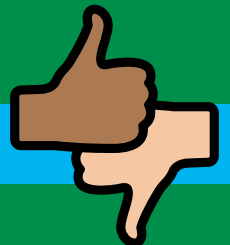


EARLY WARNING SIGNS

The actual and anticipated impact
of the Mexico City Policy on the HIV
response for marginalised people
in Cambodia and Malawi

FRONTLINE INSIGHT

POLICY REPORT



ABOUT FRONTLINE AIDS

Frontline AIDS wants a future free from AIDS for everyone, everywhere. Around the world, millions of people are denied HIV prevention, testing, treatment and care simply because of who they are and where they live.

As a result, almost 2 million people were infected with HIV in 2017 and almost 1 million died of AIDS-related illness.

Together with partners on the frontline, we work to break down the social, political and legal barriers that marginalised people face, and innovate to create a future free from AIDS.

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**A report by Frontline AIDS
and Watipa, with support
from Sida**



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ABOUT THIS REPORT



INTRODUCTION

The Early Warning Signs report is based on a study carried out in 2018 on the impact of the US Mexico City Policy (MCP) and its expansion in 2017, when it was renamed Protecting Life in Global Health Assistance (PLGHA).

The study explored early indications of the policy's impact in Malawi and Cambodia on HIV and sexual and reproductive health services (SRHR) for marginalised people, including people living with HIV, sex workers and men who have sex with men. This report presents the findings, draws conclusions, and makes recommendations toward highlighting the policy's impact on HIV programming at local and national levels.

REPORT SUMMARY

KEY FINDINGS

The study findings suggest that in both countries:

- 1 The policy has created some **disruption to HIV programmes**, outreach services, and referrals to safe, tailored, integrated services for marginalised people, including sex workers, transgender people and men who have sex with men.
- 2 The policy has created an **environment of mistrust, confusion, and isolation** among civil society actors, and tightened the space for advocacy on comprehensive SRHR.
- 3 These changes have **compromised access to HIV prevention, testing and treatment services** for marginalised people.

On 23 January 2017, US President Donald Trump signed an executive order reinstating the Mexico City Policy (MCP). The policy requires foreign non-government organisations (NGOs) to declare that they will not “perform or actively promote abortion as a method of family planning” with any of their funds (including funds not received from the USA) as a condition for receiving assistance from the US government.⁴ The policy prohibits NGOs from providing counselling or referrals for safe abortion services (apart from when the woman's life is in danger, or in the case of rape or incest), and engaging in advocacy to decriminalise abortion or expand abortion services.

President Trump renamed the policy Protecting Life in Global Health Assistance (PLGHA). This significantly expanded the policy's scope so that it applies to HIV funding under the US President's Emergency Plan for AIDS Relief (PEPFAR), and funding for maternal and child health, nutrition, and malaria among other issues. The expanded scope constituted an approximate 16-fold increase of the reach of the policy. Frontline AIDS (formerly the International HIV/AIDS Alliance) partnered with Watipa to conduct a study looking at the actual and potential impacts of the expanded policy on marginalised people affected by HIV in Malawi and Cambodia.

The study was supported by the Swedish International Development Cooperation Agency (Sida).

In particular, the study explored the links between the expanded policy and service provision, service uptake, and funding of HIV and sexual and reproductive health and rights (SRHR). The aim was to understand and forecast the implications of the policy for the HIV response, particularly the potential impact on marginalised people. Integrated HIV and SRHR services are often an entry point for many people – particularly for marginalised people and those at higher risk of HIV – in accessing HIV diagnosis, treatment, care and support services.

Throughout this report, the MCP/PLGHA will be referred to as the Mexico City Policy or ‘the policy’.

EARLY WARNING SIGNS

The study looked at three main areas:

1 Disintegration of services.

Does or will the Mexico City Policy disrupt HIV services, as well as disrupting access to abortion and other SRHR services?

2 Impact of the policy on marginalised people at risk of or living with HIV.

Can or will the real impact of the Mexico City Policy be seen at community level, in terms of who receives and accesses services, rather than the total number of services?

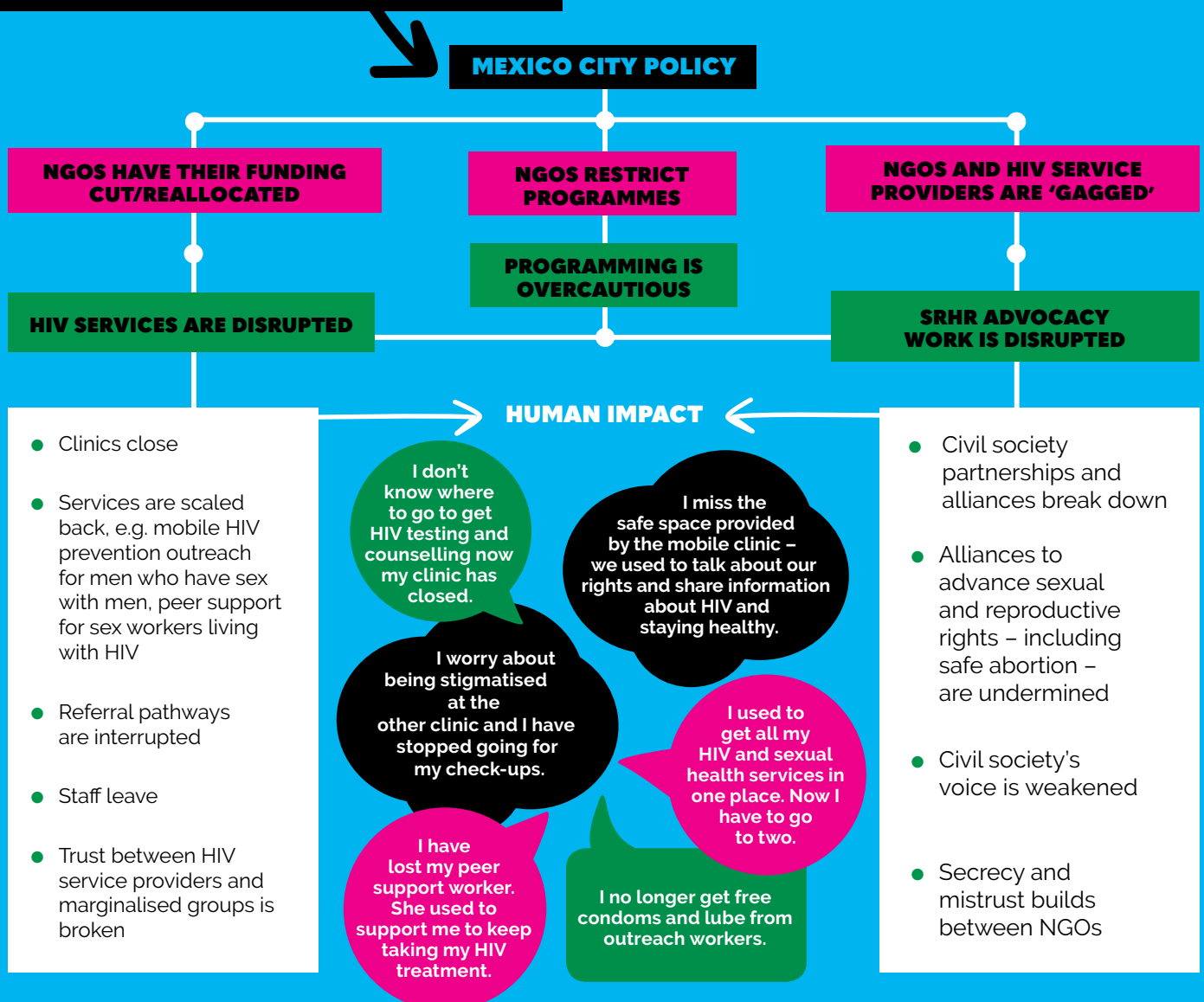
3 Lack of retention in care.

