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Policy Implementation Versus Revocation: A Qualitative Exploration of Policy Change Communication between the U.S. Government and Global Health Implementing Partners in Malawi, Mozambique and Zimbabwe

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Policy Implementation Versus Revocation: A Qualitative Exploration of Policy Change Communication between the U.S. Government and Global Health Implementing Partners in Malawi, Mozambique and Zimbabwe

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An abstract of

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

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Abstract

Policy Implementation Versus Revocation: A Qualitative Exploration of Policy Change Communication between the U.S. Government and Global Health Implementing Partners in Malawi, Mozambique and Zimbabwe

By Margaret Switzer

Context: The Global Gag Rule (GGR), also known as the Mexico City Policy (MCP), is a United States-based foreign policy that, when implemented, prohibits foreign nongovernmental organizations (NGOs) that receive certain categories of U.S. foreign assistance funds from providing or advocating for abortion, or counsel on or refer clients for abortion services as a method of family planning. Since 1984, this policy has been repeatedly enacted by Republican presidents and revoked by Democratic presidents. In 2017, former President Trump implemented an expanded version of the policy, renamed Protecting Life in Global Health Assistance (PLGHA). On January 28, 2021, President Biden revoked PLGHA via presidential memorandum.

Objective: To analyze the communication patterns of Trump's PLGHA and Biden's 2021 revocation from the perspectives of NGOs from three countries, and the associated implications for sustainable global health programming.

Methods: This study utilized 41 in-depth interviews with representatives from global health implementing partners in Malawi, Mozambique and Zimbabwe. Participants were recruited via purposive and snowball sampling. Interviews were conducted virtually via Zoom, recorded, and transcribed verbatim. Thematic analysis was conducted using MAXQDA.

Results: The implementation of PLGHA in 2017 was accompanied by more consistent communication from the U.S. government and prime partners, as compared to its revocation in 2021. This lack of comprehensive information and guidance on the proper implementation of the revocation of the GGR placed uncertainty on study participants. Due to uncertainties about what was permissible under current restrictions and fears of the policy being reinstituted by a future U.S. president, global health partners experienced unsteadiness moving forward with their programs and funding decisions in the wake of PLGHA's revocation.

Discussion: The United States, through its reneging of the GGR every 4-8 years, has caused negative impacts on NGOs' abilities to effectively implement global health programs, especially in sexual and reproductive health and rights (SRHR). If this policy remains as is, to be implemented and revoked by Republican and Democratic presidents, then U.S. implementing agencies and global health prime partners are responsible for providing more comprehensive guidance and communication about the policy to NGOs to ensure complete and accurate implementation.

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Table of Contents

Acronym List

CHANGE: Center for Health and Gender Equity
CDC: Centers for Disease Control and Prevention
CSO: Civil Society Organization
GGR: Global Gag Rule
DoD: United States Department of Defense
DREAMS: Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
GBV: Gender-Based Violence
HHS: United States Department of Health and Human Services
HIV/AIDS: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICPD: International Conference on Population and Development
INGO: International Non-Governmental Organization
IPPFWHR: International Planned Parenthood Western Hemisphere Region
PEPFAR: President's Emergency Plan for AIDS Relief
PLGHA: Protecting Life in Global Health Assistance
PMI: President's Malaria Initiative
MCP: Mexico City Policy
NGO: Non-Governmental Organization
SRHR: Sexual and Reproductive Health and Rights
USAID: United States Agency for International Development
WASH: Water, Sanitation and Hygiene
WHO: World Health Organization

Introduction

Introduction and Rationale

The Mexico City Policy (MCP), also known as the Global Gag Rule (GGR), is a United States-based foreign policy that, when en

acted, prohibits foreign nongovernmental organizations (NGOs) that receive certain categories of U.S. foreign assistance funds from using their own non-U.S. funds to provide or advocate for abortion, or counsel on or refer for abortion services as a method of family planning.[1] Abortion is considered a method of family planning when it is "for the purpose of spacing births, including for the physical or mental health of the woman or in cases of fetal abnormalities."[2] Activities prohibited by the GGR include provision of abortion as a method of family planning, counseling and referrals for abortion, conducting public awareness campaigns on the benefits of abortion, and advocating for the liberalization of abortion.[3]

First instituted by President Ronald Reagan in 1984 at the International Conference on Population and Development (ICPD) in Mexico City, the policy has been historically enforced by Republican U.S. presidents and revoked by Democratic U.S. presidents, most recently revoked by President Biden on January 28, 2021.[4] The policy was expanded by Former President

[1] CHANGE, Trump's Global Gag Rule Policy and Research Brief (2020). Retrieved from: https://srhrforall.org/download/trumps-global-gag-rule-policy-and-research-brief/
[2] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257
[3] "Fact Sheet: The Global Gag Rule and the Helms Amendment: Dual Policies, Deadly Impact". Guttmacher Institute. (May 2021). Retrieved from: https://www.guttmacher.org/fact-sheet/ggr-helms-amendment
[4] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

Trump in 2017 and renamed Protecting Life in Global Health Assistance (PLGHA).[5] This expansion broadened the scope of the policy, applying to not just family planning assistance like before, but all U.S. global health assistance; this includes funding for malaria, HIV/AIDS, tuberculosis, nutrition, water, sanitation & hygiene (WASH), non-communicable diseases and Zika virus.[6]

There is a lack of research documenting the process by which this directive is communicated to global health program implementing partners, particularly in low- and middle-income countries that receive large amounts of financial assistance from the U.S. government.[7] The U.S. government is legally responsible for ensuring that prime partners are aware of this policy change. Prime partners are also responsible for ensuring that they communicate policy changes to sub-prime partners and that sub-prime partners understand how to adapt their programming to remain compliant with the policy. While these entities are bound to these responsibilities, it is unknown to what extent these duties are fulfilled, and any potential consequences that result from different levels of fulfillment. There is also a lack of research on how foreign NGOs and global health implementing partners receive communications from either the U.S. government or prime partners, and how these communications affect their operations, programming and service provision. Figure 1 demonstrates the typical chain of communication from the White House and Congress to program implementing partners and communities.

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[5] Trump, Donald J. *Presidential Memorandum Regarding the Mexico City Policy*. Presidential Memoranda. Trump White House, Archives. Retrieved from: https://trumpwhitehouse.archives.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/

[6] "Trump's Global Gag Rule: Policy and Research Brief". *Center for Health and Gender Equity*. (2021 March). Retrieved from: https://srhrforall.org/download/trumps-global-gag-rule-policy-and-research-brief/?wpdmdl=2335&refresh=624e5a5c793d81649302108

[7] "Exporting Confusion: U.S. Foreign Policy as an Obstacle to the Implementation of Ethiopia's Liberalized Abortion Law". Leitner Center for International Law and Justice, Fordham Law School. (May 2010). Retrieved from: http://www.leitnercenter.org/files/Publications/LeitnerCtr_EthiopiaReport_WebVersion.pdf

Figure 1. Policy Change Implementation and Communication Pathway[8]

To address the dearth of literature documenting this process, this research utilizes the testimonies of representatives from organizations in Malawi, Mozambique and Zimbabwe. Each of these countries have been recipients of U.S. global health assistance; Table 1 provides context into the level of assistance each country received in Fiscal Year 2020.[9]

[8] "Policy Change Implementation and Communication Pathway". Wynne, Allison. (2021). Created using https://www.canva.com. Retrieved from: The Global Gag Rule Revoked: A Qualitative Evaluation of Policy Change Implementation and Public Health and Rights Implications in Malawi, Mozambique, and Zimbabwe

[9] "foreignassistance.gov". U.S. Agency for International Development and Department of State. (n.d.) Retrieved from: https://foreignassistance.gov/

Table 1. Global Health Funding Landscape for Malawi, Mozambique and Zimbabwe[10]

Country	**Number of U.S. Global Health Programs**	**U.S. Global Health Funds Allocated in FY20**
Malawi	47	$111,721,844.83
Mozambique	93	$171,075,016.40
Zimbabwe	48	$87,764.295.58

The evidence provided in this research, despite only capturing the perspectives of organizations in Malawi, Mozambique and Zimbabwe, may assist in providing insight into the larger communication process between the U.S. government and its foreign global health partners.

Problem Statement

The Global Gag Rule (GGR) has been well-documented in terms of its health effects, particularly on sexual and reproductive health, especially when the policy is in place. However, there is a dearth of knowledge and awareness regarding the systems of communication that exist to implement and revoke this policy. Furthermore, it is worth investigating whether these communication systems help or hurt the policy's implementation or revocation, as well as any related effects on the health outcomes of those that utilize the services impacted by the policy.

Research Question

What are the differences in communication between the implementation of PLGHA and its revocation in 2021, and how do these differences affect programs, services and health outcomes in Malawi, Mozambique and Zimbabwe?

Purpose Statement

This study seeks to explore and analyze the differences in communication frequencies, styles, and methods between U.S. government entities and prime partners to sub-prime partners working in global health in Malawi, Mozambique and Zimbabwe, specifically regarding the

[10] "foreignassistance.gov". U.S. Agency for International Development and Department of State. (n.d.) Retrieved from: https://foreignassistance.gov/

January 2017 implementation of the "Protecting Life in Global Health Assistance" (PLGHA) policy and its subsequent revocation in January 2021. Any implications for programs, services and health outcomes related to differences in communication will also be examined.

Significance Statement

By conducting an in-depth analysis of policy communications related to the 2017 implementation and 2021 revocation of the GGR, this research will provide insight and context into potential effects of changes in U.S. foreign assistance policy on global health programs and services. This study utilizes qualitative in-depth interviews with key stakeholders in Mozambique, Zimbabwe and Malawi to elicit their perspectives on the nature of communication regarding PLGHA's implementation in 2017, as compared to its revocation in 2021. The findings from this research contribute to the general body of knowledge at the intersection of policy and public health. Findings from this research may have larger implications for the dissemination of U.S. foreign assistance or global health policy. This research could also inform changes or improvements to the global health policy implementation process by the U.S. government, so that U.S. federal officials can improve future communication procedures. This work could also inspire future research into U.S. foreign policies that affect global health assistance partnerships and programs.

Definition of Terms

- *International Non-Governmental Organization:* A transnational organization, not affiliated with any government, that is formed to provide services or advocate for a public policy[11]

[11] "Nongovernmental organization". *Encyclopedia Britannica*. Retrieved from: https://www.britannica.com/topic/nongovernmental-organization

- *Maternal Mortality Rate:* Defined by the World Health Organization (WHO), as "the number of maternal deaths during a given time period per 100,000 live births during the same time period"[12]
- *Non-Governmental Organization:* Typically a mission-driven advocacy or service organizations in the nonprofit sector[13]
- *Post-Abortion Care:* Defined by the Guttmacher Institute as essential elements provided to address a person's health in the wake of an abortion procedure, including treatment for unsafe abortion, mental and emotional health counseling and addressing any complications related to the abortion[14]
- *Presidential Memorandum:* Similar to Executive Orders, presidential memoranda have the force of law if founded on the authority of the President derived from the Constitution or Statute, but unlike Executive Orders, do not need to be published in the Federal Register[15,16]
- *Prime Implementing Partner:* An organization or government entity that receives U.S. government funding directly, and may either implement programs or channel the funding to sub-prime partners in charge of implementing programs[17]

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[12] "Maternal Mortality Ratio (Per 100,000 Live Births) World Health Organization. N.d. Retrieved from: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26

[13] "Nongovernmental Organizations". Harvard Law School. Retrieved from: https://hls.harvard.edu/dept/opia/what-is-public-interest-law/public-service-practice-settings/public-international-law/nongovernmental-organizations-ngos/

[14] Corbett, Maureen R. & Turner, Katherine L. "Essential Elements of Postabortion Care: Origins, Evolutions and Future Directons." *International Perspectives on Sexual and Reproductive Health*, The Guttmacher Institute. (September 2003). Retrieved from: https://www.guttmacher.org/journals/ipsrh/2003/09/essential-elements-postabortion-care-origins-evolution-and-future-directions

[15] "Executive Order, Proclamation, or Executive Memorandum?" Library of Congress. (n.d.) Retrieved from: https://guides.loc.gov/executive-orders/order-proclamation-memorandum

[16] "Presidential Directives: An Introduction". Congressional Research Service." (13 November 2019). Retrieved from: https://sgp.fas.org/crs/natsec/IF11358.pdf

[17] Constancia Mavodza et al., "The impacts of the global gag rule on global health: a scoping review," Global Health Research and Policy 4, no. 26, (2019), https://doi.org/10.1186/s41256-019-0113-3.

