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ACCESS DENIED: UGANDA

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

**CHAMPIONS
OF GLOBAL
REPRODUCTIVE RIGHTS**
pai.org



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INTRODUCTION

As one of the largest recipients of U.S. global health assistance, including family planning, Uganda will be significantly impacted by the Trump-Pence administration policy entitled “Protecting Life in Global Health Assistance.” The policy—commonly referred to as the Global Gag Rule by opponents—effectively prohibits organizations from using their private, non-U.S. funds to provide comprehensive, safe abortion services; offer information or referrals for abortions; or to advocate for the legalization or liberalization of safe abortion services. Importantly, this latest iteration of the Global Gag Rule applies to all U.S. global health assistance. Since the George W. Bush administration’s Global Gag Rule, research has demonstrated that the policy severely eroded the provision of family planning and related health care services for women in rural and other underserved areas in Uganda. Trump’s expanded policy not only undermines the effectiveness and efficiency of U.S. investments in global health, but it has the potential to roll back progress made in improving health outcomes for women, girls and communities in Uganda.



To document the preliminary impacts of Trump’s Global Gag Rule on women’s sexual and reproductive health and rights, PAI conducted a fact-finding trip to Kampala, Uganda, in October 2017. While it is too early to understand the full effect of the expanded policy—especially across all health sectors—a picture of the most severe effects on sexual and reproductive health has begun to emerge. These impacts include: increasing commodity insecurity; chilling effects on advocacy for safe abortion and post-abortion care services; the dismantling of referral networks between compliant and noncompliant organizations; heavy administrative burdens for organizations; the disruption of donor coordination; and a bolstering of Ugandan opponents of sexual and reproductive health and rights. All of these are compounded by uncertainty of future U.S. global health funding and low domestic resource mobilization for health—including family planning and reproductive health, which remain under-prioritized and under-resourced by the government of Uganda.

DONOR AND COUNTRY CONTEXT

U.S. SUPPORT FOR HEALTH IN UGANDA

Uganda is dependent on external donor financing for health care, with the United States as the country's single largest provider of global health assistance.¹ In fiscal year 2016, the United States obligated over USD 227 million to Uganda for health programs through the U.S. Agency for International Development (USAID). Seventy percent of that was funding for HIV/AIDS, family planning, as well as maternal and child health.² The U.S. government has partnered closely with the Ugandan Ministry of Health, other international bilateral and multilateral donors, and the private sector to help Ugandan families access a range of comprehensive health care services which include sexual and reproductive health care.³ Uganda is a priority country for USAID family planning programming, and the U.S. agency is among the largest development partners for family planning and reproductive health—alongside the United Kingdom's Department for International Development (DFID), the World Bank and the United Nations Population Fund (UNFPA)—and is the second-largest provider of contraceptive supplies after UNFPA.⁴

Sexual and reproductive health indicators have improved in Uganda due to an interplay of factors, including the role of bilateral and multilateral donors and nongovernmental organizations (NGOs) that have brought health services closer to the people.⁵ In 2016, USD 91.74 million of U.S. global health funds went directly to 18 not-for-profit NGOs to implement a variety of programs throughout Uganda. By comparison, in 2015, 38 of these organizations received USD 181.9 million.⁶ These prime recipients often have multiple-year cooperative agreements or grants, and subgrantees in-country to carry out the work. Subgrantees of U.S. funds are not captured in this analysis, meaning many more organizations will have to choose whether to comply with the Global Gag Rule.

In the last decade, U.S.-supported initiatives have focused on increasing the availability, affordability and quality of family planning services, including contraceptives. In 2017, USAID shipped to Uganda nearly 350,000 contraceptive implants, over 4 million injectable contraceptives, approximately 1.4 million condoms, and over 4 million oral contraceptives.⁹ Additionally, the Uganda Health Marketing Group (UHMG)—founded out of the USAID-funded AFFORD project in 2006—has now become a viable, self-sustaining NGO. Created in response to historical health commodity supply stock outs, UHMG implements the Alternative Distribution System (ADS) on behalf of the Ministry of Health for reproductive and maternal health commodities. Additionally, being a social marketing entity, UHMG provides affordable health care solutions, including supplies for HIV/AIDS, malaria, family planning, as well as maternal and child health.¹⁰ In addition to supporting health commodities as well as lifesaving maternal health and HIV programs, the U.S. government's 2016-2021 strategy for Uganda includes activities to increase the adoption of reproductive health behaviors by empowering girls to make healthier reproductive behavior choices; increasing access to reproductive health services; increasing demand for reproductive health services; and reducing or removing altogether the social barriers to healthy reproductive behaviors.¹¹

