The Impacts of the Global Gag Rule on Sexual and Reproductive Health and Rights in the Global South: A Scoping Review

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The Global Gag Rule is a United States policy that blocks global health funding to foreign non-governmental organisations if they engage in abortion-related activities. It has been implemented by every Republican administration since 1984 and remains in operation at the time of writing in its most stringent and extensive form. The policy has been criticised for its implications for women's bodily autonomy, its censorship of non-governmental organisations and health professionals, and for its impact on the health of populations in affected countries. In order to capture the effects of the Global Gag Rule to date, we conducted a scoping review in April 2020. Forty-eight articles met our eligibility criteria, and were analysed thematically, noting the effects on: (1) the operations of non-governmental organisations; (2) maternal health; (3) sexually transmitted infections; (4) marginalised social groups; (5) reproductive rights. We found that the policy increased the abortion rate and had a negative impact on maternal health, STIs, and the health of marginalised groups. We conclude that the policy amounts to the neocolonial co-optation of sexual and reproductive health in the Global South to advance an ideological agenda in the Global North. We urge that the policy be repealed as part of the broader project of protecting sexual and reproductive health globally and decolonising global health.

Keywords: Global Gag Rule, global health, health policy, human rights, sexual and reproductive health.

Word count: 6,938

1. Introduction

As the 2020 presidential elections in the United States (U.S.) draw closer, it is important to review and critique the policies of the current administration and their impact on global health. The Global Gag Rule (GGR) has become a hallmark of Republican administrations. Initially implemented by Reagan in 1984, the policy has been reinstated by every subsequent Republican president, and its scope was significantly expanded by Trump in 2017. (Bingenheimer & Skuster, 2017; Starrs, 2017; The Lancet, 2019).

The GGR blocks U.S. global health assistance to overseas non-governmental organisations (NGOs) if they use funds – obtained from any source – to carry out abortion-related activities. This forces NGOs to choose between discontinuing their abortion services or forgoing U.S funding, which in turn affects the provision of other services (Bogecho & Upreti, 2006, Starrs, 2017). Under the policy, abortion is prohibited in all cases except for rape, incest or where the life of the pregnant woman is at risk. An NGO is considered to be actively promoting abortion if it provides counselling or advice to patients regarding abortion as a method of family planning, conducts public health campaigns regarding the benefits or availability of abortion, or lobbies the government of the country within which they operate to legalise or liberalise abortion laws (United States Agency for International Development [USAID], 2020).

The policy has been dubbed the 'Global Gag Rule' by its critics due to this limitation on the freedom of speech of those working within NGOs. Its official name was previously the 'Mexico City Policy' and in its most recent, extended, incarnation it is entitled: 'Protecting Life in Global Health Assistance' (Bogecho & Upreti, 2006; The Lancet, 2019). Under iterations of the policy implemented by Presidents Reagan and Bush, the restrictions applied to bilateral family planning funding, which in fiscal year 2016 totalled US$575 million (Kaiser Family Foundation [KFF], 2016; Starrs, 2017). However, under the current

administration the requirements have been extended to all "*global health assistance furnished by all departments or agencies*", thereby jeopardising an estimated US$9.5 billion in global health aid (Salaa-Blyther, 2018; Starrs, 2017; The White House, 2017, para. 2). Foreign NGOs that receive U.S health assistance work in approximately 60 low- and middle-income countries, providing a broad range of health services – including for HIV/AIDS, malaria, tuberculosis, Zika virus, maternal and child health, neglected tropical diseases, nutrition and global health security—now face critical risks to their funding and new moral dilemmas. As the primary source of global health funding worldwide, the U.S. has enormous influence over the agenda of global health and sexual and reproductive health and rights (SRHR) (Institute for Health Metrics and Evaluation, 2019; Starrs, 2017), and the GGR should be seen as a deliberate exercise of this influence.

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

key democratic principles (Crimm, 2007; The Lancet, 2019; Legal information Institute, 2020).

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

2. Methods and materials

A scoping review is apt as it allows exploration of a topic with undefined conceptual boundaries and data of a varied and heterogenous nature (Arksey & O'Malley, 2005; Tricco et al., 2016). This study will be conducted using a framework developed by Arksey and O'Malley (2005), consisting of five stages: identifying the research questions; identifying relevant studies; selecting studies; charting the data; collating, summarising, and reporting the

results. Our research question is as follows: *What is the impact of the Global Gag Rule on the sexual and reproductive health of people living in low- and middle-income countries across the three periods that is has been in effect?*

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

[Add Table 1 here]

Additional sources and unpublished literature were retrieved by a Google search using the terms 'Global Gag Rule', 'Mexico City Policy' and 'USAID funding'. Websites of key stakeholders were then hand-searched, including Marie Stopes International, International Planned Parenthood Federation, Kaiser Family Foundation, Guttmacher Institute, Human Rights Watch, CHANGE and Population Action International. A Google Scholar Search was

also carried out using the key terms ‘Global Gag Rule’ and ‘Mexico City Policy’, providing approximately 5910 results. The first 20 pages of Google Scholar results were reviewed, and appropriate articles extracted.

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

[Add Table 2 here]

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

The results were structured according to the five major themes identified: the operations of non-governmental organisations, maternal health, sexually transmitted infections, specific social groups, and reproductive rights. Some of the major themes were then divided into sub-themes, as depicted in Table 3. (See Appendix 2 for a complete reference, theme and sub-

theme overview). The interpretation of the results and the broader implications of the study findings are considered in the discussion.

