Politicization of US Foreign Aid: The Global Gag Rule in Uganda and South Africa

By
Shannon Landheer

Submitted to
Central European University
Department of Public Policy

In partial fulfillment of the requirements for the degree of Masters in Public Policy
Supervisor: Evelyn Hübscher

Vienna, Austria
2024

AUTHOR'S DECLARATION FORM

I, the undersigned, Shannon Landheer, hereby declare that I am the sole author of this thesis. To the best of my knowledge, this thesis contains no material previously published by another person except where proper acknowledgement has been made. This thesis contains no material which has been accepted as part of the requirements made of any other academic degree or non-degree program, in English or in any other language. This is a true copy of the thesis, including final revisions.

Date: 31.05.2024 (Vienna, Austria)

Name (printed): Shannon Landheer

Signature:

ACKNOWLEDGEMENTS

I extend my gratitude to my thesis supervisor, Evelyn Hübscher, and my academic writing instructor, Sanjay Kumar, for their guidance and thoughtful feedback throughout this project. I am also deeply thankful for my family and friends, including Kathleen O'Brien and Tala Tayebi, for their support and encouragement.

ABSTRACT

This thesis examines the impact of the Trump administration's 2017 Global Gag Rule (GGR) in Uganda and South Africa. The GGR is a US policy that restricts funding to NGOs that provide or promote abortion-related services, which has operational, political, and health outcomes in recipient countries. This thesis analyzes the effects of the GGR within the distinct legal and political contexts of abortion in Uganda, where abortion is largely illegal, and South Africa, where abortion is legal but not universally accessible. Using a comparative case study approach, the research draws on existing literature and reports, supplemented by interviews with NGO representatives in the two countries. The findings suggest that the GGR had significant impacts on NGO operations, advocacy, partnerships, and the delivery of services, including legal abortion, contraception, and HIV/AIDS services, ultimately leading to an increased demand for illegal and unsafe abortions in both countries, especially in rural areas. The effects of the GGR even spilled over into the political and social spheres, emboldening opposition to abortion and influencing education curricula. This thesis contributes to the growing research on the negative impacts of the US policy and the harms of politically motivated foreign assistance. The results underscore the urgent need for foreign aid policies that prioritize global health and human rights over partisan political agendas.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

ACDP	African Christian Democratic Party
ANC	African National Congress
AIDS	Acquired Immune Deficiency Syndrome
CSE	Comprehensive Sexuality Education
CTOP Act	Choice on Termination of Pregnancy Act
GBV	Gender Based Violence
GGR	Global Gag Rule
HIV	Human Immunodeficiency Virus
MCP	Mexico City Policy
MMR	Maternal Mortality Ratio
NGO	Nongovernmental Organization
PEPFAR	The US President's Emergency Plan for AIDs Relief
PLGHA	Protecting Life in Global Health Assistance
STD	Sexually Transmitted Disease
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

Overview

Every two minutes, a woman dies due to complications during pregnancy or childbirth, a stark reality that underscores the urgency of addressing global maternal health crises (World Health Organization, 2023). Pregnancy and delivery are the leading causes of death for women aged 15–19 years worldwide (WHO, 2024). In low-income countries, the lifetime risk of maternal death is 1 in 49, compared to just 1 in 5,300 in high-income countries. Such disparities stem from differences in access to quality reproductive health care, a fundamental human right under international treaties such as the Convention on Ending Discrimination Against Women (1979), but one that remains elusive for millions of women worldwide.

In many low-income countries, foreign assistance fills critical gaps in reproductive health care delivery, especially where weak and under-funded health systems fail to meet the needs of their populations (Wadge, 2017). Nongovernmental organizations (NGOs) that provide such services rely heavily on funding from foreign governments, with the United States standing as the largest bilateral donor, contributing around a third of total global health assistance (Donor Tracker, 2024). In 2022, its $15.8 billion of funding for global health was nearly four times the amount of the United Kingdom, the second-largest donor. The influence of US foreign aid, however, is not without its complexities and controversies, and often reflects the country's turbulent and polarized domestic politics, impacting health and development outcomes of populations in recipient nations.

This harmful dynamic is epitomized by the Global Gag Rule (GGR), a policy that has oscillated with each change in US presidential administration since it was first introduced at the 1984 United Nations Population Conference by Republican President Ronald Reagan. The policy has since been rescinded by every Democratic president and reenacted by every Republican

president. Officially titled the Mexico City Policy (MCP), the policy became colloquially known by its critics as the Global Gag Rule for its "gagging" effect on NGO activities. The GGR cuts funding to non-US NGOs who provide abortion-related services and information.

Upon taking office in January 2017, one of President Donald Trump's first actions was to not just reenact, but substantially expand, the GGR – renamed Protecting Life in Global Health Assistance (PLGHA) – a decision the White House claimed "made it clear that he was a pro-life president." (New York Times, 2017). Historically, previous versions of the GGR applied only to the Department of Family Planning. The PLGHA extended restrictions to all US agencies, affecting areas including HIV/AIDs, child health, tuberculosis, malaria, infectious diseases, neglected tropical diseases, and even water, sanitation, and hygiene programs. While previous iterations of the GGR applied to $535 million in funding, PLGHA applied to an estimated $8.8 billion, which amounts to over 15 times more funding (Mavodza et al., 2019). Further, previous versions of the GGR only prevented NGOs from using US funds, but the PLGHA restricted the use of any funds - US or non-US - to provide abortion services, counsel patients about the option of abortion, refer them for abortion, or advocate for the liberalization of abortion laws. In 2019, the Trump administration further expanded the policy to prohibit NGOs from funding any partner organizations that perform or promote abortion as a method of family planning (United States Department of State, 2020).

The GGR has had significant implications for health outcomes, especially in countries where public health systems are highly dependent on NGOs receiving US funding. Under the GGR, NGOs are compelled to choose between complying with restrictive abortion-related conditions or forgoing all US funding. Both choices have profound implications for NGO

operations and service delivery, and ultimately for access to comprehensive sexual and reproductive health care and maternal health outcomes.

Paradoxically, countries exposed to the policy have experienced increases in abortions, many of which were performed under unsafe medical conditions, an outcome that is directly contrary to its supposed intentions (Brooks, 2019). The closure of clinics and reduction in contraceptive provision has been linked to a rise in unintended pregnancies (Jones, 2011). Numerous studies (e.g., Crane & Dusenberry, 2004; Bendavid, Avila, and Miller, 2011) have associated the rise in unsafe abortion practices resulting from the GGR with maternal health complications, including increases to maternal morbidity and mortality (MSI, 2018). Given these impacts, the policy undermines the public health interests of recipient countries, especially those with already poor sexual and reproductive health outcomes.

Research Aims and Rationale

This thesis examines the impact of the Trump administration's 2017 GGR on NGOs in Uganda and South Africa, two sub-Saharan African countries whose health systems are heavily reliant on US assistance, but where the legal and political landscapes surrounding abortion differ. In Uganda, abortion is illegal in most cases (Uganda Constitution, Article 22), and in South Africa, abortion is a constitutionally protected right under the CTOP Act (Government of South Africa, 1996). By exploring these divergent contexts, this study seeks to understand how the GGR's effects may manifest differently in recipient countries with different abortion landscapes.

This thesis investigates the question: how does the legal landscape of abortion in a recipient country mitigate or compound the effects of the GGR on NGOs within that country? There are two primary hypotheses:

1. In nations where abortion is legally protected and governments are committed to reproductive health, the national health systems may exhibit greater resilience in providing abortion services despite the policy.
2. Conversely, in countries where abortion is highly restricted, affected NGOs may lack the necessary domestic support to mitigate the impacts of the GGR effectively.

The research employs a comparative case study approach, with Uganda and South Africa as case countries, primarily due to their divergent legal landscapes surrounding abortion: liberal in South Africa and restrictive in Uganda. While the GGR is likely to impact both countries due to their dependence on US aid, the effects may vary based on existing abortion access within the public health system. This research aims to provide insights into the nuanced effects of the policy on NGO operations and service delivery, adding to the growing research on the negative impacts of the GGR, and providing insights into how public health systems can maintain resilience in the face of politicized foreign assistance.

