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ACCESS DENIED: NEPAL

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

Over the past 15 years, Nepal has made important progress in increasing access to and improving the quality of sexual and reproductive health information and services. Significant among these is the legalization of abortion in 2002, which has contributed to sharp reductions in maternal mortality.¹ Other principles guaranteeing the fulfillment of sexual and reproductive health and rights are enshrined in Nepal's 2015 constitution, underscoring that "[every] woman shall have the right relating to safe motherhood and reproductive health."^{2,3} The Trump-Pence administration's expanded Global Gag Rule not only fundamentally contravenes the constitutionally guaranteed rights of Nepal's citizens and the particular protections afforded to women, but further threatens more than a decade of the country's progress on health.

The Global Gag Rule prohibits foreign nongovernmental organizations (NGOs) 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 or liberalization of safe abortion services if they want to continue receiving U.S. global health 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 as well as other programming.

To document the preliminary impacts of the Global Gag Rule on women's sexual and reproductive health and rights, PAI conducted a fact-finding trip to Kathmandu, Nepal, in May 2018. The policy is already having several damaging effects. These impacts include: worsening contraceptive insecurity; dismantling partnerships, especially at the subnational level; inhibiting outreach to hard-to-reach, vulnerable and marginalized populations; increasing donor dependency; exacerbating abortion stigma and emboldening anti-choice opponents; and creating a dearth of implementing partners for U.S. agencies to carry out their own health-related objectives. The policy's impacts are further compounded by challenges related to the United States defunding the United Nations Population Fund (UNFPA).

In Nepal, the Global Gag Rule is the perfect example of how harmful U.S. foreign policy exacerbates existing weaknesses in the health system and government capacity, hampers the abilities of service providers and United Nations (UN) agencies to provide lifesaving services and contraceptive supplies, and magnifies inequities among different population groups. The loss of U.S. funding for critical organizations increases dependency on other donors in a resource-constrained environment and weakens the Nepalese government's abilities to achieve desired health and development outcomes while it is in the midst of rapid federalization, which could have additional detrimental effects on access to health services.



FIGURE 1.0: WHAT'S IN A NAME? THE MANY FACES OF THE GLOBAL GAG RULE

| OFFICIAL POLICY NAME | NAME BY OPPONENTS | DATE IMPOSED | AFFECTED AREAS |
|---|--|---|---|
| Mexico City Policy | Global Gag Rule | First imposed in 1984 by Ronald Reagan and alternately rescinded and reimposed by U.S. Democratic and Republican administrations respectively since then. Last imposed by George W. Bush (2001-2009). | <ul style="list-style-type: none"> ● Family planning and reproductive health |
| Protecting Life in Global Health Assistance | Trump's Global Gag Rule/Expanded Global Gag Rule | <p>January 23, 2017.</p> <p>Standard provision released on May 15, 2017.</p> | <ul style="list-style-type: none"> ● HIV/AIDS, including the President's Emergency Plan for AIDS Relief (PEPFAR); ● Tuberculosis; ● Malaria, including the President's Malaria Initiative (PMI); ● Pandemic influenza and other emerging threats, including global health security; ● Neglected tropical diseases and other infectious diseases; ● Non-communicable diseases; ● Health system strengthening; ● Maternal and child health; ● Family planning and reproductive health; ● Household and community-level water, sanitation, hygiene (WASH) activities; and ● Nutrition |

*For a full comparison of the differences between the Mexico City Policy and Protecting Life in Global Health Assistance, see PAI's *What You Need to Know about the Protecting Life in Global Health Assistance: Restrictions on U.S. Global Health Assistance, An Unofficial Guide*; and *A Tale of Two Gag Rules: Side-by-side Comparison of Global Gag Rule Memoranda*.^{4,5}

U.S. AND DONOR SUPPORT FOR HEALTH IN NEPAL

The United States is the largest bilateral donor to Nepal followed by the United Kingdom.⁶ For over 60 years, U.S. development assistance to Nepal has contributed to poverty reduction and progress on maternal and infant survival.⁷ In fiscal year 2017 (FY2017), USD 35.8 million of U.S. foreign assistance was obligated for global health programming. Of that, 41 percent (USD 14.63 million) went to maternal and child health; 29 percent (USD 10.41 million) to family planning and reproductive health; and 21 percent (USD 7.55 million) to nutrition.⁸ Global health assistance from the U.S. Agency for International Development (USAID) in Nepal have focused on a range of interventions, including improving childhood nutrition; reducing newborn deaths; supporting the use of social marketing to improve the quality of health commodities; improving sanitation and access to safe drinking water; and the provision of essential health services for vulnerable and hard-to-reach populations.^{9,10}