Is there, or will there be, an impact on retention in care because an integrated and comprehensive package of services will no longer be available in a single visit as a result of the Mexico City Policy?

The study was conducted between April and November 2018 and combined quantitative and qualitative components. In addition to service-level data, a range of perspectives about the impact of the policy were sought and analysed. Stakeholders – including policy makers, donors, service providers and representatives of constituency groups such as people living with HIV, men who have sex with men, and sex workers – were interviewed individually and in groups in both countries.

IMPACTS OF THE MEXICO CITY POLICY ON THE HIV RESPONSE

Key findings from a 2018 study in Cambodia and Malawi, exploring the impacts of the Mexico City Policy on access to services for marginalised groups vulnerable to HIV.



COUNTRY-SPECIFIC FINDINGS

In **Malawi**, the study findings suggest that the policy is impacting on marginalised people most vulnerable to HIV and people living with HIV, who now face additional challenges in accessing SRHR and HIV services. The policy also appears to be affecting civil society partnerships on HIV and SRHR, and limiting advocacy to legalise safe abortion.

However, the picture is complicated. It is not always clear when impacts are directly related to the policy due to a range of other challenges including organisational and social factors, the changing priorities of donors, and the country's legal and policy environment, which restricts abortion, criminalises same-sex relationships, and discriminates against sex workers. What is clear is that the policy is the cause of much confusion and concern. In a context where national laws are very restrictive of abortion, the policy has further closed the space for civil society advocacy and action on this issue. It has also caused tensions among NGOs and service providers that have signed the policy and those

that have not, and appears to have led to a loss of trust among beneficiaries and clients.

Service delivery and programming around HIV and SRHR have been affected. In some cases, this is possibly due to over-compliance stemming from a fear of contravening the provisions of the policy. In other cases, where organisations have lost funding or had to re-programme, this is the result of signing the policy or refusing to sign it.

In **Cambodia**, the findings of the study indicate that marginalised people are missing out on essential services, getting lost as referral systems breakdown, and because an integrated and comprehensive range of services is no longer available in a single visit. Entertainment workers (sex workers) and men who have sex with men are particularly affected.

The study was not always able to separate out the direct impact of the policy from the broader funding environment. It appears that there

is less funding available for HIV and SRHR work, in part due to the policy but also due to the changing priorities of USAID and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). However, the findings strongly suggest that the policy has led to the fragmentation of previously integrated HIV/SRHR services for marginalised people.

Because Cambodia's abortion laws are more liberal than the policy's provisions, NGOs and other service providers feel gagged by it. This leads to tension, resentment and a breakdown of trust between beneficiaries and service providers, and also between service providers that are affected by the policy and those that are not.

The study also found examples of overcaution and over-compliance among NGOs that were fearful of losing funding, further restricting access to a range of services for marginalised people.

LOOKING AHEAD

The US government's Mexico City Policy is detrimental to efforts to expand access to sexual and reproductive health and HIV services around the world. Civil society organisations, governments and donors must come together in solidarity with US-based organisations to demand that this policy is overturned.

A comprehensive analysis of the impact of the Mexico City Policy on HIV services for marginalised people is currently very hard to achieve. Existing service-level data systems are not

sufficiently nuanced to quantify the impact of the policy on marginalised people. The lack of longitudinal data sets following the reinstatement of the policy (due to time lags in data collection and ambiguity of the 'start date' of the policy itself), as well as data quality and availability add to the challenge. In relation to funding, it is difficult to attribute declines in US global health assistance to the Mexico City Policy as other factors, such as shifting donor priorities, are at play.

This study is a starting point for understanding the effect of the policy on marginalised people. What is clear is that the warning signs presented here need to be followed over the longer term. While this policy remains in place we need to coordinate our efforts to monitor, document and publicise the impact it is having, especially on marginalised people including those living with and most affected by HIV.

POLICY RECOMMENDATIONS

→ So we can respond specifically to the early warning signs highlighted in this study and mitigate the effects the Mexico City Policy on the HIV response, we make the following recommendations:

Prevent and counter the disruption to HIV programmes

- 1 Governments must ensure that domestic financing of the HIV response is robust enough to withstand fluctuations in donor commitments and mitigate the effects of any conditionalities. This should include funding civil society and community organisations, which are best placed to reach marginalised people and ensure sustained access to information and services.
- 2 Progressive donors including multilateral funders such as the Global Fund must step up a coordinated response to counter the loss of funding created by the policy. They should do this by explicitly funding programmes and community based organisations focusing on comprehensive SRHR – including HIV prevention, treatment and support – with and for marginalised people most affected by HIV.
- 3 Ministries of Health should work with healthcare providers to strengthen data collection in order to more effectively monitor the impact of the policy on the provision of integrated SRHR and HIV services. For example, service statistics should gather information, not only about clients reached but also about the number and type of services received per visit, referral pathways (including those from community outreach), and user feedback on the quality of services.

Address and resolve the confusion and fear among civil society


- 4 US government agencies and their representatives should provide clear and unambiguous implementation guidelines, translated into local languages, with technical assistance and legal support to enable civil society organisations to continue to implement programmes with minimum disruption, and to guard against over-extension of the policy. Prime recipients, implementing partners and local civil society should be empowered to provide a 'watchdog' function to monitor and document the negative impacts of the policy.
- 5 Civil society organisations should share, support and coordinate amongst themselves, no matter what their organisation's position might be on the Mexico City Policy. This would help civil society to map and fill gaps in programming and advocacy through partnership, and collectively communicate emerging concerns to their government and funders.