Structure

This paper proceeds as follows: Chapter 1 presents a literature review that provides a brief history of the politicization of US foreign aid, followed by the creation and politics of the GGR, and concludes with the contemporary documentation of the effects of the GGR on NGOs. Chapter 2 lays out the research design, providing information on the selected case countries, which includes the legal landscape of abortion, current public health challenges, and reliance on NGOs and US assistance. In Chapter 3, the research question is investigated through content analysis of existing literature on the effects of the GGR in the two countries, and includes interviews conducted with NGO representatives in Uganda and South Africa. Finally, the paper concludes with a discussion of the implications of politically motivated foreign aid policies and the need for stable, consistent,

and supportive policies that prioritize global health and human rights over domestic political agendas.

Chapter 1: Literature Review

This literature review maps out the existing scholarship on the intersection of foreign aid, political influences, and reproductive health policies, focusing on the impact of the GGR on NGOs. The review is structured into three sections: the politicization of foreign aid in general, the specific politics surrounding the GGR, and the impacts of the GGR on NGOs in recipient countries. Through this structure, the review will highlight what has been established in the literature and identify gaps, specifically the underexplored relationship between recipient country legislation and the effects of the GGR.

1.1 Politicization of Aid

Donor countries frequently impose health policies that reflect their domestic political ideologies, often undermining the ability of recipient countries to implement health policies tailored to their populations' needs. This imposition can erode the policy autonomy of recipient countries, leading to the adoption of inappropriate policies that fail to effectively address the public health challenges of their populations (Carothers & Brechenmacher, 2014). Political changes within donor countries often lead to unpredictable fluctuations in aid funding, making aid highly volatile (Bulir & Hamann, 2003). In twenty sub-Saharan African countries, Swedlund (2017) finds that shifts in US administrations result in changes to recipient countries' global health priorities and funding levels, and that this can divert resources away from underserved areas or populations. Further, Nunnenkamp et al., (2013) discuss how donor governments, driven by electoral cycles, may prioritize visible, short-term health interventions to demonstrate success to their

constituencies. Such abrupt changes can destabilize ongoing health initiatives, leading to gaps in service delivery and weakening health systems. Many scholars (e.g., Killick, 2004 or Kodoma, 2012) argue that the unpredictability of donors and the volatility of aid obstruct the effectiveness of the assistance and contribute to economic and social instability in recipient nations.

The politicization and volatility of aid are particularly significant in countries where national health systems are highly dependent on NGOs. This volatility forces NGOs to constantly adapt to new financial landscapes, disrupting long-term planning and program implementation. Consistent changes in funding can lead to high staff turnover within NGOs, resulting in job insecurity, poor staff retention, and low morale (Lewis, 2010). The imposition of political conditionalities can also impose a heavy compliance burden on NGOs. For example, Dietrich (2013) discusses how conditionalities can divert NGOs' focus from their primary health objectives to fulfilling donor-imposed requirements, reducing operational efficiency and effectiveness. Further, to align with donor priorities and secure funding, NGOs may experience mission drift, altering their goals and strategies away from their core objectives (Bennett, 2011). With fluctuating political priorities of donors, NGOs struggle to maintain the continuity, quality, and reach of their services for beneficiaries.

1.2 Politics of the Global Gag Rule (GGR)

In the politically polarized US, aid flows change significantly during presidential transitions as new administrations assume power with divergent priorities, often enacting sudden and major cuts or policy diversions. The on-again, off-again imposition of the GGR epitomizes these fluctuations, demonstrating how the US imposes its own domestic politics upon foreign nations. Since its inception in 1984, the GGR has been entrenched in domestic battles between Republicans and Democrats over abortion. Crane & Dusenberry (2004) argue that the GGR was

never intended to 'protect lives,' but rather as a tool for Republican presidents to appease the anti-abortion lobby in the US, guaranteeing their support for Republican administrations. Reducing abortions has been a long-standing policy objective of the Republican party, especially among the religious-right base of the party.

The 1973 *Roe v. Wade* decision to legalize abortion in the US sparked moral outrage from conservative groups, leading Congress to pass the Helms Amendment to the Foreign Assistance Act in 1973. The Helms Amendment, which remains in place today, bars organizations from using US funds to promote abortion as a method of family planning or to motivate any person to practice abortions (Helms Amendment, 1973). The religious right, gaining political influence in the 70s and 80s, deemed the Helms Amendment as insufficiently anti-abortion, and in 1984, President Reagan announced the GGR, representing a significant shift in the country's approach to family planning assistance. While the Helms Amendment is intended to prevent US taxpayer dollars from funding abortion, the GGR bars organizations from using any money, including non-US funds, to perform or promote abortion. Like the Helms Amendment, the GGR is at the heart of the Republican party's agenda, but conflicts with the pro-choice stance of the Democratic party, meaning that the implementation of the GGR is dependent upon the party affiliation of a newly elected president.

Since 1984, the GGR has undergone a continual back-and-forth pattern of Democratic presidents revoking the policy only for it to be reinstated by Republican presidents. The President has often used taking this action as an opportunity to make a public statement, and their language has reflected their administrations' political stances on abortion (as shown in Appendix 1). In these statements, Republican Presidents Bush and Trump have used language emphasizing the protection of "innocent life" and opposing the use of taxpayer funds for abortion-related activities

"either at home or abroad," aligning with the pro-life and religious-right support. In contrast, Democratic Presidents Clinton, Obama, and Biden have framed the rescission of the GGR as a move to protect women's health and rights, criticizing the policy's politicization and its effects on family planning efforts. In 2021, in the face of growing anti-abortion sentiment among political actors within the US, President Biden took the opportunity to express his administration's support for women's reproductive health rights "either at home or abroad." Each administration's rhetoric has reinforced their ideological commitments, underscoring how US domestic politics are often interlinked with its foreign assistance policies.

1.3 Impacts of the GGR on NGOs

As the US is the largest bilateral donor of global health assistance, the GGR has had significant impacts around the world (Rodgers, 2018; Schaaf et al., 2019; Vernaelde, 2022; Starrs, 2017; Sully et al., 2022). With each iteration of the GGR, more studies have revealed the harms of the policy. The negative health effects and increases in abortions laid out in the introduction are a direct result of the impacts of the GGR on NGOs in recipient countries. Previous research has documented the GGR's impacts on NGO operations, service delivery, advocacy, and partnerships, but the link between the recipient country's abortion laws and the policy's effects remains underexplored. This thesis aims to contribute to the literature on the GGR by examining how the legal landscape of abortion in a recipient country influences the policy's effects.

1.3.1 NGO Operations

The GGR significantly impacts the operational capacities of NGOs. Organizations that do not comply with the GGR often lose substantial funding, compelling them to search for alternative sources, which can be challenging for those heavily reliant on US funding. For compliant

organizations, meeting the conditionalities of the policy often requires changing the content of materials, terminating certain projects and programs, and redirecting funds and resources. The earliest studies on the GGR focused on the impacts on NGO operations. For instance, through interviews with NGOs in 10 developing countries, Camp (1987) found that the impact on family-planning services were somewhat limited, with 6 of the 31 major agencies visited stating that their agreement to comply with the policy affected their operations. As the GGR has expanded, so has the understanding of the high cost of compliance. For example, an organization in Nigeria lost over 40 staff as a result of compliance-associated costs (Population Action International, 2018). For compliant and non-compliant organizations, the termination of staff is a common outcome of the policy's effects, one that is significant in many countries where the NGO sector is already under-resourced.

1.3.2 Service Provision

The operational and financial burdens on NGOs contribute to changes in the types and reach of services provided. To reveal the impacts of the Reagan GGR, Blane and Friedman (1990) conducted interviews at 49 subproject sites in six developing countries, concluding that the policy's implementation led to the discontinuation of services, counseling, and research. After the Bush reinstatement, Crane and Dusenberry (2004) argued that the 2001 reinstatement was likely to have even more detrimental effects on the provision of family planning services than the first round of the GGR. These repercussions were confirmed by Crichton et al., (2012), documenting clinic closures and reduced service delivery, affecting not only reproductive health but also general health services such as HIV/AIDS prevention and treatment.

Since 2005, Population Action International (PAI) has conducted case studies of the GGR in several developing countries, documenting clinic closures, fewer services provided, and reduced

contraceptive supplies, as well as the impact on other health services, including screening and treatment for malaria and sexually transmitted infections (STIs) such as HIV/AIDS (Population Action International, 2005). For one organization in Senegal, the loss of US funding meant mobile outreach teams provided 30 percent fewer cervical cancer screenings and 30 percent fewer STI treatments, illustrating how the policy can affect areas of service beyond abortion care (Population Action International, 2018).

