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ACCESS DENIED: ETHIOPIA

*PRELIMINARY IMPACTS
OF TRUMP'S EXPANDED
GLOBAL GAG RULE*

CHAMPIONS
OF GLOBAL
REPRODUCTIVE RIGHTS
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ABOUT PAI

PAI champions policies that put women in charge of their reproductive health. We work with policymakers in the United States and our network of partners in developing countries to remove roadblocks between women and the services and supplies they need. For more than 50 years, we've helped women succeed by upholding their basic rights. To learn more, **visit www.pai.org**.

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INTRODUCTION

The U.S. government has historically been an important development partner in Ethiopia. However, harmful U.S. foreign policy has the potential to roll back reproductive health gains made in the last decade. In 2005, when the Mexico City Policy was in effect, Ethiopian advocates and health providers prevailed in securing a more liberal abortion law. The government's widespread implementation of the law and the expansive guidelines it issued have been instrumental in reducing maternal deaths due to unsafe abortion. The expanded Global Gag Rule imposed by the Trump-Pence administration in 2017—entitled “Protecting Life in Global Health Assistance”—flies in the face of what the Ethiopian government, public health experts and civil society know: legal, safe abortion care is critical to saving lives.

The Global Gag Rule effectively prohibits foreign nongovernmental organizations from using their private, non-U.S. funds to provide comprehensive, safe abortion services; information or referrals for abortions; or to advocate for the legalization of safe abortion services for reasons other than life endangerment, rape or incest if they want to continue receiving U.S. assistance. Importantly, the expanded Global Gag Rule applies to all U.S. global health assistance, impacting not just reproductive health and family planning, but maternal and child health, HIV/AIDS prevention and treatment, and other programming. The Trump-Pence administration's hostility toward sexual and reproductive health and rights, combined with the expanded Global Gag Rule and the defunding of the United Nations Population Fund (UNFPA), risk undermining not only the effectiveness and efficiency of U.S. health investments in Ethiopia, but also harming vulnerable populations dependent on U.S.-supported programs and services.

In February 2018, PAI conducted a fact-finding trip to Addis Ababa, Ethiopia to document the preliminary impact of Trump's Global Gag Rule on women's sexual and reproductive health and rights. At the time of publication, key populations who rely on the private sector—such as adolescents and youth, people living with HIV/AIDS and sex workers—are directly being affected by the closure of previously U.S.-supported health clinics. Additional impacts include: the loss of key U.S. partners for service delivery; the dismantling of partnerships between compliant and noncompliant organizations; the undermining of other donors' health programs and projects; and the uncertainty of securing future funding for sexual and reproductive health commodities.

Having decriminalized abortion and expanded the circumstances under which abortion is allowed, Ethiopia provides a clear example of how the Global Gag Rule will destabilize a country's domestic health agenda. As the government of Ethiopia grapples with meeting its population's sexual and reproductive health needs, U.S. policies will result in scarce resources being drawn away from other health and social programs, including from drought-affected populations and refugees. These factors are compounded by low domestic resource mobilization and the uncertainty of sufficient stopgap funding from other, non-U.S. government sources. However, given the Ethiopian government's strong commitments to family planning, its existing non-U.S. government donor support and the active steps civil society has taken to mobilize awareness of the Global Gag Rule, there is hope that the harmful effects of the policy will be partially mitigated—though questions remain at what cost.



U.S. AND DONOR SUPPORT FOR HEALTH IN ETHIOPIA

Ethiopia is the fifth-largest recipient of U.S. global health assistance and it remains a United States Agency for International Development (USAID) family planning priority country. Nearly USD 250 million in global health funds were obligated in fiscal year 2017.¹ The United States is the largest global health donor to Ethiopia, and after the United Kingdom, the U.S. is the second-largest donor for family planning—followed by the Netherlands, UNFPA and other key bilateral donors and foundations.