[Add Figure 1 here]

[Add Table 3 here]

3. Results

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

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

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

The literature emphasised the severity of the current expanded GGR and the additional impact it would have on funding and services. IPPF and MSI have identified a combined funding gap of $160 million by the end of the 2017-2020 administration (Planned Parenthood Global

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

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

Across all three policy periods, the GGR impacted integration of services and partnerships between organisations, leading to fragmented and inefficient health systems (Camp, 1987; CHANGE, 2018; PAI, 2005; Schaaf et al., 2019). Efforts to integrate HIV care into existing

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

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

small and non-English speaking organisations (CHANGE, 2018; Mavodza et al., 2019; PAI, 2018; PPG, 2019; Puri et al., 2019; Rios, 2019).

3.2 Maternal health and abortion access

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

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

saw a 40% reduction in family planning use in their clinics (Brooks et al., 2019; Jones, 2015; PAI, 2005).

Organisations expect that the current expanded GGR will cause maternal mortality to match or exceed the high levels caused by the Bush GGR (Crane et al., 2017). The current GGR has disrupted obstetric and gynaecological services including cervical cancer screening, provision of nutritional supplements to reduce anaemia, Zika prevention and training, and misoprostol adminstration for the treatment of post-partum haemorrhage (CHANGE, 2018; PAI, 2018; PPG, 2019). Services and centers for survivors of gender-based violence have been disrupted, and several discontinued, after refusing to comply with the GGR due to their dedication to providing integrated, woman-centred care which includes safe abortion (CHANGE, 2018; Rios, 2019).

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

3.3 Sexually transmitted infections

Funding cuts to non-compliant NGOs affect the prevention, detection, and treatment of STIs, including HIV. Even though they were ostensibly protected from the effects of the Bush

GGR, confusion and fear amongst NGOs led to disruption of HIV services, including exclusion of key partners in HIV prevention projects and avoidance of discussing legal abortion as an option for pregnant women living with HIV (PAI, 2005; Philpott et al., 2010).

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

3.4 Impact on marginalised groups

The literature emphasised the impact on *rural and isolated communities* due to their dependence on NGOs for healthcare and lack of alternative options if services were cut

(CHANGE, 2018; du Plessis et al., 2019; PAI, 2005; PPG, 2019; Puri et al., 2019). During the Bush GGR, rural communities in Ethiopia, Ghana, Nepal, Tanzania, Kenya, Zambia, Zimbabwe and Bolivia faced a reduction or termination of services due to a loss in U.S. funding, leaving many communities with no access to affordable healthcare (Barot & Cohen, 2015; CHANGE, 2018; Jones, 2004; Jones, 2015; PAI, 2005). In Ghana, PPAG were compelled to suspend their community-based distribution projects and close 28 rural clinics, resulting in a 45% drop in contraceptive provision and a 20-40% increase in unwanted fertility. The burden of additional unplanned pregnancies fell disproportionately on the poorest women, who were unable to access abortion services (Jones, 2015).

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

The GGR has led to the defunding of organisations that provide sexual and reproductive health services to *sexual minorities* (CHANGE, 2018; Rios, 2019; Sastrawidjaja, 2004). Under the current administration's expanded GGR, projects in Kenya, Mozambique, Zambia and across four countries in Central America that provided HIV prevention services to high-risk populations, such as sex workers, men who have sex with men (MSM) and transgender people, have shut down (CHANGE, 2018; PPG, 2019; Rios, 2019). Services for sex workers

have also been significantly reduced; a night clinic in Mozambique providing integrated healthcare to sex workers could not comply with the GGR and has closed due to inadequate funding (CHANGE, 2018; PPG, 2019).

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

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

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

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

Although humanitarian aid is excluded from the GGR, in practise the policy has significant implications for the health of *refugees and migrants*. The Reproductive Health Response in Conflict Consortium coordinates efforts for providing sexual and reproductive healthcare to women living in conflict settings. However, since MSI was a constituent member, the Consortium was forced to relinquish U.S. funding in 2003 (CHANGE, 2018; PPG, 2019). Under the expanded GGR, organisations in Uganda and Nepal working with refugees and migrants have funding shortfalls and have had to reduce or withdraw support. In Uganda, 1.3 million people live in refugee camps, half of which were previously served by Reproductive Health Uganda. Under the Trump GGR, the organisation has been forced to divert $100,000 of funding away from refugee camps to cover other areas of their work. They emphasised the importance of their work: *"When it comes to issues of family planning, adolescents [and] post-abortion care, the demand [in the camps] is huge. When someone has HIV and is on drugs and comes here as a refugee, they are lost. We've gone in and introduced services as public health facilities are overstretched"* (PAI, 2018, p.6).

3.5 Reproductive rights

Compliant NGOs in Mozambique, South Africa, Bolivia, Nepal, Senegal, Uganda, Peru, Ethiopia and Zimbabwe have stated that they feel *censored* by the GGR and are reluctant to engage in discussion around their work for fear of losing U.S. funding (Baird, 2019; Centre for Reproductive Rights, 2000; CHANGE, 2018; du Plessis et al., 2019; Gezinski, 2012; Jones, 2004; PAI, 2005, 2018; Puri et al., 2019; Rios, 2019). In both Nepal and Ethiopia, compliant NGOs have been prevented from engaging in government-initiated discussions on abortion law reform in their countries (PAI, 2005; Mavodza et al., 2019). As opponents of abortion are still able to speak freely and advocate their views, public discussion of abortion has become skewed, which may lead to long-term changes in local and national discourses around abortion (CHANGE, 2018; Petroni & Skuster, 2008; Rios, 2019). Under the expanded

GGR, fewer organisations have been attending SRHR advocacy events. At an annual conference in 2017, several groups were unable to participate in relevant workshops as abortion would likely be discussed. In South Africa, civil society organisations are fearful that abortion issues will be side-lined at national sexual and reproductive health gatherings. Stakeholders from South Africa and Nepal expressed frustration and anger at the power imbalance between the Global North and the Global South, and regarded the GGR as interference from a powerful nation openly abusing its position of economic dominance (CHANGE, 2018; Cohen, 2003; du Plessis et al., 2019; Puri et al., 2019, Rios, 2019).

