



May 2022

INTERNATIONAL FAMILY PLANNING ASSISTANCE

USAID Has Faced Implementation Challenges Related to U.S. Policy and COVID-19

GAO Highlights

Highlights of [GAO-22-104228](#), a report to congressional requesters

Why GAO Did This Study

According to USAID, the U.S. is the largest donor of bilateral FP/RH assistance to increase opportunities for voluntary healthy timing and spacing of pregnancies. This assistance also contributes to several other positive development outcomes, including reducing maternal and child mortality and HIV transmission, according to USAID. However, in a 2020 report, GAO identified instances in which FP/RH implementing partners declined the PLGHA terms and conditions and, as a result, stopped receiving planned funding that was not yet obligated under their awards. In addition, the World Health Organization and the United Nations Population Fund warned that the COVID-19 pandemic could severely disrupt access to FP/RH services for millions of women.

GAO was asked to review USAID's international FP/RH assistance. This report describes (1) the FP/RH assistance USAID provided in fiscal years 2018 through 2020, (2) the PLGHA policy's effects on the implementation of FP/RH assistance as well as actions USAID and its implementing partners reported taking to mitigate adverse effects, and (3) implementation challenges caused by the COVID-19 pandemic as well as steps USAID and its implementing partners took to address them.

GAO analyzed USAID funding data. GAO also reviewed USAID and implementing partner documents for FP/RH assistance in Senegal and Uganda and in the West Africa region, through USAID's West Africa Regional Program. In addition, GAO interviewed USAID officials, implementing partners, and other donors and reviewed studies of family planning assistance.

View [GAO-22-104228](#). For more information, contact Jason Bair at (202) 512-6881 or bairj@gao.gov.

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What GAO Found

In fiscal years 2018 through 2020, the U.S. Agency for International Development (USAID) obligated nearly \$1.7 billion for family planning and reproductive health (FP/RH) assistance. Obligations in Africa made up approximately half of this funding. In the three missions GAO selected for its review—Senegal, Uganda, and the Ghana-based West Africa Regional Program—USAID funded a variety of activities in four areas: improving the accessibility and quality of family planning services; increasing demand for FP/RH services through media communications and outreach; procuring contraceptives and supporting the supply chain; and strengthening health care systems. USAID's FP/RH assistance also leveraged other areas of USAID's health assistance, such as HIV services, post-partum care, and nutrition programs, according to USAID documents.

Mobile Clinic in Senegal Funded by U.S. Agency for International Development



Source: Famara Dabo, 2019. | GAO-22-104228

The Protecting Life in Global Health Assistance (PLGHA) policy—implemented in May 2017 and rescinded in January 2021—required foreign nongovernmental organizations (NGO) to agree, as a condition of receiving U.S. global health funding, that they would not perform or actively promote abortion as a method of family planning or provide financial support to any foreign NGO that conducts such activities. According to various sources, this had several adverse effects on implementation of FP/RH assistance. For example, in Senegal, Uganda, and the West Africa regional program, some service gaps and delays resulted after two of the largest implementing partners declined the PLGHA terms and conditions. USAID and implementing partners that accepted those terms and conditions found new organizations to fill most service gaps, but some adverse effects of the policy may have persisted after it was rescinded. For example, owing to confusion about the policy and fear of its reinstatement, some implementing partners that had accepted the PLGHA terms and conditions reduced their collaboration with partners that had declined them.

USAID and its implementing partners reported taking steps to address implementation challenges caused by the COVID-19 pandemic. For example, fear of infection, social distancing requirements, and transportation constraints reduced access to health care facilities. To address these challenges, implementing partners took steps such as encouraging the use of longer-lasting contraceptive methods to decrease women's need to visit clinics.

Contents

Letter		1
	Background	4
	USAID Provided \$1.7 Billion in Fiscal Years 2018–2020 to Support a Range of FP/RH Assistance	7
	USAID Found New Partners to Fill Most Service Gaps Linked to PLGHA Policy, but Some Adverse Effects May Have Continued	18
	USAID and Implementing Partners in Selected Locations Reported Taking Steps to Address Challenges Caused by the COVID-19 Pandemic	31
	Agency Comments	34
Appendix I	Objectives, Scope and Methodology	37
Appendix II	USAID Obligations for Family Planning and Reproductive Health and Key Indicators, by Location	40
Appendix III	Reported Steps to Address Implementation Challenges Caused by COVID-19 Pandemic for Three Selected Missions	43
Appendix IV	Comments from the U.S. Agency for International Development	44
Appendix V	GAO Contacts and Staff Acknowledgments	45
Tables		
	Table 1: Total USAID Obligations for International FP/RH Assistance in Fiscal Years 2018–2020 and Family Planning–Related Indicator Data for 2020, by Location	40
	Table 2: U.S. Agency for International Development’s (USAID) or Implementing Partners’ Reported Steps to Address Implementation Challenges Caused by COVID-19 Pandemic in Senegal, Uganda, and West Africa Regional Program	43

Figures

Figure 1: USAID’s Obligations for International FP/RH Assistance in 39 Countries, Fiscal Years 2018–2020	8
Figure 2: USAID’s Total Obligations for International FP/RH Assistance in Geographic Regions and for Worldwide Programs, Fiscal Years 2018–2020	9
Figure 3: Implant Insertion at Daloa Health Facility in Côte d’Ivoire	11
Figure 4: Postpartum Family Planning Counseling at General Hospital of Port-Bouet in Côte d’Ivoire	12
Figure 5: Community Dialogue on Family Planning and Reproductive Health Issues in Kitgum District, Northern Uganda	14
Figure 6: Assembly of Potential Youth Champions in Togo to Encourage Family Planning at Health Facilities	15
Figure 7: Training for District Health Management Teams and Facility Managers in Dokolo District, Northern Uganda	17

Abbreviations

CRS	Congressional Research Service
FP/RH	family planning and reproductive health
IPPF	International Planned Parenthood Federation
MSI	MSI Reproductive Choices (formerly Marie Stopes International)
NGO	nongovernmental organization
PAI	Population Action International
PEPFAR	President's Emergency Plan for AIDS Relief
PLGHA	Protecting Life in Global Health Assistance
PPE	personal protective equipment
UN	United Nations
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

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May 31, 2022

Congressional Requesters

More than 200 million women worldwide are estimated to have an unmet need for family planning. The U.S. Agency for International Development (USAID) has reported that the benefits of family planning include advancing individuals' rights to decide their own family size, reducing high-risk pregnancies, allowing sufficient time between pregnancies, and improving women's economic and educational opportunities. According to USAID, the U.S. government provides the largest amount of bilateral family planning and reproductive health (FP/RH) assistance worldwide and has provided such assistance since 1965. In each year since 2012, Congress has provided that not less than \$575 million should be made available for FP/RH.¹

In January 2021, the administration ended the Protecting Life in Global Health Assistance (PLGHA) policy, which was implemented in May 2017. The policy required foreign nongovernmental organizations (NGO) to agree, as a condition for receiving U.S. global health funding, that during the term of the award they would not perform or actively promote abortion as a method of family planning or provide financial support to any foreign NGO that conducts such activities. In a 2020 review of the PLGHA policy, we identified instances in which awardees² of global health assistance declined these terms and conditions and, as a result, stopped receiving

¹Since 2012, Congress has provided in each full-year appropriations act that not less than \$575 million of funds appropriated for bilateral economic assistance should be made available for FP/RH, including in areas where population growth threatens biodiversity or endangered species. According to USAID, the bilateral economic assistance funds for FP/RH are made available from the Global Health Programs and Economic Support Fund accounts.

²USAID provides assistance primarily through agreements with awardees—including NGOs, host-country governments, private voluntary organizations, and universities—that it refers to as implementing partners.

planned funding that was not yet obligated³ under their awards, possibly affecting project implementation.⁴

Since March 2020, USAID has provided FP/RH assistance during the COVID-19 pandemic, which the World Health Organization and United Nations Population Fund (UNFPA) warned could severely disrupt access to FP/RH services for millions of women.⁵ In addition, the UNFPA Supplies trust fund—one of the world’s largest providers of donated contraceptives—noted that pandemic-related budget cuts in donor countries could lead to reductions in contributions to the trust fund, limiting contraceptives’ availability to poor women and girls.⁶

You asked us to review USAID’s international FP/RH assistance, as a follow-up to our 2020 report on implementation of the PLGHA policy. In this report, we describe (1) the FP/RH assistance USAID provided in fiscal years 2018 through 2020, (2) the PLGHA policy’s effects on the implementation of FP/RH assistance as well as actions USAID and its implementing partners reported taking to mitigate adverse effects, and (3) implementation challenges caused by the COVID-19 pandemic as well as steps USAID and its implementing partners reported taking to address them.⁷

³An obligation is a definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received or that creates a legal duty on the part of the United States that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the United States.

⁴See GAO, *Global Health Assistance: Awardees’ Declinations of U.S. Planned Funding Due to Abortion-Related Restrictions*, [GAO-20-347](#) (Washington, D.C.: Mar. 18, 2020). Our 2020 report identified seven prime awards (six USAID awards and one Centers for Disease Control and Prevention award) and 47 subawards (all USAID awards) for FP/RH and other types of global health assistance for which foreign NGOs declined the PLGHA terms and conditions. As of September 2018, about \$153 million in estimated planned funding for these awards had not been obligated by the agencies.

⁵UNFPA is the lead U.N. agency focused on global population and reproductive health.

⁶The UNFPA Supplies Trust Fund noted in April 2021 that the United Kingdom planned to reduce by 85 percent—from \$211 million to about \$32 million—the funding it had committed for the trust fund’s program providing contraceptives to women and girls in 46 countries with high rates of maternal mortality and unmet need for family planning.

⁷USAID defines “implementing partner” as, among other things, an organization that carries out programs with U.S. government funding through a legally binding award or agreement and with which the agency collaborates to achieve mutually agreed objectives.

To describe USAID's international FP/RH assistance, we reviewed USAID data on funding obligated during fiscal years 2018 through 2020. We examined the data's reliability by identifying and discussing possible discrepancies with USAID officials. We determined that the data were sufficiently reliable for the purpose of identifying USAID's FP/RH funding by country and geographic region.

In addition, we reviewed USAID and implementing partner documents related to assistance provided in Senegal; in Uganda; and in the West Africa region, through USAID's Ghana-based West Africa Regional Program. We selected Senegal and Uganda because USAID had obligated moderate to large amounts for FP/RH assistance in those countries compared with other beneficiary countries and had made at least one award for assistance in those countries for which the awardee declined the PLGHA terms and conditions, according to USAID. We selected the West Africa Regional Program because of the priority USAID places on this region for FP/RH assistance and the opportunity it provided to examine both country-specific and regional projects.⁸

To identify the PLGHA policy's effects on the implementation of FP/RH assistance as well as actions USAID and its implementing partners reported taking to mitigate adverse effects, we reviewed USAID project documents provided by the USAID missions in Senegal and Uganda and the West Africa Regional Program. We also conducted a literature review of studies that were based on original research or that summarized a number of other studies. These studies were published in medical and other journals covering international family planning assistance. To avoid double counting, we reviewed only studies that presented new information or similar findings from new sources. We used the same methods to identify implementation challenges caused by the COVID-19 pandemic as well as steps USAID and its implementing partners reported taking to address them.

