A Powerful Force:

U.S. Global Health Assistance and Sexual and Reproductive Health and Rights in Malawi
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February 2020
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DREAMS beneficiaries waiting outside PSI’s service delivery site in Machinga, Malawi.
At its best, U.S. global health assistance is a powerful force for positive change in the world when policies and programs are grounded in science and human rights. However, when U.S. policies ignore evidence and stifle human rights, U.S. global health assistance contributes to negative health outcomes and human rights violations for all people. This report maps both.

In this report, CHANGE presents the findings from a fact-finding trip in Malawi. The report investigates the impact of U.S. global health assistance policies, funding decisions, and programmatic shifts on the sexual and reproductive health and rights (SRHR) of people in Malawi, with a particular focus on women and girls. Based on interviews and partnerships with civil society organizations in both Malawi and the U.S., this report provides an in-depth analysis of SRHR in U.S. global health assistance.

The Malawi case study captures first-hand accounts of the repercussions of historic and current U.S. global health assistance policies, programs, and funding decisions on SRHR in Malawi. It also highlights the successes and challenges associated with implementing U.S. global health assistance programs in-country and documents the local political and cultural factors that shape program implementation.

CHANGE finds that the siloed nature of U.S. global health assistance hinders the ability of recipient programs to meet the health needs of Malawians. For programs to truly meet the SRHR needs of beneficiaries, community partners and local organizations must be engaged at every level of U.S. global health program design, implementation, and evaluation.

In this report, CHANGE analyzes the role of U.S. global health assistance and civil society in upholding sexual well-being and promoting the positive aspects of sexual health. And, for the first time, CHANGE documents the impact of climate change on SRHR.

The primary focus of our methodology was not on the Global Gag Rule, however, it’s corrosive impact on health and human rights pervade the findings and are woven throughout the report.

The report’s primary evidence provides both an assessment and a critical reminder of U.S. commitments to the global SRHR agenda. The report also offers specific recommendations to improve U.S. global health assistance so that it is a powerful force for good in Malawi and throughout the world.

Serra Sippel
President
The Republic of Malawi, also known as the “Warm Heart of Africa,” is a small, landlocked country in southern Africa that shares a border with Mozambique, Tanzania, and Zambia. With a total population of approximately 19.8 million people, 44 percent of the population is 14 years old or younger and over 80 percent of Malawians live in rural areas. Approximately 80 percent of households engage in agriculture and rely almost entirely on subsistence farming, which is particularly vulnerable to cyclical drought, flooding, and other environmental shocks caused by climate change.

Malawi’s three administrative regions—the Northern, Central, and Southern regions—are subdivided into 28 districts. Within each district, smaller government structures contribute to the central rule of the nation. Lilongwe, Malawi’s capital, is located in the Central region and contains the national government offices as well as the majority of embassies and country offices for multilateral and international nongovernmental organizations (INGOs) that operate in Malawi. The southern city of Blantyre is the financial capital of the country.

Malawi’s current constitution was put in place in 1994 and established a system of government that mirrors Britain and the United States with three equal branches: Executive, Legislative, and Judicial. Within the Executive Branch, the President and Vice President are elected to five-year terms. Each President appoints ministers to coordinate and supervise the 18 ministries within the government. While sexual and reproductive health and rights (SRHR) and international development are cross-cutting issues coordinated by numerous ministries, the two primary ministries discussed throughout the fact-finding relevant to SRHR are the Ministry of Health & Population and Ministry of Gender, Children, Disability and Social Welfare.
Her Excellency Dr. Joyce Banda: An advocate for women and girls across the African continent

CHANGE had the privilege of meeting with Her Excellency Dr. Joyce Banda, Former President of the Republic of Malawi and the first female president in Southern Africa. During her interview with CHANGE, Dr. Banda described her personal and professional journey as a businesswoman, politician, and advocate for the health and well-being of women and girls across the African continent.

In the late 1980s, she received support to strengthen her institutional and international development skills from the United States Agency for International Development (USAID), a prominent actor in U.S. global health assistance. She noted that this experience was critical to her success as a leader both within Malawi and globally. Dr. Banda reported that USAID continues to be a vital contributor to the achievement of Malawi’s development goals. Dr. Banda continues to be a leader in global women’s issues and is committed to using her expertise and position to maintain support for the education and leadership of the African girl child.
Despite the advocacy of Malawi’s dedicated (but under-resourced) civil society, Malawi continues to score poorly on major health indicators for maternal, infant, and under-five mortality. Malawi has one of the lowest development indicators in the world: it ranks 171 out of 189 countries on the United Nations (UN) Development Program’s Human Development Index, which measures progress in life expectancy, access to education, and standard of living. An estimated 70 percent of the population lives on less than US$1.90 per day. The government of Malawi is highly reliant on foreign aid from bilateral and multilateral donors to implement its national budget and support development programs across the country.
Malawi’s engagement in regional SRHR agreements

As a member state of the African Union (AU), Malawi ratified the Maputo Protocol in 2003 and adopted the AU Maputo Plan of Action in 2006. The AU Maputo Plan of Action, a policy framework for universal access to sexual and reproductive health (SRH) services, incorporates and prioritizes the accomplishment of family planning and reproductive health goals established by the International Conference on Population and Development (ICPD) Programme of Action and the UN’s Millennium Development Goals (MDGs). Malawi is a signatory of both the ICPD Programme of Action and the MDGs, which are the foundation of Malawi’s National Sexual and Reproductive Health and Rights (SRHR) Policy.

The AU Maputo Plan of Action has nine action areas that each ratifying member state agreed to follow:

1. Integrate Human Immunodeficiency Virus (HIV), sexually transmitted infection (STI), malaria, and SRHR services into primary health care;
2. Strengthen community-based STI, HIV and Acquired Immune Deficiency Syndrome (AIDS), and SRHR services;
3. Reposition family planning as a key strategy for the attainment of the MDGs;
4. Position youth-friendly SRHR services as a key for youth empowerment, development and wellbeing;
5. Reduce the incidence of unsafe abortion;
6. Increase access to quality safe motherhood and child survival services;
7. Increase resources for SRHR, in alignment with the Abuja Declaration on HIV/AIDS, Tuberculosis (TB) and Other Related Infectious Diseases (2001), by pledging 15 percent of the national budget allocation to health;
8. Achieve SRH commodity security for all components of SRH; and
Malawi received a total of US$1.5 billion in foreign aid in 2017, which accounted for more than 24 percent of Malawi’s gross national income (GNI). The United States is one of the largest bilateral donors to Malawi, along with Germany, Japan, Norway, and the United Kingdom. The United States Agency for International Development (USAID) alone has disbursed over US$215 million in global health assistance for programming in Malawi from 2017–2019. For comparison, the international development agency of the British government, the Department for International Development (DFID), disbursed just over US$84 million during the same time period.

Malawi first received U.S. global health assistance the same year as USAID’s founding, with USAID’s first country office opening in 1960 in the country’s southern region of Zomba. The USAID Zomba office coordinated programs for English language and math instruction under the direction of USAID’s Office of Southern Africa Regional Cooperation (OSARC). According to the U.S. government, the U.S. and Malawian governments established formal diplomatic relations following Malawi’s independence from Britain in 1964. Over the next three decades, USAID’s development programs focused on supporting girls’ education and cash crop programs for small-scale farmers. At the time, family planning programming was limited by the near-totalitarian governance of President Hastings Banda from 1964–1994. Malawi transitioned to a multi-party democracy in 1994, which strengthened the diplomatic relationship between the United States and Malawi. From the perspective of the U.S. government, the United States and Malawi share common views regarding the importance of economic and political stability in southern Africa. According to the U.S. government, the two countries have worked together to promote agriculture, education, energy, environmental stewardship, health, and military strengthening in Malawi through bilateral programming.
In 1994, at the International Conference on Population and Development (ICPD) in Cairo, Egypt, the United States, along with 179 other countries (including Malawi), produced the Programme of Action. Also referred to as the “Cairo Declaration,” the Programme of Action is a human rights framework for development assistance that—for the first time—promoted the universal SRHR of women and girls. By adopting the ICPD Programme of Action, the U.S. government committed to promoting the SRHR of women and girls through its development programs, including U.S. global health assistance. U.S. global health assistance supports health areas related to SRHR through three funding categories or domains: HIV and AIDS, maternal and child health, and family planning and reproductive health.
Defining Sexual and Reproductive Health and Rights (SRHR)

In 2018, the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights established a definition of SRHR with an actionable agenda built on existing international norms. CHANGE uses the Commission’s definition of SRHR and supports the U.S. government’s adoption of the full definition and agenda as detailed by the Commission.

The Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights defines SRHR as “a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achieving sexual and reproductive health relies on realizing sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when and whom to marry;
- decide whether, when and by what means to have a child or children, and how many children to have; and
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.”47
The primary U.S. implementing agencies responsible for disbursing funds that support programs in Malawi are the Department of State, USAID, the Department of Health and Human Services through the Centers for Disease Control and Prevention (CDC), and the Department of Defense (DoD). These implementing agencies work with INGOs, local partners including civil society organizations (CSOs), and the government of Malawi to implement development programs across the global health spectrum.

U.S. global health assistance is contingent on a set of conditions, including laws and policies that dictate the ways in which U.S. global health assistance funds are programmed by the implementing agencies and their partners. These conditions determine the types of programs and activities that can and cannot be funded by U.S. global health assistance. Some policies protect and promote SRHR, while others restrict SRHR.

The significant sum of assistance that Malawi receives from the United States to implement its national SRHR strategies results in an undue influence of U.S. funding and policies on the promotion or restriction of SRHR in Malawi.

**Brief timeline of U.S. global health assistance policies related to SRHR**

**1961:** President John F. Kennedy signed the U.S. Foreign Assistance Act (FAA) of 1961, which remains the current foreign assistance framework. A landmark piece of legislation, the framework restructured U.S. foreign aid and global health assistance apparatuses into a single agency called the United States Agency for International Development (USAID). Congress appropriates funding for USAID through distinct funding categories and those that are particularly relevant for SRHR are family planning, maternal and child health, and HIV and AIDS (through the Department of State beginning in 2003).

