The impacts of the Global Gag Rule on quality abortion care: A scoping review

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This thesis is submitted in partial fulfilment of the requirements for the degree of Master of Philosophy in Global Health at the University of Bergen.

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University of Bergen, Norway

2022

Abstract

The Global Gag Rule is a United States policy that blocks global health funding to foreign non-governmental organizations if they take part in abortion-related activities. This policy has been implemented by every Republican administration since its first announcement in 1984. The policy was rescinded in 2021 by President Joe Biden but given the history of the policy there is serious concern of a reinstatement in the future. Considering this possibility, this scoping review aimed to capture the effects of the GGR on quality abortion care. Inaccessibility of quality abortion care can lead to psychical and mental health complications, financial and social burdens for women, health systems and communities. Twenty articles met the eligibility criteria and were analyzed thematically, noting the GGR´s effect on: prevalence, organizations, quality of care, abortion stigma and advocacy. This scoping review revealed that the GGR works as a barrier for engaging in abortion advocacy and accessing quality abortion care. The GGR creates a “chilling effect” and contributes to abortion stigma which leads to delay in care and lack of information on abortion care. This review also reveals that the GGR has not reduced abortion prevalence, but rather has contributed to an increase in unsafe abortion. There is an important need for more research on the effect of the GGR to understand and limit future consequences of the policy.

Innholdsfortegnelse

Abbreviation

GGR – Global Gag Rule

NGO – Non-Governmental Organization

CAC – Comprehensive Abortion Care

PAC – Post Abortion Care

WHO - The World Health Organization

MSI - Marie Stopes International

IPPF – International Planned Parenthood Federation

SRHR - Sexual and Reproductive Health and Rights

SRH – Sexual and Reproductive Health

USAID - U.S. Agency for International Development

PPAG - Parenthood Association of Ghana

FPAN - Planning Association of Nepal

UNFPA - United Nations Population Fund

Acknowledgements

I would like to thank my advisors, Professor Astrid Blystad & Professor Karen Marie Moland for their patience and guidance. I will also thank my family and friends for their unconditional support, particularly Niklas Riis and Priscilla Ilic, who know what they did.

1 Background

The Mexico City policy, dubbed to ´Global Gag Rule´ by its critics, is a U.S. government policy that, when in effect, requires foreign non-governmental organizations (NGOs) to certify that they will not perform abortion as well as not actively promote abortion as a method of family planning. The NGOs can't use any funds (including non-U.S. funds) to do this if they want to receive U.S. funding assistance. (Kaiser Family Foundation, 2021). The policy has been dubbed to ´Global Gag Rule´ because of its limitation on the freedom of speech to those working within NGOs. The policy´s official name was previously the ´Mexico City Policy´ but was renamed under the Trump administration to ´Protecting life in global health assistance´ (Human Rights Watch, 2018).

This policy was rescinded in January 2021 by President Joe Biden, marking the end of Trump´s presidency. The first announcement of the Mexico City policy was made by The Reagan Administration at the 2nd International Conference on Population held in Mexico City, Mexico, on August 6-14 in 1984. Prior to the policy in 1984, foreign NGOs was able to use non-U.S. funds on voluntary abortion-related activities as long as they maintained segregated accounts of any U.S. money they may have received. But after the policy was implemented, they were no longer permitted to do so (KFF, 2021). The Mexico City policy was in effect until President Clinton rescinded the policy in 1993, before it was then again reinstated in 2001 by President George W. Bush on his first business day in office. In January 2009, President Barack Obama rescinded the Mexico City policy, but there were serious concerns of a future President reinstating the policy (Guttmacher institute, 2017).

In 2017, President Trump reinstated the policy and expanded it. The expansion meant that the policy did not longer only apply to US bilateral family planning assistance, but also to all "global health assistance furnished by all departments or agencies" (Starrs, 2017). This indicates that the policy gets reinstated when there's a republican president and the policy gets rescinded when there's a president from a Democratic Party. Under the Trump administration, the policy was renamed "Protecting Life in Global Health Assistance". Historically, the policy applied to foreign NGOs as a condition for getting U.S. family planning

support such as family planning assistance through the U.S. Agency for international development (USAID). In 2003 the policy also expanded to include family planning assistance through the U.S. department of state. In 2003, President George W. Bush stated that the policy did not apply to funding for global HIV/AIDS programs and multilateral organizations that are associations of governments were not included among the “foreign NGOs”. But in 2017 The Trump administration expanded the policy to apply to the vast majority of U.S: bilateral global health assistance furnished by all agencies and departments, including: maternal and child health (Including household-level water, sanitation, and hygiene (WASH)), Family planning and reproductive health, nutrition, HIV under PEPFAR (President´s Emergency Plan for AIDS Relief) , tuberculosis, neglected tropical diseases, malaria under the Presidents Malaria Initiative (PMI), global health security and certain types of research activities. This policy was in effect up to 2021, when President Joe Biden rescinded the policy. Since 1984, the policy had been in effect for 21 of the past 36 years (KFF, 2021).

In this study the Mexico City policy or Protecting Life in Global Health Assistance will be referred to as the global gag rule or the GGR. Activities prohibited by the GGR, in addition to not being allowed to use funds from any source to “perform or actively promote abortion as a method of family planning” is: providing advice and information about and offering referral for abortion (even where legal), promote changes in a country´s policies and laws related to abortion as a method of family planning and take part in public information campaigns regarding abortion as a method of family planning. When the GGR has been in effect it has, however, not prohibited foreign NGOs from: providing information and advice about, performing, or offering referral for abortion where the pregnancy has posed a risk to the life of the mother or if the pregnancy was a result from incest or rape, give post-abortion care or prohibited foreign NGOs from responding to questions about where a safe and legal abortion can be obtained when the pregnant women clearly states that she wants a legal abortion (KFF, 2021).

The policy´s intended aim was to reduce abortion in developing countries (Jones, 2011). An abortion (or termination) is a medical process of ending a pregnancy, so it does not result in the birth of a baby. Depending on the number of weeks of the pregnancy, the pregnancy can be ended by taking medication or by surgical procedure (Healthdirect, 2021). Induced

abortion (the intentional interruption of an ongoing pregnancy by medical or surgical means), is a common health intervention. Approximately 7 million induced abortions take place each year worldwide. 6 out of 10 of all unintended pregnancies, and 3 out of 10 of all pregnancies, end in an induced abortion (World Health Organization, 2021).

Comprehensive abortion care (CAC) is an intervention that is proven to prevent maternal death and/or injury (IAWG, 2022). Although CAC, which includes provision of information, management of abortion, and post abortion care (PAC) is included in ´list of essential health care services´ published in 2020 by The World Health Organization (WHO), unsafe abortion is still one of the leading causes of maternal deaths and morbidities (WHO, 2021). WHO defines unsafe abortion as "a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both" (Ganatra et al., 2014). Research from 2010-2014 shows that 45% of all induced abortions are classified as unsafe. Of all unsafe abortion, 97% of them are in developing countries. Abortion is classified as safe when carried out by someone with the necessary skills, appropriate to the duration of the pregnancy and by using a WHO recommended method (WHO, 2021).