In recent years, USAID's key family planning activities have included: ensuring access and availability of modern contraceptives through procurement and delivery in public health facilities; working with the government of Ethiopia to improve monitoring and evaluation of family planning initiatives; increasing access to high-quality family planning services with a focus on permanent methods; and training government providers through outreach teams.² The U.S. government has also made instrumental investments in the health supply chain in Ethiopia to ensure vital medicines and commodities, including family planning supplies, reach those who need them. U.S. government support has worked to improve the availability of essential medicines, contraceptives and consumable supplies in public health facilities.³

In 2017, over 50 percent of USAID global health assistance funds to Ethiopia—USD 125.78 million—were obligated to reproductive health and family planning, HIV prevention and care, and maternal and child health programs. Over 77 percent of that funding went to 10 prime not-for-profit nongovernmental organization (NGO) recipients that have significant networks of foreign NGO partners and subrecipients.⁴ Some of these prime USAID organizations have as many as 20 subrecipient partners on a given grant, exponentially increasing the number of organizations that have to choose whether to comply with the Global Gag Rule.⁵ These organizational figures exclude funds from agencies like the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Centers for Disease Control and Prevention (CDC), which have different reporting periods from USAID and have additional prime and subrecipients also impacted by the Global Gag Rule. While the policy only applies to foreign NGOs, U.S. prime NGO recipients are required to enforce—or “flow down”—the policy on their foreign NGO subrecipients and ensure they are compliant.⁶ Additionally, CDC and PEPFAR funding go to many of the same USAID recipients, and that overlap shows the potential areas of impact across health sectors.

During the Bush administration, the Global Gag Rule led to severe financial losses for key NGOs with decades of experience providing quality, trusted health and family planning care to a variety of communities in Ethiopia. The policy also led to organizations losing access to USAID-donated contraceptives, worsening the country's supply shortage.⁷ By targeting these foreign NGOs, the Global Gag Rule places millions in U.S. global health assistance at risk of being lost, delayed or diverted to organizations willing to comply with the policy and critically deprives key populations of their health access points. Given the crucial roles that both the U.S. and foreign NGOs play as service providers and advocates for better health outcomes and rights in Ethiopia, a reversal or pivot away from previous U.S. government priorities could overburden the Ethiopian government's limited resources for the sexual and reproductive health sector and the wider health system.

REPRODUCTIVE HEALTH IN ETHIOPIA

With one of the lowest per capita incomes in the world, Ethiopia's resources are limited and overextended.⁸ Ethiopia is the second-most populous country in sub-Saharan Africa with a population of 102 million people, over 50 percent of whom are under the age of 20.⁹ More than 80 percent live in rural areas where accessing health services, information and supplies is more difficult. Many of these communities also host expansive numbers of displaced populations from neighboring conflicts and drought.¹⁰

Despite these challenges, the country has made significant reproductive health gains over the past 20 years.¹¹ The Ethiopian government's political will to address the health status of its population has driven crosscutting initiatives to improve sexual and reproductive health. For women's access to sexual and reproductive health services, this has included critical legal provisions that allow for the termination of pregnancies beyond the exemptions of the current Global Gag Rule. In addition to being legal in the cases of life endangerment, rape or incest, abortion is legal if the pregnant woman—owing to physical or mental reasons, including being a minor—is unprepared to bring up a child.¹² Evidence suggests that maternal mortality, which is particularly associated with unsafe abortion, has declined in Ethiopia with increased uptake in family planning and improved access to legal, comprehensive abortion care.¹³ One reproductive health professional told PAI that “when [the government] pushed through safe abortion care, women stopped dying.”¹⁴

In this liberalized abortion environment, demand for family planning has steadily increased since the early 2000s. Modern contraceptive use among married Ethiopian women climbed from six percent in 2000 to 35 percent in 2016.¹⁵ According to the Federal Ministry of Health, this success is compounded by increased access to facilities, improved supply chain management, decentralization of family planning services through community health extension workers, as well as the support of partner organizations and communities.¹⁶ Since 2007, the government's Pharmaceuticals Fund and Supply Agency (PFSA) has led the management of the health care supply chain to ensure the availability, accessibility and affordability of essential medicines.¹⁷ The PFSA—supported by its partners, including USAID—has designed and implemented the Integrated Pharmaceutical Logistics System to create a unified healthcare supply chain to provide accurate and timely data for decision-making. The PFSA is the main distributor of commodities throughout the country, though some NGOs distribute to certain facilities or *woredas* (districts).¹⁸

Currently, contraceptives throughout the country are free and the Federal Ministry of Health provides supplies to the private sector. One organization involved in commodity security reported that family planning commodities had 98 percent availability throughout the public health system, with only five percent stockouts for male condoms and birth control pills.¹⁹ However, stockouts reported in the national survey of health facilities—the Performance Monitoring and Accountability 2020 report—were much higher, with over nine percent stockout rate for male condoms and over 17 percent for pills, as well as nearly 40 percent stockout rate for injectables, a common preferred method of choice.²⁰