**1973:** Congress amended the FAA with the Helms Amendment, which prohibits all foreign assistance funding from paying for “abortion as a method of family planning” or to “motivate or coerce any person to practice abortions.” The amendment does not specifically define the language “method of family planning,” but the federal status quo on abortion restrictions suggests that this definition excludes—at the very least—cases of rape, incest, and life endangerment. Despite this, USAID has consistently misinterpreted language in the Helms Amendment to exclude funding for abortion services where it is not used as a method of family planning, such as in the case of rape.

**1981:** Congress passed the Siljander Amendment as part of the FAA, which prohibits the use of U.S. foreign assistance for lobbying for or against legislative changes in abortion law.

**1984:** The Reagan Administration announced the Mexico City Policy (MCP), commonly known as the Global Gag Rule (GGR), at the International Conference on Population and Development (ICPD) in Mexico City in August 1984. The GGR mandates that for foreign NGOs to receive U.S. foreign assistance for family planning, they cannot provide, refer, or perform abortions as a method of family planning.
planning, nor can they advocate for the liberalization of abortion laws, even if they paid for such activities with their own, non-U.S. funds. The policy provides exceptions for abortions in the cases of rape, incest, and life endangerment of the pregnant person. Organizations must choose whether to comply with the policy or lose access to U.S. funds.

**1994:** Congress passed the **Leahy Amendment** as part of the FAA, which clarifies the term “motivate” in the Helms Amendment by stating that “motivate” shall not be construed to “prohibit, where legal, the provision of information or counseling about all pregnancy options.” While underused and moot when organizations are subject to the GGR, this important amendment permits U.S. global health funds and programs to provide information, counselling, and referrals about legal abortion.

**1998:** Congress enacted the **Tiahrt Amendment** as part of the FY1999 Foreign Operations, Export Financing, and Related Programs Appropriations Act. The amendment prohibits the use of targets, quotas, or financial incentives in family planning projects, and requires projects to provide comprehensible information on family planning methods. It also aims to protect people who choose not to use family planning from being denied rights or benefits and requires that experimental family planning methods be provided only in the context of a scientific study. The intent of the amendment was to ensure that U.S. foreign assistance did not support coercive or forced sterilization practices, in accordance with the principles of voluntarism and informed choice.

**2002:** President George W. Bush launched the **U.S. President’s Emergency Plan for AIDS Relief (PEPFAR),** an unprecedented investment in U.S. global health assistance that prioritizes funding and programming to address the global HIV and AIDS epidemic. PEPFAR was formally established through the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003.

**2003:** Included in the original United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 and subsequent reauthorizations, the **Anti-Prostitution Loyalty Oath (APLO)** requires that any foreign NGO that receives PEPFAR funds under the Act pledge its organization-wide opposition to “prostitution and sex trafficking.” The U.S. government’s conflation of trafficking with consensual sex work is central to the APLO remaining law, despite public health research, human rights organizations, and sex workers themselves having evidenced the harms of this approach. While the Supreme Court found the APLO unconstitutional as applied to U.S. organizations in 2013, the APLO still applies to foreign NGOs.

**2017:** Upon taking office, President Trump reinstated and expanded the GGR through a presidential memorandum, which directed the Secretary of State and the Secretary of Health and Human Services (HHS) to extend the policy “to global health assistance furnished by all departments or agencies.” On May 15, 2017, then-Secretary of State Rex Tillerson released revised Standard Provisions for both U.S.-based NGOs and non-U.S.-based NGOs, called **Protecting Life in Global Health Assistance (PLGHA),** which included the expansion of the policy to all foreign NGOs that receive U.S. funding for global health assistance, including HIV and AIDS, family planning, and maternal and child health programs. For a thorough overview of the policy and its impacts from 1984 to 2018, see CHANGE’s report: **Prescribing Chaos in Global Health: The Global Gag Rule from 1984–2018.**
Impacts of Trump’s Expanded Global Gag Rule (GGR) in Malawi

Evidence and data gathered from more than a decade of research and fact-finding on the impact of the MCP and the PLGHA policy, referred to in this report as Trump’s expanded GGR, indicates that the policy is destructive to the health and rights of people around the world.72,73,74,75,76,77,78,79,80,81

It is not surprising that Trump’s expanded GGR also negatively impacts SRHR programming at every level in Malawi, from national to community-level projects that are implemented by a wide range of partners including INGOs and local community-based organizations who do and do not receive U.S. global health assistance.

In Malawi, abortion is legal only in cases of life endangerment of the pregnant person.82 Obtaining an abortion for any other reason could result in imprisonment for seven to 14 years.83 Unsafe abortion is a significant public health issue in Malawi; over half of pregnancies in Malawi are unintended and approximately 30 percent of unintended pregnancies end in abortion.84 A qualitative study performed in 2012 revealed that young women were most likely to experience stigma in cases of unintended pregnancy, which may lead young women to seek unsafe abortion.85 Numerous Malawian organizations that CHANGE interviewed mentioned abortion-related stigma—particularly faced by adolescent girls and young women (AGYW) who seek out abortion—as indicative of the fact that abortion is culturally taboo in Malawi.86,87,88,89,90

Though abortion is highly restricted in Malawi, some medical professionals in the private sector as well as traditional healers administer abortions, and many women self-induce, often with unsafe methods.91 According to Marie Stopes International (MSI), approximately 78,000 women undergo unsafe abortion in Malawi every year.92 One partner told CHANGE that “in the communities, there are some strange ways of terminating pregnancies: some would drink a potion like a solution of washing powder and some will use sticks” to induce an abortion.93

Women who experience moderate to severe complications from abortion are significantly more likely to be from rural areas rather than urban areas.44 Every year, approximately 51,693 women in Malawi experience complications from unsafe abortion that require post-abortion care (PAC).95 Complications from unsafe abortion are among the top five direct causes of maternal deaths contributing to nearly 18 percent of total maternal mortality in Malawi96 and up to 30 percent of maternal mortality among AGYW in-country.97 Maternal mortality has been a long-term public health issue in Malawi with a maternal mortality ratio of 349 per 100,000 live births as of 2017.98 As Emma Kaliya, the Director of the Malawi Human Rights Resource Centre and Chairperson for Coalition of Prevention of Unsafe Abortion (COPUA) notes, “as we are sitting here, someone is dying from an unsafe abortion.”99

Impact of GGR on national legislation in Malawi

The government of Malawi is highly dependent on foreign assistance, including from the U.S. government, which can create a heightened vulnerability to external influences from donors on national matters.100 According to interviews with numerous CSOs, the U.S. government is seen as a “big brother” to the government of Malawi and as a result, the government of Malawi is hesitant to pass laws that would directly contradict the policy and funding stipulations that come with U.S. global health funding.101 Representatives from a Malawian
NGO reported that the Malawi government “looks up to the U.S. and other countries within the region, and says, ‘Look, these are the policies they are putting in place,’ and if the policies are not progressive, it is most unfortunate because the government of Malawi can look to those policies and say, ‘This is an example of how things should be.’” Trump’s expanded GGR is a prime example of a restrictive U.S. global health assistance policy that the government of Malawi might be hesitant to challenge through domestic legislation such as the Termination of Pregnancy Bill.

Malawi’s abortion law has remained largely unchanged since colonial rule. Despite U.S. government influence, there has been national progress in recent years towards expanding the exceptions for abortion at the national level. The Termination of Pregnancy Bill, introduced into the Malawian Parliament in July 2015, would allow for safe abortion services in the cases of rape, incest, fetal anomaly, and danger to the mental or physical health or life of the pregnant person.

The Coalition of Prevention of Unsafe Abortion (COPUA) is the primary coalition that leads Malawi’s legal reform for safe abortion efforts and helped to develop the Termination of Pregnancy Bill. COPUA engages a myriad of stakeholders at all levels of government and civil society about the importance of abortion law reform in Malawi, from traditional authorities and religious leaders at the community level to Members of Parliament that engage in policy change at the national level. Thus far, COPUA’s strategy has been to “bring in as many stakeholders as possible to have a common front and cushion abortion law reform advocacy from any backlash. In early discussions, the government indicated clearly that we will need as many voices as possible to move the Bill forward.”
Malawi’s Termination of Pregnancy Bill

Malawi’s Termination of Pregnancy Bill is the product of a convergence of dynamic domestic and global influences. Intensive domestic advocacy has been the cornerstone of Malawi’s efforts to address unsafe abortion nationwide since the 1990s in advance of the 2006 AU Maputo Plan of Action. Most recently, domestic advocates and coalitions made the case for abortion law reform through national evidence on the magnitude, cost, and public health impact of unsafe abortion in Malawi and safe abortion as a means to reduce the country’s high maternal mortality. Through this evidence-based approach, the Termination of Pregnancy Bill has garnered the support of diverse local and national stakeholders, including politicians, medical professionals, public health organizations, advocacy coalitions, civil society organizations, medical professionals, traditional authorities, and religious leaders.

Global norms have evolved since the 1980s to focus on the promotion of women’s rights and SRHR as vital social, political, and public health issues, including access to safe abortion. This evolution has brought global attention to these issues and has sparked activists to address international and national structures that limit SRHR. Simultaneously, the international anti-choice movement has pushed back against Malawi’s Termination of Pregnancy Bill on religious and nationalist grounds.

As a member of COPUA that directly engages with Members of Parliament about the Termination of Pregnancy Bill, the Centre for Solutions Journalism (CSJ) reported that the former Minister of Health slowed the Bill in Parliament due to its potential to negatively impact the government of Malawi’s relationship with the U.S. government. The government of Malawi receives “a lot of funding from the U.S., so the government seems to act as if it cannot pass this Termination of Pregnancy Bill when President Trump is in power. I suspect the Malawi government is afraid of losing a huge chunk of funding if it is seen to be supporting the Termination of Pregnancy Bill.” Representatives from Ipas Malawi shared similar suspicions that the government of Malawi might be “treading carefully in pushing for law reform because, at the end of the day, it’s the government’s bill and the government has to pass it. The government also receives a lot of funding from the U.S. government, so it is quite an uncertain environment [for the Malawian government] to navigate when factoring in the Gag Rule.” CSJ staff object to this reason for the government of Malawi’s inaction because “issues of family planning and sexual and reproductive health are also health issues. You cannot sideline one [health issue]. If somebody dies of malaria and another one dies of unsafe abortion, you still have lost a life, so you cannot just pick and choose” which funding to accept and which services to provide.

