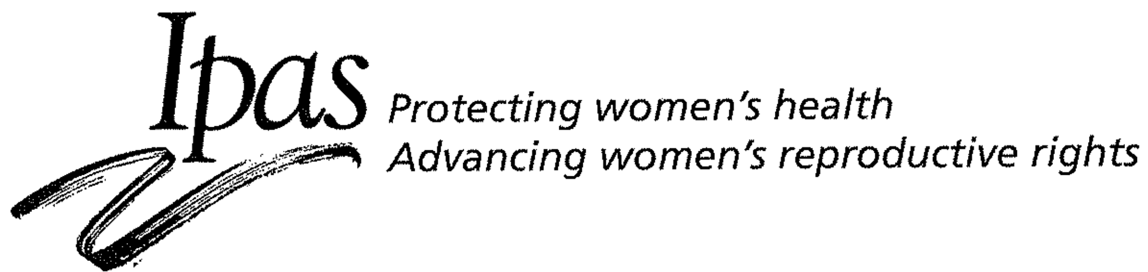


# Case Study Report

# Effects of the Global Gag Rule on Safe Abortion Programming in Nepal

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**Submitted to:** Ipas

**Submitted by:** Cherry Bird

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## List of Acronyms

| | |
|---|---|
| ANM | Auxiliary Nurse Midwife |
| BCC | Behavior Change Communication |
| BNMT | Britain Nepal Medical Trust |
| CAC | Comprehensive Abortion Care |
| CECI | Canadian Center for International Studies and Cooperation |
| CEDPA | Center for Development and Population Activities |
| CREHPA | Center for Research in Environment Health and Population Activities |
| DfID | Department for International Development |
| DHO | District Health Office |
| DoHS | Department of Health Services |
| DPHO | District Public Health Office |
| FHD | Family Health Division |
| FPA | Family Planning Assistant |
| FPAN | Family Planning Association of Nepal |
| FWLD | Forum for Women Law and Development |
| GTZ | German Technical Assistance |
| IEC | Information Education Communication |
| JHU/CCP | Johns Hopkins University Bloomberg School of Public Health/ Center for Communication Programs |
| MMR | Maternal Mortality Ratio |
| MO | Medical Officer |
| MoHP | Ministry of Health and Population |
| MSI | Marie Stopes International |
| NGO | Non-Government Organization |
| PAC | Post Abortion Care |
| PATH | Program for Appropriate Technology in Health |
| PH | Public Health |
| PHCC | Primary Health Care Center |
| PHECT | Public Health Concerns Trust |
| PPFA-I | Planned Parenthood Federation of America-International |
| RHCC | Reproductive Health Coordination Committee |
| SDC | Swiss Development Corporation |
| SMNF | Safe Motherhood Network Federation |
| SSMP | Support to the Safe Motherhood Programme |
| TCIC | Technical Committee for Implementation of Comprehensive Abortion Care |
| UNFPA | United nations Fund for Population Activities |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for Development |
| WHO | World Health Organization |

## Executive Summary

In January 2001, George Bush, as President of the United States of America, re-instated the Mexico City Policy (1993), often known as the Global Gag Rule. His executive memorandum directed the United States Agency for International Development (USAID) to re-instate all the requirements of the 1993 Mexico City Policy, which prohibits all foreign (non-US) non-government organizations that receive US government funding from performing or promoting abortion as a family planning method, even using their own or other non-US funding.

Abortion services were legalized in Nepal in December 2003, for all women, on demand, up to 12 weeks' gestation and under specified conditions later in the pregnancy. Since then, the national program has made rapid progress and services are available in 70 out of the 75 districts.

There is clear and well documented evidence of the negative effects of the Global Gag Rule on the efforts of NGOs in Nepal to provide access to safe abortion and family planning services for all women, which support and supplement government efforts. This has particularly affected poor women in under-served areas, where NGOs previously ran outreach clinics and where government services are often not available. These effects include services, information dissemination and women's empowerment programs.

This study was commissioned by Ipas to review the effects of the Global Gag Rule on safe abortion programming, and more generally on reproductive health services, in Nepal, as an important contribution to national and global evidence in support of advocacy for removal of the Global Gag Rule. Interviews were undertaken with key stakeholders at central and district levels, including representatives from the government service, international development agencies and local non-government agencies.

The study found that services were affected, either by limitations placed on the activities of NGOs or by directives from the Department of Health Services. These were mainly due to restrictions on the use of facilities for abortion services if they had been developed with US funding. Since district hospitals have limited resources, staff and space, in many cases this was seen to lead to use of sub optimal facilities. Information sharing at meetings and access to trainings is also affected

The study recommends:

- Raising the awareness of governments about the likely repercussions for abortion programming if US funding is used to support broad safe motherhood and reproductive health institutions and initiatives, to ensure clear understanding that such support may isolate abortion into vertical programming, which is less cost efficient and may have quality of service implications.

- Continuing advocacy at public events and through the media to ensure all stakeholders and the general public have a better understanding of the issue and their rights, are able to make decisions based on reality and their own choice.

- Clarifying the limits of the Global Gag Rule with government managers and decision-makers to ensure they are not unnecessarily cautious through inadequate understanding. This is important as integration of safe abortion with other reproductive health services is not only programmatically desirable but also cost effective for the government and convenient for women.

- Encouraging district and facility managers to be creative about using the best available alternative facilities when faced with rigid limits imposed by the Global Gag Rule, as this survey indicates that many are providing services under sub optimal conditions, while others are managing better. Sharing of best practices among decision-makers could help to improve this.

