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## It Is What It Is – Long-delayed Global Gag Rule Implementation Review Downplays Health Impacts

On August 18th, the Department of State released its [second review of the implementation of the Trump administration's expanded Global Gag Rule \(GGR\)](#) — about a year and half after it was initially promised. The review adds some new detail to what is already known about the impact of the GGR on foreign nongovernmental organizations (NGOs) receiving U.S. global health assistance, but like the earlier [Government Accountability Office \(GAO\) report](#), paints a back-dated picture of the situation on the ground from nearly two years ago. The review continues to minimize the adverse effects of the implementation of the expanded GGR by noting that the “vast majority” of U.S. government partners have complied with the funding conditions. For those that haven't complied, the organizations were replaced after transitions to alternative providers “that have been, for the most part, smooth.”

However, the review documents the occurrence of several significant disruptions in health care service delivery that would have had potentially serious consequences for the women and men denied health care, even if only for a relatively short time. Just to be clear, when the review refers to “a gap or disruption in the delivery of health care as a result of a declination” to comply with the policy by a foreign NGO recipient, lifesaving care is put out of the reach of individuals in need — men, women, girls who did not have access to needed health services. A woman who gets pregnant because the policy ended her ability to receive contraceptives through mobile outreach services in her rural community faces much more than a mere inconvenience as an unintended pregnancy will forever alter the course of her life.

The review reports that only eight out of 1,340 prime awardees between May 2017 and September 2018 declined to agree to abide by the GGR restrictions as a condition of receiving U.S. global health assistance, with an additional 47 subawardees also declining. Remarkably, the U.S. Agency for International Aid (USAID) awards represent virtually all of the declinations (53 out of a total of 55), with the Office of the Global AIDS Coordinator reporting none and the Department of Health and Human Services (including the Center for Disease Control and Prevention) and the Department of Defense adding one apiece. The USAID award declinations span the full spectrum of global health activities including HIV/AIDS, family planning and reproductive health (FP/RH), maternal and child health, tuberculosis and cross-cutting programs. In reading the review, one cannot help but come to the conclusion that USAID alone, among all of the implicated federal departments and agencies, took the collection of the data on prime and subrecipient awards necessary to perform a thorough quantitative and qualitative analysis of the implementation of the Trump policy most seriously.

As previously detailed in the [GAO report](#), Marie Stopes International (MSI) and the International Planned Parenthood Federation (IPPF), and their country affiliates, were two of the most significant prime implementing partners to decline U.S. global health assistance as a result of the GGR restrictions as a part of Support for International Family Planning and Health Organizations 2 (SIFPO2), a large, centrally managed family planning umbrella funding mechanism launched in 2014. The review recounts the struggles that USAID encountered in trying to find replacement NGOs to “replicate exactly what the two organizations had been doing” in about 10 African countries where MSI and IPPF were operating. MSI and IPPF have long been

among the principal targets for defunding by anti-choice activists, including Republicans on Capitol Hill, and for prior iterations of the GGR in past Republican administrations.

The review states that for the majority of subawards that were declined, the prime partner, usually a U.S. NGO, “ensured the continuation of project activities with minimal disruption” by implementing the activities itself or by identifying an existing foreign NGO subrecipient to take over for the original subrecipient that declined due to the GGR restrictions, sometimes hiring the former staff of the defunded NGO to manage the transition. The review acknowledges that such transitions to new partners in the event of a declination result in increased financial and staff costs to the project to “redesign approaches, recruit new staff and build the capacity of new partners to ensure the achievement of results.”

A chart included in the text of the review quantifies the instances in which prime recipients were unable to identify a qualified replacement for a foreign NGO partner that declines, which “resulted in the disruption of health care or delays in implementation of greater than three months.” Of the 45 subawards that declined U.S. global health assistance due to the GGR restrictions, 12 reported a gap or disruption in health care service delivery or implementation of that duration, most all of which occurred in HIV/AIDS and FP/RH activities.