Trump’s expanded GGR has halted national progress toward abortion law reform in Malawi and has undermined both national legislative process and national sovereignty. The aforementioned
assumption in Malawi directly contradicts those of other countries that receive significant U.S. global health assistance investments and have liberalized their abortion law, such as Mozambique in 2014, or Zambia, where abortion has been legal since 1972 in the case of serious fetal malformation and to protect the physical or mental health of the pregnant person. CSJ noted that U.S. global health assistance was not disrupted by the legality of abortion in these contexts, so it should not impact Malawi’s relationship with the U.S. government either if the Bill is passed. The government of Malawi “is afraid for nothing” and delaying a vote of the Termination of Pregnancy Bill is putting the lives of women and girls across Malawi at risk.

Trump’s expanded GGR fortifies existing conservative religious beliefs and social norms that have made abortion taboo in Malawi. Shy Ali, from Umodzi Youth Organization in Blantyre, reported that public discussions about issues such as abortion are taboo in Malawi due to “misconceptions that were attached to our tradition and cultural beliefs. To talk about issues to do with sex and sexuality in the community, people wouldn’t feel comfortable.” A religious leader told CHANGE that the Termination of Pregnancy Bill would “cause more abortions” and the Bill goes “directly against the word of God.” Given the importance of religion in Malawi, COPUA has organized values clarification sessions to identify “ambassadors from the religious community, the legal fraternity, media groups, and academia who are champions and are speaking positively about the Termination of Pregnancy Bill” as a means to counter these conservative beliefs.
Traditional Authorities in Malawi

Traditional authorities are “gatekeepers for foreign aid” at the village level in Malawi.\textsuperscript{125} For a public health program to be successful at the local level, it must have buy-in from the traditional authority for community members to fully trust and engage in the program. Traditional authorities are rarely consulted in the design of programs that are developed through a top-down approach, though they do play an active role in projects and programs that address the needs of their community.\textsuperscript{126}

During a focus group discussion with CHANGE, traditional authorities reported engaging in a variety of SRHR-related programs and interventions, including programs that address the prevention of mother-to-child transmission (PMTCT) of HIV, child spacing, early antenatal care (ANC), and the elimination of child marriage and early pregnancy.\textsuperscript{127}

**History of traditional authorities**

During colonialism, Malawi developed a “dual state” where rural areas function under indirect rule by traditional authorities, while urban areas and the overall country are subject to direct rule by the central government.\textsuperscript{128} Throughout Malawi’s history, the role of traditional authorities has evolved. Today, traditional authorities fulfill ‘traditional functions’ under customary law, including local matters such as cultural and religious ceremonies, weddings, funerals, and local and domestic conflicts.

Traditional authorities also lead ‘traditional justice forums’ in their respective villages as a means to settle civil disputes, act as intermediaries with local police, and address minor criminal cases. Given the fact that the vast majority of Malawians live in communities in rural areas, traditional authorities are seen as the ‘custodians of tradition and culture,’ according to Her Excellency Dr. Joyce Banda, former president of Malawi.\textsuperscript{129}
Impact of GGR on service provision through public and private clinics

Access to health care services is a significant issue across Malawi, as there are only two physicians for every 10,000 population and only 1.3 hospital beds per 1,000 population.¹³⁰,¹³¹ Comparatively, the United States has 260 physicians per every 10,000 population and three hospital beds per 1,000 people.¹³²,¹³³ Interviewees reported an overall lack of sufficient quality health care services across Malawi and that some people live as far as 20km (approximately 12.4 miles) from the nearest health facility.¹³⁴

Health care delivery in Malawi is divided into three models: public, private not-for-profit sectors, and private for-profit health facilities. Public and private not-for-profit clinics are each allocated a ‘catchment area’ and residents typically access services at the facility closest to them. Based on where someone lives in Malawi, they would only have access to one type of clinic – either a public clinic operated by the government of Malawi or a private not-for-profit provider. For people living in a catchment area with a private not-for-profit clinic, that clinic likely charges fees for basic services, while others who live near a public facility receive services for free. The Christian Health Association of Malawi (CHAM) is the largest private not-for-profit provider in Malawi, which operates a network of church-owned facilities located primarily in rural areas.¹³⁵ These two clinic systems are described in further detail in the following sub-sections of the report: Malawi’s public health system and Christian Health Association of Malawi (CHAM) clinics.

A variety of private and international service providers offer approximately three percent of health services in Malawi.¹³⁶ Key private clinics that offer SRHR services in Malawi are the MSI and International Planned Parenthood Federation (IPPF) affiliates. Both clinics received U.S. global health assistance until Trump’s expanded GGR went into effect in 2017.¹³⁷,¹³⁸

Private clinics that provide SRHR services

The two primary private clinic providers of SRHR services in Malawi are Banja La Mtsogolo (BLM) and the Family Planning Association of Malawi (FPAM). Both providers offer care on a fee-for-service model unless services are subsidized through the government of Malawi or other donor funding.

BLM, the local MSI affiliate, provides comprehensive and youth-friendly SRH services with the goal of increasing access to modern contraception, preventing HIV infection, and reducing unintended pregnancy and unsafe abortion in Malawi.¹³⁹ While SRH services are the primary focus of BLM’s programming, these clinics also provide vital services across the health spectrum, including malaria testing and other care.¹⁴⁰ BLM had received U.S. global health funding as a prime partner of PEPFAR’s Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program,¹⁴¹ which supports HIV and AIDS prevention, treatment, and care services for AGYW. In 2017, BLM was unable to comply with Trump’s expanded GGR and subsequently had to close clinics in Malawi due to the loss in funding.¹⁴² CSJ staff reported that “when you go to private family planning clinics, they not only offer family planning services or post-abortion care services; you are treated for everything else. So, if you close down that clinic, then the entire community is affected.”¹⁴³ The loss of BLM as a DREAMS implementing partner negatively impacted the
DREAMS program, which will be discussed further in the DREAMS Partnership section of this report.

FPAM is the IPPF affiliate that provides comprehensive SRH services throughout Malawi, but with a particular focus on young people and under-served rural communities in 12 districts. FPAM provides contraceptives, pregnancy testing, STI testing and treatment, and HIV and AIDS counseling and testing. FPAM received U.S. global health assistance through PEPFAR as a sub-prime of the Linkages Across the Continuum of HIV services for key populations affected by HIV (LINKAGES) program, which provides HIV and AIDS prevention, care, and treatment services for key populations (KPs), including men who have sex with men (MSM), transgender persons, and sex workers. When FPAM was unable to comply with Trump’s expanded GGR, the organization lost 35 percent of their total budget, which forced them to close operations in four districts and lay off 37 percent of their staff.

The extent of these losses are discussed at length in the LINKAGES Program section of this report.

Trump’s expanded GGR has “crippled service delivery” and “divided” actors in the global health space, according to Kaliya from COPUA. When both BLM and FPAM lost U.S. global health funding due to Trump’s expanded GGR, the subsequent decrease in service availability has had far-reaching negative impacts across Malawi.

Ligomeka from CSJ reported that “the bottom line is that people are dying. People are suffering quite a lot. The problem is that these are poor people, voiceless people, and their voices don’t even count. People are dying silently because they cannot access the services” that were once offered by private family planning clinics that were vital sources for health care.

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—Brian Ligomeka, Director, CSJ
**Impact of GGR on partnerships and coalitions**

The weakening of partnerships and coalitions is a common effect of Trump’s expanded GGR globally. Trump’s expanded GGR has severely impacted the functionality of coalitions across the SRHR landscape in Malawi as well.

As the primary coalition that focuses on safe abortion in Malawi, Ipas Malawi described COPUA as a “loose network” in that the coalition does not yet have a procedure for organizations who wish to leave the coalition. As a result, organizations can just “walk out” as of the date of publication of this report. Once Trump’s expanded GGR was implemented, COPUA lost partners, often without an explanation from the organizations. Members of COPUA reported that coalition members who receive U.S. government funds had to stop participating in COPUA activities due to Trump’s expanded GGR because advocacy for the Termination of Pregnancy Bill is in violation of the policy. Luke Tembo, the Programs Manager for Ipas Malawi and member of COPUA, stated that in coalitions like COPUA, “numbers matter.”

As a result of Trump’s expanded GGR, COPUA’s membership and budget have both shrunk, which “weakens the voice calling for reform on termination of pregnancy” in Malawi.

A representative from a large INGO that is the prime partner of a key U.S. global health assistance program in Malawi shared that staff from their organization have to “run away from those networks” that advocate for abortion and “cannot attend a meeting where people would advocate for abortion... that would be a breach of the PLGHA provision.” These are classic examples of the “chilling effect” where organizations in fear—or those unclear about the full parameters of the policy because of ambiguous communication from the U.S. government or prime partners—may unnecessarily avoid advocacy or engagement around abortion in Malawi because they believe it is in violation of Trump’s expanded GGR.

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**About prime partners and sub-primes**

A prime partner is an organization that receives U.S. global health assistance directly from the U.S. government. Both U.S.-based NGOs and foreign NGOs can be prime partners. All U.S. funding and policy requirements are passed down from prime partners to their sub-prime.

A sub-prime (also known as a “sub-grantee,” “sub-recipient,” or “sub-partner”) is an organization that receives U.S. global health assistance from a prime partner rather than directly from the U.S. government. Sub-primes are one step removed from a direct relationship with the U.S. government and communications about their funding are filtered through the prime partner.
Chance Mwalubunju, Senior Policy Consultant at Ipas Malawi, reported that Ipas partners have had to change their programs and organizational structure to remain in compliance with Trump’s expanded GGR. Organizations that want to continue to receive U.S. global health assistance are “made to change their original program and some of their projects to be in line with USAID policies. So, this meant changing beneficiaries, or changing of sites, and changing the core content of programming.”

The chilling effect has also impeded research on the impacts of Trump’s expanded GGR on health services. CHANGE requested an interview with a representative from a sub-prime of a PEPFAR-funded project, but the representative declined the meeting because the organization believed participating in research related to Trump’s expanded GGR was in violation of the policy. Another sub-prime declined to participate in the interview due to “content.” A third sub-prime requested that their participation in this research be kept anonymous at the request of their board. A prime organization did not agree to participate in an interview until they received confirmation from USAID that they were allowed to speak to CHANGE.