By 2020, the Ethiopian government has the goal of increasing contraceptive prevalence among 15 to 19-year-old women to 40 percent, and 20 to 24-year-old women to 43 percent. The government is further committed to reducing the unmet need for the two age groups to 10 percent overall.²¹ However, ensuring continuity of reproductive health supplies and distribution to the last mile remains a challenge. Gains are still fragile, as 10 percent more women in urban settings use a modern contraceptive than those in rural areas, with significant variations among the country's regions.²² Contraceptive uptake and demand generation among rural populations are limited and there is insufficient training of public health professionals. Nurses and midwives are not always equipped or adequately trained to insert or remove methods, including implants, and insertion kits may not even be available for the requisite services.²³ Additionally, while most people access contraceptives through the public sector, an estimated 20 percent rely on the private sector, including NGOs, which suffers from even higher rates of stockouts.²⁴ Because the Federal Ministry of Health governs NGO use of commodities, some organizations reported low stocks of certain methods. Additionally, private clinics and NGO providers do not charge patients for contraceptives because they are legally free. However, they do charge minimal fees for services. The government is attempting to regulate this, which could impede the necessary income generation for private organizations to sustain their work.

Ethiopia is a long way from fully meeting the health needs of its population. Currently, the country is unlikely to meet its Family Planning 2020 (FP2020) goal of adding 6.2 million new family planning users by the year 2020.²⁵ As part of its efforts to increase contraceptive uptake among key populations, the government has a new school-based initiative targeting the unmet family planning needs of adolescents. However, these and

other ambitious government plans to ensure that FP2020 activities and commodity supplies are sustained might be creating demand for nonexistent supplies.²⁶ The Global Gag Rule and other U.S. foreign policies will run counter to the goal of the Ethiopian government to expand quality, safe abortion care and family planning. The government will have to do more to increase equitable access to services, secure domestic resources and improve access to a broad range of services and contraceptives that are critical to ensuring sustainable, positive health outcomes.²⁷

SERVICES LOST, VULNERABLE GROUPS AFFECTED

Trump's expanded Global Gag Rule has threatened the closure of clinics, disrupted the activities of several organizations and stalled family planning and reproductive health program expansion for hard-to-reach, rural and vulnerable populations. Private providers are vital for service delivery to at-risk populations in Ethiopia, including adolescents and youth, people living with HIV/AIDS, rural communities and sex workers. The two largest contraceptive delivery organizations in the country will not comply with Trump's expanded Global Gag Rule, making them ineligible for any financial or in-kind contraceptive support from the U.S. government or compliant prime organizations.

Two service providers highlighted the loss of multimillion-dollar, multiyear grants—and both organizations must now close and transition these programs or find alternative funding. The Family Guidance Association of Ethiopia (FGAE) is feeling the effects of the Global Gag Rule on its services. An International Planned Parenthood Federation (IPPF) member association, FGAE has worked on family planning and reproductive health in Ethiopia for over a half century. The organization provides services and contraceptives through its 47 clinics as well as support to 350 other clinics and health facilities.²⁹

“The extended Global Gag Rule is a beast with multiple heads.”²⁸

FGAE's decision not to comply with the Global Gag Rule led to the CDC withdrawing a five-year grant awarded in 2017 which would have averaged USD 2 million per year.³⁰ If not for short-term replacement funding from the government of the Netherlands, the forfeiture of CDC funds would have resulted in the closure of 10 confidential, sex worker-friendly clinics and compromised 21 additional clinics where the CDC partially supported integrated HIV/AIDS services.³¹ According to FGAE, without these clinics over 15,000 female sex workers and almost 790,000 women, men and young people were at risk of losing access to life-saving services.³² In line with USAID procedures, FGAE is under contract to give back all the assets they received over the last seven years—including medical equipment essential to providing high-quality care, vehicles and other materials—further impacting the organization's capacity and crippling efforts to reach more clients.³³

Another foreign NGO that has declined to comply with the Global Gag Rule is in the process of closing out its USAID award. Having developed expertise in reaching remote populations, its specific U.S.-funded program complemented the method mix and choice available in the public sector. With the loss of USAID funds, the organization's work providing permanent contraceptive methods—vasectomies and tubal ligations—for rural populations will end. A representative from one U.S. organization pointed out, “Hard-to-reach areas require double or triple effort. You may need to drive 100 kilometers to reach one woman, but she has the right to family planning.”³⁴ No other organization has the technical skills and expertise to provide the same quality of service and choice. There is also the problem of the lack of comparable funders to allow the foreign NGO to continue its work. The United States has expressed commitment to providing women and communities with an array of family planning choices, including permanent methods, which are surgical and therefore more complex to provide. The foreign organization forfeiting U.S. funds underscored:

The U.S. government is “concerned about choice and tends to fund important, but expensive work. No other donor is doing that. That’s the sad part for us. The amount of money will be replaced by other donors, but... getting to rural areas, it’s too cost inefficient for other donors. Even if we find other donors it won’t be for the same things.”³⁵

Additionally, several organizations mentioned the willingness of U.S. agencies, unlike other bilateral donors, to pay for overhead and operational costs. The loss of key providers who are funded by USAID and other U.S. agencies is a dual loss for service delivery and not easily matched and replaced by other donors. Noncompliant organizations are also facing other challenges due to the expanded policy, including threats to staff retention because of the uncertainty created by the impending loss of U.S. funding: “It affects us even before funding gets cut because of job security. People don’t want to stay on for fear of losing their jobs later.”³⁶ In the short term, noncompliant organizations are bridging funds from other donors, and the Federal Ministry of Health has renewed commitments to support NGOs with family planning commodities.³⁷ One U.S.-based NGO observed, “all organizations will limp through 2019. Beyond that, I don’t see any [other donor] with the wherewithal and the funds.”³⁸

CHILLING PROGRESS ON SAFE, LEGAL ABORTION SERVICES

The Global Gag Rule risks undermining Ethiopia's progress on reducing maternal deaths—accomplished through access to high-quality, safe abortion care—as well as the government's goal of decreasing the maternal mortality ratio from 353 per 100,000 live births to 267 by 2020.³⁹ Further, the policy has the potential to shut down ongoing efforts to develop and implement progressive policy in the best interests of women and young people's sexual and reproductive health and rights.

PAI spoke with two youth-led associations that will suffer financial and capacity-building losses due to choosing not to comply with the Global Gag Rule. They expressed a “need for abortion services here. It's about knowing the need, and it's a major need for youth as part of sexual and reproductive health.”⁴⁰ While the Ethiopian government has developed policies aimed at meeting adolescents' reproductive health needs, abortion and pregnancy rates are higher among sexually active adolescents.⁴¹ Teenagers in rural areas are three times more likely to have begun childbearing than their urban peers.⁴² The majority of abortions are provided by private or NGO facilities, as public services are limited and stigma remains high for safe abortion care despite positive domestic policy and legal changes.⁴³ One service provider told PAI:

“The government support is there, but not strong, especially on abortion. The number of public health facilities providing safe abortion care is increasing, but quality is not there... When we talk about abortion it is about the spectrum of care and the client's rights... Abortion is still stigmatized; providers still don't want to provide it.”⁴⁴

While the availability and quality of safe abortion care has increased, access to comprehensive care still falls short—and despite decriminalization, abortion stigma remains high in Ethiopia.⁴⁵ Many Ethiopian women continue to have abortions outside of health facilities, often under unsafe conditions. Civil society plays a key role in providing and advocating for quality, comprehensive abortion care, which is incorporated into an array of other health services. As NGOs face additional financial and programmatic restrictions because of the Global Gag Rule, their ability to advocate for increasing access to reproductive health services for women will be further constrained. This includes organizations that would have received U.S. funding to advocate for better quality public health services, increased reproductive health funding and dissemination of adolescent health programming, among others. While Ethiopia's abortion policy has been liberalized, a restrictive legal environment in Ethiopia constricts advocacy space. “Policy and advocacy is not allowed,” a representative from an Ethiopian youth network told PAI. “To talk about human rights is not allowed. In that kind of climate, if you lose funds from external partners and you don't have extensive support... as an NGO it's unrealistic to be able to survive.”⁴⁶

The Global Gag Rule has contributed to rising fears around providing abortion services as organizations that once worked on quality, safe abortion care may have to choose between continuing services and receiving U.S. funding. As many NGOs provide technical assistance to the public sector to improve quality of care in the public health system, the impacts will be felt beyond the private sector. In April 2017, one month before the standard provisions for the implementation of the Global Gag Rule were released, a group of noncompliant organizations formed a taskforce in Addis Ababa to conduct a rapid assessment of how the policy would impact the health sector. The NGO taskforce found that even early on in Global Gag Rule implementation, organizations were not comfortable discussing issues related to abortion and became reluctant to provide information to the taskforce. One member of the taskforce explained to PAI:

“The chilling [effect] is beyond the funding loss and loss of partnerships. There is fear around abortion. When we talk with health managers, they don't want to talk about abortion. Before they were integrating safe abortion care into their services. The chilling effect is fear from organizations. If they [do not] talk or communicate about abortion, [or build] the capacity of the government with health extension leads or lower level cadres, the whole progress may collapse in the long run.”⁴⁷

