affected. Finally, the Covid-19 pandemic in combination with the GGR has also created worsened public health outcomes as a result of the loss of funding.

Beyond women's and reproductive health, the GGR's funding restrictions place a burden on NGO funding that leads to broader public health risks. As discussed earlier, many of the same care providers that provide abortion services also provide a myriad of other health services for their community as well. This is particularly prevalent in many developing countries, which are also the most exposed to the effects of the GGR. These organizations often "provide integrated health services; for instance, they offer patients contraceptive care, HIV prevention or treatment, maternal health screenings, immunisations, and information on safe abortion care all under one roof" (Starrs 2017, 486). Because of this, when funding is taken away when organizations refuse to sign the GGR, all of their services are impacted, not only abortion. In turn, men, women, and children's health can all be negatively impacted. The PLGHA had an even greater effect, as it applied to more organizations and funding than past versions of the policy (Starrs 2017, 486; Singh and Karim 2017, 387). Many different effects of the policy have been noted, including clinic closures and staff layoffs, and this is particularly important in places where there may only be a single clinic within reasonable traveling distance (Starrs 2017, 486).

Because the GGR was expanded under Trump to the PLGHA and encompassed all global health aid from the U.S., previous public health programs that had been put in place with bipartisan support were also put in jeopardy. This includes many programs that were put into effect even as the GGR was in place under the Bush Administration that worked to fight HIV/AIDS, Malaria, and Tuberculosis (Singh and Karim 2017, 387). After rescinding the GGR, Obama kept all of these programs in place and also expanded public health assistance to include reproductive health and other diseases (Singh and Karim 2017, 387).

Zika and Ebola viruses are another prevalent example of public health issues that arise from the GGR which have effects for all of society (Singh and Karim 2017, 387; Greer and Rominski 2017, 1; Starrs 2017, 485). Zika is especially related to the GGR as it can cause birth deformations and maternal health issues, which as Nunes notes are already neglected public health issues. This makes it clear that the response to Zika is often inadequate and creates further risks as the epidemic is not sufficiently treated (Nunes 2020, 148).

Children's health is another health outcome that the GGR can have detrimental effects on. Children's growth metrics in Ghana for their height and weight were "negatively associated with the 2001 reinstatement of the Mexico City policy" (Schaaf et al. 2019, 4), likely due to women

being forced to have more pregnancies than they had planned because of a reduction in family planning resources from the GGR. This results in families not having adequate resources to provide the nutrition and care that all children need to be healthy and thriving (Jones 2015, 66). These public health effects stretch far beyond the intended scope of the GGR and women's reproductive health, and clearly present a threat to general public health in affected countries.

The Covid-19 crisis is another factor which has made the GGR's wide-reaching and negative effects increasingly clear. The pandemic has created additional barriers for patients who already experienced difficulty obtaining adequate care, and particularly affected contraception and reproductive health access. Many countries did not classify reproductive health services as essential during Covid-19, and as a result of further deprioritizing this care, many women suffered the consequences (Ghosal and Anna 2020). Marie Stopes International, a reproductive health NGO that works in 37 countries, announced that 9.5 million women are at risk of losing access to health services during the pandemic (Marie Stopes International 2020). This means that this lack of vital care could result in "3 million unintended pregnancies, 2.7 million unsafe abortions, and 11,000 pregnancy-related deaths" (Marie Stopes International 2020). In Kenya, these effects are very real, with some women being so desperate to get an abortion that they are either dying from unsafe abortions or are willing to take their own life (Hunter, Hubner, and Kuczura 2021, 351). As a result of this crisis, compounded with an already difficult reproductive health situation because of the GGR, women are greatly lacking access to care, which has ripple effects for public health as maternal deaths increase and HIV services and sexual health care decrease (Hunter, Hubner, and Kuczura 2021, 354). This issue makes it abundantly clear that "in global health interventionism and international aid mechanisms, there are no gender-neutral policies" (Hunter, Hubner, and Kuczura 2021, 355). From examining these health outcomes, the data on this issue shows that the GGR and PLGHA have multiple and significant adverse impacts on both reproductive health and public health as a whole.

Conclusion

When researching the impact of the GGR on reproductive and global health, the gap in the literature on this subject is apparent. Particularly in terms of quantitative and peer-reviewed studies, there were only a handful of articles that quantitatively assessed the impacts of the policy on both women and general public health outcomes. However, the studies that have assessed this impact and which I have discussed throughout this paper have unanimously shown that the GGR both does not accomplish its intended goal of decreasing the amount of abortions globally, but rather can cause increases in abortion rates due to a loss of family planning resources. Importantly, it has also been shown to negatively impact general public health outcomes. This is because the funding from the U.S. that is put at stake by this policy goes far beyond abortion services, and therefore has much broader implications. Because there is clear data that the policy does not work to decrease abortions, there is no quantifiable or rational reason to keep it in place. If policy makers genuinely wanted to decrease abortions globally, the studies discussed in this paper unequivocally show that investing funding and resources into family planning services and education, women's economic rights, and development would be a much more effective way to accomplish that goal. Instead, by each republican administration reinstating the GGR, and most recently under the Trump administration greatly expanding it, abortions do not decrease, and vulnerable populations lives are put at greater risk instead. It is time for this policy based purely on ideology rather than science to be permanently revoked. The international community must

also work to more greatly value women's bodily autonomy and livelihood to create norms and laws that work against the continued fragility of women's access to necessary health resources. A U.S. election every four years should not so greatly affect the lives of women many thousands of miles away, and the public health risks worsened by the GGR are too great to allow to continue.

Part II: Kenya Case Study

The Global Gag Rule in Kenya: Impact of an anti-abortion policy in an already fragile reproductive rights landscape

When examining the effects of the Global Gag Rule (GGR) in practice, Kenya is a prime case study because it is highly affected by the policy. Kenya is what would be defined as a highly exposed country to the GGR, as a significant amount of U.S. aid is channeled each year into various health activities and NGOs (Ushie et al. 2020, 26; Crane and Dusenberry 2004, 131). This means that when the GGR is in effect, the financial, social, and public health impacts are wide reaching and harmful for Kenyan citizens, as a large amount of funding is put at risk by the policy (Shahvisi 2018, 17). The U.S. is Kenya's largest bilateral aid donor to health initiatives, and various health indicators have been shown to improve when this funding is high (Shahvisi 2018, 14). Importantly, "In 1997-1998, donors provided 74 percent of Kenya's public health expenditures. In addition, USAID is the largest donor of reproductive health in Kenya" (Shahvisi 2018, 14). The U.S. remains an integral health funding partner to both Kenya and Sub-Saharan Africa today, with USAID contributing an average of over \$250 million to health programs per year in Kenya (USAID 2021). However when this funding is put in jeopardy by the GGR, not only abortion and family planning services are put at risk, but broader public health issues are as a whole. In Kenya specifically, the country "spends less than the average of sub-Saharan African countries for health while donor assistance and out-of-pocket expenditure for health are generally high" (Sidze et al. 2013, 140). This context makes Kenya a particularly dangerous situation for the GGR to be implemented in and creates even more fragility of women's reproductive and health rights.

The GGR greatly impacts the funding that contributes to health issues in Kenya, and has not only affected the service delivery of reproductive health services, but has also affected HIV/AIDS funding. The policy has "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" (Ushie et al. 2020, 23). The extreme health effects in Kenya are obvious, particularly because abortion is already a legally and socially divisive issue in the country (Ushie et al. 2020, 24). Induced abortion in Kenya is common, with an estimated half a million abortions occurring per year, which is likely an underestimate due to underreporting (Izugbara, Egesa, and Okelo 2015, 9). Accordingly, the health risks from the GGR are numerous, and the "connection between restrictive abortion laws and high rates of unsafe abortion" is extremely clear (Skuster 2004, 106). Women also commonly lack access to adequate family planning services in Kenya and unsafe abortion is a leading cause of maternal mortality in the country, making the GGR's effect even more important to understand in this context (Singh et al. 2013, 7). In 2012, it was estimated that 75% of abortions that occurred in Kenya were unsafe (Izugbara, Egesa, and Okelo 2015, 9).