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

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

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

However, a number of NGOs and organisations have been motivated to increase advocacy efforts for safe, legal abortion. Several movements have formed in opposition to the policy including the SheDecides movement and the Global Health, Empowerment and Rights Act. The latter is a legal challenge to the GGR, introduced by a bipartisan group of policy makers in the U.S., and, if successful, would revoke and prevent reinstatement of the policy (CHANGE, 2018; du Plessis et al.; PPG, 2019; Rios, 2019).

4. Discussion

The findings of this study clearly demonstrate that the GGR has a negative impact on the SRHR of people in the Global South. Across all three policy periods there have been funding cuts to key organisations, leading to significant reductions in health services, including clinics, community-based distribution of commodities, and outreach teams (Camp, 1987; Jones, 2011, 2015; Moss, 2017; PAI, 2005). Reductions in funding to key organisations has not only affected abortion access but has led to an increase in maternal mortality and

morbidity through diminished access to contraception and peri-natal care, resulting in higher fertility rates, unsafe abortions, and pregnancy and birth complications (Brooks et al., 2019; CHANGE, 2018; Crane et al., 2017; Gezinski, 2012; MSI, 2017). The decimation of funding to organisations providing comprehensive sexual health care and the de-integration of HIV from basic reproductive health services has resulted in a deterioration of STI prevention and treatment efforts. This has led to an increased number of people with an untreated STI, including HIV, resulting in avoidable deaths and disability (Bingenheimer & Skuster, 2017; IPPF, 2017; Rios, 2019; Sherwood et al., 2018). The policy has disproportionately affected the limited services directed towards marginalised groups, including sex workers, LGBT people, religious minorities, refugees and migrants. Without specialised services, these groups face further barriers to accessing quality healthcare and will suffer the consequences of continued poor health outcomes and associated stigma (CHANGE, 2018; PAI, 2005; Rios, 2019; Sastrawidjaja, 2004).

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

The GGR does not fulfil its aim of reducing the number of abortions, and therefore does not realise the purported aim of the Trump policy of "protecting life." There is significant evidence that the policy has the opposite effect, while introducing devastating consequences

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

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

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

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

The restrictions imposed by the GGR are not implemented by a democratically-elected government but are imposed by the U.S. onto those in the Global South (Crimm, 2007). Despite being challenged legally, the policy undermines the abortion legislation of an estimated 37 countries where abortion is permissible in at least one circumstance prohibited

by the policy, while in a further 27 countries, opportunities for abortion law reform are inhibited (Moss, 2017). By prohibiting NGOs and healthcare professionals from speaking openly about abortion, the GGR violates several international covenants which guarantee the rights to freedom of speech, to seek and share information and to enjoy the benefits of scientific progress (United Nations General Assembly, 1966a, 1966b). This contradicts the principles of U.S. foreign policy and the mission of USAID to '*promote and demonstrate democratic values abroad*' (USAID, 2018, para. 1). The GGR, alongside similarly justified policies such as the defunding of UNFPA and the promotion of abstinence-only HIV prevention programs, has undermined the rights-based approach to global health and set a dangerous precedent for funding restrictions (Bogecho & Upreti, 2006; Crane & Dusenberry, 2004). These power dynamics bear worrying similarities to the imposition of norms and values when much of the Global South was under direct colonial rule. It is important to acknowledge that the values reproduced by the GGR around race and gender are not new. The ideas are part of similar post-colonial power relations that have been critically analysed by scholars in various research areas (Said 1978; Ayeb-Karlsson 2020). The GGR exports the limits posed by the values of a vocal political minority in the U.S. onto the SRHR of women across the Global South. It does so in the name of serving the political interests of a powerful foreign state, and with no regard to the consequences for the health and lives of millions of women. This is a form of neo-colonialism and is yet another force that serves to perpetuate growing disparities of wealth and health between the Global North and the Global South.

One positive outcome of the expanded GGR is the decreased reliance on U.S. funding. Its most recent iteration has encouraged the governments of affected nations to take action in relation to the provision of quality healthcare (PPG, 2019; Rios, 2019). Currently, a worryingly large proportion of healthcare in the Global South is delivered by NGOs in order to the address the gaps in weak, under-funded health systems (Wadge, 2017), the end-result of

the economic exploitation of colonialism and the effects of structural adjustment and political instability in the post-colonial period (Alubo, 1990; Bruhn & Gallego, 2012; Turshen, 1977). Dependence on NGOs for healthcare provision results in unsustainable health systems that are subject to troubling power dynamics, as funding is assigned in accordance with the decisions of external operators and therefore may be discontinued, reallocated, or conditional. Further, the difficulties in coordinating between NGOs and country governments can result in unequal health coverage across states and unevenness in relation to different areas of care (Hearn, 1998; Reddy et al., 2018; Wadge, 2017). The dependence of the Global South on international aid to meet the basic health needs of the population leaves countries vulnerable to the questionable political and ideological whims of the Global North (Shahvisi, 2019), creating a cycle of intensifying dependence and control.