At least three U.S.-based, compliant NGOs that receive the majority of their funds from the U.S. government expressed concerns about how the Global Gag Rule would negatively impact Ethiopia's progress in reducing maternal mortality due to unsafe abortion. One compliant U.S. NGO that has funding for reproductive, maternal, newborn and child health (RMNCH) clinics told PAI that “liberalized abortion has done a lot. Unsafe abortion has gone significantly down, so have septic abortion cases.”⁴⁸

These compliant organizations are weighing how to effectively continue their activities with noncompliant partner organizations. Two compliant organizations did not know how they could realistically enforce

the Global Gag Rule on their partners because of their support to private clinics, some of which provide abortion counseling and services and are the only health providers in certain areas of the country. One U.S. organization, which receives 80 percent of its funding from USAID, subgrants half of its budget to local organizations and targets key populations for HIV testing and treatment. “In a situation where we can’t access private facilities—and our assessment is that 60 percent provide safe abortion care—that means 60 percent loss of services for clients who can’t access those clinics.”⁴⁹ Another organization expressed similar concern about partnering with the private clinics. It had not received any clarification from USAID about how its projects with sex workers would be affected. The inability to work with private sector organizations that provide comprehensive abortion care will significantly hamstring compliant organizations.

PARTNERSHIPS DAMAGED

The interaction of the Global Gag Rule—including the loss of key service providers who decline to comply—and Ethiopia’s liberalized abortion law is creating a complex and potentially damaging environment for sexual and reproductive health services. PAI interviews revealed that prime U.S. organizations have either severed relationships with long-standing foreign NGO partners who declined to sign the policy or have acknowledged that they will not be working with them on future projects. This is concerning given the integrated nature of service delivery for reproductive health, HIV/AIDS as well as maternal and child health services. “No one wants sustained gain to be lost because of one program,” one U.S. organization told PAI. “HIV previously was very siloed in its programming, but now we’re in a fragile situation due to integrated programs.”⁵¹ There may be additional implications for U.S. and foreign NGOs working on malaria, nutrition, tuberculosis, water and sanitation, as well as other areas of global health programming.

“The Global Gag Rule is more about crippling partnerships than withdrawing resources.”⁵⁰

One noncompliant organization has not only experienced funding losses due to the Global Gag Rule, but its partnerships with two compliant prime organizations have also been damaged. These compliant organizations provided the noncompliant organization with subgrants for programmatic work and an estimated EUR 550,000 annually in family planning commodities. “The effect of the Global Gag Rule is beyond its financial and material implications,” a staff member added. “It’s about disrupting partnerships, disrupting integrated services, efforts to promote leveraging, efforts to coordinate resources among partners.”⁵² Another implementing organization that has declined to comply echoed the sentiment that the Global Gag Rule poses challenges beyond funding, stating that “it makes conversations more difficult, it makes [the question of] who can partner with us more difficult.”⁵³

Foreign NGOs and local providers offer skills and technical capacity to reach rural populations, which is critical when there are no public-sector alternatives and when NGOs provide the highest standards of health care. Crucially, the private sector is also trusted by the most vulnerable populations for family planning, abortion services and other reproductive health needs. As one organization told PAI about adolescents in particular, “Young people want a pharmacy or clinic for privacy. The public sector is not youth-friendly, so these and other vulnerable populations rely on private clinics most.”⁵⁴

One prime U.S. organization that will comply with the Global Gag Rule in order to continue receiving U.S. funds had to dissolve partnerships with noncompliant organizations, including FGAE. It recognized though, that “FGAE is more networked. They’ve been around for years. Working with them you know what you’re doing is sustainable. They work all across the country, and other [organizations] don’t. FGAE also does demand creation and people go to them for different services. So, they’re highly visible.”⁵⁵ Instead of trusted providers, organizations with less experience and reach will likely now receive financial and in-kind support. However, with potentially limited capacity to absorb such an influx in resources, these organizations could face logistical challenges, or they may choose not to provide the same services or have comparable geographic scope. One compliant organization added:

“It’s a disaster, honestly. I cannot imagine Ethiopia without [noncompliant organizations]. Not only at the service level. They train hundreds, thousands of health workers on safe abortion care. It would be a disaster. People—instead of going to the public sector for post-abortion care, family planning—they prefer NGO services.”⁵⁶