While the Global Gag Rule affects all areas of U.S. global health assistance, the most concentrated impacts in Nepal will be seen under family planning and reproductive health. Within sexual and reproductive health, the Family Planning Service Strengthening Program (FPSSP) and Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) are two signature USAID initiatives implemented by foreign organizations in Nepal. FPSSP is a USD 10 million, four-year program that seeks to “[increase] access to and the use of quality family planning services in Nepal.”¹¹ The health advances these interventions have supported are at risk because the implementers of FPSSP are the major nongovernmental sexual and reproductive health service providers in Nepal—two foreign NGOs that will not comply with the Global Gag Rule.^{12,13}

When the Global Gag Rule was last in effect under President Bush, it had detrimental consequences for the health sector. The International Planned Parenthood (IPPF) affiliate, the Family Planning Association of Nepal (FPAN), chose not to comply with the policy. As a result, FPAN lost USD 100,000 annually in U.S. funding, USD 400,000 in USAID-funded contraceptives, and was forced to lay off 60 clinical staff through the end of the Bush administration.¹⁴ When U.S. funding to another major service provider was discontinued, clients in remote rural areas lost access to sexual and reproductive health services through mobile clinics.¹⁵ These mobile clinics provided a range of services including primary health care, family planning, pre- and postnatal care as well as youth-friendly services. At the time, the Global Gag Rule also stifled advocacy around the newly passed bill to legalize abortion in 2002.¹⁶

Unfortunately, not only are similar effects expected under Trump’s expanded Global Gag Rule, but they will be magnified given the increased scope of the policy, greater integration of health services and programs in the last decade, and increased investments in family planning and reproductive health as a whole. Just as last time, those most affected by absent or reduced access to services and contraceptive supplies will be vulnerable populations, including youth and those in rural and hard-to-reach communities. The government of Nepal sees investment in family planning as an important strategy to drive down infant and maternal mortality and to achieve the country’s ambitious goal of moving from a least-developed-country to a developed country by 2022.¹⁷ The Global Gag Rule undermines more than a decade of U.S. investments in global health and puts the government of Nepal’s own objectives linked to key global commitments for family planning, health and development further out of reach.

REPRODUCTIVE HEALTH IN NEPAL

Nepal has demonstrated commitments to sexual and reproductive health and rights (SRHR) and made rapid progress improving health indicators, though challenges remain. The country is among the 20 poorest in the world, and of its population of 26.5 million, 81 percent live in rural areas and roughly a third of the population is under 15 years old.^{18,19,20} While the fertility rate has decreased from 4.6 in 1996 to 2.3 in 2015 and contraceptive prevalence among married women is 43 percent, there is significant variation in rates by region, with rural populations having lower prevalence rates compared to those in urban areas.^{21,22} Twenty-five percent of women have an unmet need for family planning, and though modern contraceptive use doubled in the last 20 years, it has remained stagnant since 2006—due in part to high rates of discontinuation.

Migration, both internal and external, is very common in Nepal, with 47 percent of Nepalese households reporting having at least one family member who migrated in the last decade.²³ While most of Nepal's progress on poverty reduction can be attributed to the economic opportunities afforded by migration, it creates obstacles for family planning uptake and continuation.²⁴ Sixty percent of women who use contraception discontinue it within 12 months, with the most commonly cited reason being that their husbands are away.²⁵ Additionally, the bulk of unmet need among married women in Nepal is driven by women who are not living with their husbands.²⁶ These factors increase the risks of unintended and unwanted pregnancy and unsafe abortion.

Youth and adolescents in Nepal face distinct inequities when it comes to their sexual and reproductive health and rights. Seventeen percent of 15 to 19-year-old women are mothers, with that proportion increasing to 33 percent in rural areas.²⁷ Almost 50 percent of women in Nepal are married by the age of 18 and unmet need among adolescent girls is 42 percent—significantly higher than the national average of 25 percent.²⁸ Childbearing at a young age increases the risk of complications during pregnancy and is generally associated with poorer maternal and infant health outcomes, not to mention increased maternal and infant death.²⁹ The World Health Organization (WHO) reports that while efforts have been undertaken by the government to provide comprehensive sexuality education in schools and offer integrated youth-friendly services, many adolescents in Nepal are unaware these services exist or the services are inaccessible to them, especially for youth in rural and hard-to-reach areas.³⁰

Nepal's 2015 constitution mandates that “the Federation, State and Local level shall make laws, make annual budget decisions, formulate and implement policies and plans on any matters related to financial powers within their respective jurisdictions.”³¹ Under this system, the subnational entities are responsible for providing basic health services while the federal government will have chief responsibility for policy formulation and the development of standards and regulations.³² Thus, Nepal is currently in the process of devolving health functions, including procurement of contraceptive commodities to its 77 districts and 753 municipalities, in the hopes of bringing health care closer to the population and ensuring universal health coverage.