The review notes that implementation of the expanded GGR has not led to significant changes in the list of foreign NGO recipients of USAID global health assistance. Out of the total of 45 subaward declinations, activities were transitioned to a new foreign NGO in only seven cases, all of which were USAID awards under the President’s Emergency Plan for AIDS Relief (PEPFAR). In five of the seven cases, the project “faced delays in implementation as the new partner hired staff and made adjustments to their intervention models to reach the intended beneficiaries.”

Models for providing health care identified by USAID that have proved particularly challenging include mobile outreach for family planning service delivery and HIV prevention; “social franchising,” especially for private sector FP/RH provision; involvement of private sector providers in tuberculosis control; and integrated approaches to HIV prevention, treatment and care to address the needs of key populations (defined by the Office of Global AIDS Coordinator as “people who inject drugs, men who have sex with men, transgender persons, sex workers and prisoners”).

The review cites one particularly egregious example in which the access to antiretroviral therapy (ART) to prevent HIV/AIDS progression for an unspecified number of clients at PEPFAR-funded treatment sites was disrupted for nearly two years. Five foreign NGO subpartners with USAID under PEPFAR declined to be bound by the expanded GGR restrictions, leading to a loss of mobile outreach for testing, treatment and care for HIV among key populations who face barriers to receiving care at free-standing clinics. Reportedly, the prime partners shifted from providing mobile outreach to making only referrals for ART and reproductive health, including cervical cancer screenings and contraceptive services. Unfortunately, in one case, the clients of a subgrantee that declined U.S. funding lost access to ART at four PEPFAR-funded treatment sites beginning in the fourth quarter of fiscal year (FY) 2017 as the “substitute partner awaited certification from the national government to initiate clients on ART and referred clients to public-sector sites in the interim.” Of the four sites, one site was not certified to provide ART by the Ministry of Health of the unnamed country until the third quarter of FY 2018 (nine months), a second site not until the second quarter of FY 2019 (18 months), and the remaining two sites did not receive approval from the ministry until the third quarter of FY 2019 — two years.

Other subawards in which USAID-funded prime partners had difficulty finding suitable replacements involved mobile outreach on family planning in West Africa and maintaining broad geographic coverage in community health activities in another instance. On the latter point, the review leaves it to the reader to do the math to understand the seriousness of the result. Prior to the GGR taking effect, one prime partner worked with a subrecipient to provide community-based outreach to 8.8 million people. This type of outreach often involves community-based health workers bringing information and services, including commodities, directly to the community. The GGR forced the prime partner to find new partners when the existing subrecipient declined to comply with the policy. Even after finding three new partners to work with, the project is now only serving 5.3 million of the original 8.8 million people. For these 3.5 million people, the GGR represents much more than a gap or a disruption.

One question remains — what took so long for the review to be released? Following the initial “six-month review” issued in February 2018, a follow-up analysis was promised by the Department of State and expected by the end of 2018. In December of that year, a month-long shutdown of the federal government began when Congress and the White House were unable to agree on a final FY 2019 appropriations package, inevitably delaying work on the review. What caused the subsequent 18-month delay remains a mystery outside the interagency process that produced the review. Data collection ceased in May 2019.

With the long passage of time, the review probably does not provide an accurate reflection of the current situation at the field level, particularly as the COVID-19 pandemic rages. Nor does it account for the potentially significant impact of Secretary of State Pompeo’s March 26, 2019 [expansive redefinition of “financial support”](#) in the GGR standard provisions, which has likely altered the sexual and reproductive health and rights policies of some foreign NGOs that are confronted with a choice between receiving large amounts of funding from the United States and the much smaller sums offered by other donor governments and private foundations.

Ultimately, the review cannot quantify and assess the impact of the U.S. government’s inability to work with organizations who will not comply with the restrictions of the expanded GGR in order to remain eligible for U.S. global health assistance. Many of these organizations have long-standing relationships with their communities, have worked to build their trust and can deliver the best quality services. Was the U.S. government able to find new partners? Yes. Are those “substitute” partners able to provide a comparable level of high-quality health services and do they have the same level of trust of the community? Maybe not. Might this adversely affect the ability of those partners to deliver services and will that impact uptake of services and consequently undermine the ability of the U.S. government to “continue to meet its critical global health goals?” Undoubtedly.