Abortion and family planning stigma, rigid gender roles, financial and policy barriers, and the chilling effect of the GGR are all outcomes and complications related to this policy that continuously endanger and disadvantage women in Kenyan society, and which I will explore in this paper. I argue that in Kenya, where women lack adequate access to safe abortion and family planning and where the country is highly dependent on U.S. health aid, the GGR greatly

exacerbates these issues—making it a prime case to study the extreme reproductive and public health risks that the policy can cause and worsen in highly exposed countries. In the following sections, I will outline the effects of the GGR in Kenya on reproductive and public health, abortion and contraceptive stigma, and examine economic factors related to the policy within Kenya. When examining the effect of the GGR on Kenyan politics, NGO abilities, and the compounded effects of the Covid-19 pandemic, the failure and harm of the policy become abundantly clear. Conflicting political decisions and policies add to and interact with this crisis, and these factors culminate in women lacking access to vital care. In Kenya and other developing countries where resources to respond to broader public health issues such as HIV/AIDS are urgently and consistently needed, ideological policies such as the GGR further worsen these issues by causing losses in funding. Turning to social factors, the political and social influence of the GGR also worsens already existing stigma in Kenya surrounding abortion and reproductive health, signaling that there is not international support for women’s health. Finally, Kenyan women’s lack of economic independence worsens the effects of the GGR, as women face significant financial barriers to accessing the care they need, particularly in rural areas. In the case of each of these issues, if they weren’t created by the GGR, they are undoubtedly worsened by it—as are women’s and Kenyan society’s overall health outcomes.

What makes Kenya vulnerable to the GGR? The unique and exacerbated effects on Kenyan politics, NGO operations, and the Covid-19 pandemic

Women in Kenya are left particularly vulnerable to each different U.S. administration’s decision on whether the GGR will be reinstated or rescinded every four to eight years. As Sagala (2005) writes, “women’s access to sexual and reproductive health services become vulnerable to the moral and political whims of foreign powers” (173). Further complicating this issue, one of the most prominent reasons that Kenya remains dependent on foreign aid for health funding is in part due to damage to health and governmental systems as a result of colonization. Women in Kenya are particularly disadvantaged by these systems, as there is a critical dependence on both U.S. funding and NGOs for reproductive health services, which are both put in jeopardy by the GGR (Sagala 2005, 176). Hearn refers to this wide reaching U.S. involvement in Kenyan healthcare as the “NGO- isation’ of Kenyan society” (Hearn 1998, 90). Interestingly, the U.S. intentionally became a major health donor to Kenya through USAID and is highly integrated into the Kenyan healthcare system, which has caused each version of the GGR to have extreme and devastating impacts for Kenyan citizens (Hearn 1998, 90). The Helms Amendment already prohibited U.S. aid from going directly to abortion, but the GGR has greatly expanded this by extending the financial and organizational impact of the policy. A myriad of factors from colonization contribute to this issue, as “economies are often weak, which is a direct consequence of colonisation. Colonisation is also implicated in the other major cause of weak economies: fragile governance” (Sagala 2005, 176). Structural adjustment policies and women’s generally low economic independence and status also greatly disempower them and create an environment that is increasingly dangerous to their health and reproductive autonomy (Sagala 2005, 176). Sagala refers to the GGR in tandem with the history of colonization and economic subjugation in Kenya as a form of “moral imperialism” (Sagala 2005, 177) in which U.S. administrations force their own views and policy agendas onto women in developing countries. At the root of this issue, Kenya’s abortion laws and penal code were previously modeled after Britain’s, which the country was formerly a colony of (Skuster 2004, 76). Consequently, Kenya’s

original abortion restrictions were the result of colonization. Because of that colonization, Kenya continues to be financially dependent on the U.S. and other more developed countries for aid, which continues to restrict reproductive health access through foreign policy that contradicts the U.S. constitution itself.

In terms of the reproductive health political landscape within Kenya, the issue is complicated to begin with domestic politics alone, and is further complicated when the GGR is introduced to the mix. In 2010, a constitutional amendment was made that liberalized abortion in the country by decriminalizing abortion in certain circumstances (Skuster 2004, 76). The constitution reads that “Article 26(4) of the Constitution permits abortion if ‘in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law’” (Skuster 2004, 76). The Kenyan government did this in an attempt to improve Kenya’s high maternal mortality rates (MMR) from unsafe abortions, and these changes to the constitution reflected a commitment to improve women’s access to health resources (Opondo 2020, 64). Additionally, “Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion” were outlined by the government in order to make it clear to healthcare providers what reproductive healthcare and abortion services had been legalized (Opondo 2020, 64). Since the 2010 constitutional amendment, the Ministry of Health (MOH) and Kenyan government have had contradictory actions concerning reproductive health rights and the enforcement of the amendment, and many women are not even aware of the fact that abortion and post abortion care (PAC) are now legalized (Opondo 2020, 64; Izugbara, Egesa, and Okelo 2015, 10; Marlow et al. 2014, 156). A prime example of this contradiction was that in 2014, “the MOH arbitrarily withdrew the Standards and Guidelines with no explanation and banned the training of medical providers on safe abortion services. The MOH further threatened to take legal action against health professionals if they attended any abortion training, despite having earlier identified this as a critical need to reduce maternal mortality and morbidity” (Opondo 2020, 64). Although reproductive health had been identified as a priority by the Kenyan government itself, support was withdrawn a short time later and the MOH took a completely opposite stance (Opondo 2020, 64). This reflects the Kenyan government’s weak and often contradictory commitment to women’s reproductive health and access to abortion.

Because of Kenya’s strong involvement with international donors for healthcare funding, their government and policies are closely tied to international influences. As Opondo argues “on close examination, it was clear that the MOH was playing in tune with powerful voices behind the scenes even to the extent of disowning its own policy positions. One such powerful voice was that of USAID” (Opondo 2020, 65). Furthermore, there is very fragile political support for abortion and the prioritization of reproductive healthcare in Kenya. Without both political and financial support for policies that protect women, it’s very difficult to effectively provide women with adequate health services. The GGR clearly worsens this, as it further stigmatizes and prevents commitment to reproductive healthcare. As Crichton writes, “reproductive health policies are particularly vulnerable to weak political commitment, because they do not tend to have strong national support bases and have historically been controversial and perceived as driven by external actors” (2008, 340). Some advocates against the GGR argue that to the Kenyan government, the policy works as an “international cover” to further restrict women’s reproductive rights, or at a minimum to not work to improve them (Ushie et al. 2020, 26). Related to this, the GGR also has the effect of slowing any progress that activists or lobbyists

work towards in Kenya. Activists have been lobbying for more liberal abortion laws for multiple decades, which conflict with and are slowed by the GGR because of its increase of stigma and reductions in funding (Skuster 2004, 76).

Turning to the GGR's exacerbated effects on NGOs in Kenya, NGOs have faced a loss of service delivery, a loss of integration, the chilling effect on advocates and lawmakers, and disruption of health partnerships because of the policy. At times when the GGR is in effect, many NGOs in Kenya close or operate at a smaller scale due to the loss of funding (Skuster 2004, 120; Gezinski 2012, 843). NGOs provide vital care in Kenya where the public and private sector fall short, making this a highly relevant piece of the issue to study. NGOs in Kenya offer services far beyond abortion, as they also provide "health education, community health and HIV/AIDS services in the rural areas and the urban poor" (Shahvisi 2018, 18). Because the country receives a high amount of funding for health care, much of which is channeled through international NGOs, the GGR has profound effects on the availability and quality of care in Kenya. Funding losses from the GGR in Kenya to organizations that would not sign the policy "forced the Family Planning Association of Kenya (FPAK) to close clinics serving 19,000 clients and Marie Stopes International Kenya (MSI Kenya) to close clinics serving 300,000 clients" (Gezinski 2012, 843). Many other organizations have been impacted by the GGR as well as the expanded PLGHA under Trump, and services that are impacted stretch far beyond abortion (Gezinski 2012, 843). This is important to note, because when health indicators such as maternal mortality, unsafe abortion, and access to contraception are already low, a policy such as the GGR significantly worsens these outcomes by decreasing crucial care that is already in short supply. In a study by Ushie (2020) on the effects of the PLGHA in Kenya, the authors found that all NGOs that they studied in Kenya, as well as the public and private health system as a whole, were negatively impacted. For example, the PLGHA caused the "fragmentation of sexual and reproductive health and HIV services, and closure of some service delivery programmes" (Ushie et al. 2020, 23) as well as staffing shortages and frequent contraception stockouts.