We searched for and reviewed studies that discussed U.S. FP/RH assistance in developing countries, covering topics such as the PLGHA policy and its predecessor during certain administrations, the Mexico City Policy; social norms; women's roles in family planning and contraceptive decision-making; U.S. government reproductive health-related policies; attitudes toward contraception; and COVID-19. We analyzed more than

⁸The West Africa Regional Program's FP/RH assistance focused primarily on four countries—Burkina Faso, Côte d'Ivoire, Niger, and Togo—and supported additional countries in West Africa through assistance to regional organizations.

50 studies to identify factors affecting the implementation of international family planning assistance.

To address all of our objectives, we interviewed USAID officials at the Bureau for Global Health’s Office of Population and Reproductive Health in Washington, D.C.; at the USAID missions in Senegal and Uganda; and in the West Africa Regional Program. We also interviewed representatives of past and current USAID implementing partners and representatives of other FP/RH donors working in the three selected locations. Appendix I provides further details on our scope and methodology.

We conducted this performance audit from February 2021 to May 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

USAID Strategy Related to FP/RH

FP/RH assistance is an element of USAID’s January 2015 “Ending Preventable Maternal Mortality” strategy, which identifies family planning, in addition to maternity care, infectious disease, and nutrition programs, as critical to the goal of reducing maternal mortality.⁹ The strategy states that meeting unmet need for modern contraceptives in the developing world would annually prevent 80,000 maternal deaths and 1.1 million infant deaths by reducing the number of pregnancies—including high-risk pregnancies¹⁰—and unsafe abortions. The strategy cites evidence that the risk of maternal death, adverse perinatal outcomes, and deaths of children younger than 5 years rises as the number of children per woman increases.

The strategy also notes that assistance should address wider health system issues, including human resources and commodities, and

⁹U.S. Agency for International Development, *Ending Preventable Maternal Mortality: USAID Maternal Health Vision for Action. Evidence for Strategic Approaches* (Washington, D.C.: Jan. 2015).

¹⁰According to the strategy, high-risk pregnancies include pregnancies in girls younger than 18 years, women older than 34, and women with more than four children.

integrate programming of multiple service areas where appropriate and feasible.

USAID's FP/RH Assistance Goals and Components

According to USAID, the overarching goal of FP/RH assistance is to enable individuals and couples to make their own informed decisions about their fertility and reproductive health and to act on those decisions without coercion or fear of violence. USAID also seeks to reduce unmet need for family planning and to increase opportunities for voluntary, healthy timing and spacing of pregnancies among all women of reproductive age.

Components of USAID's FP/RH assistance portfolio include service delivery, contraceptive supply and logistics, health communication, biomedical and social science research, policy analysis, monitoring and evaluation, and strengthening of crosscutting health systems, according to USAID. According to USAID, the portfolio also includes the integration of FP/RH services with maternal and child health and HIV programming and addresses gender-based violence and gender norms. Within USAID, the Bureau for Global Health's Office of Population and Reproductive Health, along with the agency's overseas missions, manages USAID's FP/RH assistance, according to USAID.

The agency's FP/RH assistance also contributes to other positive development outcomes, according to USAID. Such outcomes include reducing maternal and child mortality, improving women's educational and economic opportunities, reducing poverty, mitigating the impacts of population dynamics on natural resources and state stability, and reducing HIV transmission.

Mexico City Policy and PLGHA

The Mexico City Policy, which the U.S. government first announced at the UN Conference on Population in Mexico City in 1984, required foreign NGOs to agree, as a condition for receiving U.S. funding for family planning assistance, that they would not perform or actively promote abortion as a method of family planning. Subsequent administrations

have rescinded or reinstated the policy through executive branch action, typically through presidential memorandums.¹¹

In a January 2017 Presidential Memorandum, the Trump administration reinstated and expanded the Mexico City Policy, directing the Secretary of State, in coordination with the Secretary of Health and Human Services, to implement a plan to extend the requirements of the reinstated policy to all global health assistance furnished by all departments or agencies to the extent allowable by law. Consequently, the policy, later renamed PLGHA, applied to billions of dollars in annual U.S. global health assistance—such as support for maternal and child health, HIV/AIDS treatment and prevention, and malaria control—rather than only FP/RH assistance.¹² USAID began implementing the PLGHA policy in May 2017.

After the PLGHA policy was implemented, foreign NGOs receiving global health assistance funding under existing awards were required to either (1) accept the PLGHA terms and conditions to continue receiving additional global health funds or (2) decline the terms and conditions and not receive any additional planned funding that had not yet been obligated.¹³

¹¹Congress has imposed other restrictions, separate from PLGHA, on foreign assistance related to abortions and family planning activities abroad. For example, according to the Congressional Research Service (CRS), the “Helms amendment”—which was enacted first as part of the Foreign Assistance Act of 1973, Pub. L. No. 93-189 (Dec. 17, 1973) and subsequently under periodic appropriations acts—prohibits the use of U.S. foreign assistance funds to perform abortions as a method of family planning or to motivate or coerce individuals to practice abortions. Unlike the Mexico City Policy, the Helms Amendment does not prevent recipients of U.S. funding from using non-U.S. funds to engage in abortion-related activities if they maintain separate accounts for U.S. funds to demonstrate compliance with U.S. abortion restrictions, according to CRS.

¹²The PLGHA terms and conditions applied to prime awards and subawards of U.S. global health assistance made to foreign NGOs, including subawards made by U.S.-based organizations, but did not apply to assistance provided to national governments or multilateral organizations or provided directly by U.S.-based organizations. The policy prohibited prime awardees, including U.S. NGOs, from using the awards to provide assistance to any foreign NGOs that performed or actively promoted abortion as a method of family planning. Additionally, in March 2019, the Secretary of State clarified that foreign NGOs that accepted U.S. global health assistance were not permitted to provide financial support with any source of funds and for any purpose to another foreign NGO that performed or actively promoted abortion as a method of family planning.

¹³All global health assistance awards that USAID entered into while the PLGHA policy was in effect included the PLGHA provisions, according to USAID.

In January 2021, the Biden administration rescinded the policy and USAID amended its agreements with implementing partners to remove the PLGHA terms and conditions, according to officials. Awards made since the policy's rescission have not included the PLGHA provisions, according to USAID.

USAID Provided \$1.7 Billion in Fiscal Years 2018–2020 to Support a Range of FP/RH Assistance

USAID Provided FP/RH Assistance in 39 Countries and for Regional and Worldwide Programs

As figure 1 shows, USAID obligated nearly \$1.7 billion in FP/RH assistance in 39 countries in fiscal years 2018 through 2020. During this period, USAID also provided funding for regional and worldwide FP/RH programs.¹⁴ According to USAID, it prioritizes FP/RH assistance in countries where the need for family planning is greatest, including those with low rates of modern contraceptive prevalence and high rates of fertility or large populations with unmet need for contraception.¹⁵ Since 1965, when USAID began providing family planning assistance, 24 countries have transitioned from receiving such assistance after achieving high levels of modern contraception use and low levels of fertility, according to USAID.¹⁶ See appendix II for detailed data on USAID's

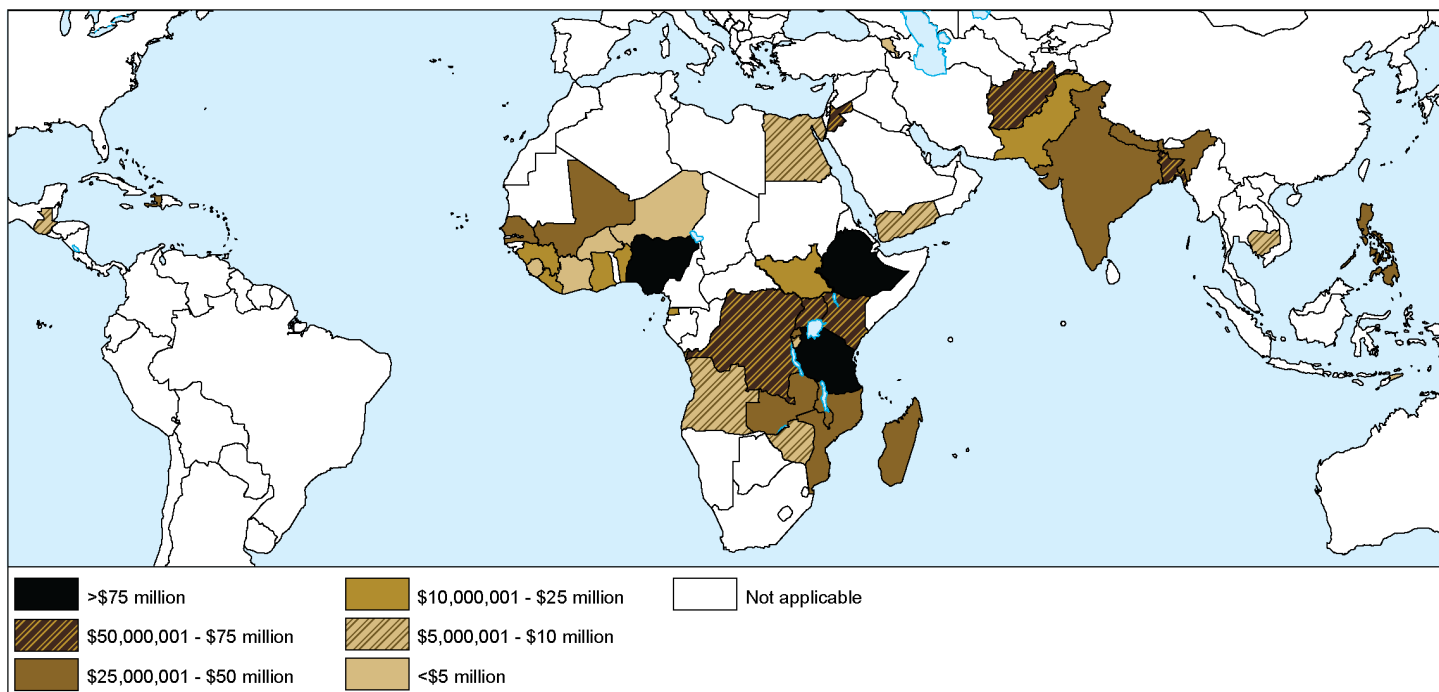
¹⁴Other countries may also have received assistance through USAID regional obligations, according to agency officials. USAID categorized funding obligated centrally by the Bureau for Global Health and the Global Development Lab and not associated with specific countries or regions as "worldwide" awards.

¹⁵Modern contraceptive prevalence rate is the proportion of women aged 15 to 49 who are using a modern contraceptive method, according to USAID. Modern contraceptive methods include female and male sterilization; IUDs; implants; injectables; pills; female and male condoms; foam or jelly; emergency contraceptive pills; and the lactational amenorrhea method, which involves exclusive breast-feeding for up to 6 months postpartum. Traditional methods of contraception include rhythm (e.g., periodic abstinence) and withdrawal. According to USAID, the total fertility rate is the number of births a woman is expected to have over the course of her reproductive years.

¹⁶According to USAID, a country has high levels of modern contraception use if at least 51 percent of women of reproductive age are using modern contraception methods. A country has low levels of fertility if each woman of reproductive age has, on average, fewer than 3.1 children. USAID officials stated that other factors have contributed to some countries' transition from receiving FP/RH assistance.

obligations and related indicators for its FP/RH assistance in fiscal years 2018 through 2020.