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

Second, some countries and regions are not represented in the study, while others are proportionally overrepresented. For example, countries in Asia and Latin America were underrepresented while the Africa region was overrepresented. This is an artefact of the openness of the methodology, yet it is likely that important consequences have accordingly been overlooked, and that the sensitivity of this issue, as well as the limited resources required to provide reports on outcomes, have posed barriers to information gathering. This may also be a result the inherent struggle in academia (and review studies in particular) where countries

with a Commonwealth connection or country contexts that may more frequently provide reports and research in English are overrepresented. Meanwhile, there is a relatively unexplored literature body in Spanish and Portuguese, for example.

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

5. Conclusion

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

This review has identified several aspects of sexual and reproductive health that have been harmed by the GGR. First, the policy does not reduce abortions but rather decreases access to family planning, resulting in a higher number of unintended pregnancies and a subsequent increase in the number of unsafe abortions. Through its impacts on services, the GGR leads to an increase in maternal morbidity and mortality, and higher rates of STIs, including HIV. These consequences have implications for the health of populations as a whole, with the greatest impact on the most marginalised. Censorship of health professionals and organisations has created an atmosphere of fear, in which the conversation on abortion and SRHR is severely constrained and nudged towards the ideological right. The net result is the stalling and reversing of global progress in advancing and protecting SRHR.

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

Declaration of interest

No potential conflict of interest to declare.

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Appendix 1: Data extraction table

	Author(s) and date	Title	Policy era	Key themes identified					Peer review
				Impact on organisations	Maternal health	STIs	Specific groups	Reproductive rights	
1	Camp S. 1987	The impact of the Mexico City Policy on women and health care in developing countries.	Reagan	IPPF would be subject to GGR in 1987, which would put 120 projects worth $23 million at risk. Administrative burden of compliance is substantial. Organisations confused about the specifics and have over-compensated to avoid funding cuts.	Impact on partnerships between family planning services and other organisations.				Yes
2	Jones KM. 2011	Evaluating the Mexico City policy: how US foreign policy affects fertility outcomes and child health in Ghana	Bush	Significant funding cuts to IPPF member associates.	No overall impact on abortion rate in Ghana, however in rural areas, contraceptive use decreased, and fertility rate and abortion rate increased during policy period.		Poorest women did not utilise abortion and suffered from greater number of unintended births.		No
3	Centre for Reproductive Rights	The Bush Global Gag Rule. A Violation of International Human Rights.	Bush					Censorship of compliant organisations means that NGOs cannot lobby for abortion law reform in Zimbabwe, or for increased access	No

								for poor and rural women in Nepal.	
4	Population Action International 2006	Access Denied Report 2005 – The Impact of the Global Gag Rule	Bush	Significant budget cuts to key NGOs in Ethiopia, Ghana, Kenya, Nepal, Tanzania and Zimbabwe, which resulted in dismissal of staff members, closure of clinics, cutbacks in community-based distribution programs and an increase in care prices.	Reported decrease in family planning use and disrupted post-abortion care.	Confusion over the inclusion of HIV funding led to de-integration of services and ending of partnerships			No
5	Population Action International 2018	Access Denied: Preliminary Impacts of Trump's Expanded Global Gag Rule	Trump	Significant budget cuts to NGOs in Uganda, Ethiopia, Nepal and Senegal. Impact on referrals to non-compliant organisation disrupting services and healthcare provision. Significant administrative burden associated with compliance and confusion surrounding terms of GGR leading to over implementation.	Cuts to family planning services and commodities across Uganda, Ethiopia, Nepal, Nigeria and Senegal.		Rural groups and refugees at risk, due to cutback in outreach teams and relocation of funding from camps to clinics. $100,000 diverted away from refugee camps to clinics. In Nepal, work focused on migrant communities and Muslim communities have been cut.	Policy limits partnership between compliant and non-compliant and non-compliant and presents as barrier to advocacy efforts. The GGR emboldens anti-choice advocates and fuels hostile rhetoric against SRHR.	No
6	Planned Parenthood Global 2019	Assessing the Global Gag Rule: Harms to Health, Communities and Advocacy	Trump	MSI and IPPF will have funding gap of $160 million by end of Trump administration. Administrative burden and widespread	This will result in additional unintended pregnancies, unsafe abortions and maternal deaths. Reduction in gynae and HIV services in Mozambique.			Stakeholders fearful to oppose policy and advocates silenced.	No

				confusion reported on application of GGR. Guidance often not given and when it is, only given in English.	Confusion has affected post-abortion care and emergency oral contraceptive pill.			Influenced national policy progress on SRHR as politicians and governments fearful of opposing U.S. or emboldened by anti-human rights agenda	
7	Centre for Health and Gender Equality 2018	Prescribing Chaos in Global Health: The Global Gag Rule from 1984-2018	Reagan Bush Trump	During Reagan era, IPPF lost 25% of total funding and under Bush, lost $100 million over 8 years, resulting in increased unintended pregnancy and abortion. $400 million in healthcare costs will be transferred onto families and governments. Across all three periods, confusion over terms of policy and lack of guidance led to over implementation.	Under Trump, MSI estimates reduced access to contraception, increased unintended pregnancy, increased unsafe abortion and increased maternal deaths. Family planning clinics closed, and supply of contraceptives disrupted.	HIV services affected; several clinics catering to adolescent girls and to rural groups closed.	Several organisations providing care for LGBT people closed and services for sex workers reduced. Community-based distribution of information and commodities to rural areas disrupted. Reproductive Health Response in Conflict Consortium, which coordinated efforts for sexual and reproductive healthcare to women in conflict areas, lost US funding in 2002 as MSI was a member.		No
8	International Planned Parenthood Association. 2017	Policy Briefing: The GGR and its impacts	Bush Trump		IPPF could have prevented 20,000 maternal deaths. Under Bush, shortages in contraceptives led to stock outs in Nepal and Ethiopia	IPPF could have provided 70 million condoms, provided treatment to			No

