amfAR
MAKING AIDS HISTORY
The Foundation for AIDS Research

October 2017
ISSUE BRIEF

Impact of Mexico City Policy on PEPFAR

Key Messages

- In January 2017, President Trump reinstated the so-called Mexico City Policy (MCP), which prohibits U.S. support for foreign nongovernmental organizations (NGOs) that perform or promote abortion as a method of family planning, with no exemption for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).
- This is a significant expansion of MCP and will impact a total of $8.8 billion in foreign aid funding, more than 14 times more than that restricted under President George W. Bush. Nearly 70% of newly implicated foreign aid funding is earmarked for PEPFAR.
- In the worst-case scenario, all funding to foreign NGOs would be impacted by the MCP. This amounts to $703 million per year, or 17.8% of total allocations through the Country/Regional Operational Plan (COP/ROP) process.
- Local NGOs that are PEPFAR partners are responsible for providing an average of 14.9% of antiretroviral therapy (ART) for adults and children and 24.7% for pregnant women living with HIV. A sudden loss of U.S. funds to these local treatment providers, due to non-signature of the MCP, would create significant vulnerabilities to clinic closures and treatment interruption.
- HIV service delivery relies heavily on local NGO partners that have well-established community relationships. The expanded MCP could funnel funds away from trusted local service providers that do not accept the restrictions on speech mandated by the MCP, resulting in loss of efficiency and putting the lives of people living with HIV at risk.

Introduction

On January 23, 2017, President Trump signed a Presidential Memorandum reinstating the Mexico City Policy (MCP). MCP was first introduced by President Reagan in 1984. Historically, it has prohibited the provision of U.S. family planning funding to any non-U.S. nongovernmental organizations (NGOs) that perform or actively promote abortion as a method of family planning. President Clinton repealed MCP in 1993; it was then reinstated by President Bush in 2001 and repealed by President Obama in 2009.

Per the Helms Amendment to the Foreign Assistance Act (1973), U.S. government funding cannot be used to pay for abortion services even when MCP is not in effect. The Mexico City Policy places further restrictions on U.S. funding, stating that all non-U.S.-based NGOs receiving U.S. funds cannot advocate for or promote access to abortion, even if the organization uses its own funds for this work. Exceptions are made in the cases of rape, incest, or when the life of the mother would be endangered. This includes restricting health care providers from even mentioning the existence of abortion or referring patients for abortion services.

This is a significant expansion of the Mexico City Policy and will impact a total of $8.8 billion in foreign aid funding.

Under previous administrations, MCP has only applied to U.S. foreign assistance for family planning programs, totaling approximately $600 million per year. President Bush specifically exempted the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) from MCP when it was created in 2003.

However, in his Memorandum reinstating MCP, President Trump directed the Secretaries of State and Health and Human Services to develop a plan to extend MCP to all global health assistance from the U.S. government. This is a significant expansion of the Mexico City Policy and will impact a total of $8.8 billion in foreign aid funding, more than 14 times more than that restricted under President George W. Bush. Nearly 70% of newly implicated foreign aid funding is earmarked for PEPFAR. On May 15, 2017, the State Department formally announced the extension to include PEPFAR. This assessment evaluates the potential impact of the extension of MCP on PEPFAR and the global response to HIV.

Table 1. Potential impact of Mexico City Policy if (1) all local NGOs in all countries are affected, and (2) only NGOs in countries with legal abortion are affected.

Scenario	Funding impacted		Adults and children on ART		Women receiving ART for PMTCT	
	To local NGOs	% of total	Total (all partners)	From local NGO partners (%)	Total (all partners)	From local NGO partners (%)
All local NGOs in all countries	$703,041,209	17.8%	12,468,549	14.9%	11,070,543	24.7%
All local NGOs in countries with legal abortion	$438,455,973	11.1%	8,639,969	10.0%	6,819,234	21.2%

Summary

For this analysis, we calculated programmatic impact by identifying partners that may be affected by MCP in countries where abortion laws are more lenient than under MCP (see Figure 1). In addition, MCP also prohibits U.S. funding for organizations that advocate for, but do not provide, abortion services. The impact of MCP is therefore also estimated in countries where abortion is not legal since PEPFAR partners that advocate for safe abortion would be impacted by MCP.