- Re-activate the central reproductive health coordination committee (RHCC) as a broad government forum covering all reproductive health issues. Since this does not have USAID support it would be able to work with abortion programming in an integrated way. It is also linked with the district RHCCs, which draw membership from a range of local stakeholders.

- Where possible, avoid the use of US funding for supporting broad safe motherhood and reproductive health institutions and initiatives.

# 1. Background

## 1.1 Abortion in Nepal

Prior to reform, Nepal had one of the most strictly enforced anti-abortion laws in the world. Women received lengthy prison sentences for abortion related "crimes" (often labeled as infanticide)[1] and studies suggest that more than half the gynecological and obstetric hospital admissions were due to complications of unsafe abortion[2], contributing significantly to the high maternal mortality ratio (MMR, 539 per 100,000 live births[3]). Throughout the 1990s the efforts of many individuals and organizations developed a momentum that led eventually to reform of the law, in March 2002, when abortion was legalized under specified conditions. Following this, in December 2003, the Procedural Order enabling legal abortion services to begin received parliamentary approval. Under the reformed law abortion is permitted up to 12 weeks' gestation for any woman above 16 years on her request, up to 18 weeks' gestation if the pregnancy is the result of rape or incest, and at any time on the advice of a medical practitioner if the life or health of the woman is in danger, the fetus is seriously deformed or has a condition that is incompatible with life. Implementation of the new law was set in motion immediately, with services and training initiated in March and April 2004 respectively.

Since then, the national program has made remarkable progress, implemented by the Technical Committee for Implementation of Comprehensive Abortion Care (TCIC) under the Family Health Division (FHD) of the Department of Health Services (DoHS), with technical support from Ipas. Services are now available in 70 of the 75 districts of the country, either from government or private/ NGO sites and behavior change communication (BCC) initiatives supported by Program for Appropriate Technology (PATH) and Ipas. This rapid progress has been the result of strong government commitment and leadership and a partnership approach, with providers such as Family Planning Association of Nepal (FPAN) and Marie Stopes International (MSI, through the local branch *Sunaulo Parival* Nepal), playing a key role. Another important element has been the increasing integration of safe abortion programming under the umbrella of the national safe motherhood program, again based on strong government leadership and with support from the DfID funded Nepal Safer Motherhood Project (1997-2003) and subsequent Support to the Safe Motherhood Program (SSMP, 2004 to date), and the German Technical Assistance (GTZ) Health Sector Support Program, Reproductive Health component.

## 1.2 The Global Gag Rule

In January 2001, George Bush, as President of the United States of America, re-instated the Mexico City Policy (1993), often known as the Global Gag Rule. His executive memorandum directed the United States Agency for International Development (USAID) to re-instate all the requirements of the 1993 Mexico City Policy, which prohibits all foreign (non-US) non-government organizations that receive US government funding from performing or promoting abortion as a family planning method, even using their own or other non-US funding. Performing or promoting abortion as a family planning method means:

- Providing abortion services in countries where it is legalized (apart from as a life saving procedure or when the pregnancy is a result of rape or incest)

[1] Centre for Reproductive Law and Policy, Forum for Women Law and Development, 2002, *Abortion in Nepal: Women Imprisoned.*
[2] Ministry of Health, 1998, *National Maternal Mortality and Morbidity Study.*
[3] Pradhan A, Aryal RH, Regmi G et al. *Nepal Family Health Survey 1996.* Ministry of Health [and Population], Kathmandu, Nepal. 1997.

- Lobbying for favorable abortion policies and programs
- Educating people about safe abortion
- Providing counseling, referral or information about safe abortion services

NGOs, hospitals or clubs receiving US funding for reproductive health related work (specifically family planning) are required to sign a memorandum of understanding related to the Mexico City Clauses, certifying that they do not perform or actively promote abortion or provide financial support to other NGOs that perform such activities. There is provision for USAID representatives to inspect documents and materials of the NGO if they suspect violation of this agreement, following which, funding may be withdrawn. This level of threat creates an atmosphere of fear among NGOs for whom access to funding is a constant source of anxiety.

The Mexico City Policy does not apply to the governments of countries receiving US funding for development purposes, provided US money is not used in any way to support abortion programs. However, indirectly it does have a profound effect on the reproductive health programs of many developing countries around the world, both those that have legalized abortion and those working towards reform of anti-abortion policies. The effects are felt by both NGOs and governments, as they are often working towards the same aims – meeting the reproductive health needs of women safely and effectively, with the ultimate aim of reducing maternal mortalities and morbidities, which in turn positively affects the health and welfare of their children.

This anti-abortion stance drives more women into the hands of unsafe abortionists. According to an article by the Center for Reproductive Rights[4], around 20 to 40 million abortions take place annually across the globe, of which at least 20 million are performed under unsafe illegal conditions. Of these around 50% require follow up gynecological care, with many suffering permanent damage and around 78,000 dying. The many organizations and governments around the world who support legal abortion believe this situation can only be addressed though the provision of safe legal abortion services and accurate information and education.