- *Standard Provision:* Clause that is inserted as standard into certain types of contracts or agreements[18]
- *Sub-Prime Implementing Partner:* An organization that receives U.S. financial assistance indirectly, by way of the funding passing through a prime partner, and directs program implementation
- *Unsafe Abortion:* According to the WHO, an unsafe abortion is a procedure for terminating an unwanted pregnancy by people lacking the necessary skills, or in an environment lacking minimal medical standards, or both.[19]
- *U.S. Foreign Aid/Assistance:* Aid given by the U.S. government to support global peace, security, and development efforts, and to provide humanitarian relief during times of crisis.[20]
- *U.S. Global Health Assistance:* U.S. funding for international health programs, such as those for HIV/AIDS, maternal and child health, malaria, other infectious diseases, global health security, and voluntary family planning and reproductive health.[21]

Literature Review

Background Information on GGR/MCP/PLGHA:

The Mexico City Policy, also known as the Global Gag Rule (GGR), or more recently, the Protecting Life in Global Health Assistance (PLGHA) policy, was first instituted in 1984 by

[18] "standard clause". *Collins Dictionary*. (n.d.) Retrieved from: https://www.collinsdictionary.com/dictionary/english/standard-clause#:~:text=(%CB%88st%C3%A6nd%C9%99d%20kl%C9%94%CB%90z),Collins%20English%20Dictionary.
[19] "Abortion". World Health Organization. (25 November 2021). Retrieved from: https://www.who.int/news-room/fact-sheets/detail/abortion
[20] "U.S. Foreign Assistance 101". Interaction. (n.d.) Retrieved from: https://www.interaction.org/aid-delivers/foreign-assistance-overview/u-s-foreign-assistance-101/#:~:text=Foreign%20assistance%20is%20aid%20given,imperative%20for%20the%20United%20States.
[21] *Protecting Life in Global Health Assistance FAQ.* United States Department of State. September 2019. Retrieved from: https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf

Ronald Reagan.[22] It was named for Mexico City, as the city was the location at the time of the United Nations International Conference on Population and Development (ICPD) in August 1984. On a basic level, the policy required foreign non-governmental organizations (NGOs) receiving U.S. family planning funds to certify that they would not perform or actively promote abortion as a method of family planning with either their U.S. or non-U.S. funds.[23] Since its initiation, the policy has been enacted by Republican presidents, such as George W. Bush and Donald Trump and revoked by Democratic presidents, such as Bill Clinton and Barack Obama.[24] Former President Donald Trump expanded the policy and titled it "Protecting Life in Global Health Assistance" (PLGHA) and implemented a wider version of the policy that not only affected funding related to family planning, but global health assistance funding in a wide range of topics, including malaria, HIV/AIDS, water, sanitation & hygiene (WASH), tuberculosis, maternal & child health and nutrition.[25] The policy was revoked under current President Joe Biden on January 28, 2021, congruent with his partisan standing as a member of the Democratic Party.[26] The table below provides an explanation for different iterations of the policy:

[22] *The Mexico City Policy: An Explainer*. Global Health Policy, Kaiser Family Foundation. 28 January 2021. Retrieved from: https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer
[23] "Policy Statement of the United States of America at the United Nations". International Conference on Population (Second Session). (August 1984). Retrieved from: https://www.uib.no/sites/w3.uib.no/files/attachments/mexico_city_policy_1984.pdf
[24] *The Mexico City Policy: A Short History*. Population Research Institute. 1 January 2018. Retrieved from: https://www.pop.org/the-mexico-city-policy-a-short-history/
[25] "Trump's Global Gag Rule: Policy and Research Brief". *Center for Health and Gender Equity*. (2021 March). Retrieved from: https://srhrforall.org/download/trumps-global-gag-rule-policy-and-research-brief/?wpdmdl=2335&refresh=624e5a5c793d81649302108
[26] "Memorandum on Protecting Women's Health at Home and Abroad". Joseph R. Biden Jr. *The White House*. (28 January 2021). Retrieved from: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/memorandum-on-protecting-womens-health-at-home-and-abroad/

Table 2. Iterations of the Global Gag Rule[27]

Policy Iteration	Key Points
Mexico City Policy (1984-1989)	Initial version issued by President Reagan at the 1984 ICPD in Mexico City; applied only to international family planning funds through USAID
Mexico City Policy (1989-1993)	Enforced under President George H.W. Bush, same stipulations as under President Reagan
Mexico City Policy (2001-2009)	Enforced under President George W. Bush; Standard Provision added to enforce in all "new grants and cooperative agreements, as well as grants and cooperative agreements that are amended to add new funding", exemption for post-abortion care added, and expanded to family planning funds through State Department
Protecting Life in Global Health Assistance (2017-2021)	Introduced by President Trump in 2017; expanded from just family planning funds to all global health assistance

The policy, incredibly controversial between the Democratic and Republican parties, was re-branded as the "Global Gag Rule" (GGR) by opponents.[28] This policy has had drastic impacts on global health funding, and subsequently, health outcomes in a variety of settings that receive global health assistance, usually low- and middle-income countries.[29] According to an array of global health partners, researchers and program implementers, the GGR, when in effect, has had detrimental effects on health outcomes, especially in the realm of sexual and reproductive health and rights (SRHR).[30] One common effect of the GGR is on international non-governmental organizations (INGOs) themselves because of financial cuts to their operating budgets, which

[27] CHANGE, "Prescribing Chaos in Global Health: The Global Gag Rule from 1984 to 2018," June 2018, https://srhrforall.org/prescribing-chaos-in-global-health-the-global-gag-rule-from_1984-2018/.
[28] *The Mexico City Policy: An Explainer*. Global Health Policy, Kaiser Family Foundation. 28 January 2021. Retrieved from: https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/
[29] CHANGE, "Prescribing Chaos in Global Health: The Global Gag Rule from 1984 to 2018," June 2018, https://srhrforall.org/prescribing-chaos-in-global-health-the-global-gag-rule-from_1984-2018/.
[30] "The Global Gag Rule and Fights Over Funding UNFPA: The Issues That Won't Go Away". Guttmacher Policy Review. *The Guttmacher Institute*. 18 (2). (3 June 2015). Retrieved from: https://www.guttmacher.org/gpr/2015/06/global-gag-rule-and-fights-over-funding-unfpa-issues-wont-go-away

results in the closure of essential programs and services.[31,32] According to Ann M. Stars in *The Lancet*, "These health providers were forced to reduce staff and services, or even shut clinics. As a result, many thousands of women no longer had access to family planning and reproductive health services from these clinics—sometimes the only provider of such services in the local community."[33] The health impacts of the GGR have been extensively documented, including a study in Ghana, where contraception use decreased up to 16% in rural areas and 10% in urban areas, as well as an 10% increase in pregnancy in rural areas during periods of time when the GGR was repeatedly implemented under Republican Presidents from 1984 until 2008.[34] In this study, researcher Kelly M. Jones from the International Food Policy Institute demonstrated the association between the GGR's implementation and decreased funding for family planning, which resulted in decreased access to modern contraceptive mechanisms supplied by the U.S. government, such as condoms, pills and injections.[35] Another example comes from Lesotho, where USAID was forced to end condom shipments to the Lesotho Planned Parenthood Association under the enforcement of the GGR by Former President George W. Bush.[36] At the time, the Lesotho Planned Parenthood Association was the only conduit available to receive

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[31] Starrs, Ann M. *The Trump Global Gag Rule: An Attack on US Family Planning and Global Health Aid*. The Lancet. 4 February 2017. Retrieved from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30270-2/fulltext

[32] CHANGE, "Prescribing Chaos in Global Health: The Global Gag Rule from 1984 to 2018," June 2018, https://srhrforall.org/prescribing-chaos-in-global-health-the-global-gag-rule-from_1984-2018/.

[33] Starrs, Ann M. *The Trump Global Gag Rule: An Attack on US Family Planning and Global Health Aid*. The Lancet. 4 February 2017. Retrieved from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30270-2/fulltext

[34] Jones, Kelly M. "Contraceptive Supply and Fertility Outcomes: Evidence from Ghana." *Economic Development and Cultural Change*. 64 (1). (October 2015). Retrieved from: https://www-journals-uchicago-edu.proxy.library.emory.edu/doi/epdf/10.1086/682981

[35] Jones, Kelly M. "Contraceptive Supply and Fertility Outcomes: Evidence from Ghana." *Economic Development and Cultural Change*. 64 (1). (October 2015). Retrieved from: https://www-journals-uchicago-edu.proxy.library.emory.edu/doi/epdf/10.1086/682981

[36] "The Global Gag Rule and Fights Over Funding UNFPA: The Issues That Won't Go Away". Guttmacher Policy Review. *The Guttmacher Institute*. 18 (2). (3 June 2015). Retrieved from: https://www.guttmacher.org/gpr/2015/06/global-gag-rule-and-fights-over-funding-unfpa-issues-wont-go-away

condoms from USAID, thus, the GGR ended all condom shipments to a country where one in four women were infected with HIV.[37]

Explanation of International Global Health Partners

Former President Trump's PLGHA included funding and programmatic impacts on organizations that receive funding as foreign NGOs (either prime or sub-prime recipients) and foreign sub-recipient partners of U.S.-based NGOs.[38] The U.S. government, most often by way of the U.S. Agency for International Development (USAID), invests its foreign assistance funding into multilateral institutions, often international non-governmental organizations (INGOs), civil society entities, or national ministries of health.[39] These entities are often referred to as "prime implementing partners" or "prime partners," as they are responsible for the management and, when applicable, delegation of the U.S. funding awards for program implementation, service provision or technical assistance.[40] Sometimes, these prime partners are themselves responsible for program implementation and engagement with the communities they serve.[41] The Center for Health and Gender Equity (CHANGE) report titled: *Prescribing Chaos in Global Health: The Global Gag Rule from 1984-2018* articulates the difference between prime and sub-prime partners as follows: "The NGO that certifies the funding agreement, the "prime

[37] "The Global Gag Rule and Fights Over Funding UNFPA: The Issues That Won't Go Away". Guttmacher Policy Review. *The Guttmacher Institute*. 18 (2). (3 June 2015). Retrieved from: https://www.guttmacher.org/gpr/2015/06/global-gag-rule-and-fights-over-funding-unfpa-issues-wont-go-away

[38] *Protecting Life in Global Health Assistance FAQ.* United States Department of State. September 2019. Retrieved from: https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf

[39] "Overview: Multilateral Partnerships". U.S. Agency for International Development. (n.d.) Retrieved from: https://www.usaid.gov/global-health/health-areas/hiv-and-aids/technical-areas/international-cooperation-working-global-fund

[40] "Overview: Multilateral Partnerships". U.S. Agency for International Development. (n.d.) Retrieved from: https://www.usaid.gov/global-health/health-areas/hiv-and-aids/technical-areas/international-cooperation-working-global-fund

[41] "Overview: Multilateral Partnerships". U.S. Agency for International Development. (n.d.) Retrieved from: https://www.usaid.gov/global-health/health-areas/hiv-and-aids/technical-areas/international-cooperation-working-global-fund

partner," has the direct fiscal relationship with the U.S. government."[42] Furthermore, a sub-prime, sub-grantee or sub-recipient partner could be a different NGO (either foreign or U.S.-based) that often have no direct contact with the U.S. government directly and rely on the prime partner for communication, as well as monitoring and compliance of U.S. policies, such as PLGHA.[43]

However, many primes partner with sub-prime implementing partners, often smaller non-governmental organizations (NGOs) and funnel funding to sub-primes for program implementation or service provision.[44] Prime partners have legal responsibility to sub-primes to communicate any major global health policy changes instituted by the United States. There is a lack of knowledge or understanding regarding the monitoring of these mandatory communications between prime and sub-prime partners. Status as a prime or sub-prime is not mutually exclusive, entities can hold both prime and sub-prime status at the same time, occupying the status in different projects.[45] Table 3 provides the definitions of commonly used terms in U.S. global health assistance, in terms of organizations' responsibilities for policy communication.

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[42] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[43] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[44] "Overview: Multilateral Partnerships". U.S. Agency for International Development. (n.d.) Retrieved from: https://www.usaid.gov/global-health/health-areas/hiv-and-aids/technical-areas/international-cooperation-working-global-fund

[45] Constancia Mavodza et al., "The impacts of the global gag rule on global health: a scoping review," *Global Health Research and Policy* 4, no. 26, (2019), https://doi.org/10.1186/s41256-019-0113-3.

Table 3. Definitions of commonly used terminology in U.S. global health assistance[46][47]

Term	Definition
Implementing agency	A division of the U.S. government through which U.S. foreign assistance is channeled; examples include the United States Agency for International Development (USAID), Centers for Disease Control and Prevention (CDC), Department of State, Department of Health and Human Services, and Department of Defense
Implementing partner	An organization that receives U.S. foreign assistance through a U.S. implementing agency (see above); these are often either prime or sub-prime partners (see below)
Prime partner	An organization that receives U.S. funding directly from the U.S. government. The U.S. agency that funds the prime partner has the responsibility of communicating relevant information, including U.S. policy changes, to said prime.
Sub-prime partner	An organization that receives U.S. funding indirectly from the U.S. government, through a prime partner; also, sometimes referred to as a "sub-recipient" or "sub-grantee." Prime partners have the responsibility of communicating relevant information, including U.S. policy changes, to their sub-primes.
Grant	Financial assistance from the U.S. government to a prime or sub-prime with minimal restrictions
Cooperative agreement	Financial assistance from the U.S. government to a prime or sub-prime that involves more involvement from U.S. implementing agency staff

Formal partnerships and projects between U.S. agencies (usually USAID) and its foreign partners involve various levels of documentation, including what are called "agreement modifications." These are legal processes that revise the terms and conditions of a financial award.[48] Agreement modifications can include the addition, removal, or revision of standard

[47] Constancia Mavodza et al., "The impacts of the global gag rule on global health: a scoping review," *Global Health Research and Policy* 4, no. 26, (2019), https://doi.org/10.1186/s41256-019-0113-3.
[48] "Frequently Asked Questions". United States Agency for International Development. (n.d.). Retrieved from: https://www.workwithusaid.org/faq/search?category=acquisition-and-assistance&themes=award-mechanisms&questions=what-are-the-characteristics-of-cooperative-agreements&go=1

provisions, as well as the addition of funding, changes to key personnel, or changes to the total estimated cost of an award.[49]

Implementation of PLGHA by former President Trump:

Former President Trump, in a presidential memorandum titled *Regarding the Mexico City Polic*y, expanded the Global Gag Rule (GGR) on January 23, 2017 to apply to all U.S. global health assistance and renamed the policy "Protecting Life in Global Health Assistance" (PLGHA).[50] In the first paragraph, the policy previously implemented by President Bush was reinstated. In the second paragraph of the memorandum, former President Trump directed the Secretary of State, in coordination with the Secretary of Health and Human Services (HHS), to "implement a plan to extend the requirements of the reinstated Memorandum to global health assistance furnished by all departments or agencies."[51] This expansion meant PLGHA would not only apply to funding designated to family planning, but to funding allocated to other global health topics, such as WASH, nutrition, malaria, tuberculosis, HIV/AIDS and maternal & child health. This expansion affected approximately $8-10 billion of U.S. funds annually, at least 15 times the amount of funding impacted by previous iterations of the policy.[52]

[49] "Frequently Asked Questions". United States Agency for International Development. (n.d.). Retrieved from: https://www.workwithusaid.org/faq/search?category=acquisition-and-assistance&themes=award-mechanisms&questions=what-are-the-characteristics-of-cooperative-agreements&go=1

[50] Trump, Donald J. *Presidential Memorandum Regarding the Mexico City Policy*. Presidential Memoranda. Trump White House, Archives. Retrieved from: https://trumpwhitehouse.archives.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/

[51] Trump, Donald J. *Presidential Memorandum Regarding the Mexico City Policy*. Presidential Memoranda. Trump White House, Archives. Retrieved from: https://trumpwhitehouse.archives.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/

[52] "Breaking Down the U.S. Global Health Budget by Program Area". *Global Health Policy*. Kaiser Family Foundation. (20 December 2021). Retrieved from: https://www.kff.org/global-health-policy/fact-sheet/breaking-down-the-u-s-global-health-budget-by-program-area/

In the *Prescribing Chaos* report from CHANGE, the initial stages of the implementation of PLGHA are further explained.[53] According to report, the GGR was reinstated and PLGHA was expanded in three phases:

1. January 23, 2017: Former President Trump's presidential memorandum reinstating the GGR that was last in effect during Former President George W. Bush's administration from 2000-2008.[54] The memorandum directed the Secretary of State and the Secretary of Health and Human Services (HHS) to extend the policy to the extent allowable by law to "global health assistance furnished by all departments or agencies".[55,56]
2. March 2, 2017: The U.S. Agency for International Development (USAID) released the George W. Bush Standard Provision as the first step in implementation, which only applied to international assistance directed to family planning[57]
3. May 5, 2017: Former Secretary of State Rex Tillerson released a revised PLGHA Standard Provision, which now detailed the expansion of the policy to include all global health assistance, not just family planning.[58]

[53] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257
[54] "Restoration of the Mexico City Policy". Bush, George W. The White House. (22 January 2001). Retrieved from: https://georgewbush-whitehouse.archives.gov/news/releases/20010123-5.html
[55] Trump, Donald J. *Presidential Memorandum Regarding the Mexico City Policy*. Presidential Memoranda. Trump White House, Archives. Retrieved from: https://trumpwhitehouse.archives.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/
[56] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257
[57] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257
[58] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

By May 2017, the United States had the authority to enforce PLGHA on all departments, agencies, and organizations that receive U.S. global health assistance, whether they engage in direct work with SRHR or abortion. At this time, the United States Agency for International Development (USAID) also released the Standard Provisions that included PLGHA, which would be included in global health prime partners' cooperative agreements.[59] To receive global health assistance, organizations were required to indicate their agreement to abide by the terms set forth by the provisions of their awards.[60]

An informational FAQ published by the U.S. State Department in September 2019 clarified the nuance as well: "President Trump's initiative applies, to the extent allowable by law, to 'global health assistance furnished by all departments or agencies' while the previous 'Mexico City Policy' applied only to voluntary family planning assistance funded by USAID and assistance for certain voluntary population planning furnished by the Department of State."[61] The *Prescribing Chaos* report also details various examples of how Trump's expanded GGR has impacted global health implementing organizations all over the world. For example, according to the report, The President's Malaria Initiative (PMI), initiated in 2005 under Former President George W. Bush to combat the global burden of malaria,[62] was impacted by the restrictions on funding because of PLGHA. PMI works in many African countries where there is a large prevalence of malaria, and a key strategy for PMI is the integration of antenatal care, especially

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[59] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[60] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[61] *Protecting Life in Global Health Assistance FAQ.* United States Department of State. September 2019. Retrieved from: https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf

[62] "President's Malaria Initiative. (2022). Retrieved from: https://www.pmi.gov/

for women at risk for malaria infection.[63] Many antenatal care programs are integrated with comprehensive sexual & reproductive healthcare services, and thus were affected by the restrictions on funding resulting from Former President Trump's PLGHA.[64]

According to an informational FAQ published by the U.S. Department of State in September 2019, "U.S. NGOs that implement global health programs are prohibited from providing Federal global health assistance funding to any foreign NGOs that perform or actively promote abortion as a method of family planning, even if the foreign NGOs conduct such activities with non-Federal funding."[65] This meant that organizations headquartered or based in the United States were not permitted to sub-grant or provide funding to international organizations that actively promoted abortion. Research provided by the GGR Research Group, a working group made up of researchers from SRHR-focused institutions and the Columbia University Mailman School of Public Health, has demonstrated that this restriction on U.S.-based funding to sub-prime foreign implementing partners resulted in negative health consequences.[66] These effects include the closure of clinics, reductions in contraceptive access, and curtailments of community health workers.[67] This contrasts slightly with a detail of the policy that U.S.-based organizations were not required to comply with PLGHA.[68] While U.S.-

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[63] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[64] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[65] *Protecting Life in Global Health Assistance FAQ.* United States Department of State. September 2019. Retrieved from: https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf

[66] "Protecting Life in Global Health Assistance? Towards a Framework for Assessing the Health Systems Impact of the Expanded Global Gag Rule." BMJ Journals. 4 (5). (2019). Retrieved from: https://gh.bmj.com/content/4/5/e001786#T2

[67] "Protecting Life in Global Health Assistance? Towards a Framework for Assessing the Health Systems Impact of the Expanded Global Gag Rule." BMJ Journals. 4 (5). (2019). Retrieved from: https://gh.bmj.com/content/4/5/e001786#T2

[68] *Protecting Life in Global Health Assistance FAQ.* United States Department of State. September 2019. Retrieved from: https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf

based organizations are not required to comply with the GGR, their international sub-grantees are required to do so.[69] According to the State Department FAQ, "U.S. NGOs are not required to agree that they will not perform or actively promote abortion as a method of family planning as a condition of receiving global health assistance funds."[70] U.S. organizations are exempt from this policy by the rights granted under the First Amendment of the U.S. Constitution, whereas foreign organizations are not afforded this same protection.[71]

Former President Trump's PLGHA allowed a few important exceptions.[72,73] According to CHANGE's *Prescribing Chaos* report, PLGHA contained exceptions for abortion advocacy, services, and counseling and referral for abortion in cases of rape, incest, and if the woman's life was at risk.[74,75] The policy also excluded any aspect of the "treatment of injuries or illnesses caused by legal or illegal abortions," such as post-abortion care.[76,77] The policy also did not restrict the provision of information on or distribution of contraception, including emergency

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[69] *Protecting Life in Global Health Assistance FAQ.* United States Department of State. September 2019. Retrieved from: https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf
[70] *Protecting Life in Global Health Assistance FAQ.* United States Department of State. September 2019. Retrieved from: https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf
[71] Hudson, David. "Freedom of Association". *The First Amendment Encyclopedia*. (n.d.) Retrieved from: https://www.mtsu.edu/first-amendment/article/1594/freedom-of-association#:~:text=First%20Amendment%20protects%20two%20types,right%20not%20to%20associate%20together.
[72] Trump, Donald J. *Presidential Memorandum Regarding the Mexico City Policy*. Presidential Memoranda. Trump White House, Archives. Retrieved from: https://trumpwhitehouse.archives.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/
[73] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257
[74] Trump, Donald J. *Presidential Memorandum Regarding the Mexico City Policy*. Presidential Memoranda. Trump White House, Archives. Retrieved from: https://trumpwhitehouse.archives.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/
[75] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257
[76] Trump, Donald J. *Presidential Memorandum Regarding the Mexico City Policy*. Presidential Memoranda. Trump White House, Archives. Retrieved from: https://trumpwhitehouse.archives.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/
[77] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

contraception.[78] There were also exceptions concerning the individuals and organizations that work in abortion provision or related services.[79] This "affirmative duty clause" meant that if local laws stipulated a duty for a health care provider to provide abortion counseling, referral, or services, the organizations or individuals complying with their local laws would not be in violation of the policy.[80] There was an exception to individuals acting in their own personal capacities and not operating on their organization's premises or on official duty.[81] Healthcare providers were allowed to make "passive referrals" for pregnant persons who; 2) clearly stated they wished to have a legal abortion; 3) asked where the safe and legal abortion could be obtained; and 4) the provider believed that the medical ethics in that particular country required a response and a referral to where the abortion may be safely and legally performed.[82]

Furthermore, foreign national or local governments remained eligible for U.S. funding even if they performed abortion-related activities, so long as they kept these funds in a separate account from the funds that supported these activities.[83] This meant that U.S. global health assistance funds needed to be kept completely separate from any funds used to provide abortion-related services.[84] Additionally, PLGHA did not apply to organizations that were public

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[78] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[79] *Protecting Life in Global Health Assistance FAQ.* United States Department of State. September 2019. Retrieved from: https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf

[80] *Protecting Life in Global Health Assistance FAQ.* United States Department of State. September 2019. Retrieved from: https://www.state.gov/wp-content/uploads/2019/10/PLGHA-FAQs-September-2019.pdf

[81] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[82] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[83] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[84] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

international or multilateral in nature, such as the United Nations (UN) and its related agencies or the World Bank Group.[85]

Additionally, organizations could conduct descriptive research on the subject of abortion but were not permitted to use the research findings to support advocacy toward the liberalization of domestic abortion laws.[86] The prohibition of foreign entities' advocacy of abortion is not unique to PLGHA, however. The Siljander Amendment is a recurring restriction included in the annual Department of State, Foreign Operations and Related Programs Appropriations Act, first passed in 1981.[87] The Siljander Amendment blocks the use of appropriations-funded foreign assistance for lobbying for or against abortion.[88]

One of the first monitoring mechanisms of the U.S. government's implementation of the policy came in the form of a six-month review, titled the PLGHA Six-Month Review, compiled by the U.S. State Department's Office of Foreign Assistance and published on the U.S. State Department's website on February 6, 2018.[89] The content of the report was compiled using both internal and external feedback.[90] Each implementing department agency (including the U.S.

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[85] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[86] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de1639502257

[87] "USAID Guidance for Implementing the Siljander Amendment". U.S. Agency for International Development. (22 May 2014). Retrieved from: https://www.usaid.gov/sites/default/files/documents/1864/USAID%20Guidance%20for%20Implementing%20the%20Siljander%20Amendment.pdf

[88] "USAID Guidance for Implementing the Siljander Amendment". U.S. Agency for International Development. (22 May 2014). Retrieved from: https://www.usaid.gov/sites/default/files/documents/1864/USAID%20Guidance%20for%20Implementing%20the%20Siljander%20Amendment.pdf

[89] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

[90] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

Agency for International Development [USAID], the Department of Health & Human Services [HHS], the Department of State and the Department of Defense [DoD]) was responsible for conducting focus group discussions with operating units, while the Department of State also contributed relevant qualitative feedback gathered from meetings and calls with implementing partners and operating units.[91] The PLGHA Six-Month Review attested that while in its initial stages of implementation, it was too early to assess the full range of benefits or challenges of PLGHA on U.S. global health assistance programs and operations.[92] One of the key activities of PLGHA implementation was to include a standard provision in grants or cooperative agreements between U.S. funding agencies and prime recipients of the funding, to ensure foreign implementing partners' knowledge of the policy when affirming agreements.[93]

The PLGHA Six-Month Review from the Office of Foreign Assistance was constructed using quantitative and qualitative data from both internal and external U.S. government sources.[94] The review summarized findings from the focus group discussions with key staff from USAID, HHS, DoD and the Department of State on the implementation of PLGHA.[95] According to the review, USAID was the agency with the highest number of grants and cooperative agreements with global health assistance funding (N=580), followed by HHS

[91] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[92] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[93] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[94] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[95] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

(N=499), State Department (N=142, including PEPFAR funding implemented through this department) and DoD (N=77).[96] Focus groups and meetings were also conducted with external partners, such as foreign organizations working as implementing partners of global health assistance.[97]

Furthermore, the Department of State requested external stakeholder comments on the implementation of the policy.[98] The external stakeholders are not explicitly named in the report, but the report acknowledges this comprised of "thirty-one stakeholder groups, including three foreign governments as well as non-governmental entities."[99] The review included this comment from the U.S. Conference of Catholic Bishops who recognized PLGHA as "one of the most significant policy initiatives on abortion ever taken by the United States in an area of foreign assistance."[100] The U.S. Conference of Catholic Bishops, however, is a historically anti-abortion entity and this commentary on the policy is a clear example of its bias.[101] The review claims that several other external stakeholder groups expressed favorable commentary about the policy,[102] but it is unknown if these groups have experience in implementation of global health programs.

