



Chaos Continues

The 2021 Revocation
of the Global Gag
Rule and The Need
for Permanent Repeal

FOS
FEMINISTA

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Fòs Feminista is the International Alliance for Sexual and Reproductive Health, Rights, and Justice

Together with +170 partner organizations across the globe, we are dedicated to expanding access to rights-based sexual and reproductive health care, education, and advocacy. This includes implementing community-based strategies that make sexual and reproductive healthcare more accessible to the most marginalized women, girls, and gender-diverse people, developing comprehensive sexuality education programs, and mobilizing communities to defend their sexual and reproductive rights.

Fòs Feminista carries forward the work and partnerships of the three organizations – IPPFWHR, IWHC, and CHANGE – that formed a feminist alliance in June 2021 with a vision to advance sexual and reproductive health, rights, and justice through an intersectional feminist lens and a commitment to the leadership from the Global South.

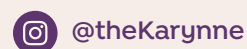
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ILLUSTRATIONS

Karynne Senna

An advertising professional by training and a self-taught artist, Karynne is an art director who spends her days scribbling away. She likes to venture into different techniques and styles of illustration and lettering. As a Black Brazilian Woman, she is always looking for ways to showcase women's strength in everyday life. To be a woman is to be diverse, and this is what Karynne's work sets out to demonstrate. Her motto is: "Black women are born from difficulty, live in resistance and Walk through life with their heads held high, conquering space with their own effort."





Acronyms

ADPP	Aid for the Development of People for People
ADS	Automated Directives System
AIDS	Acquired Immune Deficiency Syndrome
AMAMI	Association of Malawian Midwives
AMODEFA	Associação Moçambicana para Desenvolvimento da Família
AO(s)	Agreement officer(s)
AOR	Agreement officer's representative
ARC	Adult Rape Clinic
AT	Action Transmittal
BLM	Banja La Mtsogolo
CCIH	Christian Connections for International Health
CDC	Centers for Disease Control and Prevention
CDC OGS	Center for Disease Control and Prevention, Office of Grant Services
CHAM	Christian Health Association of Malawi
CHANGE	Center for Health and Gender Equity
COO	Chief operating officer
COP/ROP	Country Operational Plan/Regional Operational Plan
COPUA	Coalition of Prevention of Unsafe Abortion in Malawi
CSJ	Centre for Solutions Journalism
CSO(s)	Civil society organization(s)
DfID	Department for International Development
DoD	Department of Defense
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
F. Ariel	Fundação Ariel Glaser contra o SIDA Pediátrico
FACT	Family AIDS Caring Trust
FPAM	Family Planning Association of Malawi
FST	Family Support Trust
FSWA	Female Sex Workers Association
FY	Fiscal year
GALZ	Gays and Lesbians of Zimbabwe
GAO	Government Accountability Office
GGR	Global Gag Rule
GLOHOMO	Global Hope Mobilisation
HHS	Department of Health and Human Services
HHS OGA	Department of Health and Human Services, Office of Global Affairs
HIV	Human Immunodeficiency Virus
HP+	Health Policy Plus
ICPD	International Conference on Population and Development

ICRH-M	International Center for Reproductive Health-Mozambique
IFPC	International Family Planning Coalition
INGO	International non-governmental organization
IPN	Implementing Partner Notices
IPPF	International Planned Parenthood Federation
I-TECH	International Training and Education Center for Health
KPs	Key populations
LGBT(QI+)	Lesbian, gay, bisexual, transgender (queer, intersex)
LOE	Level of Effort
MHRRRC	Malawi Human Rights Resource Centre
NGO	Non-governmental organization
NoA(s)	Notice(s) of Awards
NOFO(s)	Notice(s) of Funding Opportunity
NRA	Nyasa Rainbow Alliance
NSC	National Security Council
OGAC (S/GAC)	Office of the Global AIDS Coordinator (State/Secretary's Office of the Global AIDS Coordinator and Health Diplomacy)
ONSE	Organized Network of Services for Everyone's Health Activity
OU(s)	Operating units
PAC	Post-abortion care
PEPFAR	President's Emergency Plan for AIDS Relief
PLGHA	Protecting Life in Global Health Assistance
PRM	Department of State Bureau of Population, Refugees, and Migration
PSI	Population Services International
PZAT	Pangaea Zimbabwe AIDS Trust
Rede DSR	Rede dos Direitos Sexuais e reprodutivos
ROOTS	Real Open Opportunities for Transformation Support
SAfAIDS	Southern Africa AIDS Dissemination Service
SAT	SRHR Africa Trust
SBCC	Social Behavior Change Communication
(S)GBV	Sexual and) Gender-based violence
SRHR	Sexual and reproductive health and rights
STI(s)	Sexually transmitted infection(s)
TB	Tuberculosis
ToP Act/Bill	Termination of Pregnancy Act/Bill
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USG	United States Government
WAG	Women's Action Group
WASH	Global Water, Sanitation and Hygiene



Executive Summary

“Globally, we will seek to end the harmful Global Gag Rule that restricts women’s access to critical health information and services.”

President Biden’s National Strategy on Gender Equity and Equality¹

The Global Gag Rule (GGR) is a destructive, neocolonial, and inhumane U.S. foreign policy that obstructs global efforts to promote health and advance human rights around the world. When enacted, the GGR—also known as the Mexico City Policy—mandates that for foreign nongovernmental organizations (NGOs) to receive certain categories of U.S. foreign assistance, they cannot perform, refer, or provide counseling about abortions as a method of family planning (FP), nor can they engage in advocacy related to the liberalization of national abortion law, even if they paid for such activities with their own, non-U.S. funds.² The policy provides exceptions for abortions in the cases of rape, incest, and life endangerment of the pregnant person.³ President Joseph Biden's first Presidential Memorandum on women's health included the revocation of the policy in late January 2021, an action that was welcomed by the international sexual and reproductive health, rights, and justice (SRHRJ) community.⁴ However, revoking the GGR does not end the policy's harm.

Proactive policies that ensure sexual and reproductive health and rights (SRHR) are respected, protected, and fulfilled are required to mitigate the damage from past policies have wrought as well as generate long overdue advancements in integrated service delivery and the promotion of SRHR. Actors at all levels of the U.S. foreign assistance system bear a responsibility to develop and implement these policies. The Biden administration, each U.S. government (USG) agency engaged in global health assistance, and prime implementing

partners have a duty to comprehensively communicate the revocation of the GGR clearly and provide consistent guidance on the promotion of SRHR to all relevant stakeholders. Anything less than this contributes to the continued implementation of the GGR.

In the months since President Biden revoked the GGR, evidence presented in this report indicates that there is a disconnect between the USG's internal procedure for communicating the revocation and the information that is communicated externally to prime and sub-prime partners around the world. At times, the USG's and prime partners' failure to provide comprehensive and prompt guidance to recipients of U.S. global health assistance caused detrimental delays in the policy's effective revocation. These same delays made it impossible for people to access the abortion care that they were legally entitled to during the nine months between when the policy was revoked in January 2021 and the last interviews were conducted in October 2021. Some organizations that were aware that the GGR had been revoked did not receive guidance that specified how to practically implement the revocation in their programming. Organizations needed urgent and immediate guidance from the USG in January 2021 that clearly instructed them to cease implementing the GGR and explained how to modify ongoing programs to align with the policy change as well as mitigate harmful impacts on communities around the world. Without clear communication, guidance, and compliance mechanisms to monitor the implementation of this policy

change, the GGR will continue to impede justice, infringe on national sovereignty, and inflict harm on communities around the world. Without permanent repeal through legislative action, this vicious cycle will continue every time there is a change in U.S. presidential administrations between Democrats and Republicans, as has been the case for nearly 40 years.

Methodology

Since its inception in 1984 by President Ronald Reagan, the policy has been implemented by four administrations and revoked by three along partisan lines. While there is extensive research on the impact of the GGR when it is implemented, there is little documentation about what happens once the policy is revoked.⁵

This report maps the flow of communication of the revocation of the policy, tracing the clarity and effectiveness of the message as it moved from the President to the USG agencies, and through implementing partners around the globe. The report highlights the impact of the revocation of the GGR on global health programs, funding, partnerships, communities, national sovereignty, coalitions, and advocacy spaces. Fòs Feminista developed this report based on in-depth interviews with USG personnel, representatives from international nongovernmental organization (INGO) headquarters, and global health organizations based in Malawi, Mozambique, and Zimbabwe.

This report is based on a three-part data collection model and builds on the qualitative research methodology developed by Fòs Feminista (formerly CHANGE) in previous rapid-response policy research conducted in Malawi, Mozambique, and Zimbabwe from 2017 to 2019.⁶ This report presents the findings from 47 virtual interviews with 53 representatives from U.S. global health implementing partners, civil society organizations (CSOs), and advocacy forums conducted between July and August 2021, as well as 10 virtual interviews with USG staff and representatives from INGO headquarters in September and October 2021. In lieu of an interview, representatives from the Office of the Global AIDS Coordinator (OGAC) at the Department of State and the Protecting Life in Global Health Assistance (PLGHA) Compliance Team at United States Agency for International Development (USAID) submitted written responses to Fòs Feminista's interview questions.⁷

Interviewees were identified through a combination of convenience and snowball sampling based on Fòs Feminista's in-country contacts with whom the organization has established relationships in addition to organizations who had been involved in prior rapid-response research on this policy, recommendations from interviewees themselves, and online resources. To protect confidentiality, each interviewee completed an informed consent process in advance of the interview or provided verbal consent at the beginning of the interview. Interviewees were given the choice to have their quotes

be attributed to them by name and/or organization, or to remain anonymous. Interviewees also reviewed and approved all verbatim quotes included in the report.

Background

In the days following President Biden's inauguration on January 20, 2021, USG staff, implementing partners, and advocates for SRHRJ eagerly awaited the new administration's expected actions designed to undo the harms the Trump administration had perpetrated against global health, international development, and human rights efforts.

On January 28, 2021, as the COVID-19 pandemic continued to ravage global health programming, President Biden's Memorandum on Protecting Women's Health at Home and Abroad announced that it is the policy of the USG to "support women's and girls' sexual and reproductive health and rights in the United States, as well as globally."⁸ To actualize this policy statement, President Biden revoked PLGHA, former President Trump's dramatically expanded version of the GGR.⁹ President Biden also established the White House Gender Policy Council on March 8, 2021 and later took the unprecedented step to issue a statement of policy seeking an end to the Global Gag Rule in the first-ever National Strategy on Gender Equity and Equality, released on October 22, 2021.¹⁰

GGR Revocation Communication

Fòs Feminista found that the general perception among USG employees interviewed within the Department of State, the Department of Health and Human Services (HHS), and USAID was that they had satisfied the expectation to communicate the revocation of the GGR across the U.S. global health system and stop its implementation by removing the policy from ongoing awards.¹¹

However, the consensus among implementing partners and advocates interviewed from INGO headquarters and operating in Malawi, Mozambique, and Zimbabwe was that the USG's communications related to the revocation of GGR were insufficient, and that guidance for implementing the policy change was wholly lacking. Prime recipients of U.S. global health assistance through awards managed by both the Centers for Disease Control and Prevention (CDC) and USAID reported inconsistent levels of communication from the USG.¹²

Staff at large INGOs with dedicated policy and compliance staff generally had access to more information about the revocation of the GGR than local partners or CSOs in all three countries, a disparity reflective of the widespread uncertainty about the meaning of the revocation for local partners and their work.¹³ In fact, some partners were not aware that the GGR had been revoked until they were invited to participate in an interview with Fòs Feminista's research team.¹⁴

Guidance, monitoring, and compliance of the revocation of the GGR

As of August 2021, interviews indicated that the GGR continued to be implemented—both in cases where it had been overapplied or implemented incorrectly when the GGR was active—and that its revocation had not been achieved consistently across programs due to lack of sufficient guidance from the USG and prime partners.¹⁵ For example, Pathfinder Mozambique, a prime implementing partner, received a cooperative agreement for a new award with the PLGHA restrictions still included even after the policy had been revoked.¹⁶

The lack of clear guidance from the USG and prime partners for implementing the revocation of PLGHA has had a particularly negative impact on survivors of rape and incest served by Family Support Trust (FST) in Zimbabwe. Tamburai Muchinguri, the Director of FST, which is a sub-prime partner that provides SRH services to survivors of rape, reported that their prime partner was incorrectly applying the policy from 2017 to 2020 by not allowing referrals for abortion in cases of pregnancy resulting from rape or incest, and then compounded this harm by continuing to incorrectly implement PLGHA after it had been revoked.¹⁷ Muchinguri stated that FST is ready to provide appropriate services for survivors as soon as they receive communication from their prime:

“On a day-to-day basis we actually come across a number of women and children who are raped. And the law in Zimbabwe is already there, that allows termination of pregnancy resulting from rape. And the courts are actually ready to give termination orders to women and children who have been raped. So, for us, as soon as we get that communication clear, we are ready to support that.”

Tamburai Muchinguri, Director, FST

Karl Hofmann from PSI noted that there is much more that the USG could be doing to communicate guidance and expectations to partners around the revocation of the policy, though he considered that this is unlikely to happen.¹⁸ He concluded:

“I mean, it’s a heroic expectation to assume that they will do what we know they should do, which is to say: ‘This is what the law allows, this is what the need dictates. We expect our partners to go to the full extent of the law.’ Yes, we know that the policy has flip-flopped back and forth but there has been no guidance from USG saying, ‘Now we expect you to do this and we will accompany you while you do this.’ It would be extremely surprising to find anybody who would do that up to and including the USAID Administrator. I just don’t see it happening. And so instead, you rely on small, whispered winks and nods and encouragement—quiet encouragement, which is there, and which is valuable, but is hard to capture.”

Karl Hofmann, CEO, PSI

Across the board, interviewees reported receiving more information about the GGR when it was implemented than when it was revoked, which contributed to confusion regarding which activities are now permissible since the GGR is no longer in effect.¹⁹ To combat this uncertainty, representatives from INGO country offices and local organizations requested that the USG publish a policy brief or position paper that explains the revocation of the GGR and includes clear instructions for all implementing partners to cease implementation of the GGR.²⁰ Stakeholders have asked for the USG to provide simplified communications that can be translated into local languages and widely disseminated through numerous channels, such as TV, radio, newspapers, and social media, to reach those that have been impacted by the GGR.²¹ Helena Chiquele from Oxfam in Mozambique explained the need for this direct communication from the USG:

“If you are revoking something that is bad, you need to make sure that you will do your utmost to erase the impact of that thing. You make sure that this information that is vital, is known for those who really need to know. I don’t think that was done.”

Helena Chiquele, Southern Africa Gender Justice Program and Policy Manager, Oxfam in Mozambique

A high-level USG employee echoed this need by noting that “revoking the policy does not necessarily erase confusion in implementing agencies in terms of what they can and can’t do.”²² Clear and specific communications and guidance regarding the revocation will institutionalize the Biden administration’s current and long-awaited policy supporting SRHR and, most importantly, ensure that organizations adapt their programs and operations to align with the revocation and the ultimate goal of undoing the myriad harms of the policy on communities around the world.²³

Impact of the revocation of the GGR

A USG employee with expertise in global health said “it’s going to take a lot of time” to measure program outcomes and impacts in communities “because the loss was so significant that, frankly, we’re just trying to get back to the baseline that was four years ago, as opposed to going forward.”²⁴ While the chilling effect²⁵ of the GGR has resulted in the documented over-application of the policy when it was in effect,²⁶ the lack of robust guidance from the USG and prime partners since the revocation likely indicates an under-application of the revocation. Providing explicit guidance will help to counter this, as well as proactively encouraging implementing partners to operate as boldly and as expansively as possible within the limits of what is allowable by U.S. global health assistance regulations until the policy is permanently repealed via legislation.

Not only are the lingering effects of previous versions of the GGR of significant concern for all those engaged in advancing SRHRJ, but, as Irene Koek, global health expert familiar with U.S. global health assistance stated, the “invocation of the policy in four or eight years is this looming threat.”²⁷ Eric Sambisa, the Executive Director of Nyasa Rainbow Alliance (NRA), a local sub-prime partner engaged in providing HIV and AIDS services for members of the LGBTQI+ community in Malawi, described the chilling effect caused by the policy’s repetitive cycle of flip-flopping in this way:

“We think it’s a little bit political and it’s really hard to be advocates [around] this policy because it changes according to the regime. So, what if another regime comes? It might affect us as CSOs implementing on the ground. It’s really scary to advocate or not. So, we’re just quiet.”

Eric Sambisa, Executive Director, NRA

Hofmann from PSI reported that organizations are hesitant to immediately adapt programs to the revocation in case the policy is reinstated again by a future U.S. President, which causes the negative impacts of the GGR to persist after the revocation:

“The absence of a noxious policy is good but the persistence of the chilling effect from the policy being imposed at various times over the past decades means a lot of the damage has already been done. It damages the ability to do truly holistic programming for women and communities. It increases the costs of

effective programming for life-saving health interventions. It leads to silos in the structure of health programming, and it undoubtedly leads to increased maternal mortality and morbidity. So, it’s all bad and the absence of the policy only to a limited extent reduces those problems because a lot of people are reluctant to snap back as though it’s never going to occur again.”

Karl Hofmann, CEO, PSI

Calls for the permanent repeal of the GGR

Though the revocation of the GGR is overwhelmingly good news for many organizations and communities, long-lasting impacts of the policy remain in place, as does the instability and uncertainty of a constantly changing policy landscape along party lines. As the data presented in this report demonstrate, the chaotic effects of the GGR linger long after it has been revoked, which significantly hinders the ability of organizations that are reliant on U.S. global health assistance funding to provide vital services to their communities. Implementing partners around the world are struggling to regain momentum and progress lost prior to January 2017 as they seek to rebuild partnerships and repair programs that were ripped apart by the GGR. Instead of spending invaluable organizational time and resources navigating compliance as they are compelled to when the policy is in place, implementing partners now can rededicate those efforts to implement comprehensive programs grounded in evidence and human

rights. In the long run, the recent revocation of the GGR, combined with this permanent repeal by Congress, could lead to a more efficient use of U.S. global health funding for program implementation within the current federal budget.

President Biden’s Memorandum on Protecting Women’s Health at Home and Abroad marked the first time a U.S. president recognized the phrase ‘sexual and reproductive health and rights’ and stated: “It is the policy of my Administration to support women’s and girls’ sexual and

reproductive health and rights in the United States, as well as globally.”²⁸ This signifies the furthest any U.S. administration has gone in its recognition of SRHR. But it is not enough. To make the promise of supporting SRHR is meaningful, but it will take more than a stroke of a pen to make this statement a reality. It will require additional time, funding, and intentional effort to realize the full potential of this policy change and support the health and wellbeing of women, girls, and gender-diverse people that engage with U.S. global health funded programs around the world.

Main Findings

- The immediate revocation of the GGR in January 2021 was necessary and welcome, but despite these efforts, the policy continues to negatively and unnecessarily impact individuals and organizations.
- Generally, USG employees interviewed believed they had done everything necessary to communicate the revocation of the GGR and stop its implementation by implementing partners. However, most implementing partners interviewed did not believe the USG’s communication was sufficient.
 - » At times, the failure of the USG and prime partners to thoroughly communicate and enforce the revocation of the GGR prolonged the policy’s implementation and unnecessarily prevented people from accessing legal abortions.
 - » The Biden administration, every USG agency engaged in U.S. global health assistance, and prime implementing partners have a duty to communicate the revocation of the GGR comprehensively and provide consistent, actionable guidance to all relevant stakeholders.
- Implementing partners and advocates voiced the need for more detailed, actionable guidance and additional monitoring and compliance support that explain how to adapt programs to fully align with the revocation of PLGHA.
 - » Proactive policies that encourage all stakeholders in U.S. global health assistance to operate as expansively as possible to ensure the SRHR of all people are respected, protected, and fulfilled are required to mitigate the ongoing harm of the GGR and pave the way for overdue advancements.

Main Findings

- Additionally, interviewees described how the COVID-19 pandemic has simultaneously exacerbated the negative ongoing effects of the GGR and made it more difficult to communicate and implement its revocation.
- Despite the many identified challenges, many of those interviewed across the USG, INGO headquarters, and organizations in Malawi, Mozambique, and Zimbabwe reported that the revocation of the GGR will have positive long-term impacts on their organizations, partnerships, and communities, including increased funding and collaboration opportunities.
- Interviewees reported that the permanent repeal of the GGR would assist organizations to recover from the harm caused by previous iterations of the GGR as well as advance SRHR across the U.S. global health landscape.

Recommendations for Congress

- Permanently repeal the Global Gag Rule through legislative action.
- Use the oversight power of Congress to monitor the revocation of the GGR to ensure it is no longer implemented and to mitigate the persistent harm of the policy.
- Address the funding and political leadership gaps highlighted by partners in this report by creating new legislative, funding, and report language to advance SRHR globally.

Recommendations for the White House

- Work with Congress to permanently repeal the GGR and state unequivocally that permanent repeal is a top foreign policy, human rights, global public health, and sexual and reproductive health and rights priority for the Biden administration.
- Increase global funding for SRHR in the President's budget with a statement of policy to support organizations that lost funding because of the GGR.
- The White House Gender Policy Council and National Security Council should take action to ensure that all USG agencies responsible for global health funding report on the steps they have taken to communicate the revocation of the GGR.

Recommendations for all U.S. Global Health Implementing Agencies

- Develop and publish a policy brief or position paper that comprehensively explains the revocation of PLGHA and affirms the Biden administration's support for SRHR as U.S. policy, including abortion services. Re-release this policy brief with periodic updates as necessary.

Recommendations

Recommendations

- Disseminate simplified communications explaining the revocation of the GGR via TV, radio, newspapers, and social media to reach the general public as well as communities that have been impacted by the GGR.
- Develop and publicly release an after-action report by January 2023 that lists the steps that have been undertaken to communicate the revocation, monitor the modification of current agreements to remove PLGHA language, and assess the implementation of the revocation by implementing partners.
- Obligate additional financial resources to existing awards and establish new awards to enable implementing partners to fully implement the revocation of the GGR and re-establish programs that were lost due to PLGHA.
- Actively engage CSOs in the implementation of revocation of the policy by creating a reporting mechanism, such as an ombudsman.
- Increase U.S. mission engagement with implementing partners, partners that declined to certify PLGHA, CSOs, and the general public at the country level through regular town halls, official statements, policy briefs, and “Dos and Don’ts” documents or “Frequently Asked Questions” documents about the revocation.
- Translate all materials related to the revocation of the GGR (e.g., communications, guidance, training programs, monitoring and compliance tools, and standard provisions) into national and local languages.
- Prepare and publish an updated Global Health eLearning Course that explains the revocation of PLGHA and provides guidance for partners to implement the policy change and adapt programs accordingly.
- Include a GGR revocation element in PEPFAR’s SIMS Above-site Assessment Tool, which would allow those completing SIMS assessments to determine if a PEPFAR site is complying with the revocation of the GGR.

Recommendations for Prime Partners

- Standardize communication of the revocation to all sub-prime partners with translations into national and local languages.
- Immediately ensure that sub-awards with an active period of performance have been modified to remove the PLGHA Standard Provision.
- Translate all materials related to the revocation of the GGR (e.g., communications, guidance, training programs, monitoring and compliance tools, and standard provisions) into national and local languages.
- Communicate the revocation of PLGHA to partners who declined to certify the GGR.



Background

On January 28, 2021, President Joseph Biden signed a presidential memorandum entitled Memorandum on Protecting Women’s Health at Home and Abroad, which immediately revoked the Global Gag Rule (GGR), also known as the Mexico City Policy or the ‘Protecting Life in Global Health Assistance (PLGHA) policy.²⁹ This action once again ended a draconian policy enacted by previous Republican administrations dating back to 1984. The GGR has hindered progress toward global health goals, violated human rights, and contributed to deaths worldwide.³⁰

President Biden’s memorandum also announced that it is the policy of his administration to “support women’s and girls’ sexual and reproductive health and rights in the United States, as well as globally.”³¹ In addition to immediately revoking PLGHA, President Biden also established the White House Gender Policy Council on March 8, 2021 and later took the unprecedented step to issue a statement of policy seeking an end to the Global Gag Rule in the first-ever National Strategy on Gender Equity and Equality, released on October 22, 2021.³²

When enacted, the GGR mandates that for foreign nongovernmental organizations (NGOs) to receive certain categories of U.S. foreign assistance, they cannot perform, refer, or provide counseling about abortions as a method of family planning (FP), nor can they engage in advocacy related to the liberalization of national abortion law, even if they paid for such activities with their own, non-U.S. funds.³³ The policy provides exceptions for abortions in the cases of rape, incest, and life endangerment of the pregnant person.³⁴ Announced by the Reagan administration during the 1984 United Nations International Conference on Population and Development (ICPD) in Mexico City, the policy is often referred to colloquially as the “Mexico City Policy.” Human rights and global health advocates refer to this policy as the “Global Gag Rule” because the restrictive nature of the policy “gags” the speech of healthcare providers and those working in global health.³⁵

The first iteration of the policy under the Reagan administration applied strictly to international FP funds awarded through the United States Agency for International Development (USAID). Subsequent Republican presidents George H.W. Bush and George W. Bush reinstated the policy, while Democratic presidents Bill Clinton and Barack Obama removed it.³⁶ Over time, the policy was expanded to apply to international FP funding from other U.S. government (USG) agencies including the Department of State.³⁷ In 2017, the Trump administration dramatically expanded the policy, applying it to all U.S. global health assistance funds, which included additional

agencies and impacted more than fifteen times the amount of funding affected by previous iterations of the policy.³⁸

In 2019, the Trump administration further expanded the policy to apply to all sub-grants from a foreign NGO that received U.S. global health assistance, regardless of the source of sub-grantee funding or the activity for which the sub-grantee was being funded. This expansion drastically increased the amount of affected funding.³⁹ This expansion meant the GGR applied to some foreign NGOs even if they did not receive U.S. funding themselves.⁴⁰ In one estimation, more than \$200 million in funding from The Global Fund to Fight AIDS, Tuberculosis, and Malaria were bound by the GGR, even though none of the recipients of those funds were recipients of U.S. global health assistance.⁴¹

The devastating effects of the expanded GGR extend far beyond family planning and reproductive health programs. The policy impacts programming related to HIV and AIDS; maternal and child health; malaria; tuberculosis; nutrition; non-communicable diseases; water, sanitation and hygiene (WASH); and the Zika virus.⁴² Every iteration of the policy weakened health systems and increased the risk of the de-integration of FP and HIV services due to disruptions to funding streams, referral systems, and service delivery.⁴³ Providing integrated FP/HIV services is vital for meeting contraceptive needs, including those for people living with HIV, preventing unintended pregnancy, averting new infant HIV infections, and improving health outcomes for those who can get pregnant

and their children.⁴⁴ Organizations reported having to make a choice: continue to provide comprehensive SRH information and services, or end those services to receive U.S. global health assistance funding.⁴⁵ The Trump administration's GGR also restricted access to SRH information and comprehensive services for pregnant women, adolescent girls and young women, women living with HIV, women in rural areas, orphans and vulnerable children, and LGBTQI+ patients due to funding cuts and service delivery closures.⁴⁶

In revoking the GGR through presidential memorandum, President Biden directed all USG agencies involved in foreign assistance to: "(i) immediately waive such conditions in any current grants; (ii) notify current grantees, as soon as possible, that these conditions have been waived; and (iii) immediately cease imposing these conditions in any future assistance awards."⁴⁷ These directives indicated that organizations that received U.S. global health assistance were now immediately able to provide, promote, and advocate around abortion using non-U.S. funds, as well as provide counseling and referrals for legal abortion care using U.S. funds.



The lingering impacts of the GGR

While the revocation of the GGR went into effect when President Biden released the presidential memorandum, several interviewees from the USG and former and current implementing partners observed a range of lingering harms after the policy was revoked.⁴⁸ In speaking about the effect of GGR under the Trump administration, Marla Smith from Save the Children Mozambique noted that “the last four years was a big step backwards.”⁴⁹ Helena Chiquele from Oxfam in Mozambique echoed this sentiment noting that “something was lost [when PLGHA was in effect], and we need to regain that.”⁵⁰

Dr. Psaki from the U.S. Department of Health and Human Services (HHS) Office of Global Affairs (OGA) stated that global health staff within the Biden administration are thinking about how to “create a little bit more stability for these programs so there’s not this constant fear that things are going to go back and forth really dramatically.”⁵¹ However, the reality is that the GGR has been “switched on” by Republican Presidents and “switched off” by Democratic Presidents since 1984, and this light switch effect has created instability among organizations implementing integrated global health programs even when the policy is not in effect.⁵² An advisor from the Center for Disease Control and Prevention (CDC) reported that the fact that the policy gets turned on and off “can be really harmful to the services that partners provide” and it is not sustainable for partners to adapt their programs and funding profiles according to changes in the U.S. administration.⁵³

Hofmann from PSI stated that organizations are hesitant to respond right away to the revocation in case the policy is reinstated again by a future U.S. President, which causes the negative impacts of the GGR to persist after the revocation:

“The absence of a noxious policy is good but the persistence of the chilling effect from the policy being imposed at various times over the past decades means a lot of the damage has already been done. It damages the ability to do truly holistic programming for women and communities. It increases the costs of effective programming for life-saving health interventions. It leads to silos in the structure of health programming, and it undoubtedly leads to increased maternal mortality and morbidity. So, it’s all bad and the absence of the policy only to a limited extent reduces those problems because a lot of people are reluctant to snap back as though it’s never going to occur again.”

Karl Hofmann, CEO, PSI

The light switch effect of the GGR may impact smaller or local organizations more than large international NGOs (INGOs) because local partners that receive U.S. global health assistance have “a lot more to lose, generally, because it’s often a significant part of their funding, so that in itself makes you self-censor if it’s a big piece of your funding,” according to Sarah Shaw, the Head of Advocacy at MSI Reproductive Choices.⁵⁴ Shaw also said that MSI’s “local partners really struggle accessing complete information” about policies like PLGHA both when the policy was in effect and when it has been revoked.⁵⁵

When describing the lingering effects of the policy even after it has been revoked, Andrea Fearneyhough from PSI said, “We’re not even a year into this current policy being revoked, so it still feels like the policy is still in effect in a way, even if it’s not.”⁵⁶ She also reported that “there’s going to be immense pressure on local organizations to choose” whether to receive U.S. global health assistance now that the GGR has been revoked.⁵⁷

A representative from an INGO spoke at length about the pressure their colleagues, particularly at country offices, experience regarding the implementation of the policy with incomplete or inaccurate information.⁵⁸ Staff at country offices have been extremely cautious about engaging in activities that they incorrectly thought were prohibited by the GGR while it was in effect.⁵⁹ This representative shared an example of a local partner’s misunderstanding of the GGR to emphasize the importance of sharing accurate information with all partners:

“I know, for example, our programme in Nepal said that they used to get referrals for rape survivors from an SGBV [sexual and gender-based violence] local organization, and overnight, these referrals stopped coming through. It was because this local organization didn’t realize that there was an exemption for sexual violence and rape in the GGR. So, it’s important to get the information like that down to local partners and give them complete information so they’re hearing the whole story and not just whispers of different parts of it.”

A representative from a prime partner that declined to certify PLGHA

This representative went on to describe the de facto over-implementation of the policy that results from unclear guidance about policy implementation and revocation:

“Even this year, I’ve had conversations with country leads who’ve been scared of doing communications around abortion in their country, because they’ve been scared of jeopardizing their relationship with USAID. And I’ve said, ‘But why? Because you are allowed to talk about the state of abortion in your country, and unless you’ve had a particular signal from your USAID mission that they’re not particularly pro-choice, I really wouldn’t worry about this because the [Global] Gag Rule’s gone. It’s a new administration.’ And so, we’ve had to really do that sort of confidence-building back up again. And it feels like there’s a gap in sort of practical guidance on how we can help restore the confidence because that’s what it [the GGR] does. It just batters everybody’s confidence.”

A representative from a prime partner that declined to certify PLGHA

A USG employee with expertise in global health also reflected on the policy’s chilling effect, noting that staffers and decision-makers involved in U.S. global health assistance are extremely cautious as a result of the zealous scrutiny the Trump administration applied to its attacks on SRHR.⁶⁰ They concluded that “a lot of parts of the U.S. government are extremely hesitant to be forward-leaning, not because they think that the [Biden] administration disagrees with their view, but frankly

because they're a bit traumatized with how much these issues were looked at in the last administration."⁶¹ This USG employee also said that "it's going to take a lot of time" to measure program outcomes and impacts in communities "because the loss was so significant that frankly, we're just trying to get back to the baseline that was four years ago, as opposed to going forward."⁶²

The chilling effect of the GGR is noticeable in everyday interactions between stakeholders engaged in global health efforts around the world. Staff from an INGO that declined to certify the GGR said that "it was very difficult for USAID colleagues to reach out to us or to meet with us or to be in the same room with us" when PLGHA was in effect.⁶³ They shared an example of how this discomfort would play out during FP Technical Working Group meetings in different countries while the GGR was in effect:

"For the FP Technical Working Groups, most of the time, it's the NGO partners who are supporting the meetings. They're hiring the room; they're providing the teas. And there has been the odd occasion in the past where if this had been funded through a USAID grant and if there was a lunch involved, I remember a colleague saying, 'Well, sorry, but I'm really worried that if your name appears on the lunch sign-in sheet, which I have to do for compliance, I'm worried that this is going to come back and be a disallowed expense and just cause me a lot of trouble with USAID, so would you mind just, just going and getting your own lunch?'"

A representative from a prime partner that declined to certify PLGHA

Madam Emma Kaliya of Malawi Human Rights Resource Centre (MHRRC) described the ways in which anxiety about maintaining compliance with PLGHA made organizations more critical of others. She reported the depths to which the strict enforcement of the policy struck fear into organizations and led them to do anything they could to avoid being found in violation of it.⁶⁴ She offered this example:

"Those who were compliant with PLGHA would come to a meeting and keep quiet, don't say anything. I remember two organizations [that declined to certify PLGHA]... we were holding a COPUA [Coalition for the Prevention of Unsafe Abortion] meeting and we were required to develop a communiqué for members of Parliament. All the organizations present appeared on the communiqué but those two of them were reprimanded by the USAID grant recipients...they requested the organizations to withdraw the names from the list or risk losing the grant. So, they wrote to me requesting the removal of their names and further telling me to write a letter to USAID, claiming the names were included by mistake...I went on to say that they are free to do what they want, but I was not prepared to write such a disclaimer. Imagine being forced to tell lies when you were part of the meeting. I said, 'You attended the meeting and today you want me to write a disclaimer? I don't think it is correct.' So, you can see the levels of desperation that this GGR issue took us to at the time."

Madam Emma Kaliya, Executive Director, MHRRC

Sarah Lance, the Director of Program Operations at Pathfinder, shared similar examples of the far-reaching impacts of PLGHA on their team and interpersonal engagement between colleagues. Lance reported that an employee that works at an organization that provides abortions had car trouble and there was a concern that a Pathfinder staff person could not pick them up in a vehicle purchased with USAID funds.⁶⁵ Lance also shared the following experience among staff at one of Pathfinder's country offices:

“In one of our offices, people weren't having lunch with a team member who worked on an abortion project because they just felt like they couldn't even sit and have a conversation with the team member. So getting into some of the clarification, ‘It's okay to have lunch with your colleagues. It's okay to talk about what you're working on.’ It's important that staff know the actual guidelines so they feel comfortable knowing that they're not putting Pathfinder at risk.”

Sarah Lance, Director of Program Operations, Pathfinder

These examples highlight the far-reaching impacts of PLGHA far beyond programmatic activities and the provision of health services.



Tracking the collective harm of the GGR

One way to understand and mitigate the collective harms of the policy from the past, present, and future will be to continue investing in research to document the ongoing impacts of the GGR and inform counter-strategies, filling what Shaw from MSI Reproductive Choices identified as an ongoing information gap:

“The bit that we’re still struggling with is that everybody’s got the guidance, and everybody knows that the Government’s changed and so on, but there is still an ongoing chilling [effect], and that’s really hard to quantify and document. There’s still a bit of a gap there around that and also around the impact of the policy and strategies to overcome it.”

*Sarah Shaw, Head of Advocacy,
MSI Reproductive Choices*

Virginia Baresch from HHS OGA highlighted the contrast between the available evidence that documented the policy’s implementation and impact and the relative dearth of information available that documented the impact of the policy’s revocation in this way:

“When we did the review and the reports for the implementation, we gathered a lot of information from countries as to the impact of the policy and its implementation. I have not seen any information about doing the reversal and collecting information. I’m sure we’re relying on agencies like you all [Fòs Feminista] and others to give us some of that information and feedback. I don’t think PEPFAR [President’s Emergency Plan for AIDS Relief] is doing what we call an after-action report on that. I haven’t heard of anything like that to kind of go back and do a reverse review of what we did during the implementation.”

Virginia Baresch, Senior Public Health Advisor, HHS Office of Global Affairs

Baresch noted that more information about mitigating the past impact of the policy after it has been revoked “would be very helpful” as “lessons learned.”⁶⁶ The evidence presented in this report aims to satisfy this request and provide guidance for improving the implementation of the revocation of the GGR moving forward across the U.S. global health landscape.