Figure 1: USAID’s Total Obligations for International FP/RH Assistance in 39 Countries, Fiscal Years 2018–2020



Sources: GAO analysis of U.S. Agency for International Development (USAID) data (data); Map Resources (map). | GAO-22-104228

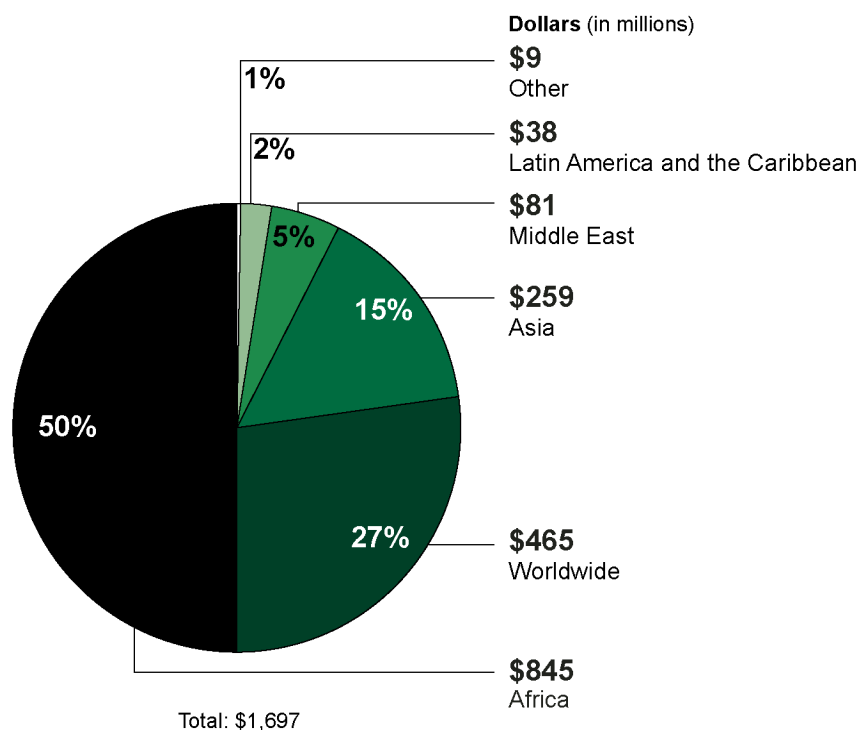
Notes: The obligations shown do not include those for regional and worldwide programs, which received about 31 percent of USAID’s obligations for FP/RH assistance (4 percent and 27 percent, respectively). Countries other than the 39 shown may also have received assistance through the regional obligations, according to USAID officials.

During this period, USAID obligated approximately \$845 million (about 50 percent of its total FP/RH obligations—the largest share) for countries and regional programs in Africa and approximately \$259 million (about 15 percent) for countries and regional programs in Asia. In addition, the agency obligated approximately \$465 million (about 27 percent) for worldwide programs. The remaining obligations were for countries and regional programs in Latin America and the Caribbean, in the Middle East, and in Europe and Eurasia.¹⁷ Figure 2 shows USAID’s total

¹⁷About \$9 million of the Asia and Near East Regional Program’s obligations for FP/RH supported assistance in countries in Asia as well as countries in the Middle East and cannot be disaggregated by region.

obligations for FP/RH assistance in geographic regions and for worldwide programs in fiscal years 2018 through 2020.

Figure 2: USAID’s Total Obligations for International FP/RH Assistance in Geographic Regions and for Worldwide Programs, Fiscal Years 2018–2020



Source: GAO analysis of U.S. Agency for International Development (USAID) data. | GAO-22-104228

Notes: USAID categorized obligations made centrally by the Bureau for Global Health and the Global Development Lab as “worldwide.” The category “other” represents obligations by the Asia and Near East Regional Program for FP/RH assistance in countries in Asia as well as countries in the Middle East and cannot be disaggregated by region. In addition to obligating the amounts shown, the agency obligated about \$22,000 (.001 percent) for assistance to Armenia in the Europe and Eurasia region.

USAID Funded a Variety of FP/RH Activities in the Selected Locations

In the three locations we selected for our review—Senegal, Uganda, and the West Africa Regional Program—USAID funded a variety of activities to improve access to family planning services and the quality of such services; increase demand for FP/RH services through media communications and outreach; procure contraceptives and support the contraceptive supply chain; and strengthen health care systems. Consistent with USAID’s 2015 strategy for reducing maternal mortality, many of these projects provided FP/RH assistance as well as assistance

Improvement of FP/RH
Services Access and Quality

that addressed other global health concerns, such as HIV/AIDS services, maternal and child health, and malaria prevention, according to USAID project documents.

In all three locations we examined, USAID's efforts to improve access to, and the quality of, FP/RH services included providing training or mentoring for health workers as well as supporting mobile clinics' efforts to deliver services to hard-to-reach populations where access is difficult and health infrastructure is poor, according to USAID documents. Further, projects often leveraged other areas of USAID's health assistance—such as HIV services, post-partum care, and nutrition programs—to deliver FP/RH services to clients, according to USAID documents. For example:

Training or mentoring. In Senegal, USAID supported training for health care providers that focused on youth sexual and reproductive health and service delivery. USAID also provided training to community health workers in Senegal to improve their capacity to offer short-term methods, pills, and injectables (both intramuscular and subcutaneous), according to USAID officials. In Uganda, USAID supported mentoring of health workers to provide clients with appropriate FP/RH information and counseling and with both short-term and long-acting reversible contraceptives. The West Africa Regional Program also provided training to community health workers that included improving their capacity to offer new methods of contraceptives (in addition to the common oral contraceptive pill and condoms) and counseling on contraceptive side effects. Figure 3 shows a midwife inserting a contraceptive implant at a primary health center in Côte d'Ivoire.

Figure 3: Implant Insertion at Daloa Health Facility in Côte d'Ivoire



Source: Dr. Anoh Adouko Georges, 2020. | GAO-22-104228

Mobile outreach clinics. According to USAID documents, all three selected USAID missions supported mobile outreach clinics that delivered FP/RH services to hard-to-reach populations where access is limited by a lack of skilled providers, commodities, and equipment. These mobile outreach clinics are intended to broaden the range of available contraceptive methods, including long-acting reversible contraceptives and permanent methods. In Senegal, where up to 70 percent of the population in some targeted districts can be reached only through mobile services, a USAID project provided mobile teams that consisted of a nurse and a midwife. The project supplied each team with a small vehicle to provide family planning services as well as antenatal, neonatal, and postnatal care. In Uganda, USAID supported mobile outreach clinics for underserved areas experiencing low contraceptive prevalence, high adolescent pregnancy, high fertility, and unmet need. In the West Africa Regional Program, a USAID project used mobile teams to deliver health services to Niger's remote and nomadic populations.

Leveraging other areas of USAID health assistance. Projects in all three locations provided FP/RH training to enable providers of postpartum health services to discuss the spacing of births or prevention of unplanned pregnancies with clients. Figure 4 shows postpartum family

planning counseling, supported by a USAID West Africa Regional Program activity, at a hospital in Côte d'Ivoire.

Figure 4: Postpartum Family Planning Counseling at General Hospital of Port-Bouet in Côte d'Ivoire



Source: Dr. Anoh Adouko Georges, 2020. | GAO-22-104228

Additional examples of USAID-funded projects that leveraged other health services to deliver FP/RH assistance include the following:

- A project in Senegal provided FP/RH counselling to women of reproductive age during malaria-prevention home visits.
- A project in Uganda offered family planning services at antiretroviral therapy clinics to women and adolescent girls living with HIV and to partners of men attending voluntary medical male circumcision camps or outreaches.
- A West Africa Regional Program project included distribution of contraceptives at sites that tested for sexually transmitted infections, including HIV, and delivered FP/RH services to mothers at malnutrition centers in Niger where children and infants required therapeutic feeding.

Use of Media and Outreach to Increase Demand for Services

USAID employed national and local mass media as well as community outreach to increase demand for FP/RH services in the three selected locations. These activities encouraged healthy practices, such as preventing early pregnancy, and addressed social norms and misconceptions that limit demand for FP/RH services (see text box).

Social Norms That Reduce Demand for FP/RH Services

USAID's media communications and outreach activities are designed to address social norms that reduce demand for family planning and reproductive health (FP/RH) services. The following are examples of the effects of social norms identified in USAID documents and by USAID officials, implementing partner representatives, and other donor officials from the three locations we selected for our review (Senegal, Uganda, and USAID's Ghana-based West Africa Regional Program):

- Limitations on women's access to services due to traditional gender roles that give men greater financial and decision-making power
- Reduced use of services as a result of early marriages and pressure to have large families
- Reduction in service access by teen girls due to stigma regarding FP/RH services, especially for young and unmarried women, and judgmental service providers
- Refusal to use contraceptives because of inadequate education or knowledge and persistent myths and misconceptions, including fear of side effects
- Reluctance of government officials and faith-based organization leaders to promote modern contraceptive methods

Twenty studies we reviewed also cited social norms—including stigma, traditional gender roles, and judgmental service providers—as limiting demand for FP/RH services.

Source: GAO analysis of information from U.S. Agency for International Development (USAID); organizations implementing USAID projects, known as implementing partners; other donors of FP/RH assistance; and studies of FP/RH assistance in developing countries. | GAO 22 104228

Media communications. In all three locations, USAID supported national and local media communications, such as radio and television public service announcements and programs, to encourage social behavior change, according to USAID documents. For example:

- In Senegal, USAID-supported media messages included encouraging mothers-in-law to support pregnant women to engage in family planning and other healthy practices.
- In Uganda, USAID media communications activities included building institutional capacity to conduct media campaigns with a toolkit of print and broadcast-ready materials and guidelines for implementation, according to a project document.
- In the West Africa Regional Program, USAID's media communications activities included a campaign called *Merci Mon Héros* that included videos of youth testimonials on reproductive health topics. Examples of such topics include first periods, family planning methods,

unprotected sex, and unplanned pregnancy. The campaign content was disseminated on television and radio stations in several countries in the West Africa region.

Community outreach. USAID also supported community outreach to adolescents and young women and men to encourage demand for FP/RH and prevent early pregnancies, according to project documents. For example:

- In Senegal, a USAID project included outreach to out-of-school youths that addressed topics such as combatting early pregnancy, early marriage, gender-based violence, and false beliefs about reproductive health.
- In Uganda, USAID’s outreach efforts included community dialogues targeting families, first-time parents, adolescent women, and cultural and religious leaders, according to a project document. The dialogues openly discussed social-cultural determinants of fertility, such as early marriages, polygamy, and unemployment. These dialogues took place in a variety of settings, including village savings and loan clubs, home visits, market days, and places of worship. Figure 5 shows residents in Northern Uganda at a community dialogue on family planning and gender-based violence, according to USAID officials.

Figure 5: Community Dialogue on Family Planning and Reproductive Health Issues in Kitgum District, Northern Uganda



Source: Comfort Aloyotoo, RHITES-N, Acholi, 2021. | GAO-22-104228

- In the West Africa Regional Program, as figure 6 shows, a USAID project in Togo worked with youth associations to create assemblies of potential “youth champions” to work at health facilities to encourage demand for FP/RH services.

Figure 6: Assembly of Potential Youth Champions in Togo to Encourage Family Planning at Health Facilities



Source: Teban Céline, 2021. | GAO-22-104228

Procurement of Contraceptive Commodities and Supply Chain Support

USAID’s FP/RH assistance included procurement and distribution of contraceptive commodities, including condoms, IUDs, oral and injectable contraceptives, and implants. USAID also funded technical assistance to improve supply systems—for example, automation to improve ordering and tracking of supplies—as well as strategic planning and budgeting to reduce stockouts of contraceptives.¹⁸ For example:

- In Senegal, USAID reported that it procured approximately 40 percent of contraceptives used in the public health system in fiscal year 2020 through routine channels and social marketing.¹⁹ USAID also paid for shipping costs and quality assurance services. In addition, USAID’s support for contraceptive supply chain management in Senegal

¹⁸A stockout is defined as the unavailability of one or more contraceptive options that, routinely or by policy, should be available at a health facility. UNFPA officials in Senegal told us that large cuts in the United Kingdom’s funding for the UNFPA Supplies Trust Fund, which provides contraceptives to women and girls in 46 countries, had already led to decreases in the quantities of contraceptives that the fund purchased for Senegal and in the fund’s family planning services in rural areas of Senegal. UNFPA and United Kingdom officials working in Uganda said that these funding cuts would likely lead to contraceptive commodity shortfalls in Uganda as well.