Ensure sustained and uninterrupted access to comprehensive SRHR and HIV services

- 6 Policy makers and civil society should advocate for the implementation of the full package of comprehensive sexual and reproductive health services as recommended by the Guttmacher-Lancet Commission's 2018 report on SRHR.² This includes services for HIV prevention, treatment and care, as well as access to family planning, safe abortion, fertility treatment, maternal health services, prevention of and response to gender-based violence, and comprehensive sexuality education. In countries where access

to safe abortion is legal this would include safeguarding against influence from external policies that threaten to undermine access to essential services. In countries where access to safe abortion is restricted, the international community should support civil society organisations that are not in receipt of US government funding to advocate for legalising abortion.

- 7 Governments should ensure their National Strategic Plans on HIV explicitly provide and prioritise safe spaces for people living with HIV and marginalised people vulnerable to HIV. This includes supporting peer outreach programmes to reach and support these communities, and sensitising health providers, police and other service providers to the needs and rights of marginalised people.



Chifundo, 23, is a young mother and sex worker, in Mchinji, Malawi.

"Packachere [Frontline AIDS partner] come to visit us, talk with us, and provide condoms and lubricant and advice on where to go for different health services."

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BACKGROUND

The Mexico City Policy

First announced in 1984 by US President Regan at the International Conference on Population and Development held in Mexico City, the policy requires foreign non-government organisations (NGOs) to declare that they will not "perform or actively promote abortion as a method of family planning" with any of their funds (including funds not received from the USA) as a condition for receiving assistance from the US government.³ NGOs may not provide counselling or referrals for safe abortion services (with some exceptions, i.e. in cases of rape, incest or endangerment of life of the woman), or conduct advocacy to decriminalise abortion or expand abortion services. The policy, also referred to as the 'Global Gag Rule' by its critics, was repealed in 1993, reinstated in 2001, and repealed again in 2009.

On January 23 2017, President Trump signed an executive order reinstating the Mexico City Policy under the title Protecting Life in Global Health Assistance⁴, and expanded it to include not only global family planning assistance provided by the US government (representing \$575 million in 2016) but also global health assistance (\$9.5 billion in 2016).

This means an approximate 16-fold increase in the reach of the policy, and a significant broadening of its scope to cover HIV funding under the US President's Emergency Plan for AIDS Relief (PEPFAR), and funding for maternal and child health, nutrition, and malaria among other issues. It is estimated that the expanded policy will impact a total of \$8.8 billion in foreign aid funding, nearly 70% of which is earmarked for PEPFAR.⁵

Other donors' responses to the policy

In terms of the donor landscape, through pooled funding and domestic and international efforts, several actors have responded to the reinstatement and expansion of the policy with initiatives to compensate for its impact. This includes the She Decides initiative, which has seen governments, youth leaders, parliamentarians UN representatives, NGOs, private foundations and the private sector come together and commit financial resources. As of March 2018, She Decides had raised approximately \$450 million⁶, which has been used to finance organisations that have been affected by the policy and other US funding cuts.

The governments of Sweden, Canada, Denmark and the Netherlands are among the various actors mobilising to fill some of the funding gaps. Canada, for example, has committed to increase its funding to international organisations to support increased access to a full range of health services, including safe and legal abortion and post-abortion care.⁷

Philanthropists such as the Bill and Melinda Gates Foundation and the Children's Investment Fund Foundation (CIFF) have also contributed, through She Decides, to plugging the gaps left by the policy.^{8,9} In addition, CIFF has directly funded initiatives to prevent discontinuity in outreach contraceptive services for women and girls living in poverty, for example through its multi-year \$10m grant for Marie Stopes International (MSI) in sub-Saharan Africa (which will fill one-third of the projected shortfall of \$31 million each year for MSI as a consequence of funding cuts).¹⁰

Despite these efforts, given the size of the US government's contribution to the HIV response, it is highly unlikely that all the funding gaps resulting from the policy will be filled, especially in relation to HIV and marginalised people.

Documenting the impact of the policy: global perspectives

A number of high-profile family planning organisations that provide sexual and reproductive health services at scale, including safe abortion, have already begun to document the impact of the policy on the provision of these services and on the organisations that provide them. This includes looking at the financial consequences of not being able to accept global health assistance from the US government.

The Guttmacher Institute has been tracking the impact of the policy on abortion rates and safety. According to a Guttmacher report published in March 2018, the global abortion rate has slightly declined over the last 25 years and access to safe abortion care is increasing in parts of the developing world.¹¹ However, these important gains to SRHR may now be under threat. When the Mexico City Policy was previously in effect, organisations had to fire health providers, reduce the services they offer, and close clinics, which resulted in a loss of access to family planning and reproductive health services.¹² Furthermore, Guttmacher estimates that, for every decrease of \$10 million in US global family planning assistance and spending on reproductive health programmes, 53,000 more abortions will take place (35,000 of which will be provided in unsafe conditions), 416,000 fewer women and couples will receive contraception and 124,000 unintended pregnancies will occur.¹³

The Center for Health and Gender Equity (CHANGE) has also analysed the impacts of the Mexico City Policy over time¹⁴, documenting some of the adverse effects experienced since the reinstatement of the policy under the Trump administration. These include the confusion created by the policy amongst non-US NGOs, and its impact

on funding partnerships and local advocacy. The report examines the policy's impact on PEPFAR's efforts to reduce the HIV burden globally due to fracturing partnerships among organisations, a loss of funding for HIV programmes, and the closure of projects such as those that offer HIV testing to marginalised people. It also highlights concerns that the reinstated policy is likely to impact service delivery and programmes for marginalised people by disrupting comprehensive access, information and services relating to SRHR and HIV.

In 2017, the Kaiser Family Foundation assessed abortion laws in countries receiving US global health assistance.¹⁵ This categorised countries into two groups: those that allow legal abortion in at least one case not permissible by the policy, and those where abortion is not legal beyond what is permissible by the policy. It found that the majority of countries that received US bilateral global health assistance in 2016 (37 of 64) allow for legal abortion in at least one case not permissible by the policy. These countries accounted for 53% of bilateral global health assistance. Countries in the two categories are affected by the policy differently. Where abortion is less restricted under national law than under the policy, NGOs would be prohibited from providing nationally permitted services, even with non-US funds. Where abortion is illegal or more restricted under national law than under the policy it would not further limit access to legal abortion, although it may have other impacts such as curtailing abortion counselling.

A research working-group convened by Columbia University in New York City and CHANGE is coordinating the efforts of a number of research and civil society organisations to monitor and assess the impact of the policy. These efforts include 31 ongoing and 75 anticipated studies examining the impact of the policy. Although some

of these studies look at the policy's impact on HIV services, most focus on its impact on sexual and reproductive health services. Crucially, those that do address HIV tend not to focus on the provision of HIV services for marginalised people; namely, people living with HIV, sex workers, transgender people, people who use drugs and men who have sex with men.