Furthermore, the integration of care within many NGOs that has been disrupted by the GGR is another important component in Kenya to examine. Many Kenyan health NGOs have integrated their care in an attempt to reach more clients efficiently—offering abortion, family planning tools, pap-smears, and HIV/AIDS testing all at one location (McGovern and Tamang 2020, 2; Shahvisi 2020, 20). However, the GGR has caused this to diminish as it halts the integration of care no matter what, as organizations either lose funding from not signing it, or lose services they would normally offer if they choose to comply (Sagala 2005, 179). There are consequences of both signing and not signing the GGR for NGOs in Kenya, and for NGOs that sign the GGR "a heavy price must be paid in their inability to provide women with unwanted pregnancies with appropriate services or counselling, or advocate for women's access to safe abortion care" (Crane and Dusenberry 2004, 132). Adding to these complications to NGOs is the chilling effect of the policy, which is compounded in Kenya by both the vagueness and reach of the GGR, as well as the confusion of the MOH's actions and stance on abortion and family planning. One issue is that the GGR is often overinterpreted by both care providers and patients when it is in effect (Skuster, Khanal, and Nyamato 2020). Examples of these instances include "during the Reagan GGR, an abortion provider in Kenya needed clarity on the permissibility of abortion for a woman living with AIDS, and another questioned if a woman verified by a psychologist to be at risk of committing suicide due to an unwanted pregnancy classified as a case of life endangerment"

(Mavodza, Goldman, and Cooper 2019, 5). While these cases clearly are examples of situations in which a woman's life is in fact in danger, care providers have often been shown to fail to provide care out of fear of breaching the policy. This is also due to the fact that the GGR is not often properly explained to the organizations and patients that it effects, with over 64% of clinicians who signed the policy under the Reagan administration reporting that the policy "had never been explained to them" (Mavodza, Goldman, and Cooper 2019, 5). Without providers being informed of what care they can and cannot provide, this can lead to misunderstanding or unnecessary overinterpretation of the policy (Ushie et al. 2020, 30).

Another important factor of the GGR to consider in Kenya is the Covid-19 pandemic. Covid-19 and the implementation of the PLGHA under the Trump administration created an even more dangerous health environment for Kenyan citizens. Lockdowns in Kenya resulted in many women no longer having access to abortion and family planning care, which had already been negatively impacted by the PLGHA alone (Hunter, Hubner, and Kuczura 2021, 353; Skuster, Khanal, and Nyamato 2020, 75). As Skuster explains, "the nationwide curfew and stigma associated with COVID-19 have led people to avoid health services, which, along with increased rates of gender-based violence, contributes to expected increases in unplanned pregnancy and need for abortion services" (Skuster, Khanal, and Nyamato 2020, 75). With the rate of unintended pregnancies increasing in Kenya due to service loss from both Covid-19 and the PLGHA, this in turn raises the demand for abortions and post abortion care, while the availability of it continues to decline. Furthermore, violence against women has also increased during periods of quarantine in Kenya, which again the combination of the PLGHA and Covid-19 limit women's access to care for (Hunter, Hubner, and Kuczura 2021, 353; Skuster, Khanal, and Nyamato 2020, 75). All of these factors make it clear that the GGR has devastating effects in Kenya for the reproductive health care that is available to women, as well as public health as a whole. Unclear and contradictory political decisions, a loss of services from NGOs, and the pandemic have created an environment in which women face a lack of access to absolutely necessary care.

Reproductive and public health outcomes of the GGR in Kenya

The reproductive and public health outcomes negatively affected by the GGR in Kenya are numerous and fall under a wide umbrella. Most closely tied to the GGR, there is an unusually high prevalence of unsafe abortion that occurs in Kenya, which is in large part due to inadequate contraception availability. For context, the World Health Organization estimates that at least 21.6 million abortions occur worldwide each year, and approximately half a million of these occur in Kenya (Ziraba et al. 2015, 2). The most recent comprehensive survey that was done by the Kenyan MOH in 2012 concluded that in Kenya, "75% of the 464,000 abortions in 2012 were conducted in an unsafe manner" (Rehnström Loi et al. 2019, 21). This means that the annual abortion incidence rate was "48 abortions per 1,000 women of reproductive age, compared to an estimated annual abortion incidence of 34 per 1,000 in the East Africa region" (Jayaweera et al. 2018, 2). This is both a high number of overall abortions and a particularly high percentage of ones which were unsafe. It is difficult to estimate how accurate this data is today nearly 10 years later, however due to other studies in Kenya that have been done more recently studying the effect of the PLGHA and abortion access and stigma, there is strong reason to believe that it has

either increased or remained the same (Rehnström Loi et al. 2019, 28; Hunter, Hubner, and Kuczura 2021, 351).

This high rate of unsafe abortion is closely tied to a lack of access to contraceptives, with over 70% of women in the country who went to a clinic in search of post abortion care (PAC), reporting not using contraception at the time of becoming pregnant (Singh et al. 2013, 7). In a study by Jayaweera (2018) on women's experiences in Nairobi, they found that "limited knowledge of sexual and reproductive health information and lack of access to contraception led to unplanned pregnancy" (Jayaweera et al. 2018, 1). This issue is both worsened and informed by the GGR, as in an environment where there is already a great need for progress concerning reproductive health, the policy only worsens it. This lack of family planning leads to a higher amount of unintended pregnancies, which in turn lead to increases of induced abortion. When the GGR is in effect, all of this not only increases but becomes less safe as well.

In addition and related to high rates of unsafe abortion under the GGR, maternal health is another aspect of reproductive health in Kenya which is negatively impacted by the policy. Maternal health is greatly affected by this issue, as "unsafe abortion remains a leading cause of maternal morbidity and mortality in Kenya. The treatment of complications of unsafe abortion also consumes significant health systems resource" (Singh et al. 2013, 7). This rate can fluctuate depending on geographic and socio-economic status in the country, for example in a study by Ziraba (2009) the authors found that "the maternal mortality ratio for the two Nairobi slums, for the period January 2003 to December 2005, was 706 maternal deaths per 100,000 live births" (1). For comparison, the maternal mortality rate (MMR) in the United States in 2019 was only "20.1 deaths per 100,000 live births" (Hoyert 2019, 1). This very high rate of unsafe abortion and MMR also puts a strain on the health system for care completely unrelated to the GGR. In Kenya, "incomplete abortions account for over one-third of gynaecological admissions" (Marlow et al. 2014, 150), which affects other health resources such as HIV/AIDS care in turn. Many women also delay seeking care after obtaining an abortion because of an extremely high amount of stigma, as well as a lack of public education on this topic. This results in women not receiving care in time in many instances, which increases the MMR (Jayaweera et al. 2018, 5). Because of this stigma, which will be explored more in depth in the following section, women in Kenya continue to not know that abortion is legal, and if they do, they often feel unsafe procuring one (Izugbara, Egesa, and Okelo 2015, 10). As Izugbara writes "the global success of public health strategies in shrinking poor health outcomes continues to be considerably hampered by their limited attention to local health notions, social contexts and conditions of people's lives" (Izugbara, Egesa, and Okelo 2015, 10). This statement rings true to the GGR in particular, as its goal is to reduce abortions, while in reality it fails to come even close to that objective. The GGR has never been shown to decrease the number of abortions that occur in a country, including in Kenya (Sagala 2005, 180). Instead of an ideologically based policy such as the GGR, implementing policies such as widely available reproductive health programs, accessible clinics, increased funding for family planning, and public health campaigns to educate patients and providers on the legality and safety of reproductive health would all be more effective strategies (Ziraba et al. 2015, 10).