How the revocation of the GGR was communicated across the U.S. government

When the Biden administration released the presidential memorandum that revoked PLGHA on January 28, 2021, communication within the USG regarding the revocation of the policy had been underway for months. Given the history of Democratic presidents removing the GGR and Republican presidents enacting it, career USG staff are “quite familiar with the process and know what to expect,” based on the political affiliation of the incoming administration.⁶⁷ According to a USG staffer with expertise in U.S. foreign policy and global health programs, staff on the Biden administration transition team were “thoughtful and intentionally methodical”

about preparing for certain executive actions such as the revocation of PLGHA to “move through the [governmental] system quite fast” after President Biden was inaugurated.⁶⁸

Once President Biden revoked PLGHA, the National Security Council (NSC) issued policy guidance in accordance with the directives outlined in the policy memorandum from the Biden administration to the USG implementing agencies involved in U.S. global health assistance, including the Department of State, HHS, USAID, and Department of Defense (DoD).⁶⁹ The NSC coordinated this process through “emails, phone calls, meetings of the sort in the virtual environment...to give guidance on what is new and how to interpret existing guidance when there is a policy shift like the one related to the Global Gag Rule.”⁷⁰ The NSC was responsible for “confirming that agencies have coordinated with each other to ensure that we don’t have conflicting guidance that comes from one agency versus another, because a partner could get funded by both USAID and OGAC [the Office of the Global AIDS Coordinator] for PEPFAR.”⁷¹

The three directives included in the presidential memorandum instructed the headquarters of each USG agency that implements U.S. global health assistance to develop and carry out their own plans to implement the revocation of the GGR through communications with “current grantees, as soon as possible.”⁷² The USG staff recognized that it was necessary for information about the revocation of the GGR to travel from the White House through the relevant USG agencies and U.S. missions around the world to the prime partners

and sub-prime partners that implement U.S. global health assistance programs (see Figure 1).⁷³ Implementing partners would only be able to adapt their program activities to align with the revocation of the policy after they received clear communication and guidance from the USG agencies for fear of otherwise violating their agreement.

Of the 47 organizations interviewed in Malawi, Mozambique, and Zimbabwe for this report, 17 of them were prime implementing partners at the time of the interview but only six had received communication regarding the revocation of PLGHA directly from the USG.⁷⁴ Other prime partners either received communication about the revocation from their own organization’s international headquarters, an updated cooperative agreement, or did not receive any communication from the USG at all.⁷⁵

Each agency was expected to review their “internal programmatic guidance to see how it either aligns or does not align with the policy vision that the Administration put out,” and develop a plan for modifying grants and cooperative agreements to remove the PLGHA Standard Provision from ongoing awards.⁷⁶ Additionally, the USG agency headquarters are responsible for coordinating with U.S. missions at the country level in order to “make sure the field understands what the policy is and under what parameters it can be implemented.”⁷⁷ A PEPFAR staffer working at a U.S. mission in sub-Saharan Africa reported that mission staff were well prepared to communicate the revocation of the policy, as PLGHA “is an example of a policy that people were familiar with because it existed before, then was rolled back, and then it was brought

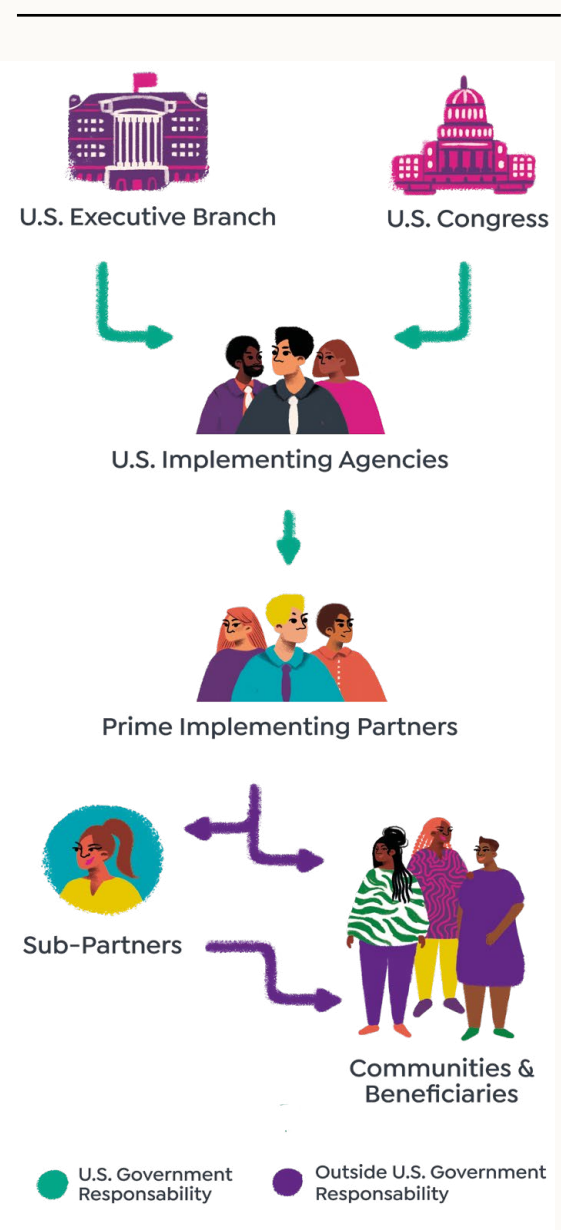
back into force.”⁷⁸ As a result, career USG staff at some missions had institutional knowledge about the GGR and its history so they were prepared to communicate its revocation.⁷⁹ The majority of organizations interviewed across the three countries reported that, in general, communications about the implementation of PLGHA during the Trump administration were “harsh,”⁸⁰ “vicious,”⁸¹ “forceful,”⁸² and “powerful”⁸³ in comparison to communications surrounding the 2021 revocation.⁸⁴

Samuel Matsikure from Gays and Lesbians of Zimbabwe (GALZ) reported that he “didn’t see the same momentum” from USG agencies or organizations to share information about the revocation as compared to when PLGHA was expanded in 2017.⁸⁵ Memory Kadau, Director of Adult Rape Clinic (ARC) in Zimbabwe, noted that while communications about PLGHA received more attention from civil society due to the expansion of the policy by the Trump administration, the communications from the USG weren’t necessarily more clear because “there was still confusion in terms of what are the exceptions” to PLGHA when it was in effect.⁸⁶ Kadau attributed much of the high level of communication when PLGHA was in effect to the collective “outrage on the implications it continued to have on women and girls accessing safe abortion services.”⁸⁷

An interviewee in Malawi also emphasized that the revocation of PLGHA was “more silent as compared to...when it came back into effect” in 2017.⁸⁸ Due to the perception that the revocation happened silently with much less public attention than the expansion of the GGR in 2017, another public health professional in Malawi reported that implementing partners must make “a lot of assumptions”

as to what is now allowed per the revocation as compared to when the policy was in effect.⁸⁹ As a result of this confusion, a number of organizations interviewed in the three countries expressed the desire for more information to understand what the revocation means for their organizations and how it would impact their programs.⁹⁰

Figure 1. **U.S. Global Health Assistance Policy – Implementation and Communication Pathway**



Imelda Mahaka, Executive Director of Pangaea Zimbabwe AIDS Trust (PZAT), put it this way:

“The Trump administration was, I mean, those guys were vicious in their communication. They left no stone unturned. Everyone knew about the [Global] Gag Rule, because the communication was airtight. I think we need the same thing here.”

Imelda Mahaka, Executive Director, PZAT

The next sections outline the communication processes implemented by specific USG agencies as well as programs to communicate and implement the revocation of PLGHA both internally and externally with implementing partners, host country governments, and other stakeholders.⁹¹

Department of State

According to written comments from OGAC (also known as State/Secretary’s Office of the Global AIDS Coordinator and Health Diplomacy, or S/GAC) at the Department of State, “the Department of State released a cable to all U.S. diplomatic and consular posts⁹² explaining the key elements and associated actions in the Memorandum on Protecting Women’s Health at Home and Abroad, including those related to PLGHA revocation” in late January 2021.⁹³ This cable is not publicly available, so the Fòs Feminista research team was unable to confirm the details and relied on interviews to understand the contents of the cable. Baresch received the cable and said it not

only explained the revocation of PLGHA to USG staff abroad working at the mission level, but also informed missions that their U.S. Embassy small grants funded through U.S. global health assistance should be modified to remove the PLGHA standard provision. It is unclear if the cable specified a timeline for this process.⁹⁴ The cable reportedly instructed the Chief of Mission to communicate the revocation of PLGHA and the Biden administration’s policy stance on SRHR with host country governments where U.S. global health assistance programs were operating.⁹⁵

The Department of State’s Bureau of Population, Refugees, and Migration (PRM) coordinated a working group with representatives from the headquarters of all USG offices and agencies that were responsible for implementing the GGR and revoking it, including OGAC, HHS, USAID, DoD, and Peace Corps.⁹⁶ According to Baresch, this working group was initially tasked with coordinating the implementation of PLGHA across USG agencies that implemented U.S. global health assistance when it was first expanded by the Trump administration in 2017.⁹⁷ As a member of the group, Baresch reported that the PLGHA working group met weekly during the first six months of PLGHA’s implementation because “it took quite a bit of work in the beginning to implement the policy, and it took many months for us to implement training and go through the legal process.”⁹⁸ Another USG staffer familiar with the process also noted that the process of implementing PLGHA took a long time because the policy was expanded to apply to all U.S. global health assistance for the first time.⁹⁹

The PLGHA working group was responsible for reviewing, approving, and disseminating all public information about the policy, including frequently asked question documents¹⁰⁰ and the two reviews of the implementation of PLGHA as ordered by the Department of State, which were released in February 2018¹⁰¹ and August 2020.¹⁰² Baresch explained that all members of the group were “very experienced in overseas grants and cooperative agreements and working with partners overseas, so they had a good understanding of how to implement PLGHA and what we needed to do to make sure that we were implementing it without too much disruption.”¹⁰³

Though the PRM-led PLGHA working group met regularly while PLGHA was in effect, Baresch reported that “for the revocation, it was just one meeting in February and that was it. Done. Simple.”¹⁰⁴

However, one meeting of this working group was not sufficient to adequately plan for the complete revocation of PLGHA across the U.S. global health assistance system, including providing communication to partners at the country level. A representative from a sub-prime partner in Malawi said that the communications released by the USG as of August 2021 were “not very clear, because currently I don’t see any change from PEPFAR, from USAID, from CDC.”¹⁰⁵

Clear communication from the major U.S. global health assistance programs and agencies represented by the PLGHA working group would assist organizations to better understand the revocation.¹⁰⁶

President’s Emergency Plan for AIDS Relief (PEPFAR)

As the largest commitment by any nation to address a single disease, the U.S. government has invested more than \$100 billion in the global AIDS response through PEPFAR programs and initiatives since 2003. OGAC leads, manages, and oversees PEPFAR, which has a budget that regularly accounts for approximately 60% of the total U.S. global health assistance funds annually.¹⁰⁷ As the funding agency for PEPFAR, the Department of State transfers and allocates funding throughout the PEPFAR interagency, which consists of USAID, HHS, DoD, and other USG implementing agencies that implement PEPFAR programs through cooperative agreements with prime partners.¹⁰⁸ A total of \$6.9 billion of PEPFAR funding was bound by the GGR for the first time when President Trump expanded the policy to apply to all \$10.7 billion of U.S. global health assistance in Fiscal Year 2017.¹⁰⁹

OGAC is responsible for notifying all PEPFAR implementing agencies, operating units (OUs), and implementing partners about policy changes like the revocation of PLGHA.¹¹⁰ OGAC also conducts outreach to civil society and other stakeholders as appropriate. In OUs, defined as countries or regions where PEPFAR programs are implemented, staff in the PEPFAR Coordination Offices help support interagency communication in-country, conduct implementing partner meetings, and “keep things on track” in terms of discussing policy changes like the revocation of PLGHA.¹¹¹

OGAC notified PEPFAR stakeholders of the revocation of the GGR by releasing an updated version of the PEPFAR 2021 Country and Regional Operational Plan (COP/ROP) Guidance for all PEPFAR Countries¹¹² on February 11, 2021 that highlighted the removal section “5.9.4 Implementation of Protecting Life in Global Health Assistance in PEPFAR Programs” (Figure 2).¹¹³ This updated version of the COP21 Guidance was formatted to show the text within the PLGHA section as crossed out, but did not provide any guidance on how OUs or implementing partners could adapt their PEPFAR programs to align with the policy change.

OGAC also published a Frequently Asked Questions document to support stakeholders

engaged in the COP21 process, which included one question about the revocation of PLGHA.¹¹⁴ According to written comments submitted by S/GAC, this Frequently Asked Questions tool was designed “as a means of further amplifying appropriate information on the revocation and the actions that should be taken by PEPFAR country teams.”¹¹⁵ However, their answer to the question about the revocation of PLGHA was nearly verbatim the presidential memorandum and did not provide detailed guidance for OUs or implementing partners to implement the policy change.¹¹⁶

To further complicate the COP21 process, a PEPFAR advisor reported that “the COP21 process was bananas and very bizarre”

~~5.9.4 Implementation of Protecting Life in Global Health Assistance in PEPFAR Programs~~

~~The Protecting Life in Global Health Assistance (PLGHA) policy applies to global health assistance furnished by all U.S. government Departments or Agencies, including PEPFAR assistance. PLGHA applies to global health assistance to, or implemented by, foreign NGOs, including global health assistance that a U.S. NGO provides to a foreign NGO through a sub-award.~~

~~The policy requires foreign NGOs to agree, as a condition of receiving global health assistance, that they will not “perform or actively promote abortion as a method of family planning in foreign countries or provide financial support to any other foreign non-governmental organization that conducts such activities”.~~

~~Relevant Departments and Agencies have been including the PLGHA standard provision in: (a) all new grants and cooperative agreements that provide global health assistance; and (b) all existing grants and cooperative agreements that provide global health assistance when such agreements are amended to add new funding.~~

~~Global health assistance to national and sub-national governments, public international organizations, and other multilateral entities in which sovereign nations participate are not subject to PLGHA.~~

Figure 2. **PEPFAR COP21 Guidance, Section 5.9.4 Implementation of Protecting Life in Global Health Assistance in PEPFAR Programs, February 2021**

because it started, then stopped, then started again “at lightning speed.”¹¹⁷ During this time, PEPFAR was operating without a permanent U.S. Global AIDS Coordinator and the spread of COVID-19 was rampant in PEPFAR countries, which impacted USG staff at missions and implementing partners operating on the ground.¹¹⁸ As a result of all of these factors, COP21 “wasn’t stakeholder-focused” and it is unclear if the revocation of PLGHA received adequate attention or discussion during the COP21 process, though PEPFAR staff hope that the revocation will be “fully communicated with a little bit more clarity” during the COP22 process.¹¹⁹

Though there were challenges communicating the revocation of PLGHA within PEPFAR, a PEPFAR advisor noted a clear difference between how quickly and effectively the Biden administration communicated news of revocation relative to how the policy was previously communicated by the Trump administration.¹²⁰ They said:

“In the experience of the last nine months, just comparing it back one administration, it [the revocation] was so clearly communicated, which was really helpful. ... I think it was difficult in the last administration because so much was getting overturned so quickly, I think that catch-up was harder to follow because the things that were getting overturned weren’t always communicated very well. Or you’d read about them in the news, and then, weeks later, your job would catch up and you’d get the update. Whereas this administration, it’s very punchy, very quick and ready. They

just seem like prepared professionals in how they’re communicating things in comparison [to the Trump administration]. So, it’s been much easier as a Government employee to be able to then take that into the field and implement it quicker.”

A technical advisor with PEPFAR experience at the U.S. mission level

The research team requested an interview to discuss the Department of State’s role in implementing the revocation of PLGHA, but instead received written comments from S/GAC. According to the written comments submitted, “S/GAC worked through the interagency to support compliance with the actions outlined in the PLGHA revocation and disseminated accurate and timely information on the revocation and the actions that should be taken by PEPFAR implementing agencies.”¹²¹ S/GAC described the responsibility for implementing agencies to communicate the revocation of PLGHA:

“Based on how PEPFAR programming is administered (i.e., through implementing agencies), S/GAC defers to other PEPFAR implementing agencies for additional details about how the revocation was communicated to various stakeholders and implemented through prime partners, successes and challenges of the revocation process, compliance with the policy, as well as key processes or systems that need to be in place to support the most efficient and effective revocation of the policy possible.”

Written comments from S/GAC

According to a technical advisor with PEPFAR experience at the U.S. mission level, the revocation of PLGHA seemed to be a “non-issue” in PEPFAR interagency and implementing partner discussions in the months following the policy change.¹²² A CDC advisor reported that sometimes CDC partners that implement HIV and AIDS programs with PEPFAR funds may have received communication about the revocation of the GGR from PEPFAR before CDC or vice versa.¹²³ She spoke of the CDC’s engagement with partners funded through PEPFAR in the following way:

“In general, CDC makes every effort to ensure that we are updating partners around our funding requirements. A large portion of CDC’s funding for global health comes from the State Department to co-implement the PEPFAR program. As such, those funds already have the provision revoking PLGHA before they are transferred to CDC. Oftentimes we are aware that PEPFAR has already advised partners of the new or changed policy, but we also alert our partners.”

An advisor from the CDC

However, two organizations that receive PEPFAR funds through CDC in Mozambique (one as a prime partner and the other as a sub-prime partner) reported that they did not receive any direct communication from their points of contact at CDC about the revocation.¹²⁴ This reality indicates a breakdown in communication within the PEPFAR program.

USAID is another PEPFAR implementing agency and is responsible for sharing information about policy changes to HIV and AIDS programs funded through PEPFAR. A public health professional reported that she and her staff working on PEPFAR programs implemented by USAID in Zimbabwe discuss relevant policy changes during monthly “coordination meetings that they normally hold with their USAID Agreement Officer’s Representative, the AOR.”¹²⁵

Given the size of the program, coordinating communication across PEPFAR is vital to ensure that all PEPFAR implementing partners have the necessary information to understand the revocation of PLGHA.

Department of Health and Human Services (HHS)

HHS consists of 11 operating divisions and agencies, including the CDC. The CDC is one of the HHS Awarding Agencies that receives U.S. global health assistance funds and was significantly financially impacted by PLGHA.¹²⁶ According to an investigative report about the implementation of PLGHA by the Government Accountability Office (GAO), only one CDC prime partner declined to certify¹²⁷ PLGHA.¹²⁸ A USG employee reported that this partner did not receive information about the revocation directly from the USG and likely learned of the policy change through their relationship with another CDC implementing partner.¹²⁹

For prime partners that did certify PLGHA, communications about PLGHA's revocation came from staff from the Office of the Secretary of Health and Human Services and OGA.¹³⁰ A number of policy and public health advisors across the USG reported that HHS staff were prepared to implement the revocation as soon as the presidential memorandum was released.¹³¹ A CDC policy advisor reported that the revocation of PLGHA felt "less chaotic than past implementations and revocations across administrations," because "with the new administration coming in, we were anticipating and expecting the changes. Since we [the USG] have revoked this policy in the past, we knew what would be required to update the policy."¹³² Similarly, another USG staffer reported that it was easier to remove PLGHA than it was to implement it, a common central difference in the perception of the degrees of difficulty involved in the revocation of PLGHA versus its implementation.¹³³

To quickly share information of the revocation across the 11 HHS operating divisions and agencies,¹³⁴ the HHS Office of Grants sent a message through the HHS intranet on January 28, 2021 that provided a summary of the policy change and stated that "implementation and enforcement of the PLGHA standard provision is waived effective immediately."¹³⁵ This internal HHS communication included links to the presidential memorandum itself through [whitehouse.gov](https://www.whitehouse.gov), [grants.gov](https://www.grants.gov), and a number of other resources that provided more information about the revocation of PLGHA and the history of the GGR more broadly.¹³⁶

On February 3, 2021, HHS OGA released an internal Action Transmittal (AT) to all HHS Awarding Agencies¹³⁷ that rescinded the three HHS ATs that had guided the implementation of PLGHA since 2017.¹³⁸ This AT included background on the expansion of PLGHA by former President Trump, as well as the revocation of PLGHA by President Biden in January 2021 and provided the following guidance:

"Effective immediately, HHS Awarding Agencies are no longer required, and shall not include the:

1. PLGHA Standard Provision in Notices of Awards (NoAs)¹³⁹ to foreign non-governmental organizations (NGOs) receiving HHS global health assistance either directly from HHS as a recipient, from a non-governmental pass-through entity, or as a subrecipient of a domestic or other foreign NGO; and,

2. Standard language required for all Notices of Funding Opportunity Announcements (NOFOs)¹⁴⁰ that expect to award global health assistance funds appropriated to the DOS [Department of State], USAID, and/or DOD [Department of Defense], and transferred to HHS."

HHS OG AT 2021 – 04

The HHS AT also instructed HHS Awarding Agencies to "revise all NoAs that were issued with the PLGHA Standard Provision and that have an active period of performance," though it did not provide a timeline or process by which agencies were expected to do so.¹⁴¹ The HHS AT also provided the following guidance:

“HHS Awarding Agencies should update internal grants and programmatic procedural guidance to reflect the removal of these two requirements. HHS Awarding Agencies should notify as soon as practicable current grant and cooperative agreement recipients of this decision to waive the implementation and enforcement of the PLGHA Standard Provision.”

HHS OG AT 2021 – 04

Like the directives related to NoAs and NOFOs, there was no specific date or timeline that HHS Awarding Agencies were expected to follow while updating internal grants and programmatic procedural guidance to align with the revocation of PLGHA beyond what the agencies deemed appropriate.¹⁴²

As instructed by the HHS AT, each of the HHS Awarding Agencies were expected to “immediately transmit this information to their grantees and grant and cooperative agreement websites” regarding the revocation of PLGHA in order to share information with the overseas missions and grantees in a timely manner.¹⁴³ During February and March 2021, HHS OGA staff followed up with staff from across HHS to inquire as to how the revocation process was going. They reported hearing repeatedly that HHS operating divisions were “doing this as fast as we can and it’s going well.”¹⁴⁴ Based on this feedback from HHS agencies, Baresch reported that HHS leadership ceased checking in with agencies on the progress of the revocation after March 2021.¹⁴⁵

Centers for Disease Control and Prevention (CDC)

Though the CDC had not been required to implement versions of the GGR prior to PLGHA because the CDC does not receive U.S. funding for international FP, CDC staff were familiar with the tendency for Democratic presidents to rescind the GGR.¹⁴⁶ Soon after President Biden released the memorandum revoking PLGHA, the CDC Office of Grant Services (OGS) led the process of revoking PLGHA and CDC policy staff “helped to ensure that CDC was communicating that information as soon as possible.”¹⁴⁷

By February 18, 2021, CDC OGS staff had updated the public-facing CDC Grants website to include information about the revocation of PLGHA through Additional Requirement 35.¹⁴⁸ The Additional Requirements include specific policy or regulatory guidance that are applied to CDC NOFOs, as relevant.¹⁴⁹ This updated website was a publicly available source of information that CDC staff could send to implementing partners regarding the revocation of PLGHA.¹⁵⁰

According to Baresch, who has extensive experience supporting the CDC’s global health work, the CDC OGS also sent their own CDC-specific AT to Project Officers and Grants Managers¹⁵¹ both at CDC headquarters and in CDC country offices to begin the process of sharing information about the revocation with prime implementing partners.¹⁵²

Staff at CDC country offices also received specific communication from CDC headquarters regarding the revocation of the GGR. According to a CDC policy advisor, the revocation was referenced on phone calls with CDC Country Directors and Deputy Directors during which policy updates are typically discussed.¹⁵³

An advisor from the CDC stated that prime partners also received communications about the revocation via email directly from OGS.¹⁵⁴ For many CDC staff, their “everyday work is working with partners,” so they were actively engaged in answering partner questions about the revocation of PLGHA.¹⁵⁵ The standard process by which the CDC communicates with prime partners regarding policy changes and ensuring compliance with policies like PLGHA or its revocation is as follows:

“We communicate with prime partners, but we do not usually communicate directly with sub-partners, as the prime partner usually conveys messages to their sub-partners. Prime partners work to ensure that their sub-partners are in compliance.”

An advisor from the CDC

This CDC advisor also reported that prime partners are familiar with the CDC’s communication systems, so the email prime partners received from OGS “would have gotten people’s attention as a special notification.”¹⁵⁶ As of September 2021, this advisor reported that CDC OGS had contacted all awardees and CDC staff are continuing to engage with “external partners about [the revocation of PLGHA] to make sure that we’ve canvassed whoever might have a need for information or whoever might also help share this information.”¹⁵⁷

Within CDC country offices, CDC OGS staff coordinated with CDC Project Officers to ensure that the content of communications received by their implementing partners via email was consistent with information that Project Officers communicated to their implementing partners during regular partner meetings.¹⁵⁸

Updating publicly available websites and releasing information electronically regarding the revocation of PLGHA supported rapid communication about the policy change both within the CDC and with prime partners.¹⁵⁹ Another CDC policy advisor reported that “in the global health space, this policy is very well known” so “you’re working with folks who understand the nuances” of the policy.¹⁶⁰ This CDC advisor explained that the fact that all meetings are virtual due to the COVID-19 pandemic made collaboration easier among Grant Managers, Project Officers, and implementing partners both in the United States and other countries.¹⁶¹ She described the communication:

“Working virtually due to COVID-19 has amplified the way that we communicate with each other. Working virtually has really opened up communications. We can do things we had not considered doing before – virtual visits, for example. Working in a virtual space has helped bring in our field colleagues even more because they can now be brought into so many more discussions that may have otherwise been in-person only discussions with consultation in a parallel fashion.”

An advisor from the CDC

In addition to the numerous interviews with various USG employees about the CDC’s triage of information related to PLGHA, the research team spoke with a CDC’s prime partner who shared a different experience. Fundação Ariel Glaser contra o SIDA Pediátrico (F. Ariel) in Mozambique, one of the CDC’s prime implementing partners for PEPFAR, had not been informed of the revocation until they were contacted for an interview for this report in July 2021, which was more than five months after the GGR was revoked.¹⁶² Dr. Paula Vaz, the Executive Director of F. Ariel in Mozambique, reported:

“Actually, we haven’t received any communication regarding this revocation. When we touched base for this interview, it’s when I realized [it had been revoked] and I searched through the internet and that’s when I came to know that President Biden has revoked [sic] the Mexico City Policy. But there wasn’t any communication in-country as far as I know.”

Dr. Paula Vaz, F. Ariel, Mozambique

Dr. Vaz hypothesized that the CDC may not have communicated with them regarding the revocation of the GGR because F. Ariel Mozambique does not “have any type of involvement in any abortion-related activities.”¹⁶³ Regardless of the services they provide, F. Ariel in Mozambique should have received information from their CDC counterparts about the revocation well before the research team contacted them for an interview.

United States Agency for International Development (USAID)

Staff from the PLGHA Compliance Team within USAID’s Bureau for Global Health submitted written comments to the research team that described USAID’s process for communicating information about the revocation of the GGR. According to the PLGHA Compliance Team, USAID “took immediate action to implement the Presidential Memorandum” and reportedly coordinated with the White House, the Department of State, HHS, and DoD.¹⁶⁴

On January 29, 2021, USAID Acting Administrator Gloria Steele issued an internal Agency Notice via email to all USAID staff that announced that USAID was immediately waiving the PLGHA requirements in all existing awards and that these conditions were no longer in effect for prime awards and any subawards.¹⁶⁵ On the same day, Steele issued a public statement recognizing “President Biden’s commitment to improving the lives of beneficiaries, particularly women

and girls, around the world by revoking the January 23, 2017 Presidential Memorandum (The Mexico City Policy), thereby rescinding the Protecting Life in Global Health Assistance (PLGHA) policy.”¹⁶⁶ According to Steele’s statement, the revocation of PLGHA means that USAID “will again benefit from an expanded partner base able to implement U.S. global health assistance,” including programs providing critical health services, such as “HIV/AIDS care for key populations, family planning information and services, and effective tuberculosis diagnosis and treatment.”¹⁶⁷

As Steele communicated with Agency staff and the public about USAID’s response to the revocation of PLGHA, USAID’s Office of Acquisition and Assistance within the Management Bureau (M/OAA) informed USAID Agreement Officers (AOs) about the revocation of PLGHA on January 29, 2021 and instructed them to remove the PLGHA Standard Provision from applicable global health awards.¹⁶⁸ On the same day, M/OAA also announced the revocation of PLGHA to all implementing partners through USAID’s Implementing Partner Notices (IPN) Portal, which was designed to “provide notices to implementing partners with current awards in a consistent and timely manner.”¹⁶⁹

Also on January 29th, the “Acting Administrator for the Bureau for Global Health shared relevant information regarding the rescission of PLGHA with all Global Health Bureau staff, USAID Mission Directors, and USAID health teams globally,” though USAID did not describe the format of these communications or what specific information was included.¹⁷⁰

According to the PLGHA Compliance Team, USAID amended the Automated Directives System (ADS) Chapter 303: Grants and Cooperative Agreements to Non-Governmental Organizations¹⁷¹ on February 4, 2021 to remove the PLGHA standard provision and issued an internal Agency Notice that announced this change about USAID’s standard operating procedures to Agency staff.¹⁷² USAID also updated the Global Health Legislative and Policy Requirements web-page to include information about the revocation of PLGHA, as well as hyperlinks to the updated ADS 303 documents, information about other legislative restrictions, and other resources.¹⁷³

In the subsequent months, USAID’s Washington, D.C. headquarters staff discussed updates on the revocation of PLGHA during regular compliance calls with U.S. mission health teams.¹⁷⁴ According to a USAID contractor at the mission level, USAID mission staff have “incredibly close partner communication” so USAID was able to communicate the revocation to local partners through regular meetings with prime implementing partners.¹⁷⁵ This contractor reported that they were not aware of any issues with partner communication about the revocation of the policy at the country level.¹⁷⁶

Though USAID’s internal communication of the revocation of the PLGHA was coordinated, swift, and comprehensive, organizations that were interviewed reported that the overall impact of its external communications to prime partners was mixed and varied in terms of timeliness, completeness, and clarity.

Carolyn Boyce, the PLGHA Compliance Advisor at Save the Children US, reported receiving the USAID IPN due to Save the Children's role as both a prime and sub-prime partner of global health programs managed by USAID.¹⁷⁷ Boyce described this communication:

“Immediately the next day [after PLGHA was revoked], we did get a message from USAID to its implementing partners clarifying that all the requirements of PLGHA were waived immediately, even though USAID still needed to modify each of the awards individually. Unlike in previous years, everything was being waived immediately in terms of the requirements... We had been talking about the process for weeks in advance and the communication was very clear about the expectations around this.”

Carolyn Boyce, Advisor, PLGHA Compliance, Save the Children US

Boyce's statements indicate that USAID's communications were helpful, particularly since the communications made it clear that PLGHA was revoked immediately, even before awards could be modified.

Additionally, two prime partners in Malawi shared that they received an initial email about the revocation from USAID, and then received more detailed information about the revocation approximately a month or two later, either from a webinar or discussions during quarterly partner meetings with USAID staff.¹⁷⁸ Representatives from three prime partners in Zimbabwe also reported

receiving information about the revocation of the GGR through “emails directly from USAID”¹⁷⁹ as well as routine management and coordination meetings with their AOR.¹⁸⁰ Gertrude Shumba from Family Aids Caring Trust (FACT) in Zimbabwe shared that “USAID always gives constant updates” about policy changes like the revocation of PLGHA.¹⁸¹

In contrast to these more positive accounts of communication from USAID regarding the revocation, Sandra Mapemba, the Technical Deputy Director of Health Policy Plus (HP+) in Malawi, a USAID-funded cooperative agreement that promotes equitable and sustainable health services, supplies, and delivery systems through policy design, implementation, and financing, reported receiving more communication from their USAID points of contact when PLGHA was implemented compared to when it was revoked.¹⁸² She described the numerous meetings that the USAID mission held to inform partners of the policy when it was put into place in 2017:

“The mission deliberately set up meetings with all the organizations that they fund, separately, to more or less highlight the new areas pertaining to the [Global] Gag Rule, and then had one partners [meeting], a more high-level meeting kind of emphasizing the point, so that we were aware of what the changes were and how to implement those changes.”

Sandra Mapemba, Technical Deputy Director, HP+ Malawi

After PLGHA was revoked, Mapemba and her staff received an email from their Agreement Officer's Representative (AOR) from the USAID mission that stated "that the bill [sic] had been rescinded and we should be mindful of that."¹⁸³ This one email was insufficient for Mapemba and her colleagues. She repeatedly mentioned that their organization had to engage in more bottom-up style communications with USAID mission staff to better understand the revocation due to the lack of clarity in the first communications they received.¹⁸⁴ Unlike when the GGR was first implemented, Mapemba and her colleagues were not invited to any mandatory meetings or webinars regarding the revocation, but instead had to "ask the mission...how to proceed" with implementing the new policy change after it was revoked.¹⁸⁵ She attributed this breakdown in communication to staffing transitions at the USAID mission:

"I think from our perspective or from a lot of the USAID-funded projects, it was more the projects asking the mission in terms of how to proceed on this. I'm aware that they're still kind of settling into the new way of doing things, and it's taken them a while to also get themselves together, because at the same time it was the same period of rotation of staff at the mission, so they were settling in whilst also trying to deal with the change of the [Global Gag] Rule... It's been more us asking, and then trying to verify with D.C. and then kind of translating that information back to us...the mission is still finding its legs."

Sandra Mapemba, Technical Deputy Director, HP+ Malawi

Many interviewees in Malawi and Mozambique expressed dissatisfaction with the communications they received from USAID country teams and voiced a desire for the local USAID mission to take a more active role in sharing information about the revocation with organizations operating in-country, particularly through meetings or webinars.¹⁸⁶ A representative from Christian Health Association of Malawi (CHAM) explained the responsibility of USAID and other USG agencies to communicate such policy changes to implementing partners in country:

"My assumption is that it's a policy change, so it was supposed to be implemented as such to say, 'Okay, now going forward, there is this policy change or new message that we are supposed to communicate to you, maybe hold small orientations to different partners on what these changes are all about, what they entail, and what is the way forward or maybe some of the repercussions, just maybe a brief overview by those donors.' But nothing of such did happen."

A representative from CHAM

In a GAO investigative report on the implementation of PLGHA, USAID identified 53 awards, six prime awards and 47 sub-awards, in which NGOs declined to certify PLGHA.¹⁸⁷ As one of the prime organizations that declined to certify PLGHA, MSI Reproductive Choices headquarters staff reported that they did not receive any formal communications about the revocation from USAID.¹⁸⁸ Instead, Bethan Cobley, the Director of Results-Based Advocacy at MSI Reproductive Choices, reported receiving informal communication

about the revocation from “friends and allies at USAID.”¹⁸⁹ The lack of direct communication from the USG regarding the revocation of the GGR in 2021 is not unusual given the varying levels of communication MSI Reproductive Choices has received during

past administrations.¹⁹⁰ Sarah Shaw, Head of Advocacy at MSI Reproductive Choices recalled that “under the [George W.] Bush GGR, officially, there was no correspondence at all. There were no emails; there were no phone calls.”¹⁹¹

Wrongful implementation of the GGR by USAID

The interviews revealed an instance of USAID’s incorrect implementation of PLGHA when it was in effect, as well as the continued implementation of the policy after it was revoked. In Zimbabwe, Tree of Life is a prime recipient of U.S. funding through USAID’s Democracy and Governance Office’s Victims of Torture Fund¹⁹² and facilitates reconciliation and provides psychosocial support for survivors of “traumatic incidents,” such as sexual violence.¹⁹³ Though USAID’s Victims of Torture Fund is not a type of U.S. global health assistance, USAID included the PLGHA Standard Provision in their cooperative agreement with Tree of Life and monitored their compliance with the policy when it was in effect, which is a clear mis-implementation of the policy.¹⁹⁴ Tree of Life should not have been required to comply with the GGR because it does not receive U.S. global health assistance funding.¹⁹⁵

Lynn Walker, Director of Tree of Life, confirmed that USAID led her organization to believe that they needed to comply with the GGR even though they did not receive U.S. global health assistance.¹⁹⁶ Even if the GGR did apply to Tree of Life’s programs,

they would have been permitted to refer survivors of rape for abortion services because that referral is an exception of the GGR.¹⁹⁷ However, in addition to wrongfully imposing the GGR on Tree of Life, USAID did not sufficiently explain the policy and its exceptions. Not understanding that Tree of Life could continue providing abortion referrals, they restricted vital services unnecessarily:

“Working with survivors of sexual violence, PLGHA was one of the conditions in our cooperative agreement with USAID... We were not permitted to use any of the U.S. government assistance for facilitating abortion or providing advice or information about abortion to any of our clients.”

Lynn Walker, Director, Tree of Life

Walker described both the Helms Amendment and the GGR. The Helms Amendment was added to the U.S. Foreign Assistance Act of 1961 in 1973 and states that “no foreign assistance funds may be used to pay for the performance of abortion as a

method of family planning or to motivate or coerce any person to practice abortions.”¹⁹⁸ The GGR builds upon this legislative restriction by controlling which organizations can receive U.S. global health assistance funds (See Table 1).¹⁹⁹ In this case, Tree of Life was rightfully compliant with the Helms Amendment but unnecessarily compliant with the GGR.

Walker noted that Tree of Life’s implementation of the GGR was also included in USAID’s regular auditing processes:

“An interesting one is the audit process, so that when we are audited specifically for our USAID funds, the auditors actually look at our cooperative agreement and don’t just look at the financial compliance areas. They do look at other compliance issues, so our implementation of PLGHA would have been one of them, as well as aspects such as marking and branding.”