**Impact of GGR on access to other funding opportunities**

A sub-prime reported that it is challenging for the organization to be shortlisted for other funding opportunities because the organization currently receives U.S. global health assistance. They explained that accepting the policies that are tied to U.S. global health assistance—particularly Trump’s expanded GGR—have “a huge impact in terms of funding opportunities for an organization like ours.” When this sub-prime applied for funding from other donors, they found that “other donors are turning away and saying, ‘You are working with U.S. funds, it means you are agreeing to the Gag Rule.’... if you are working with U.S. funds, it means you can’t work with anyone.”

**Impact of GGR on people living in rural areas**

The majority of Malawians live in rural areas, which is particularly important to note given the limited availability of health services and long distances that some people must travel to access services.

The majority of programs funded by U.S. global health assistance are not implemented nationwide, but are instead concentrated in select districts, including Blantyre, Lilongwe, Zomba, and Machinga. Numerous organizations reported that Trump’s expanded GGR reduced the availability of services across the SRHR landscape when service delivery partners could no longer participate in U.S. global health programs.

BLM and FPAM, among others, were forced to reduce their programming or close clinics due to funding shortages. BLM was an implementing partner of the PEPFAR DREAMS program for AGYW while FPAM was an implementing partner under the PEPFAR LINKAGES program for key populations (KPs).

Brian Ligomeka, the Director of CSJ, reported that “the Global Gag Rule is not achieving its intention. As a matter of fact, it is sending women in poor countries like Malawi, to their graves early. That’s it. It’s a policy that is killing women; it’s a policy that has been designed to kill women in rural areas.”

Passion for Women and Children is a local nonprofit that works in partnership with COPUA to improve the lives of women and children in Malawi through a focus on girls’ education, HIV and AIDS, and other human rights issues. Mackson Harawa, the Director, noted that restricted access to services places a
particular burden on people in rural areas. From his perspective, U.S. global health assistance policies like Trump’s expanded GGR are “made by people who are rich. They are being made by people who have never been in situations where they are in poverty and in dire need.” Policymakers that dictate U.S. global health assistance are disconnected from the lived realities of the people who are impacted by these policies.

Harawa shared that “by the end of the day, policies like the Gag Rule affect the most poor people. [These policies] are made and implemented by the rich, but by the end of the day, it is someone who does not know how to read, does not know how to write, lives below a dollar per day, who is ill-affected.”

Trump’s expanded GGR has far-reaching impacts across health areas with their own programmatic, political, cultural, and legal dynamics. Beyond the issue of unsafe abortion in Malawi, the current iteration of the GGR impacts service delivery and partnerships across the U.S. global health structure, including HIV and AIDS, family planning, and maternal and child health programming.

“By the end of the day, policies like the Gag Rule affect the most poor people. [These policies] are made and implemented by the rich, but by the end of the day, it is someone who does not know how to read, does not know how to write, lives below a dollar per day, who is ill-affected.”

–Mackson Harawa, Director, Passion for Women and Children
PEPFAR

As of January 2019, PEPFAR has invested over US$811 million to support Malawi’s HIV and AIDS response.167 PEPFAR works closely with Malawi’s Department of HIV and AIDS through the Ministry of Health and the National AIDS Commission and the Global Fund to Fight AIDS, Tuberculosis and Malaria (referred to as the Global Fund168) to implement programming across the HIV and AIDS continuum of care to achieve the UNAIDS 90-90-90 targets by 2020 and the 95-95-95 targets by 2030.169

According to data released by UNAIDS in July 2019, Malawi’s progress toward the UNAIDS targets are as follows:

- 90 percent of people living with HIV in Malawi are aware of their status;
- 87 percent of people living with HIV who are aware of their status are on antiretroviral therapy (ART); and
- 89 percent of those who are on ART are virally suppressed.170

Within PEPFAR lexicon, the achievement of the 90-90-90 goals by 2020 and 95-95-95 by 2030 in a particular PEPFAR country is referred to as ‘epidemic control.’171 Epidemic control should be recognized as a sustained state of being across all key and priority populations and age groups within a given country context. Once a country achieves the 95-95-95 targets, consistent monitoring and programming will still be required to ensure that a country continues to address the prevention of HIV, testing, and health needs of people living with HIV. Epidemic control is referenced throughout PEPFAR guidance documents, including in Malawi’s Country Operational Plan (COP).172
Malawi Country Operational Plan (COP) 2019

In Malawi’s 2019 COP, PEPFAR allocated US$159,039,935 to reach epidemic control through the following activity areas:

- Intensify case-finding through index testing, self-testing, and use of a screening tool to identify testing points;
- Maintain high linkage to care and focus on “back to care” programming to address lack of adherence to ART;
- Scale-up the transition of people living with HIV to an ART regiment based on tenofovir/lamivudine/dolutegravir (TLD);173
- Reduce HIV transmission among KPs and eliminate mother-to-child transmission;
- Strengthen activities across the HIV care and treatment cascade and scale up annual viral load testing; and
- Align PEPFAR’s human resources for health investments with the government of Malawi’s priorities.174

DREAMS Partnership

DREAMS is a US$800 million public-private partnership between PEPFAR, the Bill & Melinda Gates Foundation, Girl Effect (formerly the Nike Foundation), Johnson & Johnson, Gilead Sciences, and Viiv Healthcare with the goal of reducing new HIV infections among AGYW by 40 percent in the highest burden areas of 10 sub-Saharan African countries from 2016 to 2018.175 DREAMS consists of a core package of evidence-based interventions that includes layered approaches to “address individual, community, and structural factors that increase girls’ HIV risk, including poverty, gender inequality, gender-based violence, and a lack of education.”176 Since 2018, DREAMS continues to be implemented through the PEPFAR COP process in 15 PEPFAR countries. DREAMS programming was complemented by the DREAMS Innovation Challenge (DREAMS-IC) beginning in 2016, which provided additional resources for innovative programming, often focusing on first-time PEPFAR grantees.177

By 2017, 65 percent of the highest HIV-burden communities in all 10 DREAMS implementing countries had decreased new HIV infections in AGYW by at least 25-40 percent, and every DREAMS district reported a decline in new infections.178 By 2018, data showed declines in new HIV diagnoses among AGYW in 85 percent of the highest HIV burden districts in the 15 countries where it was expanded and implemented.179 For more information on DREAMS, refer to CHANGE’s two reports, U.S. DREAMS Partnership: Breaking Barriers to HIV
Overwhelmingly, interviewees spoke positively about DREAMS in Malawi. This included both organizations who do and do not receive U.S. global health assistance. Kurt Henne, the Country Director for Project Concern International (PCI)/Malawi, a DREAMS partner in Malawi, reported, “I’m a big fan of DREAMS. I wish we could scale that up everywhere.” Gomezgani Jenda, the Senior Technical Advisor for Health and Nutrition at Save the Children in Malawi, told CHANGE: “DREAMS is my lovely piece of work because it ...brings everything together that you need to do to support an adolescent. Whether in an urban set-up, or in a rural set-up; no matter where you are, the DREAMS package for me just brings everything together. And the more you do one piece, the more the other pieces come together. DREAMS should be implemented as one unit by a single project or consortium because the girls and boys in Malawi want that one package in totality and not fragmented approaches.”

DREAMS operates within three districts with particularly high HIV incidence among AGYW in Malawi: Blantyre, Machinga, and Zomba. Numerous prime implementing partners received DREAMS funding between FY2016 and FY2019, including FHI 360 Malawi, Girl Effect, Jhpiego, Johns Hopkins Center for Communication Programs (JH-CCP), PCI/Malawi, Population Services International (PSI) Malawi, and Save the Children.

PSI Malawi provides DREAMS-layered programming to AGYW ages 10-24 in Zomba and Machinga. DREAMS beneficiaries are most often identified through Go Girls Clubs, which are AGYW-led groups where beneficiaries can meet and discuss a variety of issues that are important to them in a safe space. These clubs are divided into the following age brackets: 10-14, 15-19, and 20-24. Go Girls Clubs are common throughout Malawi and are often—but not always—funded by One Community. Approximately 37,000 AGYW belong to Go Girls Clubs.
clubs in Machinga alone. Go Girls Clubs are also intended to increase the uptake of HIV prevention, testing, and treatment services by AGYW in DREAMS and priority districts across Malawi.

PSI Malawi works in collaboration with Go Girls Clubs that include AGYW from ages 15 to 24 in Zomba and Machinga to coordinate DREAMS service delivery programs. One Community leads the recruitment of DREAMS beneficiaries “based on a certain criteria that is used to assess vulnerability.” DREAMS Ambassadors, in partnership with the demand creation team from PSI, engage with the community in advance of a service delivery site being set up in a given community. Temporary service delivery sites are set up in rural communities for one week at a time to provide services to those living nearby.

Although DREAMS programming is targeted for AGYW within the 10-24 age range, Mwenifumbo reported that if a woman older than 24 seeks services at a DREAMS site, “DREAMS still provides services regardless of age, whether a woman is 26 or 40.” According to Mwenifumbo, since there is often a lack of services at the community level and access to health services is a human rights issue, no woman seeking services is turned away.

Women walking past the DREAMS service delivery site in Machinga, Malawi.
A DREAMS beneficiary reviewing her clinic paperwork while awaiting post-testing counseling at a PSI Malawi service delivery site in Machinga, Malawi.

PSI Malawi clinician counseling a DREAMS beneficiary about family planning options and other sexual and reproductive health topics in Machinga, Malawi.
A visit to PSI’s DREAMS service delivery site in Machinga, Malawi

CHANGE visited one of PSI Malawi’s DREAMS temporary service delivery sites in Machinga, Malawi - a rural district approximately three hours by car outside of Blantyre. When CHANGE researchers and Tamara Mwenifumbo, the DREAMS Manager for PSI Malawi, arrived at the service delivery site, a large group of approximately 70-80 women and girls of all ages—some with babies or small children—was waiting in the shade of a large tree. Across a small clearing was the service delivery site: a series of five large tents in a row that formed a streamlined access point for beneficiaries to access a variety of clinical services. Each tent was staffed by trained clinical staff and stocked with the necessary commodities to meet the needs of each beneficiary.