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[96] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

[97] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

[98] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

[99] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

[100] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

[101] "Abortion". U.S. Catholic Conference of Bishops. (n.d.). Retrieved from: https://www.usccb.org/prolife/abortion

[102] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

However, the review also included the perspectives of non-governmental entities.[103] The review acknowledged that concerns were expressed about the continuity of healthcare services, the potential "chilling effect" of the policy, as well as a desire for more guidance on proper implementation of the policy.[104] Whether or not the external stakeholders or non-governmental entities expressed these concerns about the policy was not specified in the review.[105] The review also outlined various actions for proper implementation that each of the agencies engaged in, such as the standard provision updates, website updates, conference calls and site visits.[106]

The review concluded with a list of actions to be taken by U.S. government agencies to ensure effective implementation of PLGHA, based on the recommendations from external stakeholders and feedback from implementing partners.[107] The recommendations included:

1. field-based training, tools for compliance and oversight, and translation of FAQ information into the appropriate languages[108]

[103] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[104] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[105] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[106] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[107] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[108] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html

2. clarify that the PLGHA standard provision is included in awards to U.S.-based state or local governmental entities, including state universities, in the same manner as they include it in awards to U.S.-based NGOs[109]

3. task S/GAC (Office of the U.S. Global AIDS Coordinator that leads PEPFAR at the Department of State) to develop guidance for PEPFAR implementing agencies on

how to better track, monitor and ensure compliance with PLGHA, among other actions listed at the end of the review.[110]

A second and final review of the implementation of PLGHA was published in 2020, which reviewed the number and types of awards impacted by PLGHA, including primes that declined to certify the policy.[111] Stated on the first page of this review is Former President Trump's rationale for the existence of PLGHA: "The U.S. Government is committed to protecting life—both before and after birth."[112] This review, a follow-up to the aforementioned PLGHA Six-Month Review published in 2018, detailed the actions undertaken by U.S. agencies to respond to the action items listed in the initial PLGHA Six-Month Review.[113] Between May 2017 and September 2018, only 8 out of 1,340 prime awardees with active awards during this

[109] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[110] *Protecting Life in Global Health Assistance Six-Month Review*. U.S. Department of State, Office of Foreign Assistance. 6 February 2018. Retrieved from: https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html
[111] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf
[112] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf
[113] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

time period declined to agree to PLGHA, as well as "a small portion of sub-awardees."[114] This "small portion" were 47 sub-awardees on USAID-funded awards.[115]

The PLGHA Six-Month Review listed specific action items, including the appropriate language translation of PLGHA information, monitoring and guidance materials, which was addressed in the second report.[116] According to the final review, USAID had taken the lead on translating training materials and the PLGHA standard provision included in grants and cooperative agreements into several languages.[117] USAID's PLGHA standard provisions available in Spanish and Arabic on the public USAID website, while USAID's Global Health eLearning course on PLGHA was only available in Spanish.[118] In mid-2020, USAID was working on additional translations of these materials, including French-language materials, though it is unclear if these were ever published.[119]

The aforementioned PLGHA implementing agencies (e.g., Department of State, USAID, HHS, DoD) collected quantitative program and funding data on the number of declinations of PLGHA from both prime and sub-recipients of U.S. global health assistance.[120] The report cited

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[114] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[115] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[116] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[117] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[118] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[119] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[120] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

a total of 1,340 declinations of global health awards, from 8 prime awardees and 47 sub-recipient awardees.[121] The qualitative data, according to the review, provided supplemental and contextual information: "Through the qualitative data collection and subsequent analysis, USAID identified trends related to the ability to transition various types of health activities to replacement implementing partners. As part of this analysis, USAID reviewed any changes in programmatic coverage and specific areas of programmatic expertise."[122] Some of the results of the data collected for the review included: 1) Prime partners declined to the policy's terms in 1.2 percent of USAID prime global health awards; and 2) Most declined awards or sub-awards did not experience a disruption of healthcare or significant delays, however, in a few cases, a declination resulted in some impact on the delivery of health care, in topics such as nutrition, HIV/AIDS and voluntary family planning.[123]

The conclusion of the final review first addressed the gaps in healthcare coverage, which the report related somewhat to the declinations of PLGHA: "When organizations declined the terms of PLGHA, the transitions to alternative health care providers have been, for the most part, smooth.[124] In some cases, other donors or the host government have stepped in to fill gaps that occurred because of a partner's declination to sign PLGHA."[125] Interestingly, the review

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[121] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[122] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[123] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[124] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

[125] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

mentions gaps in healthcare coverage and provision, but relates these gaps to organizations' declinations of PLGHA, not the institution of PLGHA itself.[126] For example, in Senegal, USAID-funded prime partners struggled to find sub-prime partners compliant with PLGHA to enact voluntary family planning programs.[127] In this example, this certain project was unable to implement mobile health clinics for 7-8 months due to the enactment of PLGHA.[128] The report blames the inefficiency of the USAID-funded prime partner in locating a PLGHA-compliant sub-prime implementing partner as the reason for this gap in coverage.[129]

The second section of the conclusion of this report also addressed the need for further guidance on PLGHA, as previously identified in the PLGHA Six-Month Review on the implementation of the policy.[130] Even with the release of publicly available answers to frequently asked questions, a widely accessible eLearning course, and translated versions of the PLGHA standard provision, the report acknowledged that further outreach on PLGHA was needed.[131] The review furthermore acknowledged that although federal departments and agencies have direct legal relationships with only prime recipients, there is a need for additional information and

[126] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf
[127] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf
[128] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf
[129] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf
[130] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf
[131] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf

guidance that prime implementers can share with their sub-recipient to ensure their understanding of the policy.[132]

Recent Revocation of PLGHA under President Biden:

As previously mentioned, PLGHA was revoked on January 28, 2021 by President Biden through presidential memorandum.[133] This memorandum directed the Secretaries of State, Defense, Health and Human Services, the Administrator of USAID and all agencies involved in foreign assistance to do the following:

1. "Immediately waive any conditions in any current assistance awards that require the implementation of the Trump administration's PLGHA,
2. notify current grantees, as soon as possible, that these conditions have been waived, and
3. immediately cease imposing these conditions in any future assistance awards."[134]

President Biden's memorandum also included a clause acknowledging the harm caused by PLGHA, particularly in light of the COVID-19 pandemic, which was particularly relevant at the time of the release of the memorandum.[135] Furthermore, the Presidential Memorandum confirmed the Biden Administration's support of SRHR globally with this statement: "It is the policy of my Administration to support women's and girls' sexual and reproductive health and

[132] *Review of the Implementation of the Protecting Life in Global Health Assistance Policy*. U.S. Department of State. 17 August 2020. Retrieved from: https://www.state.gov/wp-content/uploads/2020/08/PLGHA-2019-Review-Final-8.17.2020-508.pdf
[133] "Memorandum on Protecting Women's Health at Home and Abroad". Joseph R. Biden Jr. *The White House*. (28 January 2021). Retrieved from: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/memorandum-on-protecting-womens-health-at-home-and-abroad/
[134] "Memorandum on Protecting Women's Health at Home and Abroad". Joseph R. Biden Jr. *The White House*. (28 January 2021). Retrieved from: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/memorandum-on-protecting-womens-health-at-home-and-abroad/
[135] "Memorandum on Protecting Women's Health at Home and Abroad". Joseph R. Biden Jr. *The White House*. (28 January 2021). Retrieved from: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/memorandum-on-protecting-womens-health-at-home-and-abroad/

rights in the United States, as well as globally."[136] There is no available evidence of a communications plan set forth from the Biden Administration related to the dissemination of the news of the revocation to relevant U.S. agencies.

This thesis utilizes Malawi, Mozambique and Zimbabwe to serve as case studies for how the implementation of the revocation has occurred in their respective countries. The qualitative data will compare differences in style and frequency of the communication and implementation guidance when PLGHA was in effect under former President Trump and since it has been revoked by President Biden. Although President Biden revoked the policy relatively recently, the analysis will explore the styles of communication and information-sharing between the U.S. government and its global health partners in this pivotal time since the policy was revoked. This analysis will provide insight into the impact of the impact of this policy on global health programs and outcomes in these three countries. Furthermore, this analysis will document the struggles organizations face when partnering with the U.S. to administer global health assistance funding and implement programs, and whether these organizations are able to recover from frequent U.S. policy changes.

Methods

Introduction

This thesis analyzes the differences in communication frequencies, styles, and methods between U.S. government agencies and prime and sub-prime partners working in global health in Malawi, Mozambique and Zimbabwe, as well as any potential implications for programs,

[136] "Memorandum on Protecting Women's Health at Home and Abroad". Joseph R. Biden Jr. *The White House*. (28 January 2021). Retrieved from: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/memorandum-on-protecting-womens-health-at-home-and-abroad/

services and health outcomes related to differences in this communication. These will be assessed in the context of the January 2017 implementation of the "Protecting Life in Global Health Assistance" (PLGHA) policy and its subsequent revocation in January 2021. This thesis analyzes qualitative data from 41 semi-structured in-depth interviews conducted virtually over three months, July to September 2021. These data were initially collected for the purpose of a qualitative rapid-response research project conducted jointly by Fòs Feminista (previously known as the Center for Health and Gender Equity [CHANGE]) and the Emory University Global Health Institute in 2021, documenting the policy revocation process and assessing the public health implications of this policy and its revocation.

Research Partnership & Team Roles

Fòs Feminista is an international feminist alliance made up of three organizations: the Center for Health and Gender Equity (CHANGE), the International Women's Health Coalition (IWHC), and International Planned Parenthood Federation Western Hemisphere Region (IPPFWHR).[137] Fòs Feminista partners with local organizations around the globe to advance intersectional feminist strategies and activities, including advocacy, education and healthcare. Fòs Feminista is particularly focused on the sexual and reproductive health and rights of women, girls and gender-diverse people.[138] Worldwide, Fòs Feminista partners with over 135 organizations to engage in community-based strategies that support sexual and reproductive healthcare access to marginalized women and girls, as well as local advocacy movements to

[137] "Announcement of New Feminist Alliance". *Fòs Feminista.* 3 June 2021. Retrieved from: https://fosfeminista.org/media/announcement-of-new-feminist-alliance/
[138] "About Us". *Fòs Feminista*. n.d. Retrieved from: https://fosfeminista.org/about-us/

advance reproductive justice and sexual health.[139] On a global scale, Fòs Feminsta works to advance gender equality and human rights.[140]

In April 2021, two representatives from Fòs Feminista (formerly CHANGE), Samantha (Sammy) Luffy, Policy Research Officer and Bergen Cooper, Director of Policy Research, formed a partnership with a graduate research team at Emory University, in Atlanta, Georgia, with financial support from the Emory University Global Health Institute (EGHI),[141] Global Field Experience Award,[142] individual Applied Practice Experience merit scholarships[143] and the Master's in Development Practice Program at Laney Graduate School.[144] This partnership conducted the aforementioned research project, titled "The Global Gag Rule Revoked: A Qualitative Evaluation of Policy Change Implementation and Public Health and Rights Implications in Malawi, Mozambique and Zimbabwe" from the months of January to December 2021. Throughout this project, Luffy and Cooper served as Principal Investigators, along with two Global Health faculty members from the Rollins School of Public Health (RSPH) at Emory University, Dr. Roger Rochat and Dr. Anna Newton-Levinson.

The graduate student team was made up of 5 students from RSPH and one student from Emory University's Master's in Development Practice (MDP) program within Laney Graduate School. The six students were split into 2-member country-specific teams, each focusing on one

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[139] "About Us". *Fòs Feminista*. n.d. Retrieved from: https://fosfeminista.org/about-us/
[140] "About Us". *Fòs Feminista*. n.d. Retrieved from: https://fosfeminista.org/about-us/
[141] Emory Global Health Institute. Emory University, Altanta, GA. n.d. Retrieved from: https://www.globalhealth.emory.edu/
[142] "Global Field Experience Financial Award". Rollins School of Public Health, Emory University. (n.d.) Retrieved from: https://www.sph.emory.edu/rollins-life/community-engaged-learning/global-field-experience/index.html
[143] "Applied Practice Experience Program". Rollins School of Public Health, Emory University. (n.d.) Retrieved from: https://www.sph.emory.edu/rollins-life/community-engaged-learning/ape/index.html
[144] "Master's in Development Practice". Emory University. (n.d.) Retrieved from: https://web.gs.emory.edu/mdp/about/index.html

of the three countries of Malawi, Mozambique and Zimbabwe for data collection and analysis. The data for this thesis are derived from this project.

Population and Sample

The data for this thesis stem from semi-structured in-depth interviews with 43 participants from 41 global health implementing partners, civil society organizations and advocacy forums in Malawi, Mozambique and Zimbabwe. Specifically, there were 16 interviews from Malawi, 14 interviews from Mozambique, and 11 interviews from Zimbabwe. Interviews were conducted between July and August 2021. Participants were representatives working at various levels of international non-governmental organizations (INGOs), national non-governmental organizations (NGOs), healthcare providers, advocacy coalitions or civil society organizations. Participants spoke on behalf of their experiences with the policy in the context of their professional affiliations and organizations' work and whether their organization had ever been impacted by the GGR.

Participants were recruited through purposive and snowball sampling by utilizing relationships that Fòs Feminista had established with participants from prior and ongoing research. Participants were identified for inclusion based on their expertise and ability to speak to their understanding of the GGR or experience implementing the policy. To meet the third inclusion criteria, the participant's organization would have worked in SRHR in some capacity and therefore might have had experience with the GGR. The graduate research team with Emory Global Health Institute (EGHI) also undertook online research on ForeignAssistance.gov and U.S. Embassy websites to identify potential participants based on organizations currently receiving U.S. global health assistance in each country.