TABLE 4: 2015 U.S. GLOBAL HEALTH FUNDING TO NGOS IN UGANDA⁷

PROGRAM AREA	U.S. NGOS*	FOREIGN NGOS**	TOTAL GLOBAL HEALTH ASSISTANCE TO NGOS
Family Planning and Reproductive Health	USD 5.13 million	USD 8.06 million	USD 13.19 million
HIV/AIDS	USD 45.91 million	USD 6.45 million	USD 52.36 million
Maternal and Child Health	USD 7.8 million	USD 641,000	USD 8.44 million
All other Global Health Programming***	USD 7.82 million	USD 9.93 million	USD 17.75 million
Totals	USD 66.66 million	USD 25.08 million	USD 91.74 million

* Although U.S. NGOs are not subject to the Global Gag Rule, their local Ugandan subgrantees must comply with the Global Gag Rule. These partners in Uganda are not represented in this dataset.

** Foreign NGOs represent both internationally based and local Ugandan NGOs. Foreign NGOs are defined as either having an international coordinating body, or a diverse network of country offices in the field.⁸

*** Includes general health, malaria, nutrition, pandemic influenza and other emerging threats, tuberculosis, as well as water supply and sanitation.

It is unclear how the expanded Global Gag Rule may impact USAID's family planning objectives. Critically, under both the current and Bush administration versions of the Global Gag Rule, emergency contraception and post-abortion care services are permitted and organizations should not self-censor their work. However, among its other impacts, the previous Global Gag Rule under the Bush administration led to the cancellation of a USAID emergency contraception program in Uganda, as well as community education programs for post-abortion care services, despite having been identified as USAID priorities.¹² The current U.S. administration's defunding of UNFPA—the second-largest reproductive health funder in Uganda after the United States—and its anti-reproductive health rhetoric have raised alarms about how the U.S. will engage Uganda moving forward as a partner in family planning and an ally for NGOs working in the reproductive health space.

While the Global Gag Rule only applies to foreign NGOs, U.S. prime NGO recipients are required to enforce the policy on their foreign NGO subrecipients—often local NGO partners—and ensure they are compliant. In this context, contraceptive supplies may be less accessible and organizations that reject the policy, including former U.S. government implementing partners, may have to reduce programming in the wake of decreased funding. Given the crucial roles that both prime and subrecipient NGOs play as service providers and advocates for better health outcomes and rights in Uganda, beneficiaries will bear the brunt of the policy's impact.

REPRODUCTIVE HEALTH IN UGANDA

Uganda has a very young and rapidly growing population, and with its proportion of children, people of reproductive age, and HIV/AIDS prevalence, the country's health needs are immense. However, religious and cultural norms as well as insufficient investment in sexual and reproductive health impact access to services and information. Of Uganda's population of 34.6 million, people under the age of 30 make up over 78 percent, and youth under the age of 18 comprise more than 55 percent.¹³ Ugandan women have an average of 5.68 children, higher than the regional average of 4.9, and young women are disproportionately affected by HIV.^{14,15}

Still, informing women about available contraceptive options and distributing supplies remain huge challenges. While contraceptive availability has increased, only 27.3 percent of Ugandan women use a modern form of contraception, which is below average for sub-Saharan Africa.¹⁶ Three out of 10 married women and almost half of sexually active women of reproductive age have an unmet need for modern contraception—that is, they want to avoid a pregnancy, but are either not using modern contraception or are using a traditional method, which can have high failure rates.¹⁷

Though Uganda's maternal mortality rate has decreased since 2011 from 438 to 368 deaths for every 100,000 live births, it remains well above the average of 239 deaths in developing countries worldwide.^{18,19} Because national abortion laws and policies are interpreted inconsistently, medical providers are often reluctant to perform an abortion, and unsafe abortion is one of the leading causes of the high rate of maternal deaths.²⁰ Fifty-two percent of pregnancies are unintended and over a quarter end in abortion each year. In 2013, there were an estimated 314,300 abortions—a rate of 39 per 1,000 women aged 15 to 49, down from 51 per 1,000 in 2003.²¹