Lynn Walker, Director, Tree of Life

Despite regularly complying with audits around their implementation of the GGR since 2017 and flowing the provision down to sub-partners, neither USAID Headquarters nor the U.S. mission in Zimbabwe had communicated the GGR’s revocation to Tree of Life.²⁰¹ Walker said, “I have to confess, until you contacted me, I had no idea it had been revoked, actually.”²⁰² She assumed USAID had not communicated the revocation to them because they are a democracy and governance partner, as opposed to a global health partner, which are separate Bureaus within USAID.²⁰³

Table 1. **The Helms Amendment and the Global Gag Rule**²⁰⁰

Helms Amendment (1973)

- Act of U.S. Congress; must be removed by Congress
- Controls **what** can and cannot be done with U.S. foreign assistance funds

Global Gag Rule (1984)

- Presidential action; can be removed by a president or permanently ended through legislation
- Operates above and beyond the Helms Amendment
- Controls **who** can receive U.S. global health assistance funds

Furthermore, Walker reported that Tree of Life’s cooperative agreement with USAID had been modified since the GGR was revoked, but the PLGHA Standard Provision had not been removed as of the date of the interview.²⁰⁴ Since Tree of Life wasn’t aware that the policy had been immediately revoked as of January 28, 2021, they were continuing to abide by the policy over six months later in August 2021. The incorrectly broad application of the policy by USAID, and lack of communication about the revocation from USAID to all partners that were complying with the policy, represents a significant lapse in USAID’s responsibility to ensure the policy change is implemented.

Tree of Life also applied the PLGHA Standard Provision to their sub-prime partners, as they were directed to do, one of which is Adult Rape Clinic (ARC).²⁰⁵ ARC receives a sub-contract from Tree of Life to provide free medical and psychosocial support for survivors of SGBV.²⁰⁶

However, the PLGHA Standard Provision was incorrectly included in Tree of Life's sub-contract with ARC for two reasons: 1) the funding ARC received from Tree of Life was not U.S. global health assistance, so PLGHA did not apply to those funds, and 2) PLGHA only applied to assistance mechanisms (e.g., grants and cooperative agreements),

not apply to acquisition mechanisms (e.g., contracts, purchase orders).²⁰⁷

Regardless of the non-applicability of PLGHA's requirements on this sub-contract, ARC reported that they had conversations with Tree of Life as its prime partner about their compliance with PLGHA from 2017 until its revocation in January 2021.²⁰⁸ In cases where PLGHA was wrongfully implemented such as this one, organizations like ARC are compelled to redirect limited time and resources to monitor their compliance with a policy that shouldn't have been applied to their sub-contract in the first place.

Communication from the USG to host country governments

Close coordination with host country governments is a core component of U.S. global health programs around the world. When there is a significant change to the USG's stance on a particular issue or a policy change, like the Biden administration's support of SRHR and the revocation of PLGHA, it is important for USG staff to communicate with governmental and multilateral partners and explain the Administration's stance or action.²⁰⁹

USG staff working within a particular country often have close contacts within the country's government and are therefore able to effectively communicate policy

changes like the revocation of PLGHA with relevant Ministries, such as those related to health, gender, and development.²¹⁰ Baresch with the HHS Office of Global Affairs described the process of communicating the revocation of PLGHA with national governments this way:

“At the same time, that information [about the revocation of PLGHA] was going to the Ministries, either through the CDC Country Director or the Grants Manager, depending on the country and the relationship because every country is different. I am sure that information was immediately transmitted through to Ministries of Health.”

Virginia Baresch, Senior Public Health Advisor, HHS Office of Global Affairs

Both the CDC and USAID often work with partner country governments to implement a variety of development programs, including health programs, through bilateral agreements.²¹¹ A CDC policy advisor explained the role of national governments as prime partners in this way:

“If partner country governments receive funds as a prime partner, then yes, they are responsible for communicating policy shifts and any changes in funding requirements to sub-partners to ensure compliance.”

An advisor from the CDC

Similarly, USG staff working at the mission level are responsible for communicating the revocation of PLGHA to their contacts in host country governments in all cases, but this is particularly important in countries where the government is a prime implementing partner of U.S. global health programs. Marla Smith from Save the Children Mozambique said that it would be helpful if the local USAID mission “made it clear to the government [of Mozambique] that this was no longer the policy.”²¹²

Some programs that work with national governments as partners also communicated about the revocation with government stakeholders. Mapemba from HP+ in Malawi explained how her organization communicated about the revocation with their government partners:

“Mainly our partners are government, so we had written communication to them in terms of what we can now do within the current foreign policy, and then we had face-to-face meetings to discuss how that affects any of the projects or activities that were currently being implemented. And then, the government has technical working groups that meet periodically, so we just make partners aware about the rule. But as I said, there’s several other partners who attend those meetings and they too were highlighting the same, so that everybody’s just aware of what’s happening.”

Sandra Mapemba, Technical Deputy Director, HP+ Malawi

Organizations interviewed across all three countries explained the critical role of the U.S. Embassy in sharing information about the revocation of PLGHA with host country governments and stakeholders at all levels. Mwalubunju, a Senior Policy Consultant with expertise in SRHR in Malawi, said that “the U.S. Embassy here in Malawi should be proactive, should take the lead in letting partners, organizations, and people know that there is change of policy, which I haven’t seen” as of July 2021.²¹³

Santos Simione from AMODEFA in Mozambique, a past sub-recipient that lost funding when they declined to certify PLGHA, stated that it would be helpful for the U.S. Embassy “to send information officially and to clarify what does [the revocation] mean, what’s allowed, what’s not allowed.

Because even for me it's not very well clear what we can do and what we can't do, because there's a lack of information."²¹⁴

Talent Jumo, Founder and Director of Katswe Sistahood in Zimbabwe, noted that the U.S. Embassy in Harare “could play a more pivotal role in creating spaces, platforms for continuous engagement” with local organizations since PLGHA has been revoked.²¹⁵ The U.S. Embassy could support the effective revocation of PLGHA by “using their convening power because they have bilateral relationships through their own government, and they could choose their own convening power to bring parties together, offer technical assistance, to say, we need to maximize on the time we have under President Biden to ensure that we roll this out.”²¹⁶ Unfortunately, however, Jumo reported that “we don't see much of that, let alone the [U.S.] embassy actively supporting women's groups” to begin to address the impacts of PLGHA when it was in effect.²¹⁷

Ways to improve external USG communications

Clear and detailed communications from the USG directly to all current and former prime and sub-prime partners are essential to effectively implementing President Biden's revocation of PLGHA. Helena Chiquele from Oxfam in Mozambique expressed the importance of this communication from the USG by saying:

“If you are revoking something that is bad, you need to make sure that you will do your utmost to erase the impact of that thing. You make sure that this information that is vital, is known for those who really need to know. I don't think that was done.”

Helena Chiquele, Southern Africa Gender Justice Program and Policy Manager, Oxfam in Mozambique

Only one prime partner in Mozambique that was interviewed by the research team reported learning of the revocation through direct communication from the USG, though they could not remember if the communication came from USAID, CDC, or another USG agency. Emilio Jose Valverde from Aurum Institute in Mozambique, a current prime partner, was first informed of the policy change between February and March 2021 and said: “I believe I got some communications through the U.S. Government email lists, but nothing specific for Aurum and nothing specifically to me.”²¹⁸ Valverde explained that understanding the policy change is difficult and it is not quite clear what the policy change means for Aurum's programming, so more explanation is needed.²¹⁹ He said that “even if you read the policy, you have to delve a bit into the details because it's not quite clear what it means. If you go to the USAID webpage that talks about the revocation of the policy, it's kind of confusing.”²²⁰

Valverde suggested that USAID take a step further in the language used for communication, noting “sometimes the statement you get in the webpages are kind of legally complicated and hard to understand what is exactly the meaning, the consequence. So maybe to translate from the legal languages to the practical work would be something quite interesting.”²²¹ Several organizations in Malawi also expressed that they would better understand the policy change if a document explaining the revocation had been shared with them immediately after the revocation.²²² This simplified document would allow organizations to have a foundational understanding of the revocation “in layman’s terms.”²²³ Mapemba from HP+ in Malawi summarized this concisely:

“From a practical point of view, because people want to implement [the policy change], it would be easier just to get a one-pager of the dos and the don’ts. That would be faster and easier guidance rather than the legal language that you have to wade through. I think that would be really helpful to people who are actually implementing.”

Sandra Mapemba, Technical Deputy Director, HP+ Malawi

Stakeholders interviewed in Malawi and Mozambique also highlighted the importance of sharing information about the revocation of PLGHA in local languages, as well as English.²²⁴ Chance Mwalubunju, a Senior Policy Consultant with expertise in SRHR in Malawi, stated that the USG “should not

forget the local communities who do not speak English or read English.”²²⁵ Rafa Valente Machava, the Executive Director of MULEIDE in Mozambique, also said “...everything is in English. English is not our daily working language... Even if we have to speak in English, what comes to our mind first is Portuguese; we think in Portuguese first, then we translate, and then this takes a lot of time.”²²⁶

Mwalubunju and Valente’s statements reveal the USG’s assumption that those receiving communications about U.S. foreign policies, including staff from local organizations, have sufficient English skills to understand complicated legal changes like the revocation of PLGHA. Assuming that individuals working for civil society organizations can and should be able to understand a language that is not the official language of their country, nor a traditional or local language, highlights neocolonial standards prevalent in some practices of providing foreign assistance.

To overcome this challenge, Valente stated that these communications “need to be very, very simplified and translated into different languages.”²²⁷ She clarified that people supporting U.S. global health programs around the world “would like to have the policies in their own languages... Everything has to be simplified, so that it can be well understood.”²²⁸

Tamburai Muchinguri from Family Support Trust (FST) in Zimbabwe also recommended that the U.S. government adhere to a standardized communications plan when policy changes occur:

“I think the changes are just known to a few organizations, and probably only those who are US-based to some extent, but those who are really on the ground do not have a lot of information... So, there is a need to institutionalize the changes, as well as to make a lot of noise about the changes. I think that will actually help.”

Tamburai Muchinguri, Director, FST

Dr. Mildred Mushunje, from SRHR Africa Trust in Zimbabwe, reported that civil society organizations (CSOs) in Zimbabwe needed the policy translated into “simple key points” that are “user-friendly” and “easily accessible to anyone” including those CSOs and individuals living and working in remote communities.²²⁹ Dr. Vaz, Executive Director of F. Ariel in Mozambique, reported that communicating the revocation of PLGHA to USG agencies or health staff is not enough, but that a broad communication plan should be made available to the general public, including “people interested or people affected by the policy, young women, women in general, families.”²³⁰

Several organizations from all three countries recommended that the USG disseminate clear communication about the revocation in a variety of formats for health workers and the general public via fact sheets, having U.S. missions host local informational sessions, webinars, other online Q&A sessions, and utilizing TV, radio, newspapers, podcasts, and social media.²³¹ Other suggestions included regular town halls, increased dissemination of SRHR-specific information, and an official statement addressing the revocation.²³² Interviewees also expressed the need for a policy brief or position paper directly from the USG explaining the revocation of PLGHA and its effects.²³³



Communication from INGO headquarters to country offices

INGOs are often set up with a headquarters in one country (e.g., South Africa, the United Kingdom, or the United States) and country offices or affiliates around the world.²³⁴ Numerous staff from INGO headquarters and country offices participated in this research project, including Save the Children, Pathfinder, PSI, FHI 360, and World Vision. Overall, staff who heard from their organization’s headquarters about the revocation felt that communication was fairly prompt and clear, with a few notable exceptions.

Country offices from multiple INGOs explained that their headquarters teams were “on top of what is coming out of the U.S.” and “normally hold meetings updating

the country offices” to “discuss any new developments that are happening” related to U.S. foreign policies like the GGR.²³⁵ Ten organizations interviewed across Malawi, Mozambique, and Zimbabwe mentioned that their primary source of information about the revocation of the policy was through an email from a senior-level officer at headquarters or verbally during calls or technical meetings with headquarters staff.²³⁶ Most of these organizations stated that the communications from their INGO headquarters made it clear that they no longer had to implement PLGHA.²³⁷

Carolyn Boyce, the PLGHA Compliance Advisor for Save the Children US, reported that the organization “had done quite a bit of work in advance [of the revocation], hoping that the policy would be revoked” before the 2020 U.S. Presidential election.²³⁸ To prepare for the revocation of the policy, Boyce and her team designed an internal organizational communication process to prepare staff for the revocation and communicate the policy change when it went into effect:

“We created a separate communication and language [from the USAID email]. We actually have a PLGHA page on our intranet with the tools and processes explained. So those communications were sent to all the country offices, the regional offices, to the Award Managers, posted on our intranet, and discussed during meetings that we had, either departmental or team meetings.”

Carolyn Boyce, Advisor, PLGHA Compliance, Save the Children US

For the first month after PLGHA was revoked, Boyce received several questions from staff across the organization confirming the process for communicating the policy change with all staff, partners, and stakeholders.²³⁹ Overall, she reported that the advance planning she and her colleagues had done to communicate across Save the Children US was “a fairly easy process.”²⁴⁰

Gomezgani Jenda, the Senior Technical Advisor for Health and Nutrition at Save the Children Malawi emphasized that their legal advisory teams in the U.S. and the technical advisors based in the country offices were integral to the process of policy change communications, as they would receive official policy change communications from the USG and provide an interpretation of what the changes meant to the rest of the organization’s staff.²⁴¹ This interviewee appreciated the legal team’s role in this communication and policy translation process for INGOs generally:

“Normally when we get these communications, we normally have our legal team as well as our technical advisors sitting in the international office[s] to provide an interpretation of what that [policy change] really means... The legal team sitting in the U.S. coordinates any of their communication from that side to ensure that the country office is also getting those communications.”

Gomezgani Jenda, Senior Technical Advisor for Health and Nutrition, Save the Children Malawi

However, not all communications between headquarters and field staff were perceived to be as informative. PSI, a large INGO with country offices around the world that receive U.S. global health assistance funds as both a prime and a sub-prime, similarly communicated with their country offices about the revocation.²⁴² PSI's Director of Grants and Contracts received the USAID Implementing Partner Notice via email that explained the policy revocation with the presidential memorandum attached and forwarded this communication to PSI country offices. Andrea Fearneyhough, the Director for Safe Abortion Programming at PSI, confirmed that the "Grants and Contracts Office [at PSI Headquarters] sent out some communications about the revocation of PLGHA" and Hofmann from PSI confirmed that these communications were shared "from Headquarters out to our field operations."²⁴³ A representative from PSI Mozambique, a current sub-prime partner and previous prime partner during the Trump administration, reported receiving these communications about the revocation of the policy via email by their Director of Grants and Contracts at their U.S. headquarters office.²⁴⁴ Donato Gulino, the country representative for PSI Mozambique, stated that "the communication [to PSI Mozambique] at that time came actually from our Grants and Contracts Director. My understanding was that then, each country office will be approached with additional clarification if necessary and based on their funding portfolio."²⁴⁵ However, an advisor at another PSI country office reported that internal communication within PSI "was not really clear," particularly regarding the

implications of the revocation for ongoing programs, so staff at country offices had to be proactive and reach out to headquarters staff for clarification.²⁴⁶ Based on these contrasting experiences, it is unclear if all PSI country offices received or understood the communication about the revocation from PSI headquarters.

A representative from an INGO country office in sub-Saharan Africa described the information their country office received about the revocation from the grants and compliance staff at headquarters as incomplete.²⁴⁷ This country office is a sub-prime on two CDC-funded programs and relies on the grants and compliance staff at headquarters for monitoring U.S. foreign policy changes, sharing updates across country offices, and reviewing any modifications to current awards before the agreements are signed by country offices.²⁴⁸ According to the interviewee, their headquarters office received a USAID notice explaining the revocation of PLGHA on January 29, 2021, and then sent an email to all country leads on February 1, 2021 stating that "President Biden had sent out a notice to revoke the policy."²⁴⁹ They said this communication made it clear that the policy was being revoked immediately for all USAID awards, but it "didn't make any mention of the CDC awards."²⁵⁰ As a result, they believed that only "the country offices that have USAID funded awards would see formal modifications. But that doesn't apply to us since we get CDC money and not USAID."²⁵¹ They believe their country team was not included in any further communication from headquarters about

the revocation because they only receive CDC funding. Despite this lack of clarity from headquarters, the representative understood that the revocation of PLGHA likely applied to CDC funding but stated that as of August 2021 their country office was still waiting for detailed communication from headquarters for confirmation.²⁵² It is unclear if this misunderstanding of the revocation is due to inadequate communication from the CDC to the organization's headquarters or if headquarters relayed incomplete information to their country offices.

Regardless of where communication broke down, it is evident that detailed and specific communications are needed to ensure that stakeholders at all levels understand the revocation of the GGR and how it applies to their programs funded by U.S. global health assistance.



Communication from prime partners to sub-prime partners

P rime partners of U.S. global health assistance are legally required to communicate with their sub-prime partners regarding policies and restrictions like PLGHA and its revocation. Nineteen interviewees across Malawi,²⁵³ Mozambique,²⁵⁴ and Zimbabwe²⁵⁵ identified themselves as current sub-prime recipients of U.S. global health assistance as of the date of the interview. Most of these organizations received some form of communication regarding the revocation, however these communications varied in detail and source.

Some sub-prime organizations received communication about the revocation from their prime, though the communication came many months after revocation. CHAM, a sub-prime recipient of U.S. global health assistance, receives a sub-grant from Christian Connections for International Health (CCIH), a U.S.-based Christian organization.²⁵⁶ CHAM staff reported that the communication they received from CCIH regarding the revocation “was just an email...received two weeks ago,” referring to early to mid-July 2021, six months after the revocation.²⁵⁷

In some cases, multiple sub-primers of the same prime organization received different communications. Two of the organizations interviewed in Malawi are sub-primers on the same agreement.²⁵⁸ One of these organizations reported that they were informed of the revocation of the policy by their prime partner via email in April 2021 and described this communication:

“We were just sent emails informing us that the policy has been [removed]. It was [our prime] who informed us about the revocation. Since [they are] the prime recipient of the [funding], they are the ones responsible for the technical implementation of this funding. So, they are the ones that communicated to us that this policy was revoked.”

Executive Director, Sub-prime organization A

Interestingly, the other sub-prime recipient of these funds under the same prime partner did not receive direct communication from the prime regarding the revocation. They only heard from the prime partner about the policy when it was in effect.²⁵⁹ The Executive Director of this second sub-prime organization explained:

“I remember it was the first time [our prime] released their funding [to us], they said this money you cannot use for abortions... [Interviewer: So... did [the prime] explain the revocation to you or reach out to you about the change in abortion policy?] No, not yet. They didn’t explain anything about that.”

Executive Director, Sub-prime organization B

Based on this interviewee’s statements, their prime partner made it clear that no funding through their award could be used to support abortion services, which was likely due to both the Helms Amendment and PLGHA being in effect at the time the sub-award was signed. Though this interviewee did not differentiate between the Helms Amendment and the GGR, they confirmed that the prime partner had not communicated with them regarding the revocation of PLGHA, as noted in the second half of the quote above.

The research team contacted the prime partner and was told that the prime partner reached out to all their local sub-partners and that they already knew about the revocation.²⁶⁰ The prime partner said:

“So, we even went to our local organizations to say, hey, now the provision has been removed. We are now starting to prepare the document for the amendment. They said, ‘Yeah, we heard about it.’ So, it was not like something that just came to [our organization]. Everyone was aware of it, the news was all over, and everyone was happy that it was lifted.”

A representative from a prime partner in Malawi

The different experiences of two sub-partners on the same program is an example of a breakdown in communication between a prime and sub-prime partner. The difference in the sub-prime partners’ understanding of the revocation is especially stark because the prime partner assumed a general understanding of the revocation among their local sub-prime partners.

It was not uncommon for sub-primes to have heard from their primes about the implementation of the policy, but not to have heard from their prime about the revocation. ADPP in Mozambique, a sub-prime of FHI360, received no communication of the policy’s revocation from FHI360.²⁶¹ Birgit Holm, the Country Director for ADPP, reported that “even with FHI[360] as a prime... we have not gotten any other information, communication” regarding the revocation of PLGHA as of August 2021.²⁶² Holm stated that FHI360 had communicated with ADPP regularly when PLGHA was in effect and “asked specifically if we were promoting any of the activities connected to promote safe abortion, and if we had any materials that were also explicitly promoting it [safe abortion].”²⁶³ The lack of communication

ADPP has received from FHI360 since the policy was revoked stands in stark contrast to the high level of communication from their prime when PLGHA was in effect.²⁶⁴

In other cases, sub-prime partners heard from one, but not all of their prime partners. PZAT receives sub-awards from multiple prime partners, including FHI360, AVAC, I-TECH, and the University of Pittsburgh.²⁶⁵ PZAT staff stated that they were originally informed of the policy’s revocation from AVAC and they did not receive any information about the revocation from their other prime partners.²⁶⁶ Imelda Mahaka, PZAT’s Executive Director, and Definate Nhamo, Senior Program Manager, shared that they received communications only from AVAC that the PLGHA had been revoked and organizations funded by U.S. global health assistance could “provide information, services, [and] referrals for legal abortion [and] advocate for access to abortion services in Zimbabwe” within the country’s current legal framework.²⁶⁷ Mahaka shared her thoughts on the flow of information as a sub-prime partner by saying, “I think for us, the difficult part has always been because we’re not a direct grantee of USAID, we are a sub-grantee, so information sort of trickles down interestingly.”²⁶⁸

Other organizations interviewed for this report reported instances of prime partners sharing information about the revocation with their sub-prime partners. As a sub-prime on some U.S. global health awards, Boyce from Save the Children US reported that their prime partners forwarded USAID’s IPN message about the revocation to the award managers at Save the Children US “pretty

quickly” after USAID originally sent it.²⁶⁹ As a result, open lines of communication between Save the Children US and their prime partners facilitated quick and clear communication regarding the revocation of PLGHA down to the sub-prime partners.²⁷⁰ That said, it is vital to recognize that Save the Children US is a large INGO and has significant financial resources and organizational capacity to monitor changes in U.S. foreign policy and the related communications.

As a prime, Pathfinder Mozambique ensured that information about PLGHA’s revocation was available in different languages through communication with their sub-prime partners and members of the Rede dos Direitos Sexuais e Reprodutivos (Rede DSR) coalition, which they lead.²⁷¹ The Rede DSR coalition is a network of national and international organizations operating in Mozambique that seek to advance sexual and reproductive rights in the country.²⁷² MULEIDE, one of Pathfinder Mozambique’s sub-prime partners and a member of the Rede DSR coalition, reported facing a language barrier when they first received communication about the revocation in English from the USG.²⁷³ They described Pathfinder Mozambique’s communications in Portuguese to be essential to their understanding of the meaning and implications of the revocation.²⁷⁴ Pathfinder Mozambique’s communications were helpful to another sub-prime partner, which also receives a significant amount of funding from USAID and the Department of State as a prime, and yet only was informed of the revocation from the USG in the form of agreement modifications.²⁷⁵ They subsequently engaged with Pathfinder

through the Rede DSR to obtain more detailed information about the revocation.²⁷⁶ Despite the seemingly important role that Pathfinder played in conveying details about the revocation at the local level, at least one of their sub-prime partners received no information about the policy change. Donato Gulino from PSI Mozambique stated that their organization did not receive notification of the revocation from either of their primes, Pathfinder or FHI360.²⁷⁷

Though prime partners are responsible for communicating with sub-prime partners about policy changes, they have no legal or contractual responsibility to inform former sub-prime recipients of the policy revocation. AMODEFA had been a recipient of U.S. global health assistance before PLGHA was implemented but declined to certify the policy in 2017 and subsequently lost US global health funding.²⁷⁸ The relationship between AMODEFA and their former prime partner ended because of the implementation of PLGHA, so AMODEFA did not receive any formal information about the revocation from their former prime partner at the time of the interview with the research team.²⁷⁹ Santos Simione, Executive Director of AMODEFA, noted that AMODEFA “had no relationship with [the prime partner] at the moment, so they didn’t send us any information” about the revocation.²⁸⁰

Although this case provides no evidence of contractual or legal wrongdoing, it is our recommendation that prime partners make a concerted effort to inform former sub-primes of the revocation, to ensure transparent and thorough communication across organizations.

Ongoing wrongful implementation of the GGR after revocation

Family AIDS Caring Trust (FACT), a Christian national development NGO in Zimbabwe, provides SRH services through clinics operated by sub-prime partners like Family Support Trust (FST). FST operates clinics where adolescent girls and young women who are survivors of sexual abuse or rape can access sexually transmitted infection (STI) screenings, pregnancy tests, counseling, and treatment for injuries related to sexual violence. As the prime partner, FACT is responsible for monitoring FST's implementation of the PLGHA as well as notifying it at the time of the policy's revocation as implementing partners of the PEPFAR DREAMS program.²⁸¹

However, FACT failed to notify FST that some of its work was exempt from the restrictions of the GGR when the policy was in effect from 2017 to 2020. As an organization that regularly engages with clients who have become pregnant because of rape or incest or whose lives were endangered by their pregnancy, any referrals FST would have made for these clients to access abortion would not have been bound by the GGR requirements. Abortion for pregnancy resulting from rape is also permissible under Zimbabwean law.²⁸²

After completing the eLearning Course on U.S. FP restrictions after PLGHA was revoked, the Director of FST, Tamburai Muchinguri realized that FST could recommence its service delivery activities seeing that

abortion is permissible in the case of rape under Zimbabwean law.²⁸³ After flagging this mis-implementation of the policy in April or May 2021, Muchinguri was advised by their prime partner to continue misapplying the GGR and said:

“What do we do if your prime says, ‘No, you can’t do this,’ and there’s no clear communication from them? So, this is the current position right now, where it’s like it [termination of pregnancy] cannot be done. This is the common understanding, the general understanding, that it can’t be done using any support from USAID.”

Tamburai Muchinguri, Director, FST

Due to the mis-implementation of the policy, survivors of rape or incest were wrongly prevented from receiving critical services and counselling from FST while PLGHA was in effect and even after it was revoked.

By the time of the interview with the research team, Muchinguri stated that the prime partner had notified him of the revocation of the PLGHA via WhatsApp message, though this message stated that activities related to abortion were still prohibited and that FACT was awaiting ‘clarity’ from USAID.²⁸⁴ This communication lacked specificity, failing to explain how the revocation would concretely impact FST’s day-to-day operations.²⁸⁵ Muchinguri said:

“We were informed of the revocation through our prime. They actually sent us information that the policy has been revoked. But they said that still termination cannot be done as they did not have enough information and were waiting for clarity from USAID. But I think we are still yet to get more information on how exactly it [the revocation] was involved and its consequences on our activities that we do. So, it was just something like, in passing. And up to now we haven’t really gotten enough information on what really was revoked and what changes were then brought into place... It was basically a WhatsApp message that we received from our [prime]. Yeah, just in brief, I think something that they also got from the internet that there has been some revocation, but it wasn’t that detailed as such.”

Tamburai Muchinguri, Director, FST

At the time of the interview, Muchinguri reported that FST is prepared to resume the provision of comprehensive SRH services as soon as they receive additional communication and guidance from FACT as their prime:

“For us, really, if we get that communication, we are actually ready to implement that law, because on a day-to-day basis we actually come across a number of women and children who are raped. And the law in Zimbabwe is already there, that allows termination of pregnancy resulting from rape. And the courts are actually ready to give termination orders to women and children who have been raped. So, for us, as soon as

we get that communication clear, we are ready to support that.”

Tamburai Muchinguri, Director, FST

Gertrude Shumba, Director of FACT, stated that FACT received an email from USAID communicating the revocation of PLGHA within a month of President Biden’s inauguration.²⁸⁶ USAID also modified their agreement “showing that the conditions that were initially given were lifted” in alignment with the revocation of the PLGHA.²⁸⁷ Shumba reported that these communications and modified sub-awards were immediately disseminated to FACT’s sub-prime partners, though Muchinguri of FST only reported receiving a WhatsApp message communicating the revocation of PLGHA.²⁸⁸ Yet, at the time of the interview, Muchinguri reported that FACT continued to monitor FST for compliance with the since-revoked GGR:

“So, as it is right now, in terms of being monitored [by our prime], we are being monitored using the previous law [GGR] which was there before the changes were actually made. Like in, in terms of termination and abortion, we have not made any change in how we used to work or to practice since the revocation was made. So, it’s still the old way of doing things that we’re doing.”

Tamburai Muchinguri, Director, FST

Despite the lack of monitoring, Muchinguri also pointed out that their programs and services are likely to be overwhelmed when they finally reincorporate the option for termination into their programs and services:

“We can actually foresee a lot of women and girls coming to our clinics requesting termination... And once people know that there is this service, I think we will actually be overwhelmed... I’m telling you that if we started talking about the availability of termination of pregnancies and abortion, I can foresee our clinics being overwhelmed by cases.”

Tamburai Muchinguri, Director, FST

Muchinguri reflected that even the revocation of this policy could have negative implications for the community of women who were forced to carry unwanted pregnancies:

“I think the revocation has not made any impact on our programs, because nothing has changed. We have not yet thought it’s coming into place, because we have not started implementing it. And to some extent, of course, it has a negative effect, in that we would have loved to have unwanted pregnancies terminated. Some women would have loved unwanted pregnancies to be terminated and these women then continue feeling the pain and continue suffering psychologically. And we actually come across such cases, because once they visit our clinics, you know, we develop a bond with them. They become part of us, and they continue coming back to us for support, especially for psychological support. So that then somehow affects us as well as affecting them. But the effects, the positive effects, so to say, have not yet been felt, because we have not gotten clear communication on the changes.”

Tamburai Muchinguri, Director, FST



Communication from civil society

Generally, the USG reportedly heard more from CSOs when the GGR was instituted in 2017 than when it was revoked. Baresch from HHS OGA reported that “there was an uproar” from civil society and advocacy organizations when PLGHA was expanded to all U.S. global health assistance in 2017.²⁸⁹ At the time of the interview, she reported that “it’s been very quiet” since PLGHA was revoked, as she had not heard of any questions or feedback from civil society or advocacy organizations and “people just went about their business.”²⁹⁰

Another USG staffer also reported that they had not received nearly as much feedback from CSOs about the revocation as they had when PLGHA was first implemented, which the USG staffer believed indicated that stakeholders were generally happy that the policy had been revoked.²⁹¹ The staffer reported receipt of one inquiry in February 2021 from the International Family Planning Coalition (IFPC), a coalition that represents a broad range of major US-based SRHR

INGOs.²⁹² IFPC representatives met virtually with relevant CDC staff on February 26, 2021 to discuss the agency’s implementation of the revocation, including their communications with current awardees, and then followed up with CDC via email in mid-March 2021 to inquire about the status of these communications.²⁹³ This USG staffer reported that the IFPC representatives were frustrated that USG staff did not do enough to quickly implement the presidential memorandum revoking PLGHA.²⁹⁴ Though USG staff at the implementing agency level largely believed they had done enough, they recognized the importance of critically reflecting on feedback from CSOs.

As a result of this engagement with IFPC, CDC staff confirmed that CDC OGS had notified all research awardees as of March 17, 2021 and communication with non-research awardees was underway with formal notifications to be sent to all partners by March 19, 2021.²⁹⁵ CDC staff also confirmed that new NOFOs would no longer contain the PLGHA Standard Provision and that current cooperative agreements would receive updated terms without the PLGHA Standard Provision in the next NoA.²⁹⁶

The majority of CSOs interviewed across Malawi,²⁹⁷ Mozambique,²⁹⁸ the United Kingdom,²⁹⁹ and Zimbabwe³⁰⁰ reported learning about the revocation from partner organizations within established coalitions. Most said that communication with partners was not their primary source of information about the revocation.³⁰¹ However, a few organizations learned of the revocation for the first time from conversations within a coalition or with advocacy partners.³⁰²

Organizations in Malawi and Zimbabwe explicitly named CHANGE, now Fòs Feminista, as a source through which they learned about the policy change.³⁰³ Madam Emma Kaliya, Director of MHRRC, emphasized the usefulness of a one-pager published by CHANGE³⁰⁴ on the same day that President Biden released the memorandum that announced the revocation:

“CHANGE has been quite a resource for some of us, because they keep on updating us on what is happening in the U.S...in terms of what CHANGE has been sending, you can literally understand what they mean.”

Madam Emma Kaliya, Director, Malawi Human Rights Resource Centre

As an organization that declined to certify PLGHA and was not a recipient of U.S. global health assistance when the policy was revoked, MSI Reproductive Choices relies on PAI, an SRHR advocacy organization based in Washington, D.C., for information about the revocation of the policy.³⁰⁵ Shaw said:

“My go-to place for technical information and sense-checking is always PAI. So, some of the things that have been coming through PAI about the revocation of PLGHA have been really helpful and clear. And to be honest, they’re probably my default number one source because they’ve already done the analysis and the interpretation and sense-checking. And we trust them implicitly because they are the experts.”

Sarah Shaw, Head of Advocacy, MSI Reproductive Choices

Cobley, also from MSI Reproductive Choices, relies on information from PAI to understand the revocation because “without those amazing flow charts, it was pretty incomprehensible, even for people who worked in this field for years.”³⁰⁶ Cobley also said that “it’s really been down to the NGOs to work out what the revocation means, to contextualize it” due to a lack of “formal” communication about the revocation from the USG to the public.³⁰⁷

It is challenging for civil society and activist organizations to fill the gap in communication about policy changes like the revocation of PLGHA, though they have played an important role throughout the history of the GGR. An interviewee from Malawi commented on the crucial role that SRHR activist organizations played in sharing information about PLGHA when it was in effect, which they felt was missing from the revocation process:

“I remember well that during the Trump administration when the Global Gag Rule was enforced, there was a lot of communication in terms of what the Global Gag Rule means, etc. And this mostly came from international and national organizations that were opposing the Global Gag Rule. And they would exactly put it in a very clear and simple way to understand, because I think there were some other provisions which people were understanding differently. And we had to get clarification from different people and people would say, ‘Let me check if this is what it means,’ because I think there were some contradictory provisions that were in there. So, I think the way the Trump administration’s

enforcement of the [Global] Gag Rule was communicated from their side, but also from the activists who are opposing the Global Gag Rule; it made people understand what it meant and what you were supposed to do, unlike when this has been revised [by] the Biden administration. I think there hasn’t [been] that much, maybe, interest, even from the international and national organizations that were providing guidance. I think they’ve just kept quiet.”

A representative from a prime partner in Malawi

The International Center for Reproductive Health–Mozambique (ICRH–M) declined to certify PLGHA and lost their U.S. funding, which was approximately 40% of their budget.³⁰⁸ ICRH–M staff posted about the revocation of the GGR on their Facebook page on January 29, 2021 (Figure 3, see next page).³⁰⁹ This post explained the revocation of the policy, described the impact of PLGHA when it was in effect, and relayed President Biden’s stance on SRHR to ICRH–M’s coalition and advocacy partners.³¹⁰

ADPP, a current prime and sub–prime partner, described that they first heard about the revocation from AMODEFA, an organization they worked with before PLGHA went into effect.³¹¹ Birgit Holm, the Mozambique Country Director at ADPP, explained:

“Actually, we haven’t received any direct communications about [the revocation], no. So, we came to hear about it from the other organizations who we worked with before, which

were kind of removed from receiving USAID support, and from the other platforms with organizations in Mozambique, but we have not received any communication directly from USG.”

Birgit Holm, Mozambique Country Director, ADPP

Generally, robust civil society networks provided a platform through which organizations that did not receive formal communications from the USG or their prime implementing partners could better understand and discuss the implications of the revocation of PLGHA.

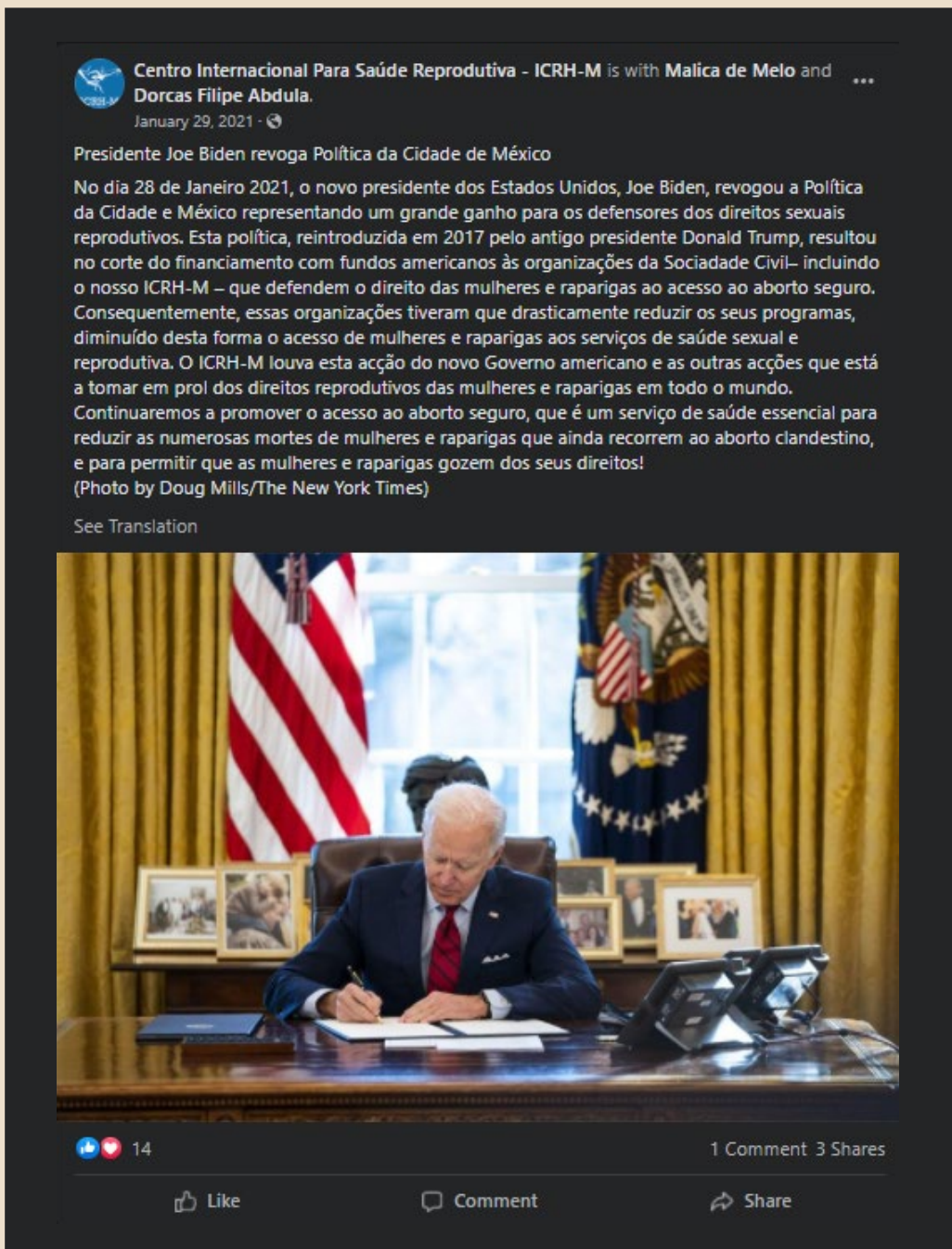


Figure 3:
International Center for Reproductive Health- Mozambique’s Facebook post about the revocation of PLGHA, January 29, 2021.