This analysis does not attempt to distinguish which partners are likely to refuse MCP terms, but rather assumes that 100% may be impacted. As such, these values are not estimates of actual programmatic changes but instead quantify the total funding received by partners that will be required to sign on to MCP, and the number of people receiving services through these contracts.

In PEPFAR's 2016 country operational plan (COP) guidance, which details planned allocations for each PEPFAR-supported country (for detailed COP analyses, go to copsdata.amfar.org), the impact of MCP is assessed using two scenarios:

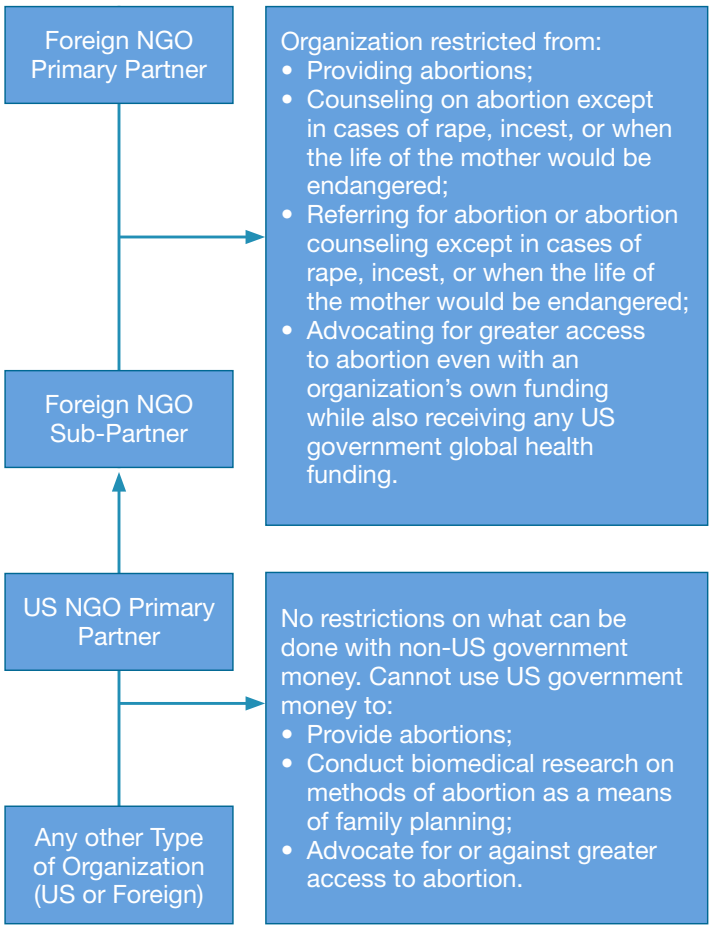
- **All local NGO partners in all countries:** MCP is applied to all non-U.S.-based NGOs in all PEPFAR-recipient countries;
- **All NGO partners in countries with legal abortion:** MCP is applied to all non-U.S.-based NGOs in all PEPFAR-recipient countries with legal abortion.

In the "all countries" scenario, we estimate that $703 million of funding could be affected, constituting 17.8% of total PEPFAR allocations (including pipeline allocations) to these countries. In the "legal abortion" scenario, $438.5 million could be affected, for a total 11.1% of PEPFAR allocations (see Table 1).

Using PEPFAR programmatic targets for local NGO partners, the "all countries" scenario finds that 14.9% of people on antiretroviral therapy (ART) receive services provided by local NGOs and could therefore be impacted by MCP, as do 24.7% of pregnant women accessing treatment for their own health and to prevent HIV transmission to their infants. In addition, 19.3% of orphans and vulnerable children beneficiaries and 17.8% of individuals tested for HIV could be impacted. In the "legal abortion" scenario, 10% of adults and children receiving ART could be impacted, including 21.2% of women receiving ART in prevention of mother-to-child transmission (PMTCT) programs.

Since only foreign NGOs are subject to the MCP, the potential impact of the policy varies depending on the proportion of the services delivered by local partners. In this analysis, the

Figure 1. How the Mexico City Policy works



percentage of funding allocated to local prime and subpartners ranged from only 8.4% in Burundi to 78.3% in South Africa. The impact is likely to be greater in countries with large PEPFAR programs: in countries allocated more than $50 million in COP 2016 (Ethiopia, Kenya, Mozambique, Nigeria, South Africa, Tanzania, Uganda, and Zambia), the average proportion of funding allocated to local prime and subpartners was 28.9%, but was only 23.1% in countries with smaller programs.