The government has demonstrated continued leadership on SRHR through several policy documents, initiatives and ambitious global commitments. These include the *National Reproductive Health Commodity Security (RHCS) Strategy (2015-2020)*, the *Nepal Health Sector Strategy (2015-2020)* and the *National Family Planning Costed Implementation Plan (2015-2020)*. Globally, the government of Nepal's Family Planning 2020 (FP2020) commitments include raising the annual budget allocation for family planning by seven percent every year through 2020 and a pledge to scale-up and strengthen adolescent-friendly services and services for marginalized, rural and migrant populations.³³

Within the new constitution, health is enshrined as a fundamental human right—including the right to safe, legal abortion.^{34,35,36,37} Before abortion law reform, an estimated 20 percent of all maternal deaths were attributable to illegal abortion and more than half of pregnancy complications were due to unsafe abortion.³⁸ Since then, Nepal has experienced dramatic declines in maternal mortality, with rates falling from 580 maternal deaths per 100,000 live births in 1995 to 239 per 100,000 in 2013.³⁹ The Global Gag Rule threatens to unravel this progress. In 2002—during the last Global Gag Rule—advocates fought for and successfully achieved abortion law reform.^{40,41} Since then, abortion has been legal in Nepal under the following conditions—all of which extend beyond the exemptions defined under the Global Gag Rule:

- Up to 12 weeks gestation for any indication, by request
- Up to 18 weeks gestation in the case of rape or incest

- At any time during pregnancy if mental/physical health or life of the pregnant woman is at risk (approval from a medical practitioner required)⁴²
- At any time during pregnancy if the fetus is deformed and incompatible with life (approval from a medical practitioner required)

By cutting off U.S. global health assistance funding to key NGO service providers, the Global Gag Rule will hinder government efforts to: increase contraceptive prevalence, decrease maternal mortality, ensure the integration of family planning and reproductive health services with other essential health care, and to improve the quality and availability of services and contraceptive supplies for adolescents and other vulnerable populations. Because the Global Gag Rule directly contradicts Nepal's abortion law, foreign NGOs that wish to receive U.S. global health assistance now face the difficult choice of retaining critical funding or violating the constitutional rights of Nepalese citizens. Foreign NGOs that choose not to comply with the Global Gag Rule will likely turn to the federal government for additional support.

However, at a time of rapid devolution of health functions to the subnational level, it is unclear whether the federal government has either the resources or capacity to provide such support. Already, the Nepalese health system is under considerable strain. The April 2015 earthquake caused widespread destruction to health care infrastructure—damaging 1,200 health facilities—consequently hindering or cutting off access to family planning and other health services previously provided in these locations.⁴³ Repairing and rebuilding these structures is incomplete and remains a priority for the government of Nepal. Faced with its existing financing challenges, the government may be unable to fill resource gaps caused by the Global Gag Rule, and sexual and reproductive health outcomes will be further jeopardized.

EARLY AND HARMFUL IMPACT

SERVICES LOST, VULNERABLE GROUPS AFFECTED

The two largest providers of sexual and reproductive health services in Nepal are foreign nongovernmental organizations. Both organizations were recipients of USAID funding under the “Support for International Family Planning Organizations 2” (SIFPO2) program. The program has a specific focus on increasing access to a variety of family planning methods for marginalized and at-risk communities; building the capacity of the public sector to deliver high-quality family planning services; increasing commodity security in the public sector and providing gender-sensitive programming for adolescents and youth.^{44,45,46} SIFPO2 was also conceived to leverage the contributions of other donors by strengthening the capacities of organizations and their existing networks. Launched in 2015, SIFPO2 represented a USD 10 million-dollar, four-year investment.⁴⁷ With this funding, the organizations coordinated their activities and work in complementary districts. Under SIFPO2, each organization was also able to significantly expand its country presence, extending its reach from seven to 11 districts. However, neither will comply with the Global Gag Rule and their SIFPO2 activities will prematurely end.