The services most frequently available at PSI's DREAMS service delivery sites are HIV self-testing followed by counseling, family planning, cervical cancer screening, STI screening, and post-violence care. PSI Malawi staff reported a high demand for HIV self-testing. Beneficiaries have the option to either complete the test at the service delivery site or take the test home and return to the clinic for confirmatory testing if necessary. If a beneficiary chooses to complete a self-test at the site, the beneficiary receives counseling and instructions from the nurse on staff and provides her informed consent to be tested. They then obtain the kit from the registration tent and walk to the next tent, which is subdivided into multiple testing rooms for privacy.

Once the self-test result is available, the beneficiary receives counseling from a trained health care provider. Depending on the result of the test, they are either offered ART or counseled on HIV prevention methods, including external condom use. Depending on the burden of HIV in a particular area, DREAMS also provides oral pre-exposure prophylaxis (PrEP) as a biomedical HIV prevention method for AGYW.192

Tamara Mwenifumbo from PSI Malawi reported that the family planning component of DREAMS programming is particularly important in Malawi “when you consider the unmet need for family planning and the panic that we’re all in with the population boom. We cannot neglect the need for providing family planning at an early age.”193 Clinical staff counsel beneficiaries on a series of family planning options available at the site, including depot medroxyprogesterone acetate (DMPA) injectable, the contraceptive implant, intrauterine device (IUD), external condoms, and tubal ligation.194 Each beneficiary receives individual counseling regarding each method and their family planning needs. Once the beneficiary has selected a method, they go to the next tent to receive it.

The next tent is a compact and functional operating room where three surgical staff can place implants, insert IUDs, and perform tubal ligations. Afterward, beneficiaries are sent to the last tent to rest and recover, if necessary, before completing a survey and providing
feedback on the quality of care they received at the site. These data are collected manually through paper reporting forms and are continuously monitored for completion on-site by a data management staff person. Before leaving the site, beneficiaries are encouraged to complete an anonymous survey to provide additional feedback about the received care.

CHANGE researchers met with a group of approximately 15 DREAMS AGYW beneficiaries to discuss the program. Overall, the beneficiaries shared that access to family planning through DREAMS allows them to continue their education and avoid unintended pregnancy. Through an interpreter, a young woman said, "With this program, we are able to learn how to protect ourselves and learn the advantages of going to access HIV self-testing services in good time, as well as how to access cervical cancer screening. So we can lean into greater services within ourselves, so we’re able to take care of ourselves, and we teach one another. So that’s become a link in our lives.”

**DREAMS and populations with specific concerns**

DREAMS programming falls short in providing targeted services for AGYW living with disabilities, engaged in sex work, identifying as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI+), or those who are seeking abortion services. For example, PSI Malawi does not offer targeted or specific services for AGYW living with disabilities or those who engage in sex work, but Mwenifumbo reported that specific programming for these AGYW “needs to be intentional moving forward.”

Mwenifumbo shared a specific case when DREAMS was able to provide services to a girl living with mental and physical disabilities in Machinga. According to Mwenifumbo, one of the girl’s family members approached PSI staff during a community outreach event and reported that the girl was home-bound due to her disability and had been repeatedly sexually assaulted. One of the DREAMS nurses went to the home to provide her with care and treatment for multiple STIs. Unfortunately, this case does not represent the ability of DREAMS programming to meet the needs of AGYW living with disabilities in Malawi. PSI staff reported that DREAMS makes an “effort to reach young people, but not necessarily those that are living with disabilities. If clients have issues with transportation to the service delivery site, we go and pick up the clients and take them to the outreach site. If we’re intentional in our approach, we would also do the same for AGYW living with disabilities. If it was a priority, I think that every time we go into a community, we would make an assessment on the needs that are there and take steps to address them.”
Meeting the needs of women living with disabilities

Disabled Women in Africa (DIWA), a membership of 11 national and regional Disabled People’s Organizations in Africa, focuses on the experiences of violence, exploitation, and abuse among women living with disabilities in Malawi. Rachel Kachaje, the Founder and Executive Director, and Ruth Kamchacha, the Malawi Country Director, shared their experience implementing human rights-based programs to meet the needs of women living with disabilities in Africa, including sexual and reproductive health, access to education, and community sensitization campaigns. Lessons learned from DIWA’s work, or other organizations focused specifically on this area of work, can be incorporated into DREAMS programming to ensure that U.S. global health-funded programs are responsive to the needs of women living with disabilities.

PSI Malawi reported that DREAMS beneficiaries who identify as LGBTQI+ are often uncomfortable disclosing their identities due to stigma and discrimination that LGBTQI+ Malawians face. Some DREAMS beneficiaries are “coming out” in the urban areas, but people are not as likely to be out in rural areas where PSI operates because “there are certain attitudes towards [being LGBTQI+] and it doesn’t come out in the open.”

PSI Malawi reported that DREAMS beneficiaries who identify as LGBTQI+ and those who engage in sex work or transactional sex would be able to receive services through LINKAGES, which is PEPFAR’s program focused on key populations including sex workers. According to PEPFAR/Malawi, LINKAGES provides the full DREAMS package for AGYW engaged in sex work in the three priority districts, Zomba, Machinga, and Blantyre, as of October 2019. FHI 360 Malawi, the prime partner of LINKAGES, provides the full DREAMS package in Zomba and Machinga while Pakachere, a sub-partner of LINKAGES, provides these services in Blantyre. Prior to October 2019, LINKAGES implemented DREAMS for female sex workers (FSWs) in all three DREAMS districts and developed “specific modules for FSW... to supplement the DREAMS toolkit for these most vulnerable girls.”

Annie Mandundu, the Accounts and Administration Assistant, outside the Disabled Women in Africa (DIWA) office in Lilongwe, Malawi.
DREAMS, abortion, and Trump’s expanded GGR

Interviewees consistently brought up the impact of the GGR on DREAMS. CHANGE was told that DREAMS beneficiaries “can’t ask” about abortion services because abortion is “not acceptable in Malawi, and it’s something that cannot come out in the open... Even if they wanted to, they couldn’t [access abortion services at DREAMS sites], because of the way that the society views abortion.” With regards to PAC, however, PSI Malawi reported that PAC services are available at private clinics such as those operated by BLM and FPAM that provide maternal health services.

Trump’s expanded GGR disrupted DREAMS services in Malawi. BLM, the local MSI affiliate, was a prime DREAMS implementing partner in the district of Zomba until Trump’s expanded GGR went into effect. When BLM could not comply with Trump’s expanded GGR as a condition of receiving U.S. global health assistance, PSI Malawi was forced to expand their services to fill the gap that BLM had left behind. PSI Malawi had supported DREAMS programming in Machinga but had not been implementing DREAMS in Zomba before taking over for BLM. During this time, Mwenifumbo from PSI Malawi told CHANGE that there was a “small gap in services” and the program lost one to two months of implementation as the activities were transferred from BLM to PSI. During this time, DREAMS beneficiaries who received care at BLM clinics in Zomba went without services.

Shy Ali, the Program Director for Umodzi Youth Organization, shared that the loss in funding for BLM clinics has had a negative impact on the overall health of young people in Malawi because “young people are getting new HIV infections because they lack information. The information that was there from Banja La Mtsozolo is no longer there and information about other contraceptives, as well as other [HIV] preventive measures cannot be given out to the young people, because BLM doesn’t have funds. The outreach has not been as huge as it used to be.”

DREAMS-like programming beyond U.S. global health assistance

In addition to organizations that implement DREAMS programming in Malawi (PCI/Malawi, PSI, and Save the Children), CHANGE met with many organizations that are involved in similar programming that is included in DREAMS but are not receiving U.S. global health assistance. The Development Initiative Network (DIN) Malawi is a community-based organization that does not receive U.S. global health assistance and operates a variety of programming to address the needs of those living in the Chikwawa district, a rural area outside of Blantyre.

DIN Malawi staff told CHANGE that Go Girls clubs in Chikwawa were started by members of the community and do not receive funding or support from One Community. DIN Malawi provides funding to local Go Girls clubs that engage in entrepreneurship programs and recently purchased two sewing machines to support their small business endeavors. It is unclear whether Go Girls clubs pre-dated One Community’s programming, but CHANGE learned through multiple interviews that these clubs have gained traction outside of U.S. global health assistance programming.

Girls Empowerment Network (GENET), a Malawian nonprofit that implements programs to improve the well-being of AGYW in Malawi, also does not receive U.S. global health assistance. Many of GENET’s activities, however, are similar to those included in DREAMS programming – including menstrual hygiene management activities that involve providing training and supplies for groups
of AGYW to make reusable menstrual pads.\textsuperscript{207,208} “One of the challenges is that girls may not be able to attend school because they might not have the resources to cover themselves during the menstrual period,” so teaching AGYW how to make reusable pads both allows AGYW to stay in school during their periods while also strengthening their sewing skills.\textsuperscript{209}

**DREAMS Innovation Challenge Fund**

There are success stories of the DREAMS Innovation Challenge (DREAMS-IC) Fund across multiple countries, including Malawi.\textsuperscript{210,211} One goal of the Fund was to strengthen “leadership and capacity of communities and grassroots, community-based organizations to support the expansion of evidence-based services.”\textsuperscript{212} Innovation Challenge winners in Malawi included: Badilika Foundation, Camfed Malawi, FHI 360 Malawi, Save the Children, and VillageReach-Malawi.

The DREAMS-IC Fund was successful in building the capacity of organizations like VillageReach-Malawi to contribute to national systems that improve the SRHR of youth in Malawi. VillageReach-Malawi used DREAMS-IC funding to make Malawi’s National Health Hotline (known in Malawi as “Chipatala cha pa Foni”)\textsuperscript{213} more youth-friendly in the following ways: hotline worker training, development of the Adolescent Sexual and Reproductive Health Module, and demand creation for youth and adolescents to access the hotline.\textsuperscript{214} The hotline has been scaled up so “a lot more adolescent[s] and youth are benefiting from the investment of the DREAMS Innovation Challenge funds in all districts in Malawi.”\textsuperscript{215}

The DREAMS-IC Fund was not extended beyond its initial scope.\textsuperscript{216} VillageReach-Malawi implemented specific changes to the health hotline to ensure that the changes would continue to be implemented “long after the DREAMS-IC funding ended”\textsuperscript{217} because the sustainability of DREAMS-IC programs was an issue raised by VillageReach-Malawi and other organizations interviewed by CHANGE.