Communication via mass media

Given the speed at which information travels through mass media and social media channels, many individuals and organizations interviewed for this project reported first learning of the revocation of PLGHA through some form of media. A PEPFAR advisor that works at a U.S. mission in sub-Saharan Africa described her experience:

“I saw it in the news before I saw it officially circulated through USG communications, but I feel like that’s just because everything breaks faster than bureaucrats can actually announce [anything] these days.”

A technical advisor with PEPFAR experience at the U.S. mission level

Several advocacy organizations across Malawi, Mozambique, and Zimbabwe were well-aware of the political landscape in the United States and were expecting the Biden administration to revoke the GGR.³¹² Actively monitoring media outlets served as a means for organizations to be proactive in seeking to better understand the revocation in real time. Many interviewees mentioned

checking social media often during the first days of the Biden presidency. Rouzeh Eghtessadi, the Executive Director of SAfAIDS Regional, reported that the organization had been tracking the policy through SRHR sectoral networks and social media, including Twitter and Facebook, in the days following President Biden's inauguration and "were tweeting and joyful" as soon as the presidential memorandum that revoked PLGHA was released.³¹³

Madam Kaliya, Director of MHRRC and chairperson of COPUA, a coalition of health service providers, SRHR advocates, legal experts, and traditional and religious leaders that advocate for safe abortion in Malawi, specified that while U.S. news channels were reporting on this policy change, the same was not true on Malawian channels.³¹⁴ She said:

"But we've not seen it being publicly announced in the newspapers or even through social media, except that we have been hearing from [the U.S.] side during the swearing in of Biden, as well as during other news press conferences where it was announced from the U.S. that the revocation has happened."

Madam Emma Kaliya, Director, MHRRC

Matsikure from GALZ, a sub-prime recipient of U.S. global health funding in Zimbabwe, noted that since the revocation of the GGR, he has seen an increased level of discourse regarding the policy on social media:

"I've been listening to a few conversations even on social media. These days people do a lot of tweeting and all that. It's something that people are able to speak about now boldly. I think there's some level of comfort and confidence that this has been revoked and the [U.S.] government is in support of what we have always said should be in place for women."

Samuel Matsikure, Programs Manager, GALZ

For most organizations that heard about the revocation of PLGHA via mass media, this happened around the same time that they heard through other channels, such as official communication from their organization's U.S. headquarters or communications from colleagues or partner organizations. One prime partner from a large INGO's country office in Malawi explained this email communication from their INGO headquarters in more detail:

"I was watching CNN News, and I saw that President Biden had signed to remove it, and the next day, I received a communication from our headquarters that we should now start looking at all the sub-agreements and remove that provision. It was so quick. I got it the next day after I got the news from CNN."

A representative from a prime partner in Malawi



GGR revocation amidst the COVID-19 pandemic

The COVID-19 pandemic has profoundly strained health systems across the world, overburdening health workers, hospitals, and clinics, and exacerbating existing inequalities in access and care experienced by women, girls, LGBTQI+ communities, people living with disabilities, and other marginalized populations.³¹⁵ Other indirect effects of the pandemic, including increased gender-based violence and protracted lack of access to basic SRH services, have also contributed to increases in unintended pregnancy, unmet need for contraception, and other adverse health outcomes.³¹⁶ Tamburai Muchinguri reported that FST, a SRH service provider in Zimbabwe, has seen “an increase in the number of rape cases taking place” during the COVID-19 pandemic.³¹⁷ Matsikure, the Programs Manager at GALZ, also reported that their organization “has seen higher rates of young women in lower education or primary school getting pregnant, who are not ready to be mothers,” through their programs that serve LGBTQI+ communities in Zimbabwe.³¹⁸

The Biden administration’s presidential memorandum that revoked the PLGHA acknowledged the impacts of the policy on global health programs both before and during the pandemic:

“The expansion of the policy has also affected all other areas of global health assistance, limiting the United States’ ability to work with local partners around the world and inhibiting their efforts to confront serious health challenges such as HIV/AIDS, tuberculosis, and malaria, among others. Such restrictions on global health assistance are particularly harmful in light of the coronavirus disease 2019 (COVID-19) pandemic.”

Memorandum on Protecting Women’s Health at Home and Abroad, January 28, 2021

Global health programs are often unable to meet the increased need for services due to the pandemic. In Mozambique, ICRH-M, a former implementing partner of U.S. global health assistance, reported low access to contraceptives and an increase in unintended pregnancies among adolescent girls and young women due to COVID-19 service disruptions.³¹⁹ Málica de Melo, the National Director at ICRH-M, explained that at the time of this interview, their safe abortion policy was “not a priority” for the Ministry of Health and other organizations because other health areas have been prioritized during the pandemic.³²⁰

Mwalubunju, a Senior Policy Consultant with expertise in SRHR in Malawi, echoed these findings, explaining that the government of Malawi failed to prioritize SRH services as an “essential service” in their initial COVID-19 response:

“At first, the government produced some guidelines and sexual health and rights was not included as an essential service. So, during that period, women were not able to go and get access to family planning methods in hospitals. They stopped. Girls would not have access to the family planning methods from youth primary health corners...and then the feedback was that high numbers of teenage pregnancies were witnessed in Malawi. High numbers of early marriages were witnessed in Malawi. And then I think this came too late, when we won our battle, where the government now included sexual health and rights as an essential service within the hospitals and then they directed hospitals to allow women to proceed with their normal services.”

Chance Mwalubunju, Senior Policy Consultant with expertise in SRHR in Malawi

Rouzeh Eghtessadi from SAfAIDS Regional described the compounded impacts of COVID-19 and PLGHA on SRHR in this way:

“The global catastrophe of COVID-19 is deepening the damage that GGR had caused, increasing the risks and vulnerabilities, and the violations on the rights of women and adolescent girls to access safe abortion, and, to a great degree, access and choices regarding family planning, contraceptives, and other essential SRH commodities.”

Rouzeh Eghtessadi, Executive Director, SAfAIDS Regional

A USG staffer with experience in global health agreed that “the policy of the last Administration combined with the operational restrictions of organizations from the pandemic created a really detrimental impact on communities across the world, where these services are probably the most critical.”³²¹ It has been particularly challenging for USG agencies and implementing partners to communicate and implement the revocation of PLGHA and help global health programs recover during the pandemic.³²²

According to written comments from USAID’s PLGHA Compliance Team, USAID carried out the specific steps to revoke PLGHA “in the midst of the COVID-19 pandemic when USAID mission teams and implementing partners faced unprecedented challenges,

including lockdowns, programmatic shifts and adaptations, and stressful personal circumstances.”³²³ According to a USAID contractor at a mission, USAID’s communication and engagement with partners changed due to COVID-19 in the following ways:

“We used to go out and do site visits all the time. We used to be in the field all the time. And that’s something that has just not been safe to do in [country] in the pandemic with such a small general population being vaccinated and/or adherent to prevention protocols like mask-wearing and handwashing. So, we are now very reliant on what our partners tell us is going on versus actually being on the ground and being part of some of those meetings like we used to be.”

A USAID contractor at a U.S. mission

Maintaining clear and consistent lines of communication between USG agencies and implementing partners during the pandemic is essential, particularly as standard communication pathways, modes of engagement, and program performance have been impacted by COVID-19.



Guidance, monitoring, and compliance of the revocation of the GGR

USG agencies and implementing partners are responsible for enacting monitoring activities to ensure compliance with the first and third directive in the presidential memorandum, including updates to agreements through formal modifications, NOFOs, PEPFAR compliance mechanisms, and publicly available Global Health eLearning courses and internal organizational training materials.³²⁴

At the Executive level, the role of the NSC is to “get confirmation from agencies” that programmatic guidance has been revised to align with Administration policies, like the revocation of PLGHA.³²⁵ Though the NSC does not perform direct program oversight, it can ask USG agencies to describe their monitoring and evaluation processes “to have a sense of [the] impact” of specific policy changes and monitor the level to which agencies have carried out the directives in the presidential memorandum.³²⁶ According to a USG staffer with expertise in U.S. foreign policy, the White House “did not receive any indication that there were barriers to shifting programmatic agreements to align with the policy” as of the time of the research team’s data collection in late September 2021.³²⁷

Interviewees in Malawi, Mozambique, and Zimbabwe generally described PLGHA monitoring and compliance mechanisms in the context of the policy’s implementation, such as the Global Health eLearning course about PLGHA, site visits, and coordination meetings with USG staff.³²⁸ No one interviewed across the three countries were aware of any formal mechanisms through which U.S. agencies or primes were monitoring their compliance with the revocation of the policy.

Agreement modifications

To meet the requirements of the first directive in the memorandum: “immediately waive such conditions in any current grants,” award management staff across USG agencies at both the headquarters and country levels are responsible for revising all current awards with prime partners to remove the PLGHA Standard Provision through an agreement modification.³²⁹ HHS and USAID staff confirmed that staff both at headquarters and Missions have worked with prime implementing partners to implement the policy change, including beginning the process of modifying awards to remove PLGHA.³³⁰ Once the award with a prime partner has been modified, “prime implementing partners are responsible for ensuring compliance with award provisions, and for ensuring that sub-recipients are aware of which requirements and provisions are applicable to their award” which would include removing the PLGHA Standard Provision from all sub-awards.³³¹

However, not all prime partners received accurate agreement modifications from USG implementing agencies since PLGHA was revoked. Pathfinder Mozambique, a prime implementing partner, received a cooperative agreement for a new award with the PLGHA language still included.³³² Though they could not confirm the USG agency because procurement processes for new awards are confidential until the award is finalized, Mobaracaly said:

“Even recently, we received one of the agreements for a new award that is coming through. And they had still kept the clause on PLGHA, and we just mentioned that there might be a mistake, because this has been revoked recently. It’s just copy/paste, but please, just be sure that you take this out.”

*Riaz Mobaracaly, Country Director,
Pathfinder Mozambique*

Maintaining accurate cooperative agreements are a vital component to ensuring that programs are informed of and compliant with the current U.S. foreign policies and restrictions.

HHS and CDC

The HHS AT released on February 3, 2021 instructed HHS Awarding Agencies to “revise all NoAs that were issued with the PLGHA Standard Provision and that have an active period of performance.”³³³ These revisions must “indicate that implementation and enforcement of the PLGHA Standard Provision is effectively immediately waived.”³³⁴ The HHS AT did not, however, specify a timeline for these modifications or clarify whether or not these modifications should be done explicitly to remove PLGHA or if PLGHA should be removed the next time a NoA is modified for another reason.³³⁵

The majority of CDC awards are modified annually on October 1st to coincide with the start of the new federal fiscal year (October 1 to September 30). New NoAs would have

been issued in October 2021, eight months after the revocation, to remove the PLGHA Standard Provision.³³⁶ USG staff familiar with the NoA modification process reported that the PLGHA Standard Provision should have been removed from all CDC cooperative agreements as of early October 2021.³³⁷ Baresch from HHS OGA stated that “other than the legal requirements of signing a new NoA and having to legally abide by that,” there are no other mechanisms that HHS uses to ensure that prime and sub-prime partners are complying with the policy change.³³⁸ Baresch also reported that HHS leadership held a call with relevant staff across the HHS Awarding Agencies “to see if they had any questions, and actually nobody had any questions because we had worked so hard on how to implement [PLGHA] that it was very easy to actually undo it.”³³⁹

At the time of the interview, CHAM in Malawi was the largest faith-based provider of health services in-country and was a prime recipient of U.S. global health funds through the CDC, as well as a sub-prime recipient of FHI360 on a USAID award.³⁴⁰ Representatives from CHAM shared that the CDC included information about the revocation on the very last page on an updated NoA in April 2021 and did not provide any other communication explaining the revocation.³⁴¹ One of the representatives from CHAM emphasized how easily that information could have been missed, especially since CHAM did not receive separate direct communication from the CDC explaining the revocation:

“It was just a communication to us, and this communication was not to say there are changes in the policy... But it came in another document, a Notice of Award. So, it was at the end of this Notice of Award document where this information [about the revocation] was put. So, I would say, for someone like me or our institution, we just concentrate on the issues which we are seeing maybe on the first or second or third page. But it was difficult to see the information which was put at the end [of the NoA] of which it was also very important for that information to be seen and to be taken as such.”

A representative from CHAM

Based on this report from CHAM, it appears that all the CDC’s prime partners may not have received the necessary initial communications from CDC in the weeks following the revocation of PLGHA. Direct and clear communication from HHS and all its operating agencies to all prime partners is necessary to ensure the most effective revocation of the policy possible.

USAID

According to written comments submitted by the PLGHA Compliance Team at USAID, “USAID takes compliance with all legislative and policy requirements very seriously and works with staff in Washington and overseas to ensure the proper implementation of applicable legal and policy requirements within our programs.”³⁴² With regard to specific monitoring and compliance steps, “USAID has worked with staff and

implementing partners to remove any PLGHA language from subawards and other award documents, including workplans, compliance plans, Mission Orders, and monitoring tools.”³⁴³ The USAID staffers that were interviewed did not confirm in these written comments whether or not these modifications were completed for the sole purpose of removing the PLGHA Standard Provision or if PLGHA language was removed during the next regular modification of an award.³⁴⁴

Representatives from the headquarters of two INGOs reported that several USAID AOs issued notices to prime partners in the weeks following the revocation to confirm that the PLGHA Standard Provision was immediately waived in current awards before award modifications were issued.³⁴⁵ According to one letter that the research team was able to access, an AO at a USAID mission stated that PLGHA was “no longer in effect for the prime award and all existing and future subawards as of the date of the Presidential Memorandum.”³⁴⁶ The letter also confirmed that “the award will be amended to remove the [PLGHA] Standard Provision in the next modification.”³⁴⁷ As a next step, the letter directed the prime partner to “remove this requirement from any existing subawards, and these requirements must not be a condition of any future subawards.”³⁴⁸

Irene Koek, an expert familiar with U.S. global health assistance, shared that the “immediate waiver [of PLGHA] is different than what was done in the past,” so prime partners were able to stop implementing PLGHA before awards were modified.³⁴⁹

Boyce from Save the Children US reported that she and the PLGHA compliance team had to adjust their plans to communicate and implement the policy change after they received formal guidance from USAID regarding the immediate waiver of PLGHA before awards could be modified:

“The process [of revoking PLGHA] differed in terms of in the past, as far as I know, it was always you had to wait [to stop implementing the policy] until the award was modified. So, leading up to this communication [from USAID], we had warned our offices that the projects would need to adhere to the requirements up until their awards were modified. So then of course we were very happy to give them the good news that the requirements were waived immediately, but that changed our communication slightly.”

Carolyn Boyce, Advisor, PLGHA Compliance, Save the Children US

Boyce also reported that USAID provided additional guidance to clarify that PLGHA was “waived immediately even though they still needed to modify each of the awards individually...whenever other modifications would go through” so “it was going to take a while.”³⁵⁰ Hofmann from PSI confirmed that PLGHA was removed as part of the “normal course of business modifications, taking advantage of the moments to take the language out [of agreements], but it wasn’t specific to the revocation.”³⁵¹

Even with accurate language within the agreement modification, an interviewee in Mozambique expressed that the agreement modification from USAID did not adequately explain what the revocation means for their organization’s operations and programs. The representative described what remains unclear to them in this way:

“What does the revocation of the policy mean because when the policy was enforced, we didn’t have any specific session or program to explain to us what it meant. And when it was revoked, we also didn’t [receive any explanation].”

A representative from an SRH organization in Mozambique

This staff person also said that her “understanding of the revocation doesn’t come from USAID putting that information in our modifications, but it comes from other sources of information that I looked after, so that I could understand what exactly Biden was revoking.”³⁵² These other sources included a news bulletin from an international agency such as Pathfinder or the International Planned Parenthood Federation (IPPF), which was posted immediately after the policy was revoked.³⁵³

New funding opportunities

The third requirement for implementing the presidential memorandum revoking PLGHA mandated that the PLGHA standard provision could not be included in any new awards that would include U.S. global health assistance funds.³⁵⁴ To meet this requirement, the HHS AT released on February 3, 2021 instructed HHS Awarding Agencies not to include the PLGHA standard provision in NOFO announcements.³⁵⁵ A CDC staffer with policy expertise reported that the CDC made sure that “CDC staff were aware that all new funding opportunities included the language about the revocation of PLGHA.”³⁵⁶

Opportunities for new funding are publicly available, so NOFOs are one way for the USG to share information about a policy change with new potential partners or to reach lost partners.³⁵⁷ A technical advisor with PEPFAR experience mentioned that communication about the policy revocation could be tied to a NOFO to ensure that all potential or lost partners are aware that PLGHA is no longer in effect.³⁵⁸

Three organizations in Malawi (one of which was a sub-prime partner and the other two were not current recipients of U.S. global health assistance at the time of the interview) mentioned that although they first heard about the revocation through media or colleagues, they each confirmed that they heard about the revocation indirectly from a USAID call for proposals released shortly after the revocation in January 2021.³⁵⁹ These interviewees had expressed interest in applying for U.S. global health funding in

the future, and to them, calls for proposals are a reliable source of information from the USG regarding policy changes such as the revocation of PLGHA.³⁶⁰

Many representatives from organizations in Zimbabwe expressed that they were interested in applying for grants from USAID and needed more guidance.³⁶¹ None of the interviewees in Zimbabwe had any knowledge of calls for proposals from USAID following the revocation. Nevertheless, many interviewees were hopeful that there would be more opportunities for unrestricted funding in the future.³⁶²

PEPFAR compliance mechanisms

On March 8, 2021, S/GAC, in collaboration with PEPFAR implementing agencies, “removed the PEPFAR Site Improvement through Monitoring Systems (SIMS) element related to the implementation of the PLGHA policy” and released updated SIMS materials without any mention of PLGHA.³⁶³ SIMS is a quality assurance tool used to monitor and improve program quality at PEPFAR-supported sites at the site and above-site levels.³⁶⁴ Questions related to the applicability and implementation of PLGHA were included as an ‘element’ in the SIMS assessment tool when the policy was in effect to support PEPFAR’s PLGHA monitoring and compliance processes.³⁶⁵

Three organizations based in Malawi mentioned during their interview that USAID or the prime partner staff conducted regular

compliance visits as a mechanism by which their organization's compliance with PLGHA was monitored during its enforcement.³⁶⁶ These were field visits conducted by USAID staff, prime partner staff, or occasionally both together on a quarterly PEPFAR SIMS Assessment.³⁶⁷ Interviewees mentioned that during these visits, USG or prime partner staff would check programmatic and financial records, conduct SIMS assessments, and speak with organization staff to note their compliance with the policy.³⁶⁸ Mapemba from HP+ in Malawi explained:

“USAID does quarterly compliance checking in with organizations [they fund]. So, they either go to the field and monitor some of the activities in there, or they talk directly to partners and evaluate whether we have adhered to the rules and regulations or not, and then our own personal financials and the like, they go through those to check whether compliance is being followed or not.”

Sandra Mapemba, Technical Deputy Director, HP+ Malawi

While removing the PLGHA element from the March 2021 version of the SIMS assessment tool was an actionable step toward implementing the presidential memorandum, the evaluation questions related to PLGHA were removed completely and no information about the revocation of the policy was added to the tool. The questions in the PLGHA element could have been edited to reflect the revocation of the policy in order to create a mechanism through which to monitor organizations' compliance with the revocation.

According to a technical advisor at the U.S. mission level, there are robust teams of grants and program management staff usually from both CDC and USAID that are dedicated to ensuring PEPFAR programs are being implemented correctly in strict policy environments.³⁶⁹ These mission staff are “the main and daily point of contact for the partners” and the mechanisms for monitoring compliance at the mission level are so streamlined that they would have caught it “if something wasn't correctly being implemented in terms of the revocation at this point.”³⁷⁰ As demonstrated through this research and past reporting, however, there are instances of mis-implementation of the policy both when it was in effect and since it was revoked in January 2021, so proactive policies are necessary to ensure that SRHR are respected, protected, and fulfilled.³⁷¹

PLGHA Global Health eLearning Course and organizational training

When PLGHA was expanded by former President Trump, the USAID Compliance Team developed a publicly-available Global Health eLearning course designed to provide an overview of abortion-related legal and policy restrictions related to U.S. foreign assistance, including PLGHA.³⁷² According to written comments submitted by the USAID Compliance Team, USAID updated relevant Global Health eLearning courses “to reflect the rescission of the PLGHA policy,” though USAID did not specify which courses had been updated to include this policy

change.³⁷³ As of the writing of this report, the PLGHA course has been archived³⁷⁴ and the U.S. Family Planning and Abortion Requirements course³⁷⁵ was updated on June 24, 2021 to include information about the revocation of PLGHA along with this guidance:

“As of the date of the Presidential Memorandum, the requirements in the standard provision, “Protecting Life in Global Health Assistance,” are no longer in effect for USAID prime awards and all existing and future subawards.”

U.S. Family Planning and Abortion Requirements Global Health eLearning Course, June 24, 2021

Before PLGHA was revoked, USAID encouraged implementing partners to complete the PLGHA Global Health eLearning course annually as one of the “best practices” to ensure that “staff and any subrecipients are aware of, and taking steps to ensure compliance with, the statutory and policy restrictions related to abortion.”³⁷⁶ Irene Koek, a global public health expert with experience managing USAID’s Bureau for Global Health, described “the eLearning [course] that USAID puts out is more of a tool for partners. The requirement is simply that [partners] will abide by the policy and it’s on partners to make sure that happens.”³⁷⁷

Prior research indicates that primes tended to flow this practice down to their sub-partners with the added step of requiring staff to email copies of certificates of completion to the prime as a monitoring and compliance tool.³⁷⁸ Organizations across Malawi, Mozambique, and Zimbabwe described compliance monitoring mechanisms during the policy’s implementation, including the PLGHA Global Health eLearning course as a mechanism that U.S. agencies and primes used to keep track of organizations’ compliance with the policy when it was in effect.³⁷⁹ These interviewees explained that they received repeated reminders to complete the course annually and present certificates of completion to USAID staff or their prime partner, depending on their specific organizational funding relationship with U.S. global health assistance.³⁸⁰

A representative from a sub-prime organization in Malawi reported receiving less information about the revocation compared to when PLGHA was in effect, and reminders to complete the PLGHA eLearning course were common.³⁸¹ This representative questioned if information regarding the revocation had not yet filtered down to Malawi as of the interview in July 2021:

“I don’t think I’m getting as much information as I was getting [when it was in effect]. You know, with the Trump administration, [we got] even reminders in terms of, ‘Have you completed that course? This is a course you need to complete; this is what you need to do.’ And so on. So, I feel like I may not be getting enough information right now. But that is not to say maybe my colleagues in the U.S. are not getting this. They may be getting more information. But I think at the country level, I don’t feel like I’m getting as much as I was getting under the previous administration, where basically they were focusing on the compliance issue. So, if they were focusing on compliance, right now we would be focusing on the implementation of new guidelines.”

A representative from a sub-prime partner in Malawi

Another interviewee in Malawi alluded to differential enforcement of the annual eLearning course completion requirement depending on which U.S. implementing agency was funding them.³⁸² They explained:

“Mainly it was the USAID award which they were more strict on, the one we were being sub-granted by [our prime partner]. I would say maybe USAID is the one which is more strict in terms of trying to encourage us or to push us to take these online trainings...from CDC, they have never asked [for our certificates of completion] and they have never given us any guidance on what should be done in this case.”

A representative from a prime and sub-prime recipient in Malawi

A representative from an INGO explained that the course was only available in English, so the language barrier was a hurdle as many staff in country offices may not speak English fluently. They said that “one of our biggest challenges always turned out to be the language, so if we have someone take the course, we need to make sure that they speak English or at least they understand enough to know what they’re taking the course on.”³⁸³ Translating this and other Global Health eLearning courses into multiple languages would help implementing partner staff around the world understand how to implement U.S. global health programs that align with the current policies and restrictions.

Though the PLGHA eLearning course was most commonly mentioned in the context of the policy’s implementation under the Trump administration, all of the interviewees that mentioned the eLearning course also said that they continued taking this course even after the policy was revoked in January 2021, typically because they were requested to by USAID or their prime partner.³⁸⁴ However, when asked whether the content of this course had changed since the revocation, there was no consensus among the seven interviewees as to whether or not the content of the course had been changed to reflect the policy’s revocation. Of the seven interviewees, two said the course content was the same as when the policy was in effect,³⁸⁵ two others said that changes had been made to the course content to reflect the revocation,³⁸⁶ and three were unsure whether they had seen any changes to the course content since the

policy was revoked.³⁸⁷ One interviewee who noted changes to the course content after the revocation recalled these changes and described them in detail:

“What I remember was there was a really good, big description of what were the dos and don’ts [when PLGHA was in effect], but when I was doing the course this time around, I felt that was a bit different. There were certain words that were put in at the beginning of the course about President Trump [talking] about the Global Gag Rule and the implication of it. When I was doing it, I think around June [2021], I noted that that was a bit different. Some of the words were removed. And I think they even changed it further, because I did it before much changes had happened. But those that were doing it around July, they said actually that the narrative is a bit more different than it was before. That’s what I can remember from the top of my head, comparing last year when I was doing it, and then this year as I was doing it.”

An anonymous SRHR expert in Malawi

Lance from Pathfinder’s headquarters reported that it is standard practice for their organization to “have anybody working on a USAID project complete the eLearning certificate from USAID” on an annual basis.³⁸⁸ As both a prime and sub-prime partner, Riaz Mobaracaly from Pathfinder Mozambique confirmed that staff from Pathfinder Mozambique and their sub-partners working on U.S. global health assistance-funded projects “always have to take the compliance courses of FP and abortion for U.S. funding.”³⁸⁹

Additionally, staff at Pathfinder’s headquarters developed an internal organizational package that includes Pathfinder’s own FP and abortion policy, monitoring documents, and an app that includes “a very lengthy, comprehensive checklist” to support clinic monitoring visits.³⁹⁰ According to Lance, Pathfinder has created “a pretty solid package of materials that get updated to bring in the Mexico City Policy when it’s in place and remove it when needed.”³⁹¹ This package, which Pathfinder headquarters and global staff are required to review and complete every April, also includes extensive trainings and materials related to USAID’s compliance with FP and abortion restrictions, and is translated into multiple languages.³⁹² Mobaracaly acknowledged that developing these materials and translating them into numerous languages was a “huge investment from Pathfinder to ensure that everyone knows what this really represents” and that it prevented an “overreaction” to PLGHA when it was in effect.³⁹³

In January 2021, Lance reported that Pathfinder conducted “an overview of updates and changes” to ensure their materials aligned with the revocation, which included updating all of their training and monitoring materials to remove PLGHA and adding a notification that the policy had been revoked so it was clear.³⁹⁴ Pathfinder had to wait a few months to launch the updated trainings because USAID was in the process of updating their Global Health eLearning courses, which were released in June 2021.³⁹⁵ Though Lance did not describe this as a “significant delay,” she said that

it “caused a ripple effect in terms of the changes and what’s required in making sure we’re all up to speed” because it is standard practice for headquarters staff to get trained first followed by country teams when a training has been updated.³⁹⁶

Lance also reported that Pathfinder U.S./ Global staff normally conduct in-person site visits to monitor sub-awards, which allow them to gather “more qualitative feedback from partners” about programmatic and policy-related updates.³⁹⁷ Though local country teams have continued to conduct site visits, headquarters staff have not been able to participate in person due to COVID-19 travel restrictions, so some partners “might still be fearful of what implications could be if they’re referring clients or doing any abortion activities.”³⁹⁸ As a result, Pathfinder is relying on their formal training materials to make sure “it’s clear PLGHA is no longer in place and sub-recipients don’t have to be complying with that policy anymore.”³⁹⁹

Pathfinder Mozambique is both a prime and sub-prime partner of USAID-funded global health awards and Riaz Mobaracaly, the Country Director, reported that their country office “never received any formal communication” from their USAID points of contact.⁴⁰⁰ Mobaracaly reported that the Advocacy and Communications Team at Pathfinder’s headquarters have been “really on top of things” and have successfully communicated the revocation to the entire organization through “brown bags” and internal materials, so “everyone has been deeply informed” of the revocation.⁴⁰¹

A high-level representative from Save the Children US described why intensive training and clear guidance from the INGO’s headquarters were helpful to explain the revocation of PLGHA:

“There was also a chilling effect in countries where they weren’t sure. Some countries thought that they couldn’t talk about family planning at all and so that’s why we needed those trainings and the advocacy to say, ‘No, no, you can still talk about family planning. You just can’t talk about everything else.’ So, I just wanted to note that there was a significant amount of staff time that we had to put in as advocates as well.”

A high-level representative from Save the Children US

Boyce, who managed PLGHA compliance for Save the Children US, stated that they encouraged their staff and partners to complete the PLGHA eLearning course when the policy was in effect to ensure everyone’s understanding of the policy.⁴⁰² Boyce also reported that the PLGHA eLearning course “wasn’t quite appropriate” for some Save the Children US staff and partners “given the language and internet connectivity issues” so they created their own version of the course that included “similar but more specific presentations in multiple languages...and, depending on the level of the partner, sometimes different, more targeted information was better” to help them understand PLGHA and related restrictions.⁴⁰³ Boyce also reported that Save the Children US developed a presentation of

the other U.S. foreign policies, amendments, and requirements that would continue to apply to U.S. global health assistance even after PLGHA was revoked to make sure “in very specific cases that the understanding was correct, even if PLGHA was revoked, what does that mean specifically for what we can and can’t do.”⁴⁰⁴

According to Boyce, she and her team had done so much planning that disseminating updated monitoring and compliance tools, checklists, and trainings after the policy was revoked was “a fairly easy process.”⁴⁰⁵ Boyce also reported that it was somewhat difficult to ensure all staff across such a large INGO received the updated materials since PLGHA was revoked:

“The process was easy to revoke in terms of stopping the requirements and changing the tools, but tools are already out there and in certain versions and it’s hard to have people use an updated version sometimes. So, some of our global tools that include language that was cleaned up so that it would be PLGHA-approved, even if we send [an updated version] out again, not everyone gets the new version, necessarily. So, it does have that chilling effect.”

Carolyn Boyce, Advisor, PLGHA Compliance, Save the Children US

In addition to the eLearning course and field visits, Jenda from Save the Children Malawi explained several other monitoring mechanisms that their INGO HQ generally has in place, including a “standardized [FP] checklist originating from the Global Health Bureau [at USAID] itself...to ensure that we’re compliant to all the requirements in that checklist,” a legal team that engages in a “vetting process to check [that potential partners are compliant with the policy]” before formal organizational partnerships are established, and “a full accountability department that looks at donor compliance, implementation compliance, etc. This team sits independent from all the implementation we are doing [and acts] as our watchdog in terms of implementation on the ground.”⁴⁰⁶

Save the Children had strict monitoring processes to ensure compliance with PLGHA when it was in place, however these processes do not appear to be necessary since the revocation of the policy. When asked whether the U.S. government is monitoring Save the Children’s implementation of the revocation, Marla Smith from Save the Children Mozambique said, “I don’t think that they are monitoring this change. To my understanding, they don’t have any changes in their reporting system.”⁴⁰⁷

PSI reported that the compliance mechanisms they use to monitor their sub-agreements have been updated to reflect the revocation of PLGHA, but Fearneyhough and Hofmann both described the challenges of monitoring a partner’s compliance with the revocation of PLGHA:

“PLGHA going away didn’t change that prime and sub relationship. So, it’s like a negative of a negative. When something goes away, how to ensure that it went away? I will say, through our regular auditing [processes] and through our Grants and Contracts functions as well, we are always checking for compliance with donor regulations and this policy [PLGHA] was in our compliance checks for all of those years that it was [in effect] and we have obviously updated that compliance mechanism. But even the process of [updating that] is an example of the dismantling of the mechanisms around that [policy]. We no longer have to comply with that [policy], so we can take that out of our compliance checks.”

Andrea Fearneyhough, Director for Safe Abortion Programming, PSI

Though PLGHA has been taken out of PSI’s compliance checks as Fearneyhough described, Hofmann went a step further to say that PSI is not actively monitoring partners’ implementation of the revocation:

“It’s one thing to say, ‘We’re going to check to see if you’re complying with the policy.’ It’s quite another thing to say, ‘We’re going to check to see if you’re not complying with the Policy that’s no longer in effect.’ We’re probably not doing that. We’re probably not doing that because it’s not operationally meaningful to us. We’re not required to do it and it’s not hindering the execution of our programs one way or the other.”

Karl Hofmann, CEO, PSI

As Fearneyhough and Hofmann described, PSI intentionally designed their programs in such a way to ensure that any programs or partners funded through U.S. global health assistance would not be impacted by the GGR, so it is unnecessary for them to monitor their partners’ compliance with the revocation as their work would not change now that PLGHA is no longer in effect.⁴⁰⁸

A staff person at a PSI country office explained that PSI staff had been required to take the PLGHA Global Health eLearning course every year the policy was in effect and that they did not receive guidance from headquarters stating that this would no longer be required after it was revoked.⁴⁰⁹ Instead, staff at the country office had to be proactive and check on this requirement themselves. The PSI staffer said that “when we went to the Global Health Learning page, there was a notice that said this course had been removed because the policy had been revoked. We learned that we didn’t need to take the course by going and looking for the course, as it was not officially communicated by PSI headquarters.”⁴¹⁰

Programmatic guidance

Though the presidential memorandum revoking PLGHA included directives for ceasing the implementation of PLGHA in current and future awards, it did not provide specific guidance about how to implement this policy change.⁴¹¹ Not surprisingly, interviewees from an INGO headquarters, the U.S. government, as well as the majority of local organizations operating in Malawi,⁴¹² Zimbabwe,⁴¹³ and all of the organizations interviewed in Mozambique indicated they received unclear, insufficient, or no additional guidance for interpreting and implementing the policy's revocation through their policies and programs.⁴¹⁴

Specifically, representatives from two sub-prime organizations in Malawi reported that they “do not have enough information” or “awareness about the contents of the current policy” to understand how the revocation impacts their programs because the communications from their prime partner lacked a thorough explanation of what this policy change actually meant and how it would be implemented.⁴¹⁵ These experiences of sub-prime partners reveal the importance of clear programmatic guidance from USG agencies, as well as prime partners, to support organizations as they adapt programs to align with the policy change.

A U.S. government staffer with expertise in global health speculated that improved guidance from the USG might include “specific questions as to what can be done to go further, or to clarify if there is

confusion around what can and can't be done with some of the existing policies or where we want to go.”⁴¹⁶ More than simply issuing additional formal guidance is needed, however, according to the same staffer, who said:

“I think that part of it is that there are two components that have to come together for us to have real change in this area, one is obviously what we do for policy change, but the other is cultural change in parts of the Government that actually implement and oversee programs, and I think it's in process, but I wouldn't say we're quite there yet. I think that's where we hope to be helpful to agencies to really help identify where they might have a bit of question around how to interpret guidance and help give clarity as to what it really means in an effort to not have that be something that precludes programming, but rather, have it be quite clear what is supported and actually encouraged to fund. ... I think sometimes it's as simple as telling parts of the government that they can actually be funding certain programs.”

A U.S. government staffer with expertise in global health

Critically, Dr. Stephanie Psaki, Human Rights and Gender Equity Senior Advisor with the HHS Office of Global Affairs, emphasized the importance of fostering a feedback loop between the USG, implementing partners, and CSOs to understand the clarity of the USG's process of revoking PLGHA thus far and inform future guidance.⁴¹⁷ Dr. Psaki said:

“The feedback that I have gotten from civil society organizations has been incredibly helpful on this front. Because when you’re sitting within the structure of government...it’s very black and white sometimes in terms of like the policy has been changed, and therefore we’re moving forward, and we assume it’s as clear to everybody outside of government as it is inside of government, but it’s very difficult to know whether it is actually clear to the prime implementers, also the subs and people who are operating on the ground. So, I think that piece, getting feedback...is important because it’s very hard to directly get information on whether this is clear. So, I think partly conversations with civil society have been helpful and hearing from people from different angles just saying a range of, ‘It’s not clear.’”