Under the Ugandan Penal Code, abortion is illegal except to save the life of the woman or to preserve her physical or mental health.²² Confusingly, the 2012 National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights are intended to address unsafe abortion by improving services related to reducing unwanted pregnancies and expanding access to safe, legal abortion care—including post-abortion services.²³ As a result, post-abortion care, while legal, remains controversial and sometimes difficult to provide.²⁴ Information on guidelines is neither widely disseminated to health workers nor women, and stigma remains high for issues surrounding abortion and post-abortion care.²⁵

TABLE 2: ABORTION EXCEPTIONS UNDER UGANDAN LAW AND THE GLOBAL GAG RULE

REASONS	UGANDAN PENAL CODE	2012 GUIDELINES	GLOBAL GAG RULE
Life endangerment	✓	✓	✓
Severe mental anguish	X	✓	X
Severe fetal anomalies	X	✓	X
Cervical cancer	X	✓	X
Rape and incest	X	✓	✓
Woman's choice	X	X	X

In the last five years, the government of Uganda has made a series of commitments to improve family planning outcomes. President Yoweri Museveni pledged at the 2012 London Family Planning Summit to allocate USD 5 million annually to contraceptive supplies. Uganda’s goal is to reduce unmet need for family planning to 10 percent, while increasing the modern contraceptive prevalence rate for all women to 50 percent by 2020.²⁶ In November 2014, the Ministry of Health and partners further developed the Uganda Family Planning Costed Implementation Plan 2015-2020, which sets guidelines and strategies for interventions. These include increasing age-appropriate information, access and use of family planning amongst youth; promoting behavior change to improve acceptance and use of family planning; implementing task sharing to increase access; mainstreaming implementation of family planning policy, interventions and delivery of services; improving forecasting, procurement and distribution; and ensuring full financing for commodity security in the public and private sectors.²⁷

Despite these developments, abstinence-only education continues to be promoted at the senior government level, effectively hindering commitments made by the government of Uganda to Family Planning 2020 (FP2020) and other global development goals. The political stalling of sexual and reproductive health guidelines as well as the 2016 ban on comprehensive sexuality education puts young people most at risk.²⁸ As the director of a Kampala-based health NGO told PAI: “If we don’t want to talk about contraception, or education for youth, we’re just pretending. Teenage pregnancy is very high—they make up a quarter of all pregnancies. And maternal mortality due to unsafe abortion is very high—a quarter of maternal deaths are due to unsafe abortion. We know where the problem is. And we’re increasing the problem for that particularly vulnerable group.”

“If we don’t want to talk about contraception, or education for youth, we’re just pretending.”

COMMODITY SECURITY THREATENED

When the Global Gag Rule was previously in place, it resulted in the loss of USAID-donated contraceptives—including condoms to NGOs in 29 countries, such as Uganda. Since that time, USAID has invested in the health supply chain to increase and improve access to reproductive, maternal, newborn and child health commodities.²⁹ Trump's expanded Global Gag Rule will impact commodity security in Uganda by undermining two of the largest reproductive health providers who play a critical role in the distribution of contraceptive supplies—especially at the last mile and to vulnerable populations. And, while the President's Emergency Plan for AIDS Relief (PEPFAR) was explicitly exempt from the last iteration of the policy, the expanded version will now implicate U.S. government-funded HIV assistance, including the distribution of condoms, rapid test kits and antiretroviral drugs.