					and NGO in Ethiopia to stop offering free condoms.	275,000 pregnant women LWHIV and treated 525,000 STIs.			
9	International Planned Parenthood Association 2019	Policy Briefing: The Impact of the Global Gag Rule	Trump		Funding cuts to IPPF forced member associates to stop Zika prevention and care projects in Guatemala, Honduras and Colombia. Projects to increase access to contraceptive injection halted	HIV prevention partnerships have broken down	HIV services for key populations such as sex workers, MSM and transgender people have closed. Rural communities in Botswana have lost access to healthcare.		No
10	Asiedu, E. Nanivazo, M. Nkusa, M. 2013	Determinants of foreign aid in family planning: how relevant is the Mexico City Policy?	Reagan Bush	Implementing the GGR reduced total family planning assistance by 3-6%.					Yes
11	Crane, BB. Daulaire, N. Ezeh, AC. 2017	Reproductive health in culture wars crossfire.	Bush Trump	Amref Health Africa has decided to comply with GGR, to continue serving people who depend on HIV programs in more than 30 countries in Africa.	They will have to stop providing abortion services, information and referrals.				Yes
12	Barot, S. 2017	When Antiabortion Ideology Turns into Foreign Policy: How the Global Gag Rule Erodes Health, Ethics and Democracy.	Trump	There has been a trend towards integrated services in low-income settings with NGOs providing multiple services in one facility. Under Trumps GGR many would be denied funding and more services are disrupted.	GGR reduces access to high-quality contraceptives, increasing probability of unintended pregnancy and abortion. Abortion is often unsafe in low- and middle-income countries and a major cause of morbidity and mortality.			Trend towards liberalisation of abortion law means more countries where access to legal services will be impeded.	No

13	Bendavid, E. Avila, P. Miller, G. 2011	United States aid policy and induced abortion in sub-Saharan Africa	Bush		Abortion rate was stable between 1994 and 2001 and steadily rose between 2002 and 2008, increasing from 10.4 per 10,000 woman-years to 14.5 per 10,000 woman-years. Rate remained stable in low-GGR exposure countries but rose sharply in high-GGR exposure countries. Women in HECs had 2.55 times the odds of having an abortion during the policy period. In HECs, the increase in contraceptive use proceeded at a slower pace after 2002 and was found to be 1.8% lower under the GGR than expected.				Yes
14	Bingenheimer, JB. Skuster, P.	The Foreseeable Harms of Trump's Global Gag Rule	Bush Trump	Overall funding didn't decrease but became unavailable to the largest and most well-established providers of sexual and reproductive health services.	Trump's GGR will increase maternal mortality rate due to increased unintended pregnancies.	The inclusion of PEPFAR under Trumps GGR will lead to new HIV infections and AIDS-related deaths that could have been averted		During Bush GGR, advocates in Kenya and Nepal were unable to contribute to law reform efforts.	Yes
15	Crane, BB. Dusenberry, J. 2004	Power and Politics in International Funding for Reproductive	Bush		Predicts that the GGR did not reduce abortions and by disrupting family planning services through effective NGO providers, the policy is more likely to			Difficulties in collaboration between compliant and non-compliant organisation	Yes

		Health: the US Global Gag Rule			have increased the number of abortions. In Romania, where abortion is a major means of fertility control, separation of contraceptives and abortion care due to GGR reduces opportunities to promote post-abortion contraceptive use.			impedes advocacy, training and research in post-abortion care.	
16	Marie Stopes International 2017	Global Impact Report 2016: The First Step	Trump		Estimates that Trump GGR will result in 6.5 million unintended pregnancies, 2.1 million unsafe abortions, 21,700 maternal deaths and $64.2 million in direct healthcare costs to governments, families and women between 2017 and 2020.				No
17	Marie Stopes International 2018	Global Impact Report 2017	Trump	Trump's GGR will result in a $30 million annual funding gap for MSI.					No
18	Marie Stopes International 2019	Global Impact Report 2018	Trump				20 outreach teams to rural communities in Madagascar have shut down. Women have no other source of contraception.		
19	Barot, S. Cohen, SA. 2015	The Global Gag Rule and Fights over Funding UNFPA: The Issues That Won't Go Away	Bush	Fear and uncertainty of reimplementation led to some organisations being reluctant to accept U.S. funding after GGR repealed in 2008.	GGR led to closing of some of Global Souths most effective family planning programs and cutting of contraceptive deliveries to 16 countries.		Activities in poor and rural communities particularly affected.	Proponents of SRHR tabled a Global Democracy Act which if passed would have prevented future presidents	No

								from bringing back the GGR.	
20	Bogecho, D. Upreti, M. 2006	The Global Gag Rule: An Antithesis to the Rights-Based Approach to Health	Bush	Main family planning NGOs in Kenya and Nepal refused to comply with GGR, lost funding and had to cut back services and close several clinics (8 in Kenya).			In Kenya, a clinic providing only source of healthcare to large slum area in Nairobi closed. In many underserved areas MSI and FPAK provided only source of affordable healthcare.	Although Nepal legalised abortion in 2002, the government is reliant on NGOs to provide abortion services, disseminate information and monitor effective implementation. Many NGOs not able to participate.	Yes
21	Boonstra, H. Cohen, SA. 2006	Of Gag Rules and Loyalty Oaths: Exporting Ideology at the Expense of Public Health and American Values Symposium: Family Planning and AIDS Policy in the International Community	Bush			Integration of family planning and HIV programs take advantage of long-term investments in healthcare infrastructure. GGR prevents experienced organisations from bringing expertise to integrated programs		In Ethiopia many NGOs could not participate in abortion law discussions.	Yes
22	Brooks, N. Bendavid, E. Miller, G. 2019	USA aid policy and induced abortion in sub-Saharan Africa: an analysis of	Bush	Development assistance increased from U.S. from 2008 but more so in HECs, from $0.15 per capita to $0.65 per	Abortion rate rose by 40% when policy was in effect in HECs				Yes