### 1.3 The Global Gag Rule and government reproductive health programs in Nepal

Over the years the Nepal government has received US funding for family planning, safe motherhood and other reproductive health programs, including a strong focus on Post Abortion Care (PAC). The PAC program was initiated in 1995 to address the effects of complications from incomplete and septic abortions, both spontaneous and induced, which were acknowledged to contribute significantly to maternal mortalities and morbidities. The US was the major funder for PAC, supporting training, supply of equipment and construction of 45 specialist PAC facilities across the country. Staff providing services were specifically instructed not to enquire whether the complications were the result of a spontaneous or induced abortion – the aim was to save lives and not to moralize. PAC services have now been integrated into broader safe motherhood programming, and PAC training is part of basic emergency obstetric care training and is included in the new skilled birth attendant curricula. Despite initial concerns, the PAC program was not affected by re-instatement of the Mexico City Policy.

When elective abortion was fully legalized in late 2003 it seemed obvious to build on the extensive work of the PAC program. The equipment, techniques and training required are very similar and so one of the criteria for selection of the first candidates for CAC training was knowledge and experience of PAC services, particularly in piloting the training of nurses

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[4] The Impact of the Global Gag Rule: A Country by Country Snapshot.

as service providers. The PAC program pioneered the training of nurses as service providers, proving their competency. This is an important strategy for ensuring services are available in remote areas, where doctors are often not available. It was not possible for the US to control utilization of this complementarity, since staff in public hospitals have to provide the full range of services.

However, use of buildings funded by the US could be limited by the Helms Amendment, and so although the purpose built PAC facilities and family planning clinics seemed obvious places for providing CAC services, this was expressly forbidden and carefully monitored by locally based staff from USAID. Public hospitals and Primary Health Care Centers (PHCC) were forced to use less suitable alternatives. An atmosphere of fear was created around abortion, as government program managers and decision-makers, while strongly supportive of abortion, were extremely worried about the risk of losing the extensive US funding on which family planning, PAC and safe motherhood programming depended.

**Note:** The 1973 Helms Amendment prohibits the use of US funds for abortion related activities, with the exception of cases where abortion is needed to save the life of the mother or in cases of rape or incest. However, no US funding has been used to provide abortion even in these limited cases. According to USAID policy under the Helms Amendment, equipment and facilities funded by USAID cannot be used to provide abortion, whether the funding is provided to foreign governments or non-governmental organizations. In contrast, the Global Gag Rule only applies to foreign non-governmental organizations. The Helms Amendment is a restriction on funding provided by the US government while the Global Gag Rule is a restriction on activities undertaken with non-US funds.

### 1.4 The Global Gag Rule and the non-government sector in Nepal

There is clear and well documented evidence of the negative effects of the Global Gag Rule on the efforts of NGOs in Nepal to provide access to safe abortion and family planning services for all women, which support and supplement government efforts. This has particularly affected poor women in under-served areas, where NGOs such as FPAN previously ran outreach clinics and where government services are often not available. These effects have not been limited to services, but have also reduced information dissemination and women's empowerment programs, areas of work in which NGOs are particularly active and effective. A study carried out in 2004 by a group led by Population Action International[5], concluded that:

"The [Global] Gag Rule in Nepal has left the most difficult to reach clients in need of reproductive health services and hindered the government's ability to follow through on democratically supported legal change. Efforts of leading NGOs to reach remote clients have been crippled, leaving tens of thousands without service. Fear and silence pervades the process to address unsafe abortion and raises the risk of death and injury to women in a country with one of the highest rates of maternal mortality in South Asia."

The study cites examples of specific effects that followed the reinstatement of the Global Gag Rule, in 2001. These include:

- A loss of $100,000 in USAID funding, terminating a 32 year partnership, forcing Nepal's leading family planning non-government organization, Family Planning Association of Nepal (FPAN) to lay off 60 clinic staff members and begin charging for services. FPAN refused to compromise its support for abortion law reform and thus paid the price.

[5] Population Action International, Planned parenthood Federation of America International and Ipas. Access Denied: The Impact of the Global gag Rule in Nepal. 2004.

- An exemplary program implemented through a partnership between CEDPA and FPAN to train women leaders and expand access to reproductive health care, which served over 50,000 beneficiaries, was halted, resulting in the termination of the work of 20 staff and over 1,800 volunteers.

- Temporary clinics (camps) organized by Marie Stopes International (MSI), through its local affiliate, *Sunaulo Parivar* Nepal, with USAID funding to provide reproductive health care to remote regions were discontinued as a result of MSI's insistence on continuing to support abortion law reform and abortion service provision. This left 1,500 clients annually without services.

- Many Nepali NGOs supportive of change to Nepal's formerly restrictive abortion law were silenced due to fear of losing USAID funding.

- US restrictions created barriers to the Nepal government's efforts to implement legal changes. Facilities receiving USAID support, for example family planning clinics or PAC facilities, could not be used for providing abortion services. This resulted in difficulties for the government in establishing sites for safe abortion services at public health facilities, which were forced to use inappropriate maternity units, even delivery rooms, rather than the more appropriate family planning clinics and PAC units.

It should be noted that United Nations programs, such as UNFPA, UNICEF and WHO, are also affected by the Global Gag Rule, and thus not allowed to work on abortion, as are other international agencies receiving USAID funding and working in reproductive health, such as JHPIEGO and Engender Health.

## 2. Purpose and objectives of the study

The purpose of the study is to review the effects of the Global Gag Rule on safe abortion programming and more generally on reproductive health services in Nepal, as an important contribution to national and global evidence in support of advocacy for removal of the global gag rule.