In the last three years, one of the organizations has provided more than 40,000 family planning services to communities in hard-to-reach areas; trained 257 health workers in 165 public facilities to provide long-acting reversible contraceptives (LARCs); and delivered 63,854 couple-years of protection (CYP) by offering a full mix of contraceptive methods through a combination of mobile outreach, established community clinics and a cohort of female reproductive health volunteers.⁴⁸ However, because the NGO will not certify the Global Gag Rule, its SIFPO2 funding will end in October 2018 instead of March 2019.⁴⁹ The organization will also be ineligible for funding for the next iteration of the program and any U.S. global health assistance while the Global Gag Rule is in effect. Separately from SIFPO2, the same implementing organization was partnering with another large service provider on the provision of LARCs and integrated services before the imposition of the Global Gag Rule. That partnership has ended since the other service provider chose to comply with the policy.⁵⁰

The organization is facing an additional challenge with its SIFPO2 funding ending early. Previous delays in funding and implementation due to the earthquake mean that the timeline for completing 2018 project activities is even more truncated. The organization is doubtful that it will be able to reach the planned results of the project in providing family planning services and training service providers, further short-changing communities and health workers. A representative of the organization explained, “It is going to be very difficult to spend that money by September because we have our own internal rules and regulations to ensure the quality of our programs.”⁵¹ The organization is hoping that it can replace the funding lost with other bilateral donors, but this assistance is not yet forthcoming.

The other large implementing SIFPO2 partner is in a similar situation.⁵² When its SIFPO2 funding ends, the NGO will have to lay off 80 staff and withdraw from four districts. In one of these districts, the organization’s work focused on migrant communities who have lower contraceptive prevalence rates, in addition to higher rates of discontinuation, unwanted pregnancies and unsafe abortion.⁵³ Other programs focused on predominantly Muslim communities will also come to an end. The organization was also a key partner providing LARCs—particularly implants. In 2017, it provided 43,000 of the 80,000 implants that were inserted in Nepal.⁵⁴ That work will be undermined by the Global Gag Rule as well.

A representative from the organization noted that the effects of the funding losses due to the Global Gag Rule extend beyond service provision. They will also damage private-public partnerships between NGOs and the Nepalese government. Given the unique nature of USAID funding, the organization does not foresee another donor supporting similar interventions:

“SIFPO was working for the government, so it really built trust and strengthened our relationship with them. Now that will stop. We trained government staff and helped to mobilize them to support sexual and reproductive health. No other donor is doing this kind of capacity-building for government.”⁵⁵

Given the extensive reach of both of these foreign NGOs, as well as their focus on vulnerable populations, the Global Gag Rule is undermining access to high-quality sexual and reproductive health services for marginalized, vulnerable and low-income groups including youth—who have the highest unmet need for family planning.⁵⁶ It is important to note that both organizations are central NGO partners in Nepal for referrals and the provision of integrated services (while respecting the strict USAID family planning and abortion compliance regulations). For example, one has led youth outreach in Nepal, with an emphasis on peer-to-peer learning. The organization operates more than 80 youth information centers around the country and youth outreach is a core component of SIFPO2. Both SIFPO2 partners take a comprehensive approach to the provision of services for adolescents and youth, providing integrated services and guaranteeing privacy and confidentiality. A representative from a local advocacy organization explained:

“[They] have the only NGO-run clinics in the country. At government clinics, services are free, but judgmental behavior of clinical staff especially for adolescents is a big problem. It forces [adolescents] to go far away to other facilities where they will be anonymous.”⁵⁷

The Global Gag Rule diminishes the availability and quality of services for Nepalese adolescents by constraining the operations of providers that are willing to deliver comprehensive SRHR services. Further, because both organizations provide technical assistance to the Nepalese government for improving the quality of services and supplies in public facilities under SIFPO2, the policy weakens the overall health system. Without the full partnership of these foreign NGOs, the government of Nepal is also unlikely to achieve its FP2020 commitments to:

“strengthen and gradually scale up adolescent friendly services to cater for the needs of adolescents in all health facilities; increase the availability of a broader range of modern contraceptives and improve method mix at different levels of the health care delivery system; and strengthen the capacity of health institutions and service providers to expand family planning service delivery networks to respond to the needs of marginalized, rural residents, migrants and adolescents...”⁵⁸

DONOR DEPENDENCY INCREASED AND UNFPA UNDERMINED

Compared to other countries, Nepal receives a relatively low level of bilateral assistance for health. The number of bilateral donors focused on SRHR is even smaller, with DFID and USAID dominating the sector.^{59,60} Consequently, the loss of USAID SIFPO2 funding for the two largest service providers creates a heavy funding dependency on DFID for agencies and organizations in the sector. This undercuts the overall sustainability of SRHR efforts in Nepal. According to representatives from civil society as well as donors, the need for an infusion of new funding and donors to the SRHR sector is urgent. This need is exacerbated by the fact that USAID and DFID have also traditionally coordinated their programming—covering complementary geographical areas and issues as well as shoring up government capacity where it is most needed.⁶¹ For example, under SIFPO2, both implementing organizations prioritized districts where government presence was weak or absent.⁶² Underserved populations will be the first to lose access to critical sexual and reproductive health services and supplies because of the Global Gag Rule.