¹⁹Social marketing seeks to leverage marketing concepts to influence behaviors that benefit individuals and communities for the greater social good. See HIP Partnership, *High Impact Practices in Family Planning. Social Marketing: Using Marketing Principles and Techniques to Improve Contraceptive Access, Choice, and Use* (Washington, D.C.: Sept. 2021).

Strengthening of Health
Systems Related to FP/RH and
Other Global Health
Assistance

included new software to improve tracking of commodities at the district level and assistance to national drug stores to strategically plan, budget, warehouse, and distribute commodities.

- In Uganda, USAID projects included training in supply chain management practices and assistance with an electronic requisition system to help health facilities order contraceptive commodities on the basis of need and available funds, according to USAID officials.
- USAID's West Africa Regional Program supported the contraceptive supply chains in Burkina Faso, Togo, and Niger. This activity included implementation of an early warning system to prevent stockouts of contraception supplies, according to a USAID document.

In the three locations we examined, USAID supported technical assistance and training to strengthen health systems related to all areas of global health assistance, including FP/RH. Activities included support for human resources, health policies, strategic planning, and health care financing. For example:

- In Senegal, a USAID-funded project supported the development of policies and practices for recruitment and retention of health workers in underserved areas, promoted the use of human resource information systems to track the distribution of health workers, and enhanced training and supervision of the workers.
- In Uganda, a USAID-funded project provided training in local health districts and facilities on the use of data to plan, manage, and improve health services. Figure 7 shows training provided to district health management teams and facility managers in Northern Uganda. Another project supported capacity building for private sector systems in Uganda through training and mentorship sessions for managers of health facilities affiliated with Ugandan faith-based medical bureaus.²⁰ This project also provided technical assistance to the Ministry of Health to support the development of a plan for sustainable health sector financing.

²⁰These bureaus are the Uganda Catholic Medical Bureau, the Uganda Protestant Medical Bureau, the Uganda Muslim Medical Bureau, and the Uganda Orthodox Medical Bureau.

Figure 7: Training for District Health Management Teams and Facility Managers in Dokolo District, Northern Uganda



Source: Peter Alani, John Snow Inc./RHITES-N, Lango, 2020. | GAO-22-104228

- USAID’s West Africa Regional Program supported activities to improve the capacity of the regional West Africa Health Organization.²¹ One of these activities consisted of advocacy for developing “task shifting” policies that would allow nonmedical workers to provide family planning services that could otherwise be performed only by doctors and nurses, according to USAID officials. Another activity supported the West Africa Health Organization’s implementation of a strategic plan for public–private partnership in the region’s health sector.

²¹The West Africa Health Organization is the specialized health agency for the Economic Community of West African States, a regional political and economic union of 15 West African countries.

USAID Found New Partners to Fill Most Service Gaps Linked to PLGHA Policy, but Some Adverse Effects May Have Continued

FP/RH service providers with active USAID awards that declined the PLGHA terms and conditions received no further global health funding under their awards, resulting in several adverse effects on the implementation of FP/RH services. Such effects included gaps and delays in delivery of some services after two of the largest FP/RH providers declined the PLGHA terms and conditions, according to USAID officials and other sources. According to an interagency review in 2020, USAID and its implementing partners found new partners to fill most service gaps. However, according to representatives of current and former implementing partners and USAID and other donor officials, as well as studies we reviewed, the PLGHA policy had other adverse effects—reduced provision and coordination of FP/RH services, reduced access to trusted providers, diversion of resources from serving clients, and reduced trust in the U.S. government—some of which may have continued after the policy’s January 2021 rescission. In addition, some studies we reviewed linked the PLGHA policy to reduced contraceptive use and increased unplanned pregnancies and abortions.

Some Service Gaps and Delays Resulted from Loss of Further Funding for Partners That Declined PLGHA Terms

Some gaps and delays in the delivery of FP/RH services resulted from the loss of additional funding under existing awards for USAID implementing partners that declined the PLGHA terms and conditions.²² According to our 2020 report, relatively few declined the terms and conditions.²³ However, two that did—MSI Reproductive Choices (MSI) and the International Planned Parenthood Federation (IPPF)—are major providers of global family planning assistance.²⁴ As we reported in 2020,

²²Other donors provided some funding for USAID implementing partners that declined the PLGHA terms and conditions, which allowed them to continue their activities in a reduced capacity. For example, in Uganda and the West Africa region, the United Kingdom, UNFPA, the Gates Foundation, or other donors mobilized to bridge some gaps in services by providing funding to partners that declined the PLGHA terms and conditions, according to donor representatives in these locations.

²³See [GAO-20-347](#). This report examined declinations of the PLGHA terms and conditions in all areas of U.S. global health assistance, including FP/RH assistance.

²⁴According to a study published in *The Lancet*, MSI and IPPF are two of the largest international family planning organizations. See Nina Brooks, Eran Bendavid, and Grant Miller, “USA Aid Policy and Induced Abortion in Sub-Saharan Africa: An Analysis of the Mexico City Policy,” *The Lancet Global Health*, vol. 7 (2019). MSI’s website states that MSI works in 37 countries and served 12.8 million clients in 34,000 sites in 2020. MSI representatives told us that, relative to other implementing partners, their organization provides a wider choice of contraceptive methods, including longer-term options, and its services extend further into rural areas and to marginalized groups. According to IPPF, the organization has 118 affiliated member associations working in 142 countries. Both MSI and IPPF are foreign NGOs, headquartered in the United Kingdom.

MSI and IPPF were the implementing partners for the two largest USAID awards that awardees declined because of the PLGHA terms and conditions.²⁵ In addition, local MSI and IPPF affiliates implementing many subawards ceased receiving funding because they also declined the PLGHA terms and conditions.

We identified examples of service gaps and delays that resulted from MSI's and IPPF's declining the PLGHA terms and conditions in each of the three locations we selected for our review, including:

Senegal. USAID officials stated that one implementing partner in Senegal had to recruit all new personnel when a local MSI affiliate, a subawardee, declined the PLGHA terms and conditions. According to representatives of this implementing partner, this delayed the delivery of family planning services by at least 6 months and caused gaps in mobile clinic services.²⁶ A 2020 U.S. government interagency review of the implementation of the PLGHA policy said that despite the partner's efforts to intensify mobile outreach efforts, the project experienced gaps in mobile family planning for 7 to 8 months.²⁷ Implementing partner representatives said these gaps may have contributed to a lack of progress for a key indicator—access to contraceptives—in the regions where USAID was funding MSI.

²⁵See [GAO-20-347](#). The MSI and IPPF awards included mobile family planning and reproductive health outreach activities to underserved, rural populations in multiple countries. Although MSI and IPPF were able to obtain some funding from other donors when their USAID awards were suspended, the additional funds fell far short of the funds provided by USAID, according to the organizations' representatives.

²⁶According to a November 2018 report on preliminary impacts of the PLGHA policy in Senegal by Population Action International (PAI), MSI provided family planning services in 12 of Senegal's 14 regions, with 11 mobile outreach teams assisting rural women who lacked access to clinics. The report stated that in 2017, MSI Senegal reached more than 65,000 clients for family planning, more than 23,000 for cervical cancer testing, and more than 15,000 for sexually transmitted infection treatments. According to the report, MSI also targeted youths for services and contraception with mobile outreach in schools and other public spaces. See Population Action International, *Access Denied: Senegal. Preliminary Impacts of Trump's Expanded Global Gag Rule* (Washington, D.C.: Nov. 2018). According to its website, PAI advocates for accessible, quality health care and the sexual and reproductive rights of women, girls, and other vulnerable groups.

²⁷Department of State, *Review of the Implementation of the Protecting Life in Global Health Assistance Policy* (Aug. 18, 2020). State released the report in conjunction with the Department of Defense, Department of Health and Human Services, and USAID. This review covered all U.S. global health assistance, including FP/RH assistance.

Uganda. According to IPPF representatives, Reproductive Health Uganda²⁸—an IPPF affiliate—implemented, as a subawardee, a variety of U.S.-funded FP/RH programs that were abruptly terminated in 2017 when it declined the PLGHA terms and conditions.²⁹ According to the representatives, these terminations led to large-scale interruptions of programs and services, including the introduction of a new contraceptive that women can self-administer,³⁰ programs on male engagement in family planning,³¹ and research initiatives on approaches to improve health services.³²

A 2020 study based on surveys and interviews conducted in Uganda in early 2017 and in 2018, shortly before and after the PLGHA policy was implemented, found that the policy negatively affected certain FP/RH

²⁸According to IPPF representatives, Reproductive Health Uganda has a network of stationary and mobile clinics and also conducts community outreach activities to promote FP/RH.

²⁹According to USAID, the terminated programs involved policy and advocacy, not delivery of FP/RH services.

³⁰This contraceptive, which protects against pregnancy for 3 months, is an easy-to-use injectable that combines the contraceptive drug and a needle in a prefilled system, according to PATH, the organization that developed it. According to PATH, injectable contraceptives previously could be administered only with a separate vial and syringe and often only by highly trained health care providers at facilities. As a result, obtaining these contraceptives was difficult for women facing long journeys to clinics, long waits for service, and occasional stockouts of syringes.

³¹IPPF representatives stated that male engagement in family planning involves working with male partners and leaders to support women's access to voluntary family planning—for example, by addressing myths about different contraceptive methods and fertility. According to the representatives, male engagement also involves encouraging men to support communication with female partners and support women's access to time and financial resources to obtain counseling and care for family planning and contraception.

³²According to a March 2018 PAI report on preliminary impacts of the PLGHA policy in Uganda, Reproductive Health Uganda and MSI were two of the largest contraceptive distributors in the country. See Population Action International, *Access Denied: Uganda. Preliminary Impacts of Trump's Expanded Global Gag Rule* (Washington, D.C.: Mar. 2018).

activities.³³ According to the study, one implementing partner that declined the PLGHA terms and conditions stopped receiving a large proportion of funding for its mobile outreach program, which provided additional trained staff, information, services, contraceptives, and supplies to public facilities and other venues in communities where these services were not adequately available. As a result, the partner had to cut back or discontinue several outreach teams. Another partner reported that several USAID-funded programs ended prematurely because it stopped receiving funding for staff salaries. These programs provided training and technical assistance for public facilities, community education on family planning methods, and other sexual and reproductive health–related advocacy.