Globally, 4.7%-13,2% of all maternal deaths each year can be attributed to unsafe abortion. In the developed region, it is estimated that 30 women die per 100 000 unsafe abortions. Amongst the developing countries however, this number rises to 220 deaths per 100 000 unsafe abortions. Data form 2012 indicate that 7 million women has to be treated in hospital facilities yearly due to complications of unsafe abortion (WHO, 2021). Complications like hemorrhage, peritonitis, sepsis, and trauma to vagina, cervix, uterus and abdominal organs are common from unsafe abortions. 20-50% of women that has had an unsafe abortion are hospitalized for complications (Grimes et al., 2006).

To fulfill the global commitment to the sustainable development goal (SDG) of universal access to sexual and reproductive health (target 3.7), the provision of a legal and safe abortion is essential (WHO, 2017). WHO have issued a guideline on abortion care. The guideline proclaims that to provide quality abortion care it must be timely, safe, affordable, respectful, and non-discriminatory. Quality abortion care also includes CAC and an enabling

environment. The quality of care is described as a care that is: efficient, effective, accessible, equitable, safe and acceptable/patient. An enabling environment must include respect for human rights that includes a supportive framework of law and policy, the accessibility and availability of information and a universally accessible, supportive, affordable, and well-functioning health system (WHO, 2022, p. 1).

Almost every abortion related death and disability could have been prevented through sexual education, use of contraception, and with provision of safe, legal induces abortion with timely care for complications (Grimes et al., 2006). Unsafe abortion and the inaccessibility of quality abortion care can lead to physical and mental health complications, financial and social burdens for women, health systems and communities. The lack of access to affordable, timely, safe, and respectful abortion care, and the stigma around abortion, threaten the women´s physical and mental well-being throughout life. Evidence highlights that restricting access to abortions does not reduce the abortion prevalence, but it does affect wherever the abortion attained is safe and dignified (WHO, 2021).

The Mexico City policy got rescinded in 2021, but the uncertain history of the Global Gag Rule tells us that there is no reason to believe that the policy will not be in effect again. It is important to look into the consequences of the GGR in the past to understand it´s impact on quality abortion care because the GGR may be reinstated in the future. The main purpose of this literature review is to provide a literature-based overview of the impact the GGR has had on quality abortion care. The specific objective of the study is: “How has the global gag rule impacted quality abortion care since 1984?”. The intended broad nature of the objective is to capture the potentially breadth on the policy’s impact on quality abortion care since its first announcement by The Reagan Administration.

2 Methodology

This is a scoping review of the existing literature between 1984 and February of 2022. The purpose of a scoping review is to describe the literature and other sources of information that commonly include findings from a range of different study designs and methods. A Scoping review is a relevant method for synthesizing research evidence and used to categorize or group the existing literature in a field in terms of the field's nature, volume or features. Scoping review is most appropriate when the whole literature has not yet been comprehensively reviewed or when the literature is of complex and heterogenous nature. The method is suitable for answering broader and topic focused questions beyond those that are related to the effectiveness of interventions and/or treatments (Sucharew, 2019).

The scoping review methodology was made because it aims to map, identify, and synthesize key concepts, without evaluating the quality of the included literature, like one would do in the case of a systematic review (Levac et al., 2010) I therefore decided to conduct a scoping review instead of a systematic review because I am interested in providing an overview of existing literature and analyze the available and known evidence on the policy´s effect on abortion (Sucharew, 2019).

This study followed the Preffered Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) extension for Scoping Reviews (PRISMA-ScR) and reporting guidelines. PRISMA-ScR will help me develop a greater understanding of relevant terminology, core concepts and key items to report for my scoping review (Tricco, et al., 2018).

2.1 Eligibility criteria

Any peer reviewed empirical article, doctoral dissertation or master thesis on abortion and the global gag rule from any world region were considered for the review. The eligibility criteria are presented in table 1.

Peer-reviewed empirical articles were included for the review to ensure high quality research, and master thesis and doctoral dissertation were included because it provided the review with valuable information. It had to be published between 1984 and present day because prior to 1984 NGOs were able to use non-U.S. funds if they kept a segregated account of the U.S. funds. To be included in the review the articles had to be published in English or Norwegian to ensure reliability because these are the languages known to the writer. Articles had to discuss actual or expected impact of the GGR on quality abortion care to be included in this review to ensure that the articles were relevant to answer the specific objective.

2.2 Search terms and strategy

There was conducted a systematic search on the following electronic databases: Medline OVID, Cumulative Index to Nursing and Allied Health (CINAHL), American Psychological Association (PsycINFO), Web of Science and Excerpta Medica Database (EMBASE). There was first conducted a search on Medline OVID, CINAHL and PsychINFO. After evaluating with a librarian there was decided to conduct a systematic search on Web of Science and EMBASE as well. Giving a total of 167 records.

To find the best search terms I first searched “global gag rule”, “Mexico City policy” and “abortion” on google scholar to get an overview over terms used. After this I used Population-Concept-Context (PCC) framework to help with identifying the main concepts of my review questions. The PCC framework used are presented in table 2. I decided to use PCC framework because it was a better fit for my review question than PICO (Population, Intervention, Comparator and Outcome) and the PCC framework is recommended by The Joanna Briggs Institute for scoping reviews (Aromataric & Munn, 2020).

After identifying relevant terms, I developed a search strategy. The search strategy used on each database are found in table 3. I used three terms that is often or always used while referring to the policy (Global gag rule, Mexico City Policy and Protecting life in global health

assistance) on the databases with the Boolean term “OR” to ensure that the records identified included the policy. I combined this with the Boolean term “AND” with “abortion” OR “induced abortion”. This was done to ensure that the records identified included the two main terms for this review. In order to capture the potential breath of the policy on abortion, I used very generalized terms like abortion and induced abortion.

The reference lists of all records identified were then hand-searched for relevant articles that may not have appeared during the literature search. Scoping reviews gives a descriptive account of available information, that can lead to a broad and less defines searches that require multiple structured strategies. Hand searching the literature is therefore a necessary process in order to ensure the validity of the study (Sucharew, 2019).

2.3 Screening and Data Extraction

I used an excel spreadsheet as the data extraction summary form to gather general citation information, methodology, country/region, aim, and if the article was peer reviewed. A copy was kept in a separated word document. Original research articles (any methods) and review articles were included to be as comprehensive as possible.

I first screened articles based on title, keywords, and abstract. If it was uclear if the article met the eligibility criteria, I then reviewed the full article to determine if it met the inclusion criteria and none of the exclusion criteria as presented in Table 1. Then a full text was accessed for all the included articles.