HIV/AIDS is one of the other major public health issues related to the GGR in Kenya. Because of the GGR, HIV rates in Kenya are negatively impacted by the loss of NGO funding, integrative

care, and contraception availability and education (Ushie et al. 2020, 23; Crane and Dusenberry 2004, 132). Ushie (2020) discusses the “fragmentation” (23) of reproductive care that the GGR causes, and argues that this causes HIV services to be less effective and less available to patients. Under the GGR, many clinics must separate HIV/AIDS care from other health services such as family planning or abortion, making care less available to patients in Kenya (Kmietowicz 2019, 1). In addition, this fragmentation in care particularly under the PLGHA commonly led to contraceptive stockouts (Ushie et al. 2020, 23). The authors of Ushie’s study argue 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” (2020, 23). As discussed previously, in a reproductive health rights landscape that is already so fragile, a policy such as the GGR is detrimental to both reproductive and public health. Further illustrating the reality of the GGR’s effects on HIV and broader public health, “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” (Ushie et al. 2020, 28). There is clear evidence that the GGR’s reach stretches far beyond abortion, causing integrative care to decrease which in turn has many other consequences. Shahvisi’s findings corroborate this, as the GGR has “curtailed family planning and maternal and child health care services, and weakened the collective Kenyan NGO response to HIV/AIDS” (2018, 73). The closure of clinics also clearly affects this issue, for example the closing of Marie Stopes International and the Family Planning Association of Kenya clinics when they refused to sign the policy resulted in decreases in HIV/AIDS testing and treatment, as well as contraception access (Gezinski 2012, 843). Under the PLGHA this effect was even more pronounced than in past iterations of the policy and importantly, “two-thirds of the funding that is made vulnerable by Trump’s expansion of the policy was earmarked for HIV/AIDS programmes” (Opondo 2020, 66). This makes it clear that as politics within the U.S. grow increasingly polarized, so does the ideological backing and implementation of the GGR. In countries such as Kenya where HIV/AIDS is a persistent issue that would be greatly helped by increasing access to sexual health education and contraception, instead the GGR diminishes NGOs’ ability to respond to the crisis.

Family planning stigma and gendered health inequities

Another main component of the GGR in Kenya is the high level of stigma surrounding reproductive health, as well as gendered health and social inequities that exist in the country. Abortion is widely viewed in Kenya as a “taboo” (Skuster 2004, 110) topic, which makes accurate research and care difficult. Authors also discuss a “culture of silence” (Rehnström Loi et al. 2018, 1) in Kenya surrounding sexual and reproductive health, particularly abortion. The presence of the GGR reinforces and worsens this stigma by making reproductive healthcare even more difficult for women to access, as well as being a foreign policy that condemns abortion—furthering the social stigma that already exists in the country. Particularly under the most recent GGR, the PLGHA, it is clear that the expanded policy increased already existing anti-abortion stigma and sentiment in the country (Ushie et al. 2020, 23; Kmietowicz 2019, 1). Women face fear and social consequences pertaining to their use of family planning or abortion services, making it even more difficult to reach them with proper care. In a study on women’s experiences with unplanned pregnancy in Kenya, the authors found that stigma was “the predominant barrier women in their communities face to safe abortion. Other barriers, which were often interrelated to stigma, included lack of education about safe methods of abortion,

perceived illegality of abortion, as well as limited access to services, fear of mistreatment, and mistrust of health providers and facilities” (Jayaweera et al. 2018, 1). This fear of being mistreated or shamed by their health providers is an important barrier to care, because if women do not feel safe seeking professional care then increasingly unsafe options are resorted to instead (Jayaweera et al. 2018, 10). Women in Kenya have reported drinking bleach, laundry detergent, herbal remedies, and other dangerous substances that can cause extreme sickness or death in order to abort a pregnancy when a safe abortion is not available (Jayaweera et al. 2018, 7).

Many women delay seeking care for an abortion or post abortion because of their fear of social stigma from their partners, community, or healthcare providers. In a study on abortion stigma in Kenya, one of the participants explained that “in this country, it is not good for people to find out that you terminated a pregnancy. They will never respect you again. It is like the worst thing you can do as a woman in Kenya” (Izugbara, Egesa, and Okelo 2015, 14). Further illustrating the high level of stigma surrounding this topic, in a study on the perception of abortion and contraception of secondary school students in Kenya, the authors found that a majority of students agreed with the statements “a girl who has an abortion is committing a sin”, with 89.9% agreement, followed by “A girl who has an abortion brings shame to her family”, which showed 73.4% agreement” (Rehnström Loi et al. 2019, 23). Shame, distrust, sin, etc. were all words agreed upon concerning abortion by a majority of secondary school students in Western Kenya, which shows the need for access to educational resources on sexual and reproductive health in order to combat this stigma. Unfortunately, what the GGR accomplishes is the exact opposite of this, as it decreases funding to the NGOs that would be the most likely actors in the country to fulfill this role. Because this stigma is deeply entrenched in society, “abortion stigma is deep-rooted in government and political landscapes, organisations, communities and personal relationships. The constant denial of a woman’s right to freely decide on the number and spacing of her children directly influences maternal mortality” (Rehnström Loi et al. 2018, 10). The issue of reproductive health stigma in Kenya was not created by the GGR, however the policy inarguably worsens it. This makes it extremely important for stigma to be addressed at both the level of the GGR as well as the Kenyan government and society.

A final aspect of the issue of stigma in Kenya are the gender disparities that exist between female and male partners on this subject. In the same study mentioned above concerning secondary school students’ perceptions of abortion and family planning, the authors also found that there were obvious gender disparities, as male students surveyed reported higher overall rates of abortion and contraceptive use stigma than their female counterparts (Rehnström Loi et al. 2019, 28). Related to this, as the authors of the study write, “the principal decision-maker regarding the termination of pregnancy and contraceptive use in Kenya is often the male partner” (Rehnström Loi et al. 2019, 28). This means that women are often not able to make their own decisions regarding the safe termination of their pregnancy, and are forced to negotiate with their partners who have stigmatized perceptions regarding the topic. Women also face fear because of this stigma to discuss using family planning resources with their partners, which in turn increases the number of unintended pregnancies and the need for abortions (Tao et al. 2015, 34). These factors are all clearly interwoven with one another, making stigma a major barrier to safe reproductive health and a key component of the GGR. For all these reasons, stigma under the GGR is one of the causes for the very high rates of unsafe abortion, lack of family planning access, and MMR in Kenya.

Not enough money in the bank: Setting up the failure of women's health outcomes with low economic autonomy and high out-of-pocket health costs

The final component of the GGR in Kenya which I will discuss are the economic factors that uniquely affect women under the policy. Financial constraints are one of the other main barriers that women in Kenya face to receiving adequate reproductive care. Abortion can have very high costs for Kenyan women, especially for those who live in rural areas or are socio-economically disadvantaged (Jayaweera et al. 2018, 9). Furthermore, financial instability is one of the commonly cited reasons by women in Kenya for needing an abortion in the first place (Rehnström Loi et al. 2018, 7). Women are often forced to be financially reliant on their male partners, which makes obtaining an abortion not only socially but financially difficult as well. When women do not have economic independence, it is more difficult for them to access reproductive care. This issue is influenced by the GGR because it causes funding to greatly decrease, making care increasingly difficult to receive for women who already face financial constraints (Marlow et al. 2014, 152). Furthermore, in order to receive care, many women are forced to pay out of pocket costs, which for many they cannot afford (Sidze et al. 2013, 140). Additionally, “consumers bear a disproportionate share when it comes to reproductive health and family planning expenditures in Kenya” (Sidze et al. 2013, 143). This means that the effects of the GGR are especially important to consider in terms of financial implications for women. This is one of the many reasons that sufficient NGO and health funding is critical, which the GGR depletes (Sidze et al. 2013, 145).

For example, many women in Kenya reported having to pay an “informal fee” to receive family planning resources, as “49% of public sector family planning clients reported paying a fee to obtain services” (Tumlinson et al. 2021, 2). However, for some women, they do not have the option of paying fees and instead have to forgo necessary services as a result (Tumlinson et al. 2021, 10). Women in rural areas and economically disadvantaged are often the most negatively affected by the GGR, which is illustrated by the amount of service delivery disruptions in Kenya under the policy (McGovern and Tamang 2020, 2). Finally, the sheer amount of funding that was encompassed in the latest version of the PLGHA under the Trump administration even more greatly financially affected women in Kenya, as it applied to more services and organizations (Hunter, Hubner, and Kuczura 2021, 351). These economic factors make it clear that because women lack economic independence in Kenya and that further funding is put at risk or lost by the GGR, there are significant financial barriers to receiving adequate reproductive care.

