Sida’s input to the Swedish Ministry for Foreign Affairs on actual and predicted consequences of the Mexico City Policy/Protecting Lives in Global Health Assistance (MCP/PLGHA)

1. Background

The full enjoyment of sexual and reproductive health and rights (SRHR) by all individuals is a key priority in Sweden’s development cooperation, amounting to 8 per cent of all Swedish official development assistance (ODA) and 63 per cent of Sida’s health development assistance in 2016. Sida channels SRHR funding at global, regional (Africa) and bilateral level (12 countries).

According to Swedish domestic and foreign policy, and international development policy, individuals’ full enjoyment of their SRHR means access to the full range of SRHR-related information and/or services, including access to safe and legal abortion.

In July 2017, Sida adopted a position and guidance document on US policy – the Mexico City Policy (MCP) and Protecting Lives in Global Health Assistance (PLGHA)\(^1\). Previously, when the MCP was not applied to US global health support, Sida had no need for such a guidance document. The purpose of the guidance document is to help Sida’s staff identify potential risks in the implementation of Sida-supported SRHR programmes, should partners choose to comply with the MCP/PLGHA. Following this, Sida’s head office requested that its Health and SRHR Programme officers at global, regional and country level engage in dialogues with partner organisations to understand the implications of the MCP/PLGHA on their funding situation, women’s and girls’ health, and Swedish development assistance.

Below is a summary of the information gathered from Sida’s head office and Swedish missions abroad, based on contacts with more than 30 of Sida’s partner organisations.

\(^1\) ‘Sida's position and guidance on US Policy – the Mexico City Policy (MCP)/ Protecting Lives in Global Health Assistance (PLGHA)’, 170707
Approximately one third of Sida’s partner organisations have ongoing US global health assistance (US GHA) funding. Only a few (US-based non-governmental organisations (NGOs) have reported that they will comply with the MCP/PLGHA. For partners receiving US GHA that will not comply with MCP/PLGHA, the US GHA proportion of funding accounts for between 5 and 15 per cent to approximately 60 per cent of their total budgets. Moreover, several of Sida’s SRHR partners sub-grant to other smaller NGOs. Some of these smaller sub-contracting NGOs will comply with the MCP/PLGHA, posing many challenges for Sida (see below). Furthermore, several of Sida’s partners are still considering the financial and operational implications of the introduction of the MCP/PLGHA and thus have not yet made a decision. This limits Sida’s ability to measure the full effect of the MCP/PLGHA.

Overall, Sida and several partners note a significant information gap concerning the MCP/PLGHA. USAID missions have not provided sufficient information to USAID-funded partners and/or other donors on requirements associated with the MCP/PLGHA. This has led to uncertainties among Sida’s partners and in the sector at large. Many of Sida’s partners describe the extension of the MCP/PLGHA from family planning funding to all global health assistance as a “shock”, particularly organisations with no prior experience of the MCP/PLGHA (such as HIV organisations). Some partners are still challenged by an internal understanding process, while others are talking with their implementing partners about how to mitigate operational risks. All in all, the full impact of the implementation of the MCP/PLGHA remains to be seen. Sida hopes that another review of the impact of the MCP/PLGHA will be carried out when partners have signed new agreements and activities have been carried out for some time. Only then will the full impact of the policy be evident.

2. The MCP/PLGHA as a threat to women’s health and rights, development and the implementation of the 2030 Agenda

2.1 Women’s and girls’ reproductive rights

Most of Sida’s partners consider the MCP/PLGHA to be an infringement of women’s and girls’ reproductive rights, including their right to bodily autonomy, the right to access to information and the right to make informed choices. Some partners note that the MCP/PLGHA prevents organisations from providing abortion services, even to the extent permitted by national laws, and hence interferes with domestic policy and national sovereignty. Certain partners also note that the policy goes against hard-won rights enshrined in commitments adopted by the African Union, East African Community and Southern Africa Development Community.
2.2 Discontinuation of health services

The perceived consequences of the MCP/PLGHA for the health sector include a lack of funding for, and therefore availability of, sexual and reproductive health (SRH) commodities and services. This will result in an increased number of unintended pregnancies, high-risk pregnancies, unsafe abortions, injuries and deaths. A general understanding is that consequences of the MCP/PLGHA will also negatively impact post-abortion care (PAC) services.