3 Results

There were 167 articles identified through electronic database searching and 8 articles identified through snowballing. Giving a total of 175 articles. Seventy-eight articles were then excluded as duplicates and the remaining 97 unique articles were then screened for inclusion. 71 of 97 articles were excluded, leaving 26 articles that were assessed for eligibility. Of these 26 articles four were unobtainable and two were considered not relevant. This review includes a total of 20 articles. Figure 1 presents information on numbers of sources at each stage of the review process.

Of the total of 20 articles included in this review, 18 articles were peer reviewed, and 2 articles were master thesis. All articles were written in English. See table 4 for the complete table of included articles with characteristics. All 20 articles were read at least three times. I manually coded and found emerging themes. After analyzing the themes, I grouped them into the following categories: 1) Impact on prevalence 2) Impact on organizations 3) Impact on quality of care, 4) Impact on abortion stigma and 5) Impact on advocacy. The results are summarized along the five themes that emerged from the content of the articles.

3.1 Impact on prevalence

Pregnancy and delivery are the highest cause of death for women globally aged 15-19 years old (Gezinski, 2011), and a systematic analysis from WHO (2014) found that roughly 4.7-13.2% of all maternal deaths globally are due abortion (McGovern et al., 2020). It is primarily adolescent girls that are more vulnerable to the consequences of not having access to family planning services. 15.2 million adolescents gave childbirth in 2015 and this number is projected to be 19.6 million by 2035 (Murshid & Haque, 2020). Marie Stopes International (MSI) estimated that during the Trump administration era of the GGR, there would be 6.5 million unintended pregnancies, 2.1 million unsafe abortions and 21,700 maternal deaths worldwide due to cuts in contraceptive services and International Planned Parenthood Federation (IPPF) estimated that the funding lost during the Bush era GGR led to 36 million

unintended pregnancies and approximately 15 million induced abortions (Lane et al., 2020). There is also a possible impact on higher fertility per woman-year and slight reduction in age at first birth in Ghana due to the GGR (Pramanik, 2018)

A study located in Sub-Saharan Africa that included 26 different countries found that when the Mexico City Policy was in effect (2001-2008), there was an increase in abortion prevalence by approximately 40%. They also found a symmetric reduction in use of contraception by 3.15% and an increase in pregnancies by 3.2% while the policy was enacted. This pattern of higher abortion rates and lower use of contraceptive was also reversed when the policy was rescinded (Brendavid et al., 2011). This pattern was also seen in Ghana were many community-based projects and rural clinics had to close due to funding losses and therefore resulting in a 45% drop in contraceptive provision and a 20-40% increase in unwanted fertility (Lane et al., 2020).

A study conducted in 2006 in Peru claims the number of unsafe abortions had increased since the reinstatement of the GGR, and that they did not see a correlation between an increase in abortion rates and whether abortion is legal or accessible (Seevers, 2006). A master thesis from Ethiopia found that women are less likely to seek abortions because of the policy from 2008 to 2009, and that this especially applies to rural women (Katherine & Tibone, 2013).

Organizations expected that the GGR under the Trump administration would increase the maternal mortality at a rate equal to if not bigger than during the Bush GGR (Lane et al., 2020). One of the impacted organizations, MSI, were not able to manage the alternative source of funding between 2018 and 2020, which then caused approximately 2 million marginalized women to suffer due to the inaccessibility of family planning services, 2.5 million inadvertent pregnancies, 870,000 unsafe abortions, and 6,900 avoidable maternal deaths. According to IPPF estimations the loss of funding's in three years from 2017 could result in 4.8 million unintended pregnancies, 1.7 million unsafe abortions, and 20,000 maternal deaths (Murshid & Haque, 2020).

Articles have pointed out the big gaps in data related to abortion incidence in low- and middle-income countries. The extremely limited data on abortion is due to stigma and policies which make people under- report. The data are most limited for adolescents, criminalized populations, and women that are forced to migrate. There is reason to believe that he GGR contributes to worsening already big gaps in abortion-related data. Many organizations report confusion about of the GGR impacts their ability to gather data on abortion-related subject, and the hostile sexual and reproductive health and rights (SRHR) climate makes many local NGOs nervous about engaging in research on this area. Not reporting on abortion and SRHR data will continue to complicate global governance efforts and may harm women´s health worldwide (McGovern et al., 2020).

3.2 Impact on organizations

3.2.1 Lack of knowledge

A study based in Nepal did 205 semi-structured in-depth interviews over two different phases with NGO managers, government employees, public sexual and reproductive health (SRH) service providers and private sector facility managers and SRH service providers found that the knowledge about the GGR varied withing the participants. Phase one were between August and September of 2018 and phase two were conducted between June and September of 2019. Data shows that approximately half of the participants had heard of GGR, but they were not able to provide a description of the policy, or they showed a misunderstanding of its provision. Certifying NGOs receive U.S. funds and non-certifying NGOs does not receive U.S. funds. Overall, representatives of certifying NGOs did know more about the policy than representatives from non-certifying NGOs. Many participants from NGOs got knowledge about the policy through communication with their donor or prime partner, or in policy orientations. Some of the participants from certifying organizations reported that they had never received information about the policy from their donors or prime partners. One presentative from a certified NGO said in 20018 that in their organization they did not provide detailed training on the GGR because they did not see it as

necessary. This same representative was interviewed in 2019 and told that they have now received clarification on the policy from U.S. Agency for International Development (USAID) and this representative expressed frustration over the fact that USAID had not provided them with details on the subject sooner (Tamang et al., 2020)

Lack of knowledge about the GGR were also reported by most of the Anatananarivo-based representatives from eight non-governmental or international organizations that were involved in SRH service delivery in Madagascar (Ravaoarisoa, 2020), and a study located in Bangladesh that explored the health care providers 'perception and experience of providing comprehensive abortion care (CAC) in a humanitarian setting´ reported that the availability and accessibility of comprehensive abortion care was affected and limited by the abortion policies and lack of knowledge on abortion laws and policies (Persson et al., 2021). Confusion around the policy has also been very pronounced among the newly affected organizations after the expanded GGR during Trump administration. Organizations in Nigeria, Nepal, Kenya, Ethiopia, Uganda and Mozambique has reported little to no communication with the U.S. about the policy. The organizations that had been provided with guidance on the policy had documents only provided in English and therefore served as an additional barrier to the small and non-English speaking organizations (Lane et al., 2020).

3.2.2 Loss of funds

The main economic barrier to providing safe abortion services is the lack of funding. One example of this is that most facilities located in humanitarian crises are partly or entirely funded by NGOs, and the challenges with funding SRH services translated into restricting specific services like safe abortion care (Amaral & Sakellariou, 2021). International Planned Parenthood Federation (IPPF) and Marie Stopes International (MSI) are two prime partners that did not complied with any iteration of the GGR, therefore resulting in loss of U.S. funding. During the Reagan GGR, IPPF rejection of the GGR resulted them to lose around US$11-12 million (Mavodza et al., 2019).