FHI 360 Malawi received DREAMS-IC funds to implement a two-year program aimed at keeping girls in school in two DREAMS districts, Zomba and Machinga. Program activities included paying school fees, providing school materials, training youth-friendly health service providers, and providing “some mentorship trainings in the community to take care of girls when they are at the community level.”\textsuperscript{218} Melchiade Ruberintwari, the FHI 360 Malawi Country Director, reported that “it’s really very unfortunate that the program ended” because girls can “still get some services at community level through ongoing DREAMS programming, but of course, they are not getting the school support.”\textsuperscript{219} According to PEPFAR/Malawi, lessons learned and best practices from the DREAMS-IC are currently integrated into the DREAMS program.\textsuperscript{220} It is unclear which elements of interventions funded by the DREAMS-IC were incorporated into the DREAMS package of services.
**DREAMS engagement with Department of Defense programming**

The Department of Defense (DoD) HIV/AIDS Prevention Program supports HIV and AIDS prevention, testing, treatment, and care activities in the Malawi Defense Force. The prime partner for these activities is PCI/Malawi, which provides services for active duty military, their families, and the communities that live around military barracks such as Cobbe Barracks near Zomba, Malawi.

According to Kurt Henne, the Country Director for PCI/Malawi, people in the military are vulnerable to HIV due to a “macho mentality that soldiers are untouchable,” which contributes to high-risk sexual behaviors that could put them at risk of HIV, including multiple sexual partners and infrequent use of condoms. Addressing the needs of active duty military through this partnership is a beneficial use of targeted PEPFAR programming to advance Malawi’s progress toward epidemic control.

PCI/Malawi also receives PEPFAR funding to conduct DREAMS programming in the communities surrounding military barracks in Malawi. This is an unusual case where DoD and DREAMS programming overlap; DoD programs focus on HIV and AIDS services among active duty military and DREAMS programming serves the AGYW living near the barracks. Henne reported that oftentimes, families will “encourage” their daughters to “entice” soldiers as a means of economic stability because “people in uniform have a steady salary,” which is not common in Malawi. As such, HIV and AIDS transmission is a particular issue among AGYW and military service members in Malawi that PEPFAR is working to address through DoD and DREAMS programming.

PCI/Malawi’s work in this area is a shining example of the ways in which implementing partners can leverage different types of PEPFAR funding to meet the needs of numerous populations in an integrated and intentional way.

**LINKAGES Program**

LINKAGES is a PEPFAR-supported program with the objective of reducing HIV transmission among KPs with a focus on MSM, transgender persons, sex workers, and people who inject drugs in over 30 countries that receive PEPFAR funding, including Malawi. FHI 360 Malawi is the prime partner of this five-year program and worked with a variety of Malawian sub-primes when the program began in 2014, including: Centre for the Development of People (CEDEP), FPAM, Pact, Pakachere Institute of Health and Development Communication, and Youth Net and Counseling (YONECO) to implement HIV prevention, care, and treatment programming that is KP-friendly and accessible.

Malawians who identify as LGBTQI+ have reported experiences of homophobic violence and stigma at the hands of police, religious leaders, school administrators, family members, and the general
One partner reported a specific case of discrimination experienced by an intersex child who was forced to change schools seven times due to bullying and harassment from classmates and school administrators. With regard to accessing care, MSM reported distance to the health facility, fear of stigma and discrimination, attitudes of health personnel, lack of condom-compatible lubricants, and self-stigma as the main barriers to HIV and AIDS care and treatment. When LGBTQI+ people experience discrimination, CSJ reported that “you are not only discriminating against those people, you are also fueling HIV and AIDS.”

In Malawi, HIV prevalence among MSM is approximately seven percent. According to data released by FPAM, HIV prevalence among the FSWs they serve could be as high as 77 percent. Globally, it is estimated that the risk of acquiring HIV is 12 times higher for transgender women than adults aged 15-49 years. Addressing stigma, discrimination, barriers to services, and the health needs of LGBTQI+ people and all KPs is a vital component of providing integrated services because “LGBTI+ issues are SRHR issues; all these are actually SRHR issues, although sometimes we may segment them.”

Criminalization of homosexuality in Malawi

The criminalization of homosexuality in Malawi originated with British colonialism. Malawi adopted sodomy laws in the penal code in 1930, which specifically originated from a version of Section 377 that British colonizers introduced into the Indian Penal Code in 1860. Historically, individuals convicted of homosexuality in Malawi could be sentenced with up to 14 years in prison. In 2012, however, then-President Joyce Banda’s administration issued a moratorium on the arrest and prosecution of consensual homosexual acts. During her interview with CHANGE, Dr. Banda reported that she was condemned by a cross-section of Malawians, traditional leaders, and religious leaders, as well as many people across Africa because of this moratorium. She issued the moratorium in her first address to Parliament, which is made up of representatives of the people, knowing that Malawi Parliament would pass laws that all Malawians were comfortable with and believed would benefit them. Some thought Dr. Banda was being pressured by bilateral donors, including the United States and the United Kingdom, to enact the moratorium in Malawi law, but Dr. Banda reported that this was not true and that she did not experience external pressure from other governments. From her perspective, the political pushback she received was rooted in the cultural dynamics that suggested that Malawians were not ‘ready’ to decriminalize same-sex acts at that time and may still not be ready.

As of late 2019, the legality of the moratorium on the law that bans homosexual acts is still debated. According to representatives from the Nyasa Rainbow Alliance, an LGBTQI+–led organization that advocates for the needs of LGBTQI+ in Malawi, some police and judges honor the moratorium while others do not. The inconsistency on this issue contributes to the fear and uncertainty that LGBTQI+ Malawians face every day.
LINKAGES programming in Malawi focuses on programming across the prevention, care, and treatment cascade that is appropriate and accessible for KPs. HIV prevention efforts include HIV testing and counseling; family planning counseling (but not commodities); access to internal and external condoms, lubricants, needles/syringes, and psychosocial support; regular STI screening and treatment; cervical cancer screening; and provision of oral PrEP primarily for FSWs. LINKAGES often provides these services through two mechanisms: Drop-in-Centers (DICs) or mobile clinics that provide KP-friendly care at “hotspots” because KPs are often not able to access the health care they need from anywhere else.

### Oral PrEP programming in Malawi

Oral pre-exposure prophylaxis (PrEP) is not currently available for the general population through PEPFAR’s programming. It is currently only offered through targeted programming for key populations, AGYW, and serodiscordant couples, in which only one partner lives with HIV. Oral PrEP is recognized as a key biomedical intervention in Malawi’s National HIV Prevention Strategy (2015–2020), but specific plans for rollout of oral PrEP in the general population remain unclear as of the date of publication of this report.

### LINKAGES and Trump’s expanded GGR

FPAM was a sub-prime of LINKAGES from 2014 to 2017. Before losing funding due to Trump’s expanded GGR, FPAM provided comprehensive services including HIV testing, STI screening, tuberculosis (TB) testing, family planning counseling, cervical cancer screening, and external condoms through a variety of methods that ranged from mobile clinics and drop-in centers at health facilities in Lilongwe and Machinga, to rural tent-based clinics and community-based mentorship programs led by peer educators.

Before Trump’s expanded GGR went into effect, FPAM operated mobile clinics to meet the health care needs of FSWs in Lilongwe. Services available through the mobile clinics included STI screening, family planning, HIV testing, TB testing, and cervical cancer screening. During this time, FPAM provided HIV testing, initiation of ART, and adherence counseling for 627 FSWs living with HIV. FPAM also trained 63 FSWs to become peer educators that offered community-based counseling and support through peer networks and referred an additional 2,700 women to clinics for follow-up services. Peer educators offered counseling to FSWs related to HIV, gender-based violence (GBV), condom use with lubricants, condom negotiation with clients, and pregnancy.

As the IPPF affiliate in Malawi, FPAM’s programming is rooted in the fact that everyone has a right to access “the whole component of SRHR.”

In 2017, however, FPAM lost 35 percent of the organization’s total budget and were forced to let go of 37 percent of staff when it could not comply with Trump’s expanded GGR. Tazirwa Chipeta, the current director of programs at FPAM, reported that the organization had offered a range...
of integrated SRHR services in 12 districts, but are now primarily providing family planning in eight districts.\textsuperscript{256} As a result, FPAM was forced to close its LINKAGES activities, including those in facilities, mobile clinics, and community-level activities in four districts. Chipeta reported that FPAM “had to leave some of our clients abruptly” and were unable to transition them to other service providers because of the rapid loss of funding.\textsuperscript{257}

The loss of FPAM as a sub-prime of LINKAGES “was like the end of the world for the program,” according to a partner staff familiar with the LINKAGES program in Malawi.\textsuperscript{258} In the aftermath, FHI 360 Malawi “struggled to fix the program” for two reasons: first, FHI 360 Malawi was unable to identify another implementing partner with enough in-country experience to take over the programs FPAM had been forced to close in the districts of Lilongwe and Machinga.\textsuperscript{259} To cover these districts, FHI 360 Malawi had to extend the catchment area of Pakachere,\textsuperscript{260} another sub-prime, even though they did not have prior experience working with KPs in these districts. The addition of these districts to Pakachere’s portfolio required substantial involvement by FHI 360 Malawi to monitor program implementation, and cost the program and beneficiaries over two months of implementation.\textsuperscript{261}

Secondly, FHI 360 Malawi had to find peer educators and peer navigators who were trained by FPAM because “female sex workers are very mobile. When you spend three weeks without talking to peer educators, the next time you come back [with a mobile clinic], they are no longer living in those areas.”\textsuperscript{262} Furthermore, it takes time for populations who experience stigma, including FSWs, to build trust with new staff, so service uptake often decreases after the service delivery partner changes until trust is established between the community and the new partner organization.\textsuperscript{263}

Due to the loss of FPAM as a sub-prime and the subsequent lapse in programming, “we lost practically everything. We had to restart from scratch.”\textsuperscript{264}

FPAM’s loss of funding was frustrating for FPAM, FHI 360 Malawi, and other beneficiaries because “the program had a grounded foundation and we could actually see progress on how the key populations’ lives were changing and suddenly things stopped.”\textsuperscript{265} Due to the abrupt lack of services, FPAM believes that progress has “moved backwards a little bit in the fight against HIV and AIDS” because FSWs no longer have access to comprehensive SRHR services, which will also impact the general population.\textsuperscript{266} FPAM has “lost a chance of bringing them [FSWs] onboard directly and indirectly addressing the issues that influence the greater population.”\textsuperscript{267}

FPAM released a report entitled: Global Gag Rule Hurts Malawians as a means to document the impact of Trump’s expanded GGR on FPAM’s ability to provide SRHR services in Malawi.\textsuperscript{268} The report includes direct quotes and perspectives of clients who have lost services since FPAM lost funding due to Trump’s expanded GGR. One peer educator shared that FSWs in Lilongwe do not have access to STI and HIV testing since FPAM lost funding. As a result, she said, “We [FSWs] will die early and we will infect half of Lilongwe with STIs and HIV before we do.”\textsuperscript{269} Trump’s expanded GGR not only impacts the health and well-being of direct beneficiaries of LINKAGES programming, but expands well beyond the individual patient and impacts whole communities.

