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MAKING AIDS HISTORY
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ISSUE BRIEF

The Effect of the Expanded Mexico City Policy on HIV/AIDS Programming: Evidence from the PEPFAR Implementing Partners Survey

Overview

On January 23, 2017, President Trump reinstated and significantly expanded the Mexico City Policy (MCP), which prohibits non-U.S.-based nongovernmental organizations (NGOs) from receiving U.S. global health funding if they perform, counsel on, or refer for abortion, or advocate for its liberalization outside of limited exceptions. Whereas the MCP historically only implicated family planning funding, the expanded MCP (EMCP) now applies to all federal global health assistance funding. As such, the EMCP now applies to HIV funding through the President's Emergency Plan for AIDS Relief (PEPFAR), implicating hundreds of new implementing partners (IPs) that were previously exempt. While the EMCP's impact on PEPFAR IPs is not yet known, previous iterations of the MCP prompted service reductions and clinic closures among family planning providers. In order to understand *if and how* PEPFAR IPs may be affected, amfAR, in collaboration with Johns Hopkins University, launched a confidential electronic survey and key-informant interviews with PEPFAR IPs to document any changes in organizational operations and service delivery prompted by the EMCP.

Background on the Mexico City Policy

- Since the 1970s, the Helms Amendment has prevented any U.S. foreign assistance funding from being used for abortion services, even during the Clinton and Obama administration years when the MCP was not in effect. In contrast to the Helms Amendment, however, the MCP extends restrictions to organizational activities as a whole, even those supported by non-U.S. funding. Specifically, the EMCP restricts a non-U.S.-based NGO from engaging in the following activities while receiving U.S. global health assistance: 1) abortion

Key Findings

- Survey findings strongly suggest that the **delivery of comprehensive sexual reproductive health (SRH) information and services by current PEPFAR implementing partners (IPs) is being disrupted by the expanded Mexico City Policy (EMCP).**
- One-third of all prime PEPFAR IPs surveyed r**eport altering their organizational operations or service delivery in response to the EMCP.**
    - o These organizations represent **diverse geographical locations**, operating in 31 of the 45 countries represented in the sample.
    - o Organizational changes include a reduction in the provision of critical **non-abortion-related information, including for contraception and HIV**, as well as altering advocacy, technical assistance, and research protocols to comply with the EMCP.
    - o Organizations serving **pregnant women and key populations (KPs)**, especially men who have sex with men (MSM), are more likely to alter their operations in response to the EMCP.
- Key-informant interview findings suggest that the EMCP is affecting the ability of PEPFAR IPs to provide full SRH information to their clients, **to the detriment of patient care**. Interviews further reveal that the EMCP's greatest effect is on **service delivery to already vulnerable populations** such as youth and KPs.

services; 2) counseling on abortion; 3) referring for abortion; and 4) advocating for the liberalization of abortion access. Limited exceptions in the cases of rape, incest, or if carrying the pregnancy to term would endanger a woman's life, are allowed in the EMCP language.[1] Additionally, abortion counseling/referrals are allowed if a woman has explicitly stated her intention to access a legal abortion and is seeking information, or if she lives in a country where local law protects her right to full informed consent on reproductive decisions including abortion services. However, restrictions do apply in all other cases including when a women's health is at risk or when fetal abnormalities are detected.

- On his second day in office (January 23, 2017), President Trump reinstated and announced an intention to expand the MCP via presidential memorandum. The EMCP, formally titled *Protecting Life in Global Health Assistance* and released in May 2017, prohibits non-U.S.-based/foreign nongovernmental organizations (fNGOs) from receiving any form of U.S. global health assistance unless the organization certifies that it will comply with the EMCP.
- Prior iterations of the MCP only applied to U.S. global health assistance for family planning (FP), a budget line of approximately $600 million. The EMCP now applies to nearly all U.S. global health assistance, including PEPFAR, a budget of approximately $8.8 billion. This dramatic expansion means that hundreds of additional organizations must choose between complying with these restrictions and losing their U.S. funding.
- The MCP is found to be an unconstitutional restriction of U.S.-based organizations' right to free speech, so the Policy only applies to non-U.S.-based organizations. However, U.S.-based organizations are required to ensure that all of their fNGO sub-partners comply with the Policy.