West Africa Regional Program. The 2020 interagency review of the PLGHA policy’s implementation stated that in some instances, USAID struggled to find replacement partners to replicate IPPF’s and MSI’s efforts in the West Africa region.³⁴ For example, according to the review, no other organizations in Togo were prepared to implement integrated, voluntary family planning through both mobile outreach and local fixed clinics, as IPPF affiliates had been doing.³⁵ USAID officials managing the West Africa Regional Program said that because the region lacks an adequate number of health care clinics, IPPF’s loss of U.S. funding could lead to a loss of FP/RH services, including access to contraceptives, in high-population areas.³⁶

³³Margaret Giorgio et al., “Investigating the Early Impact of the Trump Administration’s Global Gag Rule on Sexual and Reproductive Health Service Delivery in Uganda,” *PLoS ONE* (Apr. 28, 2020). Although the study’s authors stated that they had observed no immediate impact of the policy on the provision of long-acting reversible contraceptives, contraceptive stockouts, mobile outreach services, service integration, or quality of care, they observed a significant impact on the average number of community health workers in certain facilities. They concluded that the reduction in these workers could reduce contraceptive use and increase unintended pregnancies in Uganda. They further concluded that the lack of other significant findings may not be surprising given the short amount of time between the implementation of the PLGHA policy and their subsequent observations in Uganda.

³⁴Department of State, *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*.

³⁵According to the review, this was also true for one other West African country, Liberia. According to USAID officials administering the West Africa Regional Program, the program provides FP/RH assistance directly to Togo and three other countries in the West Africa region (Burkina Faso, Côte d’Ivoire, and Niger).

³⁶The officials said USAID had not studied the impact of the loss of funding for IPPF clinics in West Africa on access to family planning services.

Representatives of a USAID implementing partner in West Africa said that as a result of IPPF's loss of funding, providers were unable to refer youths to IPPF's youth-friendly centers, which were well known in the community. They also said that IPPF had provided training to community health workers and that the loss of IPPF as a partner made it more difficult to expand training for these workers.

According to representatives of private foundations providing FP/RH assistance in West Africa, MSI also had to reduce its service delivery. The representatives said the mobile clinics MSI operated in rural communities provided contraceptives, including implants—popular because the contraceptive effects last for several years—and that any cutbacks in rural areas reduced access to these contraceptives.

Over Time, USAID and Implementing Partners Identified New Partners to Fill Most Gaps in Services

For most projects, USAID or the primary implementing partner successfully transitioned activities to ensure the continuity of global health assistance previously provided by an implementing partner or subawardee that declined the PLGHA terms and conditions, according to the 2020 interagency review of the policy's implementation.³⁷

In Senegal, USAID officials told us that primary implementing partners took varying amounts of time to fill gaps in FP/RH services resulting from MSI's declining the PLGHA terms and conditions. Representatives of one partner said it took at least 6 months to replace MSI's mobile clinics with newly hired staff at government-run clinics. According to USAID officials, another partner replaced MSI's clinics with services provided by a local NGO that worked with many of the same nurses and midwives as MSI and, as a result, experienced less delay. The officials said the government clinics are providing the same services and using the same approach as MSI did and the local NGO is providing the same quality of service as MSI provided.

³⁷Department of State, *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*.

PLGHA Policy Had Other Adverse Effects, Some of Which May Have Continued after Its Rescission

Reduced Provision and Coordination of FP/RH Services

Confusion about the policy and fear of violating it caused some implementing partners that accepted the PLGHA terms and conditions to reduce their provision of FP/RH services as well as their coordination with former implementing partners that declined the terms and conditions, according to studies we reviewed and representatives of the former partners.

Reduced Provision of Services

Ten of the 55 studies we reviewed found that implementing partners reduced their services while the policy was in effect because of confusion about its requirements as well as fear of losing funding.³⁸ For example, according to a 2020 multicountry study focused on the President’s Emergency Plan for AIDS Relief (PEPFAR), its survey findings showed that a broad range of sexual and reproductive health services and advocacy initiatives unrelated to abortion were reduced or stopped in response to the PLGHA policy.³⁹ The study noted that previous data had

³⁸According to the 2020 interagency review of the PLGHA policy’s implementation, USAID had previously provided training and guidance to agency staff and implementing partners to help them understand and carry out the policy while it was in effect. This training and guidance included in-person training for agency staff in Washington, D.C., and overseas missions and for implementing partners; meetings with prime implementers to provide updates regarding the policy; and annual calls with USAID missions. See Department of State, *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. In addition, USAID issued detailed lists of frequently asked questions and answers on the policy in September 2018 and October 2019.

³⁹Jennifer Sherwood et al., “Restrictions on U.S. Global Health Assistance Reduce Key Health Services in Supported Countries,” *Health Affairs*, vol. 39, no. 9 (Sept. 2020): 1557–1565. This study focused on the PLGHA policy’s effects on U.S. funded HIV programming under PEPFAR. As we have reported previously, this U.S. program oversees about \$6 billion annually across several U.S. implementing agencies and two international organizations to address the HIV epidemic. See GAO, *President’s Emergency Plan for AIDS Relief: State Should Improve Data Quality and Assess Long-Term Resource Needs*, [GAO-21-374](#) (Washington, D.C.: May 20, 2021). We cite this and a related study focused on PEPFAR because the PLGHA policy affected all global health assistance, including FP/RH activities integrated into other programs, such as PEPFAR. We cite these studies only as they relate to the PLGHA policy’s effect on FP/RH activities.

shown that confusion about the policy’s requirements had led organizations to stop providing allowable services such as emergency contraception or referrals for other types of family planning.⁴⁰

The multicountry study stated that “over implementation” of the policy by implementing partners was taking place against a background of intense pressure not to lose U.S. funding. According to the study, this often resulted in risk-averse behavior such as unnecessarily cutting services or severing partnerships. The study further stated that these cuts likely decreased global access to sexual and reproductive health information and the availability of integrated services that are established best practices in the field.

A related 2019 study that surveyed organizations implementing PEPFAR in 45 countries found that implementing partners across multiple PEPFAR countries were altering operations in response to the PLGHA policy, regardless of the country’s abortion laws.⁴¹ The study documented the greatest disruption of services in countries with major HIV epidemics, such as South Africa, Eswatini,⁴² and Mozambique. According to the study, sexual and reproductive health information and service delivery were undermined, with an increased risk for vulnerable populations that are more reliant on outreach services and integrated health care models.

According to a 2020 study focused on Nepal, the prohibitions imposed by the PLGHA policy and the fear it engendered disrupted that country’s health system by undermining sexual and reproductive health

⁴⁰USAID officials stated that implementing partners for global health programs that were not focused on FP/RH, such as PEPFAR, were likely less prepared and less able to navigate the PLGHA policy than implementing partners focused on FP/RH. The officials noted that many of these implementing partners had previously received USAID funding that was not affected by the Mexico City Policy, which applied only to foreign organizations’ FP/RH assistance.

⁴¹amfAR, The Foundation for AIDS Research, *The Effect of the Expanded Mexico City Policy on HIV/AIDS Programming: Evidence from the PEPFAR Implementing Partners Survey*, Issue Brief (January 2019).

⁴²According to USAID, South Africa and Swaziland (now Eswatini) do not receive USAID FP/RH assistance. Nevertheless, the PLGHA policy affected FP/RH activities even in countries that do not receive funding from USAID specifically for FP/RH. For example, according to the study, in Eswatini—a country that the study noted has highly restrictive abortion laws—one former implementing partner said the policy diverted funds away from trusted providers of youth-friendly FP/RH care, resulting in the termination of outreach services that primarily benefited youths.

coordination, NGO partnerships, referral relationships, and service provision.⁴³ The study stated that these negative effects risked undoing some of the gains realized through USAID's long-term investment and partnership with foreign NGOs and Nepal's ministry of health to increase family planning access and utilization. For example, the study found that representatives of three organizations that had accepted the PLGHA terms and conditions did not make any abortion referrals, including in cases of rape, incest, or danger to the pregnant person's life—exceptions allowed by the policy—because they feared losing U.S. government funding. According to the study, it was not clear whether this overinterpretation reflected a deliberate choice to err on the side of caution or stemmed from incomplete knowledge of the policy's provisions.

Reduced Coordination of Services

Some implementing partners that accepted the PLGHA terms and conditions also reduced their coordination with providers that had declined them. For example, IPPF representatives told us that some implementing partners feared associating with IPPF would jeopardize their access to U.S. funding. As a result, according to the representatives, the PLGHA policy reduced collaboration between IPPF and other health care providers at international conferences and in working groups that served as forums for sharing expertise in family planning services. Similarly, according to five of the studies we reviewed, some partners that had accepted the PLGHA terms and conditions reduced their coordination with organizations that were operating with funding from other sources after declining the terms and conditions.

According to USAID officials, after the President rescinded the PLGHA policy on January 28, 2021, the agency took a number of actions to inform staff and implementing partners that the policy was no longer in effect.⁴⁴ However, lingering confusion about the policy continued to

⁴³Jyotsna Tamang et al., "Foreign Ideology vs. National Priority: Impacts of the U.S. Global Gag Rule on Nepal's Sexual and Reproductive Healthcare System," *Sexual and Reproductive Health Matters*, vol. 28, no. 3 (2020): 5–22.

⁴⁴According to USAID officials, USAID's actions included waiving the PLGHA conditions in all existing awards; revising the standard provisions for assistance awards to remove the PLGHA provision and issuing a notice announcing this change; informing all USAID award recipients about the policy's rescission through the agency's Implementing Partner Notices web portal; emailing the web portal link to USAID's Global Health Bureau, mission directors, and other relevant officials; telephoning mission staff to remind them to review the PLGHA rescission with implementing partners; and updating its public website to reflect the PLGHA rescission.

reduce collaboration even after its rescission, according to implementing partners that had declined the PLGHA terms and conditions. MSI representatives told us in April 2021—3 months after the rescission—that although MSI had data that could help other organizations deliver services more efficiently, these organizations were unwilling to engage with MSI because they feared doing so would cause them to lose their USAID funding.

MSI representatives informed us in February 2022 that although collaboration with other organizations had improved, some organizations, including governments, were still hesitant to engage with MSI, particularly at the country level.⁴⁵ For example, according to the representatives, health ministry officials in one country believed that MSI was not eligible to receive USAID-funded family planning commodities because the officials were not aware the policy had been rescinded.⁴⁶

Reduced Access to Trusted Providers of FP/RH Services

According to various sources, access to trusted providers of FP/RH services with established capacity and expertise diminished as a result of the PLGHA policy—an effect that may continue in some cases, even after its rescission—because of communities’ reluctance to access new providers, the time needed to obtain new USAID awards, and the possibility of the policy’s reinstatement.

Reluctance to access new providers. Target populations showed reluctance to access new FP/RH service providers that had accepted the PLGHA terms and conditions and replaced trusted organizations, according to representatives of providers that rejected the terms and conditions and to other sources. For example, IPPF representatives stated that IPPF’s clinics are well established in local communities and that clients from these populations would likely be less willing to visit

⁴⁵The PLGHA policy did not apply to assistance provided directly to national governments, such as ministries of health. However, according to USAID, the U.S. government places other abortion-related restrictions, required by law, on U.S. foreign assistance provided directly to foreign government entities; such assistance may not support any abortion activities provided by the foreign government entity, and the assistance must be placed in a separate account to ensure this.

⁴⁶MSI representatives told us that MSI’s contracts with government health ministries ended while the policy was in effect.

replacement clinics, such as those run by government agencies.⁴⁷ According to the IPPF representatives, local IPPF affiliates reported that clients seeking family planning services were reluctant to visit government-run facilities because of the stigma associated with situations they were experiencing, such as domestic abuse.

Although some entities have the capacity to replace MSI, establishing relationships and building trust with the communities in hard-to-reach rural areas that were served by MSI's mobile clinics is not easy, according to a 2018 Population Action International report on the PLGHA policy's preliminary impacts in Senegal.⁴⁸ MSI representatives told us that their organization has 50,000 outreach sites and 10,000 team members and, over time, has developed relationships with local community gatekeepers, such as religious leaders and men's groups.