For inclusion into the study sample, participants had to have one of three types of relationship with U.S. global health funding: 1) a current recipient of global health funding, 2) a past recipient of global health funding or 3) never been a recipient of U.S. global health funding. Organizations were also identified as either prime or sub-prime (sub-recipient), and in some cases, this category is not exclusive, as organizations can operate both as prime and sub-prime in different projects. Table 4 outlines the breakdown of the participants as either prime, sub-prime, both or neither.

Table 4. Organizations Interviewed in Malawi, Mozambique, and Zimbabwe regarding the January 2021 revocation of PLGHA, July-August 2021

	Prime Partner	**Sub-Prime/Sub-Recipient Partner**	**Both**	**Neither**	**TOTAL**
Malawi	5	8	2	1	16
Mozambique	1	3	5	5	14
Zimbabwe	3	2	1	5	11
					41

To participate in the research as an interviewee, it was necessary to maintain communication via email, and to utilize technology, either a computer, laptop or phone, to be able to call in for the interview. Participants were excluded from participation in the study if they had no known or suspected potential impact of the GGR or did not respond to multiple invitations to participate in an interview.

Interview Procedures

Due to the COVID-19 pandemic, the interviews were conducted virtually via Zoom, which provided additional confidentiality due to its end-to-end encryption.[145] Interviews took

[145] Zoom Video Communications, Inc. (2020). *ZOOM cloud meetings* (Version 5.9.1) [Desktop app]. Zoom.us

place between July and September 2021. To initiate contact, the project's Principal Investigator from Fòs Feminista, Bergen Cooper, first communicated with the participant via email and sent subsequent messages via WhatsApp, if necessary. Student teams moved forward with scheduling interviews using Calendly,[146] an online scheduling tool that allowed participants to reserve a one-hour time block that best suited their schedules.

Participants signed an informed consent document before completing the interviews or granted verbal consent before the interview commenced. The signed informed consent forms were stored in REDCap,[147] an online, secure database with a special license purchased by Emory University to serve as a tool in research projects. Two graduate-level researchers were present in each interview; one served as an interviewer and the other as a note-taker. A Principal Investigator from Fòs Feminista was also in attendance for most interviews.

Each interviewee was also given the opportunity to give recommendations for other organizations to participate in an interview, which served as a method of snowball sampling. Graduate student researchers obtained the contact information of these suggested participants and collaborated with Fós Feminista Principal Investigators to establish contact and coordinate an interview. Each interview was transcribed verbatim, using a professional third-party transcription service to ensure accuracy of the transcripts.[148]

Data Collection Instruments

Before starting the interview process, the research team developed a set of semi-structured in-depth interview (IDI) guides, with final approval from Fòs Feminista staff, containing three different versions that were specific to the three funding relationships an

[146] Calendly. (2022). https://calendly.com/
[147] Emory University Office of Information Technology. (2022). *Emory Enterprise REDCap.* redcap.emory.edu
[148] Top Team Transcripts. (2019). Retrieved from: https://topteamtranscripts.com.au/

organization might have with U.S. global health funding, as outlined above (see Appendix). The IDI guides contained approximately fifteen questions each on topics ranging from a detailed description of the communication from the Biden Administration, the impact of the revocation of the GGR, monitoring mechanisms under PLGHA, and comparing experiences under PLGHA and after revocation.

For participants in Mozambique, the informed consent document, email communication scripts and IDI guide were translated into Portuguese by a professional translator to ensure language accessibility for all participants. Two professional interpreters were also contracted to assist in interviews when deemed necessary by the participants. Ultimately, one interview with a Mozambican representative warranted the use of this confidential, third-party interpreter and the rest were conducted in English.

Data Analysis

Interview recordings and transcripts were stored on a shared, secure OneDrive folder licensed by Emory University. OneDrive is encrypted and configured for HIPAA compliance, which heightened the confidentiality measures the study team undertook to prevent a data breach. The student researchers conducted a thematic analysis of the data using MAXQDA20[149] from September to December 2021. The license for use of MAXQDA20 was also owned by Emory University and could be accessed by students for research or course-related projects. The student researchers reported arriving at data saturation around 30 interviews (approximately 10 interviews in each country).

To analyze the data, the study team developed an iterative codebook with deductive and inductive codes, used uniformly across all three countries. Deductive codes were formulated on

[149] VERBI Software, *MAXQDA 2020*, software, 2019, maxqda.com

topics the researchers anticipated to find in the data, based on the initial research question. Examples of deductive codes include “no communication from U.S. government (about the GGR revocation)” and “impact on programs/services.” Inductive codes were established based on topics that were repeatedly and organically brought up in interviews, unprompted by the study team. Examples of inductive codes were “mis-implementation of PLGHA” and “national SRHR landscape.”

As six members of the study team completed the coding process, inter-coder agreement was established before delegating the coding of individual interviews. Research team members worked within the 3 individual country-level pairs (each assigned to either Malawi, Mozambique or Zimbabwe) to cooperatively analyze their country-level data. The codebook was revised when necessary throughout the process to reflect the trends and themes observed in the data.

Ethical Considerations

Emory University Institutional Review Board (IRB) determined that this study was not classified as human subjects research because it was focused on evaluating programmatic activities. The data presented in this thesis are also anonymized to protect participants’ confidentiality.

Limitations and Delimitations

The countries of Mozambique, Malawi and Zimbabwe were chosen according to research priorities of Fós Feminista, as well as the ability to expand upon established professional relationships and rapport between Principal Investigators (PIs) and participants. The organizations recruited to participate in this study were identified and contacted primarily due to their knowledge and previous experiences with the GGR. Therefore, the results of this study may not be fully generalizable to all global health implementing partners. However, although this

study focuses on three countries as examples of the policy's impact, the sample is of both primes and sub-primes, to add to the diversity of experience with U.S. foreign assistance policies. Thus, the findings from this study may be informative for other global health implementing organizations, particularly those operating in southern Africa, those that work in SRHR programming, and/or that receive U.S. foreign assistance.

Results

Representatives from global health prime and sub-prime partners in Mozambique, Zimbabwe and Malawi were asked to describe the communications they received during the announcement and enforcement of PLGHA from 2017-2021, as well as the subsequent revocation of the policy by President Biden in January 2021. Participants were asked to compare the communication methods, styles and frequencies they received in 2021 to what they remember when PLGHA was in effect, and several dominant themes emerged. Overwhelmingly, participants described a contrast in the amount and level of communication they received across time periods, which influenced organizational planning, particularly in terms of programming, funding decisions, and service provision.

Communication of PLGHA

The majority of participants (8 of 16 in Malawi, 6 of 11 in Zimbabwe and 8 of 14 in Mozambique) described their experiences with communication they received regarding the 2017 enforcement of PLGHA as more consistent and authoritative, as well as stemming from more official and an increased number of U.S. government channels, in contrast to the communications they received regarding PLGHA's revocation in 2021. A participant from a previous prime and current sub-prime partner in Mozambique working in reproductive health,

HIV/AIDS, WASH and malaria stated this discrepancy in communication when the policy was enacted compared to when it was revoked:

> *"We were bombarded with communication when the policy [PLGHA] was put in place. There was also a lot of attempt[s] in understanding how the different USAID missions would have interpreted the application [of the policy], and adapted the policy, and applied it, and how they have operated in terms of modifying the agreements."*

Many participants referred to USAID country offices, programs or U.S. Embassy presences in their countries as "missions." The "modifying agreements" in this quote refers to the cooperative agreements between U.S. government agencies and prime partners, often NGOs or other implementing organizations. This "bombardment" of communications about PLGHA was noted by participants in Malawi and Zimbabwe as well. A participant from a prime partner working in HIV/AIDS and SRHR in Zimbabwe shared this observation:

> *"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."*

Other participants reflected similar experiences during the implementation of PLGHA. One participant from Malawi representing a sub-prime organization provided this insight into the sincerity of the communication regarding PLGHA:

> *"The Trump administration, it was like a warning that if you ever tried to participate in this or advocate in this [abortion], the US Government funds would be taken away from you. So, we were disciplined not to talk about those."*

While participants' responses highlighted themes of more consistent communication about PLGHA from both the U.S. government and prime partners (when applicable), the

anecdotal evidence participants provided also demonstrated that this thorough communication was to not just inform of the policy's implementation, but also to ensure organizations' adherence and compliance with the policy's restrictions. The organizations that did not report a large juxtaposition between the communications of PLGHA's implementation and the 2021 revocation largely did not work in safe abortion or SRHR-related topics.

Communication of the Revocation of PLGHA

Participants received initial communications of President Biden's January 2021 revocation of PLGHA in various forms. The majority of organizations in Malawi (11) and Mozambique (8) and some in Zimbabwe (3) received communications via methods of direct communication such as formal emails, meetings or other methods of direct communication, from either U.S. agencies to prime partners or prime partners to sub-prime partners. Other participants (4 in Malawi, 4 in Mozambique, 7 in Zimbabwe) reported initial communications of the revocation as stemming from mass media channels in their respective countries, including social media. Several organizations that had reported the initial communication through formal channels, also reported secondary communications through mass media. Other participants (1 in Malawi, 2 in Mozambique, 5 in Zimbabwe), learned of the revocation through various networks and collaborators in similar programmatic areas (e.g., HIV/AIDS). Three organizations (1 in Malawi and 2 in Mozambique), however, did not learn of the revocation until they were invited to participate in an interview for this research.

Communications from U.S. Government Agencies

Reports of direct communications from U.S. government agencies, such as USAID or CDC, varied among interview participants. In Zimbabwe, no organization reported receiving regular communications from U.S. government agencies regarding the revocation, although

some noted that they had received this during the implementation of PLGHA. One sub-prime Zimbabwean organization focused on HIV/AIDS and SRHR provided this insight:

> *"I just think maybe the administration thought by lifting the [Global] Gag Rule they've done a great job already and people must know what to do. Or it could be when we're a sub-grantee, maybe information is not filtering to us as it is maybe at the prime level."*

This quote is evidence of the nuance and variation in communications from the U.S. government. As this participant noted, their organization was at the time in a sub-prime role, receiving funding from the U.S. government through a prime partner. Thus, the U.S. government was not legally obligated to communicate with this organization in the same manner it is with prime partners. However, this participant also attested that they do maintain regular communication with the USAID office in Zimbabwe and would have appreciated more direct communication from the U.S. government. They provided this recommendation: "*I think the onus is also on USAID to call for a meeting. I would have."*

In Malawi, large prime and U.S.-based organizations received prompt communications from U.S. government agencies within a week of the revocation, whereas all but one sub-prime organization learned of the revocation directly from a U.S. government agency; most of these sub-prime recipient organizations reported that they initially learned of the revocation from their prime partners. One prime organization in Malawi focused in SRHR, tuberculosis, HIV/AIDS and nutrition provided this context on how they received communication of the revocation from their U.S. implementing agency:

> *"So [U.S. agency] kind of has a quarterly partner's meeting, and during that meeting, they basically mentioned that the [Global] Gag Rule has been rescinded and that we should just expect new contracts and look at what the language was talking about.*

They're all pretty new at [U.S. agency], and so they're trying to find their feet and then give the language."

In this quote, this participant acknowledges knowledge gaps of the U.S. agency staff present in Malawi, with "they're trying to find their feet and then give the language," providing evidence of unclear communications on behalf of the U.S. government. Furthermore, this same participant elaborates more on the unclear communications received:

"That's the thing about the [Global] Gag Rule. There's a lot of wording, a lot of language in it, and you have to kind of navigate through to kind of get the gist of it. At the end of the day, the communication is really formal, that, President Biden has rescinded the law and then projects should take into consideration these new ways of doing business and make sure that we more or less participate, in a manner of speaking. Then they attached the [Global] Gag Rule and you have to kind of wade through that information."

This quote exemplifies similar experiences reported by other participants, even in Mozambique and Zimbabwe. Several prime participants were handed the policy in its entirety and expected to understand and comprehend its implications for their organizations. As is the case for this participant from Malawi, the information required organizations to "wade through that information," placing an unnecessary burden on them. In these cases, participants expressed a desire for more clear and comprehensive information to be communicated to them to ensure complete understanding of the policy's implications.

In Mozambique, four prime organizations reported direct initial communications from U.S. government agencies, including one INGO with an office inside the U.S. Embassy in Maputo. One Mozambican organization, both a previous prime and sub-prime recipient of U.S.

funding, reported their direct communications with the U.S. government came in the form of a cooperative agreement modification:

> *"Since we have to sign modifications now and then, every three months there is a new modification for different programs, either as a sub or as a prime, since the revocation happened, we started receiving the modifications with this new paragraph added saying that the [Global] Gag Rule has been revoked. So we had the communications, but in a context of modification specifically from current agreements."*

This organization, which works in SRHR and reproductive justice, noted that this communication was similar to the communications they received from 2017 to 2021 during Trump's PLGHA. During PLGHA, communications about the policy were disseminated to this organization via agreement modifications as well.

Communications from INGO Headquarters

It was also common for INGO country office staff to have learned of the revocation through key staff at INGO headquarters offices in the United States, United Kingdom, or South Africa. Twelve of the participants interviewed (five in Malawi and seven in Mozambique) reported that their initial source of communication of the revocation of PLGHA was their headquarters office. Most of these twelve organizations stated that the communications from their INGO headquarters made it clear that PLGHA had been revoked, and they were no longer responsible for its implementation. A representative from a Malawian organization working in HIV/AIDS, tuberculosis, SRHR and maternal & child health provided this evidence for the support they received from the organization's headquarters:

> *"Normally when we get these communications [about U.S. policies], 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."