Uganda's health system is characterized by challenges of inadequate human resources, training and infrastructure; stockouts of lifesaving medicines and health supplies, including contraception; as well as health financing shortfalls.³⁰ In an effort to ensure a more reliable stock of essential medicines, the Ugandan Parliament delegated the role of procuring, storing and distributing to the National Medical Stores (NMS) for public health facilities in 1993.³¹ Still, unacceptable stockout levels for lifesaving health commodities continued. In the last few years, this included family planning commodities, particularly the pill and long-acting reversible contraceptive methods.³² In 2016, the Ministry of Health report identified shortages of second-line HIV treatment as well as malaria drugs and diagnostics on top of the gap in family planning commodities.³³

The government of Uganda depends on USD 6.7 million annually in donor funding for reproductive health supplies, and the Ministry of Health has estimated a gap of USD 9 million in funding for family planning commodities.³⁴ The USAID-supported UHMG has played a critical role in improved commodity quantification, supply and distribution, though challenges remain. As a Ugandan health care professional told PAI, "The ADS (alternative distribution system) is what keeps contraceptive distribution alive in this country. Even public sector facilities rely on the ADS."³⁵ UHMG now provides 80 percent of supplies in Uganda, and the NMS sometimes relies on the ADS for stocking its own supplies.³⁶ And while the Uganda Catholic Mission's Joint Medical Store also has health commodities for family planning, they only carry cycle beads.³⁷

Distance to health facilities remains a significant barrier to family planning access and health services, especially for rural women. Marie Stopes International (MSI) and the International Planned Parenthood Federation (IPPF) affiliate, Reproductive Health Uganda (RHU), are the two largest contraceptive distributors in Uganda. Both have declined to sign the Global Gag Rule. MSI provides more than half of Uganda's family planning services and provided an estimated 1.1 million Ugandans with contraceptives in 2016. MSI's outreach programs were in 98 percent of Uganda's districts for long-acting reversible contraceptive methods. For the moment, MSI and RHU have secured funding from other donors to ensure their continued viability, but they have had to adjust their operations at a cost to services. This will have a ripple effect across organizations that rely on MSI and RHU for supplies and other referral services—including faith-based organizations that ideologically align with the Global Gag Rule, but still have traditionally relied on these two organizations for contraceptive supplies. As a result, further funding insecurity or disruption in the services of these organizations due to the Global Gag Rule will have a domino effect on contraceptive demand generation, education and supply.

SERVICES AND PROGRAMS DISRUPTED

Noncompliance with the expanded Global Gag Rule comes at a steep cost to organizations and the communities in which they operate, with critical services being lost or scaled back. In most cases, rural, hard-to-reach and vulnerable populations are most affected. For example, RHU's 2017 budget was cut by 30 percent as a direct result of the policy and IPPF's decision to not comply. The organization has had to scale back its programming, diverting resources from providing sexual and reproductive health services in Ugandan refugee camps to other areas. The Global Gag Rule has reportedly resulted in an organizational loss of USD 300,000, and has disrupted a number of ongoing funded programs. These programs include a

five-year advocacy program with two years of implementation remaining that was cut short; a program on rights-based approaches to service delivery which was not renewed after it ended in September 2017; and a third program focused on the rollout of Sayana Press to adolescents was shut down in July instead of scaled up to five districts. The organization would have introduced the injectable contraceptive to another 6,000 adolescents seeking protection against unwanted pregnancy.³⁸ As RHU told PAI, “some of our beneficiaries are sex workers, very vulnerable groups, and the LGBT community.” If the Global Gag Rule had not been in effect, according to RHU, these populations could “be using Sayana Press and [benefit from] all the health education we would have done.”³⁹

Due to loss of funding as a result of noncompliance with the Global Gag Rule, MSI will have to cut 27 mobile health teams across Uganda—a key, integrated intervention for hard-to-reach populations.⁴⁰ Five outreach teams also had to shut down, with 12 more at risk. That would take away services from half of MSI’s country coverage, and Uganda’s most vulnerable communities.⁴¹ An MSI representative explained: “Funding from USAID allowed us to achieve scale but at the cost of the fiber of our organization. Next time we will think if we would reengage.” MSI’s USAID funding ended in July, and the organization is now relying on DFID to extend funding to compensate for the loss, or else they risk a huge gap. According to DFID, “MSI are at the center of all of this. They have established themselves in hard-to-reach places. Even if they get money from other donors, they are still left in a vulnerable position. The number of people they can reach diminishes.”⁴²

Uganda has now outpaced Ethiopia as the host of the largest number of refugees in sub-Saharan Africa with over 1.3 million, predominantly women and children fleeing conflicts in neighboring countries. Aid agencies and the Ugandan government have established temporary health center structures in the refugee settlements to serve the huge female population of reproductive age, but they are overwhelmed—especially those providing maternity care.⁴³ While U.S. humanitarian assistance funding is technically exempt from the Global Gag Rule, organizations that receive this funding still work in close coordination with local entities that do not receive such funding to provide sexual and reproductive health services. RHU, which is present in almost 50 percent of the camps, is the main sexual and reproductive health organization in the refugee settlements.⁴⁴ According to the organization, “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.”⁴⁵ However, as they are no longer able to compete for U.S. funding, RHU has had to divert USD 100,000 per year from the refugee settlements to their clinics.