Under the G.W. BUSH GGR IPPF lost around $18 million U.S. aid every year (Mavodza et al., 2019). This resulted in a loss of more than $100 million over the eight-year administration. (Global south) Family planning assistance also decrease by 3-6% and 11 different organizations reports a loss of U.S. funding during the Bush GGR (Lane et al., 2020). Planned Parenthood Association of Ghana (PPAG) is the leading NGO provider of reproductive and sexual health services in their country. In 2001, PPAG was going to receive $472,952 from USAID, but PPAG would only get these funds if they agreed to the GGR. PPAG then agreed to the policy´s conditions to keep its funding. However, from 2001 to 2003 PPAG experienced big budget losses from its funding from IPPF because IPPF refused to sign the policy and therefore IPPF´s budget got reduced by 40%. This cut in funding was therefore passed on to its member organizations. In 2003, PPAG rejected the policy and therefor lost USAID funding in addition to previous cuts from IPPF (Jones, 2015).

In Central and South America, South Asia and sub-Saharan Africa 31 IPPF member associates have lost up to 70% of their income during Trump Administration. In 2019 IPPF and MSI identified a combined funding gap of $160 million dollar by the end of 2017-2020 Trump administration. USAID funding on $3.5 million in 2017 represented almost half of an NGO´s total budget in Madagascar. After not-certifying to the GGR this NGO were only able to replace around $1million of this lost funding in 2018 (Lane et al., 2020).

Finding alternative sources of funding has proven to be difficult, but even if non-certified NGOs were able to mobilize new funding, there is still an average of an interval of 3-6 months where clients will be left without health services. This time can affect the population´s health and also trust in NGOs (Lane et al., 2020). Data collected from interviews in Nepal in 2018 and 2019 also indicated that the GGR has limited the pool of donor-funded projects that organizations could compete over for both certifying and non-certifying NGOs (Tamang et al., 2020). One article pointed out that that the decreased reliance on U.S. funding has made many stakeholders suggest that this could increase the stability for future years and could encourage governments to take greater responsibility of their health services (Lane et al., 2020).

3.2.3 Outcomes from funding loss

Since the beginning of the GGR many articles have reported negative outcome from the loss of U.S. funding's. Organizations that lost funds has reported the close of clinics and projects, restructure by reducing salaries and/or laying off staff members (Mavodza et al., 2019).

During the BUSH GGR, health services in 59 clinics from four different countries were severely impacted and forced to close and rural communities in Nepal, Tanzania, Zambia, Zimbabwe, Bolivia, and Ghana had a reduction or a termination of health services due to loss in funding (Lane et al., 2020). Family Planning Association of Kenya (FPAK) was forced to close three clinics in 2000 after the implementation of the GGR which served around 19,000 clients (Murshid & Haque, 2020), and a comprehensive report based on surveys of government, private, and NGO providers of family planning services in Ghana suggest that the contraceptive availability was lower when the policy was in effect. These surveys were undertaken in 1993, 1996 and 2002. When the policy had been rescinded the availability of pills and condoms had increased, and then again decreased after the reinstatement of the policy (2002 vs.1996) (Jones, 2015).

The loss of U.S. funds during Trump administration has forced ending of family planning program serving 6,000 adolescent girls in Uganda, 650,000 people in Zambia, 40,000 adolescent girls in Kenya, and 11 remote districts located in Nepal. Family Planning Association of Nepal (FPAN) estimated that around 10 million people, which is one third of Nepali population would be affected by funding cuts during Trump GGR (Lane et al., 2020). A large non-certifying NGO from Madagascar mentioned that their loss of funding from USAID in 2017 resulted in the closing to over 100 public and 90 private health facilities. They also had to return 12 vehicles that were used for mobile outreach teams, and therefore end its contraceptive voucher program for adolescents. This non-certifying NGO´s served around 200,000 clients and the voucher program reached approximately 25,000 young people every year. The reduce in funding due to the GGR has led to reduced support in contraceptive delivery, closure of clinics, stockouts and increased costs, ultimately resulted in unintended pregnancies (Ravaoarisoa, 2020). Organizations in Uganda and Nepal working with refugees and migrants says that the demand for family planning services and post-abortion care in the

camps are huge, but the funding cuts of $100,000 during the Trump GGR have forced them to reduce or withdraw the support (Lane et al., 2020).

Advocacy groups have claimed that det losses in funding because of the GGR has affected the availability of contraceptives to poor, rural populations, rather than provision of abortion services. Data from PPAG shows that the contraceptive provision in rural areas dropped by 45% due to funding losses and that the provision of postabortion care had increased (Jones, 2015). Organizations in Uganda and Nepal working with refugees and migrants says that the demand for family planning services and post-abortion care in the camps are huge, but the funding cuts of $100,000 during the Trump GGR have forced them to reduce or withdraw the support (Lane et al., 2020).

3.3 Impact on quality of care

The GGR has impacted integration of services and partnerships between organizations, that has led to a fragmented and inefficient health system across all the three periods the policy has been in effect (Lane et al., 2020). Although organizations that did not want to certify to the GGR has reported the most significant funding loss, NGOs in all categories still experienced some GGR-related disruptions in their referral networks, partnerships and/or the ability to deliver integrated health services. These GGR-related disruptions affected community-based organisations, as well as public and health facilities that are receiving support from NGO´s. All these damaged the ability of facilities to provide good quality care. Kenya (Ushie et al., 2020) The GGR interferes with professional judgement of health service professionals on subjects thare related to the care they provide. Since their NGOs are depended on US family planning funds, they are unable to speak openly and truthfully to patients (Crane & Dusenberry, 2004).

Public and private providers supported by a large non-certifying NGO in Madagascar has expressed concern about the decreases in the quality of care that they are providing due to the loss from U.S. funding. One community-based midwife said that the funding cuts had forced her to reduce the number of sites she visited by half. The increased cost on

contraception in Madagascar due to loss in funding has created problems for many women who describes having to choose between buying contraceptive or food for their families. These choices often then resulted in an unintended pregnancy. The unintended pregnancy was reported to give additional consequences. Many talks about increased economic difficulties and one reports that she had to quit school (Ravaoarisoa, 2020). Organizations have expressed distress about the effect of the GGR on religious minorities, especially Muslim women, since they face an additional stigma and social barriers in accessing family planning in some contexts. Program that was dedicated to serving Muslim women located in Nepal and Kenya had to close due to funding cuts (Lane et al., 2020).

Issues related to service provision were one of the main barriers to accessing abortion services. Lack of staffing, trust and inadequately trained staff has been reported by women from Jordan, Thailand, South Sudan and the DRC (Amaral & Sakellariou, 2021). Representatives from two different non-certifying NGOs in Nepal also described an extensive staff layoffs of health workers and project administrators and managers (Tamang et al., 2020). Absence of skilled and proper services make women start to rely on unskilled services and will therefore suffer from more dangerous abortions and undesirable pregnancies. Primarily, this affects adolescents (Murshid & Haque, 2020).