It is critical that the HIV dimensions of the policy are examined, modelled and captured because family planning organisations that currently provide integrated HIV/SRHR services may no longer be in a position to accept US global health assistance (e.g. PEPFAR funds) to support the HIV elements of their work, and may have to reduce or cut the provision of HIV services. Similarly, HIV-focused organisations that run integrated SRHR programmes, provide referrals to abortion services and/or advocate for comprehensive SRHR could face a difficult dilemma: can they continue to accept US global health assistance? If not, what will be the impact on HIV and other services for marginalised people most affected by HIV?

EARLY WARNING SIGNS

Early warning signs: a study on the impact of the Mexico City Policy on the HIV response in Cambodia and Malawi

The Early Warning Signs study was led by Frontline AIDS in partnership with Watipa and Sida. It seeks to complement other ongoing and forthcoming studies by focusing on the impacts of the Mexico City Policy on access to, and uptake of, HIV services by and for marginalised people in Malawi and Cambodia.

The study was carried out between April and December 2018. It investigates the actual and anticipated impacts of the policy on service delivery and referrals, NGOs and service providers, civil society partnerships, advocacy, and the promotion of rights for marginalised people living with and affected by HIV.

The study is based on four hypotheses:

- 1 Some people using SRHR services as an entry point to access HIV services may not reach, or be reached by, those services.
- 2 The real impact of the policy may be seen at community level, not in terms of the total number of services offered but in terms of who receives them.

- 3 Because an integrated and comprehensive package of services will no longer be available in a single visit the number of people retained in care may fall.
- 4 There may be a different impact in countries where the legal environment relating to abortion is more restrictive than the policy (e.g. Malawi), compared to countries with more liberal legal frameworks on abortion (e.g. Cambodia).

The study used a combination of qualitative and quantitative research methods.

In Malawi, organizations invited to participate in the study included international civil society organisations and local organisations (such as networks of people living with HIV, family planning and health service organisations). Representatives from USAID were invited to participate in the study, and took part in a key informant interview. Overall 16 organizations were represented in the process. In total 10 one-to-one interviews were conducted, and 13 participants took part in the focus group discussion. Quantitative data was analysed from two service sites, provided by organisations that work with sex workers and men who have sex with men. However, these data was unreliable and inconclusive so are not included in the report.

In Cambodia, three focus group discussions took place – one with 23 participants from civil society organisation and health care facility workers; one with eight representatives from civil society organisations; and one with six entertainment workers. Eight one-to-one qualitative interviews were also undertaken.

Quantitative data were provided on outreach activities and referrals to HIV testing and counselling, STI services and family planning clinics for female entertainment workers, transgender people and men who have sex with men. These data seem to reflect the findings from the qualitative research – showing an overall decline in activities and referrals for all three populations. However, the rapidly changing funding landscape and a lack of more recent data from 2018 onwards make it impossible to attribute data fluctuations to the Mexico City Policy alone. These limitations are discussed further below.*

*For further details on the study methodology, please contact Frontline AIDS

Sex workers in Cambodia.



EARLY WARNING SIGNS

National contexts

→ The situation in Malawi

Although the Malawi government leads and oversees its national HIV response, 95% of funding comes from international donors, with the US government and the Global Fund constituting the largest share of funding to Malawi's 2015-2020 National Strategic Plan for HIV and AIDS.¹⁶ In 2016, PEPFAR allocated 35% of its funding in Malawi to local NGOs.¹⁷ The impact of the expansion of the Mexico City Policy is therefore likely to be felt strongly across multiple aspects of the HIV response.

Abortion in Malawi is generally illegal under Sections 149-151 of the Penal Code, with penalties of between 3 and 14 years imprisonment. Under Section

243 of the code, an abortion can be legally performed in order to save the life of the pregnant woman. There has been recent pressure from civil society and others to liberalise the law and enable access to safe abortion.

Within Malawi's generalised HIV epidemic, people at higher risk of HIV face discrimination and criminalisation. Homosexuality is illegal in Malawi, punishable by up to 14 years in prison, although prosecutions were suspended in 2012.¹⁸ Sex work is not illegal in Malawi, although related criminal offences are often used as a reason to target, harass, abuse and arrest sex workers.¹⁹ In this context, sex workers and men who have sex with men often experience stigma and fear when seeking healthcare of any kind, which often prevents them from accessing HIV testing, prevention and

treatment services or being outspoken about the risk factors affecting their health.²⁰

In 2017, Malawi Members of Parliament voted to reject provisions in the HIV (Prevention and Management) Bill that had the potential to act as legal barriers to an effective HIV response, including measures to make HIV testing and treatment mandatory for selected groups on a discriminatory basis, and the criminalisation of HIV exposure and transmission. Civil society organisations, including those working to address human rights barriers faced by marginalised people at higher risk of HIV, mobilised to coordinate advocacy efforts and were instrumental in the achievement.²¹

Chisomo is an outreach worker supporting sex workers in Mchinji, Malawi, working for Frontline AIDS partner Packachere.





"I help the new girls and teach them how to use condoms and visit the clinics. Now, I am working as a group discussion facilitator. I love this job so much."

Sex worker in Cambodia.

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The situation in Cambodia ←

The Global Fund remains the single biggest source of HIV financing in Cambodia, providing 41% of funds in 2015.²² In the same year, domestic funding for HIV increased from 13% to 17%. US government funding through PEPFAR increased from \$11.4 million to \$13.7 million (23% to 29%) in 2015, but dropped back to \$12million in 2016 (with 41.5% going to local NGOs).²³ PEPFAR funding has been rapidly declining since then, following a strategy shift from direct service delivery to a technical assistance approach.²⁴ At the same time, contributions from Australia, Belgium, Germany, Japan and Sweden fell by 67% to \$332,604 (or 0.7% of spending).

In Cambodia, laws governing abortion are relatively liberal. Safe abortion, performed by a qualified healthcare provider, has been part of legislation since 1997 under Article 52 of the Constitution. Abortion is permitted to protect the life of the pregnant woman, to preserve physical and mental health, when the pregnancy

is the result of rape or incest, when there is a malformation of the foetus, for economic or social reasons and on request up to 12 weeks. After 12 weeks, abortion is only legal if it will save the woman's life or preserve her health, the pregnancy is a result of rape, or the child may be born with an incurable disease.²⁵ However, under the Mexico City Policy, organisations in Cambodia that receive US funding are no longer able to provide abortions or abortion counselling or refer women to abortion services.²⁶

Legal protections in Cambodia for people living with HIV include confidentiality laws and regulations, plus laws that prohibit HIV-related discrimination and compulsory HIV testing. The state is legally obliged to ensure all people living with HIV receive primary healthcare services from public health networks, free of charge.²⁷

HIV in Cambodia is concentrated among marginalised people, including entertainment workers (sex workers), transgender people, people who inject

drugs, gay men and other men who have sex with men.