1.3.3 Civil Society Advocacy

In multiple countries, the GGR has created a substantial "chilling effect" across civil society. The "chilling effect" of the GGR refers to organizations or healthcare providers restricting their activities beyond what is strictly required by the policy to protect themselves from being accused of non-compliance. USAID is empowered to unilaterally decide whether an NGO violated the rule and require the NGO to refund all USAID funds, leading groups to take excessive precautions to avoid even the perception that they are speaking about the forbidden subject of unsafe abortion. Organizations frequently do not understand that they can continue to work with noncompliant entities if that work excludes prohibited activities, or they shy away from partnerships out of an excess of caution.

This effect of the GGR was first documented by Blane and Friedman (1990), who found that health providers were overly cautious in their interpretation of the Reagan-era policy. The Center for Reproductive Rights (2003) conducted in-depth interviews in Ethiopia, Kenya, Peru, and Uganda, finding that participants felt censored because of the GGR, fearing the implications of voicing their opinions on abortion law. This censorship prevented them from dispelling myths about abortion and contributed to the inaction of policymakers. Under the GGR, providers in Bangladesh and Turkey stopped sharing information on menstrual regulation, and in Egypt,

providers ceased all discussion about sepsis, even when this was a major public health concern, once again demonstrating the reach of the policy beyond the topic of abortion (Mavodza et al., 2019).

The chilling effect of the GGR has even extended to recipient governments. For example, in Zimbabwe, the GGR was used as a pretext for the government's failure to update its abortion legislation (FosFeminista, 2022). In Malawi, the government's hesitation to decriminalize abortion was driven by fears of losing US government funding (Centre for Health and Gender Equity, 2018). Although the policy does not apply to foreign governments, its influence has spilled over into the public sector, affecting political and legislative outcomes.

1.3.4 Partnerships and Coalitions

The overly broad implementation and self-censorship induced by the GGR threatens valuable partnerships and disrupts coalitions within civil society. NGOs that comply with the policy often sever ties with organizations that choose not to comply. Multiple noncompliant NGOs have reported being purposely excluded from meetings and conferences on topics related to sexual and reproductive health rights to prevent tension with the US government officials in attendance (McGovern et al., 2020). In Ethiopia, one noncompliant organization lost its partnerships with two compliant organizations that had previously provided over EUR 550,000 annually in family planning commodities (Population Action International, 2018). The breakdown of partnerships and coalitions ultimately stalls progress to improve health outcomes and disrupts coordinated healthcare delivery.

The GGR has also affected partnerships between NGOs and recipient governments. For instance, in Nepal, a country with liberal abortion laws, the Trump GGR slowed and reversed progress made in a collaboration between NGOs and the Ministry of Health, resulting in the

termination of USAID-funded projects intended to help the Ministry of Health improve maternal health outcomes (Tamang et al., 2020). As documented in the literature, such partnership disruptions have implications for service delivery, often extending beyond abortion care.

Chapter 2: Research Design

This thesis contributes to the literature on the GGR's effects on NGOs by examining how the legal approaches to abortion in recipient countries may compound or mitigate the policy's impacts. The study utilizes a mixed-methods approach of content analysis and interviews, aimed at exploring the impacts of the GGR on NGOs in Uganda and South Africa.

2.1 Case Selection Process

First, the Sub-Saharan Africa region was selected due to its high exposure to and significant impact from the GGR. Historically, the US has been a major provider of foreign assistance for family planning and reproductive health services in this region, where NGOs play a critical role in healthcare delivery. This reliance makes many parts of Sub-Saharan Africa particularly vulnerable to the adverse effects of the GGR. Sub-Saharan Africa alone accounts for around 70% of global maternal deaths and has the highest estimated proportion of unsafe abortions and abortion case-fatality rates (WHO, 2024). Unsafe abortions constitute over 77% of total abortions in the region (Guttmacher Institute, 2020). Additionally, Sub-Saharan Africa bears the highest global burden of unwanted pregnancies, maternal mortality, child marriage, sexual and gender-based violence, and female genital mutilation (FGM). It is also the epicenter of HIV/AIDS, with 69% of the global population living with HIV residing there (UNAIDS, 2022). To compare two countries within Sub-Saharan Africa, Uganda and South Africa were selected due to their contrasting abortion laws,

significant sexual and reproductive health challenges, and reliance on NGOs and US assistance for public health services.

2.1.1 Divergent Abortion Landscapes

The selection of Uganda and South Africa was primarily based on the significant contrast in their legislative approaches to abortion. In Uganda, the 1995 Constitution prohibits terminating the life of an unborn child except as provided by law (Uganda Constitution, Article 22). However, the circumstances under which abortion is permitted are not explicitly stated, and no comprehensive law exists to operationalize this constitutional provision (CEHURD, 2018). Consequently, the primary legal framework regulating abortion remains the Penal Code, which criminalizes abortion providers, women seeking abortions, and anyone aiding the procedure (Penal Code Act, 1950). Although exceptions exist in cases of rape, the judicial system lacks the financial and personnel resources required to conduct thorough investigations into cases of sexual violence (CEHURD, 2016). Additionally, obtaining medical documentation of rape is difficult due to the inefficiency and overloading of healthcare systems. Progress on broadening access to safe and legal abortion has been constrained due to stigma and deeply held religious and moral beliefs, with most churches in Uganda opposing abortion and teaching against contraceptive use.

In contrast, South Africa's legislative framework regarding abortion is among the most liberal in Africa and the world (Rohrs, 2017). After 1990, the government of the post-apartheid era prioritized equitable health access to address historical racial disparities in health outcomes. The 1996 Choice on Termination of Pregnancy (CTOP) Act guarantees the constitutional right to an abortion upon request within the first 12 weeks of pregnancy and up to 20 weeks under certain conditions, such as rape, incest, or health risks. The CTOP Act also makes it illegal for anyone to prevent a lawful termination of pregnancy service, and South African courts hold healthcare

providers accountable for ensuring that patients receive adequate information for informed decisions regarding abortion services. However, as will be further discussed, accessibility remains a significant challenge, with a majority of abortions occurring outside of the public healthcare system.

2.1.2 Significant Sexual and Reproductive Health Challenges

Both Uganda and South Africa face severe challenges related to sexual and reproductive health outcomes, with Uganda particularly struggling with high maternal mortality rates and South Africa with a high prevalence of HIV/AIDS. In Uganda, addressing the historically high maternal mortality ratio (MMR) has been a longstanding government priority, yet it remains alarmingly high, well above the global average and more than three times higher than that of South Africa (as shown in Appendix 2). Both countries rank among the top five globally for the number of people living with HIV, with four out of these five countries located in sub-Saharan Africa (as shown in Appendix 3). South Africans are 71.7% more likely to be living with HIV/AIDS than Ugandans (UNAIDS Data, 2023). By reducing access to critical health services, the GGR's implementation has the potential to exacerbate these challenges, thereby undermining national health interests and goals.

2.1.3 Public Health System's Reliance on NGOs and US Assistance

Both countries depend on NGOs for the provision of services to address their health challenges, especially in rural and underserved areas. In Uganda, most sexual and reproductive health care services, including contraception, are provided by NGOs rather than the government (Findley et al., 2017). In South Africa, a significant portion of legal abortion services are provided by NGOs. In both countries, NGOs heavily rely on foreign assistance to sustain their operations. The US stands out as the primary donor in both countries, contributing $616 million to Uganda

and $527.5 million to South Africa in foreign assistance 2017 (US Department of State, 2024). Of that, $419 million and $412 million was global health assistance, among the highest in Sub-Saharan Africa (OECD). Given the vital role of NGOs in bridging gaps in national healthcare systems and their dependence on US funding, the impact of the GGR was expected to be profound in both countries. This aspect was particularly important when formulating strategies to address the research question.

2.2 Research Methods

This research investigates the GGR's impact in Uganda and South Africa through a qualitative case study. The methods include content analysis of NGO reports, academic literature, and media coverage related to the GGR in Uganda and South Africa, with a focus on how the GGR has affected the availability and accessibility of sexual and reproductive health services. Complementing this analysis, online interviews were conducted with five individuals from NGOs in Uganda (three) and South Africa (two). These participants were selected from organizations that both complied and refrained from complying with the GGR. Three of the organizations are actively engaged in abortion-related issues, including service delivery and advocacy efforts. The remaining two organizations address other sexual and reproductive health topics, including HIV/AIDS.

2.3 Ethical Considerations and Limitations

Given the sensitive nature of this research topic, efforts were made to protect the anonymity of the interviewees. To ensure confidentiality, the names of individuals and organizations were omitted from the study. All participants were provided with the interview questions in advance and were asked to sign a consent form prior to the interview, affirming their willingness to participate and acknowledging the confidentiality measures.