The specific objectives are to provide:

1. Increased clarity about the understanding of the Global Gag Rule among safe abortion program implementers and decision-makers in Nepal, both the public and private/NGO sectors
2. Information about direct effects of the Global Gag Rule on safe abortion programming and other reproductive health services in Nepal
3. Recommendations for strategies to minimize the negative effects of the Global Gag Rule
4. Learning to share with other countries implementing or seeking to implement safe abortion programs
5. Material that can be used to support advocacy for repeal of the Global Gag Rule.

## 3. Methodologies used

- Review of literature on abortion and the Global Gag Rule.
- Semi-structured interviews in **districts** across Nepal, including district/ public health offices (D/PHO) and Comprehensive Abortion Care (CAC) service sites. A total of 61

questionnaires were completed relating to 27 government CAC service sites. The questionnaire is included as annex 1 The respondents were a mix of service providers (doctors, staff nurses and auxiliary nurse midwives) and non providers, such as health service managers (district/public health officers and medical superintendents), family planning assistants and public health nurses.

- Semi-structured interviews with key staff at **central level**, including government representatives, national NGOs directly involved in abortion work and international agencies and donors working for reproductive health/ safe motherhood. The questionnaire used is included as annex 2 , and respondents were also encouraged to discuss their own thoughts and experiences more broadly.
- Informal meetings and discussions were also held with TCIC staff

## 4. Findings

The knowledge of respondents about the conditions of the Global Gag Rule was assessed, and particular effects were noted related to:

- Abortion service provision in public hospitals and PHCCs
- Abortion information dissemination
- Integration of abortion into safe motherhood and other reproductive health programming

Of the 27 government sites covered, seven were not providing services, but either had done previously but had stopped temporarily due to transfer of the service provider, or were planning to start soon. The remaining 20 were providing services, though some with quite low caseloads. See annex 3 for list of sites and designations of respondents.

More detailed interviews were carried out at central level with 10 organizations, as shown in table 1 below.

**Table 1: Central level interviews**

| Nepal government | Nepal non-government | International agency |
|---|---|---|
| 1. Family Health Division (FHD) | 3. Family Planning Association of Nepal (FPAN) | 8. Support to the Safe Motherhood Program (SSMP) |
| 2. Ministry of Health and Population (MoHP) | 4. Centre for Research in Environment Health and Population Activities (CREHPA) | 9. UK Department for International Development (DfID) |
| | 5. Forum for Women Law and Development (FWLD) | 10. United States Agency for International Development (USAID) |
| | 6. Safe Motherhood Network Federation (SMNF) | |
| | 7. PHECT (Model Hospital) | |

All respondents at both district and central were supportive of the national safe abortion program. Those at central level were specifically asked if they felt this work was important and to give their reasons. They all stated that it is important to save women's lives and reduce the national maternal mortality ratio, as unsafe abortions are a major contributor to maternal deaths. They also said it is a women's right to choose to end an unwanted pregnancy. Quotes include:

*"The high MMR [Maternal Mortality Ratio] is a key issue and safe abortion can help reduce this. Service needs to be comprehensive and high quality."* (MoHP)

*"Women should have the right to choose family size. They should not die from preventable causes. We cannot stop abortion, there will always be a need as family planning is never 100% effective."* (CREHPA)

## 4.1 Knowledge about the Global Gag Rule

***At district level:*** Among the 61 individual respondents, 36 knew nothing about the global gag rule at all, 6 knew it was "something to do with the US not supporting CAC", and 18 only knew it meant that CAC and PAC could not be mixed. Only one respondent, the DPHO of Kaski District, said he knew that the US does not support CAC, only PAC, but the Nepal government can still have a CAC program even though it receives money from the US for PAC, as long as the two are kept separate. It was noticeable that in general, nurses and administration or management staff had no idea at all about the rule, whereas most doctors had some idea about it or had at least heard of it. Most respondents' knowledge came from the instructions they had received from the Family Health Division about not mixing CAC services with PAC or family planning. It was also noticeable that the responses at particular sites were much the same, with little evidence of individual opinions, but rather an organizational view presented, even though the interviews were carried out separately. However, very few respondents said the issue was discussed at all at their site.

***At Central level:*** Not surprisingly there was a much higher, though still variable, level of understanding about the Global Gag Rule among Kathmandu respondents. All knew that US funds could not be used for abortion work. Government representatives knew that it did not affect their programs as long as they did not mix abortion with US funded work, such as PAC or family planning. NGOs were clear that it had a profound effect on their work, and that once they had become involved in abortion issues (services or information dissemination) they were no longer eligible to receive USAID support. This was resented by all the NGOs interviewed.

*"It [the Global Gag Rule] is against developing countries. ICPD was the first to recognize women's rights. The US government thinks abortion will be abused and used as a form of contraception. This is not true."* (CREHPA)

The official USAID statement given at interview is that:

*"The Helms amendment specifies that if there is no USAID funding involved the organization is neutral on abortion – neither supporting nor opposing it. If there is USAID funding the [recipient] agency cannot work with abortion in any form, services or information. This does not apply to governments of recipient countries or multilateral agencies, only NGOs."*

However the position of the UN agencies is less clear. It is generally perceived that they are less hard line in attitude, but will not directly support abortion work.

## 4.2 Government program planning and support

At central level, although government representatives understood that the Gag Rule does not directly apply to governments of countries receiving US money, they were clear that US policy does affect their work, mainly because of the limitations placed on use of US funded family planning and PAC facilities and equipment [under the Helms Amendment]. Since the US is the main funder for this work the government does not want to risk losing funding, and

noted that USAID has specifically requested them not to use these facilities for CAC services or to mix them in any way. They have passed on this instruction to district managers. It was specifically said that the Nepal government would like to expand 26 family planning clinics funded by the US into general reproductive health service sites, including CAC services, but these restrictions mean this is not possible.