Conclusion

Kenya is a prime example of how extreme and detrimental the effects of the GGR can be in practice. As a country that already faces significant political, economic, and social barriers to women's reproductive rights, the GGR compounds these issues and causes worsened outcomes for women. Beyond reproductive health, public health in Kenya as a whole is also negatively impacted by the policy, as critical U.S. funding for HIV/AIDS treatment and other health issues is lost as a consequence. Already considerable stigma is increased by the GGR as well, creating an even more dangerous environment for women in which they are unable to receive proper care. What is particularly striking are the amount of potential positive outcomes that exist if instead of ideological policies such as the GGR, funding and innovation were channeled into policies with

scientific backing in this context including contraception, HIV testing, and maternal healthcare. As Shahvisi writes, “comprehensive reproductive health and women's empowerment would prevent 23 million unplanned pregnancies, 1.4 million infant deaths, 22 million unplanned births, 142,000 pregnancy related deaths” (Shahvisi 2018, 17). The opportunities for health improvements in this area are vast, but with contradictory and baseless policies such as the GGR, they are difficult to achieve. In order for many health indicators, including unsafe abortion and MMR rates to decrease, it is imperative that the GGR not be reinstated in Kenya, as it has no scientific backing but rather has been proven to have numerous and widespread negative health effects.

Part III: Nepal Case Study

The role of the United States in limiting reform and isolating women's reproductive health improvements

Nepal's reproductive rights history is nuanced and multifaceted—spanning from being one of the most restrictive laws to becoming increasingly liberal beginning in 2002. The Global Gag Rule (GGR) has specific and magnified effects in Nepal because of this unique environment, causing losses to health resources and subsequently harming women's and public health. Nepal is a highly exposed country to the GGR, as the U.S. is their largest bilateral donor for health assistance (“Access Denied: Nepal” 2018, 6). The funding from the U.S. in Nepal goes to an extremely broad range of health initiatives, ranging from maternal health, to clean drinking water, to proper nutrition (“Access Denied: Nepal” 2018, 6). Because of this, when the GGR is in effect the negative ramifications from the losses in funding are numerous. As Tamang writes, “in 2016, the USG appropriated roughly \$42 million in bilateral global health funding to Nepal. In 2017, 65% of official development assistance received by Nepal for population policies/programs & reproductive health came from the USG” (Tamang et al. 2020, 6). This significant amount of funding from the U.S. creates a situation in which disruptions to it from the GGR have wide reaching health implications. This relationship between the U.S. and Nepal is not a recent one, but rather “spans over 70 years and includes the delivery of over \$1.5 billion in US assistance to support development” (Bajracharya 2020, 79). Furthering the impact of the policy, under the expanded PLGHA during the Trump administration, all U.S. health funding is put at risk in Nepal rather than only family planning (Starrs 2017, 485).

The unique history of Nepal's reproductive rights also contributes to the effect of the GGR in the country. Prior to 2002, abortion was highly illegal in Nepal under any circumstances, and women were routinely sent to prison for “infanticide” (Samandari et al. 2012, 2) if it was discovered that they had received an abortion. After decades of attempts at reform, in 2002 the Nepalese government legalized abortion in response to extremely high maternal mortality rates (MMR) and negative health outcomes for women due to high rates of unsafe abortion and unhealthy pregnancies (Tuladhar and Risal 2010, 77). During this time, “from a country with one of the most restrictive and strictly enforced abortion laws in the world, where many women received lengthy prison sentences for abortion related ‘crimes’, Nepal has become a model for change globally” (Tuladhar and Risal 2010, 77). Despite this progress, many barriers remain to women in Nepal accessing reproductive care and the GGR's drastic funding cuts and isolation of vital advocacy efforts directly impedes this reform (Tamang et al. 2020, 5). Further complexity is added to the reproductive health landscape in Nepal by the presence of social, gender-based, and economic divisions—all of which I will explore in the following sections.

Because Nepal is a highly exposed to the GGR, and the timing of the policy's institution under multiple U.S. presidents hampered the implementation of the reformed 2002 abortion law, the ramifications of the GGR have been deeply felt. I argue that the Global Gag Rule's institution in Nepal has violated the sovereignty of the Nepalese government and organizations to improve reproductive health indicators at a critical time, and in doing so harmed the health of men, women, and children in the highly exposed country to the policy. In the sections that follow, I will outline the historical context of reproductive rights in Nepal compared with what they are

today, and how each of these has been impacted by the GGR. I will also discuss the different ways in which caste, gender, and stigma interact with the GGR, and explore the ways in which rural women are more extremely impacted by the policy. I will then examine the ways in which reproductive advocacy efforts in Nepal have been stifled by the GGR, and lastly outline the impact of the policy on NGO service delivery.

Abortion in Nepal: Transforming one of the most restrictive abortion laws to one of the most liberal

Prior to 2002, abortion in Nepal was strictly illegal which significantly contributed to a high MMR rate in the country, which was related to a high prevalence of unsafe abortion. These high rates of negative health impacts from the law, which was referred to as the Muluki Ain, were the primary factors that drove the Nepalese government to reform it (Samandari et al. 2012, 2; Shakya et al. 2004, 75). Muluki Ain, the legal code, was in effect from 1854 to 2002, and was amended multiple times until its abolishment (Thapa 2004, 85). This law did not “permit the termination of pregnancies even if they were the result of rape or incest or threatened the woman’s life. In effect, it equated abortion with infanticide, and infanticide with other kinds of murder or homicide, and did not recognise any mitigating factors or exceptional circumstances under which abortion was not a crime of murder” (Thapa 2004, 85). This was an exceptionally strict law that greatly restricted women’s ability to terminate unhealthy, unplanned, and unwanted pregnancies that were dangerous to their health in different ways. While this law was still in effect before reform, “Nepal’s maternal mortality ratio was 539 deaths per 100,000 live births, with a large proportion of deaths attributed to unsafe abortion. One facility-based study found that 20% of maternal deaths were due to illegal abortion” (Samandari et al. 2012, 2). Comparatively, the maternal mortality rate (MMR) in the United States in 2019 was only “20.1 deaths per 100,000 live births” (Hoyert 2019, 1). This very high number was therefore a driving factor during the process of reform. Because of the restrictive law that mandated the imprisonment of women if they sought an abortion, many women were forced to go through with unsafe abortions which greatly negatively impacted many women’s health (“Access Denied: The Impact of the Global Gag Rule in Nepal” 2006, 4). During this time period, because abortion was already illegal, the GGR did not directly lead to women losing access to abortion services, as there were already extreme barriers. However, the GGR while in effect even during the restrictive law did arguably increase already existing stigma, limit family planning resources, and make the process of reform even more difficult (Bogecho and Upreti 2006, 17).

Multiple decades of advocacy efforts led to the passage of a revised abortion law in Nepal in 2002 that was fully implemented by 2010 (Shakya et al. 2004, 75; Skuster 2004, 78). Nepal’s Ministry of Public Health instituted an Abortion Task Force that was comprised of four groups who spread awareness of the new law and helped to implement it (Samandari et al. 2012, 2). These groups included gynecologists and health experts with knowledge of reproductive health, and the creation of the Abortion Task Force helped to successfully and gradually implement the reformed law (Samandari et al. 2012, 3). The process of reforming the law began in the 1970s, as activists continued to lobby over the course of over 30 years for a less restrictive law, and for abortion to not be considered murder (Thapa 2004, 85). The involvement of the U.S. during this time period was contradictory, as in the 1970s the U.S. was a key actor in holding conferences in Nepal that focused on improving “population growth through maternal and child health

programmes” (Thapa 2004, 86). Following this period in the 1980s, the U.S. pivoted under Reagan as the GGR was introduced for the first time. Following the initial institution of the GGR during a critical time for reproductive health advocacy, “the Nepal government may have been discouraged from supporting the reform movement, given that the US government was a key donor to Nepal’s health and family planning programmes” (Thapa 2004, 86-87). Because of the GGR, important advocates such as the Family Planning Association of Nepal (FPAN) and the Nepalese Ministry of Health no longer had support from the U.S. on this matter, and in fact had arguably increased stigma instead (Thapa 2004, 86). One of the most important factors to effective family planning is adequate support and commitment from governments particularly in less developed countries, which made this issue a major roadblock to reform (Mukasa et al. 2017, 389).