PEPFAR Implementing Partner Study

Introduction: Why the PEPFAR Implementing Partners Survey is timely and needed

Since PEPFAR-funded HIV programs have historically been exempt from the Policy, the full consequences of the EMCP for PEPFAR IPs are unknown. However, research on prior iterations of the MCP has demonstrated that the Policy diverted funds from trusted sexual and reproductive health providers, resulting in clinic closures and decreased access to contraceptives.[2] Reductions in contraception coverage subsequently contributed to increased rates of abortion and unintended pregnancy, especially in rural areas.[2,3,4] While HIV outcomes were not explicitly studied in previous quantitative research, contraception coverage is a known contributor to HIV prevention, averting an estimated 173,000 infant infections each year in sub-Saharan Africa alone.[5] Sub-Saharan Africa is a region with high unmet need for FP and the world's highest HIV prevalence, such that even a small proportional change in the availability of contraception can have serious consequences for new HIV infections and women's health. Indeed, a recent study found that countries where the EMCP was most likely to disrupt HIV and FP service integration were also those with the highest HIV prevalence.[6] Given that PEPFAR is the U.S.'s largest global health program, approximately $5.2 billion per year, policies that may threaten its efficiency must be closely examined.

Objectives

The aim of this study was to document the actual and anticipated impact of the EMCP on PEPFAR IPs. Specifically:

1. Collect primary, quantitative data from IPs that received PEPFAR funding in FY2016 and/or FY2017, in order to document changes in contracts and the initial in-country response to the EMCP.
2. Conduct qualitative, in-depth interviews with a subset of surveyed IPs to further explore funding and operational changes due to the EMCP.

Methods

The research team – a collaboration between amfAR, The Foundation for AIDS Research, and the Johns Hopkins Bloomberg School of Public Health – collected data between May and November 2018 on changes in PEPFAR IP funding and operations as a result of the EMCP using the following methods:

Quantitative survey

- An electronic survey of PEPFAR prime IPs was administered via an online survey platform from May 24 to September 28, 2018.
- The initial survey sample included all PEPFAR IPs identifiable through the 2016-2017 PEPFAR country operational plans (n= 980 unique country/IP combinations).
- Out of the initial sample, contact information for a recommended survey respondent was found for 504 IPs, out of which 286 links were completed (response rate of 56.7%). Survey respondents included IP country directors,

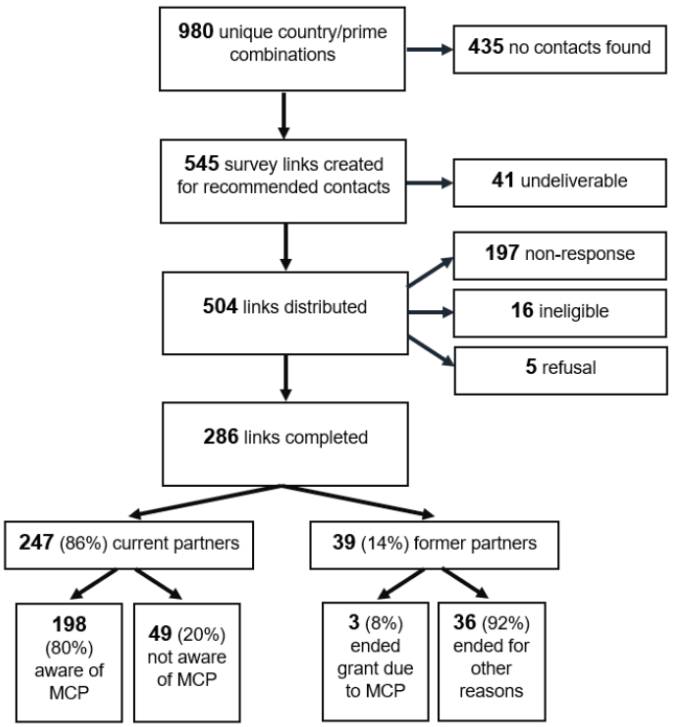
program managers, or another best-suited respondent as identified by the organization.

- The 35-item online survey was available in both English and Portuguese and took on average 10 minutes to complete. Consenting participants were asked questions covering 5 major domains: IP's scope of services, funding, awareness of the EMCP, operational changes related to the EMCP, and sub-partner information.
- Only IPs that reported being aware of the EMCP were asked questions on operational changes related to the EMCP. All questions were reviewed by an expert policy research group and piloted with IPs in South Africa and Mozambique to ensure questions were clear and not leading.