At the same time, the ability of the public sector to step in is doubtful and the funds lost to partners who choose not to agree to the Global Gag Rule are unlikely to be replaced by funds generated from domestic resource mobilization—especially at a time of rapid federalization. For example, officials from the Ministry of Health admitted that despite Nepal’s FP2020 commitment to increase budgetary allocations for family planning to seven percent per year, budget cuts mean that this is unlikely to be achieved. Instead, budgets for family planning are likely to remain stagnant or decrease.⁶³

The Global Gag Rule is therefore creating significant gaps—and not just for the women and communities who will no longer have access to high-quality sexual and reproductive health supplies. With the policy in place, USAID is allegedly struggling to find equally qualified implementing partners willing to subvert Nepal’s constitutional mandate guaranteeing the right to safe, legal abortion.⁶⁴ Without the two largest foreign NGO service providers, SIFPO2’s future—at least in its current form—remains unclear. As one key informant explained, “There is no local NGO who can [implement SIFPO2] without the support of an INGO for technical assistance or quality assurance.”⁶⁵ According to one donor, this challenge is precipitating a shift in USAID’s funding and programming priorities toward less-integrated approaches—and even away from family planning:

“[The two organizations] have a huge presence throughout the country and are important for integrated services and referrals. So, it is very difficult for [USAID] to channel their funds. They are sitting on a pile of cash and struggling to find partners. We have heard that they are trying to invest in system-building and other things that may not be linked to family planning and integrated services. To ensure human rights on reproductive health, you must have integrated services.”⁶⁶

The harmful impact of the Global Gag Rule in Nepal and the complexities of devolution are being compounded by the withdrawal of the U.S. contribution to UNFPA due to a negative Kemp-Kasten determination.⁶⁷ UNFPA plays a critical role in commodity security in Nepal, providing technical assistance to the government on procurement and supply chain management.^{68,69} However, the agency has experienced a reduction in core funding. Like other SRHR organizations in Nepal, the withdrawal of U.S. funding has increased the agency’s dependency on other donors. While other donors have been able to step in to restore a significant portion of UNFPA’s original budget, the composition of that funding has changed, affecting the type of programming in which UNFPA can engage. An agency representative reflected, “We do not have the core funding that we used to have. Other donors have come in, but that funding is earmarked, so we have lost the flexible core funding. These conditions in financing restrict your abilities to meet the needs at the local level.”⁷⁰

Unfortunately, UNFPA is experiencing these funding restrictions at a time when it is most needed to help mitigate challenges created by the federalization process and the Global Gag Rule. For example, while provincial and municipal governments continue to request support, UNFPA no longer has the flexible funding to engage in devolution technical assistance—skills-building for local officials on planning, budgeting, policy development and legal frameworks for health—that is essential for the prioritization and delivery of sexual and reproductive health at the subnational level.⁷¹ And at a time when the Global Gag Rule is causing the withdrawal of the country’s two largest service providers from key districts, UNFPA’s financial situation is necessitating its movement away from the hardest-to-reach areas such as Karnali, one of Nepal’s poorest and most remote provinces. The combined effect of the Global Gag Rule, devolution and the defunding of UNFPA is leaving vulnerable populations with few options for sexual and reproductive health services and contraceptive supplies. For example, a UNFPA staff person lamented:

“Donors want value for money, so even in Nepal, few are willing to fully fund projects to reach last-mile areas like Karnali. We have to make an unwelcome cost-benefit analysis about how many people we can reach with the least amount of money.”⁷²

Even where programming has continued, the quality of sexual and reproductive health programs has shifted due to funding constraints. UNFPA reports that it has earmarked funding for humanitarian preparedness and addressing obstetric fistula and gender-based violence. It also has earmarked funding for family planning but for demand generation and services, not commodities.⁷³ As a result, UNFPA is now spending what is left of its core funding on contraceptive supplies, and less on rights-based interventions to ensure the quality of SRHR services:

“Every local level is saying they do not have enough supplies. Our core funding is now being spent on commodities. We would have previously used that funding for more rights-based areas, but we now have to focus more on service delivery.”⁷⁴

In Nepal, the Global Gag Rule is already having significant negative effects. The inability of the two major family planning organizations to conduct services in as many geographic areas due to funding losses, the impossibility of remaining bilateral donors to fill these funding gaps, and the defunding of UNFPA all translate to a loss of integrated, high-quality sexual and reproductive health services and supplies—especially for Nepal’s hardest-to-reach and most vulnerable populations.