Today, the abortion law in Nepal legalizes abortion for any reason upon request for up to 12 weeks, and for up to 18 weeks under extenuating circumstances such as rape or incest (Henderson et al. 2013, 4). It also allows women the right to an abortion any time that the woman’s life is in danger (Henderson et al. 2013, 4). However, this still means that “women seeking later procedures without a legal indication (i.e., health, fetal anomaly, rape) cannot get care in certified settings and may go elsewhere, limiting the potential of the policy to fully curtail unsafe abortion” (Henderson et al. 2013, 4). Though not perfect, Nepal’s current abortion laws are considered liberal on a global scale. Politically in Nepal, there have also been major shifts outside of reproductive rights over the last few decades that play a role in this issue as well. In 2006, the Comprehensive Peace Agreement was signed which ended a “10-year conflict that came at a significant cost of lives and foregone economic development” (“The World Bank in Nepal” 2021). Since then, a new government was officially formed in 2018, which involves “seven new states and 753 local governments for which new legislation, institutions and administrative procedures are being formalized as constitutionally prescribed” (“The World Bank in Nepal” 2021). This means that there a large amount of different local governments to follow the new abortion law, as well as interpret and interact with the GGR.

Another aspect of Nepal’s reproductive rights reform is the Safe Motherhood and Reproductive Health Rights Act which was passed in 2018 (Skuster 2004, 78). As Skuster writes, this act “has not yet been operationalised through regulation. Government action to ensure legal abortion is further challenged by government decentralisation. In 2015, a new Constitution gave provincial and local level governments new authority over abortion services, but the lower-level governments do not yet show strong commitment to ensure abortion services for everyone who needs them” (Skuster 2004, 78). This issue compounded with the GGR has created a situation in which reproductive health has undoubtedly been improved, but still experiences a high degree of fragility and nonuniformity in Nepal. As abortion was being legalized while the GGR was in effect, “organisations that were promoting awareness of and advocating for access to safe abortion stopped abortion-related activities in order to retain US funding” (Skuster 2004, 78). Bingenheimer argues that this slowed the rate of Nepal’s progress in this area by limiting the rate of reform and advocacy due to the chilling effect and loss of funding, “NGOs with expertise in reproductive health service delivery were prohibited from contributing to the government's efforts to increase access to safe abortion, slowing the Nepali governments progress” (Bingenheimer and Skuster 2017, 284). All of these factors culminate to exemplify that the GGR played a pivotal role in slowing the rate of progress and implementation of the 2002 abortion

reform, which was aimed not at increasing the number of abortions that occur, but decreasing the numbers of women's deaths that occur from unsafe ones. As a 2006 report writes in reference to this, "U.S. restrictions have infringed upon Nepalese sovereignty by creating barriers to its efforts to deal with the public health crisis of unsafe abortion" ("Access Denied: The Impact of the Global Gag Rule in Nepal" 2006, 3). By limiting funding and advocacy efforts related to reproductive health, the U.S. has effectively undermined the decisions and sovereignty of the Nepalese government in this realm during periods in which the GGR has been in effect.

The family planning and reproductive health landscape in Nepal

Following the legalization of abortion in Nepal, there have been significant improvements to reproductive health outcomes, however persistent stigma, inadequate use of family planning, and a lack of funding still perpetuate this issue today. Many women in Nepal are still not aware that abortion is legal in the country, nearly 20 years after its legalization (Yogi, K.C, and Neupane 2018, 2). One study found that "only 44.0% of the women were aware of the legal provision of abortion in Nepal" (Yogi, K.C, and Neupane 2018, 2). Further corroborating this issue, Tuladhar and Risal (2010) found that "(66.5%) women said they were aware of legalization of abortion in Nepal. The level of awareness varied according to the age group, area of residence, occupation, ethnic group and educational status of the women" (77). This means that slightly less than half of Nepalese women are either not aware that abortion has been legalized, or are unclear on the details of the new law. Without this knowledge, it does not make it likely that the reform will achieve its goal of preventing unsafe abortions and lowering maternal mortality rates. The reasons for many women not being educated regarding the new law is related to both stigma and resource constraints. With the loss of funding from the GGR and the subsequent limit on reproductive health advocacy and education, the ability of organizations to conduct outreach to women was hampered. This is a key aspect of improving reproductive health in Nepal, as without education and advocacy, women are left without the tools to know what reproductive health resources are available to them (Tuladhar and Risal 2010, 78). Without women knowing what care they have the right to access, the progress made by the reformed law is greatly diminished.

Another important component of current reproductive health that is affected by the GGR in Nepal is access to and knowledge of family planning resources. Providing women with the choice of using family planning is a key aspect of lowering negative health outcomes such as high maternal mortality. Family planning serves dual roles in reproductive health discourse, as "an antipoverty tool at the household level, a tool of economic development at the national level, a smart investment with net gains, a means of empowering women, [and] a way of lowering maternal mortality ratios" (Brunson 2020, 1). Access to family planning is critical because it lowers the incidence of unplanned pregnancies, thereby also lowering unsafe abortions and related deaths. The GGR greatly affects access to contraception in developing countries, and "from 2001 to 2008, for example, the policy caused USAID to completely stop supplying contraceptives to sixteen developing countries and to cut off contraceptive supplies to the leading providers in an additional thirteen" (Latham 2017, 8). Adequate access to family planning services remains limited in Nepal, in part due to losses in funding and services as a result of the presence of the GGR. For example, under the Obama administration when the GGR was not in effect, "money started flowing to FPAN. In 2015 USAID earmarked \$5.5m (£4.6m; €5m) for the

organisation through its Support for International Family Planning Organisations programme. More than 233,000 people from 11 remote districts of Nepal came to rely on it” (Adhikari 2019, 1). This funding was lost when the GGR was reinstated in 2017 under the expanded PLGHA, and as a result many women lost access to vital family planning services. Furthermore, according to an FPAN clinic manager, women’s education on different family planning options and their availability is low, because of a combination of stigma and a lack of resources to provide adequate information to them (Adhikari 2019, 1). Access to family planning services remains relatively low, “with only 35% of all married women using a modern form of contraception” (Bogecho and Upreti 2006, 1). Other studies have found similar results, as “current use among married girls was 32 percent in the rural area and 60 percent in the urban area” (Mathur, Malhotra, and Mehta 2001, 94). Additionally, under the GGR, “women who go to clinics funded by USAID cannot obtain objective health care information. This can be misleading for women who are not aware of the restriction on the providers' speech and may assume that they are getting the best advice possible” (Bogecho and Upreti 2006, 24). This means that women are often not getting the most direct advice or care concerning their reproductive health because of the policy’s limits and chilling effect for providers.

Since the law reform in Nepal, and during periods of the GGR being instituted and rescinded, health metrics such as Nepal’s MMR did gradually decline, going from “539 maternal deaths per 100,000 live births in 1995 to 239 in 2015” (Tamang et al. 2020, 6). This shows that the reformed law and advocacy efforts undoubtedly made progress, however this MMR rate is still much higher than it should be. This number would arguably be lower had the GGR and PLGHA not been in effect. Other important health indicators include the “use of modern contraception increased from 26% of married women in 1996 to 43% in 2016; and the national total fertility rate has steadily declined from 4.1 children per woman in 2001 to 2.3 in 2016. However, use of modern contraceptive methods has stagnated in recent years” (Tamang et al. 2020, 6). Further corroborating these findings, “total fertility also declined by nearly half, despite relatively low contraceptive prevalence. Greater numbers of women likely obtained abortions and sought hospital care for complications following legalization, yet we observed a significant decline in the rate of serious abortion morbidity” (Henderson et al. 2013, 1). This signals that the reform did improve the safety of reproductive health services in Nepal, but that reproductive health has not yet reached its full potential, in part due to the limits of the GGR for funding and advocacy. The most recent iteration of the GGR, the PLGHA, even more negatively affected health outcomes in Nepal, as it applied to a much broader base of funding (Tamang et al. 2020, 6).