Time needed to obtain new USAID awards. According to USAID officials, because USAID's award process can take up to a year, organizations with established capacity and expertise that had declined the PLGHA terms and conditions were unable to immediately obtain agency awards and funding when the policy was rescinded. Representatives of both MSI and IPPF told us that for this reason, they could not quickly secure USAID funding after the policy's rescission.⁴⁹ These organizations also noted that they were unable to compete for several large, 5-year awards that USAID made in 2020, while the policy was still in effect, because they continued to decline the PLGHA terms and conditions.⁵⁰

⁴⁷According to IPPF representatives, IPPF specializes in providing nondiscriminatory care—for example, to hard-to-reach rural populations—which helps overcome local stigmas associated with family planning services.

⁴⁸Population Action International, *Access Denied: Senegal*.

⁴⁹MSI representatives told us that securing new USAID funding takes about a year. IPPF representatives said the USAID procurement process takes about 9 to 12 months once the agency posts a request for proposals. According to MSI and IPPF representatives, as of February 2022, both organizations had bid on USAID projects, primarily in a subawardee role within broader consortiums, but had not yet secured new USAID project funding. IPPF representatives told us that some local IPPF affiliates had received small subawards, the largest for a few hundred thousand dollars. USAID officials told us in April 2022 that IPPF was a subawardee for a global health award entered into in March 2022.

⁵⁰IPPF and MSI publicly stated that they could not meet the PLGHA terms and conditions because abortion services or referrals are part of the reproductive health care services the organizations provide and are a right to which their patients are entitled.

Possibility of policy’s reinstatement. According to representatives of a major FP/RH service provider that declined the PLGHA terms and conditions, the possibility of the policy’s reinstatement makes current USAID implementing partners hesitant to include that provider as a participant in bids for new projects, because they cannot be sure of its ability to participate for the projects’ duration.

Diversion of Resources from
Serving Clients

According to five of the studies we reviewed, diversion of resources from serving clients to complying with the PLGHA policy (for implementing partners that accepted the PLGHA terms and conditions) or seeking alternative funding (for implementing partners that did not) slowed the provision of FP/RH services.⁵¹ For example, according to a Population Action International policy brief of research in Burkina Faso, Ethiopia, India, Kenya, Nepal, Nigeria, Senegal, and Uganda, the PLGHA policy imposed costs both for NGOs that accepted the PLGHA terms and conditions and for NGOs that did not.⁵²

According to the study, NGOs spent resources on, among other costs, covering unanticipated overhead and seeking clarification from funders, which detracted from service provision and directly affected clients and beneficiaries. For example, the study found that services implemented by an organization in Uganda that accepted the PLGHA terms and conditions fell 4 to 6 months behind because of the expenditure of staff time and resources on legal and administrative fees and on office and personnel changes to comply with the policy. The study also found that an organization in Nigeria that declined the PLGHA terms and conditions expended significant resources on raising funds in the region and hiring staff with expertise in U.S. policy and in fundraising to identify funding sources to replace multiple USAID grants.

Reduced Trust in U.S.
Government

Some foreign NGOs have expressed reduced trust in the U.S. government because of the intermittent reinstatement of the Mexico City and PLGHA policies, according to USAID and other donor officials. For example, the “on again, off again” nature of the Mexico City Policy and its

⁵¹According to the 2020 interagency review of the policy’s implementation, 60 percent of the awards with declinations included funding for the provision of health care to clients. The remaining 40 percent focused on other types of health activities, such as increasing demand for FP/RH services, procuring contraceptive commodities and supporting contraceptive supply chains, and strengthening health systems.

⁵²Population Action International, *So Far, So Bad: The Wide-Ranging Impacts of the Global Gag Rule Happening Now* (Washington, D.C.). This report is undated but refers to information dated April 2018 and earlier.

expansion into the PLGHA policy have contributed to a perception that the policy was not focused on development goals, according to non-U.S. donor officials in Uganda. The officials said that this has undermined trust in the U.S. government among members of the NGO community and could in turn reduce U.S. influence.

The officials also noted that one major FP/RH implementing partner is now considering alternative funding sources. In addition, USAID officials told us the policy continues to affect some organizations that may be reluctant to seek USAID funding because of the risk of losing funds if the policy is reinstated.

Some Studies Linked PLGHA Policy to Reduced Contraceptive Use and Increased Unplanned Pregnancies and Abortions

Fourteen of the studies we reviewed linked the PLGHA policy or its predecessor during certain administrations, the Mexico City Policy, to decreased contraceptive use, increased unplanned pregnancies, or increased abortions.⁵³ Five of these studies linked the policy to all of these outcomes. One of the five studies also identified some locations where the policy was associated with decreased abortions.

For example, a 2019 study that analyzed data from 26 sub-Saharan African countries found that the restrictions imposed by the Mexico City Policy resulted in a reduction in modern contraceptive use, an increase in pregnancies, and an increase in abortions among women living in countries highly affected by the policy during periods when it was in force.⁵⁴ The study also found these trends reversed when the policy was not in force. According to the study, the increased abortions were likely to be unsafe and may also have led to a rise in maternal deaths, because

⁵³USAID officials stated that it is difficult to attribute population-level changes in use of FP/RH services to the PLGHA policy alone, since other factors may affect FP/RH service delivery in a given country. In some cases where USAID has seen a dip in use of FP/RH services in Uganda, USAID officials in that country attributed the dip to supply chain issues such as stockouts or to human resource issues. For a discussion of the PLGHA policy's effects on human resources and the use of FP/RH services in Uganda, see Giorgio et al., "Investigating the Early Impact of the Trump Administration's Global Gag Rule on Sexual and Reproductive Health Service Delivery in Uganda."

⁵⁴Brooks, Bendavid, and Miller, "USA Aid Policy and Induced Abortion in Sub-Saharan Africa."

they were less likely to be performed or guided by experienced organizations and providers.⁵⁵

Another 2019 study summarized findings from several organizations that collected data from countries in sub-Saharan Africa and Asia regarding the early impacts of the PLGHA policy.⁵⁶ According to the study, these early results suggested that the Mexico City Policy and the PLGHA policy produced the same chain of consequences: reduced access to contraception and increased unintended pregnancies, unsafe abortions, and poor birth spacing. In addition, according to the study, the findings revealed negative effects on organizational resources, including family planning program budget cuts, staff terminations, clinic closures, and increased costs passed to patients for contraceptive services.

A 2020 study analyzing information from 48 prior studies presented similar findings.⁵⁷ According to this study, organizations involved in abortion-related activities are key suppliers of contraceptives. The authors stated that reductions in funding to these organizations due to the Mexico City Policy and its expansion as the PLGHA policy affected abortion access and led to increased maternal illness and death as a result of diminished access to contraception and perinatal care, resulting in higher pregnancy rates, unsafe abortions, and pregnancy and birth complications.

⁵⁵USAID characterized this study's approach as flawed, stating that the data on abortions were limited and poor and that the data on contraceptive use were incomplete. USAID also stated that the study's use of U.S. country-level FP/RH funding as a proxy for the PLGHA policy's impact ignored other country-level factors that may have affected modern contraceptive use, unplanned pregnancies, and abortions. USAID further stated that some of the countries in the sample received little or no U.S. FP/RH funding during the study period. The study's authors acknowledged such concerns and described statistical modeling efforts to mitigate limitations. They also noted aspects of the analysis that underestimated the PLGHA policy's effects. For example, the available abortion data underestimated the impact of the policy because women underreport abortions on country health surveys.

⁵⁶American Public Health Association, *Preventing and Reducing the Harm of the Protecting Life in Global Health Assistance Policy in Global Public Health* (Nov. 5, 2019)

⁵⁷Suzie Lane, Sonja Ayeb-Karlsson, and Arianne Shahvisi, "Impacts of the Global Gag Rule on Sexual and Reproductive Health and Rights in the Global South: A Scoping Review," *Global Public Health* (Nov. 5, 2020). The 48 studies included some that we reviewed and many that we did not. The authors culled the 48 studies from over 300 items captured by their search, excluding opinion pieces, news articles, and mass media articles, many of which were sensationalist and of poor quality. They also excluded articles that did not contribute any new information or that cited findings from articles already included in the review.

The study described findings related to specific countries and regions, noting that the policy was linked to increased abortions in some cases and to decreased abortions in other cases. According to the study, four of six prior studies investigating the policy's effect on abortion rates found a significant increase in the likelihood of abortion in sub-Saharan Africa. One of the six studies found a substantial increase in the likelihood of abortion in Latin America and sub-Saharan Africa but a decrease in Eastern Europe and in Asia. Another of the studies found a decrease in the likelihood of abortion in Ethiopia.

USAID and Implementing Partners in Selected Locations Reported Taking Steps to Address Challenges Caused by the COVID-19 Pandemic

USAID and implementing partners in Senegal, Uganda, and the West Africa region reported taking steps to address challenges caused by the COVID-19 pandemic that affected FP/RH service delivery, according to USAID officials, implementing partner representatives, and a UN study.⁵⁸ For example:

- **Reduced access to health facilities.** Fear of COVID-19 infection, social distancing requirements, and transportation constraints limited access to health facilities. To reduce women's need to access clinics, USAID implementing partners in all three locations took steps that included prescribing oral contraceptives to cover longer intervals and encouraging use of longer-lasting contraceptive methods, such as injections that women can self-administer. Implementing partners also provided family planning commodities in ways that did not require clients to come to clinics. For example, in Uganda, peer counselors disseminated contraceptives when they visited adolescent girls in their homes or met with groups of girls at designated times and places nearby. Also in Uganda, health workers visiting HIV-positive clients delivered contraceptives along with antiretroviral pills.
- **Reduced in-person outreach to teens and young adults.** The pandemic has most greatly affected outreach activities—especially those conducted in person—to raise awareness about contraceptives, according to donor officials from the United Kingdom's Foreign, Commonwealth and Development Office. The officials said the loss of face-to-face contact particularly hampers outreach to adolescents,

⁵⁸FP2020, *Family Planning in the Time of COVID* (Washington, D.C.: United Nations Foundation, 2021). Nine of the studies we reviewed described effects of the pandemic on FP/RH service provision and responses to these effects. See appendix III for a summary of steps that USAID or its implementing partners reported taking to mitigate the pandemic's effects on FP/RH project activities in Senegal, Uganda, and the West Africa Regional Program. Because the COVID-19 pandemic is recent, ongoing, and evolving, we are unable to assess the long-term efficacy of these steps.

who are best approached in person and in small groups. To reach teens and young adults in the COVID-19 environment, a USAID implementing partner covering the West Africa region strengthened its online and social media strategy, for example, by including messages from popular influencers such as musicians.

- **Limited availability of health workers due to initial personal protective equipment (PPE) shortages.**⁵⁹ In Senegal, the pandemic resulted in limited availability of health workers due to PPE shortages. To address this challenge, representatives of one implementing partner told us they obtained USAID authorization to procure locally sourced masks and gloves. Representatives of an implementing partner covering the West Africa region said they developed a plan to provide PPE with the help of the United Nations Population Fund (UNFPA) in Togo. According to the representatives, another partner contributed to this plan by informing the public that health facilities remained open and would provide clients with masks.
- **Reduced ability to communicate and plan.** To reach health facility managers, health care workers, and clients, implementing partners used cell phones and mobile apps to compensate for social distancing requirements and lockdowns, which limited in-person gatherings, and for poor internet connectivity for virtual meetings. For example, a partner in Uganda facilitated meetings with community health workers and the district health officer by providing increased phone airtime. A partner covering the West Africa region used WhatsApp to pretest materials with family planning messages and also provided internet credit and modems to facilitate communication with government officials by increasing participants' bandwidth.