Dr. Stephanie Psaki, Senior Advisor, Human Rights and Gender Equity, HHS Office of Global Affairs, Office of the Secretary

Hofmann from PSI noted that there is much more that the USG could be doing to communicate guidance and expectations to partners around the revocation of the policy, though he considered that it is unlikely to happen.⁴¹⁸ He concluded:

“I mean, it’s a heroic expectation to assume that they will do what we know they should do, which is to say: ‘This is what the law allows, this is what the need dictates. We expect our partners to go to the full extent of the law.’ Yes, we know that the Policy has flip-flopped back and forth but there has been no guidance from USG saying, ‘Now we expect you to do this and we will accompany you while

you do this.’ It would be extremely surprising to find anybody who would do that up to and including the USAID Administrator. I just don’t see it happening. And so instead, you rely on small, whispered winks and nods and encouragement—quiet encouragement, which is there, and which is valuable, but is hard to capture.”

Karl Hofmann, CEO, PSI

Brian Ligomeka, the Director of the Centre for Solutions Journalism (CSJ), a media advocacy group that leads SRHR advocacy efforts in Malawi and is not a recipient of U.S. global health assistance but leads SRHR advocacy efforts in Malawi, echoed Hofmann’s sentiment based on his observations in this way:

“In the ideal situation, the U.S. government or U.S. agencies are supposed to have a Zoom meeting to say, ‘We have this policy. This policy has been revoked and now... A, B, C, D.’ Unfortunately, the U.S. government and government agencies hardly do that. If you are to find out things and how to access support, then you get it from partners that you work with who are most of the time informed by some of their associates within the bureaucracy in government. But all you hear is that ‘We have revoked the Global Gag Rule.’ That is the policy of the new government. The Global Gag Rule has been revoked but...to expect U.S. agency or government officials to come down to say, ‘Partners or former partners, this is the way you do things now.’ No, they never do that, at least in Malawi they never do that.”

Brian Ligomeka, Director, CSJ

Representatives from CHAM in Malawi described the lack of guidance they received regarding implementing the revocation of PLGHA through their programs:

“In terms of instructions on how this can be implemented I think it wasn’t very clear...it was just embedded in a certain communication, and they just said, ‘If you want more information, refer to this link or to this website.’ So, in terms of the actual implementation, I think it wasn’t very clear on what needs to be done.”

A representative from CHAM

Another representative from a sub-prime organization in Malawi explained the points which they felt were lacking in terms of guidance on the revocation:

“We know what the changes are and when the changes have come into effect, but how to translate those into programming, so into the work that we’re doing on a day-to-day basis. Does that change how we approach our work? If it does, how does that change how we approach our work? Does that change how we report to USAID?... How do we on the ground in the various countries actually get to implement this?”

A representative from a sub-prime partner in Malawi

Organizations interviewed across Mozambique and Zimbabwe desired specific guidance on how to change programs and practices to better align with the policy’s revocation.⁴¹⁹ A public health professional in Zimbabwe described the need for more

information about the “dos and don’ts” now that the policy has been revoked.⁴²⁰ This clear guidance would help ensure that implementing partners are adapting programs appropriately according to the revocation of PLGHA while also remaining compliant with the Helms Amendment and other abortion restrictions on U.S. global health funding that remain in effect.⁴²¹

A representative from a Mozambican SRH organization that is both a prime and sub-prime partner described the guidance they would like to receive from the USG in the following way:

“I think what we would need is a clarification from USAID that it’s okay to have funding, that it’s okay to use our other donors’ funding to implement all the sexual reproductive health programs.”

A representative from an SRH organization in Mozambique

Two organizations in Malawi that were interviewed described receiving detailed guidance for implementing the revocation of PLGHA from INGO headquarters staff.⁴²² One interviewee explained that because their organization is “very keen” on things related to policy, they “receive instructions” on implementation and “have a team that follows up to make sure that decision[s] are executed or implemented up to the field level.”⁴²³ The other interviewee, Jenda from Save the Children Malawi, said that they receive “very definite guidance all the time once [policy] change[s] occur.”⁴²⁴ A high-level advisor at Save the Children US’s headquarters reported they issued parallel

programmatic and advocacy-related guidance to country staff immediately in the wake of the revocation to help foster connections with local partners.⁴²⁵ They said:

“We had to send out updated guidelines on advocacy, [we] had calls and meetings about it, and let everyone know you may let your partners or advocacy partners in your home countries know that we are no longer compliant [with PLGHA]. We can talk about these issues now.”

A high-level representative from Save the Children US

It is apparent that INGOs with dedicated staff for monitoring changes to U.S. global health policies are better equipped to provide their country offices with detailed guidance regarding the revocation of PLGHA, though this was not reported across every country team affiliated with an INGO.

While the chilling effect of PLGHA and past iterations of the GGR have resulted in the documented over-application of the policy when it was in effect,⁴²⁶ the lack of robust guidance from the USG and prime partners post-revocation indicates a likely under-application of the harm-mitigating effects of ending the policy. A high-level USG staffer with expertise in global health took it a step further by saying “revoking the policy does not necessarily erase confusion in implementing agencies in terms of what they can and can’t do.”⁴²⁷ This lack of information represents a missed opportunity to ensure that implementation of PLGHA is ceased until the policy is permanently repealed legislatively. Providing explicit guidance will help to counter this, and proactively encourage implementing partners to operate as boldly and as expansively as possible within the limits of what is allowable by U.S. global health assistance regulations.



Impact of the revocation of the GGR

Many of those interviewed across the U.S. government, INGO headquarters, and organizations in Malawi, Mozambique, and Zimbabwe reported that the revocation of PLGHA will have a positive impact on their organizations, partnerships, and communities in the long term. The most named impacts of the revocation were increased funding for organizations and greater opportunities for new partnerships as a result of the revocation.⁴²⁸ Interviewees also noted factors that could delay the impact of the revocation, such as hesitancy of organizations to adapt their financial planning to align with the revocation given the fact that it repeatedly gets turned on and off.⁴²⁹

Funding

Interviewees predicted that the revocation of the GGR will increase the amount of funding that organizations can access as well as the number of organizations that are eligible to receive U.S. global health assistance. Talent Jumo, the Founder and Director of Katswe Sistahood in Zimbabwe, shared that their organization lost USG funding when they declined to certify the GGR in 2017.⁴³⁰ When PLGHA was in effect, Jumo described the promise of U.S. global health funding as “a carrot being dangled in front of you to say, ‘Just sign [the GGR] and then you will get resources.’”⁴³¹ Though Katswe Sistahood was not receiving U.S. global health funds at the time of the interview, they are interested in opportunities to apply for funding in the future now that the GGR has been revoked.⁴³² Jumo described their confusion about how the USG plans to make more resources available to work on issues previously prohibited by the policy:

“We are also having our own conversation around what this [revocation] means. You know, does it mean we can apply to USAID or PEPFAR and be funded? Is there going to be a special fund dedicated for this work [safe abortion work], seeing its importance? Because sometimes policy proclamations without tangible support by way of availing resources may not actually mean much.”

Talent Jumo, Founder and Director, Katswe Sistahood

As described by a U.S. government staffer with expertise in global health, “revoking a policy or putting a policy in place basically either removes or puts in red tape. The ability to do something about it is dependent on the budget, and so that actually is where we have a lot of power.”⁴³³ If budgets are moral documents that reflect values and policy priorities, then “what will make or break [a policy] is if you actually have money to give to organizations to do the work.”⁴³⁴

Jorge Matine, Country Director of Ipas Mozambique, stated that though he didn’t have a “clear picture” of the impact of the revocation as of July 2021, their first response to the revocation is “relief” and secondly, “that there’ll be more funds available and less restriction to access those funds, and [that we will] have a pool of partners. That could be very interesting.”⁴³⁵

Dr. Mildred Mushunje, Country Director from SRHR Africa Trust (SAT) in Zimbabwe, a former recipient of U.S. global health assistance that lost funding as a result of restrictions put in place by the GGR, reiterated Matine’s feeling of relief now that PLGHA has been revoked by saying:

“I think there’s more optimism now. There is a feeling of international global support. There’s a sense of expectation in terms of mobilizing more resources for the safe abortion agenda. So, whilst currently we haven’t been able to secure any funding per se, I think the fact that now the door is open, it means that

the conversation is different. It's now about what is it that we can do to advance the safe abortion agenda, given that there is a possibility of attracting resources. So definitely there's a sense of huge relief, optimism."

Dr. Mildred Mushunje, Country Director, SAT Zimbabwe

There may be a delay between the revocation and its measurable impact on organizations' funding because it takes time for organizations to respond to policy changes like this, including adapting their financial planning processes. A PEPFAR advisor at a U.S. mission stated that they expect the impact of the revocation will be more clear "in the next few years" as new partners, as well as partners who were ineligible for U.S. global health funding when PLGHA was in effect, sign future cooperative agreements.⁴³⁶ The financial impact of the policy was not immediately reversed when PLGHA was revoked because organizations that previously lost U.S. global health funding due to the policy do not automatically receive funding once again. Instead, organizations must apply for new funding when the opportunity arises.

Mapemba from HP+ in Malawi explained that it can take months for organizations to understand a policy change and align procedures and programs accordingly.⁴³⁷ Describing when the GGR was expanded in 2017, Mapemba noted:

"When policy changes come into play, it's about going back to workplans, looking at activities, it's about going back and checking which partnerships you go at and whether you can maintain those partnerships or not. So, it will take a good month of just internal review and quick emails to partners to put their activities on hold, and then another month before you've got implementing partners come forth with the same thinking capacity, and by the third month you're basically then ready to kind of readapt. But in all that as well, as you're changing your workplans, you can't do that on your own, so it goes back to USAID and there's the waiting process, they have to vet them, and then it comes back. So, you've lost a whole quarter and then some months before you can really start firing up again."

Sandra Mapemba, Technical Deputy Director, HP+ Malawi

While Mapemba's statements reflected on the process required to adapt programs when PLGHA was in effect, it is important to analyze these experiences to understand the processes that organizations may need to follow to implement the revocation of PLGHA.

Interviews also uncovered organizational impacts related to staff—specifically, the amount of time and resources required to inform and educate existing and new staff about the policy change.⁴³⁸ Representatives from a prime and sub-prime partner, respectively, explained the importance of educating staff about the policy change:

“I can see organizations spending resources [to support] that orientation or that awareness for staff members, so that everybody knows what are the new [policy] changes and how it’s impacting them. So, for an organization like ours, we’ve got close to 400 staff members in-country. So, to be able to orient everyone, that would be an expense that may be incurred.”

Tamara Mwenifumbo, a representative from a prime implementing partner in Malawi

“Every time the policy changes... there’s a little bit of time there that we need to spend talking to our staff and our partners. And as we get new staff, make sure as we are onboarding them, they are up to date in terms of the new guidelines. So, I think that’s where we are investing a lot of our energy. Every time there’s a policy shift, we have to take time to invest in bringing our staff up to date on those new policy shifts.”

A representative from a sub-prime partner in Malawi

Organizations reported that they will be able to dedicate more funding to programs and service delivery instead of spending time maintaining compliance with the GGR. Boyce said that the revocation of PLGHA has allowed Save the Children US to transfer more funds to support programs because “the LOE [level of effort] that you spend on ensuring the compliance with PLGHA across an organization like ours is incredible, and just the ability to shift those finances towards actual direct implementation is amazing.”⁴³⁹

A USG staffer reported that organizations engaged in valuable FP and health equity work with non-U.S. funds will no longer be barred from receiving U.S. global health assistance funds if they are engaged in programs or activities that may have been prohibited when the GGR was in effect.⁴⁴⁰ Organizations that lost U.S. global health assistance when they declined to certify PLGHA must carefully consider their relationships with the U.S. government and other donors, as well as strategize about how to continue their safe abortion work moving forward while applying for new funding opportunities.

In the case of MSI Reproductive Choices—one of the largest prime partners that declined to certify PLGHA in 2017—the revocation of PLGHA is a cause for celebration and a factor in funding considerations. Though collegial relationships between MSI and USG staff can now continue, Cobley reported that MSI has applied a “careful, considered approach to reengagement” with USG agencies such as USAID since the revocation.⁴⁴¹ Cobley acknowledged that MSI’s reengagement with U.S. global health assistance is “a long process.”⁴⁴² Internally, MSI Reproductive Choices has decided to “spend the next few months better understanding missions at an individual country level: who’s being funded, what funding mechanisms are being used, thematic preferences, contacts within the local mission, decision-making processes, and pipelines” before re-establishing relationships with the USG.⁴⁴³

Dr. Mushunje from SAT in Zimbabwe stated that time and resources will be dedicated to understanding the policy and seeking new funding opportunities from the USG.⁴⁴⁴ Dr. Mushunje shared that efforts will include:

“Reading up, looking up what opportunities exist out there within the confines and the provisions of the new law or policy. So, it’s really, I think, around spending time developing projects, developing proposals that can be submitted for funding. There is a cost to that in terms of time and also in terms of maybe paying someone to work with us on such proposals. And I think also just networking with other organizations to identify ways that we can collaborate to make maximum use of the new provisions.”

Dr. Mildred Mushunje, Country Director, SAT Zimbabwe

Dr. Mushunje went on to explain that SAT had not applied for U.S. global health assistance funding when GGR was in effect because they were receiving funds from Sida, Sweden’s government agency for development cooperation. Sida had their own guidance to ensure that activities that promoted SRHR, including safe abortion services, were able to continue if a partner also received U.S. global health assistance funding.⁴⁴⁵ Dr. Mushunje said:

“In the past, when we were planning for resource mobilization, we would not even include the US. Why? Because we were receiving funding from Sida. So, we couldn’t tap into both pots because of the Global Gag Rule and the US was not funding abortion work. We had to make the strategic decision of which [donor] to go with. Now that we can access funding from both [donors], it’s not an issue anymore. So definitely the way we mobilize resources will be different. In the past, you had to make the decision to be funded by a particular funding partner who would not allow you to access resources from, say, the US, and vice versa...because of the [Global] Gag Rule.”

Dr. Mildred Mushunje, Country Director, SAT Zimbabwe

An SRH organization in Mozambique that implements community-based health programs in SRH, HIV/AIDS, FP, cancer, and other infectious diseases with U.S. global health assistance funds reported choosing to comply with the GGR at the expense of funding from other donors. The representative mentioned losing nearly a million dollars from a European donor when they agreed to comply with the GGR.⁴⁴⁶ To compensate for this loss of funding, the organization sought increased funding from USAID and, while this organization stated that the increased USAID funding covered some of the funding lost from other donors, their partnerships with these donors were negatively impacted in the long term.⁴⁴⁷ A representative from this organization stated:

“If you leave the funding component aside, we also value partnerships that don’t necessarily have funding implications. And I think those kind of partnerships were affected, especially with European based donors like [European country]. With the [donor] we saw a decrease from \$1 million to \$200,000 because of the [Global] Gag Rule. It was a huge implication for [our organization], but at the same time we had a huge increase [in funding] from USAID. So in terms of funding for the organization, the impact was little, but the impact in terms of building strong and valuable partnerships, it was bad.”

A representative from an SRH organization in Mozambique

The representative from this organization also said they “don’t think it’s going to be so easy” to rebuild the relationships with European donors that were negatively impacted during the Trump administration.⁴⁴⁸ Even though PLGHA has been revoked, the representative explained that:

“The implications of PLGHA are still there. The impact in the perception about [organization name] is still there. So these donors still look at [our organization] as an organization who decided to agree with the [Global] Gag Rule. And, yeah, even if we had to do it [certify PLGHA] to survive and to keep the doors open and the programs running, there are implications. And one of the implications is that donors will not forget so soon.”

A representative from an SRH organization in Mozambique

Damaged donor-recipient relationships can have negative implications on that organization’s programming and services, particularly in regards to breadth and scale. The fact that the GGR had these negative implications on organizations’ relationships with even international, non-U.S. government donors as a result of organizations’ survival tactics invokes more meaning into the far-reaching impacts that the policy can have around the world.

Nyasha Mantosi is a Programs Officer at ROOTS, an organization that had been implementing the PEPFAR DREAMS program in Zimbabwe before the GGR was expanded in 2017.⁴⁴⁹ ROOTS declined to certify PLGHA and could no longer implement DREAMS, so USAID had to transfer this award to other organizations to continue the implementation of this important PEPFAR program for adolescent girls and young women.⁴⁵⁰ As a result of declining to certify PLGHA, ROOTS lost all of their U.S. global health funding and Mantosi described the impact of the policy on their organization’s finances:

“The coming in of the Global Gag Rule affected our funding because the DREAMS program constituted around 80% of our total funding for the organization. So, when this program stopped, it also really affected our funding as an organization.”

Nyasha Mantosi, Programs Officer, ROOTS

Now that the policy has been revoked, ROOTS expects they will be able to incorporate new funding streams, including U.S. global health assistance, into their work.⁴⁵¹ Mantosi stated that ROOTS expects to work with a much larger budget in the future, saying:

“I think it’s also going to help us, because the Global Gag Rule affected the consortium [we were a part of in 2017]. Now that there’s reform within that policy, we are looking forward to other consortiums to come in, and other funding to come in as well... Other organizations had signed the Global Gag Rule policy so now that it’s no longer that restrictive [in effect], we are hoping that we’re also going to get collaborations from them and resources from other partners as well.”

Nyasha Mantosi, Programs Officer, ROOTS

Eghtessadi from SAfAIDS Regional also indicated that the revocation of PLGHA will have a positive impact on SAfAIDS’ programmatic expansion in the sphere of SRHR and its financial planning.⁴⁵² When the policy was in place, SAfAIDS chose not to be compliant with PLGHA because the policy was contrary to SAfAIDS’ organizational mandate to uphold SRHR, which meant relinquishing the existing USAID funds it had already secured and ceasing applications for new USAID funding while the policy was in effect.⁴⁵³ When PLGHA was revoked, SAfAIDS became open to reengaging with USAID and exploring opportunities to bid for this funding channel again.⁴⁵⁴ Eghtessadi said:

“The revocation has provided an opportunity for us to reengage with USAID and PEPFAR, which will contribute to expanded business growth opportunities, and subsequently widen the reach of the SRHR and HIV services we render across the Southern African Development Community region. We can now submit proposals either as the prime recipient or apply as a sub-recipient in another consortium, with a clear conscience that there is no PLGHA to sign, which previously didn’t align with our principles of upholding all SRHR.”

Rouzeh Eghtessadi, Executive Director, SAfAIDS Regional

It will take organizations time, energy, and funding to reinvest in programs that they had to abandon from 2017-2021 when PLGHA was in effect. They remain mindful of the risk that PLGHA could be reinstated as soon as January 2025 depending on the outcome of the next presidential election.

Partnerships and priorities

According to the PLGHA Compliance Team, USAID views the revocation of PLGHA as an “opportunity to re-establish relationships with implementing organizations around the world,” including local partners.⁴⁵⁵ Irene Koek, a global health expert familiar with U.S. global health assistance, reported that a positive impact of the revocation of PLGHA is that “there are fewer restrictions on who you can work with at the country level.”⁴⁵⁶

Interviewees across Malawi, Mozambique, Zimbabwe, and the U.S. discussed the impact of the revocation on partnerships, specifically noting that the revocation opened up the possibility for rebuilding partnerships with organizations who were previously barred from receiving U.S. global health funds during PLGHA's implementation because those organizations provided services that were prohibited by the policy.⁴⁵⁷ As a result of the revocation, organizations are able to consider “many partnerships which previously would have been difficult to explore” during PLGHA's implementation, including partnerships established with non-U.S. funds that would have been gagged when PLGHA was expanded.⁴⁵⁸ A representative from a current prime partner in Malawi stated the importance of re-engaging partners that declined to certify PLGHA and said their organization “would have benefited a lot if we could have had a new program now including those who had left because of PLGHA.”⁴⁵⁹

In three cases in Malawi, interviewees who are current U.S. global health implementing partners explained that while their ability to partner with other organizations was not impacted by PLGHA, their partners were sometimes restricted in their operations due to efforts to remain compliant with the policy.⁴⁶⁰ An interviewee with experience working for a prime implementing partner in Malawi explained that the revocation did not “affect the partnerships, only that our partners now are able to function without restrictions.”⁴⁶¹ Representatives from a sub-prime partner in Malawi corroborated this statement and went on to report that the

revocation of PLGHA opened the doors for implementing partners “to communicate with other organizations that are...being affected directly by the changes of this policy.”⁴⁶²

The policy limited the ways in which large INGOs like Save the Children US could engage with host country governments, other funders, and other stakeholders on issues related to SRHR. A high-level representative from Save the Children US stated:

“There were ripple effects too to the organization because we decided as an international federation to comply. We were not invited to advocacy round table discussions on SRHR where non-compliant issues such as access to comprehensive SRHR, access to safe abortion services [were discussed] just because we could not talk about it. We weren't invited to the table, nor were we invited to the meetings with Parliament, Members of the Parliament in Canada, in the EU, in Germany, and so it had some ripple effect on longer-term implications on Save the Children and how we do or don't speak out on SRHR issues.”

A high-level representative from Save the Children US

When PLGHA went into effect, Carolyn Boyce reported that Save the Children US “had to change a handful of partners with active grants and agreements, but probably even more importantly, we couldn't partner with some very key partners that we would have liked to partner with over the period of time” including a local organization in South Africa.⁴⁶³ Since PLGHA was revoked, Save the Children US has established partnerships

with organizations that they could not work with when the policy was in effect because “the timing worked so that we were able to actually partner with them right away,” which has been a positive impact of the revocation.⁴⁶⁴ One of Boyce’s colleagues described the importance of partnering with local partners at the country level in this way:

“Not being constrained by who we can work with particularly at the country level and with local partners is hugely important. The communities that Save the Children works with are often the most affected by discrimination and the most marginalized and the hardest to reach by normal structures, and so very often working with those local [civil] society and partners is certainly what we do and having constraints on who you can work with and who you can’t is a huge barrier.”

A high-level representative from Save the Children US

This Save the Children US colleague reported that “being able to at least provide some information and referrals makes a big difference for the health of some of the communities that we serve,” because Save the Children is able to “provide life-saving work and not be worried about over-complying [with PLGHA] in a few cases that I’m sure were happening.”⁴⁶⁵ On a strategic level, another representative from the INGO said that the revocation of PLGHA has enabled Save the Children US to operationalize their stance on SRHR:

“The revocation of the policy led us to actually operationalize all of the conversations that had begun about us becoming more vocal and visible around SRHR. So now we have a draft SRHR policy brief, and we are going to amplify the strategy around this in the next three-year strategy period that we’re developing at the moment. So, it’s really led and forced us to think about our value add, our voice in these issues, and how we contribute to this space in a much more constructive and organized manner.”

A high-level representative from Save the Children US

Since the revocation, Save the Children can be intentional about establishing partnerships that will support their strategy and stance on SRHR. Though Smith from Save the Children Mozambique reported that they did not have any partners that were not compliant with PLGHA at the time of the interview, she confirmed that they had plans to begin some activities with local partners who provide abortion services, as it was the first time they could engage with these partners in several years.⁴⁶⁶ Smith stated:

“Just recently in the last two months or so, we have been looking forward to new opportunities around providing information and facilitating safe abortions as an alternative to unsafe abortions. And it is important, because we’re focused on adolescents and stopping child marriages. Mozambique has one of highest rates of child marriage in the world, and child marriage is highly associated with adolescent pregnancies.”

Marla Smith, Health and Nutrition Advisor, Save the Children Mozambique

A staff member at a PSI country office reported that their team has started to build relationships with new partners since PLGHA was revoked and described that it has been “a relief not having to worry about whether those organizations were involved or not in any safe abortion work” that would have been prohibited under PLGHA.⁴⁶⁷

Staff from an INGO that declined to certify the GGR reported that the revocation “has obviously been hugely welcomed and it makes our lives a lot easier” because their staff can once again engage with their USG colleagues even though those relationships had been strained when PLGHA was in effect.⁴⁶⁸ Since the GGR has been revoked, staff from this former prime partner are “more relaxed if the USAID representative finds themselves sitting next to us in a meeting, whereas previously, they might have made an effort to not sit next to us.”⁴⁶⁹

Staff at this prime partner also described the ways in which professional relationships with USAID staff can begin to recover since PLGHA was revoked:

“[T]hen things change, and we know that there’s still a lot of goodwill and personal and professional relationships there. We might have been in the wilderness for a few years, but we were still allies working together.”

A representative from a prime partner that declined to certify PLGHA

A representative from an SRH organization in Malawi that declined to certify PLGHA explained that the revocation had changed the reality for partnerships on the ground and as a result, more partners are interested in working with them.⁴⁷⁰ Sometimes, the interviewee’s organization initiated the conversation with partners they previously lost, while in other cases, external organizations reached out to the interviewees to discuss opportunities for partnership.⁴⁷¹

An interviewee from a current prime organization in Malawi described the negative impact PLGHA had on their relationships with sub-partners and emphasized that the revocation can positively impact communities because partnerships with key organizations can be reestablished at the local level:

“When the Trump administration came in, we were already having partnership[s] with other organizations, including those that were under [an INGO]. So, it disturbed our programs a lot, because we had to lose those organizations that were under [INGO] because they refused to sign compliance to the PLGHA provision. We had to close the sub-agreements and we had to look for other local partners that were willing to sign the compliance to the PLGHA provision, which of course disturbed the program[s] because, you know, when something happens suddenly, especially around programs, and also in countries where you do not have many strong organizations that can implement the scope of work you have...we struggled, but at the end of

the day, we tried to build the capacity of the new partner who replaced the one that left. But it was not easy, frankly. We spent almost three months without services to beneficiaries, because we were still building the capacity of that new partner who had come in to replace that one who had left because of compliance to the PLGHA provision... After the revocation, the local organization that left [due to PLGHA], they said now that the provision is no longer there, we'd like to continue our partnership because we were really enjoying our partnership... So that's what I'm saying that the benefits will be more seen when we see all of those partners coming back. Because when you lose a partner who has coverage at the country level, it's really hard to bridge. And we know that, even if we replace that partner, we are still really feeling their absence because that partner had several private clinics that were providing services, and you know in many African countries, the health infrastructures are very limited, so when you lose such a partner that has private clinics, it's really a big loss."

A representative from a prime partner in Malawi

When it was in effect, PLGHA damaged numerous partnerships and agreements and disrupted the provision of vital clinical services and key programs supported by U.S. global health assistance. The USG and implementing partners must actively repair and expand the relationships between the USG, implementing organizations, and donors that had been damaged when the policy was in effect.

Programs and communities

A USG staffer with expertise in global health said that “every time there’s a policy shift, it really disrupts services” and it impacts organizations that “receive sizable amounts of funding from the U.S. government.”⁴⁷² This interviewee went on to explain that most people who work in global health—particularly USG staff—“really support a wider ability to provide different services or fund the provision of different services,” which can become more of a reality now that PLGHA has been revoked.⁴⁷³ She went on to say that it will be important to understand “how health outcomes link not just to individual, community, or population health, but to economic development and other development goals” as organizations adapt their global health programs to reflect the revocation of PLGHA.⁴⁷⁴ This USG staffer acknowledged that organizations and programs will need time to adapt to the revocation and show results:

“We had such a significant setback [due to PLGHA] that we can do things like the policy change, and we can do it quite quickly, but I think it's going to take a long time before we actually see programmatic outputs get to the level of where we want them to be.”

A U.S. government staffer with expertise in global health

Helena Chiquele from Oxfam in Mozambique said PLGHA had an “effect when a community cannot access the information that they would normally access” when it was in place.⁴⁷⁵ Chiquele stated that the communities served by Oxfam will have access to more complete information related to safe abortion now that PLGHA has been revoked, but also expressed concerns about the setbacks their partnership with communities had suffered when it was in place.⁴⁷⁶ Chiquele stated:

“I think the policy revocation will benefit us because the SRHR information [that we provide] will be complete. But, like I said, we have suffered a setback and that affected the relationship that we had built with these communities around this issue [of safe abortion], because safe abortion was never an easy topic, even in cities, even with some of women’s rights organizations, it was never an easy topic. And a lot of vocal organizations had to stop talking about this.”

Helena Chiquele, Southern Africa Gender Justice Program and Policy Manager, Oxfam in Mozambique

Chiquele’s statement emphasizes how difficult it is for organizations to regain trust in the USG after they have been negatively impacted by policies like PLGHA. She said it is not sufficient for the USG to “come back and say, well now we have changed, you can now come to us” because it may be difficult to connect with communities that have experienced restricted access to services due to PLGHA.⁴⁷⁷ Chiquele reported that “there is some work that needs to be done

to reverse all the bad things” caused by the implementation of PLGHA through outreach to let communities know that the policy has been revoked and when programs have adapted to the revocation.⁴⁷⁸

Jorge Matine of Ipas Mozambique reported that “sexual and reproductive health for adolescents and youth is not receiving the attention it’s supposed to” since PLGHA was in effect and described the potential impact of the revocation on the expansion of comprehensive SRH programs in Mozambique:

“Based on our experience in the field, in terms of implementation for the project and working with local partners, the [Global] Gag Rule was seen as an obstacle to expanding access to sexual and reproductive health services. And we see now, as an important achievement, the removal of the [Global] Gag Rule, because the U.S. government was the main donor of the health systems and programs in Mozambique, [so] the [Global] Gag Rule was a huge setback. So now that the [Global] Gag Rule was removed, everybody’s very positive about the future in terms of new programs and expanding the right to and access to comprehensive health services, including all important services for women and girls in Mozambique.”

Jorge Matine, Mozambique Country Director, Ipas

Matine explained the importance of supporting community health workers in rural communities in Mozambique after the revocation by saying that “the continuity of care, it’s based on community health workers. So, if you remove that rule, I think that we will see a major change.”⁴⁷⁹ Matine elaborated on the work Ipas conducts in villages in rural areas and shared why it is important to be transparent about the revocation and its implications for programs: “We work even with remote villages, and it would be important if the information was available for our government officers, and all service providers about the [revocation of the Global] Gag Rule, for expanding the access to services.”⁴⁸⁰

Riaz Mobaracaly from Pathfinder Mozambique emphasized that the revocation created space for local and community-based organizations to speak about SRH in a much more comprehensive way so that they “have more freedom with advocacy work” with the populations they serve.⁴⁸¹ Birgit Holm from ADPP in Mozambique confirmed that the revocation of PLGHA increases people’s access to safe abortion services, as girls and women often must undergo unsafe abortion if safe services are unavailable.⁴⁸² She said:

“Because in spite [of] the law under Trump, it didn’t mean that abortions et cetera didn’t happen, but it actually meant much worse for women who had to do an abortion for various reasons.”

Birgit Holm, Country Director, ADPP

Two interviewees from sub-prime organizations involved in health service delivery in Malawi also specified that in light of the revocation, they are now able to provide their clients with information regarding safe abortion as one of the options available to them within the confines of Malawi law.⁴⁸³ One of these interviewees operates a hotline where clients call in for services, and hotline workers are now free to discuss safe abortion as an option for those who are interested.⁴⁸⁴ This interviewee explained the way in which the revocation not only impacted their full scope of work, but also allowed them to redirect organizational focus and resources towards programs and services rather than policy compliance:

“With [PLGHA] being rescinded now, we think that we have now more time to focus on programming, than we would if we had to critically track any non-compliance, any possible issues, but also just to get ourselves up to date in terms of understanding what all the various [provisions of PLGHA] meant and where there could be a possible violation. So, I look at that in terms of the other way that maybe now we actually have more time to focus on programming... [The revocation] gives us flexibility to also operate in terms of making sure that the services that are being provided also cover essential services for critical post-abortion care that might be needed.”

A representative from a sub-prime partner in Malawi

Even organizations with an anti-abortion stance reported that while the revocation of PLGHA has not altered their programs, it may still impact the communities they serve. Nicholas Ahadije from World Vision Mozambique believes that the revocation of PLGHA will provide an additional range of services to their communities, recognizing that not all the communities they serve are Christian or share their perspective about abortion.⁴⁸⁵ Ahadije described the effects of the revocation on the communities World Vision serves in this way:

“It [The revocation] provides a range of additional services to the community and we do recognize that the community we serve is not predominantly Christian. There are other faiths and then there are also people who do not have any faith at all. And so, they should have a range of services available to them that will help them achieve their goals in life. And so, for those who would request such services [as abortion], I think it’s a great opportunity for them. And our organization doesn’t do anything to prevent them from accessing those [services].”

Nicholas Ahadije, Grants Acquisition & Management Director, World Vision Mozambique

National abortion policy landscapes

Both U.S. foreign policies like PLGHA and national policies related to SRHR impact organizations’ programs and their ability to advocate for safe abortion and other SRHR issues, particularly in countries with restrictive abortion laws.⁴⁸⁶ Dr. Psaki from HHS OGA acknowledged “how important the role of the U.S. government is in a lot of these discussions and the authority that the U.S. government brings with it, for better or for worse.”⁴⁸⁷ Baresch from HHS OGA recognized PLGHA as just one element of “the erosion of good U.S. diplomacy overseas,” which has become a trend in recent years.⁴⁸⁸

PLGHA had a unique impact in Mozambique where abortion has been legal since 2014 up to 12 weeks of pregnancy with exceptions for rape, incest, and fetal anomaly after 12 weeks.⁴⁸⁹ A representative from an SRH organization explained that the introduction of PLGHA in 2017 prevented local CSOs from fully operationalizing the new abortion law.⁴⁹⁰ Now that it has been revoked, this organization is able to discuss safe abortion openly with the Ministry of Health and advance SRHR in Mozambique to the fullest extent of their ability.⁴⁹¹ This representative explained:

“In 2014, we had our law on safe abortion approved. For us, as a civil society organization, it was a very big challenge to operationalize this. We only could operationalize it in 2017. And we pushed a lot for this to come through. So, we were pushing a lot to the Ministry of Health. As you know,

all the services on safe abortion on this law who has to implement is the National Health Services. USAID is one of the big donors, it's a lot of funds. So, for us it was a really negative surprise to receive that policy [PLGHA] at the time... And that's why it [the revocation of PLGHA] was a relief, because we now can speak about safe abortion openly, freely, and we can discuss it openly at the Ministry of Health in meetings and with partners."

A representative from an SRH organization in Mozambique

Smith from Save the Children Mozambique reported that it is challenging to engage with the Mozambican government given the cultural sensitivities and stigma related to abortion regardless of whether the GGR is in effect or not.⁴⁹² In order to navigate this dynamic, their organization has “to be careful with how we raise issues around abortion with the government, to make sure that there’s space and openness to discuss such a sensitive issue, and that takes time and effort.”⁴⁹³

Lack of clear communication from the USG to the government of Mozambique about the revocation of PLGHA could be another reason why the revocation has not had a demonstrative impact on domestic SRHR policy in Mozambique as of the time of the interviews. Smith stated that “the U.S. government has not been vocal about the policy change here, that I’m aware of. There has not been any policy statement or any form of mass communication. I’m not sure if they’ve communicated it to the Mozambique government. The change just quietly came in” so it is unclear if the revocation has

contributed to any domestic policy changes related to safe abortion.⁴⁹⁴

The restrictions put in place by PLGHA largely mirror Zimbabwe’s own national abortion policy in which abortion is illegal except in cases of rape, incest, or danger to a mother’s life.⁴⁹⁵ Known as the Termination of Pregnancy (ToP) Act and enacted in 1977, the ToP is more liberal than the GGR, allowing abortion in cases of fetal anomaly and risk to the health of the woman.⁴⁹⁶ Two interviewees stated that PLGHA and its revocation had no bearing on the Zimbabwean SRHR landscape because the ToP Act is already law in Zimbabwe, so PLGHA did not further enforce any restrictions but echoed those that were already in place.⁴⁹⁷

Interviewees did note that the U.S. government’s policies are often used to excuse the Zimbabwean government’s failure to update the ToP Act.⁴⁹⁸ Jumo from Katswe Sistahood noted:

“[When the GGR is in effect] it just means that our countries also slow down on the kind of changes that they could make, because they are referring back to Americans saying, America is supposed to be that civilization. And if America is rejecting [safe abortion policy] how dare you even try to talk about it, because America is the epitome of civilization. So just recognizing that when [the Global] Gag Rule is active, there are a lot of drawbacks in our own countries, the funding space shrinks, the anti-choice movement is well funded, and it can grow, and they can do a lot of work.”