Certain limitations exist in terms of scope and representation of the diverse array of NGOs affected by the GGR. Securing interviews with individuals willing to speak about the GGR is a common challenge for researchers who aim to document the policy's effects. Despite these limitations, participants' responses revealed valuable insights into the impacts of the GGR within their respective countries.

Chapter 3: Implications of the Global Gag Rule in Uganda and South Africa

This chapter first describes the practical impacts of the GGR on the operations and finances of NGOs, and the ramifications for NGOs' ability to provide important health services, specifically those related to abortion, contraception, and HIV/AIDS. Next, it will discuss how the GGR curtailed NGOs' advocacy and coalition building abilities. Finally, it will highlight some additional effects of the GGR beyond NGOs, in the social and political contexts, and the resulting negative consequences for public health.

3.1 Operational Burdens

When the GGR came into effect, NGOs faced a critical decision: comply with the stipulations of the policy to continue receiving US assistance or forgo US funding to continue providing comprehensive sexual and reproductive health services. Interview responses indicate that the decision to decline US funding was predominately influenced by the nature of the NGO's services and the extent to which the policy conflicted with their organization's mission and values. Interviewees also indicated that this decision would not be feasible for many organizations heavily reliant, if not entirely dependent, on US funding.

For compliant organizations, the implementation of the GGR imposed considerable operational challenges. Though spared from outright funding cuts, compliant organizations had to adapt the content of programs to meet GGR criteria, creating an administrative burden generally perceived as a waste of resources. For instance, one interviewee from an NGO in Uganda recounted the measures taken to split programs, creating separate administrative and operational structures, which was both costly and inefficient (NGO, Uganda). Another NGO in Uganda reported being 4-6 months behind in implementing their projects because of diverting efforts to comply with the policy (Population Action International, 2018). The additional layers of bureaucracy strained their financial resources and hindered their ability to provide integrated and holistic health services to their communities.

Compliance with the policy often meant diverting resources away from core activities, resulting in program termination and staff layoffs. One interviewee from a local NGO in Uganda revealed that five full-time staff were let go following the termination of a particular project, a significant cut for a smaller organization (NGO, Uganda). Furthermore, organizations were forced to revise training materials, restructure their programs, and closely monitor their activities to ensure compliance with the GGR. In one instance, a Cape Town-based NGO reported having to discard all printed materials containing any information on sexual and reproductive health (Mabaso, 2019). This shift from service provision to compliance management reduced the efficiency of these NGOs and substantiated the findings of Dietrich (2013) that donor-imposed conditionalities can divert NGOs' focus away from their primary health objectives, undermining their overall effectiveness.

These operational burdens align with the literature on mission drift, where NGOs may alter their goals and strategies away from their core mission in order to comport with donor priorities

(Bush, 2015). An interviewee from a South African NGO remarked that their activities had shifted away from meeting clients' health needs to ensuring compliance with GGR guidelines, which compromises the organization's mission (NGO, South Africa). The imposition of GGR conditionalities highlights the issue of financial dependency, as many organizations lacked alternative funding options and thus felt compelled to comply in order to sustain their operations. As one interviewee put it, some organizations chose to comply "just to get the money to be able to keep their institution running" (NGO, South Africa). This underscores the profound influence of US-imposed conditionalities on NGOs, illustrating how financial reliance can compel organizations to compromise their operational efficiency and mission integrity.

3.2 Implications for Service Provision

By restricting and redirecting the resources and permissible activities of compliant organizations, the GGR significantly impaired their capacity to deliver important sexual and reproductive health services. At the same time, funding disruptions for non-compliant organizations often led to clinic closures and the reallocation of funds from critical programs and services. As a result of these impacts on NGO operations, many communities experienced a reduction in access to legal abortion, contraception, and HIV/AIDS services.

3.2.1 Reduction in Legal Abortion Care

The GGR reduced access to legal abortion services in South Africa, despite abortion being a constitutionally protected right in the country. Under the CTOP Act, abortion services should be available for free in public clinics, yet fewer than one in ten public clinics actually perform abortions, and over half of all abortions occur in private facilities (Macleod et al., 2016, Amnesty International, 2017). Consequently, NGO-run clinics play a crucial role in bridging this gap within

the public healthcare system. As one interviewee emphasized, "NGOs are crucial for providing abortion in South Africa because we are addressing many of the barriers that women face" (NGO, South Africa). When the GGR took effect, many of these NGOs lost their ability to provide abortion services.

The impact of the GGR was particularly significant for Marie Stopes International (MSI), the largest provider of legal abortions in South Africa. In many parts of South Africa, especially rural areas, MSI is the only private and safe abortion option. Interviewees from South Africa indicated that many women fear being recognized by people from their own community if they use public clinics and turn instead to private facilities like MSI. By refusing to comply with the GGR, MSI experienced an annual funding loss of $30 million, resulting in the closure of several clinics across South Africa. Both interviewees from South Africa raised the significance of this outcome, with one emphasizing that the effect of the GGR was clearly visible. Before 2017, he explained, “there would be a Marie Stopes in every big city in South Africa” but now, some cities have none. In the Eastern Cape province, where this interviewee resides, there’s only one Marie Stopes left to serve a population of almost 8 million people (NGO, South Africa).

While MSI is the largest provider of legal abortions, other abortion providers were also affected by non-compliance with the GGR. For instance, a 2019 report from Sonke Gender Justice detailed the GGR’s impacts on an NGO in the gender-based violence (GBV) sector (Mabaso, 2019). This organization provided survivors of domestic and sexual violence with access to justice, psycho-social support and sexual and reproductive health services (Mabaso, 2019). Before the GGR, the NGO operated a clinic in Cape Town, where an average of 100 to 120 women per month accessed surgical abortions, and many more received other services such as HIV testing, pap smears and breast examinations. However, the GGR forced the organization to close the clinic in

order to maintain US funding for other programs. This closure had significant impacts for the most vulnerable populations, including migrants, impoverished women, and survivors of abuse. Although these women are entitled to abortion services under the CTOP Act, the lack of effective implementation left them exposed to the harmful impacts of the GGR.

Outside of urban centers, implementing the law protecting abortion access has been a challenge due to poor rural healthcare infrastructure and societal attitudes. NGO clinics serve as crucial access points, particularly in areas where the public health facilities are limited or absent. One interviewee, a former medical doctor in South Africa, explained the difficulty in finding trained personnel to provide abortions in rural areas, as most trained midwives and nurses are in urban areas (NGO, South Africa). In addition to resource and personnel constraints, the unregulated conscientious objection of healthcare providers serves as another barrier for accessing abortion. At many public hospitals and clinics, providers refuse to perform abortions or be trained to do so (Harries et al., 2014; Jim et al., 2023). Without meaningful access to publicly provided abortion care, women often turn to illegal and unsafe means of pregnancy termination, a dynamic that the GGR worsens by forcing clinics to close.

Due to the inaccessibility of legal abortions, an estimated 54% of the 260,000 annual abortions in South Africa are performed illegally, resulting in severe health repercussions (Government of South Africa, 2018). Women are often provided with incorrect medical, herbal, and traditional alternatives, which make them ill, place their health at risk, and fail to terminate the pregnancy. Illegal abortion providers in Cape Town use marketing tactics to appear legitimate. As an interviewee from South Africa explained, “in some areas of the country, you’ll see stickers everywhere with people claiming they can do abortion services” (NGO, South Africa). This interviewee, a medical doctor, went on to explain that these abortions are not provided by trained

medical professionals, and women often develop complications as a result. In many parts of the country, women continue to undergo these unsafe abortions because they are the only option. By forcing the closure of NGO-run clinics, and by increasing conscientious objection within public facilities, the GGR encourages more women to seek illegal and unsafe abortions.

3.2.2 Reduction in Contraception Delivery

Despite a differing legal landscape in Uganda, the GGR also had the effect of increasing the need for illegal abortions there, because so many organizations reduced their provision of contraception. For instance, Marie Stopes Uganda provides free contraceptives, including long-term intrauterine devices (IUD). In 2017, Marie Stopes Uganda was receiving around $6.5 million in US assistance annually, providing contraception to more than 1.2 million women. With the loss of US funding, five of their 35 outreach teams serving remote and poor communities ended and staff were terminated. According to MSI Uganda's Country Director, Dr. Carole Sekimpi, the closure of outreach programs meant the organization could not visit certain locations as often, and some places not at all (Jalan, 2019). As was the case in South Africa, these closures resulted in limited access to sexual and reproductive health services for those who need them most.