An inadequate infrastructure and a lack or destroyed supplied were one of the main barriers to accessing abortion services. Many humanitarian programs did not give referrals to safe abortion services or post abortion care were not offered to women in need and the lack of support from local health system makes it difficult to implement abortion care services (Amaral & Sakellariou, 2021). USAID stopped the supply of contraceptive to 16 different countries in the Global South due to non-compliance with the GGR (Gezinski, 2011), and contraception is one of the things that may prevent unsafe abortion (Murshid & Haque, 2020). Both availability and accessibility of comprehensive abortion care are limited by abortion policies, lack of knowledge around abortion laws and policies, health care providers own beliefs and lack of cultural safety (Persson et al., 2021).

Data from a qualitative study in Kenya show that some of the GGR certified organizations and facilities did not provide passive referrals to their patients, even though this is a policy exception. A handful of the participants in the interview incorrectly stated that the policy prohibited these referrals, and very few participants correctly stated that the referrals were allowed. One NGO representative said that they were allowed to do passive referrals, but that it´s problematic so they won´t do that (Tamang et al., 2020). Refusal to provide abortion services and/or referrals, despite legal availability, can result in considerable delays in care (Moore et al., 2021).

3.3.1 The chilling effect

Several articles reported a "chilling effect" due to the GGR. Many NGOs has reported that they have unnecessarily overinterpreted the policy in fear of losing their funding's and from being accused of non-compliance (Mavodza et al., 2019). This fear can even lead organizations to adopt a blanket ban on all abortion-related services (Banwell, 2019).

One media organization based in Zambia, eliminated a whole chapter on emergency contraception from a brochure it produced on contraceptive methods in fear of losing their funding's (Crane & Dusenberry, 2004). Withholding timely and critical information to their patients can lead to procedural barriers for women (Moore et al., 2021). Both in Bangladesh and Turkey, some providers stopped sharing information about menstrual regulation, which led to frustration among long-term clients and many patients stopped seeking other family planning services that could benefit them. Other even feared being associated with abortion services, like a USAID-funded family planning organization based in Asia which refused to sell sterilization equipment to a legal abortion clinic, even though this would not have violated the GGR requirements (Mavodza et al., 2019).

Service providers and facility managers in Kenya from four different non-certifying NGO facilities reported that they no longer received any kind of referrals from NGOs that certified the GGR, or clinics that are affiliated with these organizations. Several participants in the study that works for a GGR certified organization describes restricting family planning

services. One participant reported that their organization over-restricts family planning activities purposely and gave the impression that this was done to avoid any policy-related scrutiny, another participant from a Kenya based NGO also said that the fear of losing US funding ha “muted” the organization’s voice in advocating for sexual and reproductive health (Ushie et al., 2020). Data from interviews in Nepal indicated that over-interpretation of the GGR influenced the partnerships between health facilities and NGOs. They referred to an example where participants from three GGR-certifying NGOs said that their organization do not make abortion referrals, even in cases of incest or rape, or if the pregnant person is in danger. One representative from a certified NGO expressed frustration over the chilled environment and expressed their concern on how the severing of the partnership could create barriers for women in need of health care for themselves and their families (Tamang et al., 2020). Multilateral organization, like UN agencies, are not formally bounded by the GGR, but several affiliated respondents reported that many multilateral organizations are self-censoring to not impact their funding’s from the US government. An interviewed participant that works for a multilateral organization reported that they routinely excise the word “abortion” from their policy documents (McGovern et al., 2020).

Another study based in Kenya show that some of the GGR certified organizations and facilities did not provide passive referrals to their patients, even though this is a policy exception. A handful of the participants in the interview incorrectly stated that the policy prohibited these referrals, and very few participants correctly stated that the referrals were allowed. One NGO representative said that they were allowed to do passive referrals, but that it´s problematic so they won´t do that (Tamang et al., 2020). There is also an overall chilling of reproductive advocacy that is happening in Peru, and this is hurting Peruvian NGO´s ability to advocate (Seevers, 2006). Facility staff and providers may provide inadequate information to patients about public funding for abortion services. Facility staff may withhold information about abortion because they may be afraid that sharing this information could threaten their state family planning funding. Withholding timely and critical information to their patients can lead to procedural barriers for women (Moore et al., 2021).

3.3.2 Unsafe abortion

A case study located in Latin-America tells the story of a woman that wants to terminate her pregnancy but does not have the access to safe services. This woman goes to a USAID-funded NGO clinic and the midwife tells her that she is pregnant. She then says that she does not want this pregnancy. The GGR prohibit the staff from providing abortion information and care. The midwife then tells the pregnant woman that many women feel uncertain about the pregnancy in the beginning and scheduled a new appointment in one month. This pregnant woman comes back three days later in the middle of the night and complaining about pain and vaginal bleeding. This woman´s self-induced termination resulted in an incomplete abortion. The Mexico City policy does not apply to PAC so the midwife´s personal and professional ethics dictated that she provided care for her patient. The women´s uterus was emptied by manual vacuum aspiration. The data insinuate that the policy has an adverse impact on women´s accessibility to safe abortion care and that PAC is not restricted by the Mexico City policy, is the key to preventing abortion-related mortality and morbidity (Miller & Billings, 2005).

Organizations that are not compliant to the policy are seeing that less women are accessing safe abortion due to lack of education and referrals from compliant organizations and Many NGOs and facilities have expressed confusion about providing safe abortion referrals under the condition of the policy (Tamang et al., 2020). For example, a stakeholder in Kenya said that their wards were empty, and that they get cases about women who had an unsafe abortion, often with septic or other complications (Lane et al., 2020). Several participants in a study located in Madagascar that are providers in the health system reported seeing an increase in the number of unintended pregnancies. They talked about seeing an increase in numbers of post-abortion care clients after the clients have gone through an unsafe abortion. A few female participants from the same study interviewed described how they or other women they knew had terminated their pregnancy. One woman said that she induced abortion by drinking concoction and had to seek post-abortion care (Ravaoarisoa et al., 2020)

A study using the context of the conflict located in Syria shows how the GGR and defunding of UNFPA has impacted the lives of the war-affected female populations that are seeking to terminate their pregnancies resulting from rape. Pregnancy as a result of rape can exacerbate the traumatic experience of survivors in conflict/crisis or post-conflict/crisis situations, there access to emergency and safe abortion care is critital. Unsafe abortion prevalence is high in conflict and emergency setting, and it´s estimated that around 25% of maternal deaths in refugee settings happens due to unsafe abortions. Syrian girls living in refugee camps have a higher risk of unwanted pregnancies, and their access to a safe abortion will be imdpacted by the defunding of United Nations Population Fund (UNFPA). Maternal mortality ratio in Syria has increased from 49% to 69% per 100,000 sine the conflict started in 2011. Problems and delays in accessing the necessary reproductive health care that includes access to safe abortion, are among one of the main causes for maternal deaths (Banwell, 2019).