CHANGE spoke with a sub-prime that does comply with Trump’s expanded GGR and continued to receive
funding under LINKAGES. When deciding whether or not to comply with Trump’s expanded GGR, the Executive Director shared that the organization was “caught up in a bit of a difficult situation. The organization was running drop-in centers for sex workers, and to just leave them [without funding] became problematic because it’s either we close the centers, because they are predominantly purely funded by the [LINKAGES] project, or we sustain them. So, we looked at the lesser evil, which was to sustain the drop-in centers.”

Malawi’s public health system

The government health system, managed by the Ministry of Health, provides 60 percent of health care delivery in Malawi and offers services at no charge. Facilities are divided into three tiers: the primary tier consists of rural health centers run by medical assistants and nurses, but no doctors, where medical supplies are scarce. While health centers are intended to serve an average of 10,000 people, some facilities serve up to 237,000 people, particularly those near urban areas. The second tier are district hospitals which are centrally located in each district (28 total) and treat individuals who are referred from rural health centers. The tertiary level consists of four central hospitals in urban areas that offer the highest level of care.

U.S. global health assistance supports public, government-run clinics in Malawi primarily through PEPFAR funding that supports service provision for people living with HIV. PEPFAR funds a number of partners, including the Baylor College of Medicine, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAP), PCI/Malawi, and the University of North Carolina’s Lighthouse program, all of which provide facility-based HIV and AIDS services, including testing, care, and treatment.

CHANGE researchers were able to tour the Kawale Health Center in Lilongwe District, a public clinic that provides such services free of charge through government of Malawi and PEPFAR funding. Andrew Mphongolo, a clinician at Kawale Health Center, reported that though PEPFAR-funded HIV and AIDS services are not enough to meet the needs of the community without support from the government of Malawi, “they [PEPFAR-funded programs] have made a difference. In the areas where Lighthouse and Baylor are available, the services are going on very well. Not all the [public] facilities have those partners... But the facilities which have these partners usually do well in terms of provision of services.”

According to Mphongolo, PEPFAR also supports programs that provide youth-friendly services through the Youth Corner. Both boys and girls can access services through a holistic approach that includes HIV and AIDS services, STI screening, family planning counseling, external condom distribution, psychosocial support, sexuality education, educational empowerment activities, and a safe space for youth to engage in recreation and art. Mphongolo reported that providing comprehensive services through the Youth Corner is essential because services are provided in one program, which addresses the barriers that prevent youth from accessing services outside of a youth-friendly environment. Youth Corners should continue to be a primary component of PEPFAR-supported programs in public health facilities to support the SRHR of Malawian youth.
Christian Health Association of Malawi clinics

Christian Health Association of Malawi (CHAM) clinics provide approximately 37 percent of all health services in Malawi and follow a fee-for-service model that charges patients for services that many Malawians cannot afford. To make services more accessible to those who live in catchment areas with a CHAM clinic, the government of Malawi has established service level agreements with CHAM to provide a package of essential health services for free or lesser charge to some beneficiaries.

CHAM clinics serve populations in areas where government facilities are not located. According to CHAM headquarters staff, CHAM provides holistic health services that are in compliance with the Ministry of Health and Population Policies and Standard Operating Procedures. CHAM does not “discriminate against anyone, including key populations” when it comes to accessing health services. If somebody who belongs to this group comes to seek health care services in our facilities, they are welcome.” CHAM staff reported “the services are there for everybody.”

The majority of CHAM clinics provide primary health care, including ANC, immunizations, chronic disease treatment, cervical cancer screenings, and PAC. Depending on the facility, family planning and HIV and AIDS services may be found in one location or at separate clinics. Only certain family planning methods are offered at CHAM facilities due to the religious designations within the organization. According to CHAM staff, some CHAM clinics offer modern contraception methods while others only offer external condoms. Internal condoms and lubricant are not available at CHAM clinics. CHAM clinics refer patients who desire a method that is not offered at the CHAM facility to the nearest public clinic. Specific CHAM facilities provide HIV and AIDS services, including voluntary medical male circumcision (VMMC), external condoms, and antiretroviral therapy (ART) services for people living with HIV.

In partnership with the CDC, seven high-need CHAM clinics currently receive PEPFAR funds to strengthen infrastructural, technical, and human resources capacity; increase uptake of VMMC; and expand youth-friendly HIV services. Youth-friendly services are particularly important in Malawi because, according to national data, 19 percent of Malawian girls have sex for the first time before the age of 15, and 59 percent have had sex by the time they turn 18. More than half (52 percent) of adolescent girls aged 13-17 have experienced forced sexual initiation, which puts them at higher risk of HIV and AIDS, other STIs, and unintended pregnancy.

Furthermore, youth in Malawi report experiencing stigma and poor treatment from health care workers when accessing SRHR services. During an interview with a group of local organizations that provide SRHR services, youth “feel comfortable when the one who is handling them is also youth-friendly. But, if you go to government health centers, the way health center maybe treats these young ones, ... they were not comfortable talking about all these issues to do with sexual and reproductive health.” According to CHAM staff, CHAM’s partnership with
CDC has increased the availability of youth-friendly services in Malawi, which are essential to addressing the health needs of young people, including HIV and STI prevention, testing and treatment, unintended pregnancy, and violence prevention.301

There exists a dueling perception that patients will receive higher quality care at CHAM clinics than public clinics because of the fee-for-service model. GENET staff reported that “because you need to pay [for services at a CHAM clinic], it means the services are there. Where they are free [at a government clinic], there are no services because the demand is high. That’s where the challenge is.”302

Though commodity availability and quality of services are consistent challenges across Malawi’s health system, organizations told CHANGE that some people don’t go to CHAM clinics because they know that other people are able to access the same services at public facilities for free elsewhere in Malawi. As staff from GENET explained, “the problem is [knowing] another community has free services [from a government clinic] and then you have to pay. You’re not even willing to pay even when you have the money because you know other people are accessing the same services for free.”303

Regardless of whether the services at CHAM clinics are higher quality and potentially more desirable, interviewees reported that many Malawians are not willing to pay for services at CHAM clinics so are more likely to delay or avoid seeking care.304,305

According to interviews, this unequal access to affordable services across Malawi creates barriers to service uptake that cannot be addressed by government subsidies to CHAM clinics or U.S. investment in both public and CHAM facilities.

CHAM also works closely with traditional authorities to implement a bylaw that requires both the male and female partner to attend an ANC appointment together to receive free health care at CHAM health facilities, including those that receive U.S. global health assistance through the CDC.306 If both partners are not present at the appointment, the clinic will charge the woman for the ANC services. To receive ANC services for free if a woman’s partner is not available to attend an appointment, the woman is required to provide a signed letter from the local traditional authority explaining the male partner’s absence.307

U.S. global health assistance supports private clinics that charge certain people for ANC services if a partner is not with them.308 While PEPFAR does not prohibit private clinics from charging patients, it does support equitable access to services. While CHAM staff reported that this bylaw promotes maternal and child health because it increases male involvement in ANC,309 this bylaw also proves problematic. This bylaw reinforces heteronormative gender norms that imply every pregnant person is female and must have a male partner.

The bylaw also does not take into account the needs of people who become pregnant outside of a partnership, whether through consensual sex or rape. Maxwell Kasonga, the Director of the Centre for Youth Development, referred to the issue of GBV experienced by pregnant people in Malawi this way: “There are some women who experience prenatal and postnatal abuse by partners that die silently.”310 This bylaw can put a pregnant person at increased risk of GBV if they are forced to notify a partner to access services.311

Furthermore, requiring a pregnant person to obtain approval to receive free ANC services puts an undue burden on them, particularly if the pregnancy was unintended or the result of a rape or incest. Depending on the situation surrounding the pregnancy, this bylaw could prevent pregnant persons from accessing ANC, which is a vital component of maternal and child health care.
Bylaws intended to promote maternal and child health

Given their important role at the community level, traditional authorities have instituted bylaws to address some of the public health concerns they have witnessed in their villages. A key example of such a bylaw that impacts SRHR in Malawi is the requirement for all women to give birth in a health facility.312 Her Excellency Dr. Joyce Banda issued the Presidential Initiative for Safe Motherhood in 2012 that made it mandatory for all women to give birth in a health facility313 as a means to reduce the country’s high maternal mortality ratio of 749 maternal deaths per 100,000 live births as of 2000 and 444 deaths per 100,000 live births in 2010.314 The most recent maternal mortality rate estimate (2017) is 349 maternal deaths per 100,000 live births in Malawi.315 As a means to increase labor and delivery in a facility, traditional authorities were tasked with enforcing this bylaw and extensive research in this area determined that traditional authorities used multiple techniques for enforcement, such as encouragement, fear, punishment, or coercion.316 One chief told CHANGE that this bylaw is an important health intervention because “if they deliver at home, they can easily die.”317

If a woman does not deliver at a facility, she or her family must pay the traditional authority a fine, most often in the form of livestock, such as a goat or chicken.318 According to a variety of stakeholders interviewed by CHANGE, this type of bylaw is widely considered an effective and appropriate way to reduce maternal mortality and promote SRHR at the community level, though some religious leaders do believe that imposing such fines is unfair to those who are already experiencing poverty.319

There has been limited quantitative research conducted in Malawi to understand the numerous factors that may influence a pregnant person’s decision to give birth at home versus a facility. One barrier to giving birth in a facility is the far distance that many people must travel to access health services, particularly in rural areas where the majority of Malawians live.320 People may also be deterred from delivering in a health facility due to fear of disrespect and abuse during labor and delivery from health care providers.321 Limited qualitative research suggests that some level of disrespect and abuse during delivery is relatively common in Malawi, but additional research should be conducted to better understand the respectful maternity care needs of pregnant persons in Malawi.322
Contraceptives, external condoms, and internal condoms under PEPFAR

In Malawi, the total fertility rate is relatively high, with 4.3 children born per woman. More than half of women use a modern method of contraception, such as injectables, implants, and external condoms. Approximately 19 percent of currently married women and 40 percent of unmarried, sexually active women have an unmet need for family planning. Enabling beneficiaries to receive numerous services through one program is particularly important for SRHR issues that are as interconnected as HIV and AIDS and family planning.