Fine lines: The interaction of gender, caste, and stigma with the GGR

Various factors of gender, caste, and stigma interact with the GGR in Nepal in ways that compound the negative effects of the policy. Many women are married at a young age and have an unmet need for contraceptives, partly due to stigma and a lack of decision making power compared to their male partners. “One in every six married adolescent girls experiences emotional, physical or sexual violence by her spouse. The country’s adolescent birth rate is 88 per 1000 women, with 17% of girls aged 15–19 years already mothers of at least one child. Only 15% of married adolescent girls use modern contraceptive methods and 35% have an unmet need for modern family planning methods” (Bajracharya 2020, 80). Early age at first marriage is common for women in Nepal, and “many women are still not allowed the power to decide when

and whom to marry” (Chapagain 2006, 164). Interestingly, studies have found that both men and women support the use of family planning after marriage, but that often this need continues to go unmet (Mathur, Malhotra, and Mehta 2001, 97). Having children at a young age also increases risk factors for both women and their children, with higher rates of maternal mortality and poor health outcomes for young children (“Access Denied: Nepal” 2018, 7).

Economic and social status related to Nepal’s previous caste system also influence women’s reproductive health, and the GGR makes already difficult to reach care for disadvantaged women even less available. “Currently married adolescent girls have the highest unmet need for family planning of any age group. Pregnancy among adolescents is associated with poverty, social status, including socially disadvantaged castes, disadvantaged ethnic groups, and unemployment” (Bajracharya 2020, 80). This means that economic status is closely associated with unplanned pregnancy, largely due to a lack of family planning access. Earning power is also unequal between men and women in Nepal, and as Sunam (2017) writes “the poor are not a homogenous group but, rather, are differentiated along the lines of caste, gender, ethnicity and asset-holdings” (68). Women also have lower wages on average than men, making them financially dependent or insecure, particularly in the event of unplanned health expenses (Sunam 2017, 75). Furthermore, multiple challenging factors compound with the GGR to create a fragile landscape for women’s reproductive health, as “adolescents in Nepal face severe poverty, limited access to education and health services and restrictive cultural and sexual norms” (Mathur, Malhotra, and Mehta 2001, 91). Multiple studies show that economic means greatly influence women’s reproductive health outcomes, and “women in the poorest wealth quintile and those who had lower educational attainments and those who were younger were more likely to undergo unsafe abortion” (Yogi, K.C, and Neupane 2018, 9). Women with less social capital and resources are more likely to have to seek unsafe medical care. Health and social indicators are on average worse for women in Nepal, with a lower life expectancy and literacy rate of 19% of women compared with 54% of men (Mathur, Malhotra, and Mehta 2001, 91). These factors make women more vulnerable to the impacts of the GGR, and cause their health outcomes to be worsened.

Lastly, stigma is another major factor that affects women’s ability to access appropriate reproductive care, and the level of stigma in Nepal has been worsened by the GGR. Related to this, girls do not receive “comprehensive sexuality education” (Bajracharya 2020, 80), and comprehensive sexuality education is not required in public education. When reproductive health can’t be discussed openly between women, their partners, and care providers that they trust, they do not have access to the necessary resources. In a study by Bajracharya (2020), it was found that storytelling was one tool that has “helped dispel stigma and increase support for abortion access” (81). Furthermore, the GGR has been shown to increase stigma surrounding women’s reproductive healthcare while in effect, as “the level of heightened rhetoric from the highest office in the US has only served to embolden anti-abortion extremists and to propagate stigma” (Bajracharya 2020, 81). This is particularly critical as Nepal has been in the process of reform, as worsened social stigma of reproductive health has slowed the process of improving women’s access to safe care.

The extreme effects of the GGR on rural Nepalese women

The GGR has particularly negative effects on rural Nepalese women, as this population already faces barriers to accessing proper care, which is an issue that the policy worsens. Programs that reach rural places such as mobile health clinics and community health workers decrease or are cut altogether under the policy because of the loss of funding that it causes for organizations who do not comply (“Access Denied: The Impact of the Global Gag Rule in Nepal” 2006, 3). The landscape in Nepal makes many communities difficult to reach, and the country “faces formidable barriers to extending safe abortion care to isolated rural areas, with steep mountain terrain and slow transportation” (Henderson et al. 2013, 4-5). In 2014, a study found that only 53% of Nepal’s rural population was within a “half an hour travel time of their closest health facility, compared to 80% in urban areas” (Mehata et al. 2014, 3). This is due in part to challenging topography, as well as a lack of adequate infrastructure in rural areas (Mehata et al. 2014, 3). This makes it even more necessary for consistent flows of health funding to be in place in order to ensure that these populations are reached, but the GGR puts this in jeopardy. As Adhikari explains, “the global gag rule is making health services less accessible, especially for already marginalised and underserved populations...girls are dying because of this rule” (2019, 2). Public health as a whole and many different populations are negatively impacted by the GGR, but rural women present an especially pronounced case of the negative ramifications that the policy has.

While the GGR is in effect, a significant amount of critical funding for health programs is lost, resulting in the closure of programs and a lack of available resources in rural areas. A branch manager of FPAN explained that “because of the global gag rule we recently had to close our biggest programme, serving 11 remote districts of Nepal,” he says. “It provided comprehensive family planning services, including awareness, mobile camps, and training across the country” (Adhikari 2019, 1). Often in rural communities, if the clinic that operated there closes or the mobile units stop coming, that main source of care is not easily replaceable. As McGovern and Tamang (2020) write about this phenomenon, “this has a particularly devastating impact on women in rural and remote areas where there may be only one clinic offering a wide array of services. At public and private health facilities, participants reported staffing shortages, stockouts of family planning and safe abortion commodities, and a disruption of referral networks” (2). The combined effects of living in a remote area, facing economic hardships, and having the GGR in effect culminate to have exacerbated and unsafe health effects for rural populations. Bogecho and Upreti (2006) discuss the important role that local health clinics serve in rural women’s lives, as they are often a reliable outlet for women who are otherwise impoverished and may lack economic and decision making autonomy (23). The authors write that “for women constrained by these challenges, the local health service provider assumes an important role by acting as an advocate for their health interests and by giving legitimacy to their voices” (Bogecho and Upreti 2006, 23). These unique aspects of the interaction between rural areas and the GGR make it even more clear that rather than losses of funding from the policy, increased access to family planning and health services is greatly needed.

The GGR’s isolation of Nepalese reproductive health advocacy efforts

The timing of the GGR’s reinstatement in the early 2000s under the Bush Administration is particularly important, because it directly impeded advocacy efforts as the abortion law reform in Nepal was occurring. Leading up to the legalization of abortion in Nepal, the U.S. was initially

supportive of the reform, and helped to organize conferences in the 1970s to begin conversations around the issue (Thapa 2004, 86). Then, under Reagan the first iteration of the GGR came about, and all U.S. support for reforming the restrictive law diminished (Thapa 2004, 86). During this time the GGR effectively “stifled advocacy” concerning the implementation of the new law, as it silenced efforts to lobby or offer reproductive services from organizations who complied with the policy (“Access Denied: Nepal” 2018, 6). The chilling effect of the GGR is also highly prevalent here, and “foreign NGOs described the environment under the policy as creating a greater sense of isolation for those engaged in abortion advocacy, making it more difficult to accomplish their objectives and get buy-in from donors and other key stakeholders who are already trepidatious around abortion” (“Access Denied: Nepal” 2018, 14). At a time when communication between advocates and health organizations was crucial to make the reform effective and to decrease MMR rates, the GGR slowed this progress. Tellingly, “when the world’s most powerful country is against abortion, it makes a big impact on the policymakers at the local level” (“Access Denied: Nepal” 2018, 14). The influence of the U.S. on this matter stretches beyond funding to the damaging of social norms and policy making surrounding women’s reproductive health.