3.4 Impact on abortion stigma

Abortion stigma impact women that are seeking abortion or post-abortion care at every level. The abortion stigma makes it difficult for women to find accurate and timely information about abortion services, even in countries where abortion isn't illegal. This may lead to delays in receiving care and accurate information on abortion services that can result in an unnecessary increase in direct and indirect costs of care (Moore et al., 2021). A qualitative study in Cox´s Bazar, Bangladesh, found that the GGR has resulted in discrimination against some aspect of comprehensive abortion care in humanitarian settings which could have led to unnecessary delays due to referrals and missed opportunities to meet women´s SRH needs (Persson et al., 2021).

Social stigma is an important barrier in accessing safe abortion care. Many women fear social repercussions like spousal abandonment. Cultural and religious beliefs, patriarchal power structures and the politicization of childbirth affect the accessibility to abortion services (Amaral & Sakellariou, 2021). Woman that can't confide in and rely on their own social support network are less likely to have adequate financial resources to access abortion.

Women may feel uncomfortable asking for information about abortion due to the possibility of facing stigma from peers. In Australia, one study participant said that they traveled for hours for an abortion procedure even though they had a hospital nearby. Another study participants had to visit five different general practitioners before meeting one that could give them a referral for abortion services (Moore et al., 2021).

Stigma around accessing abortion services in an anti-abortion environment can lead to loss of job. An example from Zambia; a woman seeking abortion services travelled to another town to receive abortion care in an attempt to keep the situation confidential, but her boss found out about the procedure, and she ended up being fired from her job as a result. Community and provider-based stigma around abortion can lead people to abortion services outside of formal sector and outside of the legal restrictions. This can lead to unregulated and very high service fees. Some providers in India have reported that unmarried women were averagely charged three to five times more than married women (Moore et al., 2021). A study from Kenya says that many providers speak disrespectful to women seeking PAC services, and this particularly affect young unmarried women in the country. Providers may withhold information or failed to treat them with courtesy. Many unmarried patients also lied about their marital status, so they could gain the same access of care as provided to married patients (Mutua et al., 2018). Abortion providers has also reported harassment, in Mexico City, there is reported that healthcare professionals would make an atmosphere of hostility in the workplace towards abortion, therefore resulting in longer wait for abortion services (Moore et al., 2021).

The results from a study in Kenya indicated that the expansion of GGR has exacerbated already existing hostility towards abortion in the country. One participant also stated that "the government of Kenya had bought into GGR for their own political reasons" (Ushie et al., 2020). A review that investigated the connection between the economics of abortion and its link with abortion stigma found that the GGR has institutionalized abortion stigma within its global foreign assistance structure and that this is done by enacting restrictions to funding (Moore et al., 2021).

Interviews participants in Kenya also reported that organizations that are funded by the U.S. and certified to the GGR are unwilling to attend meetings with NGO´s that had not certified the expanded GGR, even when the topic was unrelated to abortion. One participant said that even when you are invited to meetings, you would feel stigmatized if you did not believe in the GGR and were pro-choice (Ushie et al., 2020).

3.5 Impact on advocacy

GGR certified-NGOs in Mozambique, South Africa, Nepal, Bolivia, Senegal, Uganda, Ethiopia, Peru and Zimbabwe have stated that they feel censored due to the GGR and that they fear engaging in discussion around their work because they do not want to lose U.S. funding (Lane et al., 2020). The GGR creates barriers to advocacy and set a limitation on free speech related to abortion. No matter how big the local demand for abortion reform is in Peru, the GGR make´s this issues specifically “off limits” for NGOs. Although USAID is facilitating an increase in free speech and democracy in Peru and has recognized NGO´s as essential actors in democracy promotion, NGO´s are prevented from certain political speech related to reproductive right due to the GGR. Free speech is necessary to democracy and political advocacy (Seevers, 2006).

Women´s ability to participate in GGR efforts will also likely be heavily influenced by cultural norms, religion and community acceptability. The cost of speaking about GGR or abortion can be high in many countries. Also, the women´s ability to participate in these efforts will largely depend on their own economic resources because concerns regarding their basic needs may take precedence over political activism (Gezinski, 2011),

There hase been fewer organisations attending SRHR advocady events under the expanded GGR and there is a ongoing and broad concern that the GGR is creating a hostile climate for researching on sexual and reproductive health (McGovern et al., 2020). Several groups were not able to participate in relevant workshops where abortion would be discussed at an annual conference in 2017. Stakeholders from South Africa and Nepal expressed frustration and anger towards the power imbalance between the Global North and Global South and saw the GGR as interference from a powerful nation abusing their position of economic

dominance (Lane et al., 2020).

37 of 64 countries that were recieveing U.S. global health assistance in 2016 had laws that allowed for abortion in circumstances which were not permitted by the GGR. In some countries where abortion has been decriminalized, the governements may have a slow implement of the new legislation and ensure access to these services. The GGR then works like an additional barrier sine many governments fear losing their U.S. support. Stakeholders worries that economic constraints and censorship of abortion advocates could shift policy away from the focus on human rights, health and wellbeing, towards one on moralism, religious values or on economic pragmatism (Lane et al., 2020).

4 Discussion

The findings from this study shows that the GGR has had a negative effect on quality abortion care since the policy´s first announcement in 1984. To provide quality abortion care it has to be in a context of an enabling environment with a supportive framework of law and policy (WHO, 2022, p. 1). The GGR is a policy that articles point out make it difficult for women to seek abortion care and even speak about abortion (Lane et al., 2020). Even in countries where abortion is considered legal, the GGR works as an additional barrier to quality abortion care because governments are afraid to lose U.S. support. (Lane et al., 2020). An article from Peru specifically talks about how the GGR makes an abortion reform "off limits" for NGOs, even if the local demand for it is big (Seevers, 2006), and GGR certified-NGOs from Mozambique, South Africa, Nepal, Bolivia, Senegal, Uganda, Ethiopia, Peru and Zimbabwe stated how they feel censored due to the GGR (Lane et al., 2020). The GGR makes it difficult for countries to develop a supportive framework of law and policy for quality abortion care because it prevents NGOs from engaging in abortion advocacy.

An enabling environment require the accessibility and availability of information on quality abortion care (WHO, 2022, p. 1), but several articles (n = 8) report that the GGR has created a "chilling effect". The GGR leads people to overinterpreted the policy because they fear the loss of U.S. funds. Mavodza et al., 2019). Organizations withhold critical information about abortion, provide inadequate information, remove information about abortion and stop with abortion referrals (even in cases of rape or incest) because they fear the loss of funding's. (Moore et al., 2021; Mavodza et al., 2019; Ushie et al., 2020; Tamang et al., 2020). Not providing women timely and right information about abortion does create an enabling environment for quality abortion care and can result in considerable delays in care (Moore et al., 2021).