Government representatives said they resented this imposition of American policies:

*"It [the Global Gag Rule] is not right for Nepal – we are committed to CAC at all levels and this is important. It should not affect us."* (FHD)

*"The US is imposing their manifesto. It is a political issue. Ordinary people suffer for this. It is not appropriate for Nepal."* (MoHP)

*"The 45 PAC sites around the country cannot be used for CAC. These are good units and should be used. Not all are fully USAID funded, but still no-one can or will use them for CAC as they are afraid it will cause problems."* (FWLD)

### 4.3 Effects of the Global Gag Rule on service provision and training

District respondents were asked whether they were aware of the Global Gag Rule having any effect on CAC services. Three said that keeping CAC and PAC separate made it difficult for management and five said CAC and family planning services should logically be together for client convenience, but this was not allowed.

Table 2 shows the places where CAC services are provided at the 27 government sites covered, with comments about whether or not respondents thought these places were the best option.

**Table 2: Summary of information about places where CAC services provided**

| Place | Number | Satisfactory | Not satisfactory | No comment |
|---|---|---|---|---|
| Maternity unit | 12 | 5 (of which 3 had separate room/ unit) | 4 | 3 |
| Operating theater | 7 | 3 | 3 | 1 |
| Out patients department | 2 | 2 (with separate unit) | | |
| Family planning linic | 2 | 2 | | |
| Separate unit not specified where | 2 | 2 | | |
| No services and no place identified | 2* | | | |
| Total | 27 | 14 | 7 | 4 |

*The other 5 sites not currently providing services but with identified places are included in the other figures

The reasons given for lack of satisfaction were mainly lack of privacy and "congestion", referring to overcrowded and busy units. The greatest levels of dissatisfaction seemed to be for services provided in the maternity unit (often in the delivery/ labor room) without a separate room or unit. Table 2 clearly shows that all sites with a separate unit or room were satisfied with the facility, as were the sites using family planning clinics or outpatient clinics.

The reasons given for choosing the places used for CAC were not very specific, but included comments such as "no other space available" (6), "trained staff available" (3), "clean" (3), "good facilities" (1), "emergency backup available" (1), "convenient" (not specified for whom) (2). Not all respondents were able to answer this question. Thus it seems that CAC service sites have been selected on a rather ad hoc basis, with little thought given to client needs. Although it was not specified in the answers to this question, the fact that a number of respondents knew that CAC had to be kept separate from PAC and family planning services suggests that this was a strong factor in not using these premises, thus driving decision-makers towards using maternity units, especially as this was where trained staff could be found. Without the constraints of the US policy it is highly likely that a much higher number of sites would choose PAC units, family planning or outpatient clinics for CAC services, and that this is generally viewed as a more satisfactory option.

Discussions with the TCIC staff, who travel regularly to a variety of sites, revealed that overall a handful (perhaps five or six) sites are now using family planning clinics for abortion services. Over the whole country, 24 clinics in 21 districts have, in the past, received US funding. Although they have now been handed over to the Nepal government and US support has been phased out, use of these facilities for abortion services is still constrained. The TCIC staff noted that in districts where US project staff are based, or where they visit regularly, warnings are given that US funded facilities should not be used for abortion. If there is no US presence, district authorities feel more autonomous and able to use premises as they see fit.

***Training:*** Special CAC training sites (including service provision units) had to be constructed at the Maternity Hospital in Kathmandu and Lumbini Zonal Hospital in Rupandehi (Western Nepal), with funding from DfID), although at Maternity Hospital has an under-utilized PAC site constructed with US funding. As the DfID respondent commented, this represents increased implementation and opportunity costs (money and resources used that could have been used for other purposes).

### 4.4 Effects on the work of NGOs

All the NGOs interviewed had experienced challenges as a result of their decision to work on abortion, whether as information providers, activists or service providers. All remained totally committed to abortion work, despite the difficulties, which included major loss of funding, constraints associated with working with partners and being excluded from US funded events, such as trainings and conferences. In the cases where funding was lost, the NGOs frequently had to deal with a lengthy period of program cuts, including laying off staff and even total cessation of their work. As a result, services and information that should have been available to the public was not. Table 3 summarizes the effects on the five NGOs interviewed, which were:

1. ***Family Planning Association of Nepal (FPAN)*** – one of the major providers of family planning services in Nepal, with 28 clinics in urban and rural areas and outreach activities through around village 500 outreach centers
2. ***Centre for Research in Environment Health and Population Activities (CREHPA)*** – has wide experience in reproductive health research and information dissemination programs related to rural development
3. ***Forum for Women Law and Development (FWLD)*** – provides legal support and advice and campaigns on a range of human rights based issues, especially abortion
4. ***Safe Motherhood Network Federation (SMNF)*** – an association of NGOs with a focus on raising awareness and campaigning on safe motherhood issues. Member NGOs are based in urban and rural centers across the country

5. ***Public Health Concerns Trust (PHECT)*** – an NGO providing reproductive health services at three centers, linked with information dissemination and empowerment.

It can be seen in table 3 that out of the five NGOs interviewed, three have suffered considerable effects, which still continue, while the other two have never sought US funding and live with the fact that this is not an option and they remain cut off from any US supported events and activities. This, as one remarked, is not good for program integration. It also limits potential information sharing.