There are no laws penalising same-sex relationships in Cambodia.²⁸ In regards to sex work, the 2008 Law on the Suppression of Human Trafficking and Sexual Exploitation confirms pre-existing provisions against human trafficking and procuring with the use of force or coercion, and extends them to all third-party involvement in sex work. This criminalises all social and financial transactions connected to sex work (such as accommodation, transport, employment and advertising) and applies regardless of the consent of the sex worker.²⁹ It is illegal to solicit in public places in Cambodia.

STUDY FINDINGS

Marginalised people have less access to tailored HIV and SRHR services – with negative consequences for their health and well-being

In Malawi, the most notable impact of the policy so far is that additional barriers are now in place which are restricting access to essential health services for marginalised people living with, or at higher risk of, HIV. Since the policy was reinstated, sex and entertainment workers and men who have sex with men have experienced a reduction in services tailored to their needs.

One participant, who works on policy and advocacy programmes for marginalised people, said the policy is impacting access to HIV treatment and care services in Malawi because ***"some of the organisations pulled out and stopped offering services. It is also limiting choices for the target groups to access those services"***.

In one US-funded project serving marginalised people, the closure of clinics and the revision of implementing partners has affected who receives HIV services. Participants in the qualitative interviews described how these changes are affecting sex workers.

"Despite being an HIV programme, the services we were offering were an integrated service so we were providing female sex workers with cervical cancer screening, family planning, HIV and STI testing and treatment. [The Mexico City Policy] meant that we were supposed to stop all that, which we did."

This reduction in tailored services also means a loss of safe spaces for marginalised people such as men who have sex with men.

"Malawi cannot easily accept this highly stigmatised population. This project had created a safe space for them, but MSM [men who have sex with men] who were previously accessing services are now denied access."

In some cases, people may be losing access to services because organisations are over-interpreting the policy out of fear of losing their funding. (See below for more on over-compliance.)


Marginalised people are most affected by reduced HIV and SRHR services

"No one cares for us [entertainment workers] now."

In Cambodia, all the NGO outreach workers interviewed identified entertainment workers as the people who have been most affected by the policy. They provided examples of lower condom distribution, fewer referrals to health facilities for HIV and STI testing, poorer retention in HIV care, and examples of women undergoing unsafe abortions directly as a result of the policy.

The entertainment workers interviewed felt more isolated from healthcare advice and services since the policy was reinstated because a number of US-funded programmes had been stopped or not renewed. There were fewer outreach workers who could support them and help them attend health facilities for testing and treatment. They felt more vulnerable to HIV and other STIs, unintended pregnancy and complications from unsafe abortions. Entertainment workers living with HIV who were on antiretroviral treatment (ART) were experiencing gaps.

EARLY WARNING SIGNS



Funding cuts mean more costs are being passed on to service users, with the most marginalised and poorest people worse affected.

One participant in Cambodia described how, previously, an outreach worker would pick her up and take her to the health facility every two to three months for an HIV/STI check-up, and provide her with free condoms. But due to a reduction in outreach workers, service access has become more challenging, and funding cuts mean more costs are being passed on to people using the services.

"At the health facility we would pay a flat fee of half a dollar for the consultation and any STIs prescription... Now we have to pay \$2 for our health visit, we go alone and often have to wait a long time, hours, to get seen."




Marginalised people are less able to access family planning and HIV protection

"We now have to pay for our condoms but are too shy to go to the pharmacy so we ask the client to bring a condom with them."

Outreach workers in Cambodia also used to provide free oral contraceptives and condoms. Female entertainment workers interviewed from areas outside of Phnom Penh described how they now have to buy condoms and oral contraceptive pills at the pharmacy. Ordinarily, the women avoid coming into contact with pharmacists who they feel judge them due to the nature of their work.

Participants talked about fellow entertainment workers who no longer use oral contraceptive pills because they can't afford them and because they are too embarrassed to buy them from a pharmacy. Instead, they rely on condoms for both contraception and HIV protection. However, since they no longer get free condoms from outreach workers, they have to find money to buy their own, pass that cost on to their clients, or depend on clients to provide them. Clients can take advantage of this situation and some do, insisting on sex without a condom.



Fewer outreach workers mean marginalised people are less likely to attend services

In Cambodia, female entertainment workers and other vulnerable women, including those with poor literacy, have not traditionally felt welcome at government health facilities. Outreach workers provided a bridge between these women and the services they need, helping people to navigate lengthy registration

and waiting times while reducing stigma and discrimination. Much of this work has now stopped, resulting in fewer marginalised women attending drop-in centres as well as health facilities. Women who did attend wished for better and quicker appointments at the health facility for their STI checks.

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Marginalised people have lost safe spaces and opportunities to connect with each other

A consequence of these changes has been the loss of safe spaces and opportunities for entertainment workers to connect and stay in touch with each other. The reduction and/or cessation of outreach programmes has left entertainment workers in Cambodia vulnerable to ill-health, caused breakdowns in the referral system, and jeopardised treatment-adherence support for people living with HIV.

In addition, service providers are unable to reach people like they used to.

“People are already feeling the pinch of the Mexico City Policy. Most organisations, which were actively empowering people and providing services to people with the aid from the United States, right now their delivery has gone down and they are unable to reach out to people as they used to do. For sure it has affected service delivery.”



The range of SRHR and HIV services offered has been reduced and programmes have been cut

“Those [sex workers] who had a safe space to get tested, to get their ARVs [antiretrovirals] and have adherence promoted through peer-to-peer support no longer do as the project is no longer there.”


The policy itself, and the widespread confusion around what it means in terms of which services can and cannot be provided, has already reduced the range of SRHR services offered.

In Malawi, a representative of one organisation talked about mobile clinics and safe spaces, including clinics within

bars, which enabled female sex workers to access services at night and in their workplace. These clinics made use of peer educators who distributed condoms and encouraged HIV and STI testing, as well as making service referrals, providing education on HIV transmission and gender-based violence, and empowering women to persuade clients to use condoms. The participant noted that when the programme was running around 630 women were supported to test for HIV and initiate and adhere to antiretroviral treatment, and around 2,700 were referred to services. This is no longer happening.

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Attendance at drop-in centres has declined because clients no longer feel they get the help they need




"The impact of fewer outreach workers has meant that key populations are less likely to come to the health facility for testing and care because there is still a lot of stigma associated with being from a key population and also from having an STI or needing family planning advice."

Once NGO-provided services were no longer available in Cambodia, marginalised people's fear or anticipation of experiencing stigma in a public health facility resulted in people no longer accessing services.

One Cambodian NGO verbally reported a decrease in its drop-in centre for entertainment workers and men who have sex with men, from 300 to 100 attendances per quarter in the last year. Staff said this was due to a combination of funding cuts and clients feeling they would no longer receive the help they need.