⁵⁹On March 20, 2020, the USAID COVID-19 Task Force notified USAID's Bureau for Humanitarian Assistance that no USAID funds could be used to procure PPE. According to bureau officials, it was initially unclear how to handle applications that had already been submitted with PPE components, which constituted most applications. Specifically, the restriction notice did not specify which types of PPE were covered or whether USAID would make exceptions for emergency humanitarian programming. On June 9, 2020, the USAID COVID-19 Task Force approved revised guidance on award language that loosened the restriction by allowing procurement of PPE without prior USAID authorization under specified conditions. The revised guidance allowed implementers to procure PPE from any source if it was to be used by the implementers' staff. However, any PPE intended for beneficiaries of USAID programs had to be procured locally or in the same region where USAID was providing assistance, as long as the PPE was not, and could not reasonably be, intended for the United States. See GAO, "International Humanitarian Assistance" in *COVID-19: Sustained Federal Action Is Crucial as Pandemic Enters Its Second Year*, [GAO-21-387](#) (Washington, D.C.: Mar. 31, 2021).

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- **Supply chain disruptions.** A 2021 study we reviewed found that supply chains for contraceptive commodities were seriously disrupted at the start of the pandemic. According to the study, two-thirds of the 103 countries surveyed by the World Health Organization reported disruptions to family planning and contraceptive services.⁶⁰ However, the study found that the supply chains have largely recovered owing to global effort and collaboration. According to the study, UNFPA and the USAID Global Health Supply Chain Program moved quickly to cope with these disruptions, working closely with governments and other partners to prioritize supply requests, orders, shipments, production schedules, and other operational aspects of procurement.

USAID provided missions with technical considerations for ensuring the continued provision of FP/RH goods and services during the pandemic. USAID also solicited input from mission staff due to the evolving nature of the situation. USAID recommended that missions take the following actions, among others:

- Engage with government counterparts to make sure that FP commodities were included in any list of essential drugs identified for special consideration during the pandemic
- Collaborate with the private sector by considering alternative forms of commodity distribution—such as through pharmacies and drug shops—in areas where community health workers may no longer be visiting homes and by strengthening ties with private sector clinics and pharmacies to relieve pressure on public health facilities
- Implement World Health Organization guidelines on the rational use of PPE in the event of shortages
- Integrate family planning messages with broader health communication efforts aimed at addressing the pandemic
- Address the needs of adolescent populations who may be out of school because of lockdowns and therefore more vulnerable to

⁶⁰FP2020, *Family Planning in the Time of COVID* (Washington, D.C.: United Nations Foundation, 2021).

unintended pregnancy, sexually transmitted infections, and harmful traditional practices such as child marriage⁶¹

- Ensure the availability of FP/RH goods and services to other vulnerable populations, such as HIV-positive individuals, and women and girls who may be experiencing increased intimate-partner or gender-based violence due to the added stress and isolation of COVID-19 lockdowns

Agency Comments

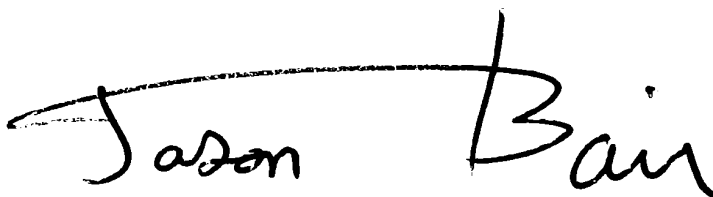
We provided a draft of this report to USAID for review and comment. USAID provided written comments, which are reproduced in appendix IV. USAID also provided technical comments, which we incorporated as appropriate.

In its written comments, USAID expressed appreciation for our documentation of implementation challenges related to the PLGHA policy and the COVID-19 pandemic and actions taken in response. USAID also noted that our findings regarding implementation of the PLGHA policy aligned with findings in the interagency review released by the Department of State and other agencies in August 2020.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 6 days from the report date. At that time, we will send copies to the appropriate congressional committees and the Administrator of the U.S. Agency for International Development. In addition, the report will be available at no charge on the GAO website at <https://www.gao.gov>.

⁶¹According to donor officials from the United Kingdom's Foreign, Commonwealth and Development Office in Uganda, the Ugandan government reported a substantial increase in teenage pregnancies across the country that may be associated with school shutdowns during the pandemic. The officials said data have shown a strong correlation between keeping girls in school and delaying first births. According to USAID officials in Uganda, schools were locked down twice, in 2020 and 2021, for several months each time, and all schools reopened in January 2022. The USAID officials said that data from antenatal clinics indicate that the country's teen pregnancy rate, while high, remained stable from 2019 through 2021. However, the officials noted that these data underestimate pregnancy rates, as they reflect pregnancies only for individuals who visited health facilities.

If you or your staff have any questions about this report, please contact me at (202) 512- 6881 or bairj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.

A handwritten signature in black ink that reads "Jason Bair". The signature is written in a cursive style with a long horizontal stroke over the word "Jason".

Jason Bair
Director, International Affairs and Trade

List of Requesters

The Honorable Patty Murray
Chair
Committee on Health, Education, Labor
and Pensions
United States Senate

The Honorable Gregory W. Meeks
Chairman
Committee on Foreign Affairs
House of Representatives

The Honorable Richard Blumenthal
United States Senate

The Honorable Susan M. Collins
United States Senate

The Honorable Lisa Murkowski
United States Senate

The Honorable Jeanne Shaheen
United States Senate

The Honorable Ami Bera, M.D.
House of Representatives

The Honorable Diana DeGette
House of Representatives

The Honorable Barbara Lee
House of Representatives

The Honorable Jackie Speier
House of Representatives

Appendix I: Objectives, Scope and Methodology

This report describes (1) the family planning and reproductive health (FP/RH) assistance that the U.S. Agency for International Development (USAID) provided in fiscal years 2018 through 2020, (2) the Protecting Life in Global Health Assistance (PLGHA) policy's effects on the implementation of FP/RH assistance as well as actions USAID and its implementing partners reported taking to mitigate adverse effects, and (3) implementation challenges caused by the COVID-19 pandemic as well as steps USAID and its implementing partners reported taking to address them.

To describe USAID's FP/RH assistance, we reviewed USAID's data on obligations during those 3 fiscal years for FP/RH activities. Data elements included obligations by fiscal year, project award, and operating unit as well as project descriptions.¹ USAID provided these data from its Phoenix Financial Management System and its Global Acquisition and Assistance System, according to USAID officials. We examined the reliability of the obligations data by identifying and discussing possible discrepancies with USAID officials. We also verified USAID's obligations data for projects in Senegal, Uganda, and the Ghana-based West Africa Regional Program with USAID officials based in those missions. We found the obligations data to be sufficiently reliable for the purposes of presenting FP/RH assistance funding by country and geographic region for fiscal years 2018 through 2020.

In addition, to describe USAID's FP/RH assistance activities in selected locations, we reviewed USAID and implementing partner documents, such as annual and quarterly project reports and portfolio reviews, related to assistance provided in Senegal, in Uganda, and in West Africa through USAID's West Africa Regional Program. We examined key projects with FP/RH components that were active as of June 1, 2021, which we identified on the basis of discussions with USAID officials. We selected Senegal and Uganda because USAID had (1) obligated moderate to large amounts for FP/RH assistance in those countries compared with other beneficiary countries and (2) entered into at least one award for assistance in each country for which the awardee declined the PLGHA terms and conditions, according to USAID.² We selected the West Africa

¹USAID operating units may include headquarters-based bureaus and overseas country or regional missions.

²See GAO, *Global Health Assistance: Awardees' Declinations of U.S. Planned Funding Due to Abortion-Related Restrictions*, [GAO-20-347](#) (Washington, D.C.: Mar. 18, 2020).

Regional Program because of the priority USAID places on this region for FP/RH assistance and the opportunity the program provided to examine both country-specific and regional projects.³

To describe the PLGHA policy's effects on implementation of FP/RH assistance as well as actions that USAID and its implementing partners reported taking to mitigate adverse effects, we reviewed USAID project documents for the three selected missions. We also conducted a literature review of studies that were based on original research or summarized a number of other studies, were published in medical or other journals covering international family planning assistance, and presented new information or similar findings from new sources. We used the same methods to describe implementation challenges resulting from the COVID-19 pandemic as well as steps that USAID and its implementing partners reported taking to address them.

We searched for and reviewed studies that discussed U.S. FP/RH assistance in developing countries, covering topics such as the PLGHA policy and the Mexico City Policy that preceded it, social norms, women's roles in family planning and contraceptive decision-making, government reproductive health-related policies, attitudes toward contraception, and COVID-19.⁴ Our initial search produced a list of 131 studies and articles. Three reviewers examined these studies and agreed that 55 of them met the criteria for inclusion in our literature review. As we began reviewing these 55 studies, we identified factors related to the PLGHA policy and to the COVID-19 pandemic that affected the implementation of international family planning assistance. We created a spreadsheet to record factors discussed in each study, and we created a summary table tabulating the number of studies that discussed each factor.⁵ To ensure consistency in our reviews, two reviewers examined each study to identify factors mentioned in the reviews, and a third reviewer examined any studies as needed to resolve any disagreements.

³The West Africa Regional Program's FPRH assistance focused primarily on four countries—Burkina Faso, Côte d'Ivoire, Niger, and Togo—and supported additional countries in West Africa through assistance to regional organizations.

⁴We searched databases such as the Cumulative Index to Nursing and Allied Health Literature, Embase, Medline, ProQuest's Health and Medical Collection and Policy File Index, Scopus, and Harvard Kennedy School's Think Tank Search.

⁵Two of the studies were based on the same survey data and interviews. We included both studies because they presented this information in different ways to make distinct points. To avoid double-counting, we included only one of these studies in our tabulations.

To address all of our objectives, we interviewed USAID officials at the agency's Bureau for Global Health, Office of Population and Reproductive Health, in Washington, D.C.; at USAID missions in Senegal and Uganda; and in the West Africa Regional Program. We also interviewed representatives of 12 organizations that as of June 1, 2021, were implementing USAID projects with FP/RH components in Senegal, Uganda, or the West Africa Regional Program. In addition, we interviewed two former USAID implementing partners—MSI Reproductive Choices and the International Planned Parenthood Federation—that served as the partners for the two largest USAID awards that awardees declined because of the PLGHA terms and conditions when the policy was implemented in 2017.⁶ Finally, we interviewed or corresponded with representatives of other FP/RH donors working in Senegal, Uganda, and West Africa.

We conducted this performance audit from February 2021 to May 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁶As we reported in [GAO-20-347](#), MSI Reproductive Choices (formerly Marie Stopes International) and the International Planned Parenthood Federation were implementing USAID FP/RH projects when the Mexico City Policy was reinstated and expanded as the PLGHA policy. Both organizations declined the PLGHA terms and conditions and thus ceased receiving U.S. funding under USAID's awards. As of September 30, 2018, USAID had not obligated a total of about \$79 million in funding planned for these awards.

Appendix II: USAID Obligations for Family Planning and Reproductive Health and Key Indicators, by Location

As table 1 shows, in fiscal years 2018 through 2020, the U.S. Agency for International Development (USAID) obligated nearly \$1.7 billion for family planning and reproductive health (FP/RH) assistance to 39 countries and to regional or worldwide programs.