**Table 3: Effects of the Global Gag Rule on NGOs**

| NGO | Effects |
|---|---|
| FPAN | • In 2001 FPAN lost $100,000 for clinics under a partnership with Engender Health because of its refusal to stop working on abortion.<br>• 60 staff had to be laid off<br>• An annual budget of $400,000 for contraceptive supplies was also lost.<br>• All FP work stopped for about a year, many branch/ outreach clinics have still not re-opened, leaving many women in remote areas without FP services.<br>• Although FPAN is gradually getting funding from other sources to restart, it is difficult to plan long term because of the uncertainty of other funding<br>• Forming local partnerships is difficult since they may be affected by the rule.<br>• Permanent contraception (sterilization) work has suffered the most because it costs more to support and needs better facilities.<br>• Access to FP supplies is still affected, despite support from other partners.<br>• Support for the CEDPA/ FPAN women's empowerment program ENABLE worth $60,000 withdrawn and program discontinued. Not been reinstated. |
| CREHPA | • CREHPA is confident in its work as a lead agency in abortion information and research and does not rely on US funding. Thus no direct problems.<br>• However, potential local partners have to be warned of possible effects, which limits availability of partners.<br>• CREHPA also has to caution potential funding agencies as they may also be affected (eg AED lost funding as a result of supporting CREHPA's work)<br>• CREHPA cannot participate in workshops, conferences, trainings etc if US funding is involved. |
| FWLD | • FWLD has not suffered direct effects because it does not have major USAID funding. It has always campaigned strongly for abortion as a woman's right and worked to get women in prison for abortion related "crimes" released. |
| SMNF | • In 2003 SMNF lost US support (CEDPA), for secretariat, staff salaries, newsletter production, research and a whole program of safe motherhood advocacy activities, when it became known that SMNF supported abortion.<br>• There was a period of 2 to 3 years without funding, surviving with the help of volunteers who gave their time without payment and local NGOs who gave secretariat support. This limited activities significantly and the program lost momentum, which is only just picking up again. During this time, SMNF could have done more district strengthening and gained more members.<br>• Funding remains a challenge, but PPFA-I support enables SMNF to work.<br>• Other agencies receiving US funding are afraid of losing it as are local NGOs, so some who would like to become SMNF members do not join. Some manage if their US funding is not for reproductive health work.<br>• SMNF is now not supposed to go to the important White Ribbon Alliance (safe motherhood) conference because this has US support. Even if they were able to go, they could not talk about abortion. |
| PHECT | PHECT has never applied for US funding as they intended to provide abortion services and knew this was not an option. |

### 4.5 Position of international agencies

Among the many international agencies involved in reproductive health work in Nepal, only DfID and GTZ have consistently supported abortion work, thus limiting the resources available to the government program and condemning abortion to continue as a vertical program, rather than being fully integrated into reproductive health programming, as it should be. The position of the UN agencies, while less strict than those aligned with USAID, still prevents their supporting abortion work, either at district or central level.

There is a significant effect on information dissemination, as TCIC discovered when planning a communication strategy for abortion. In order to ensure that Information Education Communication (IEC) materials and other communication efforts reached all districts, TCIC talked with international agencies supporting district safe motherhood programs, encouraging them to include abortion IEC materials with their other information resources and to support dissemination and discussion of abortion through local women's groups. However, only those without US or UN support were able to help. Services are also affected, since it was noticeable in the early stages of TCIC that districts with international project support, in particular those under GTZ, were more likely to have active and successful public sector abortion services. UNICEF is an SSMP implementing partner[6], supporting service strengthening and access work in eight districts, but is not able to support abortion services or abortion information dissemination in those districts.

Coordination and partnership between organizations is also affected, and creative approaches are needed to circumvent difficulties. For example Johns Hopkins University Bloomberg School of Public Health/ Center for Communication Programs (JHU/CCP), as an SSMP implementing partner, was contracted to provide technical support for the development of national standards for technical content of all reproductive health messages, including those for abortion. However, since JHU/CCP is not able to work on abortion, TCIC took responsibility for the abortion messages, and since the publication was funded by SSMP/ DfID money, no rules were broken.

Another example of limitations placed on coordination and integration efforts is the Safe Motherhood and Newborn Health Sub Committee, which is chaired by FHD as a multi-partner coordination forum. Since it receives US funding, initially abortion was not discussed at all or covered in the safe motherhood newsletter. This situation has now improved and if abortion comes up as a part of other discussions it can be included, although specific presentations on abortion are not accepted. This tends to isolate abortion into a vertical program. The information gathered on abortion from the 2006 Nepal Demographic and Health Survey may have been limited by the fact that the lead support for this work was USAID. Initially, after lengthy discussions, it was agreed that a number of questions on abortion would be included. However, in the end only very sketchy information was gathered, as a part of pregnancy history questioning. Overall, as the DfID respondent observed, the restrictions and atmosphere of caution created by the Global Gag Rule affects relationships and trust, allowing the potential for misunderstandings and consuming energy that could be focused on program and policy development. Even dialogue with USAID on abortion is not tolerated, and staff are especially reluctant to communicate by email on the subject, since these can be checked.

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[6] The structure of SSMP includes a team of central policy level advisers and five contracted partner agencies responsible for district level implementation

## 5. Conclusions and Recommendations

The effects of the Global Gag Rule in Nepal are multiple and not only restricted to abortion services.