Some partnerships stalled even before the Trump-Pence administration came into office. “As soon as we heard there was a new Republican administration, [we knew] it cannot be business as usual,” one complying U.S. organization admitted.⁵⁷ Because its selected partner would not comply with the Global Gag Rule, the organization preemptively ended a project on improving referral networks, which had implications beyond family planning and reproductive health. It acknowledged the project had no future without the noncompliant organizations because there was no one else who could effectively do the work. As a result, the Global Gag Rule “takes time and is a waste of resources” for the implementation of programs and fragments service delivery throughout the country.⁵⁸

The United States and prime U.S. organizations cannot simply transfer projects, funds and contraceptives to different, compliant organizations and expect the same quality, categories of services and geographic reach. With the breakdown of partnerships and loss of key providers, implementation of the Global Gag Rule could derail contraceptive and reproductive health outreach, and women in rural and hard-to-reach areas—as well as key vulnerable groups—will find it more difficult to access services.

CONTINUED CONFUSION

NGOs, donor governments and even U.S. agencies displayed confusion about the implementation of the Global Gag Rule. Such confusion can result in over-implementation, inadvertent noncompliance and self-censorship. In its assessment in April 2017, the Global Gag Rule NGO taskforce found a lack of understanding about the expanded policy and overreach in its implementation. At the time, over half of the 46 U.S. government grantees that responded to the taskforce’s survey did not have adequate knowledge about the expanded policy. Many were directly implementing programs and had not received any communication or explanation about the policy from the U.S. government or grant administrators, and still had questions about the scope and implementation of the policy.⁵⁹

In February 2018, the U.S. State Department released a review of Trump’s Global Gag Rule. Though the analysis only covered four-and-a-half months of the policy’s implementation, it provides three revisions and clarifications to the policy’s standard provisions.⁶⁰ The document additionally underscores the “outreach to and training for its staff in the field and headquarters” for implementation of the policy and “meetings with implementing partners to discuss the standard provision and its application.”⁶¹ The review highlights the number of staff trained on the Global Gag Rule at affected U.S. agencies and reflects outreach to prime implementing partners, recognizing that for USAID, most of this outreach occurs at the mission level where there have been varying degrees of quality.

There is evidence that these trainings may not be fully meeting the needs of partners. At the end of 2017, the U.S. government reportedly conducted a training in Addis Ababa on the Global Gag Rule that both U.S. and foreign NGOs described as lacking in sufficient information. One attendee reported, “People who came out seemed more scared than when they went in. And it still left a lot of questions unanswered.”⁶² It cannot be emphasized enough that U.S. and foreign NGO partners need to feel empowered to ask their questions about the policy and request further explanation when something is unclear. Ideally, this would happen during U.S. government training sessions on the policy.

Questions that PAI received in February 2018, from U.S.-based and foreign NGOs alike, suggest that there is further need for technical assistance with prime organizations and their subrecipients. Lack of understanding and confusion was apparent among both foreign organizations and U.S.-based prime recipient organizations. One U.S. organization funding two Ethiopian regional associations was allegedly not communicating about the policy to its subrecipients. While this is not universal, it does reflect the influence of individual organizational approaches as well as organizational structures in how the policy is interpreted and implemented. The taskforce attempted to provide both subrecipients with information, though ultimately, the prime organization stopped working with the two noncompliant associations.⁶³

U.S. government agencies and prime partners responsible for flowing-down the policy would be well-served to work together to create a standard tool for discussing the policy with subrecipients. As it stands now, that discretion is left solely to the prime implementing partner. Ongoing confusion could mean that foreign NGOs may be unwittingly in violation of the Global Gag Rule and in a position to have to return U.S. funds and other equipment. This is highly concerning for organizations that are heavily reliant on U.S. support. “These people have nowhere to go,” a donor acknowledged. “For these local organizations, they don’t have lawyers to review their contracts. They think of the money and what it can do for their programs. The U.S. is still the largest funder for social programs.”⁶⁴

One Ethiopian health association representative appeared unaware about whether the Global Gag Rule language was in its latest grant, saying, “Who’s going to read a document hundreds of pages long?”⁶⁵ Another local organization that has operated in the country for several decades and provides integrated health services, including HIV/AIDS and family planning, receives 60 percent of its funding from donors—half of which is from U.S. sources. While the organization allegedly discussed the details of the Global Gag Rule with its two prime U.S. NGO funders, the local NGO representatives were still confused about how the Global Gag Rule interacts with Ethiopia’s abortion law.⁶⁶ When it comes to understanding the policy, PAI was told, “A lot of organizations are operating in the dark.”⁶⁷

GOVERNMENT AND DONOR PRIORITIES UNDERMINED

The effects of the Global Gag Rule extend to the funds provided by other donors, undermining their health priorities and programs and those aligned with the Ethiopian government, as well as civil society efforts. While the Dutch and British governments and other non-U.S. government donors have committed to support organizations that will experience funding gaps because of the Global Gag Rule, the policy is also directly affecting their existing work. The clear result in Ethiopia is an overreach of U.S. foreign policy, causing fragmentation of programs, disrupting efficiency of service delivery, creating uncertainty around commodity security and potentially impacting future sexual and reproductive health advocacy.