While MCP does not directly affect overall funding levels in a given country, it may greatly impact the continuity of services that are being provided, particularly given PEPFAR's efforts to integrate programs with domestic infrastructure and to partner with local implementers. Local capacity to implement programs is essential to the long-term sustainability, efficiency, and effectiveness of programs, and such capacity takes years to develop through strong partnerships and established relationships between, in many cases, U.S.-based NGOs and local counterparts.

All PEPFAR programs would end up being more expensive, less efficient, and less effective.

In circumstances where local implementing partners cannot agree to MCP terms, subjecting PEPFAR funding to MCP will effectively dismantle many of those relationships and leave U.S.-based implementing partners without significant local capacity to implement their programs, as most countries lack alternative organizations that can absorb funding and implement effective programs. This analysis does not consider the complementarity of services provided by both U.S. and non-U.S. organizations. In practice, relatively few individuals interacting with the health system in a country would be reached only by a U.S.-based implementing partner.

In COP 2016, local NGOs in Cambodia, Mozambique, and Zambia were slated to initiate ART for more than 20% of all new patients. In India, Lesotho, Rwanda, Swaziland, and Zambia, local NGOs are primarily responsible for more than 20% of the patients currently on HIV treatment. It is simply not possible, over the next few months, to create, capacitate, and staff new organizations capable of absorbing a significant amount of funding or performing at the same level as organizations that have spent years cultivating such experience, employing health care workers and lay counselors, and developing technical expertise. All PEPFAR programs would end up being more expensive, less efficient, and less effective as a result, and the lives of people living with HIV, including women and infants, would be put at risk.

Notes on the analysis

1. Although local organizations do not provide abortion services in countries where they are not legal, the scenario of MCP impacting all PEPFAR countries is nonetheless included since partners may (1) operate in multiple countries with varying legality of abortion, or (2) advocate for the legality of sexual and reproductive health services such as safe abortion.
2. COP 2016 partner allocation data (including pipeline allocations) are taken from copsdata.amfar.org.
3. Subpartner allocation amounts are not available after 2010. To estimate the percentage of U.S.-based implementing partners that subpartner to local organizations, the average retention rate from 2007 to 2009 is calculated for each international partner. Briefly, this is calculated by measuring the percentage of each mechanism that is retained by the prime partner ("retention rate") and the percentage of subpartner funding that is given to local partners ("local subpartner split"). Local subpartner totals are thus calculated:

   *U.S. Partner Total * (1-Retention Rate) * (Local Subpartner Split) = Local Subpartner Total*

   Subpartner splits from local primary partners are not calculated, as all funding to a non-U.S. primary partner is subject to MCP. For partners that were not in the data from 2007 to 2009, a funding agency-wide retention rate average is used.
4. An organization's location for the purposes of evaluating MCP applicability was determined by the location of the organization's headquarters. From the available PEPFAR funding data, it was not possible to conclude if the agreement or contract was made with the central organization or an affiliate organization. Therefore, only the location of the central organization was used to determine whether the organization is U.S.-based. Note that an affiliate may be legally independent of the central organization; if they are legally independent entities, MCP may not apply to all affiliates or to the central organization itself.
5. For funding that was not allocated (partner = "Not Available"), the international-local split is estimated using a funding agency average.
6. Four PEPFAR indicators are analyzed: "% of HIV+ pregnant women who received ART," "Number of individuals who received HIV Testing Services (HTS) and received their test results," "Number of beneficiaries served by PEPFAR orphans and vulnerable children (OVC) programs for children and families affected by HIV," and "Individuals currently on treatment (ART)." Note that the PMTCT

indicator specifically measures women receiving treatment for the purposes of preventing mother-to-child transmission and does not include other services included as part of PMTCT programs (for example, testing services).

7. Targets impacted by MCP are calculated by the fraction of COP targets that are implemented by local NGO partners. In some countries, a portion of country funding is not yet allocated to a partner and therefore does not have associated targets; as such, the actual target values may ultimately differ somewhat from those presented here.
8. Abortion is considered legal in a country if abortion laws are more lenient than under MCP. Countries in which abortion is illegal, with exceptions for the life of the mother, rape, or incest, are considered illegal since these exceptions are permitted under MCP.