Many smaller, local organizations cannot afford to lose U.S. global health assistance funding. However, some still have foregone U.S. funding, including those who work with the most-at-risk populations, such as sex workers, the LGBT community and youth. They are now adversely affected by not competing for U.S. government funds, cancelling planned expansions and other programs to reach more vulnerable groups. As one NGO working on advocacy for people living with HIV/AIDS told PAI, they are still deciding whether they will compete for more funding because of the policy, even though they do not work on abortion access or advocacy.⁴⁶ They want to see abortion harm reduction and increase access for key populations—including access to contraception—but are concerned the Global Gag Rule will affect their work.

“When it comes to issues of family planning, adolescents [and] post-abortion care, the demand [in the camps] is huge.”

REFERRAL NETWORKS DISMANTLED

Despite progress over the last decade, rural populations in Uganda continue to suffer disproportionately from lower access to basic services.⁴⁷ MSI is the private health provider with the most free-standing clinics in Uganda, providing critical services in rural communities. More than 79 percent of the population lives outside of urban centers.⁴⁸ Because of the reach of MSI and RHU, a key threat is clinic closures—which would not only cut off populations from their health providers, but also impact referrals from other organizations that rely on MSI and RHU.

Crucially, organizations that choose to comply with the Global Gag Rule will no longer be able to refer clients to MSI and RHU because of their noncompliance with the policy. This will have repercussions beyond family planning. As MSI told PAI, “We’re working with many agencies doing HIV who do referrals to us. Some people may find it scary to refer to us now.”⁴⁹ One local NGO network for at-risk populations told PAI, “It impacts our partners who have longstanding relationships with RHU. You channel a referral to the most convenient place.”⁵⁰ In several cases, community-based organizations (CBOs) are physically located next door to MSI and RHU clinics. Because CBOs have increased their coordination in-country to decrease duplication of efforts and provide more integrated services for their clients, there will be gaps without the availability or access to MSI and RHU services. These organizations depend on MSI and RHU for both supplies and referrals for services—particularly in remote locations—including humanitarian contexts in northern districts.⁵¹

No organization compliant with the Global Gag Rule has the longstanding presence and reach to effectively step in and fill the voids left by MSI and RHU. Two other U.S.-based organizations told PAI that no compliant organization is located in the same number of communities, providing the same set of quality services or contraceptive method mixes.⁵² As an official at the Ministry of Health told PAI, “there would be a gap if organizations cannot provide their services... and it’s not going to be easy just to fill the gap. MSI has national coverage in Uganda. The whole country would be affected.”⁵³ Disruptions in referrals because of the Global Gag Rule will make it more difficult for many people to access comprehensive health services, especially rural and vulnerable populations—including refugees. Accessing the same package of services would involve multiple, sometimes long, trips to see different providers. The increased time and resources required to seek out multiple providers may force some clients to forego critical services altogether.

OVERBURDENED BY COMPLIANCE

To continue receiving U.S. funding, some organizations that have agreed to comply with the Global Gag Rule are spending valuable resources on unanticipated overhead and other costs associated with compliance. NGOs’ decisions about whether to comply are rooted in organizational ethics—or in many cases, financial survival due to dependency on U.S. funding. The choice to comply can create a heavy operational burden that detracts from service provision and directly impacts clients and beneficiaries of U.S. global health assistance.