Key informant in-depth interviews

- Twelve in-depth interviews were conducted with key informants (KIs) from current and former PEPFAR IPs based in Eswatini (n=4) and South Africa (n=8). All KIs had previously responded to the survey and were aware of the EMCP.
- Qualitative interview guides were open ended and adapted to be relevant to each IP. Primary topics included organizational background information, Policy interpretation, organizational changes made as a result of the EMCP, and observed and anticipated population level impacts of the Policy.

Figure 1. Sampling flow chart



Findings

Overall, the majority of organizations in this study were current IPs, of which 80% (198/247) were aware that the EMCP was added to their grant agreements at the time of the survey. Despite this, IPs reported low levels of training by their U.S. government funder, with only 53% (132/247) indicating that they had received training since January 2017. Implementers were a mix of U.S.-based NGOs (47%), fNGOs (32%), U.S.-based universities (8%), non U.S.-based universities (2%), and other types of organizations. Most commonly, IPs received funding through cooperative agreements (73%, 180/247), followed by grants (11%, 27/246), and contracts (8%, 18/246). On average, 60% of IPs' total budget was from the U.S. government and 26% of IPs reported that over 90% of their budget came from U.S. global health funding.

Broad geographic reach

In 31 of the 45 countries (69%) represented in the survey sample, at least one organization reported an EMCP-related change to services or operations. These changes were most common in Sub-Saharan Africa, where the majority of PEPFAR funding is allocated. EMCP-related changes were reported regardless of a country's abortion legality. For instance, in nearly half (13/31, 42%) of the countries where EMCP-related impacts were found, abortion is legal only if performed to save a woman's life. While local law in these settings restricts abortion services beyond the language of the EMCP, Policy impacts were still detected.

In Eswatini, a country with highly restrictive abortion laws, 57% of current partners reported altering operations in relation to the Policy. As one KI describes, the EMCP has diverted funds away from trusted providers of youth-friendly SRH care in Eswatini, resulting in the termination of outreach services that primarily benefited youth:

> *"Young people who are living with HIV have big barriers to health care in government facilities. They used to get their family planning from the outreach/mobile clinics because they live out of town, but now those services have stopped… Youth ARV care can also be disrupted because they used to get HIV treatment through outreach programs, but now they have to travel to a government facility that they don't prefer... There is a very high potential for new infant infections."*
>
> — Eswatini, former partner

According to the survey, the countries with the highest number of EMCP-affected organizations are South Africa, Eswatini, Kenya, and Mozambique. These are countries with generalized HIV epidemics that have historically received a large proportion of PEPFAR's budget. Key informants from countries with high levels of PEPFAR funding repeatedly described a complex relationship with U.S. funding, in which governments must balance the desire to make their own programmatic decisions with the continued reliance on U.S. support:

> *"We don't fully blame the US government. We are grateful that we have been given the money. Our government should be taking over because it is our country and our issues. The South African government should be fighting for its people. It is also the South African government who are failing the adolescent girls and young women."*
>
> — South Africa, current partner

Disruptions in the delivery of sexual and reproductive health services and information by PEPFAR IPs

Among organizations aware of the EMCP, 34% (n=67) reported an actual or anticipated organizational change as a result of the Policy. The type of funding an organization received or services it provided, such as technical assistance, outreach, or clinical services, did not predict whether or not an IP reported a change in operations in response to the EMCP.

The most commonly reported organizational change was a reduction in the provision of SRH information, including pregnancy counseling (28 organizations, 42%). Other commonly reported changes included reductions in the provision of information on legal abortion, SRH community trainings or advocacy, and contraception counseling and referrals. One-third of the changes reported by IPs were not directly related to abortion, and included HIV services, cervical cancer screening, adolescent health guidance, and advocacy [Figure 3]. Since the EMCP does not regulate these activities, the reduction in the provision of non-abortion services may reflect disruptions to integrated care models, declining patient numbers, or misinterpretation/over-implementation of the EMCP.