Table 2. COP 2016 funding and treatment data

Country or region	2016 funding (COP + pipeline)			Adults and children receiving ART		Women receiving ART for PMTCT	
	Total	To local NGOs	To local NGOs (%)	Total	From local NGO partners (%)	Total	From local NGO partners (%)
Abortion legal							
Asia Regional Program	$16,227,702	$953,375	5.9%	4,392	8.9%	-	-
Botswana	$40,915,992	$5,308,102	13.0%	194,194	0.2%	16,351	0.1%
Burundi	$15,668,862	$1,226,584	7.8%	31,101	0.0%	89,932	0.0%
Cambodia	$12,000,000	$4,974,841	41.5%	19,017	43.6%	-	-
Cameroon	$39,522,943	$1,245,049	3.2%	173,781	0.0%	332,298	0.0%
Caribbean Region	$26,861,938	$501,265	1.9%	29,035	0.0%	-	-
Central America Region	$21,040,049	$1,392,626	6.6%	10,174	0.0%	-	-
Central Asia Region	$14,940,986	$1,212,019	8.1%	3,323	0.0%	-	-
Ethiopia	$172,687,209	$7,712,634	4.5%	503,258	0.0%	1,389,834	0.0%
Ghana	$12,195,798	$468,041	3.8%	-	-	-	-
India	$23,687,606	$6,029,999	25.5%	153,859	0.0%	193,833	100.0%
Indonesia	$9,800,329	$732,338	7.5%	6,867	0.0%	-	-
Kenya	$497,317,740	$68,998,167	13.9%	1,091,446	2.0%	1,192,291	8.6%
Lesotho	$48,624,531	$3,013,130	6.2%	128,054	8.4%	26,130	24.6%
Mozambique	$336,752,130	$27,568,253	8.2%	855,689	21.4%	1,093,638	8.4%
Namibia	$32,951,065	$3,539,991	10.7%	174,644	0.2%	54,111	0.0%
Rwanda	$66,885,968	$963,151	1.4%	101,317	0.0%	635,058	85.8%
South Africa	$395,144,992	$247,331,351	62.6%	3,378,840	85.2%	35,551	0.0%
Swaziland	$51,294,798	$4,338,937	8.5%	152,990	0.0%	1,175,358	27.6%
Ukraine	$35,252,322	$5,917,450	16.8%	38,773	0.0%	-	-
Zambia	$349,027,156	$37,736,991	10.8%	568,583	36.9%	380,362	37.0%
Zimbabwe	$100,999,999	$7,291,679	7.2%	1,020,632	3.8%	204,487	4.1%
Abortion illegal							
Angola	$16,414,380	$362,602	2.2%	87,304	0.0%	-	-
Burma	$9,000,000	$51,605	0.6%	3,361	0.0%	-	-
Cote d'Ivoire	$135,050,922	$12,672,058	9.4%	145,012	48.9%	384,185	42.1%
Democratic Republic of the Congo	$64,254,563	$3,680,959	5.7%	61,666	0.0%	174,093	0.0%
Dominican Republic	$14,879,431	$1,074,182	7.2%	14,861	30.6%	-	-
Haiti	$93,404,533	$10,423,006	11.2%	80,236	24.5%	232,849	12.1%
Malawi	$92,932,306	$32,541,461	35.0%	656,253	60.6%	490,255	63.6%
Nigeria	$389,944,587	$108,215,348	27.8%	801,925	55.3%	1,640,653	55.0%
Papua New Guinea	$6,425,000	$686,860	10.7%	878	0.0%	131,975	0.0%
South Sudan	$21,283,304	$1,448,505	6.8%	34,245	0.0%	50,598	43.1%
Tanzania	$418,382,515	$58,322,420	13.9%	910,869	35.3%	1,146,701	32.3%
Uganda	$373,811,292	$35,106,230	9.4%	1,031,970	24.7%	-	-
Total	**$3,955,582,948**	**$703,041,209**	**12.2%**	**12,468,549**	**14.9%**	**11,070,543**	**24.7%**