COMMODITY SECURITY THREATENED

Like many countries, Nepal has not achieved commodity security. Though there has been some progress, as evidenced through the 2015 National Reproductive Health Commodity Security Strategy, the government is still struggling to procure contraceptives, resulting in severe shortages throughout the country.⁷⁵ These stockouts have real-world consequences: UNFPA estimates that every USD 1 million shortfall in commodity

security assistance results in an additional 360,000 unintended pregnancies, 150,000 induced abortions and 11,000 infant deaths.⁷⁶ Unfortunately, at time of writing, there were indications that government allocations for procurement of family planning commodities remained inadequate.⁷⁷ According to an interviewee from a major social marketing organization:

“The government is on board, but supplies in government facilities are very erratic, especially if there is no support from the private sector or social marketing. There has not been a major multimillion-dollar procurement to ensure continuous supply in the last 10 years.”⁷⁸

NGOs and donors in Nepal attribute at least some of this to high staff turnover in the Ministry of Health and insufficient technical skill with contraceptive quantification and procurement. In this context, the Global Gag Rule is a harmful accelerant, and its detrimental effects work through several pathways. First, by making the two major foreign NGO providers of family planning services and supplies ineligible for U.S. global health assistance, it disrupts the abilities of two critical government civil society partners to deliver contraceptive services and supplies. The loss of SIFPO2 funding will force both organizations to cease operations in four hard-to-reach districts, respectively. Worse, both organizations are key providers of LARCs, which are important both for increasing method mix and as contraceptive choices for vulnerable populations with a lack of access to consistent services and supplies. One of these organizations alone is responsible for delivering half of all implants in Nepal.⁷⁹ The role of the organization is even more important when one considers that there is bifurcation with respect to the availability of contraceptives in the public and private sectors. Long-acting methods are in the public sector, while short-acting methods such as pills and condoms predominate in the private sector. Much of this service provider’s work under SIFPO2 was focused on training on LARCS in public facilities—where services are free. The loss of this highly qualified government partner endangers both the availability and quality of long-acting methods in the public sector in Nepal. As one key informant explained:

“The government has made a lot of progress, but training on LARCs is still very difficult. Very few people are trained to implement LARCs. This is the work that [the foreign NGO] is doing.”⁸⁰

While Nepal’s constitution mandates free coverage of contraceptives, that requirement is limited to the public sector—private facilities may still charge for commodities. By undermining major service providers, the Global Gag Rule will increase out-of-pocket spending for individuals, again placing a heavy burden on disadvantaged communities and youth as they seek alternative care from the private sector: “The private sector is stronger than the public sector in Nepal... three times larger,” one donor pointed out, “And the private sector does not have to provide anything for free.”⁸¹ Another donor reinforced the notion of the financial burden created by commodity insecurity:

“Out-of-pocket is high in Nepal—more than 50 percent—and most of that cost is on medications. There is heavy private sector dependence because the government is unable to fully procure.”⁸²

Consequently, disadvantaged and marginalized communities with the least access to services and the least ability to pay are most affected by commodity stockouts and reductions in quality of care due to the policy.

This complex interplay of factors is further exacerbated by Nepal’s federalization process. Starting in the summer of 2018, Nepal will be one of the only countries in the world to completely devolve procurement of commodities to the local level. Provinces will have autonomy to procure, but a quality assurance system does not yet exist at the subnational level.⁸³ The government of Nepal is hoping to ease this transition and help to ensure the availability and quality of a subset of essential medicines—including family planning commodities—by permanently procuring them at the federal level.⁸⁴ However, under Nepal’s constitution, provinces and municipalities still have the right to procure for themselves.⁸⁵ Unfortunately, this is expected to present challenges of scale as subnational governments simply lack the purchasing power of the federal government. This will likely result in smaller quantities of and higher costs for contraceptive commodities at the subnational level—increasing the risk of stockouts.