Another significant organization that reduced contraception provision was Reproductive Health Uganda (RHU), an affiliate of the International Planned Parenthood Federation (IPPF). In its 2019 Annual Report, the organization explained that the decision not to comply with the GGR was taken because its "fight for reproductive justice will not be threatened as a result of the domestic whims of the US government" (IPPF, 2019). This led to an organizational loss of $300,000, approximately 30% of its budget, having ripple effects on country-level organizations like RHU. One program that was terminated focused on the rollout of Sayana Press, a long-term injectable contraceptive. The program would have introduced the contraceptive to another 6,000

adolescents seeking protection against unwanted pregnancy (Population Action International, 2018). Additionally, RHU was forced to divert $100,000 of funding away from refugee camps to cover other areas of its work. Considering that RHU had previously served over half of the 1.3 million people living in Ugandan refugee camps, this had a particularly significant impact on vulnerable communities.

By reducing access to contraception, the GGR undermines national health objectives and exacerbates the problem of unintended pregnancies. In Uganda, where abortion is generally illegal and highly inaccessible, reduced access to contraception means that more women will seek abortion services, particularly outside of the formal healthcare sector and often performed under unsafe medical conditions. This outcome of the GGR is detrimental given the country's high maternal mortality rates, further highlighting the critical need for accessible reproductive health services.

3.2.3 Reduction in HIV/AIDS Services

The GGR had impacts on the provision of non-abortion related services, including HIV/AIDs testing and treatment. As family planning and HIV/AIDS services are often integrated in service delivery settings, noncompliant organizations could lose resources for HIV prevention and services as well (Crane & Dusenberry, 2020). Many HIV/AIDS NGOs are heavily reliant on US funding, with several engaging in broader sexual and reproductive health programs or research activities that may inadvertently violate the GGR's provisions, which creates challenges for compliant organizations (Jogee, 2019). For instance, an NGO in Uganda was affected at an operational level by having to separate abortion from HIV and AIDs services, creating extra vulnerability for women living with HIV who have unintended pregnancies (Mavodza et al., 2019).

Another organization in Uganda had to discontinue an HIV project serving 14,000 adolescent girls because their prime funder did not comply with the GGR (CHANGE, 2018).

As HIV/AIDS services are so often integrated within broader sexual and reproductive health care, many organizations working on HIV/AIDS chose not to comply. Unlike previous versions, the Trump GGR affected funds channeled through the President's Emergency Plan for AIDS Relief (PEPFAR), a critical initiative launched to combat the global HIV/AIDS epidemic. Remarkably, in South Africa, funds from PEPFAR that would have gone to organizations that did not sign the GGR were redirected to conservative entities such as Focus on the Family, an anti-LGBTQ+ organization (Rios, 2019). PEPFAR funding is especially vital for organizations working to combat the high prevalence of HIV/AIDs, with South Africa being home to the largest number of people living with HIV/AIDs. The impact of the GGR on services other than abortion, particularly HIV/AIDs, a major public health concern, illustrates the policy's broad reach and the repercussions on a variety of health outcomes.

3.3 Stifled Advocacy and a Chilling Effect

In both countries, the GGR stifled abortion-related advocacy and had a chilling effect on compliant organizations. The chilling effect of the policy was brought up by multiple interviewees, with one observing, "organizations have gone silent, and they haven't come back" (NGO, South Africa). An interviewee from an advocacy-oriented NGO in Uganda stated that a coalition to stop maternal mortality due to unsafe abortion is being stalled because some organizations opted to go silent after the GGR, despite their organization urging these partners that "you're going to be gagged and you'll be gagged forever" (NGO, Uganda).

Compliant and noncompliant organizations experienced disruptions in their efforts to provide education, awareness raising, and advocacy related to safe abortion and abortion rights. In

South Africa, many women, especially in rural areas, often do not know they have a right to free abortion services, or where they can access these services. Through public education campaigns, NGOs work to increase awareness and to reduce stigma and dispel misinformation about abortion. However, the GGR has reduced NGOs' ability to carry out this work. As one interviewee from South Africa explained, "I think it's exactly what it's called – it gags us. It makes it impossible for those who are arguing for pro-choice to be able to speak about it and advocate for it (NGO, South Africa). In South Africa, curtailing awareness and advocacy limits the ability of civil society to hold the government accountable and to encourage stronger implementation of legislation regarding sexual and reproductive health care access.

In Uganda, advocacy to promote awareness and support for sexual and reproductive health rights is also crucial considering the restrictive legal and political environment. Due to funding loss, RHU canceled multiple advocacy projects, including two "designed to create a more open environment and to build political support for sexual and reproductive health," as well their Rights Based Approach and Advocacy for Better Health projects, which made national advances in comprehensive sexuality education and access to modern family planning." (IPPF, 2019). Additionally, for the Center for Health, Human Rights and Development (CEHURD), a research and advocacy organization in Uganda, the decision to not comply meant the organization lost two USAID grants amounting to around $100,000 in funding. As a small, local organization, this had "devastating effects" on the reach of their work (Center for Health, Human Rights and Development, 2018). As a result, CEHURD terminated multiple projects focused on maternal and child health advocacy (CEHURD, 2018). For many organizations that chose not to comply, the decision was informed by their mission and commitment to speaking about abortion-related topics.

However, despite their noncompliance, the GGR was still able to affect these organizations' advocacy efforts, emphasizing the vast and pervasive reach of the US policy.

3.4 Partnership Disruptions and Fragmented Coalitions

As one interviewee put it, "NGOs are most effective when they work in coalitions" (NGO, Uganda). In both countries, the GGR resulted in partnership disruptions, especially between compliant and noncompliant organizations. Interviewees confirmed sensing the tensions created between NGOs that accepted and those that refused US funds. An abortion service provider in South Africa explained that the implementation of the Trump GGR reduced their ability to partner with many organizations that are US-funded (International Women's Health Coalition, 2019). Often a result of the "chilling" effect, the strain placed on existing partnerships between organizations significantly reduced opportunities for comprehensive service delivery as well as joint advocacy efforts.

These relational disruptions fractured existing coalitions and foreclosed potential future partnerships. For instance, in order to comply with the GGR, several organizations severed partnerships with RHU on work related to sexual and reproductive health rights, contributing to the termination of a five-year advocacy program with two years of implementation remaining. Also in Uganda, the Coalition to End Maternal Mortality through Unsafe Abortion (CSMMUA), unites health service providers, legal experts, professional associations, civil society organizations, and individuals. As a result of the GGR's restrictions, many members of CSMMUA had to withdraw, weakening the reach of the coalition's efforts to decrease maternal morbidity and mortality. One organization that complied with the GGR pulled out of the coalition because some members were working on the legal component of safe abortion, explaining, "We had wanted to expand our work; we know it's right. But we shelved it" (Population Action International, 2018).

Other compliant organizations in Uganda reported being excluded from abortion reform conversations (Mavodza et al., 2019). As Ndabula et al. (2024) reports, the lack of collaboration between NGOs leads to strained conversations and promotes distrust between organizations.

3.5 Broader Implications of the Global Gag Rule - Beyond NGOs

While the primary focus of this study has been the effects of the GGR on NGOs, it is important to note that the GGR has also influenced the broader political and social realities in the recipient countries, resulting in negative impacts on several areas of public health.

3.5.1 Emboldened Political Opposition to Abortion

Organizations in both countries have suggested that the GGR has emboldened political and social opposition to abortion, providing an opportunity for anti-abortion and conservative voices to advance their agendas.

In Uganda, the GGR gave abortion opponents a platform to speak out, and to "take forward conversations about family values and the family as a unit" (NGO, Uganda). This was primarily shown by the country signing the Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family, an anti-abortion joint statement, which affirms "no international right to abortion" (Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family, 2021). The Geneva Consensus was introduced by the Trump administration in 2020 and signed by thirty-six countries, including Uganda and the United States. One interviewee from Uganda reflected on this action being an escalation of the GGR, stating, "the GGR and the anti-abortion conversations coming out of the US encouraged the government to sign the Geneva Consensus, to say, 'yes, we'll protect the family'" (NGO, Uganda). The policy

provided an opportunity for an already restrictive legal environment in Uganda to take further steps to limit access to sexual and reproductive health care in the country.