		the Mexico City Policy		capita. U.S. dominant provider of assistance, accounting for 30% between 1995 and 2014. No changes in non-U.S. funding when policy was in place fully accounted for reductions in U.S. funding.					
23	Cohen, SA. 2003	Global Gag Rule Revisited: HIV/AIDS Initiative Out, Family Planning Still In	Bush	Government clinics in Kenya not in a position to compensate for lost NGO clinics nor regain the trust of women turned away.	In Romania, health minister ready to issue protocol requiring all abortion providers to offer contraception counselling to patients. No U.S. funds can be used for this.			Taskforce discussing legalisation of abortion in Ethiopia reluctant to progress as fearful of jeopardising relationship with USAID.	No
24	Baird, KL. 2004	Globalizing Reproductive Control: Consequences of the "Global Gag Rule"	Bush	FPAN lost funding as it decided to continue its advocacy efforts.				Organisation in Peru and Nepal unable to lobby for decriminalisation of abortion.	No
25	Grollman, C. Cavallaro, FL. Duclos, D. Bakare, V. Alvarez, MM. Borghi, J. 2018	Donor funding for family planning: levels and trends between 2003 and 2013	Bush	Family planning assistance rose form under $400 million prior to 2008 to $886 million in 2013. More than 2/3 of assistance came from U.S. After reimplementation in 2001, other donors did					Yes

				not increase funding to offset lost U.S. funds.					
26	Cohen, SA. 2004	U.S. Global Reproductive Health Policy: Isolationist Approach In an Interdependent World	Bush		BRAC, largest and most successful NGO in Bangladesh, provides a very early form of abortion at request of the government. Therefore, had to refuse GGR and forgo funding.		Key projects they run aim at generating income for poorest women in Bangladesh.		No
27	Tibone, KL 2013	Did the Mexico City Policy affect pregnancy outcomes in Ethiopia? The impact of U.S. policy on reproductive health and family planning programs.	Bush		Women are less likely to have an abortion when GGR in effect in 2008 than not in effect in 2009. Women with highest education are more likely to have an abortion during GGR. Author expressed concern about validity of data and recall bias. When examining data, author found discrepancies. Author hypothesised that abortions underreported due to stigma and discrimination and true number is higher.				No
28	Gezinski, LB. 2012	The Global Gag Rule: Impacts of conservative ideology on women's health	Bush				Impact on community-based distribution of contraceptives and for referrals for maternal and child health services to rural areas in Kenya.	In Ethiopia, Kenya, Peru and Uganda, NGOs felt censored by GGR and feared implications of voicing opinions regarding law. Indicated that	Yes

								censorship prevented them from dispelling myths about abortion and contributed to inaction of policymakers.	
29	Jones, AA. 2004	The "Mexico City Policy" and Its Effects on HIV / AIDS Services in Sub-Saharan Africa	Bush	Clinics closed: 17 in Uganda, 5 in Kenya, one outreach program in Ethiopia and several in Tanzania. MSI Kenya reduced staff by 1/5, cut salaries and raised client fees. FGAE funding cuts resulted in loss of service to 301,054 women and 229,947 men in urban areas.		De-integration of HIV and family planning services particularly effects pregnant women with HIV.	NGO in Bolivia lost funding and had to limit outreach to rural communities.	Prevention communication of legal rights e.g. abortion legal in Zimbabwe if threat to women's health including HIV. 4 NGOs in Bolivia had to stop campaigning about abortion.	Yes
30	Rios, V. 2019	Crisis in Care – Year Two Impact of Trump's Global Gag Rule	Trump	GGR will cause U.S. to lose leadership role and may help Nigerian government prioritise family planning and fulfil promises. Lack of clarity leads to organisations overcompensating.	GGR will increase abortion rate and is 'pro-birth' not 'pro-life'. Services for GBV survivors affected as they cannot stop abortion services. Makes post-abortion care less accessible.	Threatens PEPFAR investment to integrate HIV services in sexual and reproductive health services. Services and education to 13,000 orphans and children living with HIV closed.	Organisation in Kenya working with sex workers can no longer provide information or abortion referrals. In Kenya, services for religious minorities closed, due to stigma and social barriers they relied on outreach. Comprehensive sexuality education policy in South Africa affected by GGR.	In Kenya, concern that GGR delaying finalising guidelines on reducing unsafe abortion as it has increased anti-choice rhetoric. Concern that abortion would be side-lined at national events in South Africa.	No

31	Jones, KM. 2015	Contraceptive Supply and Fertility Outcomes: Evidence from Ghana	Bush	PPAG clinics reduced from 41 rural and 16 urban to 13 rural and 11 urban	Increased probability of conception by 5.6% overall and by 10% in rural areas. Of additional unwanted pregnancies, 1 in 5 was aborted. There was a 5-10% increase in total fertility which represents a 20-40% increase in unwanted fertility.		Burden of unwanted births fell disproportionately on poorest women.		Yes
32	Miller, S. Billings, DL. 2005	Abortion and Postabortion Care: Ethical, Legal, and Policy Issues in Developing Countries	Bush		Women presenting to clinic told midwife she didn't want pregnancy. Midwife under GGR and felt she couldn't openly address woman's concerns. Woman attended 3 days later having attempted to self-procure abortion. Abortion legal if health of mother at risk, which it was in this case due to anaemia.				Yes
33	Mollmann, M. 2004	Who Can be Held Responsible for the Consequences of Aid and Loan Conditionalities ?: The Global Gag Rule in Peru and Its Criminal Consequences	Bush	Many NGO workers and professionals not aware of the less restrictive provisions in policy because the law has never been relayed to them in its totality. USAID published guide but it is only in English.				Advocates prevented from lobbying for change in abortion laws. Has also affected lobbying for provision of post-abortion care and emergency contraception. GGR legitimises	No