In this quote, the participant expresses general satisfaction and recounts clear communication between their INGO headquarters and Malawian country office.

Communications from Prime Partners to Sub-Primes

Twenty-one total organizations in this research were sub-prime recipients of U.S. global health assistance at the time of the interview. Prime partners are legally required to notify their sub-prime partners of changes regarding PLGHA, as well as other pertinent policy updates. Evidence from this research demonstrates that this responsibility of policy communication from prime to sub-prime partners is not regularly monitored by the U.S. government. Across the 21 sub-prime partners, the style and frequency of communication they received from their prime partners varied. Common communication methods from prime partners to sub-prime implementers included emails, WhatsApp messages, and formal meetings, including meetings that were originally called for other purposes, but where the revocation was discussed. A representative from a sub-prime organization focused on human rights in Malawi shared this reflection on the nature of communications from their prime partner:

"Apart from the email, there is no other document that we have received. We don't really know about the whole policy apart from the email that we were communicated to. We literally don't have the information about the change. So, even the contents of the current policy, we're not aware of. We really lack awareness on the changes in the policy."

This participant shared that while their prime partner did inform them of the policy change via email, they were still left with a level of uncertainty about the revocation and needed

to find other sources of information. Furthermore, this participant reflected that they were hesitant to seek guidance from their prime partner, as they did not have a good understanding of the policy as a basis for questions.

A Zimbabwean organization recounted their experience of communication with their prime partner, in which the prime partner advised them to mis-implement the GGR, evidence of the "chilling effect" mentioned in the literature review of this thesis. This organization worked directly with clients that had become pregnant because of rape or incest, and who were thus exempt from the restrictions of the GGR and could provide referrals for legal abortion services in these cases under Zimbabwean law. After taking the GH eLearning course, this organization realized their work fit into the exemptions of the GGR for pregnancies resulting from rape or incest and that they could commence their abortion-related activities to their clients through the "affirmative duty clause" of PLGHA with other donor funds. However, when the sub-prime organization raised this issue with their prime partner, the prime advised them to continue mis-implementing PLGHA, even after the policy had been revoked.

At the time, the prime partner was awaiting more guidance on the revocation from their U.S. government funding agency. As the sub-prime participant recounted:

> "*The conditions and nitty-gritties of the revocation were not clear. To us, especially as a clinical organization, we were coming across a lot of children and women who were pregnant as a result of rape. And we have been discussing such cases with the funder to say, we are getting challenges here...We could not do anything... In terms of the programs that we are actually doing, in terms of activities that we are actually doing, with funding from [U.S. agency], it is assumed it cannot be done. After we did our e-learning [GH eLearning course], we realized that there is a law here that allows*

termination [of pregnancy] … What do we do if our prime says, 'No, you can't do this [provide abortion referrals],' 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 [U.S. government agency]."

Despite receiving incorrect guidance from their prime partner, the participant acknowledged their organization had the capacity and was ready to support access to abortion services for their clients:

"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."

This quote exemplifies the essential services that are cut both when PLGHA is in effect and when there is unclear communication between primes and subs on the correct implementation of PLGHA or its revocation. This case study represents how essential it is to have comprehensive, thorough communication throughout the U.S. global health system, from the U.S. government to implementing partners. In this case, this participant shared that their initial learning of the revocation came in the form of a WhatsApp message from their prime partner.

In contrast, one organization in Mozambique working in women's legal assistance, gender-based violence (GBV) and SRHR described that the communications from their prime

partner about the revocation were instrumental because the prime partner had translated the communications from the U.S. government into Portuguese and provided education to ensure their complete understanding of the policy. However, this example is outside the norm of the evidence provided in this research.

Communications from Civil Society Organizations

Eight participants (1 in Malawi, 2 in Mozambique, 5 in Zimbabwe) reported their first communication of the revocation as coming from civil society organizations working in similar global health topics. An additional seven participants across the three countries reported that partner organizations, coalitions or working groups were secondary sources of information about the revocation. Thus, fifteen total participants across the three countries reported that their knowledge or understanding of the revocation was strengthened by coalitions or partnerships with other organizations, particularly those working in SRHR.

This information-sharing among civil society was instrumental to participants' understanding and comprehension of both the 2017 implementation and 2021 revocation of PLGHA. In some cases, these partnerships among colleagues in civil society came as a result of a lack of clear communications from U.S. government or prime partners, most notably in the context of the 2021 revocation. One organization in Mozambique focused on education, health and humanitarian aid shared this insight:

> *"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 [U.S. government agency] support, and from the other platforms with organizations in Mozambique, but we have not received any communication directly from the U.S. government."*

While the coalitions and network of partners working in SRHR were instrumental in information-sharing regarding the policy, many participants acknowledged these were also secondary sources of information, having first learned of either PLGHA or the revocation from either primes or the U.S. government agencies from which they receive funding.

Communications from Mass Media Channels

Fifteen participants across the three countries learned of PLGHA's revocation through mass media channels, such as social media, news outlets or WhatsApp. One participant expressed their views on learning of the policy change through mass media outlets:

> *"I saw it in the news before I saw it officially circulated through U.S. government communications, but I feel like that's just because everything breaks faster than bureaucrats can actually announce [anything] these days."*

Most of these fifteen participants explained that they were watching the news in the days after President Biden's inauguration, expecting PLGHA to be revoked. A few expressed their optimism regarding an expected revocation, on par with President Biden's stance as a member of the Democratic Party, given that typically Democratic presidents revoke the policy.

Dovetailing with learning of the revocation from coalitions or partnerships, many participants noted they learned of the revocation through fellow partners' social media accounts. For one Mozambican participant, whose organization works in SRHR and women's legal assistance, seeing the news on mass media channels confirmed that PLGHA had truly been revoked:

> *"It was soon after it was revoked. We were still in doubt, is it really? Then when it started to be written on the newspaper and on the radios then we said, oh, yes, it is. Yes."*

The participants that referenced witnessing news of the revocation on mass media channels, did not attest that this news included information on the technicalities of the revocation. Moreover, participants reported that the mass media sources simply provided the news of the revocation. These sources did not provide in-depth information on implementation of the revocation, nor did they include any indications of future opportunities to partner with the U.S. government in areas of safe abortion or SRHR.

Comparison of Communications Between 2017 and 2021

While most participants provided evidence to the contrast between the communications of the two policy changes in 2017 and 2021, one participant from an SRHR-focused organization in Mozambique alleged that neither communication pattern was particularly clear:

> *"Even for me it's not very well clear what can we do and what we can't do, because there's a lack of information. When it [PLGHA] was re-installed there was a lot of misunderstanding. Even the information was not enough for all of us to have a better understanding of what would happen. That's why, for example, you could see some organizations just stopping to be part of some network groups, because those network groups were linked to sexual and reproductive rights. Some of them just stopped going to the meetings, because it was not clear for them how the policy [PLGHA] would be implemented. I think that before [in 2017] and after [in 2021] there was always lack of information or lack of clear information."*

While this quote demonstrates an accordance in communications between the 2017 and 2021 policy shifts, the quote also further illustrates the general frustrations participants described with the U.S. government or prime partner communications about the policy. Furthermore, the

"chilling effect" is seen again in this quote, with organizations stopping to attend meetings with network groups, out of fear of being connected with organizations working in SRHR.

Overwhelmingly, participants agreed that the communication of the 2017 implementation of PLGHA was more consistent, frequent and thorough than the 2021 communication of PLGHA's revocation. One reason for this discrepancy was that some organizations felt they received more guidance during the implementation of PLGHA to ensure they were compliant with the policy. For example, an organization working in safe abortion, SRHR and HIV/AIDS in Mozambique expressed these sentiments by saying:

> *"We were bombarded with communication when the policy [PLGHA] was put in place. There was a lot of attempts in understanding how the different [U.S. government agency] missions would have interpreted the application, and adapted the policy, and applied it, and how they have operated in terms of modifying the agreements. When this was put in place, we were receiving 80% of our funding was coming directly from [U.S. government agency]. There was a lot from my side into making sure that things were done a certain way... When PLGHA basically started a lot of communication. When it was revoked there was just one email and that's all."*

This quote also reflects the sentiments other participants shared, that their organizations needed to adjust and adapt to PLGHA's 2017 enforcement. These adaptations occurred as these organizations' programs were funded by the U.S. government, and the organizations experienced financial impact because of PLGHA's enactment. For example, one participant from Zimbabwean women's rights organization shared this reflection:

> *"Under the Trump administration I think the communication was quite clear, because we saw what happened to organizations that were being funded by [U.S. government*

agency] and they refused to sign. The funding was automatically withdrawn. So, it was clear. We saw what it meant, what this Global Gag Rule meant. We saw organizations collapse, sending members of staff home because there were no jobs anymore. We saw the effects of the Global Gag Rule. We saw the effect and the impact on organizations, and the impact at community level. That was really apparent. For example [Zimbabwean NGO], which is part of [INGO] organization, they had more than 50% of their funding withdrawn."

Here, the participant provides quantifiable evidence ("50% of their funding withdrawn") as well as an impassioned explanation of PLGHA's impact on organizations that declined to certify the policy and thus lost their U.S. global health funding: "*We saw organizations collapse, sending members of staff home because there were no jobs anymore."* These passages exemplify the sentiment expressed by many organizations; that they felt an immense pressure to comply with PLGHA or risk losing their U.S. government funding, which meant the closure of programs and dismissal of staff. Many participants reflected on the dramatic impacts of PLGHA.

Participants also reflected that while they felt the burden of complying with PLGHA, they also experienced more thorough communication regarding PLGHA in 2017 during its initial enactment, in comparison to 2021 with its revocation. A participant from an organization in Malawi working in nutrition, HIV/AIDS and malaria described the different level of communication in this way:

"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, et cetera. This mostly came from international and national organizations that were opposing the Global Gag Rule. 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 them 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. 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."

In this example, the participant mentions that many communications of PLGHA between 2017 and 2021 were provided by INGOs and NGOs opposed to the GGR, as well as from the U.S. government during the Trump administration. This participant continues with this common theme highlighted in the data, the contrast between the two administrations' level of communication:

"...[U]nlike when this has been revised based on the Biden administration. I think there hasn't [been] that much interest, even from the international and national organizations that were providing guidance. I think they've just kept quiet. I don't know whether because now people are now back in their comfort zones, but I wish there was that type of communication. That could have helped people to understand what this [the revocation] means."

This participant's observation that "I think they've just kept quiet" in the wake of the 2021 revocation contrasts to the level of detail and frequency of the 2017 PLGHA implementation communications, not just from the U.S. government, but also from INGOs and advocacy NGOs that had provided guidance and information about the policy during PLGHA's implementation.

Participants also noted the divisive topic of the GGR between the Democratic and Republican parties in the U.S. and provided reflections on how they viewed this division as affecting policy communication and the United States' partnerships in foreign assistance. One participant from Zimbabwe provided this reflection:

> *"I think that communication was more rigorous for the Republicans' government as opposed to now, because they were just communicating, and they really wanted to assert the position that you're not eligible for funding. It was almost like a campaign on its own, that they are withdrawing funding if you don't want to comply. Their communication is more rigorous in that way. I just think also because it rouses a lot of discomfort from women's sector, for example, who would call each other and say, oh, my God, you know, this is happening again...I think it was much loud[er] then, because it was almost like a campaign or a communications campaign. Ditch pro-choice, sign on, and be sure to access funding."*

The reflections from this participant reflect not only the contrast in communication between the two policy changes in 2017 and 2021, but also potential partisan influences on why that communication was varied. This quote particularly seems to implicate anti-abortion advocacy or sentiment as a pressure to comply with the GGR: "*...it was almost like a campaign or a communications campaign. Ditch pro-choice, sign on, and be sure to access funding."*

Another participant from Zimbabwe, whose organization previously received U.S. funding, also demonstrated their insight into the partisan nature of the GGR by sharing that

> *"Basically, this is the politics between the Democrats and the Republicans that we from the develop[ing] world are just pawns in, and we are just victims of that."*

This quote reflects the frustrations expressed by several participants about the GGR, not only when the policy is either implemented or revoked, but how the frequent policy changes can be disruptive to their organizations and those they serve.

Participants also acknowledged the shortcomings of the communication about PLGHA's revocation in 2021 by reporting the lack of clear communication from the U.S. government regarding the revocation. This particular sentiment was echoed by a participant in Mozambique, whose organization works in WASH, gender justice and humanitarian assistance:

> *"I'm not sure if it's fair to say that an administration that lifted a bad policy is somehow trying to just win some-I'm not saying votes, but making people happy, but still not going all the way. I'm not sure this [the revocation] was on purpose, but for me, it reveals that this is not taken as seriously as it should be. Because 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."*

These findings are congruent with evidence that participants felt there needed to be stronger communication of the revocation of PLGHA. In this vein, participants expressed a need for President Biden's administration to not only revoke the policy but also take active steps to ensure this process was efficient and thorough as well as to go further in erasing the harms that it the policy had caused. This participant particularly implicates the Biden Administration to make advancements in undoing the harm imposed by PLGHA, not simply revoking it.

