

Policy Briefing: February 2026

US Administration Regressive Policies

Navigating the America First Global Health Strategy, the Expansion of the Global Gag Rule and the Major Escalation of Regressive Foreign Policies

The IPPF abridged briefing notes provide information and analysis on the impacts of recent US global health policy shifts on Sexual and Reproductive Health, Rights, and Justice (SRHRJ).

The America First Global Health Strategy (AFGHS) has marked a major shift in US foreign health assistance toward direct bilateral agreements with governments, prioritizing US strategic interests and national security over broader global health goals. Built around disease surveillance, direct procurement partnerships, and promotion of American health innovation (and interest), the strategy moves away from multilateral institutions and long-standing NGO partnerships in favour of government-to-government "compacts" framed as promoting country self-reliance.

The America First Global Health Strategy is silent on sexual and reproductive health, rights and justice. This silence aligns with broader US policy trends under executive orders restricting diversity, equity and inclusion (DEI) initiatives. Together, **these shifts, including** the reinstatement and the significant expansion of the Mexico City Policy, also known as **the Global Gag Rule (GGR)**, the restructuring of foreign aid, and the de-prioritisation of SRHRJ in US global health financing, **have quickly reshaped the funding landscape and disrupted essential service delivery for millions.** Through these measures, the US administration has weaponized aid, effectively prohibiting funding to any foreign NGO that provides comprehensive information on abortion and pregnancy options or performs abortion, thereby severing support for a vast network of SRH providers.

What are the implications for SRHRJ?

The AFGHS and the expanded GGR represent an active, targeted assault on SRHRJ: it not only signals a continued effort to erase SRHRJ from US health policies but also threatens to dismantle systematically existing reproductive health services and undermine established policies worldwide. Latest measures go beyond historical precedents by:

- Framing standard contraception as "abortifacients" to broaden prohibited activities, a trend that risks expanding the range of contraceptive commodities that could fall under Helms and Global Gag Rule restrictions.
- Prohibiting organisations from counselling or advocating for legal abortion, even with non-US funds.
- Banning work on gender equality, gender-affirming care and DEI under the guise of preventing "divisive" concept.

The effects on and risks to sexual and reproductive health and rights and to service delivery are several:

- **SRHRJ and family planning are being omitted entirely in the compact agreements** with risk of further funding cuts extending to all non-military US Foreign assistance, including humanitarian aid.
- **Emerging conditionalities that link foreign assistance to the very broadly defined "American Values" pose a new layer of risk in compact negotiations and the AFGHS.** These conditionalities may in fact allow the US to use political and ideological leverages over governments (particularly in areas such as gender, sexuality and rights), potentially constraining domestic policy space and narrowing the scope of what is acceptable for SRHRJ programming.
- **The retreats from DEI frameworks will corrode attention to intersectionality,** particularly affecting adolescent girls, LGBTQI+ people and all marginalised communities. This is and will lead to less funding for advocacy and systems strengthening, and could end up influencing donor attitudes in bilateral domestic funding streams.



- As AFGH negotiations take priority on multilateral engagement, **UN agencies may lose space and leverage** in shaping global health norms, which could further marginalise SRHRJ within international coordination platforms.
- **The combined effect of the expanded GGR and US compact agreements are undermining the stability of SRH programmes**, weakening long-term planning and making it harder for organizations to maintain consistent and high-quality delivery services. The shift toward procurement and frontline delivery and worker support, coupled with cuts to technical assistance, will significantly reduce funding for advocacy, policy development, and system strengthening, core areas that sustain SRHRJ service delivery.
- The US compact agreements and expanded GGR **restrict the flexibility needed to deliver integrated SRHR services**, forcing providers to narrow their services package and to deprioritise essential sensitive care. **Disruption of service delivery networks, clinic closure and staffing cuts** already initiated by the existing GGR-related funding losses, are exacerbating and reduce the number of functioning SRHRJ service points even more, particularly in rural settings.
- **Disruption of supply chain and increased shortages of contraceptives**, extended waiting times, reduced outreach programmes and mobile clinics are disproportionately affecting marginalised communities.
- The damage of this new architecture extends beyond stock availability to the institutional backbone that makes supply systems function. **Once technical expertise, coordination mechanisms, and logistics infrastructure are dismantled, they cannot be quickly reassembled**. This creates prolonged vulnerability in commodity forecasting, procurement planning, and last-mile distribution, increasing the likelihood of stockouts and service interruptions.
- **The co-financing requirements embedded in the compact agreements could be unrealistic**. In contexts where health budgets are already constrained, large domestic pledges such as those suggested by the Compact Agreements, risk crowding out other health priorities or leading to underfunded commitments that cannot be sustained. The transition model assumes that governments can rapidly increase domestic financing for specific disease commodities, yet declining health budget allocations in some countries have so far suggested otherwise. This creates the possibility of mid-term funding gaps once US support fades.