Survey results highlight the intentional reduction in the provision of accurate reproductive health information, including on safe abortion services, by current PEPFAR partners. Informants described this 'gagging' of IPs as having a negative impact on their ability to maintain community trust and patient care:

> *"We are trusted in the community to provide information, but we can't talk about it [abortion], we have to act like we don't know about it. We have to act like we don't know about the girls dying because they go to a so-called doctor who tells them to drink bleach. It seems like even the Department of Health has turned a blind eye."*
>
> — South Africa, current partner

Figure 2. PEPFAR partners in 31 countries report changes due to the EMCP

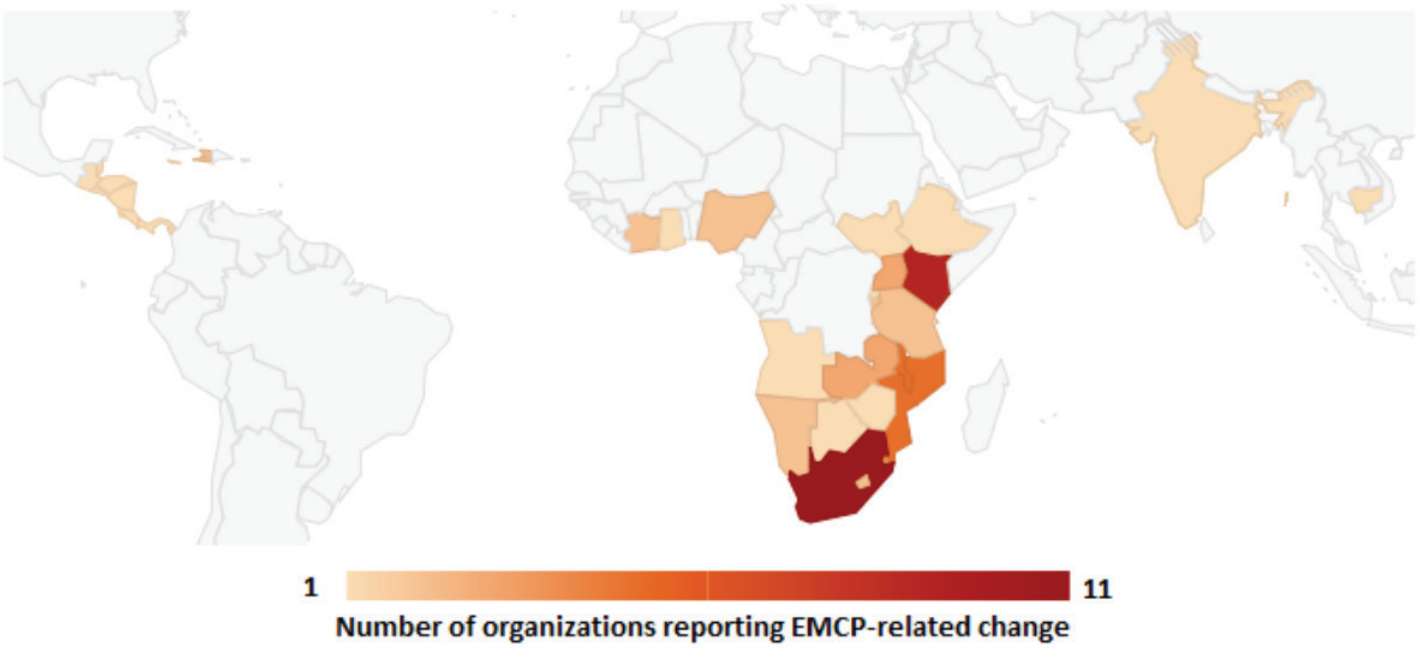
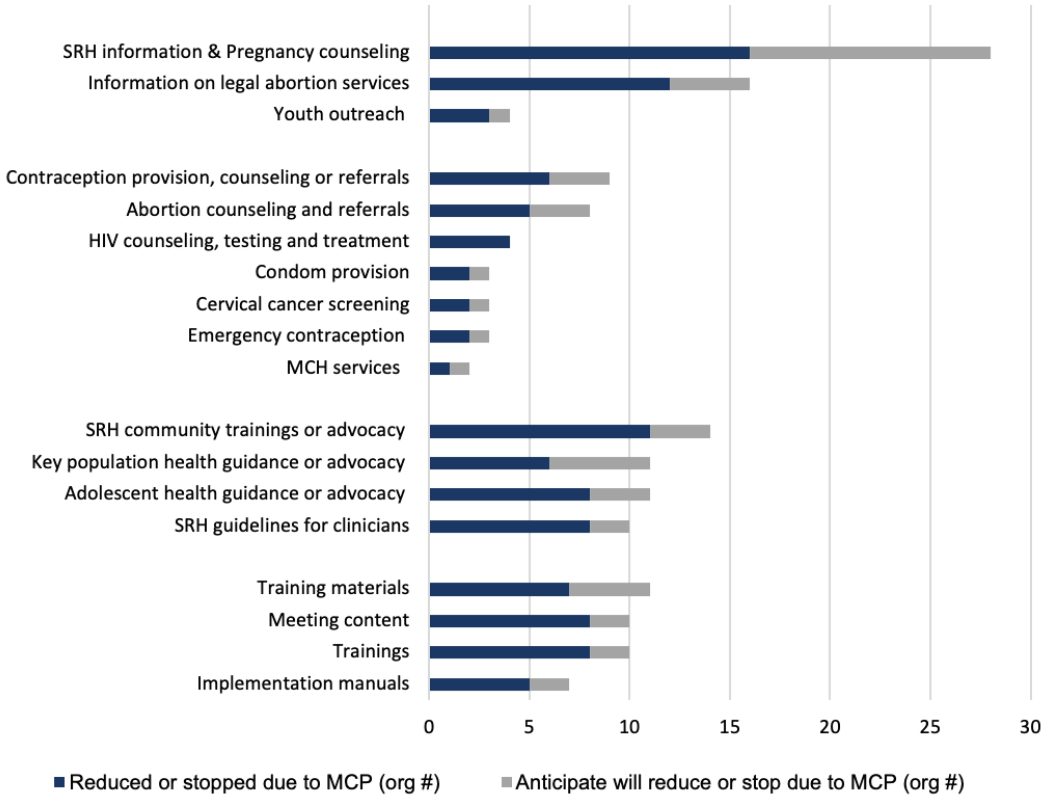