### 5.1 Effects on the national safe abortion program

***Services:*** As a direct result of the Global Gag Rule restrictions, and despite the fact that the rule is not supposed to be applied to governments, venues chosen for provision of CAC services in public sector sites are less than ideal for clients or staff. In many cases, especially smaller facilities, service providers are forced to use maternity units, often the labor/delivery room, which is totally inappropriate in terms of both ethics and quality of service. The crowded and busy environment means a woman is less likely to receive proper counseling, assessment and post procedure contraceptive services. Privacy is also an issue since presence of a woman who is not obviously pregnant seeking services is likely to raise questions about the kind of service she is seeking. In a family planning or outpatient clinic her presence would not be remarkable and in the calmer environment staff would be able to ensure she received proper comprehensive care. In a PAC unit, the care required for the two types of client is very similar.

***Information:*** The success of the national abortion program is dependent on women's access to knowledge, which is still at a very low level, especially in rural areas. In 2005 a survey carried out by CREHPA and PPFA-I[7] showed that only 43% of women interviewed were aware of the availability of safe abortion services, and of those only 20% knew abortion had been legalized. TCIC relies on a variety of partners to support information dissemination about the dangers of unsafe abortion and the availability of safe services. Yet only two major donor agencies (DfID and GTZ) are able to support this, and smaller agencies, such as Britain Nepal Medical Trust (BNMT), Canadian Center for International Studies and Cooperation (CECI) and the Swiss Development Corporation (SDC) can only do so if they are not receiving US funding. Local NGO potential partners are similarly limited, so that only a handful of NGOs, who have been willing to stand up against this rule and sacrifice US funding, can be partners. This limits the availability of essential reproductive health information, especially for women in remote rural areas, where the national media does not reach.

### 5.2 Effects on the national safe motherhood program

In the safe motherhood and newborn health long term plan (2006), the Nepal government has committed to an integrated approach to all services relating to safe motherhood, including abortion, family planning and prevention of mother to child transmission of HIV. There are sound reasons behind this, both at central level (more cost effective planning and better overall coverage) and district level (convenience for women, effective use of facilities and staff resources). Yet this rational approach is directly hampered by the Global Gag Rule, which not only prevents use of good facilities for abortion services, but also limits the involvement of international partners, who are supposed to support the overall safe motherhood program. Programs such as SSMP strongly support this integrated approach, but coordination efforts are affected by US restrictions. For example, the restrictions on discussion of abortion at safe motherhood and newborn health sub committee meetings and

[7] CREHPA/ PPFA-I. 2005. Married men and women's knowledge attitude and perspectives on abortion law, women's reproductive rights and safe abortion. Network for Addressing Women's Reproductive Rights in Nepal. Kathmandu.

other events receiving US financial support. The overall effect of this situation is to drive abortion back towards being a vertical program.

### 5.3 Effects on non-government organizations

When the Global Gag Rule was reinstated by the Bush administration in 2001, there were immediate and profound effects for a number of leading NGOs working in reproductive health, especially family planning, in Nepal. Although many have since found other sources of funding, some of the effects remain, limiting the work they are able to do and the local partners they are able to work with. An atmosphere of caution and even fear has been created around abortion, even though nationally there has been surprisingly little resistance on moral grounds to the principle of abortion, as highlighted by the quote below.

*"Usually women seeking abortion are desperate, no-one would want to have an abortion unless the situation was desperate, so we should not be judgmental of their personal decisions. Safe abortion is a woman's right. Americans have double standards as they impose one view on other countries while still having services in their own."* (SMNF)

Family planning services and public education and information campaigns run by organizations such as FPAN, MSI and latterly SMNF have been significantly limited, and some have not fully recovered. Thus women are denied services and knowledge.

### 5.4 Effects on reproductive health events

The US control over who participates in international and national events (conferences, meetings, trainings etc) and what is discussed (abortion being omitted from safe motherhood events for example) is a significant issue, which limits the comprehensiveness of such events and the potential for effective information sharing, not only for abortion per se but also for broader safe motherhood and women's rights issues. This is an insidious effect not widely considered, with potentially serious effects on the whole safe motherhood scene.

*"It [global gag rule] is an example of American hegemony in the world and repressive fundamentalist Christian attitudes. The US should not work in reproductive health at all if they impose this view."* (SMNF)

### 5.5 Recommendations

#### *All national and international stakeholders*

- It is important to raise awareness of governments about the likely repercussions for abortion programming if US funding is used to support broad safe motherhood and reproductive health institutions and initiatives (such as the Safe Motherhood and Newborn Health Sub Committee and safe motherhood/ reproductive health conferences). There needs to be clear understanding that such support may isolate abortion into vertical programming, which is less cost efficient and may have quality of service implications.

- Local staff need to ensure abortion is not excluded from reproductive health and safe motherhood programming by US policy, and driven into being a vertical program. This is especially important in relation to partnerships, for example within SSMP, other partners and advisers have to compensate for the fact that JHU/CCP cannot cover abortion work, and this was acknowledged when the partnership was established.

- Continuing advocacy is needed at public events and through the media to ensure all stakeholders and the general public have a better understanding of the issue and their rights, are able to make decisions based on reality and their own choice.

***Developing country governments***

- Government managers and decision-makers need to be very clear about the limits of the Global Gag Rule to ensure they are not unnecessarily cautious about use of facilities and institutions through inadequate understanding. This is important as integration of safe abortion with other reproductive health services is not only programmatically desirable but also cost effective for the government and convenient for women.