PLGHA Monitoring, Compliance or Guidance Mechanisms

For some organizations, formal mechanisms for monitoring and compliance of PLGHA served as methods of information-sharing about the policy. Participants explained their experiences with PLGHA monitoring and compliance mechanisms when the policy was in

effect, such as agreement modifications, site visits from U.S. officials, such as staff from the U.S. Office of Inspector General (OIG) or USAID-delegated Agreement Officers (AOs), who are typically responsible for the administration and oversight of assistance agreements on behalf of USAID.[150] A representative from a sub-prime partner working in maternal and child health and HIV/AIDS in Mozambique described their monitoring and compliance experience, and relationship with their U.S. implementing agency as such:

> *"We have a very good partnership and [the U.S. agency] is very hands-on and very present. We meet with the [U.S. agency] on a monthly basis to review progress of our implementation. We discuss data issues. They provide a lot of on-the-ground technical support by visiting facilities where we operate and providing feedback on elements that they'd like to see changed. We are co-creators when it comes to what are the changes that need to be made on the ground level if certain indicators are not resulting in the outcomes that, that we've set out."*

In this case, the Mozambican representative described a positive and reciprocal relationship with its U.S. government implementing agency and provided evidence of a synergy between the two in terms of monitoring, compliance and guidance. However, this participant did not share specific examples of monitoring or compliance related to PLGHA.

Several participants (4 in Zimbabwe, 4 in Mozambique, 10 in Malawi) described their experiences with taking an online course that reviewed details of PLGHA when it was in effect as a form of compliance. Staff working on programs funded by U.S. global health assistance were required to share proof of course completion with U.S. agencies or prime implementing partners, often on an annual basis. It was available for prime and sub partners to complete when

[150] Infographic: "The Role of the AO & AR in Assistance Award Administration". USAID. (30 January 2017). Retrieved from: https://www.usaid.gov/sites/default/files/documents/1861/India_RFIP_RoleAOvsAOR.pdf

the policy was in place to help their staff understand the policy, as well as the support implementing partners' compliance with the policy's requirements. The course was accessible while PLGHA was in effect on a website maintained by the USAID called the Global Health eLearning Center.[151] The Global Health eLearning Center offers several other online courses in global health topics, such as antimicrobial resistance and public health emergency response. While the PLGHA-specific course is no longer offered as part of The Global Health eLearning Center, a similar, but separate, course is offered, titled, "U.S. Family Planning and Abortion Requirements."[152] This course has been updated to include brief information of PLGHA's 2021 revocation.[153]

Interviewers asked participants about the now-removed course the "Protecting Life in Global Health Assistance eLearning course" when asking participants about their experiences with it. Most interview participants referred to the course as "the GH eLearning course" or "global health eLearning course," not by its official title. A prime representative working in HIV/AIDS and SRHR from Zimbabwe stated this about their experience taking the course:

> *"It was an online training. One would conduct that training individually, so as to appreciate more about the Mexican [sic] City Policy. And then it would take about two hours or so to go through the training and then one would get the certificate online. After the trainings, we would then present the certificates to [the USG agency] and also to [our prime partner] as confirmation that we have gone through the trainings."*

[151] Global Health eLearning Center. U.S. Agency for International Development. (n.d.) Retrieved from: https://www.globalhealthlearning.org/

[152] Global Health eLearning Center. U.S. Agency for International Development. (n.d.) Retrieved from: https://www.globalhealthlearning.org/course/us-family-planning-and-abortion-requirements

[153] Global Health eLearning Center. U.S. Agency for International Development. (n.d.) Retrieved from: https://www.globalhealthlearning.org/course/us-family-planning-and-abortion-requirements

This quote provides evidence of one mechanism of monitoring organizations' compliance with PLGHA, and outlined the required steps to provide proof of completion to the U.S. government. The course did present challenges for one organization in Mozambique, a mainly Portuguese-speaking country.[154] A participant from a prime and sub-prime organization working in maternal & child health and HIV/AIDS in Mozambique identified the need for the GH eLearning course to be offered in languages other than English:

> *"I think for Mozambique, specifically, one of our biggest challenges always turned out to be the language. 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."*

This quote not only demonstrates that organizations performed their required duties in terms of conformity with the policy, but also encountered barriers in doing so. Offering the course in only the English language presented an unnecessary challenge to this Mozambican organization, one which was not seen in the Malawian and Zimbabwean organizations, as both those countries are majority English-speaking. This quote exemplifies an extra obstacle faced on the part of global health organizations to fully understand the policy when it was in effect.

Monitoring & Compliance of 2021 Revocation

No participants in this research described any experiences related to formal mechanisms that the U.S. government or prime partners are implementing to monitor, provide guidance or ensure their compliance with President Biden's 2021 revocation of PLGHA at the time of the

[154] "Language Data for Mozambique" Translators Without Borders. (2022). Retrieved from: https://translatorswithoutborders.org/language-data-for-mozambique#:~:text=Portuguese%20is%20the%20country's%20official,Sena%2C%20Chwabo%2C%20and%20Tswa.

study, between July and August 2021. A participant from a Malawian organization working in healthcare provision and systems strengthening, provided this evidence:

> *"As of now, I'm not sure whether there's any policy in place or we have the guidelines we have to comply to the policy that was revoked. I haven't seen the new guidelines that we are to adhere to now that the revocation has happened."*

This quote most accurately matches the sentiments expressed by the other participants when asked about systems for monitoring the implementation of the 2021 revocation.

For one organization, it was unclear whether there was a continued need to take the GH eLearning course. A participant from a Mozambican sub-prime (and former prime in previous years) organization focused on safe abortion and SRHR mentioned their experience with misunderstanding the requirement to take the course after the revocation:

> *"When we went to the Global Health Learning page, the one where the course was provided, there was a notice that explained it with this main memorandum revoking the PLGHA policy, this course had been removed. So, we learned that through just going and looking for the course. It was not officially communicated by [name of participant's organization]."*

Before venturing to the course website, this participant had been informed of PLGHA's revocation by other means. To expound on this piece of data, the participant had provided contextual information that their organization/employer had not "officially communicated" to its employees whether they needed to take the PLGHA course. This removal of the course provides evidence of a lack of monitoring and compliance mechanisms related to the revocation of PLGHA. Furthermore, the confusion on behalf of the organization demonstrates organizations'

misunderstandings of the processes in place from the U.S. government to fully implement the revocation.

Impact of Frequent Policy Changes

Many participants, particularly those more focused on SRHR, directly addressed the impacts on their organizations that result from the frequent changes between either implementation or revocation of the GGR. Participants most dominantly spoke of impacts on organizational planning and financial sustainability. Even among participants that do not focus as narrowly on SRHR, references were still made of the long-term impacts because of the turbulent policy shifts every 4-8 years, particularly on the formal establishment of partnerships with other organizations. The establishment of formal, long-term partnerships can be essential for program implementation. For example, one prime and sub-prime organization in Mozambique focused on tuberculosis, educational attainment and nutrition, referenced this missed opportunity for partnership during PLGHA:

> *"Before [during PLGHA] we were actually interested in applying as a partnership with [Mozambican SRHR-focused organization], which we couldn't. Now in any other future, it gives us opportunity, wider partners that we can work with."*

While this participant speaks optimistically of future partnerships because of the revocation, this quote provides evidence of the policy's impact on organizational planning and partnership development. Several participants highlighted the hindrance they felt because of uncertainties in the future because of this frequent policy change. One participant from Zimbabwe working in youth-based SRHR services provided an experience where, while in the planning stages of a formal partnership with a prime organization to receive U.S. funding for an

SRHR-related program, the planning was interrupted by former President Trump's 2016 election:

> *"Yes, we could have applied for the grant through [prime partner], but we ended up not applying because of the policy [PLGHA]. In terms of financial planning, indeed, it can affect us. It affected us when we were planning with [prime partner]. Apparently, we had done all the work with [prime partner], and now that was the time for us to sign and we were not very sure whether Trump was going to win the second term in office."*

This participant further elaborated that once former President Trump had won the 2016 election, the intended project was abandoned, and the previous efforts that had been undertaken by the organization and their prime partner to apply for a U.S.-funded grant were obsolete. This participant's experience is one example of the long-term financial impact of the policy, as well as the organizational impacts of frequent policy changes.

One participant, both prime and sub-prime, working in maternal and child health in Mozambique spoke of their organization's adaptation to the frequent policy shifts:

> *"Quite frankly, it feels like every four to eight years there seems to be a ping-pong from one side to another so people are becoming a little bit more aware as to how to navigate it."*

The "ping-pong" this participant refers to is the either the enforcement or revocation of the GGR, which historically has "ping-ponged" back and forth every four to eight years, usually congruent with the political party stance of the sitting president. Another participant, representing an organization working in safe abortion and SRHR in Mozambique expressed the frustration they felt about the policy's turbulence:

> *"It looks like [U.S. government agency] doesn't know what they want to do. Yeah, it's crazy. We thought we had the space, and liberty, and freedom to speak out. We didn't know how that would retaliate back on us. Now that we know, I think we are more cautious, because it can affect the organization. Actually, with the amount of programs we have now and funding we have now, it can affect our beneficiaries tremendously, because we do impact a huge number of beneficiaries since [Mozambican NGO] grew so much since the [Global] Gag Rule was enforced up to now. It's the first time we have encountered such [a] policy that every five years we will see changes in relation to the policy. It makes me feel very insecure, not knowing what's going to happen in five years from now."*

This quote illustrates the insecurity organizations feel about their abilities to conduct strategic, long-term planning because of the GGR. Furthermore, this participant alluded directly to the related impact on their beneficiaries because of the organization's hampered abilities to conduct organizational planning.

Discussion

Overall participants wanted more information concerning the GGR, particularly in the months after it was revoked in January 2021. Many participants stated their understanding was simply that the GGR had been revoked by President Biden, and they expressed the need for more comprehensive guidance on what the revocation actually meant for their organizations and how they should proceed with their programs moving forward. Participants reported varied methods of communication such as emails, topical newsletters, mass media, updates to project agreements, communications from coalitions or partner spaces and even no communication until

the study team had established contact. Participants also emphasized the need for more thorough communication from either the U.S. government and/or prime partners (or both, when applicable), concerning the 2021 revocation of PLGHA.

Additionally, most participants experienced monitoring for compliance with the policy when PLGHA was in effect, particularly participants that worked in programs relating to safe abortion or SRHR. No organization recounted that they were aware of any compliance measures undertaken to ensure adherence with the revocation.

In lieu of more copious communication and guidance from either the U.S. government or prime partners, organizations often found themselves filling this gap with information from other civil society organizations in coalitions or working group spaces or independently seeking out information about the GGR, whether from the Internet or from advocacy organizations like CHANGE to address knowledge and awareness gaps. Some participants provided specific examples of how these communication patterns and gaps have affected their organizations, whether in financial impact or in the over-implementation of the GGR when it was no longer applicable.

When comparing the two policy changes in 2017 and 2021, participants recounted their experiences with PLGHA implementation and noted that the overall communication and guidance regarding the policy change at that time had been more extensive than those related to the 2021 revocation. Participants also expressed frustrations at the turbulence of the policy being switched on and off over time and provided evidence of how the semi-routine policy shifts according to U.S. presidential cycles created organizational challenges related to programming, partnerships and sustainability.

Not only does the turbulence associated with this policy have effects on organizations' sustainability and sovereignty, but participants also referenced the impacts of the policy on formal partnerships and organizational growth. This is exemplified by one of the Zimbabwean participants, who shared the experience of organizations "collapsing" and sending members of staff home because of the loss of job opportunities. The GGR's impacts are not just effects on the employees sent home from organizations or the collapse of the organizations themselves. The literature review has demonstrated its effects on the essential healthcare services these entities provide for communities, as well as the cascading effects on communities and individuals that depend on these organizations.[155,156]

Furthermore, as was emphasized by participants, these findings illustrate that simply revoking the GGR (or PLGHA, in its most recent iteration) is not enough to mitigate the harms of the policy. Evidence from this thesis demonstrates that efficient communications and the dissemination of information related to the revocation of policies such as the GGR's are necessary to ensure that the policy is no longer implemented after it has been revoked. Further, these case studies exemplify that without comprehensive guidance from the U.S. government or prime partners, the negative impacts of the GGR can still linger and continue to perpetuate harm to communities.

Implications & Recommendations

[155] "The Global Gag Rule and Fights Over Funding UNFPA: The Issues That Won't Go Away". Guttmacher Policy Review. *The Guttmacher Institute*. 18 (2). (3 June 2015). Retrieved from: https://www.guttmacher.org/gpr/2015/06/global-gag-rule-and-fights-over-funding-unfpa-issues-wont-go-away

[156] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de163950225

This research has many implications for action for policymakers, members of civil society, advocates, U.S. global health implementing partners and researchers interested in global SRHR. These four categories can benefit from this research in these specific areas:

Policymakers/Legislators

The findings from this study provide context and insight into how global health partners around the world receive and disseminate U.S. policy changes that affect their operations. The detailed qualitative data in this study can be used to better understand the relationships between global health implementing partners and the U.S. government. Furthermore, the findings provide insight into how the U.S. government can improve in terms of efficiency, clarity and harm reduction, such as the provision of guidance to INGOs on how to implement the revocation, how to engage in future opportunities with U.S. funding, and how to recover from the damages incurred to organizations under PLGHA.

This evidence supports the need for comprehensive, transparent and thorough dissemination of policy change communications from the U.S. government to its global health implementing partners. The U.S. government, in partnering with foreign NGOs to execute global health programs, is obligated to ensure that its policy stipulations for funding are well-understood in a timely and efficient manner. The various methods of communication between either the U.S. government or prime partners with prime or sub-prime implementing partners indicate complex dynamics at play in the U.S. global health landscape, not only in the relationships between the U.S. government and its global health partners, but also in the efficiency of policy change implementation related to SRHR.