The GGR effectively empowered the dominant anti-abortion majority to further entrench abortion restrictions in Uganda. Conversely, in South Africa, the GGR emboldened the opposition minority and allowed it to amplify its message. As one interviewee explained, while the ruling African National Congress (ANC) party is largely pro-choice, and the public support for liberal abortion laws remains relatively strong, "there has always been quite some opposition within conservative and religious groups" and "the GGR was a political win for them" (NGO, South Africa). For instance, the conservative African Christian Democratic Party (ACDP) has used the GGR to bolster its anti-abortion rhetoric (Ndabula et al., 2024). A member of the ACDP remarked, "the pro-life voice is 'suppressed' in South Africa, which the PLGHA helps to relieve" (Ndabula et al., 2024). This is especially concerning considering the need for stronger action from the government to implement legislation related to sexual and reproductive health care access.

Despite the ruling South African ANC party espousing a pro-choice stance, the government was largely silent in reaction to the GGR (Ndabula et al., 2024). A report investigating the domestic political response to the GGR, documented behaviors of silence, ignorance, avoidance, and overly broad interpretation of the policy among South African government officials. The authors found that between February 2017 and June 2022, the GGR was mentioned only once within Parliament, while abortion and related issues were discussed frequently. This suggests that the government is interested in reproductive health issues but avoids addressing the GGR directly. One participant speculated that "the continued silence of the Minister of Health on abortion might actually be tied to the US's view that abortion is not a priority" (Ndabula et al., 2024). The only brief mention of the GGR was in November 2020, over three years after its implementation, when a member

proposed debate in Parliament, which did not occur. This indicates a surprising level of silence on the GGR's effects for a government interested in promoting women's rights to sexual and reproductive health.

With little government intervention, the emboldened opposition spilled over into the public healthcare sector in South Africa. A report assessing the impact of the GGR in South Africa documented an increase in conscientious objections among healthcare providers, an already existing barrier to accessing abortion as previously discussed (Du Plessis et al., 2022). According to organization members, the GGR contributed to sexual and reproductive health and abortion-related projects within the Department of Health "evaporating" (Du Plessis et al., 2022). Additionally, Department of Health programs such as MomConnect and BeWise, have self-censored by removing all content related to abortion. MomConnect is focused on supporting maternal health and BeWise aims to provide information about health, sex, relationships, contraceptives, and STIs, including HIVs. By limiting women's ability to access information regarding abortion rights and services through self-censorship, this development threatens the maternal health outcomes that the country is seeking to improve.

South Africa's experience demonstrates that, even in a country with strong support for constitutional abortion rights, those rights can be undermined when the government is reluctant to take a vocal and active stand against intrusive US policy. In both countries, the policy's effects extended beyond NGOs and into the political sphere, similar to the outcomes in Zimbabwe and Malawi noted in the literature review (FosFeminista, 2022, Centre for Health and Gender Equity, 2018).

3.5.2 Comprehensive Sexuality Education

The galvanized political opposition to abortion resulting from the GGR also spilled over into the education system, influencing abstinence-only sexuality education curriculum in both countries. According to an interviewee from Uganda, when the GGR was implemented, "there were certain policies that were enacted in Uganda because the Ministry of Health is also a direct beneficiary of USAID" (NGO, Uganda). For instance, the US supported the development of sexuality education focused on an abstinence-only approach, which the interviewee saw as "an escalation of the GGR" (NGO, Uganda). In 2018, the government introduced the National Sexuality Education Framework, a set of guidelines that does not include information on condom use or contraceptives (United Nations Population Fund, 2018). Even though one quarter of Ugandan girls aged 15-19 years will become pregnant, the government rejected calls for comprehensive sexuality education (CSE), which includes information on contraceptives, STDs, and safe sex practices, and has been found to reduce unwanted and teenage pregnancies (Targan et al., 2021; Mark et al., 2022). The reluctance to include information on safe sex practices within sexuality education frameworks suggests that the inaccessibility of information on contraceptive use is influenced by a range of government actions, beyond the legal status of abortion itself. Through the GGR, the US was able to influence these additional mechanisms, further restricting women's access to sexual and reproductive health care.

In South Africa, the 2019 national Scripted Lesson Plans for Comprehensive Sexuality Education, funded by USAID, neglected to include important information regarding sexual and reproductive health care. When PEPFAR funding was cut due to organizations not signing the GGR, organizations like Focus on the Family received the funding to do work on abstinence-only CSE. According to an NGO representative, "they [Focus on the Family] want to cure homosexuals,

it's just shocking. They've got money from the US government to do this" (Rios, 2019, p.27). One interviewee highlighted the lack of information available about the CTOP Act and people's rights under it within the curriculum, as well as the absence of guidance on avoiding illegal and unsafe abortions. They noted that while some teachers might find the topic difficult, "it is a complete disservice to learners to not give them even just the factual information" (NGO, South Africa). Considering the high prevalence of illegal abortion in South Africa, neglecting to inform young people about their right to legal abortion care exacerbates the occurrence of unsafe and dangerous abortion practices.

While the guidelines of the GGR did not explicitly cause these developments within the recipient countries' political and social spheres, the ideology behind the policy seems to have spilled over, influencing far more than the policy's claimed intentions. The opposition to abortion among key actors involved in the abortion landscape, including government officials, healthcare providers, and educators ultimately reinforces the stigma surrounding comprehensive sexual and reproductive healthcare and further limits access to safe and legal abortion. As discussed, not providing legal abortion does not result in fewer abortions; it results in more unsafe abortions. This is counterproductive for Uganda's efforts combatting its maternal mortality crisis, as well as for South Africa's aim to reduce unsafe abortions.

Conclusion

At the core of this thesis, the politicization of aid can significantly disrupt NGO operations and undermine recipient countries' health systems. As the literature review documents, foreign assistance policies such as the GGR are often entangled with the politics of a donor country, imposing significant implications for populations in recipient nations and undermining domestic

health and development priorities. This study contributes to the literature on the GGR in order to inform the development of more nuanced and context-sensitive global health strategies, particularly important for countries reliant on assistance that is too often politicized.

The study addresses gaps in the existing literature regarding the relationship between a recipient country's legislative and political landscape on abortion and the effects of the GGR, demonstrating that even in countries where abortion is legal, the GGR can severely undermine national health priorities. The case studies of South Africa and Uganda provide evidence of how the GGR has disrupted NGO operations, finances, and service delivery, with differences between noncompliant and compliant organizations, and between organizations in Uganda and South Africa. These disruptions led to reduced access to crucial sexual and reproductive health services, most notably legal abortion care in South Africa and contraception delivery in Uganda, which ultimately increased the demand for unsafe abortions. Vulnerable communities were most impacted, with mobile outreach teams to hard-to-reach areas often being the first services eliminated. The GGR also stifled advocacy, severed partnerships, and weakened coalitions, with anti-abortion sentiments gaining increased prominence in political and social spheres, even spilling over into education curricula.

The initial hypotheses posited that countries with legal abortion laws may be better situated to mitigate against the impact of the GGR. However, as seen in South Africa, the legal protection of abortion did not shield the country from the policy's adverse impacts. In both Uganda and South Africa, the negative impacts of the GGR were exacerbated by the public health systems' dependence on US funding and NGOs to provide essential health services, especially in remote areas. While NGOs are vital partners in supplementing public healthcare, this reliance leaves the recipient populations vulnerable to fluctuations in donor funding. The inadequacy of national

health systems in providing safe abortion services further compounded the GGR's detrimental effects.

In Uganda, reducing stigma and expanding the legality of abortion are necessary to reduce the prevalence of unsafe abortions, with legislative reform supported by political will and thorough implementation of the law. South Africa's experience demonstrates that the constitutional right to abortion does not ensure accessibility without sufficient implementation. The failure of the South African government to provide the basic health services that women are entitled to compounded the harmful effects of the GGR. Given that neither country was able to withstand the effects of the GGR, future research into this topic should focus on how NGOs and recipient countries have in the past, or can in the future, build greater resilience against the GGR and similar policies.

As US politics become more polarized and unpredictable, these corrosive effects will continue to be felt around the world. With the 2024 elections approaching, the US is also heading into a very uncertain future that may have severe consequences for the provision of aid. The rise of anti-abortion actors gaining political influence in the US suggests that recipient nations should anticipate and prepare for the possible return or even expansion of abortion-related restrictions tied to US aid.