What is IPPF doing?

- **Rapid mobilisation and evidence gathering on funding cuts:** IPPF is responding swiftly to escalating funding cuts across the Federation, as over half of affected MAs and CPs faced reductions with at least \$85.2 million withdrawn and 8.5 million people potentially losing access to essential SRHRJ services – particularly in Africa and South Asia. We also launched a second survey to capture emerging and further evidence of deepening service losses and growing threats to SRHRJ access – **the latest results are available [here](#)**.
- **Intel gathering and raising awareness:** work is ongoing to strengthen intelligence gathering and raise awareness in collaboration with other partner organizations. This includes regular calls with partners to share updates and coordinate efforts. As bilateral MOUs began to be negotiated directly between the US government and individual countries, IPPF worked to obtain draft texts and generic templates in order to understand their structure and implications. Particular attention has been paid to clauses relating to abortion restrictions, the expansion of the global gag rule, as well as provisions concerning long-term health data access, policy conditionality, and co-financing obligations. An analysis of how these agreements align or conflict with national laws on data protection, public finance management, and human rights is also ongoing.
- **Government engagement:** in many contexts, Ministries of Health were excluded from negotiations despite the health focus of the agreements, so outreach to these ministries to ensure they understand the operational and health system implications is being prioritised. Engagement of parliamentarians and parliamentary committees to raise concerns around due process, fiscal oversight, and long-term sustainability is ongoing. Helping government officials understand the real-world implications of abortion-related funding restrictions with a particular focus on their potential to increase maternal mortality or disrupt HIV services, has been an important part of this engagement.



- **Communications and narrative strategies:** the US government and recipient governments have actively shaped the narrative, framing these MOUs as anti-neocolonial and suggesting that civil society opposition is motivated by loss of funding. In response, work is ongoing to shift the conversation toward public health outcomes, fiscal sustainability, and accountability. This includes working with journalists, producing evidence-based briefings, and assessing public sentiment to better understand how these agreements are perceived domestically.
- **Preparedness of other IPPF regions:** preparedness across other IPPF regions continues to be critical as the US aims to complete 71 compacts signed by the end of 2026, with the next wave foreseen in Latin America. Wider coordination is currently active to build on best practices across regions.
- **Information and mobilization of donor countries:** continuous leveraging on donors who can ensure continuity of SRHRJ services and protect rights-based frameworks, including gender equality. Strengthen multilateral mechanism, support civil society space and fund CSOs directly, provide predictable financing for long-term resilience and coordinate positions to maintain global accountability and standards.
- **Fight Back Fund:** after the newly elected Trump administration issued a wave of transphobic, exclusionary Executive Orders and halted all US government aid, IPPF launched a "Harm Mitigation" initiative to support the most affected MAs and protect essential services. This marked the start of the development of a broader fight - back initiative to confront the deepening threats.

What IPPF MAs are doing?

1. **Engage and act:** continue to engage with Ministries, particularly Ministries of Health, to ensure SRHRJ is integrated and prioritised into national health strategies and budgets before compact terms are finalised. Ongoing engagement is critical, once terms are set, it becomes far harder to insert new priorities and influence the agenda-setting. Building technical understanding among policymakers about how abortion restrictions, policy conditionality, and data-sharing clauses affect service delivery and human rights can create openings for internal accountability.
2. **Engage actively in all further rounds of negotiations:** ensure that national governments, civil society, and affected communities are included in further stages of MoU and compact discussions to help safeguard country ownership, advocate for SRHRJ priorities and influence conditionalities.
3. **Advocate for rights-based commitments and language in the agreements:** call for open, inclusive, transparent negotiation process, and push for inclusion of normative SRHRJ and DEI mandatory language on SRHRJ in MoUs and compacts.
4. **Expose contradictions and foreign impositions:** highlight how the compact model conflicts with broader fiscal and equity reforms and to underscore the risk of foreign interference in national health policy. Emphasise how bilateral compacts that are negotiated outside multilateral platforms can undermine ongoing global efforts to promote more equitable investments in health. The compacts pose a risk of creating a new cycle of dependency from US funding. For instance, these are in contrast with current global demand to restore fiscal space, reduce or cancel debt burdens and to establish a more equal and just global economic structure.
5. **Cross-regional and cross-movement coordination:** Sharing strategies, legal analyses, and communications approaches across countries can mitigate the isolating effects of bilateral negotiations and help resisting fragmentation.
6. **Monitor closely:** monitor publicly released documents and announcements from the US State Department and partner governments to track which countries are entering compact talks and the terms under discussion.