Talent Jumo, Founder and Director, Katswe Sistahood

The impact of PLGHA on advocacy efforts to liberalize the national abortion law in Zimbabwe was similar in Malawi, where the Penal Code only allows for abortion in cases of life endangerment of the pregnant person. Stakeholders across sectors in Malawi have introduced the ToP Bill to add four additional grounds on which abortion would be allowed, including situations of rape, incest, defilement, and fetal malformation, which would bring Malawi’s Penal Code in alignment with the Maputo Protocol.⁴⁹⁹ The Termination of Pregnancy Bill was drafted by the state Malawi Law Commission and was informed by abortion reform lobby efforts on the part of several local advocacy groups, notably the COPUA.⁵⁰⁰

The enforcement of PLGHA beginning in 2017 stalled these advocacy efforts because of the USG’s influence on Malawian politics and cultural attitudes toward abortion.⁵⁰¹ The USG is seen as a model to emulate for political decision-making and could be called “a big brother to many governments” according to a number of interviewees in Malawi.⁵⁰² Four interviewees spoke to this dynamic in the context of Malawi’s financial dependency on U.S. government funding and the economic implications of this reliance in particular.⁵⁰³ Several interviewees explained that Malawi’s health sector is “hugely funded”⁵⁰⁴ by the United States and that USAID funds a lot of health programs related to HIV, malaria, and other programs,⁵⁰⁵ and that the Malawian government is one of the “highest beneficiaries of money from USAID.”⁵⁰⁶ As a result, the implementation of PLGHA caused Malawi government officials to feel “reluctant” to engage in abortion

liberalization efforts, as they felt this would have “angered” the U.S. government and led to a “freezing of support and aid.”⁵⁰⁷ As Ligomeka from CSJ explained:

“We have been lobbying for abortion reform in Malawi and the state Malawi Law Commission actually drafted a proposal of the Termination of Pregnancy Bill and that was drafted before the former President Donald Trump came into power. When he came into power, the government stopped championing the enactment of said bill. That’s what happened. We [tried] but the government was playing lots of delaying tactics to the extent that an opportunity to turbo [fast-track] the bill in Parliament failed. We couldn’t make any breakthrough.”

Brian Ligomeka, Executive Director, CSJ

Mapemba from HP+ explained that Malawi is a small and conservative country and public sentiment is “divided” into “two camps, for and against abortion, and the against seem to be louder because it’s all the people who are pushing policy decisions rather than the younger generations.”⁵⁰⁸ Comments from Madam Kaliya from MHRRC—who is also the Chairperson of COPUA—expanded on Mapemba’s statements by describing the impact that PLGHA continues to have in Malawi even after it has been revoked:

“The GGR just cemented the resistance that was already there [in Malawi] and it authenticated the thinking of many, especially those that believe more Christian than all of us, so they were even use the same to say, ‘You see, the United States of America does not want [to support safe abortion]. It means that these things that you are introducing are wrong and immoral for our society.’ Hence it has been very bad. It was a bad recipe to all the efforts that we’ve had for so many years trying to reform the abortion law in Malawi and therefore just disturbed the whole process, to the extent that the situation is failing to normalize to this day, regardless of the fact that America has removed [the PLGHA policy]. ... So, you can see that [PLGHA] really had some influence and continues to have an influence to date. Though PLGHA is not an issue in the U.S. anymore, here [in Malawi] it remains a big problem because they’re using it [PLGHA] as a yardstick for rejecting the abortion law reforms and saying, ‘If America can do this, we can also do this.’”

Madam Emma Kaliya, Director, MHRRC

Some interviewees expressed that the revocation of PLGHA by the Biden administration could have significant impacts on the domestic policy environment around SRHR in Malawi, Mozambique, and Zimbabwe, including funding and identifying national policy priorities regarding safe abortion and other issues.⁵⁰⁹ Ten interviewees in Zimbabwe noted that they felt the revocation of the policy had or would have at least some bearings on domestic policy within the country.⁵¹⁰

Matine from Ipas Mozambique highlighted the critical impact of the Biden administration’s support for SRHR on Mozambique and the broader donor landscape, noting the importance even though the abortion law has been liberalized and PLGHA has been revoked.⁵¹¹ He said:

“There is still a long way to go, even abortion, even Mozambique, as the penal code allows abortion through some circumstances. We still think there’s still a lot of work to do. So, having the U.S., like a major funder for the health sector in Mozambique, also on our side, in terms of supporting sexual and reproductive health and abortion, it’s very important. I think that would be a major change, in terms of making funds available, bringing other donors to the same.”

Jorge Matine, Country Director, Ipas Mozambique

Simione from AMODEFA stated that the revocation could have a positive impact on the national government of Mozambique, particularly alluding to the relationship between the U.S. government and the Mozambican government:

“[W]hat I can see is that maybe now the [Mozambican] government can really talk openly and also can do more and more on this field in terms of implementation [of safe abortion work] since at that time [they were] receiving very good support from U.S. as a government, especially the Ministry of Health, at the same time knowing that the American government was not pro-abortion, I can imagine that the [Mozambican]

government didn't do enough in that direction [when PLGHA was in effect]. And I can expect that now that the [Global] Gag Rule is not there anymore, eventually the [Mozambican] government also will do more in that direction."

Santos Simione, Executive Director, AMODEFA

Kadau from ARC stated that "American policies have an impact on what happens in our countries, with regard to access to funding, SRHR programming, and priority program areas, for example."⁵¹² Another interviewee, Tamburai Muchinguri, from Family Support Trust, an organization providing crisis rape services, noted that advocacy organizations could use the revocation of PLGHA as an argument for liberalizing abortion policy in Zimbabwe.⁵¹³ They said:

"So, this revocation definitely can have a very strong influence on our national laws, because we will actually be relying on it as well in, in arguing our cause, because really, in as much as even our laws are also restrictive, a number of unwanted pregnancies are taking place. And to some extent also, a number of illegal abortions are happening, simply because we are not allowing women to abort legally."

Tamburai Muchinguri, Director, FST

Although interviewees in Malawi, Mozambique, and Zimbabwe largely felt positive regarding the GGR's revocation, the revocation on its own will by no means be enough to advance SRHR. A representative from a prime implementing partner in Malawi called for the USG to advocate for the removal of harmful policies.⁵¹⁴ He said:

"Several African countries are too conservative. [So] the population may not even feel the benefits of the removal of that policy, if some countries cannot change their behavior that limits people to get services. That's why I'm saying removing that policy is not enough, we also need the U.S. government to advocate, so that those conservative policies in countries can be also removed... So that's why I was saying, [the revocation] has just improved the communications, messages, but not the practice. Because many countries are still conservative. If they hear you talking about rights to abortion and whatever, they would even jail you. That's why I'm saying, we need to move from just messages to practice. To the practical. And that's what I want to see happen. And that can't happen as long as many African countries are too conservative, and they don't want to bring that wisdom."

A representative from a prime partner in Malawi

An interviewee from a sub-prime organization in Malawi noted the enormous power held by the USG to influence national policy priorities in other countries, observing that, “the U.S. is a big donor to our country and therefore if it had a very strong policy on the promotion of abortion and other stuff, I think it would really also speak volumes in terms of policy direction.”⁵¹⁵

A clear statement from the Biden administration in support of safe abortion access as a critical component of SRHR could restore relationships with partner governments, open dialogue related to SRHR, and reignite SRHR advocacy efforts around the world.

SRHR coalitions and advocacy spaces

Around the world, PLGHA had a detrimental impact on organizations’ involvement in coalitions and advocacy spaces related to SRHR when it was in effect.⁵¹⁶ Organizations receiving U.S. global health assistance across Malawi, Mozambique, and Zimbabwe stopped participating in some advocacy coalitions and changed their programs to remove any activities related to advocacy for safe abortion when the policy was in effect, and it will take time to recover lost ground since the GGR was revoked.⁵¹⁷

One of the coalitions that was impacted by PLGHA in Mozambique was the Rede DSR coalition. Mobaracaly from Pathfinder Mozambique leads this coalition and stated that sharing information among coalition

members about the GGR is important because “sometimes there is that risk of overreacting to this policy and blocking the services where it’s not needed.”⁵¹⁸ An SRH organization in Mozambique that receives U.S. global health assistance decided to leave the Rede DSR in order to remain compliant with PLGHA.⁵¹⁹ After learning of its revocation, the representative from this organization described their engagement with the network:

“We went back immediately after the revocation to be part of the sexual reproductive health network we were part of before the Trump administration enforced the [PLGHA] policy. So, when the [Global] Gag Rule came [into effect], a number of organizations in Mozambique decided to strengthen the work on sexual reproductive health and on abortion, especially to compensate for the [Global] Gag Rule, the impact of the [Global] Gag Rule. We had to step out of the sexual reproductive health network in Mozambique because their work on abortion was very strong and it had a strong advocacy component, a strong behavioral change component. So, the visibility was going to impact [our organization’s] ability to continue our programs with USAID. So, we decided to step out. And now that the policy was revoked, we immediately went back to be part of the platform.”

A representative from an SRH organization in Mozambique

When PLGHA went into effect, a prime organization in Malawi that had been an active member of COPUA left the Coalition in order to remain compliant with the policy.⁵²⁰ However, a representative from this prime partner explained that since the revocation occurred in January 2021, their organization has been engaging in efforts to re-join COPUA:

“Now we can start working to rejoin the Coalition and be part of the advocacy work to try and make sure that Malawi reviews its laws on abortion. So, I think that’s the team that I’ve engaged. Actually, I had to explain to them that now this is the situation, now any organization that pulled out [of COPUA] because of that [policy] can come back...and several other individuals and organizations did withdraw, because [of] working with USAID. So now we are trying to revive [the Coalition], get back to work with our partners, and make sure that women are given the right choices in terms of accessing their preferred methods of family planning, but also access to other SRHR services.”

A representative from prime partner in Malawi

However, this prime implementing partner also explained their concern about the sustainability of advocacy work done during the revocation period, given the historical context of the policy and its ever-changing implementation and revocation across U.S. presidential administrations.⁵²¹ He said:

“There are fears to say as much as this [policy] is done, we are investing in rebuilding the relationship and our involvement in such advocacy campaigns. But what if, in the next four years, the Democrats lose and then Republicans come back? Is it worth it to work on such investments if this is going to be changing every other four or eight years? So, these are the questions that we usually have.”

A representative from a prime partner in Malawi

Eric Sambisa, the Executive Director of Nyasa Rainbow Alliance (NRA), a local sub-prime partner engaged in providing HIV and AIDS services for members of the LGBTQI+ community in Malawi, described how the threat of the GGR being reinstated in the future silences advocates:

“We think it’s a little bit political and it’s really hard to be advocates [around] this policy because it changes according to the regime. So, what if another regime comes? It might affect us as CSOs implementing on the ground. It’s really scary to advocate or not. So, we’re just quiet.”

Eric Sambisa, Executive Director, NRA

Though some interviewees expressed hesitance to restart advocacy efforts related to abortion since PLGHA has been revoked, a number of organizations across Malawi, Mozambique, and Zimbabwe expressed hope and feelings of optimism, particularly regarding their ability to engage in advocacy efforts to advance safe abortion as well as other SRHR issues.⁵²² CSOs in Malawi generally felt that the revocation increased their comfort in terms of advocacy outreach efforts and made them “more free to engage” on different advocacy issues, such as safe abortion, women’s choices, and reduction of the high maternal mortality rate.⁵²³ PZAT, a sub-prime partner that engages in advocacy in Zimbabwe, reported that they are planning to expand their advocacy activities and sub-grant to local organizations that are engaged in SRH advocacy efforts now that PLGHA has been revoked.⁵²⁴ Another sub-prime partner, ARC, also noted that they can now support “the liberalization of Termination of Pregnancy Act in Zimbabwe” now that PLGHA has been revoked.⁵²⁵

At the country level, the revocation initiated discussions about safe abortion among U.S. global health implementing partners and CSOs. A representative from an SRH organization in Mozambique reported that “USAID now is more aware of the national civil society growth” in Mozambique and that “it’s the new policy of USAID to work closely with the national civil society now” that PLGHA has been revoked, so the organization is trying to position themselves to be prepared for future opportunities to expand their advocacy work for the remainder of the Biden administration.⁵²⁶

Two interviewees in Malawi, one from a prime partner and one from a local organization that does not receive U.S. global health assistance, reported that the revocation created a freer atmosphere and allowed people to speak more openly about abortion.⁵²⁷ A representative from a prime recipient in Malawi expressed that the revocation would help “amplify the voices of people that are advocating for the right to choose for women all over the world and without necessarily being pinned for it.”⁵²⁸ Emma Kaliya shared her perspective as the Director of the Malawi Human Rights Resource Centre (MHRRRC), a local organization that advocates for safe abortion:

“We’ve seen that it has opened up the systems, and that [people] are free to speak on issues of abortion, free to speak on issues to do with LGBTI [communities], things that most people were very afraid to mention [before the revocation], because if you were just spotted in a meeting supporting the two issues, they would pick on you and start blacklisting your organization’s to the extent that if you benefitted from any USAID-funded project, they could easily recommend withdrawal of such funding.”

***Madam Emma Kaliya, Director,
MHRRRC***

In addition to impacting program provision, Machava from MULEIDE in Mozambique, spoke about the freedom to speak openly about abortion since the revocation of PLGHA, and the positive effects for young women and girls:

“We are free to talk about the abortion issue, which is key. It’s one of the first, if not the second, most important health issues for women, and especially young girls. As you know, in underdeveloped countries, there is this high index of premature marriage. A child of 16, 12 years cannot deliver a baby. So, if this is discovered earlier, it’s possible to do an abortion. For us it’s powerful. It’s powerful.”

Rafa Valente Machava, Executive Director, MULEIDE

While the revocation of PLGHA created space and increased opportunities for organizations in Malawi, Mozambique, and Zimbabwe to engage in SRHR coalitions and advocacy efforts (particularly related to safe abortion services), some organizations are hesitant to do so due to fear that the policy could be reinstated by a future presidential administration.



Calls for the permanent repeal of the GGR

Not only are the effects of past versions of the GGR of significant concern for all those engaged in advancing sexual and reproductive health, rights, and justice, but as a global health expert familiar with U.S. global health assistance Irene Koek flagged, the “invocation of the policy in four or eight years is this looming threat.”⁵²⁹

Dr. Psaki from HHS OGA similarly described some of her “bigger concerns” about the disruptive effects of U.S. policy changes on service providers in other countries, including “the fear of what is going to happen when there’s another change in Administration, and concerns about the administrative costs and

risks to organizations of continuing to shift back and forth, so that, for recipients of U.S. government funding, it almost becomes less relevant what the policy is currently versus what's going to happen in the future and how do we adjust our work so that it can survive changes in the U.S. administration."⁵³⁰ The precarity of the implementing environment, made particularly volatile during the Trump administration's never-before-seen expansions of the GGR, continues to impact individuals and organizations as of the last interview in October 2021.

A particularly insidious effect of turning the policy 'on' and 'off' in this manner is the sense of uncertainty created by the constant threat of such drastic policy shifts. It can also be difficult for USG staff to accommodate, as a technical advisor with PEPFAR experience at the U.S. mission level shared:

"It's also just really frustrating as a Government employee. This is my third administration that I'm working under, and just to see a flip-flop, the back and forth, it's really difficult to continue to really clearly articulate to your partners and stakeholders why this is happening because it doesn't make sense to outsiders. And it doesn't make sense to a lot of folks to watch the back and forth. And it's very political, obviously. But on an implementation [level], explaining that to folks that aren't in that political machine, it gets difficult to be able to just do it in a concise way."

A technical advisor with PEPFAR experience at the U.S. mission level

Multiple interviewees expressed their frustration with the regular removal and re-enactment of the policy.⁵³¹ Many organizations were regularly affected by the policy, making it difficult, if not impossible, for these entities to maintain continuity in their programming. Interviewees across all three countries suggested that a permanent removal of the policy would allow them to improve their planning and operations and support the provision of comprehensive health services.⁵³²

Ligomeka from CSJ emphasized the need to permanently repeal the GGR, as the constant back-and-forth creates fear that the policy would be reinstated again with the next administration change:

"We have been appealing to some of our partners that why can't they lobby that the GGR should go for good? Because it is now like ping-pong. This government comes in and you have it enforced and when that government goes [and] the new government comes in, it is revoked. In four years time, if there will be another change of government, then the GGR will be there. In terms of advocacy and programming, you go forward and then take two steps back, so we don't know what can happen."

Brian Ligomeka, Executive Director, CSJ

One interviewee from a prime partner requested that the U.S. government not only remove the policy but also go a step further and advocate for the governments of countries in sub-Saharan Africa to liberalize their own domestic abortion laws as well.⁵³³



Recommendations

Permanently repealing the Global Gag Rule (GGR) is critical to advancing sexual and reproductive health, rights, and justice (SRHRJ) for women, girls, and gender diverse people around the world. Though *Fòs Feminista* applauds the Biden administration's swift action to revoke PLGHA on January 28, 2021, this action on its own is not enough. Temporarily revoking a deadly policy that has been reinstated and expanded by every Republican administration since 1984 does not undo its accumulating and accelerating harms, nor does it protect communities around the world from the possibility of its reinstatement by a future U.S. administration.

Recommendations for Congress

- Permanently repeal the Global Gag Rule through legislative action.
- Use the oversight power of Congress to monitor the revocation of the GGR to ensure it is no longer implemented and to mitigate the persistent harm of the policy.
- Address the funding and political leadership gaps highlighted by partners in this report by creating new legislative, funding, and report language to advance SRHR globally.

Recommendations for the White House

- Work with Congress to permanently repeal the GGR and state unequivocally that permanent repeal is a top foreign policy, human rights, global public health, and sexual and reproductive health and rights priority for the Biden administration.
- Increase global funding for SRHR in the President's budget with a statement of policy to support organizations that lost funding because of the GGR.
- The White House Gender Policy Council and National Security Council should take action to ensure that all USG agencies responsible for global health funding report on the steps they have taken to communicate the revocation of the GGR.

Recommendations for all U.S. Global Health Implementing Agencies

- Develop and publish a policy brief or position paper that comprehensively explains the revocation of PLGHA and affirms the Biden administration's support for SRHR as U.S. policy, including abortion services. Re-release this policy brief with periodic updates, as necessary.
- Disseminate simplified communications explaining the revocation of the GGR via TV, radio, newspapers, and social media to reach the general public as well as communities that have been impacted by the GGR.

- Develop and publicly release an after-action report by January 2023 that lists the steps that have been undertaken to communicate the revocation, monitor the modification of current agreements to remove PLGHA language, and assess the implementation of the revocation by implementing partners.
- Obligate additional financial resources to existing awards and establish new awards to enable implementing partners to fully implement the revocation of the GGR and re-establish programs that were lost due to PLGHA.
- Actively engage CSOs in the implementation of revocation of the policy by creating a reporting mechanism, such as an ombudsman.
- Increase USG Mission engagement with implementing partners, partners that declined to certify PLGHA, CSOs, and the general public at the country level through regular town halls, official statements, policy briefs, and “Dos and Don’ts” documents or “Frequently Asked Questions” documents about the revocation.
- Translate all materials related to the revocation of the GGR (e.g., communications, guidance, training programs, monitoring and compliance tools, and standard provisions) into national and local languages.
- Prepare and publish an updated Global Health eLearning Course that explains the revocation of PLGHA and provides guidance for partners to implement the policy change and adapt programs accordingly.
- Include a GGR revocation element in PEPFAR’s SIMS Above-site Assessment Tool, which would allow those completing SIMS assessments to determine if a PEPFAR site is complying with the revocation of the GGR.

Recommendations for Prime Partners

- Standardize communication of the revocation to all sub-prime partners with translations into national and local languages.
- Immediately ensure that sub-awards with an active period of performance have been modified to remove the PLGHA Standard Provision.
- Translate all materials related to the revocation of the GGR (e.g., communications, guidance, training programs, monitoring and compliance tools, and standard provisions) into national and local languages.
- Communicate the revocation of PLGHA to partners who declined to certify the policy.



Methodology

This report is based on a three-part data collection model and builds on the qualitative research methodology developed by Fòs Feminista (formerly CHANGE) in previous rapid-response policy research conducted in Malawi, Mozambique, and Zimbabwe from 2017 to 2019.⁵³⁴

In partnership with graduate student researchers and faculty from Emory University, Fòs Feminista conducted virtual interviews via Zoom in July and August 2021 with organizations in Malawi, Mozambique, and Zimbabwe. The Institutional Review Board (IRB) at Emory University determined that this project did not require IRB review because it was not research with “human subjects.”⁵³⁵ To protect interviewee confidentiality, each interviewee completed an informed consent process either virtually via REDCap in advance of the interview or provided verbal consent at the beginning of the interview. Fòs Feminista and Emory University researchers interviewed 53 representatives from 47 U.S. global health implementing partners, CSOs, and advocacy forums to document the flow of information about the January 2021 revocation of PLGHA by President Biden as well as learn more about the U.S. government’s implementation of the revocation in each country. Some of the organizations were current recipients of U.S. global health assistance, while others were not (See Table 2). Interviewees were identified through a combination of convenience and snowball sampling, based on

a list of Fòs Feminista’s in-country contacts with whom the organization has established relationships, and those who were involved in prior rapid-response research on this policy (see CHANGE’s prior reports with data from [Malawi](#) and [Mozambique and Zimbabwe](#) for more information), recommendations from interviewees themselves, as well as online resources such as [foreignassistance.gov](#).

Fòs Feminista staff also conducted 10 virtual interviews in September and October 2021 with USG and representatives from INGO headquarters to document the revocation of PLGHA and what information the USG has shared regarding the revocation, as well as their perspectives on the impact of the revocation on U.S. global health assistance and global health programs around the world. In lieu of an interview, representatives from OGAC at the Department of State and the PLGHA Compliance Team at USAID submitted written responses to Fòs Feminista’s interview questions.

All interviews were conducted via Zoom, audio-recorded, and transcribed by the research team or by a professional, third-party transcription service. Emory University researchers and Fòs Feminista staff developed a codebook using inductive

and deductive codes, and the graduate student researchers divided into three pairs to code each transcript from Malawi, Mozambique, and Zimbabwe. They analyzed themes across interviews using MAXQDA 2020 (VERBI Software, 2019). Fòs Feminista researchers followed the same analysis protocol to develop a codebook and code the interviews with U.S. government staff and representatives from INGO headquarters using MAXQDA 2019 (VERBI Software, 2018). Fòs Feminista researchers followed the same protocol to code and analyze the written responses from U.S. government agencies. Emory University researchers and Fòs Feminista staff developed this report using thematic analysis and selected specific quotes from the interviews that most comprehensively document the flow of information about the revocation of PLGHA and describe the impact of the revocation of PLGHA on global health work around the world, with specific examples from interviewees in Malawi, Mozambique, and Zimbabwe. Interviewees were given the choice to have their quotes be attributed to them by name and/or organization, or to remain anonymous. Interviewees also reviewed and approved all verbatim quotes included in the report.

	Current U.S. global health implementing partner	Former U.S. global health implementing partner	Never received U.S. global health funding	TOTAL
Malawi	13	1	3	17
Mozambique	9	4	3	16
Zimbabwe	7	4	3	14
TOTAL	29	9	9	47

Table 2. **Organizations Interviewed in Malawi, Mozambique, and Zimbabwe regarding the January 2021 revocation of PLGHA, July-August 2021**



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Center for Reproductive Health-Mozambique (ICRH-M) - Málica de Melo; **Ipas Mozambique** - Jorge Matine; **Katswe Sistahood** - Talent Jumo; **Kulima** - Mercedio Andre; **Malawi Human Rights Resource Centre (MHRRC)** - Emma Kaliya; **MSI Reproductive Choices** - Bethan Coble and Sarah Shaw; **Nyasa Rainbow Alliance (NRA)** - Eric Sambisa and George H. Kachimanga; **Oxfam in Mozambique** - Helena Chiquele; **Pathfinder International** - Sarah Lance; **Pathfinder Mozambique** - Mohamed Riaz Mobaracaly; **Pangaea Zimbabwe AIDS Trust (PZAT)** - Imelda Mahaka and Definate Nhamo; **Population Services International (PSI)** - Andrea Fearneyhough and Karl Hofmann; **PSI Mozambique** - Donato Gulino; **ROOTS** - Nyasha Mantosi; **SAfAIDS Regional** - Rouzeh Eghtessadi; **Save the Children Malawi** - Gomezgani Jenda; **Save the Children Mozambique** - Marla Smith; **Save the Children US** - Carolyn Boyce; **SayWhat** - Jimmy Wilford; **SRHR Africa Trust (SAT) Malawi** - Robert Phiri, Novice Bamusi, and Judith Pangani; **SAT Zimbabwe** - Dr. Mildred Mushunje; **Tree of Life (TOL)** - Lynn Walker; **Women's Action Group (WAG)** - Edinah Masiyiwa; **World Vision Mozambique** - Nicholas Ahadije; Auxilia Muchedzi; Chance Mwalubunju; Irene Koek; Smita Baruah; Tamara Mwenifumbo; anonymous representatives from prime, sub-prime, and CSOs in Malawi, Mozambique, and Zimbabwe; and representatives from the U.S. Department of State, the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), and the United States Agency for International Development (USAID).

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Samantha (Sammy) Luffy, Policy Research Officer at Fòs Feminista, led the student research team, conducted the USG and INGO interviews and analysis, and is the primary author of the report. Skye Beare, Senior Program Officer, supported the USG and INGO interviews and contributed to the writing of those sections of the report. Jillian Montilla, Policy Research Intern, provided writing and editing support. Stephanie Schmid, Senior U.S. Foreign Policy Consultant, and Serra Sippel, Chief Global Advocacy Officer, provided policy guidance. Bergen Cooper, Director of Policy Research designed, led, and directed the research and report. Giselle Carino, Chief Executive Officer, and Debora Diniz, Deputy Chief Executive Officer, provided guidance for this work. The views expressed and conclusions drawn in this report are those of Fòs Feminista.



Annexes

Status of Abortion Law in Malawi, Mozambique, and Zimbabwe

Malawi

Since colonial rule, Malawi's federal law on abortion remains extremely restrictive with its Penal Code only affording statutory protections for legal abortion "for the preservation of the mother's life," and carries a punishment of four to seven years imprisonment for obtaining an abortion for any other reason.⁵³⁶ However, there have been several promising developments in expanding exceptions for abortion in Malawi's national law in recent years. In July 2015, the Termination of Pregnancy Bill was introduced into the Parliament of Malawi and would liberalize access to safe abortion services in the cases of rape, incest, fetal anomaly, and danger to the mental or physical health or life of the pregnant person.⁵³⁷ Progress toward passing this Bill stalled when former President Trump was in office and as of the writing of this report, the Bill has not yet become law.⁵³⁸ In June 2021, the Malawi High Court issued a ruling on a judicial review application to access safe abortion that, while upholding the current Penal Code, recognized that safeguarding the mental and physical health of the pregnant woman or girl is included in the preservation of life.⁵³⁹ According to Dr. Godfrey Kangaude, an attorney and SRHR advocate, this ruling represented a "welcome

step towards an authoritative interpretation of the abortion law and opens the door for women and girls to seek lawful access to safe abortion."⁵⁴⁰ This is the "very first instance that the High Court of Malawi has acknowledged and discussed the position that abortion can be lawfully performed in Malawi," marking a milestone for the visibility of Malawi national debate to liberalize abortion access.⁵⁴¹ Activists, scholars, and public health practitioners are hopeful that the Court's recent ruling will open the door for future reform of Malawi's Penal Code and support momentum toward Malawi's fulfillment of its obligations to women and girls' SRHR as enumerated in the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, also known as the Maputo Protocol, which it ratified in 2005.⁵⁴²

Mozambique

In the past decade, Mozambique has accelerated its progress in securing a pregnant person's right to abortion. Since the liberalization of its abortion law in 2014, Mozambique maintained the right of a pregnant woman ("uma mulher pejada") to access abortion up to 12 weeks of gestation, up to 16 weeks in cases of rape or incest, and

up to 24 weeks in cases of fetal anomaly.⁵⁴³ Though the liberalization of national law expanded the grounds for safe abortion in Mozambique, the country's penal code, which dated back to the 1800s, continues to impede pregnant people's ability to access safe abortion care.⁵⁴⁴ A 2019 reform of its penal code brought Mozambique's criminal law in line with its national abortion law, decriminalizing abortion in cases of irreversible damage to the pregnant woman's mental health and effectively paving the way to "more meaningful implementation of the abortion law, which is one of Africa's most liberal laws."⁵⁴⁵ Despite these key legal developments, knowledge of Mozambique's liberalized abortion law remains low among women of reproductive age, which may contribute to the country's maternal mortality ratio of 289 deaths per 100,000 live births, 6.7% of which are estimated to result from abortion-related complications.⁵⁴⁶ Other barriers that impede access to safe abortion in Mozambique include abortion-related stigma⁵⁴⁷ as well as intersecting constraints that limit autonomous decision-making around health, such as parental consent requirements for persons younger than 16 years⁵⁴⁸ and high rates of intimate partner violence and forced child marriage.⁵⁴⁹ As one of the first State Parties to ratify the Maputo Protocol in 2005, Mozambique has made notable progress in liberalizing access to abortion, but there remains opportunities to strengthen its efforts to promote and fulfill its obligations set out by the Protocol.⁵⁵⁰

Zimbabwe

Zimbabwe's Termination of Pregnancy Act of 1977 permits abortion only if "the continuation of the pregnancy so endangers the life of the woman concerned or so constitutes a serious threat of permanent impairment of her physical health...where there is a serious risk that the child to be born will suffer from a physical or mental defect...or where there is a reasonable possibility that the foetus is conceived as a result of unlawful intercourse."⁵⁵¹ Section 60 of the Criminal Law and Codification Reform Act levies a punishment of up to five years imprisonment and/or a fine should these parameters not be met.⁵⁵² In spite of these exceptions, most pregnant people in Zimbabwe are forced to seek abortions outside of the formal health care system.⁵⁵³ At 462 deaths per 100,000 live births, Zimbabwe has one of the highest maternal mortality rates worldwide.⁵⁵⁴ Excessive legal, administrative, and socioeconomic barriers, as well as stockouts of key equipment and commodities, continue to impede abortion access for pregnant people who meet the law's criterion and Zimbabwe's progress on fulfilling its obligations as a State Party to the Maputo Protocol since 2008.⁵⁵⁵

U.S. global health assistance definitions

Types of funding agreements⁵⁵⁶

- » **Acquisition award:** A USG agency purchases goods and services from a contractor to implement an activity with U.S. global health funding as directed by the USG agency. Types of acquisition awards include contracts, purchase orders, etc.
- » **Assistance award:** “Financial support from the U.S. Government to an organization—through a grant or cooperative agreement—to help carry out a project that benefits the community and advances the objectives of the U.S. Foreign Assistance Act.”⁵⁵⁷

Cooperative agreement

A legal instrument used when the principal purpose of the award is to transfer anything of value to a recipient to accomplish a public purpose of support authorized by Federal statute when substantial involvement from the USG implementing agency is needed. May also be called an “award” or “agreement.”⁵⁵⁸

- » **Notice of Award (NoA):** Within the HHS system, a Notice of Award (NoA) is “the official legally binding award document that: (i.) notifies the recipient of the award of a grant; (ii.) contains or references all the terms and conditions of the grant and federal funding limits; and (iii.) provides the documentary basis for recording the obligation of federal funds in the agencies’ accounting systems.”⁵⁵⁹

Notice of Funding Opportunity (NOFO)

- » **USAID’s definition:** A solicitation that announces that assistance funding is available to address a development challenge through a grant or cooperative agreement. Also known as a “procurement” or “solicitation.”⁵⁶⁰
- » **CDC’s definition:** “An awarding office’s formally issued announcement of the availability of Federal funding through one of its financial assistance programs. The announcement invites applications and provides such information as eligibility and evaluation criteria, funding preferences/priorities, how to obtain application kits, and the submission deadline.”⁵⁶¹

Standard Provision

The required procedures and standards for the award and administration of USAID grants and cooperative agreements⁵⁶²

- » **USAID’s Automated Directives System (ADS):** The operational policies and procedures that guide USAID’s programs and operations. The ADS “contains the organization and functions of USAID, along with the policies and procedures that guide the Agency’s programs and operations. It consists of over 200 chapters organized in six functional series: Agency Organization and Legal Affairs, Programming, Acquisition and Assistance, Human Resources,

Management Services, and Budget and Finance. The information is continuously updated to align USAID's policies with the latest Federal regulations, Administrator policy statements, and other overarching guidance.⁵⁶³

Agreement Modification

- » A legal process that revises the terms and conditions of a NoA (for HHS) or an award (USAID), including adding, removing, or revising Standard Provisions, adding incremental funding, making changes to key personnel, or updating the total estimated cost or period of performance of an award.

Award management staff

- » **CDC:** Includes the Grants Management Officer (GMO), Grants Management Specialist (GMS), and Project Officer at the headquarters or CDC country office level. Usually, the GMO is legally responsible for a particular NoA, while the GMS is responsible for the day-to-day management of the NoA and carries out many functions on behalf of the GMO. The Project Officer manages the technical and programmatic elements of the NoA.⁵⁶⁴
- » **USAID:** Includes the Agreement Officer (AO), Agreement Officer's Representative (AOR), and Technical Advisor(s) at the headquarters or U.S. mission level. Usually, the AO is legally responsible for the award, while the AOR is a technical expert responsible for the day-to-day management of the award and carries out many functions on behalf of the AOR. The Technical Advisor(s) support the AOR in managing the technical and programmatic elements of the award.⁵⁶⁵

Implementing Partner

An organization, for profit or nonprofit, that receives funding from the U.S. government to implement the activities as specified in a funding agreement, such as a grant or cooperative agreement.⁵⁶⁶

- » **Prime partner:** An organization that receives U.S. global health assistance directly from the U.S. government. Both U.S.-based NGOs and foreign NGOs can be prime partners. All U.S. funding and policy requirements are passed down from prime partners to their sub-prime(s).
- » **Sub-prime partner:** An organization that receives U.S. global health assistance from a prime partner rather than directly from the U.S. government. Sub-primes (also known as a "sub-grantee," "sub-recipient," or "sub-partner") are one step removed from a direct relationship with the U.S. government and communications about their funding and relevant policies or procedures are filtered down to them through the prime partner.



Endnotes

- 1** The White House, National Strategy on Gender Equity and Equality 20 (2021), <https://www.whitehouse.gov/wp-content/uploads/2021/10/National-Strategy-on-Gender-Equity-and-Equality.pdf> [hereinafter National Strategy on Gender Equity and Equality].
- 2** Policy Statement of the United States of America at the United Nations International Conference on Population (Second Session) 5–6 (Aug. 6–14, 1984), https://www.uib.no/sites/w3.uib.no/files/attachments/mexico-city_policy_1984.pdf [hereinafter 1984 Policy Statement of the United States of America at the United Nations International Conference on Population].
- 3** U.S. DEPARTMENT OF STATE, PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE, FREQUENTLY ASKED QUESTIONS AND ANSWERS 16 (2019), <https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf> [hereinafter U.S. DEPARTMENT OF STATE, PLGHA FAQs (Sept. 2019)].
- 4** Memorandum on Protecting Women’s Health at Home and Abroad, 86 Fed. Reg. 33,077 (Jan. 28, 2021) [hereinafter Memorandum on Protecting Women’s Health at Home and Abroad].
- 5** See generally Constanca Mavodza et al., *The impacts of the global gag rule on global health: a scoping review*, 4 GLOB. HEALTH RES. POLICY 1 (2019) [hereinafter Mavodza et al., *The impacts of the global gag rule on global health: a scoping review*]; CENTER FOR HEALTH AND GENDER EQUITY (CHANGE), PRESCRIBING CHAOS IN GLOBAL HEALTH: THE GLOBAL GAG RULE FROM 1984–2018 (2018), <https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=621e81f99260d1646166521> [hereinafter CHANGE, PRESCRIBING CHAOS IN GLOBAL HEALTH]; CHANGE, A POWERFUL FORCE: U.S. GLOBAL HEALTH ASSISTANCE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN MALAWI (2020), <https://srhrforall.org/download/a-powerful-force-u-s-global-health-assistance-and-sexual-and-reproductive-health-and-rights-in-malawi/?wpdmdl=2254&refresh=621e820fcc31f1646166543> [hereinafter CHANGE, A POWERFUL FORCE]; WALTER LEITNER INTERNATIONAL HUMAN RIGHTS CLINIC, LEITNER CENTER FOR INTERNATIONAL LAW AND JUSTICE, EXPORTING CONFUSION: U.S. FOREIGN POLICY AS AN OBSTACLE TO THE IMPLEMENTATION OF ETHIOPIA’S LIBERALIZED ABORTION LAW 5 (2010), http://www.leitnercenter.org/files/LeitnerCtr_EthiopiaReport_WebVersion2010.pdf.
- 6** CHANGE, PRESCRIBING CHAOS IN GLOBAL HEALTH, *supra* note 5; CHANGE, A POWERFUL FORCE, *supra* note 5.
- 7** Written response from U.S. Department of State, Secretary’s Office of the Global AIDS Coordinator and Health Diplomacy (OGAC), to Fòs Feminista (Nov. 2021) [hereinafter Written response from U.S. Department of State, OGAC]; Written response from USAID/Bureau for Global Health PLGHA Compliance Team to Fòs Feminista (Oct. 2021) [hereinafter Written response from USAID/Bureau for Global Health PLGHA Compliance Team].
- 8** Memorandum on Protecting Women’s Health at Home and Abroad, *supra* note 4, sec. 1.
- 9** *Id.*, sec. 2(b).
- 10** Exec. Order No. 14,020, 86 Fed. Reg. 13,797 (Mar. 8, 2021) [hereinafter Exec. Order No. 14,020]; NATIONAL STRATEGY ON GENDER EQUITY AND EQUALITY, *supra* note 1, at 20; Press Release, The White House, Fact Sheet: National Strategy on Gender Equity and Equality (Oct. 22, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/22/fact-sheet-national-strategy-on-gender-equity-and-equality/> [hereinafter Fact Sheet: National Strategy on Gender Equity and Equality].
- 11** Zoom interview with Virginia Baresch, RN, MPH, Senior Public Health Advisor, Permanent Detailee from CDC/CGH/DGHT to Office of Global Affairs (OGA), Department of Health and Human Services (HHS) (Oct. 2021) [hereinafter Zoom interview with Virginia Baresch]; Zoom interview with an anonymous U.S. government employee (Oct. 2021); Written response from U.S. Department of State, OGAC, *supra* note 7; Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.
- 12** Zoom interview with representatives from the Christian Health Association of Malawi (CHAM) (July 2021) [hereinafter Zoom interview with CHAM]; Zoom interview with Sandra Mapemba, Technical Deputy Director, Health Policy Plus (HP+), Malawi (Aug. 2021) [hereinafter Zoom interview with Sandra Mapemba].
- 13** Zoom interview with Carolyn Boyce, Advisor, PLGHA Compliance, Save the Children US (Sept. 2021) [hereinafter Zoom interview with Carolyn Boyce]; Zoom interview with an anonymous PSI country office staffer (July 2021); Zoom interview with Brian Ligomeka, Centre for Solutions Journalism (July 2021) [hereinafter Zoom interview with Brian Ligomeka].
- 14** Zoom interview with Dr. Paula Vaz, Executive Director, Fundação Ariel Glaser contra o SIDA Pediátrico (F. Ariel), Mozambique (July 2021) [hereinafter Zoom interview with Dr. Paula Vaz]; Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview

with Lynn Walker, Director, Tree of Life (Aug. 2021) [hereinafter Zoom interview with Lynn Walker].