The GGR is merely one example of how the domestic politics of the US negatively impacts the wellbeing of people in other countries. The politicization of aid applies to many policy fields beyond reproductive health and family planning. Political debates within the US have implications for funding to areas such as humanitarian and refugee assistance, environmental causes, and LGBTQ+ rights. As the largest donor of foreign aid, the US has an outsized ability to negatively impact populations in recipient countries by infusing its own domestic politics into its foreign aid

agenda. The effects of the GGR on NGOs, and ultimately on health outcomes in recipient countries, exemplify this much larger problem.

This thesis highlights the urgent need for stable, consistent, and supportive foreign aid policies that truly prioritize global health and human rights over partisan political agendas. Strengthening legal and institutional frameworks within recipient countries is crucial to withstand donor pressure and to mitigate the negative impacts of politically motivated donor policies. By fostering more resilient and accessible health systems and ensuring that foreign assistance aligns with the needs and rights of the populations it aims to serve, the global community can better address public health challenges.

REFERENCES

Bendavid, E., Avila P., & Miller G. (2011). United States Aid Policy and Induced Abortion in Sub-Saharan Africa. Bulletin of the World Health Organization https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3260902/

Bennett, Roger & Savani, Sharmila. (2011). Surviving Mission Drift How Charities Can Turn Dependence on Government Contract Funding to Their Own Advantage. Nonprofit Management and Leadership. DOI:10.1002/nml.20050

Brooks, N., Bendavid, E., & Miller, G. (2019) USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy. The Lancet. https://www.thelancet.com/journals/langlo/article/PIIS2214-109X1930267-0/fulltext

Bulir, A., & Hammann, J. (2003). Aid Volatility: An Empirical Assessment. International Monetary Fund. https://www.imf.org/external/pubs/ft/staffp/2003/01/PDF/Bulir.pdf

Camp, S. (1987). The impact of the Mexico City policy on women and health care in developing countries. NYUJ Int'l L. & Pol., 20, 35.

Center for Health, Human Rights and Development. (2018). Annual report 2018. https://www.cehurd.org/publications/download-info/annual-report-2018/

Center for Reproductive Rights. (2003). Breaking the Silence: The Global Gag Rule's Impact on Unsafe Abortion. https://reproductiverights.org/sites/default/files/documents/bo_ggr.pdf

Centre for Health and Gender Equality. (2018, June). Prescribing Chaos in Global Health. The Global Gag Rule from 1984-2018. https://srhrforall.org/prescribing-chaos-inglobal-health-the-global-gag-rule-from_1984-2

Carothers, T., & Brechenmacher, S. (2014). Closing Space. Democracy and Human Rights Support under Fire. Carnegie Endowment for International Peace.

Crane, B., & Dusenberry, J. (2004). Power and Politics in International Funding for Reproductive Health: The US Global Gag Rule. Reproductive Health Matters, 12(24), 128–137. http://www.jstor.org/stable/3776588

Donor Tracker. (2024). United States: Global health. SEEK Development. https://donortracker.org/donor_profiles/united-states/globalhealth

Findley, M. G., Harris, A. S., Milner, H. V., & Nielson, D. L. (2017). Who Controls Foreign Aid? Elite versus Public Perceptions of Donor Influence in Aid-Dependent Uganda. International Organization, 71(4), 633–663. doi:10.1017/S0020818317000273

FosFeminista. (2022). The Helms Amendment and why it needs to end. https://fosfeminista.org/wp-content//2022/Fos-Feminista-Fact-Sheet-Helms-Amendmentpdf

Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family. (2021). https://www.theiwh.org/wp-content/uploads/2022/02/GCDDeclaration-2021-2.pdf

Government of South Africa. (1996). Choice on Termination of Pregnancy Act 92 of 1996. https://www.gov.za/documents/choice-termination-pregnancy-act

Government of South Africa. (2018). Social Development co-hosts abortion and reproductive justice dialogue. South African Government. https://www.gov.za/news/media-advisories/government-activities/social-development-co-hosts-abortion-and-reproductive

Harries, J., Cooper, D., Strebel, A. et al. (2014). Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. Reprod Health 11, 16. https://doi.org/10.1186/1742-4755-11-16

ICAP. (2020). Uganda Population-based HIV Impact Assessment (UPHIA) Summary Sheet. https://phia.icap.columbia.edu/wp-content/uploads/2022/08/UPHIA-Summary-Sheet-2020.pdf

International Planned Parenthood Federation (2019). 2019 Annual Performance Report. https://www.ippf.org/2019-annual-performance-report

International Women's Health Coalition (IWHC). (2019). Young women, powerful voices: The rights and realities of young women who migrate for work. https://backup.thinkteam.co.za/srjc/wp-content/uploads/2019/03/IWHC_Report.pdf

Jim, M., Smith, A., & Johnson, L. (2023). Barriers to safe abortion services in public hospitals and clinics. International Journal of Reproductive Health. https://doi.org/10.1016/j.ijrh.2023

Jogee, F. (2019). The effect of the Protecting Life in Global Health Assistance policy in South Africa. Southern African Journal of HIV Medicine. https://journals.co.za/doi/pdf/10.7196

Jones, K. (2011). Evaluating the Mexico City policy: How US foreign policy affects fertility outcomes and child health in Ghana. International Food Policy Research Institute. https://www.ifpri.org/publication/evaluating-mexico-city-policy

Killick, T. (2004). Politics, Evidence and the New Aid Agenda. Development Policy Review Overseas Development Institute. https://doi.org/10.1111/j.1467-8659.2004.00235.x

Kodoma, M. (2012). Aid Unpredictability and Economic Growth. World Development. Vol. 40, issue 2. 10.1016/j.worlddev.2011.07.015

New York Times. (2017). Trump revives ban on foreign aid to groups that give abortion counseling. The New York Times. https://www.nytimes.com/2017/01/23/world/trump-ban-foreign-aid-abortions.html

Mabaso Z. (2019). The Impact of the 'Global Gag Rule' on migrant women and women from poor households in Cape Town: A case study. Cape Town: Sonke Gender Justice. https://genderjustice.org.za/publication/the-impact-of-the-global-gag-rule-in-cape-town

Mark, N, & Wu, L. (2022). More comprehensive sex education reduced teen births: Quasi-experimental evidence. Proceedings of the National Academy of Sciences of the United States of America, 119(8), e2113144119. https://doi.org/10.1073/pnas.2113144119

Mavodza, C., Goldman, R. & Cooper, B. (2019). The impacts of the global gag rule on global health: a scoping review. Global health research and policy https://doi.org/10.1186/s41256-0190113-3

McGovern, T., Schaaf, M., Battistini, E., Maistrellis, E., Gibb, K., & Casey, S. E. (2020). From bad to worse: global governance of abortion and the Global Gag Rule. Sexual and reproductive health matters, 28(3), 1794411. https://doi.org/10.1080/26410397.2020.1794411

Ndabula, Y., Macleod, C. I., du Plessis, U., & Moore, S. (2024). South African government responses to Trump's Global Gag Rule: Silence, ignorance, and avoidance. Critical Social Policy. https://doi.org/10.1177/02610183241229046

The Penal Code Act. Chapter 120. (1950). http://www.wipo.int/wipolex/en/text.jsp?file_id=170005

Nunnenkamp, et al., (2013). Donor coordination and specialization: did the Paris Declaration make a difference? Review of World Economics. https://doi.org/10.1007/s10290-013-0157-2

Population Action International. (2005). The impact of the Global Gag Rule in Ghana 2005 updates.https://pai.org/Access-Denied-The-Impact-of-the-Global-Gag-Rule-in-Ghana.pdf

Population Action International. (2018). So far, so bad: The wide-ranging impacts of the Global Gag Rule. https://pai.org/So-Far-So-Bad-the-wide-ranging-Impacts-of-the-GGR-revised-7-17-18.pdf

Rodgers, Yana. (2018). The Global Gag Rule and Women's Reproductive Health: Rhetoric Versus Reality. 10.1093/oso/9780190876128.001.0001.