Public literature demonstrates that the GGR has not achieved it´s intended aim of reducing the use of abortion in developing countries (Jones, 2011), but that it may have had an opposite effect. Several studies (n = 7) commented on the connection between higher fertility rate and the GGR. One article from sub-Saharan Africa found and increase in

abortion prevalence by 40% and an increase in pregnancies by 3.2% when the policy has been in effect versus when it´s been rescinded (Brendavid et al., 2011). This pattern show´s that the GGR has not reached they're aim across all three policy periods it has been in effect. There is also reason to believe that the abortion rate and fertility rate may be higher due to big gaps in data related to abortion incidence in LMIC´s (McGovern et al., 2020).

One study from Peru claims that abortion rate is not affected by legality or accessibility, but that the GGR has increased the numbers of unsafe abortion (Seevers, 2006). Several articles (n = 8) have commented on the connection between the GGR and unsafe abortion. Organizations from Madagascar and Kenya report how they are seeing less women accessing safe abortion services and that the gynae wards are empty (Tamang et al., 2020; Lane et al., 2020). Organizations are expressing confusion about providing safe abortion referrals under the condition of the policy. Articles report that the organizations have a lack of knowledge about the GGR and that their organization has not been provided with guidance of the policy (Tamang et al., 2020; Ravaoarisoa, 2020; Persson et al., 2021; Lane et al., 2020). NGOs are not prohibited from offering referral for abortion where the pregnancy pose a risk to the life of the mother or if the pregnancy are a result from incest or rape, and they can respond to question about where a safe and legal abortion may be obtained when the pregnant patient states that she wants a legal abortion (KFF, 2021). The lack of knowledge about the GGR, lack of guidance on the policy and the fear of losing U.S. funds makes less women seek quality abortion care and may result in an increase in unsafe abortion. Not providing abortion services and/or referrals can result in a considerable delay in care (Moore et al., 2021).

The GGR stops funding to non-certified NGOs and the main economic barrier to providing quality abortion care is the lack of funding. The lack of funding has forced the close of clinics and projects, forced the ending of family planning programs and it has made NGOs reduce salaries and/or laying off staff members. (Mavodza et al., 2019; Lane et al., 2020; Murshid & Haque, 2020; Ravaoarisoa, 2020). This has impacted many people across many countries, and this especially affects poor and rural women (Jones, 2015). Contraceptive is one of the things that may prevent unsafe abortion (Murshid & Haque, 2020), but the end of family planning programs and increased cost of contraception has created problems for women

that may have to choose between food for their family or contraceptive. Choices like this has often led to unintended pregnancies (Ravaoarisoa, 2020). Organizations has expressed concerns about the decrease in the quality of care due to the loss from U.S. funding and issues related to service provision are one of the main barriers to accessing abortion services. Lack of staff, absence of skilled staff and inadequately trained staffed oppose a risk to quality abortion care because it is not safe (Amaral & Sakellariou, 2021; Tamang et al., 2020; Murshid & Haque, 2020).

The GGR has institutionalized abortion stigma within its global foreign assistance structure by restricting funding (Moore et al., 2021), and the GGR may exacerbated already existing hostility towards abortion in countries where abortion stigma is widespread (Ushie et al., 2020). To provide quality abortion care it has to be respectful and non-discriminatory (WHO, 2022, p. 1). The abortion stigma impact women at every level that are seeking abortion care and post-abortion care and the abortion stigma makes it difficult for women to find timely and accurate information about abortion services (Moore et al., 2021). There has been reported that providers speak and treat patients that are seeking PAC services disrespectful and may withhold information (Mutua et al., 2018). Abortion stigma may lead to delays in receiving care and accurate information on abortion services (Moore et al., 2021).

4.1 Limitations

There are several limitations from this study that must be mentioned. To mention a few of them; the search strategy only included articles that were published in English or Norwegian and therefore poses a potential limitation on relevant works that may have been published in other languages. Furthermore, this study also only included published articles, master thesis and doctoral dissertations and can therefore potentially have missed relevant information that could have been gathered from grey literature.
Finally, there is little primary data included in the study and there was no quality appraisal carried out because it was decided that the inclusion of a broad range of studies was necessary to fulfill the research aim (Levac et al., 2010). Some countries and regions were also underrepresented in the study, while others are overrepresented. Countries in Asia and

especially Latin America were underrepresented, while Africa, especially sub-Saharan Africa were overrepresented.

5 Conclusion

This review has identified several aspects of quality abortion care that has been harmed by the GGR since 1984. The GGR does not promote an enabling environment for quality abortion care by making it difficult for NGOs to engage in abortion advocacy and the GGR works as an additional barrier to accessing quality abortion care. The GGR also limits the information on quality abortion care by creating a "chilling effect" which leads to NGOs overinterpreted the policy because they fear the loss of U.S. fund. Organizations fear the loss of funds because this may have big consequences for their clinics and family planning programs that benefit many populations.

The lack of information, less referrals to abortion services, "chilling effect" and abortion stigma due to the GGR leads to a delay in care which can have big consequences. The evidence shows that the GGR has not reduced the use of abortion, but rather has contributed to an increase in unsafe abortion. The increase in unsafe abortion is directly the opposite of what the intention of giving quality abortion care is. The GGR has been rescinded by President Joe Biden in 2021, but there is serious concern that the policy may be in effect again in the future, there is therefore an important need for more research on the effect of the GGR to understand and limit future consequences of the policy.

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Tables and Figure

Table 1 – Inclusion and exclusion criteria

Inclusion critera	**Exclusion criteria**
Peer reviewed empirical article, master thesis, doctoral dissertation	News article, mass media article, opinion piece
Article discussing actual or expected impact of the GGR on quality abortion care	Articles not including the GGR or abortion
Published between 1984 and present	Published prior to 1984
English or Norwegian language	Other languages

Table 2 - PCC

PCC element	
Population	NA *
Concept	Global Gag Rule The Mexico Policy Protecting life in global health assistance Abortion Induced abortion
Context	Global

Table 3 – Search terms

Database search terms:	**(Global gag rule) OR (Mexico City Policy) OR (Protecting life in global health assistance)**
	AND (Abortion) OR (Induced abortion)

Table 4 - Complete table of included articles with characteristics

Authors/Year/Title	**Peer review/ Master thesis**	**Country/region focus**	**Methodology**	**Aim**
Lane, S., Ayeb-Karlsson, S., & Shahvisi, A. (2020) Impacts of the Global Gag Rule on sexual and reproductive health and rights in the Global South: A scoping review.	Peer review	Global South	Scoping review	What is the impact of the Global Gag Rule on the sexual and reproductive health of people living in low- and middle-income countries across the three periods that is has been in effect?
Tamang, J., Khanal, A., Tamang, A., Gaspard, N., Magee, M., Schaaf, M., McGovern, T., & Maistrellis, E. (2020). Foreign ideology vs. national priority: impacts of the US Global Gag Rule on Nepal's sexual and reproductive healthcare system.	Peer review	Nepal	Qualitative interviews & analysis	This paper examines the impact of the GGR on civil society, NGOs, and SRH service delivery in Nepal.