15 Zoom interview with Memory Kadau, Director, Adult Rape Clinic (ARC) (July 2021) [hereinafter Zoom interview with Memory Kadau]; Zoom interview with Lynn Walker, *supra* note 14; Zoom interview with Tamburai Muchinguri, Director, Family Support Trust (FST) (July 2021) [hereinafter Zoom interview with Tamburai Muchinguri].

16 Given the history of Pathfinder Mozambique receiving funds through USAID, the authors assumed the new award is managed by USAID, though Mobaracaly did not confirm the U.S. implementing agency responsible because the award was not yet signed and thus the information was procurement-sensitive at the time of the interview. Zoom interview with Riaz Mobaracaly, Country Director, Pathfinder Mozambique (July 2021) [hereinafter Zoom interview with Riaz Mobaracaly].

17 Zoom interview with Tamburai Muchinguri, *supra* note 15.

18 Zoom interview with Karl Hofmann, CEO, and Andrea Fearneyhough, Director for Safe Abortion Programming, PSI (Sept. 2021) [hereinafter Zoom interview with Karl Hofmann and Andrea Fearneyhough].

19 Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with Samuel Matsikure, Programs Manager, Gays and Lesbians of Zimbabwe (GALZ) (July 2021) [hereinafter Zoom interview with Samuel Matsikure]; Zoom interview with Tamara Mwenifumbo, public health professional in Malawi (July 2021) [hereinafter Zoom interview with Tamara Mwenifumbo].

20 Zoom interview with Nyasha Mantosi, Programs Officer, ROOTS, Zimbabwe (July 2021) [hereinafter Zoom interview with Nyasha Mantosi]; Zoom interview with Imelda Mahaka, Executive Director, and Definate Nhamo, Senior Program Manager, Pangaea Zimbabwe AIDS Trust (PZAT) (Aug. 2021) [hereinafter Zoom interview with PZAT].

21 Zoom interview with Dr. Mildred Mushunje, Country Director, SRHR Africa Trust, Zimbabwe (July 2021) [hereinafter Zoom interview with Dr. Mildred Mushunje]; Zoom interview with Talent Jumo, Founder and Director, Katswe Sistasood (July 2021) [hereinafter Zoom interview with Talent Jumo]; Zoom interview with Dr. Paula Vaz, *supra* note 14; Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with Caleb Thole, Executive Director, Global Hope

Mobilisation (GLOHOMO) (Aug. 2021) [hereinafter Zoom interview with Caleb Thole]; Zoom interview with Robert Phiri, Malawi Country Director, Novice Bamusi, Country Program Director, and Judith Pangani, Malawi Country Coordinator, SRHR Africa Trust (SAT) (Aug. 2021) [hereinafter Zoom interview with SAT Malawi]; Zoom interview with Chance Mwalubunju, Senior Policy Consultant with expertise in SRHR in Malawi (July 2021) [hereinafter Zoom interview with Chance Mwalubunju]; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with Eric Sambisa, Executive Director, and George Kachimanga, Program & Operations Manager, Nyasa Rainbow Alliance (NRA) (July 2021) [hereinafter Zoom interview with NRA]; Zoom interview with Nicholas Ahadjie, Grants Acquisition & Management Director, World Vision Mozambique (July 2021) [hereinafter Zoom interview with Nicholas Ahadjie]; Zoom interview with Málica de Melo, National Director, International Centre for Reproductive Health–Mozambique (ICRH–M) (Aug. 2021) [hereinafter Zoom interview with Málica de Melo]; Zoom interview with a representative from an SRH organization in Mozambique (July 2021); Zoom interview with a senior leader at an organization that receives U.S. government funding in sub-Saharan Africa (Aug. 2021); Zoom interview with Donato Gulino, Country Representative, PSI Mozambique (July 2021) [hereinafter Zoom interview with Donato Gulino]; Zoom interview with Marla Smith, Health and Nutrition Advisor, Save the Children Mozambique (July 2021) [hereinafter Zoom interview with Marla Smith]; Zoom interview with Birgit Holm, Mozambique Country Director, and Helen Hallstrom, Partnership Officer, Aid for the Development of People for People (ADPP) (Aug. 2021) [hereinafter Zoom interview with ADPP]; Zoom interview with Rafa Valente Machava, Executive Director, Associação Mulher, Lei e Desenvolvimento (MULEIDE) (Aug. 2021) [hereinafter Zoom interview with Rafa Valente Machava]; Zoom interview with Nyasha Mantosi, *supra* note 20; Zoom interview with PZAT, *supra* note 20; Zoom interview with Helena Chiquele, Southern Africa Gender Justice Program and Policy Manager, Oxfam in Mozambique (July 2021) [hereinafter Zoom interview with Helena Chiquele].

22 Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).

23 See CHANGE, *PRESCRIBING CHAOS IN GLOBAL HEALTH*, *supra* note 5, at 30–32.

24 Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).

- 25** The “chilling effect” refers to when “organizations or health care providers restrict their activities beyond what is required by the policy in order to protect themselves from being accused of non-compliance.” Organizations may also be unaware of the full parameters of the policy due to ambiguous communication from the U.S. government or prime partners. Mavodza et al., *The impacts of the global gag rule on global health: a scoping review*, *supra* note 5, at 15. See also CHANGE, *PRESCRIBING CHAOS IN GLOBAL HEALTH*, *supra* note 5, at 36–38; CHANGE, *A POWERFUL FORCE*, *supra* note 5, at 24.
- 26** CHANGE, *PRESCRIBING CHAOS IN GLOBAL HEALTH*, *supra* note 5, at 36; Boniface Ayanbekongshie Ushie et al., *Foreign assistance or attack? Impact of the expanded Global Gag Rule on sexual and reproductive health and rights in Kenya*, 28(3) *SEXUAL AND REPRODUCTIVE HEALTH MATTERS* 23, 29 (2020) [hereinafter Ayanbekongshie Ushie et al., *Foreign assistance or attack?*]; INTERNATIONAL WOMEN’S HEALTH COALITION (IWHC), *CRISIS IN CARE: YEAR TWO IMPACT OF TRUMP’S GLOBAL GAG RULE* 26 (2019), https://31u5ac2nrwj6247cya153vw9-wpengine.netdna-ssl.com/wp-content/uploads/2019/06/IWHC_GGR_Report_2019-WEB_single_pg-2.pdf [hereinafter IWHC, *CRISIS IN CARE*]; Mavodza et al., *The impacts of the global gag rule on global health: a scoping review*, *supra* note 5, at 15; GLOBAL JUSTICE CENTER & CHANGE, *CENSORSHIP EXPORTED: THE IMPACT OF TRUMP’S GLOBAL GAG RULE ON THE FREEDOM OF SPEECH AND ASSOCIATION* 4–5 (2019), https://globaljusticecenter.net/files/Censorship_Exported_Impact_of_Trumps_GGR.pdf [hereinafter GLOBAL JUSTICE CENTER & CHANGE, *CENSORSHIP EXPORTED*].
- 27** Zoom interview with Irene Koek, expert familiar with U.S. global health assistance (Sept. 2021) [hereinafter Zoom interview with Irene Koek].
- 28** Memorandum on Protecting Women’s Health at Home and Abroad, *supra* note 4, sec. 1.
- 29** Memorandum on Protecting Women’s Health at Home and Abroad, *supra* note 4; The Mexico City Policy, 82 Fed. Reg. 8,495 (Jan. 23, 2017) [hereinafter The Mexico City Policy (2017)].
- 30** Memorandum on Protecting Women’s Health at Home and Abroad, *supra* note 4. See generally GLOBAL JUSTICE CENTER & CHANGE, *CENSORSHIP EXPORTED*, *supra* note 26; IWHC, *CRISIS IN CARE*, *supra* note 26.
- 31** Memorandum on Protecting Women’s Health at Home and Abroad, *supra* note 4, sec. 1.
- 32** Exec. Order No. 14,020, *supra* note 10; NATIONAL STRATEGY ON GENDER EQUITY AND EQUALITY, *supra* note 1, at 20; Fact Sheet: National Strategy on Gender Equity and Equality, *supra* note 10.
- 33** 1984 Policy Statement of the United States of America at the United Nations International Conference on Population, *supra* note 2, at 5–6.
- 34** U.S. DEPARTMENT OF STATE, *PLGHA FAQs* (Sept. 2019), *supra* note 3, at 16.
- 35** CHANGE, *PRESCRIBING CHAOS IN GLOBAL HEALTH*, *supra* note 5, at 7; GLOBAL JUSTICE CENTER & CHANGE, *CENSORSHIP EXPORTED*, *supra* note 26, at 1.
- 36** CHANGE, *PRESCRIBING CHAOS IN GLOBAL HEALTH*, *supra* note 5, at 13–15; Memorandum on the Mexico City Policy, 29 WEEKLY COMP. PRES. DOC. 88 (Jan. 22, 1993); Memorandum on Restoration of the Mexico City Policy, 37 WEEKLY COMP. PRES. DOC. 216 (Jan. 22, 2001); Mexico City Policy and Assistance for Voluntary Population Planning, 74 Fed. Reg. 4,903 (Jan. 23, 2009).
- 37** Memorandum on Assistance for Voluntary Population Planning, 39 WEEKLY COMP. PRES. DOC. 1124 (Aug. 29, 2003).
- 38** The Mexico City Policy (2017), *supra* note 29. See also U.S. Department of State, *PRM Press Guidance, Implementation of Protecting Life in Global Health Assistance (Formerly known as the “Mexico City Policy”)* (May 15, 2017), at 5 (2017) (on file with Fòs Feminista); CHANGE, *TRUMP’S GLOBAL GAG RULE: POLICY AND RESEARCH BRIEF* 1 (2021), <https://srhrforall.org/download/trumps-global-gag-rule-policy-and-research-brief/?wpdmdl=2335&refresh=61df0ae9930631642007273>.
- 39** USAID, *ADDITIONS TO THE ANSWERS TO FREQUENTLY ASKED QUESTIONS (FAQS) RELATED TO THE REVISED STANDARD PROVISION FOR GRANTS AND COOPERATIVE AGREEMENTS TO IMPLEMENT THE PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE (PLGHA) POLICY* 3–4 (2019), https://srhrindex.srhrforall.org/uploads/2020/04/2019_Additions-to-the-Answers-to-FAQs-Related-to-the-Revised-Standard-Provision-for-Grants-and-Cooperative-Agreements-to-Implement-the-PLGHA-Policy_June-2019.pdf [hereinafter USAID, *PLGHA FAQs* (June 2019)]; AMFAR, *THE EXPANDED MEXICO CITY POLICY: IMPLICATIONS FOR THE GLOBAL FUND 2* (2019), <https://www.amfar.org/wp-content/uploads/2022/04/issuebrief-globalfund.pdf> [hereinafter AMFAR, *THE EXPANDED MEXICO CITY POLICY*].
- 40** Beirne Roose-Snyder et al., *Call in the lawyers: mitigating the Global Gag Rule*, 28(3) *SEXUAL AND REPRODUCTIVE HEALTH MATTERS* 71, 71 (2020).
- 41** AMFAR, *THE EXPANDED MEXICO CITY POLICY*, *supra* note 39, at 4.

- 42** See generally PAI & WATERAID, HOW THE EXPANDED GLOBAL GAG RULE AFFECTS WATER, SANITATION AND HYGIENE (WASH) (2019), <https://res.cloudinary.com/dhu2eru5b/images/v1630072763/websites/pai2020/PAI-and-WaterAid-Updated/PAI-and-WaterAid-Updated.pdf>; FRONTLINE AIDS, EARLY WARNING SIGNS: THE ACTUAL AND ANTICIPATED IMPACT OF THE MEXICO CITY POLICY ON THE HIV RESPONSE FOR MARGINALISED PEOPLE IN CAMBODIA AND MALAWI (2019), <https://frontlineaids.org/wp-content/uploads/2019/03/FrontlineAIDS-MexicoCityPolicy-Report-A4-WEB.pdf>; Saina Beitari et al., *Trump's Global Gag Rule and its Impact on Maternal Health Worldwide*, 7 MCGILL JOURNAL OF GLOBAL HEALTH 17 (2018); U.S. DEPARTMENT OF STATE, REVIEW OF THE IMPLEMENTATION OF THE PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE POLICY (2020), <https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf> [hereinafter U.S. DEPARTMENT OF STATE, REVIEW OF THE IMPLEMENTATION OF THE PLGHA POLICY]; AMFAR, THE EFFECT OF THE EXPANDED MEXICO CITY POLICY ON HIV/AIDS PROGRAMMING: EVIDENCE FROM THE PEPFAR IMPLEMENTING PARTNERS SURVEY (2019), <https://www.amfar.org/wp-content/uploads/2022/04/issuebrief-globalfund.pdf> [hereinafter AMFAR, THE EFFECT OF THE EXPANDED MEXICO CITY POLICY ON HIV/AIDS PROGRAMMING].
- 43** See generally Marta Schaaf et al., 'Protecting Life in Global Health Assistance'? Towards a framework for assessing the health systems impact of the expanded Global Gag Rule, 4 BMJ GLOBAL HEALTH e001786 (2019); Jennifer Sherwood et al., *Mapping the impact of the expanded Mexico City Policy for HIV/ family planning service integration in PEPFAR-supported countries: a risk index*, 18 BMC PUBLIC HEALTH 1 (2018) [hereinafter Sherwood et al., *Mapping the impact of the expanded Mexico City Policy for HIV/ family planning service integration in PEPFAR-supported countries*].
- 44** Sherwood et al., *Mapping the impact of the expanded Mexico City Policy for HIV/ family planning service integration in PEPFAR-supported countries*, *supra* note 43, at 10.
- 45** IWHC, REALITY CHECK: YEAR ONE IMPACT OF TRUMP'S GLOBAL GAG RULE 2 (2018), https://web.archive.org/web/20210115073626/https://iwhc.org/wp-content/uploads/2018/05/GGR-Formatted-Report_FINAL.pdf. See generally Sherwood et al., *Mapping the impact of the expanded Mexico City Policy for HIV/ family planning service integration in PEPFAR-supported countries*, *supra* note 43.
- 46** AMFAR, THE EFFECT OF THE EXPANDED MEXICO CITY POLICY ON HIV/AIDS PROGRAMMING, *supra* note 42, at 4-6; IWHC, CRISIS IN CARE, *supra* note 26, at 13-16, 27, 31.
- 47** Memorandum on Protecting Women's Health at Home and Abroad, *supra* note 4, sec. 2(c).
- 48** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021); Zoom interview with Bethan Cobley, Director of Resilience, Advocacy, and Partnerships and Sarah Shaw, Head of Advocacy, MSI Reproductive Choices (Sept. 2021) [hereinafter Zoom interview with MSI Reproductive Choices]; Zoom interview with Irene Koek, *supra* note 27; Zoom interview with Dr. Stephanie Psaki, PhD, Senior Advisor, Human Rights and Gender Equity, Office of Global Affairs (OGA), Office of the Secretary, Department of Health and Human Services (HHS) (Oct. 2021) [hereinafter Zoom interview with Dr. Stephanie Psaki]; Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).
- 49** Zoom interview with Marla Smith, *supra* note 21.
- 50** Zoom interview with Helena Chiquele, *supra* note 21.
- 51** Zoom interview with Dr. Stephanie Psaki, *supra* note 48.
- 52** CHANGE, Prescribing Chaos in Global Health, *supra* note 5, at 8, 22. See generally CREHPA & IWHC, IMPACTS OF PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE POLICY IN NEPAL (2021), https://crehpa.org.np/wp-content/uploads/2021/09/Impacts-of-PLGHA-Policy-in-Nepal_CREHPA-2020-2021.pdf.
- 53** Zoom interview with an advisor from the CDC (Sept. 2021).
- 54** Zoom interview with MSI Reproductive Choices, *supra* note 48.
- 55** *Id.*
- 56** Zoom interview with Karl Hofmann and Andrea Fearneyhough, *supra* note 18.
- 57** *Id.*
- 58** Zoom interview with a prime partner that declined to certify PLGHA (Sept. 2021).
- 59** *Id.*
- 60** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).
- 61** *Id.*
- 62** *Id.*
- 63** Zoom interview with a prime partner that declined to certify PLGHA (Sept. 2021).

- 64** Zoom interview with Madam Emma Kaliya, Director, Malawi Human Rights Resource Centre (MHRRC) (July 2021) [hereinafter Zoom interview with Madam Emma Kaliya].
- 65** Zoom interview with Sarah Lance, Director of Program Operations, Pathfinder International (Sept. 2021) [hereinafter Zoom interview with Sarah Lance].
- 66** Zoom interview with Virginia Baresch, *supra* note 11.
- 67** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).
- 68** *Id.*
- 69** “The Secretary of State, the Secretary of Defense, the Secretary of Health and Human Services, the Administrator of USAID, and appropriate officials at all other agencies involved in foreign assistance shall take all steps necessary to implement this memorandum, as appropriate and consistent with applicable law.” Memorandum on Protecting Women’s Health at Home and Abroad, *supra* note 4, sec. 2(c).
- 70** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).
- 71** *Id.*
- 72** Memorandum on Protecting Women’s Health at Home and Abroad, *supra* note 4, sec. 2(c)(ii).
- 73** Zoom interview with Dr. Stephanie Psaki, *supra* note 48. See also Zoom interview with Virginia Baresch, *supra* note 11; Zoom interview with an advisor from the CDC (Sept. 2021); Zoom interview with an anonymous U.S. government employee (Oct. 2021); Written response from U.S. Department of State, OGAC, *supra* note 7; Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.
- 74** Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with Gertrude Shumba, Director, Family AIDS Caring Trust (FACT) (Aug. 2021) [hereinafter Zoom interview with Gertrude Shumba]; Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Emilio Valverde, Country Director, Aurum Institute (Aug. 2021) [hereinafter Zoom interview with Emilio Valverde].
- 75** Zoom interview with Riaz Mobaracaly, *supra* note 16; Zoom interview with ADPP, *supra* note 21; Zoom interview with Dr. Paula Vaz, *supra* note 14.
- 76** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021); Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7; Letter from USAID Mission Agreement Officer to an INGO country office (Feb. 1, 2021) (on file with Fòs Feminista) [hereinafter Letter from USAID Mission Agreement Officer to an INGO country office]; Action Transmittal from Alice Bettencourt, Deputy Assistant Secretary, Office of Grants (OG), Office of the Assistant Secretary for Financial Resources (ASFR), U.S. Department of Health and Human Services (HHS), to HHS Grants and Cooperative Agreements Awarding Agencies (Feb. 3, 2021) (on file with Fòs Feminista) [hereinafter HHS Action Transmittal].
- 77** Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).
- 78** *Id.*
- 79** *Id.*
- 80** Zoom interview with Gertrude Shumba, *supra* note 74.
- 81** Zoom interview with PZAT, *supra* note 20.
- 82** Zoom interview with Talent Jumo, *supra* note 21.
- 83** Zoom interview with Tanya Nyakatawa, Zimbabwe Country Focal Person, GLOHOMO (Aug. 2021) [hereinafter Zoom interview with Tanya Nyakatawa].
- 84** Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with CHAM, *supra* note 12; Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with NRA, *supra* note 21; Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with Ann Phoya, President, Association of Malawian Midwives (AMAMI) (Aug. 2021) [hereinafter Zoom interview with Ann Phoya]; Zoom interview with Gomezgani Jenda, Senior Technical Advisor for Health and Nutrition, Save the Children Malawi (July 2021) [hereinafter Zoom interview with Gomezgani Jenda]; Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Edinah Masiyiwa, Executive Director, Women’s Action Group, Zimbabwe

(July 2021) [hereinafter Zoom interview with Edinah Masiyiwa]; Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with Rouzeh Eghtessadi, Executive Director, SAfAIDS Regional, Zimbabwe (July 2021) [hereinafter Zoom interview with Rouzeh Eghtessadi]; Zoom interview with Gertrude Shumba, *supra* note 74; Zoom interview with PZAT, *supra* note 20; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with Tanya Nyakatawa, *supra* note 83; Zoom interview with a senior leader at an organization that receives U.S. government funding in sub-Saharan Africa (Aug. 2021); Zoom interview with Donato Gulino, *supra* note 21; Zoom interview with Dr. Paula Vaz, *supra* note 14; Zoom interview with Marla Smith, *supra* note 21; Zoom interview with Helena Chiquele, *supra* note 21; Zoom interview with Santos Simione, Executive Director, AMODEFA, Mozambique (July 2021) [hereinafter Zoom interview with Santos Simione]; Zoom interview with Riaz Mobaracaly, *supra* note 16; Zoom interview with ADPP, *supra* note 21.

85 Zoom interview with Samuel Matsikure, *supra* note 19.

86 Zoom interview with Memory Kadau, *supra* note 15.

87 *Id.*

88 Zoom interview with Sandra Mapemba, *supra* note 12.

89 Zoom interview with Tamara Mwenifumbo, *supra* note 19.

90 Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with NRA, *supra* note 21; Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with Donato Gulino, *supra* note 21; Zoom interview with Emilio Valverde, *supra* note 74.

91 The Department of Defense (DoD) did not respond to repeated requests for an interview.

92 The U.S. Department of State operates U.S. Embassies, Consulates, and Diplomatic Missions around the world, which may differ slightly in terms of staffing, programs, and function, but are generally referred to as

“U.S. missions” in this report. For more information, see USEMBASSY.GOV, <https://www.usembassy.gov/> (last visited Mar. 6, 2022).

93 Written response from U.S. Department of State, OGAC, *supra* note 7.

94 Zoom interview with Virginia Baresch, *supra* note 11.

95 *Id.*

96 *Id.*

97 *Id.*

98 *Id.*

99 Zoom interview with an anonymous U.S. government employee (Oct. 2021).

100 U.S. DEPARTMENT OF STATE, PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE FREQUENTLY ASKED QUESTIONS (2018), <https://grants.nih.gov/grants/files/hhs-interagency-plgha-faqs.pdf>; USAID, PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE FREQUENTLY ASKED QUESTIONS AND ANSWERS (2018), https://srhrindex.srhrforall.org/uploads/2019/11/2018_Protecting-Life-in-Global-Health-Assistance-FAQs_September-2018.pdf; USAID, PLGHA FAQs (June 2019), *supra* note 39; U.S. DEPARTMENT OF STATE, PLGHA FAQs (Sept. 2019), *supra* note 3.

101 U.S. DEPARTMENT OF STATE, PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE SIX-MONTH REVIEW (2018), <https://2017-2021.state.gov/wp-content/uploads/2019/06/PLGHA-6-month-review-final-for-posting.pdf>.

102 U.S. DEPARTMENT OF STATE, REVIEW OF THE IMPLEMENTATION OF THE PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE POLICY, *supra* note 42.

103 Zoom interview with Virginia Baresch, *supra* note 11.

104 *Id.*

105 Zoom interview with SAT Malawi, *supra* note 21.

106 *Id.*

107 PEPFAR, PEPFAR 2022 COUNTRY AND REGIONAL OPERATIONAL PLAN (COP/ROP) GUIDANCE FOR ALL PEPFAR-SUPPORTED COUNTRIES 12 (2022), https://www.state.gov/wp-content/uploads/2022/01/COP22-Guidance-Final_508-Compliant.pdf [hereinafter PEPFAR 2022 COP/ROP GUIDANCE]; *U.S. Global Health Budget Tracker*, HENRY J. KAISER FAMILY FOUNDATION (KFF) (Apr. 29, 2021), <https://www.kff.org/interactive/u-s-global-health-budget-tracker/> [hereinafter *U.S. Global Health Budget Tracker*, KFF]. See

also PEPFAR, LATEST GLOBAL PROGRAM RESULTS (2021), https://www.state.gov/wp-content/uploads/2021/12/PEPFAR-Latest-Global-Results_WAD-2021.pdf.

108 PEPFAR 2022 COP/ROP GUIDANCE, *supra* note 107, at 12-13.

109 *U.S. Global Health Budget Tracker*, KFF, *supra* note 107.

110 *How Are U.S. Government Agencies Working to End HIV and AIDS Around the World?*, HIV.gov, <https://www.hiv.gov/federal-response/pepfar-global-aids/us-government-global-aids-activities> (last updated Nov. 30, 2021); *About Us – PEPFAR*, U.S. DEPARTMENT OF STATE, <https://www.state.gov/about-us-pepfar/> (last visited Mar. 6, 2022).

111 Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021); see also PEPFAR, PEPFAR 2021 COUNTRY AND REGIONAL OPERATIONAL PLAN (COP/ROP) GUIDANCE FOR ALL PEPFAR COUNTRIES 19-20 (2021), <https://www.state.gov/wp-content/uploads/2021/02/PEPFAR-COP21-Guidance-Final.pdf> [hereinafter PEPFAR 2021 COP/ROP GUIDANCE].

112 Led by S/GAC, the annual Country and Regional Operational Planning (COP/ROP) process is part of an annual assessment of all PEPFAR Operating Units (OUs), which includes planning, budgeting, and monitoring components. This process actively engages U.S. government staff across the PEPFAR interagency at headquarters and the regional level, as well as civil society stakeholders, advocates, other funders, and host country governments. The COP/ROP process is also an opportunity to ensure programmatic alignment with U.S. foreign policies, global strategies, and host country government priorities. For more details within the COP/ROP22 Guidance for All PEPFAR-Supported Countries, see PEPFAR 2022 COP/ROP GUIDANCE, *supra* note 107, at 12-13.

113 PEPFAR 2021 COP/ROP GUIDANCE, *supra* note 111, at 160-161.

114 OGAC, COP/ROP 2021 FREQUENTLY ASKED QUESTIONS 20 (2021), <https://www.state.gov/wp-content/uploads/2021/05/2021-05-11-COPROP21-Planning-Consolidated-FAQ.pdf> [hereinafter COP/ROP 2021 FAQs].

115 Written response from U.S. Department of State, OGAC, *supra* note 7.

116 COP/ROP 2021 FAQs, *supra* note 114, at 20.

117 Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).

118 From February 2020 through the time of publication, there was no PEPFAR Ambassador-at-Large after Ambassador Bix left her post in February 2020 to join former President Trump's pandemic task force. To date, Dr. Angeli Achrekar serves as the Acting U.S. Global AIDS Coordinator of PEPFAR. Dr. Angeli Achrekar, U.S. DEPARTMENT OF STATE, <https://www.state.gov/biographies/angeli-achrekar/> (last visited Mar. 6, 2022); Apoorva Mandavilli, *PEPFAR Is Still Without a Leader. H.I.V. Activists Want to Know Why*, NEW YORK TIMES, July 20, 2021, <https://www.nytimes.com/2021/07/20/health/pepfar-leader-hiv.html>; Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).

119 Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).

120 *Id.*

121 Written response from U.S. Department of State, OGAC, *supra* note 7.

122 Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).

123 Zoom interview with an advisor from the CDC (Sept. 2021).

124 Zoom interview with ADPP, *supra* note 21; Zoom interview with Dr. Paula Vaz, *supra* note 14.

125 Zoom interview with a public health professional in Zimbabwe (July 2021).

126 *U.S. Global Health Budget Tracker*, KFF, *supra* note 107.

127 Declining to certify PLGHA means an organization will not abide by the requirements of the policy and therefore will not be eligible to receive U.S. global health assistance funding.

128 UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE, GLOBAL HEALTH ASSISTANCE AWARDEES' DECLINATIONS OF U.S. PLANNED FUNDING DUE TO ABORTION-RELATED RESTRICTIONS 15 (2020), <https://www.gao.gov/assets/gao-20-347.pdf> [hereinafter GAO, GLOBAL HEALTH ASSISTANCE AWARDEES' DECLINATIONS OF U.S. PLANNED FUNDING DUE TO ABORTION-RELATED RESTRICTIONS].

129 Zoom interview with an anonymous U.S. government employee (Oct. 2021).

- 130** Zoom interview with Virginia Baresch, *supra* note 11; Zoom interview with Dr. Stephanie Psaki, *supra* note 48.
- 131** Zoom interview with Dr. Stephanie Psaki, *supra* note 48; Zoom interview with an advisor from the CDC (Sept. 2021); Zoom interview with an anonymous U.S. government employee (Oct. 2021).
- 132** Zoom interview with an advisor from the CDC (Sept. 2021).
- 133** Zoom interview with an anonymous U.S. government employee (Oct. 2021).
- 134** *HHS Agencies & Offices*, HHS.gov, <https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html> (last updated Jan. 5, 2022).
- 135** Zoom interview with an advisor from the CDC (Sept. 2021).
- 136** *Id.*
- 137** According to the HHS Action Transmittal OG AT 2021 – 04 issued on Feb. 3, 2021 regarding the revocation of PLGHA, HHS Awarding Agencies are defined as HHS agencies “making grant or cooperative agreement awards (collectively grants).” HHS Action Transmittal, *supra* note 76.
- 138** *Id.*
- 139** Within the HHS system, a Notice of Award (NoA) is “the official legally binding award document that: (i.) notifies the recipient of the award of a grant; (ii.) contains or references all the terms and conditions of the grant and federal funding limits; and, (iii.) provides the documentary basis for recording the obligation of federal funds in the agencies’ accounting systems.” For more information, see *Dictionary of Terms: Notice of Award (NoA)*, CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), <https://www.cdc.gov/grants/dictionary/index.html#n> (last updated Feb. 23, 2022) [hereinafter *Dictionary of Terms: NoA*, CDC]; *Notice of Award and Administrative Regulations*, CDC, <https://www.cdc.gov/grants/welcome-packet/noa-administrative-regs/index.html> (last updated June 29, 2021) [hereinafter *Notice of Award and Administrative Regulations*, CDC].
- 140** With regard to U.S. global health assistance, a Notice of Funding Opportunity (NOFO) is the mechanism by which the USG publicly releases an opportunity for new funding through a grant or cooperative agreement. The CDC defines this mechanism as “An awarding office’s formally issued announcement of the availability of Federal funding through one of its financial assistance programs. The announcement invites applications and provides such information as eligibility and evaluation criteria, funding preferences/priorities, how to obtain application kits, and the submission deadline.” For more information, see *Dictionary of Terms: Notice of Funding Opportunity (NOFO)*, CDC, <https://www.cdc.gov/grants/dictionary/index.html#nofo> (last updated Feb. 23, 2022) [hereinafter *Dictionary of Terms: NOFO*, CDC]; *Understanding the Notice of Funding Opportunity (NOFO)*, CDC <https://www.cdc.gov/grants/applying/understanding-nofo.html> (last updated June 29, 2021) [hereinafter *Understanding the NOFO*, CDC].
- 141** HHS Action Transmittal, *supra* note 76.
- 142** *Id.*
- 143** Zoom interview with Virginia Baresch, *supra* note 11. See also *Additional Requirement – 35: Protecting Life in Global Health Assistance is waived, effective January 28, 2021*, CDC, <https://www.cdc.gov/grants/additional-requirements/ar-35.html> (last updated June 29, 2021) [hereinafter *Additional Requirement – 35*, CDC]; National Institutes of Health, *Policy on Protecting Life in Global Health Assistance is Revoked*, NOT-OD-21-063 (Feb. 12, 2021), <https://grants.nih.gov/grants/guide/notice-files/NOT-OD-21-063.html>.
- 144** Zoom interview with Virginia Baresch, *supra* note 11.
- 145** *Id.*
- 146** Zoom interview with an anonymous U.S. government employee (Oct. 2021); Zoom interview with an advisor from the CDC (Sept. 2021).
- 147** *Id.*
- 148** Zoom interview with an anonymous U.S. government employee (Oct. 2021); see also *Additional Requirement – 35*, CDC, *supra* note 143.
- 149** *Additional Requirements*, CDC, <https://www.cdc.gov/grants/additional-requirements/index.html> (last updated Aug. 23, 2021).
- 150** Zoom interview with an anonymous U.S. government employee (Oct. 2021).
- 151** CDC Project Officers manage the technical aspects of ongoing awards and are responsible for informing prime implementing partners about policy changes like the revocation of the GGR, while CDC Grants Managers are responsible for managing all the cooperative agreements in a particular country,

including modifying NoAs to update the standard provisions according to policy changes like the GGR revocation. See Annex 2 for additional information. Zoom interview with Virginia Baresch, *supra* note 11; Zoom interview with an anonymous U.S. government employee (Oct. 2021).

152 Zoom interview with Virginia Baresch, *supra* note 11.

153 Zoom interview with an advisor from the CDC (Sept. 2021).

154 *Id.*

155 *Id.*

156 *Id.*

157 *Id.*

158 Zoom interview with an anonymous U.S. government employee (Oct. 2021).

159 *Id.*

160 Zoom interview with an advisor from the CDC (Sept. 2021).

161 *Id.*

162 Zoom interview with Dr. Paula Vaz, *supra* note 14.

163 *Id.*

164 Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.

165 *Id.*

166 Press Release, Acting Administrator Gloria Steele, USAID Welcomes President Biden's Commitment to Women and Children (Jan. 29, 2021), <https://www.usaid.gov/news-information/press-releases/jan-29-2021-usaid-welcomes-president-biden-commitment-women-and-children>.

167 *Id.*

168 Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.

169 *Id.*; see also *Implementing Partner Notices Portals*, USAID, <https://www.usaid.gov/work-usaid/resources-for-partners/implementing-partner-notice-portals> (last updated Mar. 17, 2016).

170 Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.

171 USAID's Automated Directives System (ADS) is the operational policy for the Agency. According to the USAID website where these materials are publicly available, the ADS "contains the organization and functions of USAID, along with the policies and procedures that guide the Agency's programs and operations. It consists of over 200 chapters organized in six functional series: Agency Organization and Legal Affairs, Programming, Acquisition and Assistance, Human Resources, Management Services, and Budget and Finance. The information is continuously updated to align USAID's policies with the latest Federal regulations, Administrator policy statements, and other overarching guidance." For more detail, see *Operational Policy (ADS)*, USAID, <https://www.usaid.gov/who-we-are/agency-policy> (last updated Sept. 30, 2021) [hereinafter *Operational Policy (ADS)*, USAID].

172 Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7; see also *ADS Chapter 303*, USAID, <https://www.usaid.gov/ads/policy/300/303> (last updated Mar. 7, 2022).

173 *Global Health Legislative & Policy Requirements*, USAID, <https://www.usaid.gov/global-health/legislative-policy-requirements> (last updated Jan. 28, 2022).

174 Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.

175 Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).

176 *Id.*

177 Zoom interview with Carolyn Boyce, *supra* note 13.

178 Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021).

179 Zoom interview with Samuel Matsikure, *supra* note 19.

180 Zoom interview with Auxilia Muchedzi, Public Health Professional, Zimbabwe (July 2021) [hereinafter Zoom interview with Auxilia Muchedzi]; Zoom interview with Gertrude Shumba, *supra* note 74; Zoom interview with Samuel Matsikure, *supra* note 19.