"The Mexico City Policy has limited access to services because our partners can't offer the same services as they did previously".

Comprehensive services are no longer available in one place, and referrals do not meet people's needs



"[Public health facilities in Malawi] are still hostile to the key population and these are no longer safe spaces for them to access to services. The referral mechanism is as good as dead."

With the loss of funding and subsequent closure of programmes, the policy appears to have affected where people are referred, which in turn has resulted in people no longer accessing services.

One participant in Malawi gave an example of men who have sex with men being referred to public health facilities rather than a trusted provider known to be welcoming of men who have sex with men, even though stigma experienced and anticipated by men who have sex with men in public health facilities is known to impede access to health services.

Service-level data gathered in Malawi seems to support this. In the period after

the policy was reinstated, fluctuations in service uptake and referrals for men who have sex with men, and an increase in referrals for ART, suggests that a complete package of services is no longer available at those service-delivery sites. While referrals may have increased, the data suggests that people do not always follow-up these referral, especially if they feel they might be stigmatised.

The study found similar issues in Malawi for sex workers. Even though NGOs are no longer offering one-stop services, referrals are being made to local public health facilities. However, sex workers' experiences and anticipation of stigma are preventing them from taking up those services. In addition, because the services on offer are no longer integrated, opportunities to link HIV testing, treatment and care with screening and treatment for other STIs and with family planning may be being missed.

Trust has broken down between providers and clients



"It takes time to build trust with clients, and not giving advice means the trust is broken."

In Cambodia, the policy has had a major impact on the relationship between outreach workers, community health workers and their clients. Trust has been broken because of the disruption to services. Some spoke of a reduction in client numbers because entertainment workers had stopped coming to drop-in centres.

Some outreach workers gave personal examples of meeting clients off site and in their private time so they could properly discuss all options of care and refer them to appropriate services, something that was no longer possible in their professional capacity. They feared they would be blamed for failing to provide correct advice.

"We are no longer in touch with some of the clients. We hear that some women are seeking traditional birth attendants instead, but it is not possible to know as we are not allowed to ask. There have been instances of women coming to the centre with bleeding after going to a traditional birth attendant instead of getting a safe abortion."

Many of the outreach workers interviewed also felt conflicted and angry about the policy. Staff described a feeling of being gagged.

"We now have to shut our mouth when a woman comes to us for help."

In Malawi, an organisation that works on human rights for people at higher risk of HIV and on HIV prevention also highlighted the policy's detrimental impact on the relationship between the organisation and its beneficiaries:

"The beneficiaries couldn't understand what this policy is because all along we were working with volunteers so if you are pulling out, the members couldn't understand what the policy was all about. It affected the relationship between the organisation and the beneficiaries because the policy came in the middle of implementation. This was a challenge."


In Cambodia, participants described how the policy has led to trust breaking down between providers and the clients they serve, and a reduction in referrals.

"There has been a decrease in a number of referrals because when they cannot ask us about any information related to abortion, they feel like they cannot depend on us and they do not come get our services anymore."

Monitoring of incomplete referrals for services (referrals that are issued but not taken up), as well as completed referrals (those issued that resulted in someone receiving a service) would be helpful to track and analyse retention in care. This would also be useful to verify the extent to which perceptions and anticipation of stigma in public health facilities creates barriers that prevent marginalised people from taking up the services for which they have been referred.

EARLY WARNING SIGNS

Organisations have shrunk in terms of budget, services and staff



"As a believer of rights, we said no to the [policy] and that led to the termination of that big grant... this had a severe impact on the clinics in three districts. It meant we had to reduce staff and reduce our programmes drastically. We are sustaining the other services at a small scale... and we are still looking for other funders."

In Malawi, organisations that decided not to sign the policy have found their budgets affected, with an impact on clients, services and staff.


At the same time, Malawi organisations signing the policy were also affected by budget cuts. A family planning service delivery organisation that received US funding to support projects to improve access to SRHR and HIV services for young women (including young sex workers), stated that the policy has cost

them 35% of their total organisational budget, and as a result, 37% (almost 4 out of every 10) staff members had to be let go.

As a result, the policy's affect on jobs and livelihoods in the sector was a concern.

"Apart from affecting service delivery there is an effect on the livelihoods of people in the NGO sector in Malawi. People are out of employment and this is something we didn't expect."

In Cambodia, the study also found that the number of outreach workers has been affected, organisational budgets have shrunk, and some programmes and services discontinued. Some staff losses appear to be directly attributable to the reinstatement of the Mexico City Policy. However, the picture is complicated due to overall declines in international funding (see below).



Project implementation has been disrupted and continuity affected

Organisations that signed the policy find they are no longer able to provide some services under the policy's provisions. In Malawi, an SRHR and HIV service delivery organisation, running as a country office to a large international NGO, was unable to continue to implement a project because of the policy, and had to hand over to another implementing organisation.

"The project we had here had to find another partner that could continue to implement because our hands were tied. That has been the major blow in

terms of our implementation because we had a project with funds and we were implementing but now we can no longer directly implement."

In Cambodia, participants also indicated concern and confusion about the policy.

"This is affecting my organisation – what is the Mexico City Policy all about?"

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Service providers feel 'gagged' and unable to do their jobs well

The impact of the policy has affected motivation and professional development opportunities for healthcare workers. In Cambodia, some health providers reported feeling 'gagged', unable to do their job as they would wish, while others have begun providing services in their personal rather than professional capacity. Some lamented the breakdown in trust caused by the policy, describing how it interferes with the range of advice and counselling they are able to provide, and the rapport they have developed with clients.

In Cambodia, NGOs have played an important role in training healthcare workers to provide integrated family planning and SRHR services. Participants in the stakeholder focus-group discussion expressed concern that trainings had been affected by the policy, and worried about how the gaps in training would be addressed.



Partnerships and coalitions have disintegrated

The policy has already affected civil society coalitions and organisational partnerships in Malawi, causing fragmentation, tension and mistrust in these relationships.

A coalition of more than 45 civil society organisations representing women, young people, healthcare providers, community partners and others has seen a reduction in its membership since 2017, which it attributes to the constraints of the policy. In another case, an organisation found

its partnerships breaking down because some partners felt unable to sign the policy.

"We have been working with partners to implement services. We have partners who could not sign the policy because it was contradicting with the whole essence of why that organisation was established... it's like you are at ransom because you are part of an institution receiving money and then you are being forced to change."




Secrecy and mistrust has affected organisational reputations

Organisations in Cambodia felt that the implementation of the policy had also led to reputational risk and affected their partnerships. Those that had stopped working with partners who provide abortion services or advice expressed concern that this was seen as poor performance on their part and had

jeopardised existing collaborations, some of which had taken many years to build. This left them with great uncertainty in regard to their future relationships with other NGOs and implementing partners.