Ushie, B. A., Juma, K., Kimemia, G., Magee, M., Maistrellis, E., McGovern, T., & Casey, S. E. (2020). Foreign assistance or attack? Impact of the expanded Global Gag Rule on sexual and reproductive health and rights in Kenya.	Peer review	Kenya	Qualitative interviews & analysis	This paper describes the effects of the expanded GGR policy in Kenya eighteen months after its reinstatement.
Ravaoarisoa, L., Razafimahatratra, M., Rakotondratsara, M. A., Gaspard, N., Ratsimbazafy, M. R., Rafamantanantsoa, J. F., Ramanantsoa, V., Schaaf, M., Midy, A. C., & Casey, S. E. (2020). Slowing progress: the US Global Gag Rule undermines access to contraception in Madagascar.	Peer review	Madagascar	Qualitative interviews & analysis	Document the impact on women who themselves described their increased difficulties obtaining contraception ultimately resulting in discontinuation of contraceptive use, unintended pregnancies and unsafe abortions.
McGovern, T., Schaaf, M., Battistini, E., Maistrellis, E., Gibb, K., & Casey, S. E. (2020).	Peer Review	N/A	Qualitative interviews & literature review	The paper discuss how, by chilling debate and reducing transparency, PLGHA fractures health systems and contributes to the ghettoization of SRHR work.

From bad to worse: global governance of abortion and the Global Gag Rule.				
Gezinski, L. B. (2011). The Global Gag Rule: Impacts of conservative ideology on women´s health.	Peer review	N/A	Review article	The purpose of this article is to conduct a review of the existing literature pertaining to the GGR´s impact of conservative ideology on women´s health.
Bendavid, E., Avila, P., & Miller, G. (2011). United States aid policy and induced abortion in sub-Saharan Africa.	Peer Review	Sub-Saharan Africa	Quantitative analysis	Empirically examine patterns of modern contraception use, pregnancies, and abortion among women in 26 countries in sub-Saharan Africa in response to the reinstatement and subsequent repeal of the Mexico City Policy across three presidential administrations
Miller, S., & Billings, D. L. (2005). Abortion and postabortion care: ethical, legal, and policy issues in developing countries.	Peer Review	Latin American country	Case Study	Case study of a woman who wants to terminate her pregnancy but does not have access to safe services explores the technical, ethical, and legal effects of the Mexico City Policy (Global Gag Rule) on health care providers working in developing countries. This woman's self-induced termination resulted in an incomplete abortion, and she sought care from a midwife.
Crane, B. B., & Dusenberry, J. (2004).	Peer review	N/A	Review article	This paper reviews the history of the Gag Rule, including its roots in US domestic abortion politics,

Power and Politics in International Funding for Reproductive Health: the US Global Gag Rule				and analyses the short and long-term damage the Gag Rule is causing to the health and lives of women in the developing world.
Mavodza, C., Goldman, R., & Cooper, B. (2019). The impacts of the global gag rule on global health: a scoping review	Peer review	14 domains in global health	Scoping review	this scoping review aimed to describe and map the impacts of the GGR on global health
Murshid M.E., & Haque, M. (2020). The Global Gag Rule: The death trap for comprehensive sexual and reproductive healthcare and way to overcome the US gag rule	Peer review	N/A	Review article	This article has attempted to let the readers know about the impacts of GGR around the world and how global leaders are trying to overcome the harmful effects of this rule
Persson, M., Larsson, E.C., Islam, N.P, Gemzell-Danielsson, K., & Klingberg-Allvin, M. (2021). A qualitative study on health care providers' experiences of providing comprehensive abortion care in Cox's Bazar, Bangladesh	Peer review	Bangladesh	Qualitative interviews & analysis	This study explores health care providers' perceptions and experiences of providing comprehensive abortion care in a humanitarian setting in Cox's Bazar, Bangladesh and identifies barriers and facilitators in service provision.
Amaral B, D., & Sakellariou, D. (2021). Maternal Health in Crisis: A Scoping Review of Barriers	Peer Review	Global n = 14	Scoping review	What are the challenges humanitarian organisations face in providing ToP in humanitarian settings and

and Facilitators to Safe Abortion Care in Humanitarian Crises				how do they overcome them?
Banwell, S. (2019). Gender, North–South relations: reviewing the Global Gag Rule and the defunding of UNFPA under President Trump	Peer Review	N/A	Review article	This article reviews the implications of President Trump's executive order as well as the impact of the defunding of UNFPA.

Mutua, M. M., Manderson, L., Musenge, E., & Achia, T. (2018). Policy, law and post-abortion care services in Kenya	Peer review	Kenya	Qualitative interviews & analysis	The article draws on data from PAC service providers and patients in Kenya to illustrate how the quality of PAC in healthcare facilities is impacted by law and government policy.
Jones, K.M. (2015). Contraceptive Supply and Fertility Outcomes: Evidence from Ghana	Peer review	Ghana	Quantitative analysis	Examine Ghanaian women's response to a reduction in the availability of modern contraceptives in terms of contraceptive access and use, resulting pregnancies, use of induced abortion, and resulting births. The exogenous change in availability is due to GGR-related loss of funding and the associated outcomes of this loss.

Seevers, R. E. (2006). The Politics of Gagging: The Effects of the Global Gag Rule on Democratic Participation and Political Advocacy in Peru.	Peer review	Peru	Qualitative narratives & analysis	Examine the damaging effects of the Global Gag Rule on civil participation and political advocacy by NGOs focusing on reproductive rights in Peru and the overall effect this may have on the country's emerging conception of democracy
Katherine, L., & Tibone, B.A. (2013) Did the Mexico City policy affect pregnancy outcomes in Ethiopia? The impact of U.S. policy on reproductive health and family planning programs	Master thesis	Ethiopia	Quantitative analysis	Examine the impact of the GGR on pregnancy outcomes in Ethiopia

Moore, B., Poss, C., Coast, E., Lattof, S. R., & van der Meulen Rodgers, Y. (2021). The economics of abortion and its links with stigma: A secondary analysis from a scoping review on the economics of abortion	Peer review	N/A	Scoping review	An analysis of secondary data from a scoping review on the economic impact of abortion to understand the intersections between stigma and economics outcomes at the microeconomic (i.e., abortion seekers and their households), mesoeconomic (i.e., communities and health systems), and macroeconomic (i.e., societies and nation states) levels

Pramanik, P. (2018). Impacts of the Global Gag Rule: Evidence from Ghana	Master thesis	Ghana	Quantitative analysis and literature review	Examine the impact of the GGR on fertility rate, mortality rate and abortion rate in Ghana

Figure 1 - Numbers of sources at each stage