Rohrs, S. (2017). The influence of norms and values on the provision of termination of pregnancy services in South Africa. International Journal of Africa Nursing Sciences. https://doi.org/10.1016/j.ijans.2017.02.003

Schaaf, M., Maistrellis E., Thomas H., and Cooper B. (2019). Protecting Life in Global Health Assistance? Towards a Framework for Assessing the Health Systems Impact of the Expanded Global Gag Rule. BMJ Global Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6747899/

Skuster, P., Sully, E. A., & Friedrich-Karnik, A. (2024). Evidence for Ending the Global Gag Rule: A Multiyear Study in Two Countries. Guttmacher Institute. https://www.guttmacher.org/report/evidence-for-ending-global-gag-rule

South African National AIDS Council. (2022). Global AIDS Monitoring (GAM) Report 2020. https://sanac.org.za/2022/South-Africa-Global-AIDS-Monitoring_GAM-Report-2020.pdf

Starrs A. M. (2017). The Trump global gag rule: an attack on US family planning and global health aid. The Lancet. 389(10068), 485–486. https://doi.org/10.1016/S0140-6736(17)30270-2o

Sully, et al., (2022). Impact of the Trump Administration's Expanded Global Gag Rule Policy on Family Planning Service Provision in Ethiopia. Studies in family planning. https://doi.org/10.1111/sifp.12196

Swedlund, H. (2017). The Development Dance. How Donors and Recipients Negotiate the Delivery of Foreign Aid. Cornell University Press. https://doi.org/10.7591/cornell/9781501712876.001.0001

Tamang, J., Khanal, A., Tamang, A., Gaspard, N., Magee, M., Schaaf, M., ... & Maistrellis, E. (2020). Foreign ideology vs. national priority: impacts of the US Global Gag Rule on Nepal's sexual and reproductive healthcare system. Sexual and Reproductive Health Matters. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7888035/

UNAIDS. (2022). In danger: UNAIDS global AIDS update 2022. UNAIDS. https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update

UNAIDS. (2023). UNAIDS Data 2023. https://www.unaids.org/sites/default/files/media_asset/data-book-2023_en.pdf

United Nations Population Fund. (2018). Reproductive Health Supplies Coalition: Catalog 2018. https://s3-eu-west-UNFPA-68-090518.pdf

United States Department of State. (2020). Review of the implementation of the Protecting Life in Global Health Assistance Policy: Executive summary. https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final.pdf

United Nations (1979). Convention on the Elimination of All Forms of Discrimination Against Women, T.I.A.S. No. 11647, 1249 U.N.T.S. 13.

Vernaelde J. (2022). The U.S. Global Gag Rule in Ethiopia: a foreign policy challenging domestic sexual and reproductive health and rights gains. Reproductive health, https://doi.org/10.1186/s12978-022-01329-6

Wadge, A. (2017). The sexual and reproductive healthcare challenges when dealing with female migrants and refugees in low and middle-income countries. BMC Public Health. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-017-4565-1

World Health Organization. (2023). Adolescent pregnancy. A woman dies every two minutes due to pregnancy or childbirth - UN agencies. https://www.who.int/item/a-woman-dies-every-two-minutes-due-to-pregnancy-or-childbirth

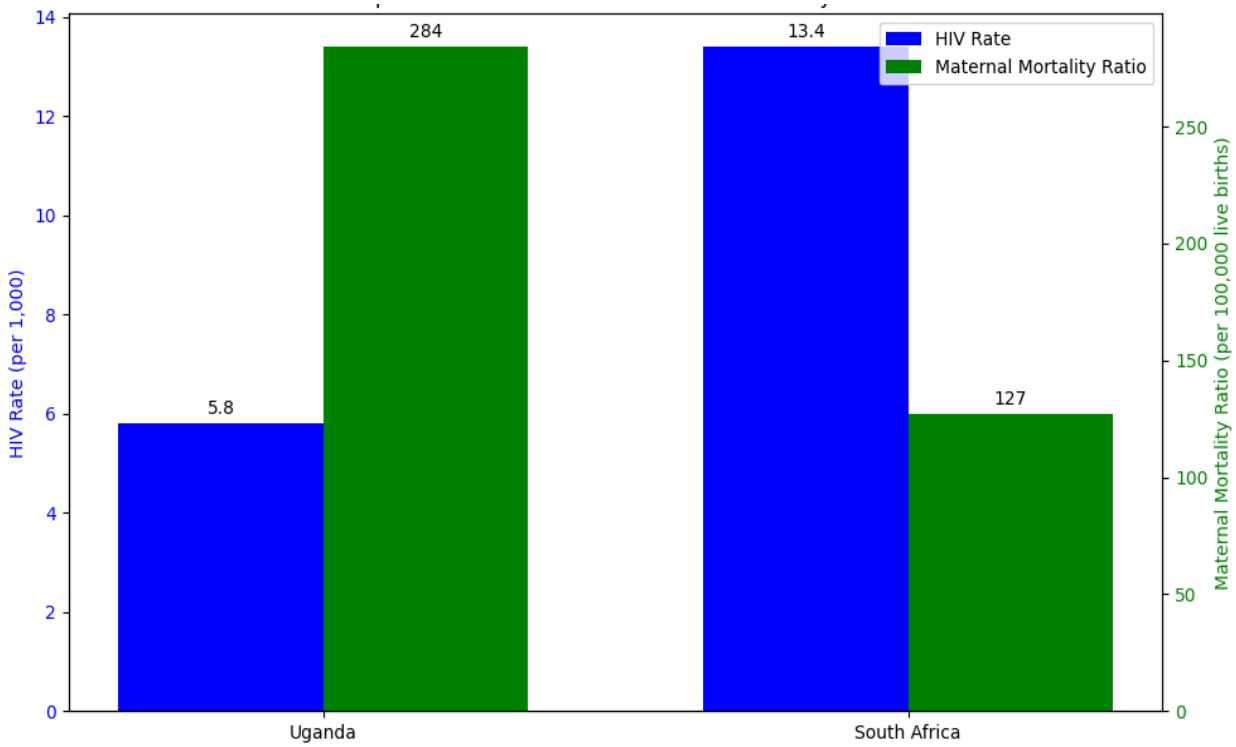
World Health Organization. (2024). Adolescent pregnancy. https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy

APPENDIX

Appendix 1: Statements from US Presidents on the Global Gag Rule

Year	President	Party	Quote
January 1993	Clinton	Democratic	"These **excessively broad anti-abortion** conditions are unwarranted [...] they have undermined efforts to promote safe and efficacious family planning programs in foreign nations."
January 2001	Bush	Republican	"It is my conviction that **taxpayer funds** should not be used to pay for abortions or advocate or actively promote abortion, either **here or abroad**. It is therefore my belief that the Mexico City Policy should be restored."
January 2009	Obama	Democratic	"For too long, international family planning assistance has been used as a **political wedge issue**, the subject of a back-and-forth debate that has served only to divide us. I have no desire to continue this stale and fruitless debate. It is time that we **end the politicization** of this issue."
September 2019	Trump	Republican	"Americans will also never tire of defending innocent life. We are aware that many United Nations projects have attempted to assert a global right to **taxpayer-funded** abortion on demand, right up until the moment of delivery. Global bureaucrats have absolutely no business attacking the sovereignty of nations that wish to protect innocent life. Like many nations here today, we in America believe that every child — born and unborn — is a **sacred gift from God**."
January 2021	Biden	Democratic	"For too many women today, both **at home and abroad**, that is not possible. Undue restrictions on the use of Federal funds have made it harder for women to obtain necessary healthcare. The Federal Government must take action to ensure that women **at home and around the world** are able to access complete medical information, including with respect to their reproductive health… [I]t is the policy of my Administration to support women's and girls' sexual and reproductive health and rights **in the United States, as well as globally**."

Appendix 2: HIV Prevalence Rate and Maternal Mortality Ratio in Uganda and South Africa



Created by author. Data from (ICAP, 2022) and (South African National AIDS Council, 2022).

Appendix 3: Top Five Countries with the Most HIV Cases in 2024

Country	Number of People Living with HIV
South Africa	7,600,000
India	2,500,000
Mozambique	2,400,000
Tanzania	1,700,000
Zambia	1,400,000
Uganda	1,400,000

Created by author. Data from (World Population Review, 2024)

Appendix 4: Sample of Interview Questions

GGR's Effects

1. How was [organization name] affected by the 2017 implementation of the GGR – either directly or indirectly?
2. What informed the organization's decision to comply or not comply with the policy?
2. Historically, the GGR has been found to have a 'chilling effect' in various countries, characterized by reduced advocacy and self-censorship. Is this something that has occurred in [country]?
3. How did the government of [country] respond to the 2017 GGR?
4. Did the policy have any political repercussions or influence the government's actions?

Abortion Landscape

1. Can you briefly describe the legislative and political landscape surrounding abortion in [country]?
2. How accessible is abortion care in [country]? What kind of barriers do women face when seeking legal abortion?

NGOs in South Africa

1. What role do NGOs play in providing abortion related services in [country]?
2. When the GGR was reinstated in 2017, some NGOs chose to comply while others chose to forgo US funding. What factors may have informed other organizations' decisions to comply or not comply with the policy?