Table 1: Total USAID Obligations for International FP/RH Assistance in Fiscal Years 2018–2020 and Family Planning–Related Indicator Data for 2020, by Location

Country/operating unit ^b	Total FP/RH obligations, fiscal years 2018–2020 (dollars in thousands) ^c	Family planning–related indicators ^a		Total fertility rate, 2020 ^f
		Estimated contraceptive prevalence: any modern method, 2020 (percentage) ^d	Unmet need for family planning: any modern method, 2020 (percentage) ^e	
Africa				
Ethiopia	102,337	27.6	15.1	4.05
Nigeria	84,949	12.5	19.0	5.25
Tanzania	75,116	31.0	20.4	4.77
Uganda	63,966	30.9	22.3	4.70
Democratic Republic of the Congo	60,754	14.4	32.4	5.72
Kenya	54,422	42.2	14.3	3.37
Mozambique	42,821	24.6	19.9	4.71
Senegal	40,648	19.2	16.2	4.49
Rwanda	32,781	30.5	14.3	3.93
Malawi	31,811	47.3	14.1	4.05
Mali	31,158	16.5	21.3	5.69
Madagascar	29,298	35.7	19.4	3.98
Zambia	27,144	35.2	17.3	4.50
West Africa Regional	27,099	NA	NA	NA
Ghana	22,271	21.9	23.1	3.77
South Sudan	21,253	5.1	20.4	4.54
Liberia	16,423	23.8	28.9	4.18
Sahel Regional	15,140	NA	NA	NA
Guinea	11,642	12.0	18.3	4.55
Benin	10,633	12.9	28.1	4.70
Burundi	9,703	16.4	19.8	5.24
East Africa Regional	6,337	NA	NA	NA
Angola	6,079	14.4	28.3	5.37
Africa Regional	6,000	NA	NA	NA
Zimbabwe	5,965	48.7	8.2	3.46

Appendix II: USAID Obligations for Family Planning and Reproductive Health and Key Indicators, by Location

Country/operating unit ^b	Total FP/RH obligations, fiscal years 2018–2020 (dollars in thousands) ^c	Family planning–related indicators ^a		
		Estimated contraceptive prevalence: any modern method, 2020 (percentage) ^d	Unmet need for family planning: any modern method, 2020 (percentage) ^e	Total fertility rate, 2020 ^f
Burkina Faso	4,838	26.5	21.3	5.03
Niger	3,974	14.8	16.1	6.74
Sierra Leone	317	25.1	20.8	4.08
U.S. Mission to the African Union	250	NA	NA	NA
Cote d'Ivoire	25	21.9	24.8	4.54
Africa subtotal	845,153			
Asia				
Bangladesh	62,933	45.0	16.7	1.99
Afghanistan	50,359	16.2	19.3	4.18
Philippines	43,362	26.0	19.3	2.49
Nepal	36,889	36.2	22.5	1.84
India	35,811	38.2	13.7	2.18
Pakistan	17,738	18.5	17.7	3.39
Cambodia	9,493	30.8	18.8	2.45
East Timor	2,386	16.2	15.7	3.85
Asia subtotal	258,972			
Europe and Eurasia				
Armenia	22	20.4	26.8	1.76
Europe and Eurasia subtotal	22			
Latin America and Caribbean				
Haiti	28,278	24.7	26.3	2.84
Guatemala	6,614	35.4	15.3	2.78
Latin America and Caribbean Regional	3,000	NA	NA	NA
Latin America and the Caribbean subtotal	37,893			
Middle East				
Jordan	62,833	21.5	16.8	2.64
Yemen	9,174	19.7	22.0	3.61
Egypt	8,817	42.8	10.5	3.24
Middle East subtotal	80,824			

Appendix II: USAID Obligations for Family Planning and Reproductive Health and Key Indicators, by Location

Country/operating unit ^b	Total FP/RH obligations, fiscal years 2018–2020 (dollars in thousands) ^c	Family planning–related indicators ^a		
		Estimated contraceptive prevalence: any modern method, 2020 (percentage) ^d	Unmet need for family planning: any modern method, 2020 (percentage) ^e	Total fertility rate, 2020 ^f
Other regional				
Asia and Near East Regional	8,972	NA	NA	NA
Other regional subtotal	8,972	NA	NA	NA
Worldwide				
Global Development Lab	1,000	NA	NA	NA
Bureau for Global Health	463,733	NA	NA	NA
Worldwide subtotal	464,733			
Total obligations	1,696,568			

Legend: FP/RH = family planning and reproductive health, NA = not applicable, USAID = U.S. Agency for International Development.

Source: GAO analysis of USAID data and United Nations (UN), Department of Economic and Social Affairs, Population Division data. | GAO-22-104228

^aThe data shown for family planning–related indicators are estimates for 2020 published by the UN Department of Economic and Social Affairs’ Population Division. The data shown for contraceptive prevalence and unmet need for family planning are estimates for all women aged 15 to 49 years. According to the UN Population Division, the estimates reflect the results of nationally representative household surveys. Data on fertility rates can be obtained from three sources: civil registration systems, sample surveys, and censuses, according to the UN Population Division.

^bOperating units may include USAID’s headquarters-based bureaus and overseas country or regional missions. According to USAID officials, countries (including countries not shown) may have received additional assistance through obligations managed by regional program operating units or USAID bureaus based in Washington, D.C. USAID identified funding obligated centrally by the Bureau for Global Health as “worldwide.” “Other regional” represents obligations by the Asia and Near East Regional Program for FP/RH assistance in countries in both Asia and the Middle East and cannot be disaggregated by region.

^cBecause of rounding, obligations shown may not sum precisely to totals shown.

^dModern contraceptive prevalence rate represents the proportion of women aged 15 to 49 years using a modern contraceptive method, according to USAID. USAID defines high levels of modern contraception use as 51 percent or higher. Modern contraceptive methods include female and male sterilization, IUDs, implants, injectables, pills, female and male condoms, foam or jelly, emergency contraceptive pills, and the lactational amenorrhea method, which involves exclusive breast-feeding for up to 6 months postpartum. Traditional methods of contraception include rhythm (e.g., periodic abstinence) and withdrawal.

^eAccording to USAID, women in need of family planning who are not currently using a modern contraceptive method are considered to have an unmet need for modern methods. According to the UN, in a country with a high rate of unmet need for family planning, more than 20 percent of women of reproductive age who want to avoid pregnancy are not using any contraceptive method, either modern or traditional.

^fAccording to USAID, the total fertility rate is the number of births a woman is expected to have over the course of her reproductive years. According to the UN, women have, on average, fewer than 2.1 children in countries with low fertility levels, between 2.1 and 5 children in countries with intermediate fertility levels, and 5 or more children in countries with high fertility levels.

Appendix III: Reported Steps to Address Implementation Challenges Caused by COVID-19 Pandemic for Three Selected Missions

Table 2 summarizes steps that the U.S. Agency for International Development (USAID) and its implementing partners reported taking to address challenges caused by the COVID-19 pandemic that affected implementation of family planning and reproductive health project activities in one or more of three selected USAID missions—Senegal, Uganda, and the West Africa Regional Program.

Table 2: USAID’s or Implementing Partners’ Reported Steps to Address Implementation Challenges Caused by COVID-19 Pandemic in Senegal, Uganda, and West Africa Regional Program

Challenges	USAID or implementing partner steps
<ul style="list-style-type: none"> Reduced access to health facilities due to fear of infection, social distancing requirements, and transportation constraints 	<ul style="list-style-type: none"> Arranged delivery of family planning commodities by a designated community member or at a designated place and time to minimize travel for clients and to reduce contact with health facilities Produced radio spots to inform public that health facilities, which provided family planning and reproductive health (FP/RH) services, were open and would supply clients with masks Provided oral contraceptives to cover longer intervals and encouraged use of longer-lasting contraceptive methods to compensate for women’s reduced access to clinics Strengthened IT platforms at regional hospitals to facilitate telehealth
<ul style="list-style-type: none"> Disruption of outreach to youths due to restrictions on in-person contact 	<ul style="list-style-type: none"> Increased use of social media and messaging from popular influencers to appeal to youths
<ul style="list-style-type: none"> Limited availability of health workers due to shortages of personal protective equipment (PPE) 	<ul style="list-style-type: none"> Aligned interventions with host-government guidance to incorporate infection-prevention-and-control activities and PPE provision for providers and clients at health facilities Supported host-government designation of family planning as an essential service, to allow facilities to remain open during lockdowns—for example, by developing a plan to provide PPE to health workers Procured locally sourced PPE Sourced PPE with the help of commodity suppliers such as the United Nations Population Fund
<ul style="list-style-type: none"> Limited availability of contraceptive supplies due to stockouts and disruption of supply chains, including a shift by some manufacturers from producing FP/RH and other health commodities to producing COVID-19-related commodities such as PPE 	<ul style="list-style-type: none"> Provided training and guidance to minimize supply chain disruptions Moved FP/RH commodities out to district facilities and local clinics instead of waiting for the districts and clinics to come to supply depots
<ul style="list-style-type: none"> Reduced ability to monitor projects due to social distancing, travel restrictions, and internet access limitations 	<ul style="list-style-type: none"> Improved virtual communication by shifting to online meetings, using social media to vet FP/RH messages and conduct meetings, and conducting remote project monitoring via smartphone video call

Legend: FP/RH = family planning and reproductive health, PPE = personal protective equipment, USAID = U.S. Agency for International Development. Source: GAO analysis of information from USAID and implementing partners in Senegal, Uganda, and the West Africa Regional Program. | GAO-22-104228

Note: Not all of the challenges and steps shown were reported for all three missions.

Appendix IV: Comments from the U.S. Agency for International Development



May 10, 2022

Jason Bair
Director, International Affairs and Trade Team
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20226

Re: INTERNATIONAL FAMILY PLANNING ASSISTANCE: USAID Has Faced
Implementation Challenges Related to U.S. Policy and COVID-19 (GAO-22-104228)

Dear Mr. Bair:

I am pleased to provide the formal response of the U.S. Agency for International Development (USAID) to the draft report produced by the U.S. Government Accountability Office (GAO) titled, *INTERNATIONAL FAMILY PLANNING ASSISTANCE: USAID Has Faced Implementation Challenges Related to U.S. Policy and COVID-19* (GAO-22-104228). USAID takes seriously all the legislative and policy requirements that guide our programming and remains committed to providing Agency staff and our implementing partners with the timely and accurate information and support they need to understand and implement these laws and policies. We appreciate the GAO's documentation of the challenges created by the Protecting Life in Global Health Assistance (PLGHA) policy and the COVID-19 pandemic and of the actions taken by USAID to respond. We note the overall alignment of the GAO's findings regarding PLGHA implementation with those in the interagency *Review of the Implementation of the Protecting Life in Global Health Assistance Policy* issued by the State Department in August 2020. USAID does not have any Agency comments on the document.

I am transmitting this letter from USAID for inclusion in the final report. Thank you for the opportunity to respond to the draft report and for the courtesies extended by your staff while conducting this engagement. We are grateful for GAO consideration of USAID's technical comments and recommendations (submitted separately) on this engagement. We appreciate the opportunity to participate in the review.

Sincerely,

A handwritten signature in cursive script that reads "Colleen R. Allen".

Colleen R. Allen
Assistant Administrator
Bureau for Management

Appendix V: GAO Contacts and Staff Acknowledgments

GAO Contact

Jason Bair, (202) 512- 6881 or bairj@gao.gov

Staff Acknowledgements

In addition to the individual named above, Leslie Holen (Assistant Director), Colleen Candrl, Howard Cott, Neil Doherty, Justin Fisher, Kay Halpern, Nicholas Jepson, Reid Lowe, Andony Payne, and Alexander Welsh made significant contributions to this report.

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