Certain larger, U.S.-based implementers that have relied on local affiliates are returning to a system of country offices to effectively comply with the Global Gag Rule. When that is not possible, these implementers are separating out fiscal structures more clearly, shifting staff and resources away from the local affiliate. This response, while understandable, undermines USAID’s goal of increasing local ownership of activities. As a result of these attempts, one organization described being four to six months behind on implementing service projects because of diverting efforts to comply with the policy. The group acknowledged losing knowledgeable technical staff in key geographic locations, impacting the most vulnerable populations. The country director told PAI:

The biggest issue with compliance is the time taken away from implementing the work. It’s disruption of projects and spending lots of time in board rooms. Compliance is legal fees, office changes, administrative fees, bank accounts, but mostly it’s staff time, which is quite considerable... At the service level, projects cannot perform at the same level [that they used to]. We are behind schedule because of changes in key personnel. We are not performing as we used to.⁵⁴

Of note and concern is the lack of communication reported by local NGOs from the responsible U.S. funding agency, or from the prime U.S. funding recipient. In the void of information, local organizations are coming to their own conclusions about policy guidelines and the implications for their work. In one case PAI discovered, an organization did not even realize it had agreed to comply when it received a new tranche of funding from the Centers for Disease Control and Prevention (CDC).⁵⁵ Lack of communication and education—where organizations can ask clarifying questions—may have further consequences in the future if organizations find themselves unwittingly noncompliant and potentially having to reimburse U.S. funding.

ABORTION ADVOCACY CHILLED

By effectively curtailing freedom of speech and enabling a hostile environment for any work viewed as tied to abortion, the Global Gag Rule prevents dissemination of information on unsafe abortion and information on the use of key health commodities, thereby risking increasing Uganda's already high maternal mortality.⁵⁶

The Global Gag Rule has begun to have a chilling effect for organizations that work to liberalize safe abortion guidelines. These organizations over-implement the policy, fearing reprisals due to their reliance on U.S. funding. In Uganda, family planning providers and advocates coordinate through the Uganda Family Planning Commission (UFPC). While abortion was never a direct advocacy topic for the coalition, there is concern about how the Global Gag Rule will impact the commission's work, particularly since UFPC is comprised of organizations both compliant and noncompliant with the policy.⁵⁷ One NGO member that planned to work on maternal mortality due to unsafe abortion stopped engaging in the commission's work on the topic. A representative told PAI that because of the Global Gag Rule, "With partners working on the legal component of safe abortion, we can't go along with them now. We had wanted to expand our work; we know it's right. But we shelved it."⁵⁸

The policy has also had an impact on training for post-partum hemorrhage and post-abortion care. Even without the Global Gag Rule, MSI described a high level of controversy surrounding misoprostol because it can be used to induce abortion. However, the policy further "promotes stigma and health workers are afraid."⁵⁹ Fear of noncompliance will likely lead to more self-censorship and the loss of opportunities that would not be in violation of the policy. One organization mentioned that they stopped training health workers in the use of misoprostol for post-partum hemorrhage because of USAID funding: "You can't say much without being seen as promoting [abortion]."⁶⁰ Misoprostol is not just used to induce medical abortion, but is also used for the treatment of post-partum hemorrhage and post-abortion care (both spontaneous and induced).⁶¹ Due to its wide-ranging applications in reproductive health, misoprostol is on the World Health Organization Model List of Essential Medicines. Without proper training, health workers do not understand the uses of misoprostol or its allowances under Ugandan law—rendering them unable to discuss safe administration with communities.

The expansion of the Global Gag Rule and the confusion it has created in an environment with abortion stigma leads to even greater over-implementation and self-censorship. Some compliant organizations do not understand that they can continue to work with noncompliant organizations, as long as that work excludes the prohibited activities around abortion identified in the policy. A compliant organization had planned to work with RHU on a sexual and reproductive health and rights program, but decided it had to stop because RHU was not complying with the policy.⁶² MSI added that they are already feeling a "quite serious indirect effect: we lose partners, the people who have complied."⁶³

U.S. LEADERSHIP LOST AND DONOR COORDINATION DAMAGED

The effects of Trump's Global Gag Rule on programs, supplies and communities will be magnified not only because of the expanded scope of the policy, but also due to Uganda's own hostile policy environment and the country's stance on abortion and sexual and reproductive health and rights. Given Uganda's dependency on U.S. development and humanitarian assistance, the United States has had an important political influence on the government of Uganda, which can serve to liberalize policies. However, sexual and reproductive health and rights advocates are concerned that the reintroduction of the Global Gag Rule threatens to significantly roll back gains made in family planning advocacy and sexual and reproductive health and rights broadly—emboldening political opponents of contraception and comprehensive sexuality education. "The Global Gag Rule is reinforcing an already restricted policy environment... our government listens to bigger governments, bigger donors. If a donor reinforces the same sentiment, there's nowhere for us to run to," the director of a local health NGO told PAI. "You want external support, not reinforcement of local restrictions."⁶⁴ The policy undermines progress, which has resulted in implementing partners and advocates losing the U.S. government as an ally in encouraging the Ugandan government to promote sexual and reproductive health.