Figure 3. Changes in current PEPFAR IP operations by service type



Vulnerable populations disproportionately affected by the EMCP

Quantitative and qualitative study findings highlight that young women and other vulnerable populations are more likely to be impacted by the EMCP. At the organizational level, PEPFAR IPs that serve pregnant women and key populations, particularly MSM, were significantly more likely to report service disruptions in response to EMCP [Table 1]. The reasons for this are not fully understood. Some qualitative data suggest that organizations that serve key populations are more likely to also provide comprehensive family planning and thus disproportionately affected by restrictions on reproductive health information, which threatens integrated SRH care for key populations.

> *"HIV programs have to be integrated – cutting HIV funds means we are cutting everything. Integrated care is especially important for youth, key populations and other groups who are limited in resources and can't afford to make multiple trips for services."*
>
> — Eswatini, former partner

At the patient level, key informant interviews highlighted how pregnant young women are particularly impacted by the EMCP, as they are the population that is most in need of accurate reproductive health information:

> *"They [adolescent girls and young women] are the populations that are the most affected. When they are pregnant, they still want to go to school, and they say, 'Should I get an abortion?' and we are in limbo, we don't know what to tell them. When they come to you, they need to be counseled, they need to know their options. The girls say 'Abortion, what is that?' and you can't say."*
>
> — South Africa, current partner

Altering implementing partner relationships

Key informant interviews highlighted the ways in which the EMCP altered existing partner relationships and damaged coalition-building efforts. For example, IPs with longstanding roles in the HIV response that did not comply with EMCP restrictions reported being excluded from national campaigns and partnership agreements to the detriment of national service delivery. Prime partners were also forced to drop sub-partners

Table 1: PEPFAR IPs reporting reducing or stopping a service due to the EMCP by populations served

Population served	Total IPs aware of the EMCP n = 198	Any change from the MCP n = 56	No change from the MCP n = 142	P-value^
General population (%)	83.8	89.3	81.7	.28
Pregnant women (%)	62.4	72.7	58.3	**.04****
Adolescents (%)	75.8	73.2	76.8	.60
Key Populations[1] (%)	60.1	64.3	58.5	.45
Sex Workers (SW)	49.0	53.6	47.2	.41
MSM	43.4	53.6	39.4	**.07***

[1]Includes SW, MSM, transgender, people who inject drugs, and people in prison
^Fisher's exact test if any cell <5, otherwise Pearson's chi-squared test
**p<.05, *p<.1

that did not comply with the EMCP, or chose to end agreements with sub-partners who they saw as "too risky" to continue a relationship.