- When faced with rigid limits imposed by the Global Gag Rule, district and facility managers need to be creative about using the best available alternative facilities, as this survey indicates that many are providing services under sub optimal conditions, while others are managing better. Sharing of best practices among these decision-makers could help to improve this.

- At central level, currently the safe motherhood and newborn health sub committee (which has USAID support) is the only active general safe motherhood sharing forum between government and external partners. Other sub committees have specific specialist areas, such as child health. Every effort should be made to re-activate the central reproductive health coordination committee (RHCC) as a broad government forum covering all reproductive health issues. Since this does not have USAID support it would be able to work with abortion programming in an integrated way. It is also linked with the district RHCCs, which draw membership from a range of local stakeholders.

- Every effort should be made to avoid the use of US funding for supporting broad safe motherhood and reproductive health institutions and initiatives (such as the Safe Motherhood and Newborn Health Sub Committee and safe motherhood/ reproductive health conferences).

ANNEX 1

## Questionnaire for district health facilities

**Name of facility:**

**Name of person interviewed:**

**Position/ designation of person interviewed:**

**Name of person conducting the interview:**

**Date of interview:**

1. Does your facility provide safe abortion (CAC) services?

2. If so, in which part of the hospital do you provide services? (maternity unit, out-patient clinic, family planning clinic, antenatal clinic etc)

3. What were the reasons for choosing this place?

4. Is this the best place or first choice for services?

5. What do you understand by the global gag rule?

6. Are you aware of it having any effects on the provision of safe abortion (CAC) services at your facility

7. Has this issue been discussed in your facility?

## ANNEX 2

### Questionnaire for Central Level Interviews

**Name of organization:**

**Name of person interviewed:**

**Position/ designation of person interviewed:**

**Name of person conducting the interview:**

**Date of interview:**

1. In what way(s) is your organization involved with safe abortion (CAC) services or information dissemination?

2. Do you feel this work is important? For what reason(s)?

3. What is your understanding of the global gag rule?

4. Has it affected the work of your organization in any way? Explain how

5. Does your organization have a position or policy related to the global gag rule?

6. Explain this

7. Do you have a personal opinion about the global gag rule and its effects? (confidential info)

8. Do you have any suggestions for strategies for working with the global gag rule to minimize any negative effects

9. Do you think change is needed? If so, do you have any suggestions for ways to advocate for change?

## ANNEX 3

### List of Facilities and Interviewees

| Name of facility/ organisation | Service providers (Dr/nurse/ANM) | Non providers | Comments |
|---|---|---|---|
| 1. Bharatpur Hospital | Med Sup't<br>Nurse<br>Counselor | PHN | No USAID |
| 2. Nuwakot Hospital | Nurse | | No USAID |
| Nuwakot DHO | | PHN<br>PH Admin | |
| 3. Nawalparasi Hospital | MO (Dr) | | |
| Baglung DHO | | PHO | |
| 4. Baglung Hospital | MO<br>S Nurse | | |
| 5. Gorkha Hospital | MO | | |
| 6. Janakpur ZH | Med Sup't<br>Staff nurse x 2<br>Gynecologist | DPHO<br>PH Admin<br>FP supervisor | |
| 7. Western Regional Hospital, Kaski | | | |
| Kaski DPHO | | FPA<br>DPHO | |
| Rupandehi DPHO | | FPA | |
| 8. Lumbini ZH, Butwal | Sister in charge<br>ANM<br>3 x Ob/gyn | | |
| 9. Rupandehi PHCC | ANM | | Services not yet started but will soon |
| 10. Myagdi DPHO | | FPA | |
| 11. TUTH | S Nurse | | |
| 12. Palpa Hospital | ANM<br>S Nurse<br>MO | | |
| 13. Saptari DHO | | DPHO | No services now in PHCC |
| 14. Bojpur Hospital | Dr/ DHO | | |
| 15. Dadeldhura Hospital | S Nurse | | Services stopped |
| Mahottari DHO | | FPA | |
| 16. Mahottari Hospital | | FPA x 2 | No services |
| 17. Dhading DHO | | GTZ PH advisor<br>PH Admin<br>PHN | |
| 18. Bara Hospital | Dr/ DHO | | |
| 19. Rautahat Hospital | | FPA | Services stopped |
| 20. Pyuthan Hospital | Nurse<br>Doctor | | |
| 21. Nepalgunj Zonal Hospital | Ob/gyn | Nursing Admin | No services |
| 22. Bardiya Hospital | Med Superintendent<br>Doctor | | |

| | | | |
|---|---|---|---|
| 23. Dailekh Hospital | Doctor | | |
| 24. Ramechap Hospital | Doctor | | |
| 25. Sarlahi Hospital | Doctor | | No services |
| 26. Sankuwasabha Hospital | DHO | PHN | |
| 27. Koshi Zonal, Morang | Gynecologist x 5<br>Nurse in charge | | |
| **Total: 27 service sites (27 government)** | **40 service providers/ assistants** | **21 non providers** | **7 sites not providing services** |

61 questionnaires completed from 27 government service sites, 7 of which are not currently providing services but either previously did (provider transferred) or plan to soon.

Of interviewees, 40 were or could be service providers (doctor or nurse provider or nurse/ AMN assistant)
NB position of medical superintendents is not clear – in small hospital they could be providers, in larger facilities they may not be.