While the Global Gag Rule does not cut any funding contained in the U.S. foreign aid budget, the actions and stance of the Trump administration—including prohibiting funding to UNFPA—have raised uncertainty among U.S. and foreign NGOs about future U.S. funding for health in Uganda. Additionally, donor coordination has been compromised. In 2015, USAID and DFID had divided up the country geographically to roll out a

coordinated, approximately USD 70 million multiyear family planning program.⁶⁵ According to NGOs who had competed in 2017 for the five-year, USD 35 million USAID portion of the extension—Expanding and Strengthening Family Planning Service Options in Uganda—no organization was selected to carry out the work at time of writing, creating a significant gap.^{66,67}

DFID and other donors including Canada, Sweden and Norway have made commitments to provide more family planning funds. But, even as the second-largest bilateral donor, DFID cannot match the U.S. contribution. According to data on gross disbursements in 2016, Uganda received over USD 1.76 billion in official development assistance (ODA). The U.S. government dwarfed other bilateral donors, accounting for over 30 percent of all assistance. In comparison, the United Kingdom provided 8.5 percent of ODA.⁶⁸ Ultimately, it remains to be seen if European and other non-U.S. support will be sustained or if it is just an interim stopgap.

CONCLUSION

The impacts documented to date are preliminary. The Global Gag Rule has been in place for less than a year, and some NGOs have not yet been faced with the decision to accept or reject the policy. Further documentation will be required once more organizations either receive new funding or updated cooperative agreements and grants; when funds that were disbursed prior to the implementation of the Global Gag Rule in May 2017 run out; or when stopgap funding from other sources is not renewed, as some NGOs fear will be the case. This means that the full effects of the policy will likely not be evident until late 2018 or even 2019.

Without a doubt, the current policy will have far-reaching impact on beneficiaries given the expansion. Trump's expanded Global Gag Rule has already caused confusion and burdened NGOs, taking their efforts away from service delivery; resulted in the loss of critical implementing partners for referrals; and created fear around legal post-abortion care services. Additionally, the U.S. administration's stance on family planning overall has raised fears around future funding cuts, stoked by the defunding of the UNFPA. Any reduction in health funding to Uganda through these channels will reduce the number and reach of service providers and technical support staff, causing critical disruptions of the health system and compounding the impact of the Global Gag Rule.

Uganda's Costed Implementation Plan for Family Planning, the National Family Planning Action Plan and FP2020 commitments all indicate the Ugandan government's goal to improve access to family planning and reproductive health. Trump's Global Gag Rule contravenes those commitments and goals, shoring up in-country opposition to sexual and reproductive health and rights. Ugandan policymakers will have to apportion more of the very limited funds for sexual and reproductive health to offset potential impacts of the expanded Global Gag Rule, and ensure that progress to date on sexual and reproductive health is not lost. The government of Uganda will have to make difficult decisions about which areas of health care to focus limited resources on and possibly put critical services further out of reach for vulnerable communities.

METHODOLOGY

PAI conducted a fact-finding trip to Kampala, Uganda, in October 2017 to document the preliminary impacts of the Trump administration's expanded Global Gag Rule on women's sexual and reproductive health and rights. With a focus on 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 20 organizations and agencies. These groups included Ugandan, U.S. and other foreign not-for-profit NGOs providing sexual and reproductive health services or advocacy; officials from the Ugandan Ministry of Health; bilateral and multilateral donors; and health professionals.

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*.⁶⁹

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 Uganda.

ENDNOTES

- 1 United States Mission to Uganda. (2017). *Report to the Ugandan People*. Retrieved from: https://ug.usembassy.gov/wp-content/uploads/sites/42/2017/06/REPORT-TO-THE-UGANDAN-PEOPLE_FINAL_WEB_READY.pdf
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