The federalization process is moving at a rapid pace, and most subnational officials are new to their posts and new to health policy formulation and implementation. Few understand the importance of investments in health. As one key informant explained:

“Health is not a priority. Politicians are more interested in projects that are visible. Most of these people have never been in power and they have no strategies. Infrastructure projects are being positioned as ‘health’ interventions. Municipalities have a lot of money and don’t know what to do with it; they are only building roads.”⁸⁶

Even in a best-case scenario where sexual and reproductive health and commodity security are prioritized, the challenges currently being experienced by the federal government in finding and retaining qualified staff around quantification and procurement will likely be multiplied several times over at the provincial and municipal levels, again contributing to stockouts and putting lifesaving supplies out of reach for populations.

Nepal’s unique federalization growing pains are happening while the Global Gag Rule is limiting the reach of the two major family planning providers—and at the same time that the Kemp-Kasten amendment is reducing funding for UNFPA and restricting its ability to provide technical assistance to both the federal and subnational governments. Thus, the Global Gag Rule and U.S. foreign policy are increasing commodity insecurity; decreasing method mix and quality of care in public facilities; and placing women and adolescents in Nepal at greater risk for unintended pregnancies, unsafe abortions and maternal deaths.

ABORTION ADVOCACY STIFLED AND PARTNERSHIPS DISMANTLED

“There is no confusion. This policy is against our constitution.” — Foreign NGO Representative⁸⁷

While the legalization of abortion has reduced maternal deaths, advocates in Nepal still see opportunities to strengthen and further liberalize the existing law to achieve progress on maternal health. For example, efforts are underway to enable nurses to provide abortion beyond nine weeks, while legal initiatives seek to remove abortion from the criminal code.⁸⁸ However, the Global Gag Rule is undermining abortion advocacy in Nepal in several ways. Its most damaging effect is that it limits the number of partners available to conduct campaigns to ensure safe abortion access for poor and rural women. The policy is also increasing abortion stigma amongst policymakers and emboldening anti-choice opponents. This is especially harmful at a time of rapid federalization when many subnational health officials do not yet understand the value of prioritizing issues of SRHR. Finally, confusion around the policy has made recipients and nonrecipients of U.S. global health assistance uneasy, further limiting abortion advocacy and creating barriers to the provision of services.

One noncompliant advocacy organization that trains health care workers on the provision of abortion described the policy as limiting the partners it can work with.⁸⁹ Efforts to integrate abortion with other basic health care services have faltered because some of the partners have decided to comply with the Global Gag Rule. The unavailability of partners has predictably affected the scale of the program. The organization was hoping to work in five districts, but that has now stalled because a key organization withdrew from the partnership after complying with the Global Gag Rule. A representative from the advocacy organization explained:

“It’s hard to find CBOs [community-based organizations] or NGOs not working with USAID—hard to find partners at the community level. Organizations at the community level no longer want to work with us because the money they receive from USAID is much more than they receive from us. This is hindering coordination at the local level and hindering access for rural women.”⁹⁰

The dearth of partners with which to conduct advocacy was also attributed to confusion around the Global Gag Rule. Even when organizations may not be recipients of U.S. global health assistance, lack of clarity around the policy is leading them to shy away from partnerships out of an overabundance of caution. One NGO staff person told PAI:

“Providers are confused. If a building was even partially funded by USAID, they are saying abortion services cannot be provided there.”⁹¹

According to staff from two advocacy organizations, some of this confusion stems from unclear communication from the USAID mission about the scope and potential impact of the Global Gag Rule. They described mission staff as reticent “and a bit confused themselves.”⁹²

PAI spoke with the executive director of one vlarge, compliant implementing organization who had comprehensive knowledge about the Global Gag Rule and who understood the intricacies of the policy and the dangers of over-implementation.⁹³ The organization had supplemented compliance materials developed by the USAID mission and conducted in-depth, in-person technical assistance with sub-awardees at the community level. The executive director attributed his insight and the organization’s proactivity to his and other long-time staff members’ experiences with previous iterations of the policy. Given reports of unclear and insufficient communication from the USAID, it may be helpful for missions to consider peer-to-peer technical assistance among implementing organizations where there is strength in the network to minimize misinterpretation and over-implementation of the policy.

Interviews PAI conducted with several foreign NGOs confirmed widespread confusion about the policy, most frequently around the expansion and the other areas of health it now affects. For example, a foreign NGO engaged in the water, sanitation and hygiene sector admitted that the policy was largely unfamiliar to organizations in the sector and few understood the implications for their work.