The International Planned Parenthood Federation (IPPF), one of Sida’s key global SRHR partners, has estimated the consequences of lost US GHA funding for a number of membership associations if they do not sign. One example is the Family Guidance Association of Ethiopia (FGAE), which estimates that funding cuts in Ethiopia due to implementation of the MCP/PLGHA will result in 1.8 million people being denied access to sexual and reproductive services over the next three years, of whom 55 percent will be young people under 24 years of age.

Another example is the member association in Mozambique, where the consequences will be severe, as its programmes are largely funded by US sources. The loss of these funds will directly affect 414 000 adolescent and young clients, 11 400 adults and 11 900 people who will lose access to life-saving services. Specifically, it means a reduction of 810 000 SRH services to adolescents, 14 900 HIV and tuberculosis services for adults, and 35 700 HIV, care and nutrition services for vulnerable children.

The Family Planning Association of Malawi (FPAM) is expected to lose 20 percent of its budget. For 2017–2019, this means that staff is expected to be reduced by 53 percent across all clinics, 101 service delivery points will be affected and 1.8 million clients will not be reached with services.

In Latin America, the MCP/PLGHA will impact emergency response funding for the Zika epidemic, thereby jeopardising the integrated SRH response. In Colombia, Profamilia was poised to receive USD 1.2 million from a USAID grant that combined Zika emergency response with SRH services for displaced people in the Choco, a majority Afro-Colombian province ravaged by the decades-long conflict. This project will not be rolled out.

2.3 Disintegration of services and fragmentation of health systems

One large risk of the MCP/PLGHA noted by Sida and its partners is the potential roll-back of gains made in recent decades on HIV/SRHR integration. In Africa, for example, there has been an increased focus on comprehensive HIV and SRHR programming for adolescent girls and young women who are at disproportionate
risk of HIV. Between 2012 and 2016, Sida and the European Commission supported the regional UNAIDS-UNFPA programme, entitled ‘SRH-HIV Linkages Project’, in seven countries in Southern Africa. The programme aims to link SRH/HIV services at political, policy and service level. Sida fears that the MCP/PLGHA will jeopardise the gains achieved to date and contribute to the disintegration of HIV and SRHR programmes.

Some partners fear that the MCP/PLGHA will have a fragmenting effect on overall health systems, as services providers are prohibited from providing safe abortion services, thereby forcing the establishment of parallel structures.

Sida and partners note that the MCP/PLGHA risks polarising and dividing the broader SRHR/HIV/LGBTI/right to health movements between those who choose to comply and those who do not. This polarisation will undermine movement-building across sectors and issues. This seems to be an issue particularly at regional level in Africa and in certain countries where partners are asking Sida to be a safe space and bridge this gap.

2.4 Affecting the furthest left behind

Sweden’s health development assistance has been allocated to SRHR and maternal health, with the overall aim of reducing maternal mortality and morbidity in low-income countries and amongst the furthest left behind. Sida sees an obvious risk that the MCP/PLGHA will undermine Sweden’s and other donors’ investments in maternal health, in particular when key partners lose funding, have to close down services or limit their engagement on broader SRHR issues. This implies direct threats to the achievement of the Sustainable Development Goals (SDGs) of the 2030 Agenda, in particular SDG 3 (Ensure healthy lives and promote wellbeing for all at all ages), and SDG 5 (Achieve gender equality and empower all women and girls).