181 Zoom interview with Gertrude Shumba, *supra* note 74.

182 Zoom interview with Sandra Mapemba, *supra* note 12.

- 183** *Id.*
- 184** *Id.*
- 185** *Id.*
- 186** *Id.*; Zoom interview with a representative from an SRH organization in Mozambique (July 2021); Zoom interview with Santos Simione, *supra* note 84; Zoom interview with Riaz Mobaracaly, *supra* note 16; Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with Marla Smith, *supra* note 21.
- 187** GAO, GLOBAL HEALTH ASSISTANCE AWARDEES' DECLINATIONS OF U.S. PLANNED FUNDING DUE TO ABORTION-RELATED RESTRICTIONS, *supra* note 128, at 15.
- 188** Zoom interview with MSI Reproductive Choices, *supra* note 48.
- 189** *Id.*
- 190** *Id.*
- 191** *Id.*
- 192** Zoom interview with Lynn Walker, *supra* note 14.
- 193** *Id.*
- 194** *Id.*
- 195** *Id.*; USAID, DEMOCRACY, HUMAN RIGHTS AND GOVERNANCE: EMPOWERMENT AND INCLUSION DIVISION: VICTIMS OF TORTURE PROGRAM (2015), https://www.usaid.gov/sites/default/files/documents/2496/vot%202_2016.pdf.
- 196** Zoom interview with Lynn Walker, *supra* note 14.
- 197** CONGRESSIONAL RESEARCH SERVICE (CRS), INTERNATIONAL FAMILY PLANNING: THE "MEXICO CITY" POLICY 2 (2001), https://www.everycrsreport.com/files/20010402_RL30830_c36ae9159587c6ca12d4da8edacc125b1394ce6c.pdf.
- 198** Foreign Assistance Act of 1961, Pub. L. No. 87-195, § 104(f)(1), 75 Stat. 424, as amended by the Foreign Assistance Act of 1973 (Pub. L. No. 93-189).
- 199** See CHANGE, THE HELMS AMENDMENT, AND WHY IT NEEDS TO END (2021), <https://srhrforall.org/download/the-helms-amendment-and-why-it-needs-to-end/?wpm=2898&refresh=61fc35c2a6de61643918786>.
- 200** *Id.*
- 201** Zoom interview with Lynn Walker, *supra* note 14.
- 202** *Id.*
- 203** *Id.*
- 204** *Id.*
- 205** *Id.*
- 206** Zoom interview with Memory Kadau, *supra* note 15.
- 207** See CHANGE, A POWERFUL FORCE, *supra* note 5, at 51.
- 208** Zoom interview with Memory Kadau, *supra* note 15.
- 209** Zoom interview with Dr. Stephanie Psaki, *supra* note 48.
- 210** Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).
- 211** Zoom interview with an advisor from the CDC (Sept. 2021); see also *Bilateral and Multilateral Donors*, USAID, <https://www.usaid.gov/partnership-opportunities/donor-institutions> (last updated Nov. 15, 2018).
- 212** Zoom interview with Marla Smith, *supra* note 21.
- 213** Zoom interview with Chance Mwalubunju, *supra* note 21.
- 214** Zoom interview with Santos Simione, *supra* note 84.
- 215** Zoom interview with Talent Jumo, *supra* note 21.
- 216** *Id.*
- 217** *Id.*
- 218** Zoom interview with Emilio Valverde, *supra* note 74.
- 219** *Id.*
- 220** *Id.*
- 221** *Id.*
- 222** Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with Gomezgani Jenda, *supra* note 84; Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with

a representative from a prime partner in Malawi (Aug. 2021).

223 Zoom interview with Tamara Mwenifumbo, *supra* note 19.

224 Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with Rafa Valente Machava, *supra* note 21.

225 Zoom interview with Chance Mwalubunju, *supra* note 21.

226 Zoom interview with Rafa Valente Machava, *supra* note 21.

227 *Id.*

228 *Id.*

229 Zoom interview with Dr. Mildred Mushunje, *supra* note 21.

230 Zoom interview with Dr. Paula Vaz, *supra* note 14.

231 *Id.*; Zoom interview with Dr. Mildred Mushunje, *supra* note 21; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with NRA, *supra* note 21; Zoom interview with Nicholas Ahadjie, *supra* note 21; Zoom interview with Málica de Melo, *supra* note 21; Zoom interview with a representative from an SRH organization in Mozambique (July 2021); Zoom interview with a senior leader at an organization that receives U.S. government funding in sub-Saharan Africa (Aug. 2021); Zoom interview with Donato Gulino, *supra* note 21; Zoom interview with Marla Smith, *supra* note 21; Zoom interview with ADPP, *supra* note 21; Zoom interview with Rafa Valente Machava, *supra* note 21.

232 Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with PZAT, *supra* note 20; Zoom interview with Nyasha Mantosi, *supra* note 20; Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with Edinah Masiyiwa, *supra* note 84; Zoom interview with Rouzeh Eghtessadi, *supra* note 84.

233 Zoom interview with Nyasha Mantosi, *supra* note 20; Zoom interview with PZAT, *supra* note 20.

234 Zoom interview with Carolyn Boyce, *supra* note 13.

235 Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with SAT Malawi, *supra* note 21.

236 Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with Auxilia Muchedzi, *supra* note 180; Zoom interview with Marla Smith, *supra* note 21; Zoom interview with Donato Gulino, *supra* note 21.

237 Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with Auxilia Muchedzi, *supra* note 180; Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021).

238 Zoom interview with Carolyn Boyce, *supra* note 13.

239 *Id.*

240 *Id.*

241 Zoom interview with Gomezgani Jenda, *supra* note 84.

242 Zoom interview with Karl Hofmann and Andrea Fearneyhough, *supra* note 18. See also *Where We Work*, PSI, <https://www.psi.org/where-we-work/> (last visited Mar. 7, 2022).

243 Zoom interview with Karl Hofmann and Andrea Fearneyhough, *supra* note 18.

244 Zoom interview with Donato Gulino, *supra* note 21.

245 *Id.*

246 Zoom interview with an anonymous PSI country office staffer (July 2021).

247 Zoom interview with a senior leader at an organization that receives U.S. government funding in sub-Saharan Africa (Aug. 2021).

248 *Id.*

249 *Id.*

- 250** *Id.*
- 251** *Id.*
- 252** *Id.*
- 253** Zoom interview with CHAM, *supra* note 12; Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with Gomezgani Jenda, *supra* note 84; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with NRA, *supra* note 21; Zoom interview with Zinenani Majawa, Executive Director, Female Sex Workers Association (FSWA) (July 2021) [hereinafter Zoom interview with Zinenani Majawa].
- 254** Zoom interview with Nicholas Ahadjie, *supra* note 21; Zoom interview with Málica de Melo, *supra* note 21; Zoom interview with a representative from an SRH organization in Mozambique (July 2021); Zoom interview with Donato Gulino, *supra* note 21; Zoom interview with Dr. Paula Vaz, *supra* note 14; Zoom interview with ADPP, *supra* note 21; Zoom interview with Rafa Valente Machava, *supra* note 21; Zoom interview with Riaz Mobaracaly, *supra* note 16.
- 255** Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with PZAT, *supra* note 20; Zoom interview with Tamburai Muchinguri, *supra* note 15.
- 256** Zoom interview with CHAM, *supra* note 12.
- 257** *Id.*
- 258** Zoom interview with Executive Director of Sub-prime A (July 2021); Zoom interview with Executive Director of Sub-prime B (July 2021).
- 259** Zoom interview with Executive Director of Sub-prime B (July 2021).
- 260** Zoom interview with a representative from a prime partner in Malawi (July 2021).
- 261** Zoom interview with Donato Gulino, *supra* note 21; Zoom interview with ADPP, *supra* note 21.
- 262** Zoom interview with ADPP, *supra* note 21.
- 263** *Id.*
- 264** *Id.*
- 265** Zoom interview with PZAT, *supra* note 20.
- 266** *Id.*
- 267** *Id.*
- 268** *Id.*
- 269** Zoom interview with Carolyn Boyce, *supra* note 13.
- 270** *Id.*
- 271** “Rede DSR,” or the Rede dos Direitos Sexuais e Reprodutivos (Sexual and Reproductive Rights Network, or the “Network”), is a coalition space in Mozambique for CSOs working on SRHR issues. REDE DE DEFESA DOS DIREITOS SEXUAIS E REPRODUTIVOS, <https://www.wlsa.org.mz/criada-rede-de-defesa-dos-direitos-sexuais-e-reprodutivos/> (last visited April 12, 2022).
- 272** *Id.*
- 273** Zoom interview with Rafa Valente Machava, *supra* note 21.
- 274** *Id.*; Zoom interview with a representative from an SRH organization in Mozambique (July 2021).
- 275** Zoom interview with a representative from an SRH organization in Mozambique (July 2021).
- 276** *Id.*
- 277** Zoom interview with Donato Gulino, *supra* note 21.
- 278** Zoom interview with Santos Simione, *supra* note 84.
- 279** *Id.*
- 280** *Id.*
- 281** The PEPFAR Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program supports HIV and AIDS prevention, care, and treatment services for adolescent girls and young women. PEPFAR announced the flagship DREAMS public-private partnership on World AIDS Day 2014 with private sector partners: the Bill & Melinda Gates Foundation, Girl Effect, Gilead Sciences, Johnson & Johnson, and ViiV Healthcare. For more information, see *DREAMS Partnership*, U.S. DEPARTMENT OF STATE, <https://www.state.gov/pepfar-dreams-partnership/> (last visited March 1, 2022).
- 282** Termination of Pregnancy Act, Acts 29/1977, 8/2001 (s. 27), 22/2001 (s. 4), 23/2004 (s. 282), (1977) (Zimbabwe), sec. 4(c) [hereinafter Termination of Pregnancy Act (Zimbabwe)].
- 283** Zoom interview with Tamburai Muchinguri, *supra* note 15.
- 284** *Id.*

- 285** *Id.*
- 286** Zoom interview with Gertrude Shumba, *supra* note 74.
- 287** *Id.*
- 288** *Id.*; Zoom interview with Tamburai Muchinguri, *supra* note 15.
- 289** Zoom interview with Virginia Baresch, *supra* note 11.
- 290** *Id.*
- 291** Zoom interview with an anonymous U.S. government employee (Oct. 2021).
- 292** E-mails between IFPC and CDC staff (Mar. 15-18, 2021) (on file with author) [hereinafter E-mails between IFPC and CDC staff].
- 293** *Id.*
- 294** Zoom interview with an anonymous U.S. government employee (Oct. 2021).
- 295** E-mails between IFPC and CDC staff, *supra* note 292.
- 296** *Id.*
- 297** Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Madam Emma Kaliya, Director, *supra* note 64.
- 298** Zoom interview with Málica de Melo, *supra* note 21; Zoom interview with a representative from an SRH organization in Mozambique (July 2021); Zoom interview with Helena Chiquele, *supra* note 21; Zoom interview with ADPP, *supra* note 21; Zoom interview with Santos Simione, *supra* note 84; Zoom interview with Rafa Valente Machava, *supra* note 21.
- 299** Zoom interview with MSI Reproductive Choices, *supra* note 48.
- 300** Zoom interview with Edinah Masiyiwa, *supra* note 84; Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with PZAT, *supra* note 20; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with Nyasha Mantosi, *supra* note 20; Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with Dr. Mildred Mushunje, *supra* note 21; Zoom interview with Jimmy Wilford, Executive Director, SAYWHAT, Zimbabwe (July 2021) [hereinafter Zoom interview with Jimmy Wilford].
- 301** Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Madam Emma Kaliya, *supra* note 64.
- 302** Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021).
- 303** Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with Edinah Masiyiwa, *supra* note 84.
- 304** CHANGE, GLOBAL GAG RULE REVOCATION EXPLAINED (2021), <https://srhrforall.org/download/global-gag-rule-revocation-explained/?wpdmdl=2801&refresh=61b84dc080d8d1639468480>.
- 305** Zoom interview with MSI Reproductive Choices, *supra* note 48; see also PAI, <https://pai.org/> (last visited Mar. 10, 2022).
- 306** Zoom interview with MSI Reproductive Choices, *supra* note 48.
- 307** *Id.*
- 308** CHANGE, PRESCRIBING CHAOS IN GLOBAL HEALTH, *supra* note 5, at 47-48.
- 309** Zoom interview with Málica de Melo, *supra* note 21.

- 310** *Id.*
- 311** Zoom interview with ADPP, *supra* note 21.
- 312** Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Jorge Matine, Country Director, Ipas Mozambique (July 2021) [hereinafter Zoom interview with Jorge Matine].
- 313** Zoom interview with Rouzeh Eghtessadi, *supra* note 84.
- 314** Zoom interview with Madam Emma Kaliya, *supra* note 64.
- 315** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021); Vaibhav Mishra et al., *Health Inequalities During COVID-19 and Their Effects on Morbidity and Mortality*, 13 J. HEALTHC. LEADERSH. 19 (2021); U.N. Office of the High Commissioner for Human Rights, COVID-19 and the Rights of Persons with Disabilities: Guidance (Apr. 29, 2020), https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf.
- 316** UNFPA, IMPACT OF COVID-19 ON FAMILY PLANNING: WHAT WE KNOW ONE YEAR INTO THE PANDEMIC 1 (2021), https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf. See generally WHO, SECOND ROUND OF THE NATIONAL PULSE SURVEY ON CONTINUITY OF ESSENTIAL HEALTH SERVICES DURING THE COVID-19 PANDEMIC (2021), <https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS-continuity-survey-2021.1>; KIDS IN NEED OF DEFENSE (KIND), DUAL CRISES: GENDER-BASED VIOLENCE AND INEQUALITY FACING CHILDREN AND WOMEN DURING THE COVID-19 PANDEMIC IN EL SALVADOR, GUATEMALA, AND HONDURAS (2021), https://supportkind.org/wp-content/uploads/2021/12/KIND-GBV-Report_Final.pdf; Salma A.E. Ahmed et al., *Impact of the COVID-19 pandemic on intimate partner violence in Sudan, Malawi and Kenya*, 18 REPROD. HEALTH 1 (2021); Merike Blofield et al., *The Shadow Pandemic: Policy Efforts on Gender-Based Violence during COVID-19 in the Global South*, 6 GIGA FOCUS GLOBAL (2021), <https://www.giga-hamburg.de/en/publications/28568014-shadow-pandemic-policy-efforts-gender-based-violence-during-covid-19-global-south/>.
- 317** Zoom interview with Tamburui Muchinguri, *supra* note 15.
- 318** Zoom interview with Samuel Matsikure, *supra* note 19.
- 319** Zoom interview with Málica de Melo, *supra* note 21.
- 320** *Id.*
- 321** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).
- 322** *Id.*; Zoom interview with an advisor from the CDC (Sept. 2021); Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021); Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.
- 323** Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.
- 324** Memorandum on Protecting Women's Health at Home and Abroad, *supra* note 4, sec. 2(c); Zoom interview with Virginia Baresch, *supra* note 11; Zoom interview with an anonymous U.S. government employee (Oct. 2021); Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7; Written response from U.S. Department of State, OGAC, *supra* note 7; HHS Action Transmittal, *supra* note 76.
- 325** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).
- 326** *Id.*
- 327** *Id.*
- 328** Zoom interview with Gertrude Shumba, *supra* note 74; Zoom interview with PZAT, *supra* note 20; Zoom interview with Auxilia Muchedzi, *supra* note 180; Zoom interview with Lynn Walker, *supra* note 14; Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with CHAM, *supra* note 12; Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with NRA, *supra* note 21; Zoom interview with a senior leader at an organization that receives U.S. government funding in sub-Saharan Africa (Aug. 2021); Zoom interview with Riaz Mobaracaly, *supra* note 16; Zoom interview with Donato Gulino, *supra* note 21.
- 329** Memorandum on Protecting Women's Health at Home and Abroad, *supra* note 4, sec. 2(c)(i). See also HHS Action Transmittal, *supra* note 76; Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.
- 330** Zoom interview with Virginia Baresch, *supra* note 11; Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.
- 331** Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.

- 332** Given the history of Pathfinder Mozambique receiving funds through USAID, the authors assumed the new award is managed by USAID, though Mobaracaly did not confirm the U.S. implementing agency responsible because the award was not yet signed and thus the information was procurement sensitive at the time of the interview. Zoom interview with Riaz Mobaracaly, *supra* note 16.
- 333** HHS Action Transmittal, *supra* note 76.
- 334** *Id.*
- 335** *Id.*
- 336** Zoom interview with an anonymous U.S. government employee (Oct. 2021).
- 337** *Id.*
- 338** Zoom interview with Virginia Baresch, *supra* note 11.
- 339** *Id.*
- 340** Zoom interview with CHAM, *supra* note 12.
- 341** *Id.*
- 342** Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.
- 343** *Id.*
- 344** *Id.*
- 345** Zoom interview with Sarah Lance, *supra* note 65; Zoom interview with Karl Hofmann and Andrea Fearneyhough, *supra* note 18.
- 346** Letter from USAID Mission Agreement Officer to an INGO country office, *supra* note 76.
- 347** *Id.*
- 348** *Id.*
- 349** Zoom interview with Irene Koek, *supra* note 27.
- 350** Zoom interview with Carolyn Boyce, *supra* note 13.
- 351** Zoom interview with Karl Hofmann and Andrea Fearneyhough, *supra* note 18.
- 352** Zoom interview with a representative from an SRH organization in Mozambique (July 2021).
- 353** *Id.*
- 354** Memorandum on Protecting Women's Health at Home and Abroad, *supra* note 4, sec. 2(c)(iii).
- 355** HHS Action Transmittal, *supra* note 76.
- 356** Zoom interview with an advisor from the CDC (Sept. 2021).
- 357** See GRANTS.GOV, <https://www.grants.gov/> (last visited Mar. 13, 2022).
- 358** Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).
- 359** Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with Caleb Thole, *supra* note 21.
- 360** Zoom interview with Madam Emma Kaliya, *supra* note 64.
- 361** To assist organizations in working with USAID, the Agency launched [WorkwithUSAID.org](https://www.usaid.gov/work-with-usaid) on Nov. 4, 2021, which was after the time of the interviews. Press Release, USAID, USAID Launches WorkwithUSAID.org (Nov. 4, 2021), <https://www.usaid.gov/news-information/press-releases/nov-4-2021-usaid-launches-work-with-usaid-org>. See also Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with Nyasha Mantosi, *supra* note 20; Zoom interview with Rouzeh Eghtessadi, *supra* note 84.
- 362** Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with Nyasha Mantosi, *supra* note 20; Zoom interview with Dr. Mildred Mushunje, *supra* note 21; Zoom interview with Jimmy Wilford, *supra* note 300.
- 363** Written response from U.S. Department of State, OGAC, *supra* note 7; PEPFAR Fiscal Year 2021 Site Improvement Through Monitoring System Guidance Materials, U.S. DEPARTMENT OF STATE, <https://www.state.gov/pepfar-fy-21-sims-guidance-materials/> (last visited Mar.13, 2022).
- 364** PEPFAR, SITE IMPROVEMENT THROUGH MONITORING SYSTEM (SIMS) FY21 ABOVE-SITE ASSESSMENT TOOL 1 (2020), https://www.state.gov/wp-content/uploads/2020/10/FY21-SIMS-4.1-Above-Site-Tool_cleared.pdf.
- 365** *Id.* at 76-78.
- 366** Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Caleb Thole, *supra* note 21.
- 367** See generally PEPFAR, FY21 SITE IMPROVEMENT THROUGH

MONITORING SYSTEM (SIMS) IMPLEMENTATION GUIDE (2020), https://www.state.gov/wp-content/uploads/2020/10/FY21-SIMS-4.1-Implementation-Guide_15Aug2020.pdf.

368 Zoom interview with Sandra Mapemba, *supra* note 12.

369 Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).

370 *Id.*

371 PAI, ACCESS DENIED: ETHIOPIA, PRELIMINARY IMPACTS OF TRUMP'S EXPANDED GLOBAL GAG RULE 9 (2018), <https://res.cloudinary.com/dhu2eru5b/images/v1630082021/websites/pai2020/Access-Denied-Ethiopia-JULY-2018/Access-Denied-Ethiopia-JULY-2018.pdf>; CHANGE, PRESCRIBING CHAOS IN GLOBAL HEALTH, *supra* note 5, at 33–35.

372 *Protecting Life in Global Health Assistance and Statutory Abortion Restrictions – 2020*, GLOBAL HEALTH ELEARNING CENTER, <https://www.globalhealthlearning.org/course/protecting-life-global-health-assistance-and-statutory> (last updated Jan. 6, 2020) [hereinafter *PLGHA and Statutory Abortion Restrictions* (2020)].

373 Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.

374 *PLGHA and Statutory Abortion Restrictions* (2020), *supra* note 372.

375 *U.S. Family Planning and Abortion Requirements*, GLOBAL HEALTH ELEARNING CENTER, <https://www.globalhealthlearning.org/course/us-family-planning-and-abortion-requirements> (last updated Jan. 1, 2022).

376 Letter from Alma L. Golden, M.D., Assistant Administrator, Bureau for Global Health, USAID, to Implementing Partners, at 2 (Oct. 30, 2020), <https://www.usaid.gov/sites/default/files/documents/WO-Letter-Implementing-Partners-PLGHA-WRS.pdf>.

377 Zoom interview with Irene Koek, *supra* note 27.

378 CHANGE, A POWERFUL FORCE, *supra* note 5, at 50.

379 Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with Gomezgani Jenda, *supra* note 84; Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with CHAM, *supra* note 12; Zoom interview with a representative

from a prime partner in Malawi (Aug. 2021); Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with a representative from an SRH organization in Mozambique (July 2021); Zoom interview with Riaz Mobaracaly, *supra* note 16; Zoom interview with Donato Gulino, *supra* note 21; Zoom interview with a senior leader at an organization that receives U.S. government funding in sub-Saharan Africa (Aug. 2021); Zoom interview with Gertrude Shumba, *supra* note 74; Zoom interview with PZAT, *supra* note 20; Zoom interview with Auxilia Muchedzi, *supra* note 180.

380 Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with Gomezgani Jenda, *supra* note 84; Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with CHAM, *supra* note 12; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with Tamara Mwenifumbo, *supra* note 19.

381 Zoom interview with a representative from a sub-prime partner in Malawi (July 2021).

382 Zoom interview with CHAM, *supra* note 12.

383 Zoom interview with a senior leader at an organization that receives U.S. government funding in sub-Saharan Africa (Aug. 2021).

384 Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with CHAM, *supra* note 12; Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021).

385 Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Ann Phoya, *supra* note 84.

386 Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with a representative from a prime partner in Malawi (Aug. 2021).

387 Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with CHAM, *supra* note 12; Zoom interview with Tamara Mwenifumbo, *supra* note 19.

388 Zoom interview with Sarah Lance, *supra* note 65.

- 389** Zoom interview with Riaz Mobaracaly, *supra* note 16.
- 390** Zoom interview with Sarah Lance, *supra* note 65.
- 391** *Id.*
- 392** *Id.*
- 393** Zoom interview with Riaz Mobaracaly, *supra* note 16.
- 394** Zoom interview with Sarah Lance, *supra* note 65.
- 395** *Id.*
- 396** *Id.*
- 397** *Id.*
- 398** *Id.*
- 399** *Id.*
- 400** Zoom interview with Riaz Mobaracaly, *supra* note 16.
- 401** *Id.*
- 402** Zoom interview with Carolyn Boyce, *supra* note 13.
- 403** *Id.*
- 404** *Id.*
- 405** *Id.*
- 406** Zoom interview with Gomezgani Jenda, *supra* note 84.
- 407** Zoom interview with Marla Smith, *supra* note 21.
- 408** Zoom interview with Karl Hofmann and Andrea Fearneyhough, *supra* note 18.
- 409** Zoom interview with an anonymous PSI country office staffer (July 2021).
- 410** *Id.*
- 411** Memorandum on Protecting Women’s Health at Home and Abroad, *supra* note 4.
- 412** Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with CHAM, *supra* note 12; Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with Zinenani Majawa, *supra* note 253; Zoom interview with NRA, *supra* note 21.
- 413** Zoom interview with Dr. Mildred Mushunje, *supra* note 21; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with Edinah Masiyiwa, *supra* note 84; Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Jimmy Wilford, *supra* note 300; Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with PZAT, *supra* note 20; Zoom interview with Tamburai Muchinguri, *supra* note 15; Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with Lynn Walker, *supra* note 14; Zoom interview with Nyasha Mantosi, *supra* note 20.
- 414** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021); Zoom interview with Karl Hofmann and Andrea Fearneyhough, *supra* note 18; Zoom interview with Dr. Stephanie Psaki, *supra* note 48.
- 415** Zoom interview with NRA, *supra* note 21; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021).
- 416** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).
- 417** Zoom interview with Dr. Stephanie Psaki, *supra* note 48.
- 418** Zoom interview with Karl Hofmann and Andrea Fearneyhough, *supra* note 18.
- 419** Zoom interview with Dr. Mildred Mushunje, *supra* note 21; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with Edinah Masiyiwa, *supra* note 84; Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Jimmy Wilford, *supra* note 300; Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with PZAT, *supra* note 20; Zoom interview with Tamburai Muchinguri, *supra* note 15; Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with Lynn Walker, *supra* note 14; Zoom interview with Nyasha Mantosi, *supra* note 20; Zoom interview with Helena Chiquele, *supra* note 21; Zoom interview with a representative from an SRH organization in Mozambique (July 2021).

- 420** Zoom interview with a public health professional in Zimbabwe (July 2021).
- 421** See generally CRS, ABORTION AND FAMILY PLANNING-RELATED PROVISIONS IN U.S. FOREIGN ASSISTANCE LAW AND POLICY (2020), https://www.everycrsreport.com/files/2020-08-21_R41360_3a2dc5ca6cd-5891c40566468a0b691ecb2b22a72.pdf.
- 422** Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Gomezgani Jenda, *supra* note 84.
- 423** Zoom interview with a representative from a prime partner in Malawi (July 2021).
- 424** Zoom interview with Gomezgani Jenda, *supra* note 84.
- 425** Zoom interview with Smita Baruah, expert familiar with U.S. global health assistance (Sept. 2021).
- 426** CHANGE, PRESCRIBING CHAOS IN GLOBAL HEALTH, *supra* note 5, at 36–38; Ayanbekongshie Ushie et al., *Foreign assistance or attack?*, *supra* note 26, at 29; IWHC, CRISIS IN CARE, *supra* note 26, at 26; Mavodza et al., *The impacts of the global gag rule on global health: a scoping review*, *supra* note 5, at 15; GLOBAL JUSTICE CENTER & CHANGE, CENSORSHIP EXPORTED, *supra* note 26, at 4–5.
- 427** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).
- 428** Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with CHAM, *supra* note 12; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with NRA, *supra* note 21; Zoom interview with Edinah Masiyiwa, *supra* note 84; Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Jimmy Wilford, *supra* note 300; Zoom interview with Nyasha Mantosi, *supra* note 20; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with Dr. Mildred Mushunje, *supra* note 21; Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with Auxilia Muchedzi, *supra* note 180; Zoom interview with PZAT, *supra* note 20; Zoom interview with Gertrude Shumba, *supra* note 74; Zoom interview with Tanya Nyakatawa, *supra* note 83.
- 429** Zoom interview with Jimmy Wilford, *supra* note 300; Zoom interview with Irene Koek, *supra* note 27; Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with CHAM, *supra* note 12; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021).
- 430** Zoom interview with Talent Jumo, *supra* note 21.
- 431** *Id.*
- 432** *Id.*
- 433** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).
- 434** *Id.*
- 435** Zoom interview with Jorge Matine, *supra* note 312.
- 436** Zoom interview with a technical advisor with PEPFAR experience at the U.S. mission level (Oct. 2021).
- 437** Zoom interview with Sandra Mapemba, *supra* note 12.
- 438** Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021).
- 439** Zoom interview with Carolyn Boyce, *supra* note 13.
- 440** Zoom interview with an anonymous U.S. government employee (Oct. 2021).
- 441** Zoom interview with MSI Reproductive Choices, *supra* note 48.
- 442** *Id.*
- 443** *Id.*
- 444** Zoom interview with Dr. Mildred Mushunje, *supra* note 21.
- 445** Sida is Sweden’s government agency for development cooperation, which works with organizations, government agencies, and the private

sector to invest in sustainable development for all people. For more detail, see THE SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY, <https://www.sida.se/en> (last visited Mar. 13, 2022). In its guidance on PLGHA, Sida underlines that partners that choose to comply with the GGR are responsible for “ensur[ing] that the Sida-funded program can continue.” The guidance reserves Sida’s right to phase out programming or terminate the agreement completely should partner organizations fail to fulfill their SRHR obligations, which includes ensuring the provision of safe abortion services. Though not stated explicitly, some partner organizations felt that they were effectively compelled to choose between complying with the GGR and continuing to receive Sida funding. For more information, see CHANGE, *PRESCRIBING CHAOS IN GLOBAL HEALTH*, *supra* note 5, at 60.

- 446** Zoom interview with a representative from an SRH organization in Mozambique (July 2021).
- 447** *Id.*
- 448** *Id.*
- 449** Zoom interview with Nyasha Mantosi, *supra* note 20.
- 450** *Id.*
- 451** *Id.*
- 452** Zoom interview with Rouzeh Eghtessadi, *supra* note 84.
- 453** *Id.*
- 454** *Id.*
- 455** Written response from USAID/Bureau for Global Health PLGHA Compliance Team, *supra* note 7.
- 456** Zoom interview with Irene Koek, *supra* note 27.
- 457** Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with Sandra Mapemba, *supra* note 12; Zoom interview with Chance Mwalubunju, *supra* note 21; Zoom interview with CHAM, *supra* note 12; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with a senior leader at an organization that receives U.S. government funding in sub-Saharan Africa (Aug. 2021); Zoom interview with Donato Gulino, *supra* note 21; Zoom interview with Marla Smith, *supra* note 21; Zoom interview with Memory Kadau, *supra* note 15.
- 458** Zoom interview with a representative from a sub-prime partner in Malawi (July 2021).
- 459** Zoom interview with a representative from a prime partner in Malawi (July 2021).
- 460** Zoom interview with Ann Phoya, *supra* note 84; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with NRA, *supra* note 21.
- 461** Zoom interview with Ann Phoya, *supra* note 84.
- 462** Zoom interview with NRA, *supra* note 21.
- 463** Zoom interview with Carolyn Boyce, *supra* note 13.
- 464** *Id.*
- 465** Zoom interview with a high-level representative from Save the Children US (Sept. 2021).
- 466** Zoom interview with Marla Smith, *supra* note 21.
- 467** Zoom interview with an anonymous PSI country office staffer (July 2021).
- 468** Zoom interview with a prime partner that declined to certify PLGHA (Sept. 2021).
- 469** *Id.*
- 470** Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021).
- 471** *Id.*
- 472** Zoom interview with a U.S. government staffer with expertise in global health (Sept. 2021).
- 473** *Id.*
- 474** *Id.*
- 475** Zoom interview with Helena Chiquele, *supra* note 21.
- 476** *Id.*
- 477** *Id.*
- 478** *Id.*
- 479** Zoom interview with Jorge Matine, *supra* note 312.
- 480** *Id.*
- 481** Zoom interview with Riaz Mobaracaly, *supra* note 16.

- 482** Zoom interview with ADPP, *supra* note 21.
- 483** Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with a representative from a prime partner in Malawi (Aug. 2021).
- 484** Zoom interview with a representative from a sub-prime partner in Malawi (July 2021).
- 485** Zoom interview with Nicholas Ahadije, *supra* note 21.
- 486** CHANGE, A POWERFUL FORCE, *supra* note 5, at 17-20; see also CHANGE, PRESCRIBING CHAOS IN GLOBAL HEALTH, *supra* note 5, at 17, 21.
- 487** Zoom interview with Dr. Stephanie Psaki, *supra* note 48.
- 488** Zoom interview with Virginia Baresch, *supra* note 11.
- 489** Mozambique, IPAS, <https://www.ipas.org/where-we-work/mozambique/> (last visited Mar. 13, 2022).
- 490** Zoom interview with a representative from an SRH organization in Mozambique (Aug. 2021).
- 491** *Id.*
- 492** Zoom interview with Marla Smith, *supra* note 21.
- 493** *Id.*
- 494** *Id.*
- 495** Termination of Pregnancy Act (Zimbabwe), *supra* note 282, sec. 4(a), 4(c).
- 496** *Id.*, sec. 4(a)-(b).
- 497** Zoom interview with Jimmy Wilford, *supra* note 300; Zoom interview with Gertrude Shumba, *supra* note 74.
- 498** Zoom interview with Memory Kadau, *supra* note 15; Zoom interview with Jimmy Wilford, *supra* note 300.
- 499** The African Union Maputo Protocol (2003) and Maputo Plan of Action (2006) are a regional policy framework for universal access to SRH services. The goal of the Maputo Protocol is to “to ensure that the rights of women are promoted, realised and protected in order to enable them to enjoy fully all their human rights.” For more information, see African Union, Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, at 3, Maputo, Mozambique, July 11, 2003, <https://www.ohchr.org/Documents/Issues/Women/WG/ProtocolontheRightsofWomen.pdf> [hereinafter Maputo Protocol]; Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010, Maputo, Mozambique, Sept. 18-22, 2006, https://www.ippf.org/sites/default/files/maputo_plan_of_action.pdf. See also Zoom interview with Chance Mwalubunju, *supra* note 21; Termination of Pregnancy Bill (2015), art. 3 (Malawi), http://www.smdmalawi.com/media/com_acymailing/upload/termination_of_pregnancy_bill_1.pdf [hereinafter Termination of Pregnancy Bill (Malawi)].
- 500** Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021).
- 501** Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Madam Emma Kaliya, *supra* note 64; CHANGE, A POWERFUL FORCE, *supra* note 5, at 17-20.
- 502** Zoom interview with Caleb Thole, *supra* note 21; Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Madam Emma Kaliya, *supra* note 64; CHANGE, A POWERFUL FORCE, *supra* note 5, at 17-20.
- 503** Zoom interview with SAT Malawi, *supra* note 21; Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021); Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with Brian Ligomeka, *supra* note 13.
- 504** Zoom interview with SAT Malawi, *supra* note 21.
- 505** Zoom interview with anonymous SRHR expert in Malawi (Aug. 2021).
- 506** Zoom interview with Madam Emma Kaliya, *supra* note 64.
- 507** Zoom interview with Brian Ligomeka, *supra* note 13.
- 508** Zoom interview with Sandra Mapemba, *supra* note 12.
- 509** Zoom interview with PZAT, *supra* note 20; Zoom interview with Dr. Mildred Mushunje, *supra* note 21; Zoom interview with Tamburai Muchinguri, *supra* note 15; Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Jorge Matine, *supra* note 312; Zoom interview with Brian Ligomeka, *supra* note 13.
- 510** Zoom interview with Jimmy Wilford, *supra* note 300; Zoom interview with Memory Kadau, *supra* note

15; Zoom interview with Nyasha Mantosi, *supra* note 20; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with PZAT, *supra* note 20; Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Tanya Nyakatawa, *supra* note 83; Zoom interview with Samuel Matsikure, *supra* note 19; Zoom interview with Dr. Mildred Mushunje, *supra* note 21; Zoom interview with Tamburai Muchinguri, *supra* note 15.

511 Zoom interview with Jorge Matine, *supra* note 312.

512 Zoom interview with Memory Kadau, *supra* note 15.

513 Zoom interview with Tamburai Muchinguri, *supra* note 15.

514 Zoom interview with a representative from a prime partner in Malawi (July 2021).

515 Zoom interview with SAT Malawi, *supra* note 21.

516 CHANGE, PRESCRIBING CHAOS IN GLOBAL HEALTH, *supra* note 5, at 37-38; CHANGE, A POWERFUL FORCE, *supra* note 5, at 24-25; PAI, ACCESS DENIED: SENEGAL, PRELIMINARY IMPACTS OF TRUMP'S EXPANDED GLOBAL GAG RULE 6-7 (2018), <https://globalgagrule.org/resource/access-denied-senegal/>; PAI, SO FAR, SO BAD: THE WIDE-RANGING IMPACTS OF THE GLOBAL GAG RULE HAPPENING NOW 1-2 (2018), <https://pai.org/wp-content/uploads/2018/07/So-Far-So-Bad-the-wide-ranging-impacts-of-the-ggr-revised-7-17-18.pdf>; PLANNED PARENTHOOD GLOBAL, ASSESSING THE GLOBAL GAG RULE: HARMS TO HEALTH, COMMUNITIES, AND ADVOCACY 17-21 (2019), https://www.plannedparenthood.org/uploads/filer_public/81/9d/819d9000-5350-4ea3-b699-1f12d59ec67f/181231-ggr-d09.pdf.

517 Zoom interview with a representative from a prime partner in Malawi (Aug. 2021); Zoom interview with Santos Simione, *supra* note 84; Zoom interview with Nyasha Mantosi, *supra* note 20.

518 Zoom interview with Riaz Mobaracaly, *supra* note 16.

519 Zoom interview with a representative from an SRH organization in Mozambique (July 2021).

520 Zoom interview with a representative from a prime partner in Malawi (Aug. 2021).

521 *Id.*

522 Zoom interview with a representative from an SRH organization in Mozambique (July 2021);

Zoom interview with a senior leader at an organization that receives U.S. government funding in sub-Saharan

Africa (Aug. 2021); Zoom interview with Donato Gulino, *supra* note 21; Zoom interview with Marla Smith, *supra* note 21; Zoom interview with Helena Chiquele, *supra* note 21; Zoom interview with Santos Simione, *supra* note 84; Zoom interview with Rafa Valente Machava, *supra* note 21; Zoom interview with Málica de Melo, *supra* note 21.

523 Zoom interview with Ann Phoya, *supra* note 84; see also Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021).

524 Zoom interview with PZAT, *supra* note 20.

525 Zoom interview with Memory Kadau, *supra* note 15.

526 Zoom interview with a representative from an SRH organization in Mozambique (Aug. 2021).

527 Zoom interview with a representative from a prime partner in Malawi (July 2021); Zoom interview with Madam Emma Kaliya, *supra* note 64.

528 Zoom interview with Tamara Mwenifumbo, *supra* note 19.

529 Zoom interview with Irene Koek, *supra* note 27.

530 Zoom interview with Dr. Stephanie Psaki, *supra* note 48.

531 Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Jimmy Wilford, *supra* note 300; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with CHAM, *supra* note 12; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021).

532 Zoom interview with Rouzeh Eghtessadi, *supra* note 84; Zoom interview with Jimmy Wilford, *supra* note 300; Zoom interview with Talent Jumo, *supra* note 21; Zoom interview with a representative from an SRH organization in Malawi (Aug. 2021); Zoom interview with Madam Emma Kaliya, *supra* note 64; Zoom interview with CHAM, *supra* note 12; Zoom interview with a representative from a sub-prime partner in Malawi (July 2021); Zoom interview with Brian Ligomeka, *supra* note 13; Zoom interview with Tamara Mwenifumbo, *supra* note 19; Zoom interview with a representative from a prime partner in Malawi (Aug. 2021).

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