The Global Gag Rule has undermined European-funded projects because of the tension between compliant and noncompliant organizations. In one case, a Dutch-funded project of USD 9 million over four years for comprehensive abortion care came to a halt because the lead organization was complying with the Global Gag Rule and could no longer carry out the work.⁶⁸ The Dutch representative acknowledged that the U.S. was offering three times the amount for its project. “You can’t say no to USD 30 million. But it’s a huge miss for the program on quality of service.”⁶⁹

At the London Family Planning Summit on July 11, 2017, the United Kingdom’s Department for International Development (DFID) dedicated GBP 90 million over four years in Ethiopia for work with the Federal Ministry of Health to provide modern family planning services.⁷⁰ DFID’s work has risked being delayed because of a compliant NGO and noncompliant subrecipients.⁷¹ To adhere to the Global Gag Rule, the compliant NGO could no longer continue working with the other NGOs, and the project is now attempting to move forward by separating safe abortion care from the rest of the reproductive health portfolio. DFID explained that for other donors, the Global Gag Rule is creating “hard-to-design projects that aren’t ideal,” by fragmenting reproductive health service delivery and safe abortion care.⁷² In a country still contending with abortion stigma, when “you take away safe abortion from the reproductive health service package, women lose.”⁷³ The program temporarily came to a halt. It took nine months to reorganize the grant in a way that allowed the work to continue. The Global Gag Rule places an extraordinary burden on other donors and ultimately delays programs reaching beneficiaries.

The Global Gag Rule is also frustrating reproductive health security in Ethiopia by compounding existing harmful U.S. foreign policies and funding decisions that have direct impacts on other donors and population needs throughout the country. To meet Ethiopia’s sexual and reproductive health commodity needs, the country’s bilateral and multilateral donors—including the United States—have dedicated roles in the contraceptive requirement forecast. In 2017, 73 percent of public sector contraceptives in Ethiopia were donated by USAID, and 20 percent were provided by UNFPA.⁷⁴ However, to date, it was reported that USAID had not indicated its 2018 spending level for contraceptives.⁷⁵ UNFPA and USAID financial contributions for commodities have each averaged USD 5 to 8 million per year of the annual requirement of USD 25 million.

With U.S. funding absent or delayed, the Ethiopian government must find other ways to make ends meet for the contraceptive needs of its population. Historically, when there has been a funding gap, the Federal Ministry of Health drew resources to fund family planning commodities from its Sustainable Development Goals (SDG) Performance Fund—a “pool fund” designed for underfunded priority areas within the country’s Health Sector Transformation Plan.⁷⁶ Donor partners contribute to this pool fund, including the British government, which allocated GBP 70 million over four years. USD 40 million of the pool fund is already designated for family planning and reproductive health, of which USD 15 million is for services and programs.⁷⁷

Though USAID will most likely continue to provide condoms, the two largest contraceptive service delivery organizations in the country will not be able to receive financial or in-kind donations from the

U.S. government. The Ethiopian government has recognized that part of the pool fund may have to be reprogrammed to fill gaps in reproductive health, including organizational gaps for noncompliant organizations: “The government of Ethiopia is required to raise that funding now. We need to cover USD 10 million of an annual gap and go deep into limited funds that could have gone to UHC [universal health coverage].”⁷⁸ This reallocation would come at the expense of the broader health system, including from areas like nutrition for communities displaced by the drought, refugees and other health priority areas.⁷⁹

The Trump-Pence administration’s defunding of UNFPA in 2017 further compounds the problem of health service delivery in Ethiopia, a country that hosts an estimated 800,000 refugees and has an internally displaced population of more than one million people.⁸⁰ In Ethiopia, UNFPA received USD 1 million for gender-based violence work and another USD 1.5 million for reproductive and maternal health in humanitarian settings from USAID.⁸¹ Both programs and their renewals were cut short due to the Kemp-Kasten amendment determination. Like the Global Gag Rule, this amendment restricts U.S. foreign assistance related to sexual and reproductive health and rights, though it also affects multilateral organizations and U.S. NGOs, as well as foreign NGOs.⁸² This means that while the Global Gag Rule does not directly apply to humanitarian funding, the interactions of U.S. policies have outsized ramifications beyond sexual and reproductive health and rights to the broader health system and development goals in a country like Ethiopia.