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Confusion, over-compliance and a lack of clarity



Within organisations, there is often a lack of clarity about the policy, and people have difficulty explaining it to colleagues and others. A study participant in Malawi commented:

"It's about the signatories and the source of our funding and not about providing abortion. This was difficult to explain to our colleagues."

In Malawi, lack of clarity and confusion was also causing problems within partnerships and organisational relationships.

"We had to stop implementing a project and that affected our relationship with the district council... We had to do a lot of explaining about why we were not able to implement, as there was a lot of confusion about what the Mexico City Policy was about. The services continued but we were not able to implement."

The confusion around what is and is not permitted under the policy in a context where abortion is already legally restricted, as in Malawi, seems to lead to extreme caution, to the extent of organisations over-applying the provisions of the policy.

Likewise, some of the examples given in interviews in Cambodia, where abortion is legal up to 12 weeks of pregnancy, appear to demonstrate over-compliance.

In addition, participants in Cambodia reported that, due to the alternating rescindment and reinstatement of the policy from US administration to administration, some NGOs chose to adhere to its terms even when it was not in force so as to avoid having to make programmatic adjustments when it was reinstated. In this respect, the policy seems to be resulting in over-compliance, even when not in force.

Furthermore, one NGO reported that they were advised as early as December 2016 (immediately after President Trump has been elected, but before the executive order was announced) to suspend SRHR activities. As a result, the number of people the NGO reached with integrated SRHR/HIV services fell from 52,822 in 2016, to 6,345 in 2017; a drop of 88%. It's not clear whether these included activities permitted by the policy; in any event, the policy should not have affected what was an existing contract.



Advocacy and activism on abortion and human rights has been crippled


"When you have a super power also enforcing conservative policies like this, it is like you are giving energy to government, who do not want to change, to continue doing the same practices... Eventually the rights institutes – who are promoting the rights of people, including the right for safe abortion – will be targeted. In the end their stamina to do their work on the ground is crippled."

Before the policy was reinstated, there were some focused civil society advocacy initiatives for the liberalisation of abortion laws in Malawi. Some participants said they were no longer part of these due to the change in policy. They noted that

the policy would enable the government to remain conservative in relation to advocacy efforts to liberalise existing abortion laws in Malawi. While there were participants who felt that the policy would force programmes to align with the more restrictive national legislation around abortion (which they saw as a positive influence), others feared the policy would cripple activism for safe abortion and human rights.

In Cambodia, some interviewees felt it was problematic to have an international policy restricting abortion in a country where abortion law is more liberal.

Funding gaps are not easy to fill



Participants in Malawi described how organisations are seeking alternative funding to mitigate losses sustained as a result of not signing the policy.

However, the gaps are not easily filled. The Global Fund, for example, continues to fund similar work in different areas, but it does not necessarily cover the districts previously funded by the US government. Many anticipate a decrease in future funding availability for family planning or SRHR services and advocacy activities. However, others argue that in the absence of US funding, other sources of funding will become available. But with 95% of funding for Malawi's HIV response currently coming from international donors, with the US government and the Global Fund constituting the largest share of funding³⁰, the impact of funding reductions caused by the policy should not be underestimated.

In Cambodia, declines in funding from international agencies have been felt across the country and have affected the range of HIV services available. PEPFAR's discontinuation of funding to civil society

organisations for direct service delivery has resulted in the closure of some NGOs, and programmes ending without follow-up funding.

Service disruption may not only be related to changes in PEPFAR's funding priorities and conditionalities; some government health clinic staff said they had experienced a reduction in referrals and support from NGOs in recent months due to funding cuts but were unclear of the reasons. They described a current gap in funding due to slow Global Fund procedures that has resulted in antiretroviral (ARV) shortages and stock outs. Since 2018, people living with HIV have been asked to come and collect their ARVs every six months rather than every three to reduce the burden on clinics. In the past, NGOs provided a critical link between facilities and people living with HIV, ensuring people did not miss appointments (picking up people at home if necessary) and supporting people to adhere to HIV treatment. The reduction in outreach services means that such support is no longer available.

Anticipated longer term impacts



Participants in Malawi anticipated that the effects of the policy would be amplified for marginalised people.

"When you have a discriminatory policy which affects everyone, to the vulnerable groups it comes with a bigger blow because they are already [negatively] affected."

Asked what they anticipated will be the short-term and longer-term impact of the policy, participants in Malawi expressed a range of views. Many said that it will have an impact on health outcomes such as maternal deaths, pregnancy rates (especially among adolescent girls and young women) and on HIV acquisition.

Participants in Cambodia anticipated that the policy could lead to a (continued) decline in referral rates, a reduction in data on marginalised people, a loss of trust between entertainment workers and outreach workers, an increase in unsafe abortions and a related increase in the number of women dying from unsafe abortions, an increase in HIV and STI transmission, and negative effects relating to entertainment workers' quality of life.

If NGO-provided services were no longer available, fear or anticipation of stigma in public health facilities meant that marginalised people would no longer access certain services.