Finally, Sida fears that that those who will be hardest hit by the sectoral consequences of the MCP/PLGHA will include those who are already marginalised, such as the poorest people, people in rural areas, LGBTI communities, people living with HIV, and adolescent girls and young women, thereby compounding their vulnerabilities. In particular, HIV organisations that do not themselves provide abortion services or advocacy, but that do provide some level of counselling and referrals, find it close to impossible to choose between the decision forced upon them by the MCP/PLGHA to support work on women’s rights to comprehensive health service and advice or providing vital support for tens of thousands of people living with HIV.
3. Shrinking space for SRHR organisations and slow-down of progress on normative SRHR work and research

Sida works closely with key partners on policy reforms in the areas linking SRHR to gender equality and sustainable development. Sida supports UN partners working on normative and policy issues in relation to gender equality and SRHR, and fears that the MCP/PLGHA will have a direct negative impact on the overall policy environment in the years to come. It may also indirectly affect the activities undertaken in collaboration with partners (UN, civil society, research) whose position on SRHR issues may be influenced by the MCP/PLGHA.

Sida has done substantial work around the shrinking democratic space affecting, for example, civil society and the media, linking it to the global decline of democracy and human rights abuses in several parts of the world, including many low-income countries. The concern, also expressed by many of Sida’s partners, is that the MCP/PLGHA has a ‘silencing effect’, meaning that organisations may decide to remain silent on the broader SRHR agenda and the link between individuals’ enjoyment of their SRHR and sustainable development because they fear losing funding and/or partnerships with the US Government.

Sida has already noted this in some of our partner countries and views these trends as unfortunate in an already difficult environment for democracy and human rights in general.

Moreover, it is a concern for Sida’s research unit and research partners that the MCP/PLGHA will have a silencing effect on academia and ‘the independence of science’. One of Sida’s research partners reports that the academic institutions it partners with have already indicated an unwillingness to engage in research related to certain components of SRHR.

All in all, the reinstatement of the MCP/PLGHA may undermine US global leadership to promote global health support, international health research and gender equality (including SRHR).

4. Organisational consequences for partners and for Sida

Four (possibly five) of Sida’s key SRHR partners expect to lose significant parts of their US funding due to non-compliance with the MCP/PLGHA. This will put their operations and provision of essential SRH services at risk, threatening the health and wellbeing of women and girls. It will also lead to significant staff reductions and fundamental organisational restructuring.

Key financial and operational consequences for some of Sida’s US-based NGO partners include the need to restructure operations to protect the delivery of safe abortion services, transferring such activities to their own organisation rather than
sub-granting funds to local NGOs. For one of Sida’s partners (Save the Children Sweden), the implementation of a regional SRHR programme in Africa will be transferred from Save the Children International to Save the Children Sweden in order to deliver on the SRHR activities included in its cooperation agreement with Sida. All of this will come at substantial cost for affected partner organisations: reorganisation, recruitment of new staff, and revision and renegotiation of cooperation agreements and implementation plans.

A specific challenge for Sida is sub-granting by our partners. Although it appears that most of our immediate SRHR partners will not comply with the MCP/PLGHA, many of them still sub-grant to smaller NGOs that may comply because they independently access US GHA funding. Depending on the number of sub-grants and the overall context, this situation poses both operational and administrative challenges and costs for our partners and for Sida.

Organisational restructuring at partner organisations means that Sida must discuss and possibly adjust the expected outcomes in cooperation agreements with these organisations. Sida will also most likely have to accept the reallocation of its support (often channelled as core support) to partners’ internal management instead of to service provision and core operational activities. It may also have to accept that such organisations will spend more time (again, funds stemming from Sida’s support) on fundraising, trying to fill the gaps due to lost US GHA funding. Furthermore, there is concern over difficulties navigating partnerships, both at national and organisational level, due to the potential divide the MCP/PLGHA may create among partners on whether or not to comply with the policy.

In recent months, Sida colleagues at head office and in the field have spent a significant amount of time discussing the MCP/PLGHA with partners, including updating assessments in Sida’s contribution management system and, in some instances, looking for new partners to ensure that Sida can deliver on the expected SRHR outcomes specified in Sweden’s development cooperation strategies (global, regional and local) adopted by the Swedish Government. This extra work will continue for the foreseeable future as Sida and Swedish embassies must now conduct additional risk analysis and risk management discussions regarding the MCP/PLGHA with all health and SRHR partners.