								current restrictive policies.	
34	Moss, K. Kates, J. 2017	How Many Foreign NGOs Are Subject to the Expanded Mexico City Policy.	Trump	If policy had been in effect between 2013 and 2015, at least 1,275 foreign NGOs would be affected, and 494 US NGOs would have to ensure subrecipients were in compliance. Funding supported efforts in at least 91 countries across all major global health programs.	82 family planning and reproductive health prime recipients and $175 million in funding would be subject to GGR.	HIV had greatest number of prime recipients affected. 470 prime recipients subject to GGR, resulting in $873 million in funds at risk.			No
35	Sastrawidjaja, ST. 2004	What happened to safer sex? How the US abstinence-only and Global Gag Rule policies affect sexual minorities.	Bush	Some organisations mistakenly believe that GGR prevents them from disseminating information about HIV and condom use.		Non-compliant organisations are denied access to US-supplied condoms. Supplied condoms dramatically reduced in 29 countries including PEPFAR countries.	GGR defunded programs that reach out to sexual minorities. Organisation in Ghana that does outreach for MSM can no longer distribute condoms as most reliable supplier will not provide them.		No
36	Sagala, JK. 2005	Bush's Global Gag Rule and Africa: Impact on Reproductive Health.	Bush	Loss of funding meant that FGAE could no longer serve 300,000 clients that desperately needed reproductive health services in Ethiopia.		GGR will adversely impact HIV efforts as same family planning providers that refuse to adhere to GGR are at the frontline battle against spread of HIV.	Outreach services in Ghana severely affected, and staff reduced by more than 40%.		Yes

37	Philpot, S. Slevin, KW. Sharipo, K. Heise, L. 2010	Impact of Donor-imposed Requirements and Restrictions on Standards of Prevention and Access to Care and Treatment in HIV Prevention Trials	Bush		Uncertainty about GGR meant that HIV prevention trail staff avoided discussing pregnancy options with participants, even though in some cases abortion would be legal.			In South Africa, 'option counselling' for pregnant women with HIV is legal requirement. But staff did not provide it and instead referred women to local family planning clinics.	Yes
38	Sherwood, J. Sharp, A. Honerman, B. Horrigan, C. Chatterjee, M. Jones, A. Cooney, C. Millet, G.	Mapping the impact of the expanded Mexico City Policy for HIV/ family planning service integration in PEPFAR-supported countries: a risk index	Trump		De-integration of HIV and family planning will lead to decreased access to family planning, especially for women living with HIV who are more likely to use contraception while accessing integrated care. Meeting needs of women living with HIV important to reduce unintended pregnancies and avert new infant HIV cases.	High risk of de-integration of HIV and family planning services with Trump's GGR. 10 out 31 countries in study report 90% HIV sites to be integrated with family planning services.			Yes
39	Singh, JA. Karim, SSA. 2017	Trump's "global gag rule": implications for human rights and global health.	Trump		Bush GGR lead to increase in abortion rate, probably due to decreased contraception access and increased unwanted pregnancy. Predicts Trumps GGR will yield similar or worse results. In Bolivia, government urge women to avoid pregnancy due to Zika. Loss of funding			Compliance may require clinicians to violate professional code of conduct and countries laws by denying women information about pregnancy options.	Yes

					to MSI likely to affect access to contraception and fertility control.				
40	Petroni, S. Skuster, P. 2008	The Exportation of Ideology Reproductive Health and Rights in U.S. Foreign Policy.	Bush					Imbalance of arguments in abortion debate in Ethiopia may have resulted in more restrictive law than sought by advocates. In 2004, law expanded but is still crime punishable by prison for women and provider in many cases.	Yes
41	Starrs, AM. 2017	The Trump global gag rule: an attack on US family planning and global health aid.	Trump		Policy could increase abortions. Anecdotal data shows main effect is to reduce quality of contraceptive services, increasing unintended pregnancy. Integration of services means that lots of different areas affected.				Yes
42	Rodgers, YVDM. 2018	Impact of the Global Gag Rule: New Estimates	Bush		In Latin America and Caribbean, abortion rate increased by three times under policy and in sub-Saharan Africa two times. There was a decrease in abortion rate in Eastern Europe and Central Asia and South and Southeast				No

					Asia, but in Eastern Europe and Central Asia it was offset by increased funding form other donor countries.				
43	Shen, JY. 2017	Three essays on the effects of donor supplied contraceptives on fertility, usage, and attitudes.	Bush		Increase in donations of contraception to Zambia after 2008. Amount between 2008 and 2014 is almost 7 times that between 2000 and 2007. Increase in fertility rate between 2001 and 2007.		Increase in fertility between 2001 and 2007 particularly seen in rural areas.		No
44	Adhikari, R. 2019	US "global gag rule" on abortion is limiting family planning choices for women in Nepal.	Trump	FPAN lost US funding in 2018. Director Genera, of FPA estimates $9 million needed to fully operate but they are currently running on $4 million. 10 million people will be affected by cuts.	Although abortion is legal in Nepal, government is reluctant to discuss the rule and unlikely they will replace lost services.		Contraceptive programme serving 11 remote districts forced to close.		Yes
45	Puri, M. Wagle, K. Rios, V. Dhungel, Y. 2019	Early impacts of the expanded Global Gag Rule in Nepal.	Trump				Cuts in funding affect the supply of equipment and therefore the price, resulting in increased service fee. Will affect poor populations the most.	Key stakeholders described the policy as 'wrong' and 'damaging. It violates legal right afford to Nepali women. Organisations expressed frustration over power imbalance between Global North and South. Organisations don't feel able to	No