Much of the advocacy related to reproductive rights in Nepal has been silenced during periods of time that the GGR has been in effect, slowing progress and creating increased social stigma against topics of women’s health. Organizations that have had to comply with the GGR have had to stop advocacy efforts to educate women on safe abortion and its legalization during the periods that it has been instated have had to curtail their reproductive health programs (Skuster, Khanal, and Nyamato 2020, 78). Additionally, the policy has slowed the progress of implementing the reformed law. For example because of the Helms Amendment and the GGR, “the Government of Nepal had to build separate facilities for abortion care even though the US funded government facilities for treating complications of unsafe abortion already had appropriate equipment. In addition, because they were funded by the US government, Nepali government publications and training manuals omitted mention of abortion” (Skuster, Khanal, and Nyamato 2020, 78). U.S. policy in this context creates situations in which funding, resources, and advocacy are unnecessarily constrained, further burdening and harming women. Increased lobbying and information sharing is critical following the legalization of abortion, but the presence of the GGR effectively limited this. Instead of U.S. health funding being an aid to Nepal in this situation, it has acted as a roadblock. Research showed that in Nepal while the GGR was in place during the Bush administration, “discussions about national abortion law reform included fewer stakeholders, and lawmakers reported lack of access to critical information” (Schaaf et al. 2019, 4). Furthermore, the GGR impedes the effectiveness of the revised law by limiting the ability of organizations to spread awareness of it. “Public education and advocacy campaigns are crucial to create awareness about the new legislation and availability of services. Unless the advocacy and awareness campaign reaches women, they are not likely to benefit from the legal reform and services” (Tuladhar and Risal 2010, 76). Because the GGR limits advocates' abilities to do this, the process of effective reform in Nepal has been slower.

A final point related to the GGR and the effect of U.S. policy on reproductive rights reform in Nepal is that the policy would be illegal if it were imposed in the U.S. itself. Furthermore, by extending the policy, the U.S. has impeded on Nepal’s sovereignty over their own countries'

reproductive rights. In effect, “The Global Gag Rule undermines more than a decade of U.S. investments in global health and puts the government of Nepal’s own objectives linked to key global commitments for family planning, health and development further out of reach” (“Access Denied: Nepal” 2018, 6). By restricting funding as well as lobbying activities, advocacy and progress are stymied in Nepal as a result. For example, as a Nepalese NGO worker commented in reference to the GGR, “you are creating a standard that is not a problem in your country but is a problem in a third-world country that is in need of reproductive health services” (“Access Denied: The Impact of the Global Gag Rule in Nepal” 2006, 3). As the largest bilateral health donor to Nepal, the U.S. has had every opportunity to positively influence the course of the law reform and reproductive rights in the country. Instead, with multiple reinstatements of the GGR, the effect has instead been a negative one for much of the last few decades. Furthermore, “the gag rule is also at odds with the Nepalese government’s ability to democratically enact and implement a law designed to reduce unsafe abortion, which is a public health crisis for Nepali women and their families” (“Access Denied: The Impact of the Global Gag Rule in Nepal” 2006, 3). While choosing to focus on an ideologically based abortion policy rather than the real health crisis of high MMR and unsafe abortion, women’s health in Nepal has paid the price. All of these factors related to the isolation of reproductive health advocacy efforts in Nepal by the GGR exemplify another facet of the policy that has profound negative health effects.

The impact of the GGR on NGO effectiveness and subsequent health outcomes in Nepal

Another pronounced aspect of the GGR’s effect in Nepal has been on NGO operations. Many reproductive and public health NGOs in the country have faced losses of funding and interruptions to their service delivery and work as a result of the policy. Major organizations that serve large portions of the Nepalese population faced major funding cuts due to the policy, including FPAN and Marie Stopes International (MSI) (“Access Denied: The Impact of the Global Gag Rule in Nepal” 2006, 5-6). When the GGR was reintroduced in the early 2000s, “unwilling to abide by the terms of the gag rule, FPAN lost its 32-year partnership with USAID...terminated a total of 60 staff members...and introduced a fee for services in order to generate revenue to keep the clinics running” (“Access Denied: The Impact of the Global Gag Rule in Nepal” 2006, 5). During this time, FPAN also “lost \$400,000 in USAID-funded contraceptives, which represented two-thirds of its total stock” (“Access Denied: The Impact of the Global Gag Rule in Nepal” 2006, 5). These statistics illustrate the stark reality that major NGOs that contribute heavily to Nepal’s family planning services were forced to cut staff and resources as a result of the policy. MSI also chose not to comply with the GGR, and as a result lost U.S. funding and was forced to discontinue their mobile health clinics, effectively “leaving its rural clients without service” (“Access Denied: The Impact of the Global Gag Rule in Nepal” 2006, 6). Furthermore, in an environment such as Nepal in which public health resources are already constrained, NGOs are even more vital. As Shakya et al. (2004) explains, “in many remote areas government health services are virtually non-existent, with health posts infrequently staffed and medicines unavailable or out of date” (77). This makes it clear that significant losses of funding to NGOs, both to prominent and smaller local organizations, can have detrimental health impacts.

Health outcomes under the GGR and the PLGHA for Nepal have been shown to worsen when the policy is in effect, largely related to the loss of care that results from it being instituted. When

women have access to family planning methods and can therefore choose to space their children farther apart, health metrics of both women and children improve (Bingenheimer and Skuster 2017, 283). The GGR diminishes women's ability to do this in Nepal, therefore threatening their health outcomes simultaneously. The PLGHA also caused losses to HIV/AIDS funding in Nepal, which has public health implications for all of society (Bingenheimer and Skuster 2017, 285; "Access Denied: Nepal" 2018, 6). Related to these factors, the GGR also depletes the integrated care model that many NGOs have incorporated in recent decades (Starrs 2017, 486). For example, "NGOs in low-income settings often provide integrated health services" (Starrs 2017, 486). These services range from immunizations, to maternal health, to STD prevention—and as a result when funding is lost from the GGR, more services in Nepal are lost than abortion. In turn, these impacts of the policy "increases dependency on other donors in a resource-constrained environment and weakens the Nepalese government's abilities to achieve desired health and development outcomes" ("Access Denied: Nepal" 2018, 4). Another aspect of this is the chilling effect of the policy in Nepal, which not only relates to advocacy efforts as discussed above, but health outcomes as well. NGO providers have reported feeling confusion and overinterpretation of the policy, which can lead to even further losses of care to women and their families (Bogecho and Upreti 2006, 18; McGovern and Tamang 2020, 3; Tamang et al. 2020; 12).

Finally, unexpected events that have occurred during the GGR or just before its reinstatement such as the 2015 earthquake and the Covid-19 pandemic exemplify the fragility of women's reproductive health in Nepal that the policy greatly contributes to. The major earthquake that occurred in Nepal in 2015 caused damage to over 1,000 health facilities which cut off service to many citizens, and "faced with its existing financing challenges, the government may be unable to fill resource gaps caused by the Global Gag Rule, and sexual and reproductive health outcomes will be further jeopardized" ("Access Denied: Nepal" 2018, 8). This event exemplifies the vulnerabilities that the GGR creates in health systems, which are even more pronounced during times of crisis. The Covid-19 pandemic is another prime example of this, as it has made a number of reproductive health services increasingly unavailable to women who need them. This was even more pronounced as the pandemic began while the PLGHA was in effect (Skuster, Khanal, and Nyamato 2020, 75). In addition to this, during the pandemic "high numbers of migrants have returned to Nepal from working abroad, stressing health systems and interrupting their contraceptive care. Supply chains have also been interrupted" (Skuster, Khanal, and Nyamato 2020, 75). These times of crisis and the interruption to health services that they create are further worsened and complicated by the GGR, signifying yet another reason that the policy is both ineffective and harmful to the Nepalese people.

Conclusion

Throughout this paper, I have aimed to explore the widespread and consistently negative impacts of various iterations of the GGR in Nepal. When looking at these factors together as a whole, it becomes clear in another specific case study that the effects of the policy do not achieve its intended goal, but rather harm women and public health with alarming consistency. In Nepal, the institution of the GGR over the last few decades has arguably stifled advocacy efforts to improve women's health, and slowed the progress of the country's own abortion reform. Rather than being a force of advancement for women's rights in Nepal, the U.S. has served as a hindrance during the periods in which the policy has been in effect. Furthermore, by looking at this case

study and the implementation of the GGR in any case, it becomes clear that abortion is not the issue. Whenever the right to abortion is being attacked in a country, women as a whole are too. This is clear from the fact that as abortion is made illegal, women's health metrics across the board are negatively impacted, and maternal mortality rates skyrocket in turn. This is because any law that aims to restrict a woman's right to abortion reflects a society and leaders that in turn wish to restrict women's bodily autonomy, decision-making, economic independence, and social status as well.

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