Foreign NGOs described the environment under the policy as creating a greater sense of isolation for those engaged in abortion advocacy, making it more difficult to accomplish their objectives and get buy-in from donors and other key stakeholders who are already trepidatious around abortion.^{94,95,96} For example, a major service provider that engages in abortion advocacy described a chilling effect among bilateral donors and multilateral organizations even before the expanded Global Gag Rule was imposed:

“[As civil society organizations,] whenever we want to go for very big issues, we are alone. We have no one to support us. None of the UN agencies will attend safe abortion meetings. WHO will not attend safe abortion meetings—even though the guidelines come from them. On top of that, issues like task-sharing are against the self-interest of many local policymakers since they are doctors.”⁹⁷⁸

In some cases, U.S. policy actions unrelated to the Global Gag Rule but linked to traditional U.S. funding restrictions related to abortion further compound this sense of isolation and complicate efforts to ensure equitable access for all Nepalese women. For example, one advocacy organization claimed that USAID was supporting the development of government quality of care indicators—an important and valuable intervention. However, quality of care indicators for safe abortion were excluded from the exercise, making it more difficult to integrate programs and provide high-quality services in a holistic way at the clinical level: “There needs to be integration. Funding harmonization is put at risk. Safe abortion as a standalone project is a failure.”⁹⁸

A staff member at another advocacy organization that does not receive U.S. government funding, and which is not compliant with the Global Gag Rule, emphasized similar barriers at the national and subnational levels:

“It is still a challenge to talk about abortion with government policymakers. Even though safe abortion is free, many are still not on board with access to safe abortion. In terms of our advocacy, the Global Gag Rule is making abortion a contentious issue again.”¹⁰⁰

Worse, NGOs, researchers and legal experts report that the Global Gag Rule is encouraging the advocacy of anti-choice, anti-woman opponents who have traditionally struggled to gain a foothold in the Nepalese SRHR policy space. While these groups allegedly do not yet have significant policy experience, they are practiced at media engagement and have a ready audience with policymakers predisposed to thwarting abortion liberalization efforts. Policymaker reticence in a rapidly devolving environment where subnational officials still need to be convinced to prioritize health will make achieving advocacy objectives even more difficult—and make it harder for poor and rural women to access free services. The Global Gag Rule magnifies these challenges, especially among parliamentarians who may be skittish around task-shifting, abortion for adolescents and late-term abortion. A staff member from a women’s health advocacy group summarized, “When the world’s most powerful country is against abortion, it makes a big impact on the policymakers at the local level.”¹⁰⁰

CONCLUSION

In Nepal, the Global Gag Rule provides a stark example of how harmful U.S. policy can risk unravelling country progress on sexual and reproductive health and rights. In 2002, Nepal undertook abortion reform to reduce maternal mortality and the unsafe abortions that were a root cause. The right to safe, legal abortion is now enshrined in Nepal's constitution, and since 2002, maternal mortality has plummeted. However, by denying funding to the two largest NGO providers of sexual and reproductive health services and forcing compliant foreign NGO health care providers to not uphold the full range of abortion services required under local law, the policy risks undoing more than a decade of progress on maternal health.

Not only will the Global Gag Rule make U.S. investments in Nepal less effective by dismantling integrated U.S. global health assistance programs, it will also undermine government initiatives to integrate family planning with other health services and achieve universal health coverage. In all cases, adolescents, migrants, rural and other marginalized communities are most at risk of losing access to reproductive health services and supplies. Further, because two of the largest foreign NGO family planning service providers are actively engaged in partnering with the government to increase capacity around commodity security, their funding and programmatic losses will translate to a weaker health system and lower quality of sexual and reproductive health care in public facilities overall. Compromised quality of care or absent services will increase reliance on the private sector and increase out-of-pocket costs for women and communities in a country where poverty is still pervasive despite recent economic gains. Lastly, the Global Gag Rule is sowing confusion and fear that, in turn, is increasing abortion stigma and harming partnerships by creating a dearth of advocacy partners at the community level.

These harmful ripple effects are magnified in a country context where there are relatively few bilateral donors and other implementing organizations with the needed scale, skills and community trust to undertake the provision of services and supplies—as well as technical assistance to the government. The federal government of Nepal has demonstrated strong commitment to continued investments in SRHR, but it is unlikely that it can serve as a bulwark against the Global Gag Rule given the competing priorities of post-earthquake recovery and federalization. Without an infusion of new donor funding and increased advocacy to prioritize sexual and reproductive health with policymakers at the subnational level, it is unlikely that Nepal will be able to achieve its ambitious health and development goals.

METHODOLOGY

PAI conducted a fact-finding trip to Kathmandu, Nepal, in May 2018 to document the preliminary impacts of the Trump administration's expanded Global Gag Rule on women's sexual and reproductive health and rights. PAI held interviews and meetings with representatives from over 20 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. PAI also spoke with officials from the Ministry of Health and Population 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*.¹⁰¹

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 Nepal.

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