In February 2018, at the first annual Scientific Reproductive Health Conference in Addis Ababa, the Federal Ministry of Health acknowledged the challenges that current U.S. foreign policy poses to sexual and reproductive health in Ethiopia, including safe abortion care. The director of the Maternal and Child Health Directorate noted that U.S. government restrictions and the defunding of UNFPA are having a negative impact that will force the ministry to make difficult choices about the areas of health care on which to focus limited resources.⁸³

CONCLUSION

The Ethiopian government, civil society actors and donors should coordinate to mitigate the impact of the Global Gag Rule on Ethiopia's ambitions for comprehensive sexual and reproductive health, and more broadly for the country's health system and societal goals. As one NGO representative said: "The government, donors and NGOs, all must come together for programming, advocacy [and] work in solidarity to overcome the misfortune of the Global Gag Rule. We need to think of short and long-term strategies. Trump could be three years, or another term, or another Republican after that."⁸⁴ Unlike under the Bush administration—as evidenced by the taskforce to document the effects of the Global Gag Rule—organizations, non-U.S. donors and the Ethiopian government are raising awareness of the policy to minimize its over-implementation and counter its harmful impacts.

While the Federal Ministry of Health is committed to meeting its FP2020 goals and has indicated support for organizations losing funds due to Global Gag Rule, the demand for family planning is immense, and resurgence of HIV—particularly among young women and sex workers—has resurfaced as a challenge.⁸⁵ Some organizations and individuals believe the Global Gag Rule provides an opportunity to reframe how the country operates and depends on donors.⁸⁶ This shift could entail the government creating an enabling environment for organizations to recover costs by charging for quality services. Additionally, it would require domestic resource mobilization to sustainably support sexual and reproductive health programming.

Given the state of the Ethiopian government's resources, non-U.S. government donors occupy a critical role. However, as many actors have acknowledged, "Even if donors are stepping in to fill the gap, it's big shoes to fill."⁸⁷ Additionally, there is fear among organizations that are still spending down U.S. funds that by the time they need support from other donors, it will not be available. As donors have different funding priorities, objectives and capacities, one dollar from another donor is not equivalent to a dollar from a U.S. agency like USAID.

Considering this vulnerable environment, any reduction in global health funding for qualified, trusted providers could have severe negative impacts on the Ethiopian health system and ultimately the health and lives of women, girls and their communities. U.S. government funding has built up and strengthened health systems like Ethiopia's. The Global Gag Rule rolls back those achievements, including the country's own domestic efforts to save women's lives through progressive abortion policies. In order to meet the family planning resource gap, the Ethiopian government may be forced to make a dangerous trade-off—which could destabilize other areas of health and development.

PAI conducted a fact-finding trip to Addis Ababa, Ethiopia, in February 2018 to document the preliminary impacts of the Trump-Pence administration's expanded Global Gag Rule on women's sexual and reproductive health and rights. With a focus on the country's liberalized abortion law, the reproductive health commodity supply chain and the policy's effects on service delivery and reproductive health advocacy in-country, PAI held interviews and meetings with representatives from over 25 organizations and agencies. These groups included U.S. and foreign not-for-profit NGOs providing sexual and reproductive health services or advocacy; bilateral and multilateral donors; and other health professionals. As a participant of the First Annual Scientific Reproductive Health Conference in Addis Ababa hosted by the Consortium of Reproductive Health Associations (CORHA), PAI also spoke with officials from the Federal Ministry of Health and other representatives from the sexual and reproductive health sector.

With all key stakeholders, PAI discussed the purpose of the interview, its voluntary and confidential nature, and the way the information would be used. All names of individuals and organizations have been withheld unless consent was given for PAI to use identifying information. As part of the discussions, PAI provided technical assistance on the Global Gag Rule and shared with participants the PAI guide to the policy, *What You Need to Know about the Protecting Life in Global Health Assistance: Restrictions on U.S. Global Health Assistance, An Unofficial Guide*.⁸⁸

PAI would like to thank all those who were willing to share with us their insight and experiences regarding how the Global Gag Rule will affect their work and how it will impact the health and rights of women, youth and communities in Ethiopia.

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