Forcing prime partners to choose sub-partners based on funding restrictions, as opposed to performance, is described as being to the detriment of PEPFAR programming. Indeed, key informants discussed how the loss of high-performing sub-partners has led U.S.-based prime partners to retain the grant and attempt to implement a program themselves. This loss of local expertise by a trusted sub-partner was seen as a major disadvantage to PEPFAR programming, especially when providing services to hard-to-reach and vulnerable populations.

> ***"Now the U.S. primes are trying to be the implementers and do the work but it's not as good. Sometimes these large international NGOs are just chasing numbers and they don't understand the context on the ground, which causes care to suffer… Usually only around 10% of their staff are local and they don't know how to implement locally. Services are compromised."***
>
> — Eswatini, former partner

Key Takeaways

- PEPFAR IPs are altering services, delivery of health information, and partnerships in response to the EMCP. These changes are due to U.S. government funding requirements as opposed to best practices in the delivery of SRH services.
- Organizations across multiple PEPFAR countries are altering operations in response to the EMCP, regardless of the country's abortion laws. Particularly troubling is that the greatest disruption of services is documented in countries with major HIV epidemics, such as South Africa, Eswatini, and Mozambique.
- Reduction of non-abortion-related services and information by PEPFAR IPs is common. These findings may reflect disruptions in integrated care models, declining patient numbers, or misinterpretation/over-implementation of the EMCP.
- While this study does not measure the population-level health impact of the EMCP, it demonstrates that SRH information and service delivery are being undermined. The results indicate an increased risk for vulnerable populations that are more reliant on outreach services and integrated care models.
- Additionally, partnerships and coalitions are being disrupted by the EMCP. In some countries partner agreements are being altered such that the most suitable local partner is not

able to implement programs. This runs counter to PEPFAR's expressed goals of improving efficiency and shifting grant-making to local organizations.

Recommendations

This study provides evidence of disruptions in HIV/AIDS programming prompted by the EMCP, and more broadly, the delivery of comprehensive, evidence-based SRH services by PEPFAR IPs. All stakeholders can work to mitigate and respond to these risks.

Suggested responses for IPs:

1. To avoid over-implementation of the Policy, IPs should know the provisions of the EMCP. USAID/CDC training on the Policy should be supplemented with guidance from external sources, including individual legal counsel, SRH policy expert groups, and online resources, when needed.[7]
2. Prime partners, who are responsible for communicating the Policy to their sub-partners, should vet communications with Policy experts and translate materials if necessary.
3. Coalition building across signing and non-signing groups is not prohibited by the EMCP, nor are consortia and projects undertaken between these groups, as long as activities do not violate the Policy.
4. IPs can consider establishing in-country networks of organizations receiving US global health assistance to share information on best practices in the context of the Policy and to recognize gaps in services resulting from the Policy that other partners might fill.

Suggested responses for PEPFAR:

1. To avoid over-implementation of the Policy, all PEPFAR staff working closely with IPs should be routinely trained on the EMCP so that they can transmit accurate information and offer appropriate guidance when needed.
2. Increased clarity on the Policy provisions could be transmitted in upcoming COP guidance and training documents that emphasize what is still allowable under the EMCP and which activities are restricted. Document translation into non-English languages is required.
3. Where possible, PEPFAR program and partner funding data should be used to monitor the impacts of the EMCP on PEPFAR IPs and any related health impacts. This may include documenting where partner and sub-partner agreements were terminated due to the EMCP. These data must be made publicly available to aid stakeholders in the development of targeted harm reduction responses.

Suggested responses for policymakers:

1. It is essential that policymakers solicit feedback from the organizations implementing U.S.-funded global health programs and align policies with the current evidence from the field.
2. Current data on the EMCP show policy-related disruptions to PEPFAR programming and service delivery. This is counter to the goals of U.S. global health assistance and strongly suggests that the Policy should be repealed. Ignoring emerging data on the EMCP risks derailing progress on hard-won gains in SRH and HIV epidemic control.

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