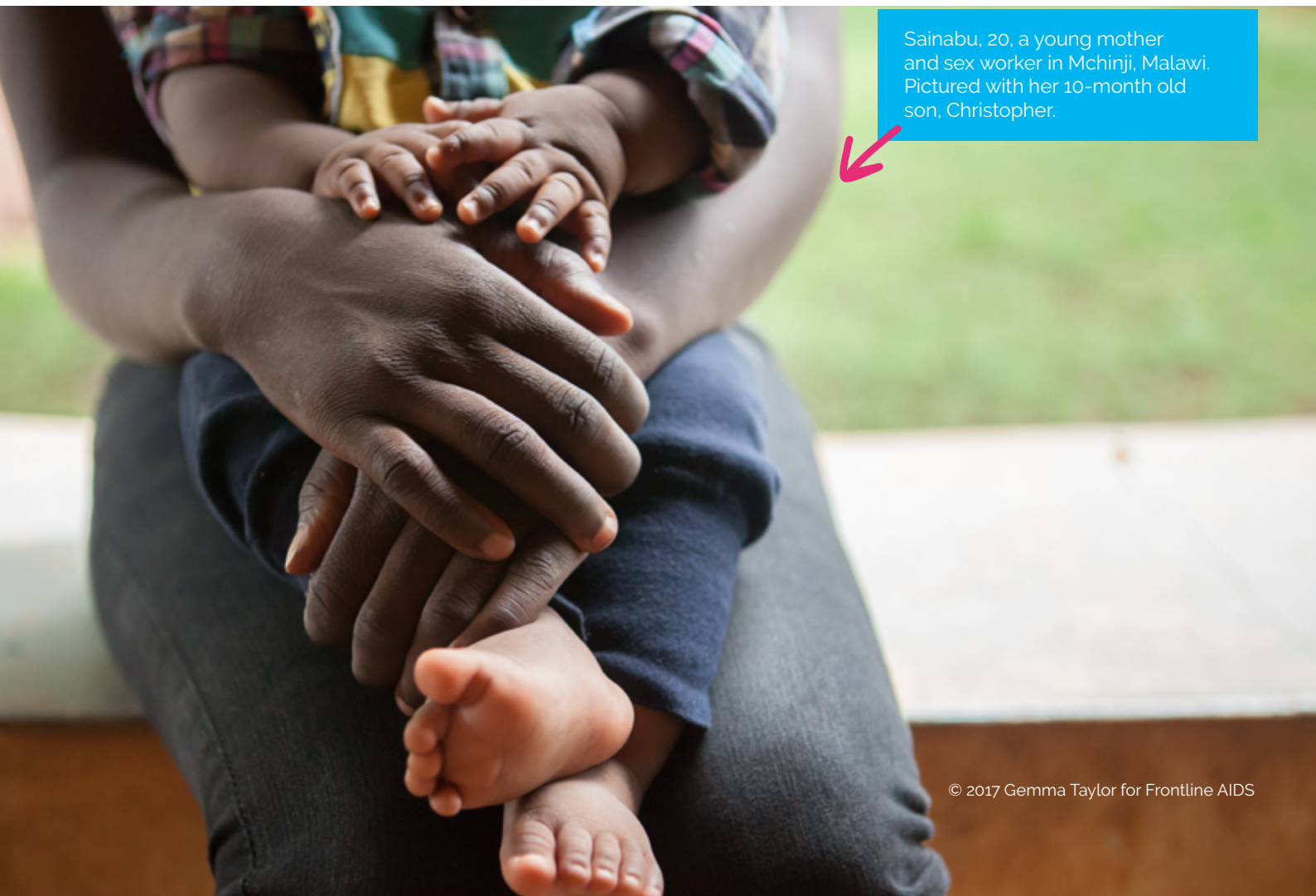
STUDY LIMITATIONS

The qualitative findings strongly indicate negative impacts of the policy on HIV and SRHR programming and access for marginalised people, but there was some caution and even fear among participants around expressing this.

There were some questions relating to attribution that could not be satisfactorily answered; namely, it was unclear as to whether changes to services had been caused by the policy or by other factors such as programmes ending or shifting donor priorities – particularly in Cambodia where US government funding has been declining rapidly since 2016 as programme cycles come to an end.

In Cambodia, data for 2018 was not yet available. In addition, comparative analyses with previous years will not be possible as the donor-funding structure changed

in 2018, with funding now restricted to different provinces from previous years. In addition, although relatively good health data information exists in Cambodia, the data systems are not designed to track the impact of specific donors nor a specific policy. The quantitative data from Malawi on service access was inconclusive. It was not possible to draw conclusions from the data about access to integrated services. Although a client may receive one or more integrated activities during the same encounter, this information is only collected (if at all) at the local level and not consistently transferred to a central database. This highlights the importance of strengthening data collection in order to monitor the impact of the policy.



Sainabu, 20, a young mother and sex worker in Mchinji, Malawi. Pictured with her 10-month old son, Christopher.

CONCLUSION



The expanded Mexico City Policy has already had an impact, in terms of closure of services and reduction in outreach to people from marginalised communities. This has increased isolation and reinstated barriers to accessing health services for marginalised people, particularly sex workers, entertainment workers and men who have sex with men.

In both countries, the qualitative evidence shows that under the policy, **some people using SRHR services as an entry point to access HIV services are now not reaching or being reached by those services (hypothesis 1)**. Changes in service delivery (provision and uptake) were perceived by participants in the study in both countries, and were also demonstrated by the quantitative analysis. The policy contributes to a scenario in which someone vulnerable to contracting HIV will find it more difficult to get regular HIV tests to monitor their sexual health. For someone living with HIV who already knows their status, access to regular testing to monitor the virus may be more difficult. With the disintegration of integrated HIV and SRHR services resulting from the policy, changes to where and when to collect anti-retroviral medication have also created additional challenges to adhering to treatment plans. The cessation of some outreach services has also made peer support and the sharing of SRHR and HIV information to marginalised people more challenging.

The findings strongly suggest that the policy has led to the fragmentation of previously integrated

HIV/SRHR services delivered to marginalised people. Its impact is being seen in terms of **who is able to receive services at community level (hypothesis 2)**, particularly in cases where tailored integrated services are withdrawn and replaced by referrals to public services that do not feel welcoming to marginalised people and may not be completed, **resulting in a lack of retention in care (hypothesis 3)**. The policy, combined with changing donor priorities, has begun to erode the existence of 'safe spaces', and is leading to the scaling back of programmes that reach marginalised people in their communities, and gaps in fundamental HIV prevention, treatment, care and support services.

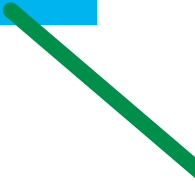


The data available for the study did not allow for an interrogation of the policy's affect on the range of integrated services offered or taken up by different clients per visit. However, changes to referral pathways, lack of retention in care, and disruptions to essential SRHR and HIV services for these communities are already in evidence. The extent to which these were directly caused by the policy is unclear as the study was not always able to separate out the direct impact of the policy from the broader

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funding environment. In Cambodia, it appears that there is less funding available for HIV and SRHR work, in part due to the policy but also due to the changing priorities and funding models of other donors.

What is clear is that the policy has caused confusion, tension, mistrust and breakdowns in partnership working. Organisations wishing to comply do so in ways that sometimes appear to go beyond or outside the scope of the policy to ensure their funding is not in jeopardy. Some organisations were reluctant to participate in the study for this reason. Representatives of other organisations were unwilling to talk about the impact of the policy, and had difficulties distinguishing between the impacts of the policy and the impacts of other changes to donor priorities and the resulting reduction in funding availability.

The qualitative data indicates that, **in the two study locations, there are similar effects since the reinstatement of the policy on HIV and SRHR services for marginalised people (hypothesis 4)**. In Malawi, where the legal context around abortion is more restrictive, it appears to have closed down possibilities for advocacy and partnership around abortion liberalisation, and around HIV and SRHR more broadly, creating divisions between organisations willing to comply and those that are not. In Cambodia, where the legal context around abortion is more liberal, civil society representatives felt constrained and 'gagged' by the policy, and at the mercy of international donors, with little voice.



It is too early to understand the full impact of the reinstatement and extension of the policy, and these may not be well understood until or after the policy is reversed again. However, these findings indicate that marginalised people's access to integrated HIV and SRHR services is already being affected. Do we want – and can we afford – to wait until the full impact can be quantified before we act?

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