								express opinions about GGR.	
46	Du Plessis, U. Sofika, D. Macleod, C. Mthethwa, T. 2019	Assessing the impact of the expanded Global Gag Rule in South Africa.	Trump	Compliant organisations have started to decline invitations to conferences and workshops where abortion could be discussed. Adapting the contents of programs to comply with GGR perceived to be massive waste of expenses.			Organisations providing sexuality education to young people have had to close.	Stakeholders considered policy to be a form of bullying by a powerful nation. Argument that services needed to become more sustainable and less reliant on US.	
47	Schaaf, M. Maistrellis, E. Thomas, H. Cooper, B. 2019	'Protecting life in global health assistance'? Towards a framework for assessing the health systems impact of the expanded Global Gag Rule.	Trump	Funding. Predicted that the GGR will force de-integration of services and stop health services referring patient's for abortion related care.					Yes
48	Mavodza, C. Goldman, R. Cooper, B. 2019	The impacts of the global gag rule on global health: a scoping review.	Reagan Bush	Under Reagan IPPF lost approx. $11 million. Under Bush IPPF lost $18 million annually.		Organisations in Uganda forced to separate abortion from HIV services creating vulnerability for women living with HIV.		Organisations in Ethiopia, Kenya, Mozambique, Nigeria and Uganda were excluded from abortion discussions.	Yes

Appendix 2: Colour-coded themes relevant to each source

Title	Impact on organisations			Maternal health	STIs	Impact on specific groups				Reproductive rights		
	Funding	Health services	Cost of compliance			Rural	Sexual minorities	Religious minorities	Refugees, migrants	Censorship	Right to abortion	Galvanising advocates
The impact of the Mexico City Policy on women and health care in developing countries.												
Evaluating the Mexico City policy: how US foreign policy affects fertility outcomes and child health in Ghana												
The Bush Global Gag Rule. A Violation of International Human Rights												
Access Denied Report 2005 – The Impact of the Global Gag Rule												
Access Denied: Preliminary Impacts of Trump's Expanded Global Gag Rule												
Assessing the Global Gag Rule: Harms to Health, Communities and Advocacy												
Prescribing Chaos in Global Health: The Global Gag Rule from 1984-2018												
Policy Briefing: The GGR and its impacts												
Policy Briefing: The Impact of the Global Gag Rule												
Determinants of foreign aid in family planning: how relevant is the Mexico City Policy?												
Reproductive health in culture wars crossfire												

When Antiabortion Ideology Turns into Foreign Policy: How the Global Gag Rule Erodes Health, Ethics and Democracy.												
United States aid policy and induced abortion in sub-Saharan Africa												
The Foreseeable Harms of Trump's Global Gag Rule												
Power and Politics in International Funding for Reproductive Health: the US Global Gag Rule												
Global Impact Report 2016: The First Step												
Global Impact Report 2017												
The Global Gag Rule and Fights over Funding UNFPA: The Issues That Won't Go Away												
The Global Gag Rule: An Antithesis to the Rights-Based Approach to Health												
Of Gag Rules and Loyalty Oaths: Exporting Ideology at the Expense of Public Health and American Values Symposium: Family Planning and AIDS Policy in the International Community												
USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy												
Global Gag Rule Revisited: HIV/AIDS Initiative Out, Family Planning Still In												

Globalizing Reproductive Control: Consequences of the “Global Gag Rule”												
Donor funding for family planning: levels and trends between 2003 and 2013												
U.S. Global Reproductive Health Policy: Isolationist Approach in an Interdependent World												
Did the Mexico City Policy affect pregnancy outcomes in Ethiopia? The impact of U.S. policy on reproductive health and family planning programs.												
The Global Gag Rule: Impacts of conservative ideology on women's health												
The "Mexico City Policy" and Its Effects on HIV / AIDS Services in Sub-Saharan Africa												
Crisis in Care – Year Two Impact of Trump’s Global Gag Rule												
Contraceptive Supply and Fertility Outcomes: Evidence from Ghana												
Abortion and Postabortion Care: Ethical, Legal, and Policy Issues in Developing Countries												
Who Can be Held Responsible for the Consequences of Aid and Loan Conditionalities?: The Global Gag Rule in Peru and Its Criminal Consequences												

How Many Foreign NGOs Are Subject to the Expanded Mexico City Policy.												
What happened to safer sex? How the US abstinence-only and Global Gag Rule policies affect sexual minorities.												
Bush's Global Gag Rule and Africa: Impact on Reproductive Health.												
Impact of Donor-imposed Requirements and Restrictions on Standards of Prevention and Access to Care and Treatment in HIV Prevention Trials												
Mapping the impact of the expanded Mexico City Policy for HIV/ family planning service integration in PEPFAR-supported countries: a risk index												
Trump's "global gag rule": implications for human rights and global health.												
The Exportation of Ideology Reproductive Health and Rights in U.S. Foreign Policy.												
The Trump global gag rule: an attack on US family planning and global health aid.												
Impact of the Global Gag Rule: New Estimates												
Three essays on the effects of donor supplied contraceptives on fertility, usage, and attitudes.												

Table 1. Database search strategy including Boolean operators.

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

Table 2 - Inclusion and exclusion criteria

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

Table 3: Major themes identified in the review

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

Figure 1: Flow chart of included publications