The styles of communications about PLGHA analyzed in this thesis illustrate aspects of the bureaucratic policy change and communication process that in some ways are helpful to

global health implementers, such as the candid and swift messages of PLGHA's revocation from either prime partners or U.S. agencies. Regarding this, the participants that attested receiving timely communications (within one week of the presidential memorandum) reported that the explicit initial message of revocation was helpful. However, many of these same participants and several others also reported a dearth of more comprehensive, explanatory information guiding their understanding and implementation of the revocation and next steps, and, in its absence, left many implications for progress and advancement of these organizations' programs, especially in SRHR.

Advocates & Civil Society

Both U.S.-based and foreign civil society organizations were attributed by participants as beneficial and helpful in their understanding of both the implementation and revocation of PLGHA. Thus, this research supports the work that many civil society organizations undertake to aid in information dissemination, education and comprehension of SRHR policies. Furthermore, this research highlights remaining gaps in understanding and comprehension on behalf of implementing organizations, thereby providing indicating where civil society can provide instrumental guidance.

This research has many implications for advocacy groups, including those that advocate against the implementation of the GGR, as these findings provide evidence of the damage caused by the GGR. Moreover, advocacy groups can utilize these findings to assist in championing more comprehensive and intentional policy dissemination communications from the U.S. government.

Global Health Implementing Partners

These findings demonstrated the cascade of communication from the U.S. government to global health implementing partners, and one area of tremendous future improvement could come from

the communication pathway between prime partners to sub-prime partners. Evidence from this research suggests that prime partners did not always provide clear guidance to their sub-prime partners, in terms of both the implementation and revocation of PLGHA. Therefore, there are many implications for improvement especially for INGOs operating as prime partners. These entities should ensure complete understanding and comprehension of policy adherence on the part of their sub-prime organizations.

Future Research

Further research into this topic is warranted. First, similar studies should be conducted that analyze policy communications from the U.S. government to global health partners in other parts of the world that receive large amounts of U.S. foreign assistance, such as countries in Latin America, Asia, and the Middle East. Similar studies conducted with INGOs in other areas of the world would promote the generalizability of these findings. Second, more quantitative research is warranted to support the breadth of quantitative and qualitative data that documents the impacts of the GGR. Third, as PLGHA was recently revoked in 2021, future research is warranted to assess any long-term damage from the policy that this research was unable to capture due to the study's limited time period between July and August 2021. Future research could also assess any long-term damage related to the gaps in communications of the revocation to the present day, which this research was also unable to capture due to the study period of within one-year post-revocation.

Recommendations for Future Action

This research corroborated prior findings of the GGR's many harms on health outcomes, particularly for communities that rely on U.S. global health programs for vital health

services.[157,158] This study's findings also provide additional evidence for the GGR's many harmful effects on global health and human rights, which corroborate existing evidence.[159] Importantly, these findings contribute to the limited data that indicate that these impacts are not easily reduced or eliminated altogether, even when the GGR is revoked.[160]

While there is room for improvement in policy change communications related to the GGR, this research also provides arguments against the policy's existence. Permanent repeal of the GGR by the U.S. Congress would rectify any tangential negative effects of its unstable transitions over time, as well as grant U.S. global health implementing partners the autonomy and sovereignty they deserve to make their own decisions about how best to address the health needs in their countries.

[157] "The Global Gag Rule and Fights Over Funding UNFPA: The Issues That Won't Go Away". Guttmacher Policy Review. *The Guttmacher Institute*. 18 (2). (3 June 2015). Retrieved from: https://www.guttmacher.org/gpr/2015/06/global-gag-rule-and-fights-over-funding-unfpa-issues-wont-go-away

[158] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de163950225

[159] CHANGE: Center for Health and Gender Equity. *Prescribing Chaos In Global Health: The Global Gag Rule from 1984-2018*. June 2018. Retrieved from: https://srhrforall.org/download/prescribing-chaos-in-global-health-the-global-gag-rule-from-1984-2018/?wpdmdl=1064&refresh=61b8d1b18c2de163950225

[160] "Exporting Confusion: U.S. Foreign Policy as an Obstacle to the Implementation of Ethiopia's Liberalized Abortion Law". Leitner Center for International Law and Justice, Fordham Law School. (May 2010). Retrieved from: http://www.leitnercenter.org/files/Publications/LeitnerCtr_EthiopiaReport_WebVersion.pdf

Appendix

In-Depth Interview Guides

Interview Guide 1: Organizations that currently receive U.S. global health assistance

Part 1. Introduction

1. Do you prefer we use the phrase "Mexico City Policy, Expanded Mexico City Policy, Protecting Life in Global Health Assistance, or Global Gag Rule" during this interview?
2. Can you briefly tell us about the work your organization does?

Part 2. U.S. Funding

3. Does your organization currently receive global health assistance from the U.S. government?
    a. Has your organization ever received U.S. global health assistance?
    b. Does your organization receive money directly from a U.S. government agency?
        i. Which agency or agencies?
        ii. Do you use U.S. global health assistance funding to sub-grant to any other implementing partners? If so, what organizations?
    c. Does your organization receive a sub-grant from a prime partner?
        i. Which prime partner or partners?
    d. How long has your organization been a recipient of U.S. global health assistance?
    e. Can you tell me what types of programs your organization implements with U.S. global health assistance funds?
        i. When does your current agreement(s) expire?
    f. Are you considered a U.S. based organization?

Part 3. Experiences with the policy's revocation:

4. What is your understanding of the revocation of the policy by President Biden?
5. Could you describe the kind of communication you/your organization has received to date regarding the policy's revocation?
    a. Who informed you of this policy change?
    b. How did you receive these communications? For example, did you receive emails, WhatsApp, phone calls, or other modes of communication?
        i. Did you receive any information about the policy change from other channels of communication (like social media, the news, press releases, network of colleagues, etc.)?
    c. When did you receive these communications?
    d. What do you feel has been communicated clearly?
    e. What has not been communicated clearly?
    f. How have these communications compared to any policy implementation communications you may have received when the policy was in effect under the Trump Administration?

6. Did you receive any guidance on how to implement the revocation of the policy?
    a. Can you please describe this guidance?
        i. Was this guidance specific to your organization, programs, or country or was it more general?
    b. How helpful was this guidance in changing your organization's operations or program implementation?
    c. What additional information or guidance do you or your organization need to implement this policy change?
7. If you do not understand or have questions about the policy, who do you go to?
8. How are you communicating internally within your organization about the revocation of the policy?
9. How are you communicating the revocation of the policy to partner organizations?
    a. Has the policy change affected your organization's work with any partners? If so, how?
10. How are you communicating this policy change to organizations that you sub-grant to?
    a. Has the policy change affected your organization's work with any sub-grant partners? If so, how?
11. How does the U.S. government [or your prime partner] monitor your organization's implementation of the revocation of the policy?

Part 4: Effects on Program Planning and Services

12. Can you tell me a bit about the organizational time and resources that go into adapting to this policy change?
    a. How has the revocation of the policy impacted your organization's financial planning?
    b. Are there other organizational or other factors you anticipate having to navigate related to this specific policy change?
13. How has the revocation of the policy impacted your organization's portfolio of work?
    a. For example, now that the policy has been revoked, are there programs/services that you are able to implement that you weren't able to while the policy was in place?
    b. How does the revocation affect communities that your organization serves?
    c. How does it impact who you can or will partner with?
        i. Do you have to seek out new partnerships?
        ii. Do you have to end relationships with partners?
14. How has the revocation of the policy impacted domestic policy related to sexual and reproductive health and rights?

Part 5: Closing

15. What do you see as the key processes or systems that need to be in place to support the most efficient and effective revocation of the policy generally? In your country? In your organization?

16. Finally, is there anything about the revocation of the policy that we haven't discussed that you would like to discuss? Is there any piece of the story that we are missing?

Interview Guide 2: Organizations that have previously received U.S. global health assistance

Part 1. Introduction

1. Do you prefer we use the phrase "Mexico City Policy, Expanded Mexico City Policy, Protecting Life in Global Health Assistance, or Global Gag Rule" during this interview?
2. Can you briefly tell us about the work your organization does?

Part 2. U.S Funding

3. Has your organization ever received U.S. global health assistance?
    a. Did your organization receive money directly from a U.S. government agency?
        i. Which agency or agencies?
        ii. Did you use U.S. global health assistance funding to sub-grant to any other implementing partners? If so, what organizations?
        iii. When did your funding relationship with the U.S. government end?
    b. Did your organization receive a sub-grant from a prime partner?
        i. Which prime partner or partners?
        ii. When did your funding relationship with the prime partner end?
    c. Can you tell me about the types of programs your organization implemented with U.S. global health assistance funds?
    d. Are you considered a U.S. based organization?

Part 3. Experiences with the policy's revocation:

4. What is your understanding of the revocation of the policy by President Biden?
5. Could you describe the kind of communication you/your organization has received to date regarding the policy's revocation?
    a. Who informed you of this policy change?
        i. From U.S. government staff at headquarters, mission staff, other partners or coalitions?
    b. How did you receive these communications? For example, did you receive emails, WhatsApp, phone calls, or other modes of communication?
        i. Did you receive any information about the policy change from other channels of communication (like social media, the news, press releases, network of colleagues, etc.)?
    c. When did you receive these communications?
    d. What do you feel has been communicated clearly?
    e. What has not been communicated clearly?

    f. How have these communications compared to any policy implementation communications you may have received when the policy was in effect under the Trump Administration?
6. Did you receive any guidance on how to engage with U.S. global health funding or partners now that the policy has been revoked?
    a. Was this guidance specific to your organization, programs, or country or was it more general?
    b. How helpful was this guidance?
        i. What additional information or guidance do you or your organization need?
7. If you do not understand or have questions about the policy, who do you go to?
8. How are you communicating internally within your organization about the revocation of the policy?
9. How are you communicating the revocation of the policy to partner organizations?
    a. Has the policy change affected your organization's work with any partners? If so, how?
10. How are you communicating this policy change to organizations that you sub-grant to?
11. Has the policy change affected your organization's work with any sub-grant partners? If so, how?

<u>Part 4: Effects on Program Planning and Services</u>

12. Can you tell me a bit about the organizational time and resources that go into adapting to this policy change?
    a. How has the revocation of the policy impacted your organization's financial planning?
    b. Are there other factors you anticipate having to navigate related to this specific policy change?
13. How has the revocation of the policy impacted your organization's portfolio of work?
    a. For example, now that the policy has been revoked, are there programs/services that you are able to implement that you weren't able to while the policy was in place?
    b. How does the revocation affect communities that your organization serves?
    c. How does it impact who you can or will partner with?
        i. Do you have to seek out new partnerships?
        ii. Do you have to end relationships with partners?
14. How has the revocation of the policy impacted domestic policy related to sexual and reproductive health and rights in (country)?

<u>Part 5: Closing</u>

15. What do you see as the key processes or systems that need to be in place to support the most efficient and effective revocation of the policy generally? In your country?

16. Finally, is there anything about the revocation of the policy in (country) that we haven't discussed that you would like to discuss? Is there any piece of the story that we are missing?

Interview Guide 3: Organizations that have never received U.S. global health assistance

Part 1. Introduction

1. Do you prefer we use the phrase "Mexico City Policy, Expanded Mexico City Policy, Protecting Life in Global Health Assistance, or Global Gag Rule" during this interview?
2. Can you briefly tell us about the work your organization does?

Part 2. Experiences with the policy's revocation:

1. What is your understanding of the revocation of the policy by President Biden?
2. Could you describe the kind of communication you/your organization has received to date regarding the policy's revocation?
    a. Who informed you of this policy change?
        i. From U.S. government staff at headquarters, mission staff, other partners?
    b. How did you receive these communications? For example, did you receive emails, WhatsApp, phone calls, or other modes of communication?
        i. Did you receive any information about the policy change from other channels of communication (like social media, the news, press releases, network of colleagues, etc.)?
    c. When did you receive these communications?
    d. What do you feel has been communicated clearly?
    e. What has not been communicated clearly?
    f. How have these communications compared to any policy implementation communications you may have received when the policy was in effect under the Trump Administration?
3. Did you receive any guidance on how to engage with U.S. global health funding or partners now that the policy has been revoked?
    a. Was this guidance specific to your organization, programs, or country or was it more general?
    b. How helpful was this guidance?
        i. What additional information or guidance do you or your organization need?
4. If you do not understand or have questions about the policy, who do you go to?
5. How are you communicating internally within your organization about the revocation of the policy?
6. How are you communicating the revocation of the policy to partner organizations?
    a. Has the policy change affected your organization's work with any partners? If so, how?

Part 3: Effects on Program Planning and Services

7. Can you tell me a bit about the organizational time and resources that go into adapting to this policy change?
    a. How has the revocation of the policy impacted your organization's financial planning?
    b. Considering the recent revocation of the policy, would your organization apply for U.S. global health funding now or in the future? Why or why not?
    c. Are there other factors you anticipate having to navigate related to this specific policy change?
8. How has the revocation of the policy impacted your organization's programs or services that you currently provide or plan to provide in the future?
    a. How does the revocation affect communities that your organization serves?
    b. How does it impact who you can or will partner with?
        i. Do you have to seek out new partnerships?
        ii. Do you have to end relationships with partners?
9. How has the revocation of the policy impacted domestic policy related to sexual and reproductive health and rights in (country)?

Part 4: Closing

10. What do you see as the key processes or systems that need to be in place to support the most efficient and effective revocation of the policy generally? In your country?
11. Finally, is there anything about the revocation of the policy in (country) that we haven't discussed that you would like to discuss? Is there any piece of the story that we are missing?