Avoiding early pregnancy among AGYW was one of the key elements related to family planning programming in Malawi that was brought up consistently across interviews. Organizations repeatedly emphasized the importance of offering integrated youth-friendly services that could provide contraception, HIV and AIDS testing and treatment, and other relevant services. PEPFAR funds public and CHAM health facilities across Malawi to support youth-friendly services, particularly due to the threat of HIV and AIDS among young people.

Supporting the integration of family planning and HIV and AIDS services—particularly through PEPFAR programming like DREAMS and LINKAGES—is a priority of USAID as a means to make progress toward the global 90-90-90 goals. PSI Malawi reported that they receive contraceptive commodities for distribution through their DREAMS mobile clinic model from Malawi’s national supply chain program, which receives significant support from USAID’s family planning program. SIFPO2 (Support for International Family Planning Organizations 2) is the USAID-funded program that operates in a number of countries, including Malawi, to support national family planning programs and private sector networks to ensure contraceptive commodities are available in-country.

LINKAGES partners also provide family planning services through PEPFAR-funded Drop-in Centers (DICs) and mobile clinics. Members of the Female Sex Workers Association (FSWA) told CHANGE that LINKAGES DICs only provide external condoms that smell strongly of chemicals and sometimes break. They brought out a few condoms to show CHANGE researchers and they were packaged in nondescript silver packaging and had an unpleasant latex smell. Zinenani Majawa, the Founder and Executive Director of FSWA, said that FSWs often
don’t want to use such condoms, so instead opt to purchase condoms from bars that may be higher quality but are very expensive. FSWA staff also shared that internal condoms are expensive and only available at private pharmacies. As a result, FSWs lack access to condoms that they are inclined to use, which further puts them at risk for HIV or STI acquisition and unintended pregnancy.

Across Malawi, “condom availability and access and stigma associated with male and female condoms remain challenges among priority populations.” Across Malawi, “condom availability and access and stigma associated with male and female condoms remain challenges among priority populations.” According to PEPFAR’s COP for Malawi in 2019, PEPFAR’s condom supply chain improved in 2018; PEPFAR distributed approximately 56 million external condoms to the general public in Malawi and an additional 10 million external condoms to key populations in 2018. In 2017, PEPFAR had distributed less than 54 million external condoms in the public sector. The distribution of internal (female) condoms decreased from 416 thousand in 2017 to 375 thousand in 2018, though.

Two hundred and eighty million internal and external condoms are needed annually to support ongoing condom programming that focuses on all sexually active men and women, youth, and key populations in Malawi. Throughout FY 2020, Malawi’s COP intends to leverage USAID’s Commodity Fund to “continue to fund Malawi’s lubricant needs, socially-marketed condoms, and female condoms to prevent gaps in condom supplies.” It is not clear how the Commodity Fund will address current gaps in condom supplies in Malawi, so additional transparency from PEPFAR and USAID is needed to ensure accountability of this mechanism.

Key Population Investment Fund (KPIF)

Malawi is a focus country for PEPFAR’s Key Population Investment Fund (KPIF). KPIF was first introduced as a plan to invest over US$360 million over five years to support the “scale-up of KP-led community approaches to enhance and expand quality HIV and AIDS services for key populations” that take into account the issues of stigma, discrimination, and violence experienced by KPs. Through the end of the Obama Administration and into the Trump Administration, agencies failed to agree on a mechanism to disburse the funds directly to local partners that are best placed to meet the needs of KPs and were instead forced to disburse funds through PEPFAR implementing agencies and prime implementing partners.

CSOs interviewed by CHANGE were aware of the original plan for KPIF to channel approximately US four million dollars through local ‘indigenous’ organizations that work with key populations in Malawi between 2019 and 2021. As of July 2019, KPIF funds are intended to increase alignment between Malawi’s National HIV Program and the Global Fund’s programming in Malawi, and establish a strategic information system for KP programming that includes national unique identifier codes. When CSOs learned that PEPFAR decided to route

External condoms procured by USAID and distributed by PSI Malawi.
the funds through existing prime partners including FHI 360 Malawi, KP-led CSOs were surprised and troubled by this change of course for fear that funds would not be made available to local organizations as was originally promised under KPIF.\textsuperscript{338,339}

In response, they created the Diversity Forum, a coalition to respond to the foundational changes to KPIF and “ensure that indigenous KP-led organizations are at the very center of decision-making, grant management, and implementation under the KPIF.”\textsuperscript{340} The Diversity Forum is a consortium of local LGBTQI+-led organizations operating in Malawi, including the CEDEP, the Nyasa Rainbow Alliance, FSWA, and others.\textsuperscript{341}

On June 18, 2019, the Diversity Forum sent a letter directly to PEPFAR/Malawi outlining their concerns about the changes to the KPIF and the lack of engagement of LGBTQI+-led organizations in the planning process for KPIF in Malawi. According to the letter (which is available online), most of the implementing partners involved in PEPFAR’s KP programming until 2019 have had “no history of work with LGBTQI+ communities, no real knowledge of the complex issues and challenges faced by these communities, and no links to members of these communities” with a specific reference to FHI 360 Malawi.\textsuperscript{342}

As a result, the Diversity Forum claims that KP programming does not fully meet the needs of beneficiaries because the programs are not based in the cultural, ethical, economic, or geographical contexts that shape the lived experience of KPs in Malawi. This letter requests that the Diversity Forum is “at the center of planning and implementing any and all activities, interventions, or programming targeting LGBTQI+ people and key populations in Malawi” to ensure that programming is comprehensive and meets the needs of beneficiaries.\textsuperscript{343}

Members of the Diversity Forum confirmed that PEPFAR/Malawi responded to their letter approximately a month later. PEPFAR/Malawi agreed that “any programming aimed at serving key populations must work closely with KP-led and KP-competent organizations to ensure effective programs that meet the needs and reinforce the rights of and service delivery preferences of the intended beneficiaries.”\textsuperscript{344} PEPFAR/Malawi pushed back against the Diversity Forum’s assertion that past programming lacked direct engagement with KP-led organizations. PEPFAR stated that funding had been channeled through local KP-led and ‘KP-competent’ organizations since 2016, including CEDEP, Pakachere, and YONECO.\textsuperscript{345}

Due to the “urgency of programming these resources for maximum epidemic control, [PEPFAR] plan[s] to program through existing awards and sub-awards with local organizations in the short term,” but reported that they “look forward to the Diversity Forum’s involvement during the planning, implementation, and monitoring of KP-focused programs.”\textsuperscript{346} However, PEPFAR has not made explicit if and how they will compensate civil society for their involvement in KP-focused programs. PEPFAR must not rely on small civil society organizations to provide expertise without compensating them with money or capacity building.

As of November 2019, the Diversity Forum reported that their engagement with FHI 360 Malawi has improved since the submission of their letter. Members of the Diversity Forum have had several meetings with representatives from FHI 360 Malawi, and occasionally USAID Malawi, to discuss changes to the KPIF that would directly benefit KPs. Members of the Diversity Forum are hopeful that their organizations will continue to be involved in the implementation of PEPFAR’s KPs programming in Malawi, including LINKAGES and KPIF.
Anti-Prostitution Loyalty Oath

As a component of PEPFAR legislation, the Anti-Prostitution Loyalty Oath (APLO), often referred to as the “prostitution pledge,” states that no PEPFAR funds may be used to provide assistance “to any [foreign] group or organization that does not have a policy explicitly opposing prostitution and sex trafficking.” The APLO detrimentally impacts the provision and accessibility of HIV and AIDS services for FSWs. For more detailed information on the impacts of the APLO on the health and rights needs of FSWs, see CHANGE’s report, All Women, All Rights, Sex Workers Included: U.S. Foreign Assistance and the Sexual and Reproductive Health and Rights of Female Sex Workers.

Sex work in Malawi

Sex workers in Malawi face a range of challenges ranging from barriers to accessing health services to experiencing stigma, discrimination, and violence. Sex work is criminalized in Malawi and, like many countries, the legal mechanisms that impact sex work in Malawi consist of a patchwork of codes regarding loitering, vagrancy, and solicitation. The burden of HIV among female sex workers (FSWs) is high with an estimated national HIV prevalence of 55 percent. FSWs face high levels of discrimination when seeking SRH services and from police when seeking victim support services, which further increases their vulnerability to HIV, STIs, and unintended pregnancy.

During an interview with the Centre for Human Rights Education, Advice, and Assistance (CHREAA), staff explained that it is common for FSWs to experience violence from police. “Once they [the police] arrest them, they were actually raping them, and then releasing them...they were targeting the sex workers because of their vulnerability.”

Transactional sex is associated with an increased risk of HIV acquisition and unintended pregnancy among young women in sub-Saharan Africa, including Malawi. Women in Malawi engage in transactional sex for numerous reasons including housing, food, clothing, payment of school fees, or access to a cell phone. This can contribute to increased risk of HIV acquisition because of the unequal gender power dynamic and the fact that it is more difficult for women to negotiate safe sex in these interactions.
A representative from an organization that receives U.S. global health assistance in Malawi described the implementation of the APLO as fraught with misunderstanding across PEPFAR implementing partners. He said, “Think about the interpretation [of the APLO], how this is being interpreted, and also the harmful effects in terms of reaching out to what is a marginalized group... you are already marginalizing that group [due to the APLO] and how do you reach them? How do you get them to open up?...If you are strictly focusing on the [APLO], or policy, then you’re leaving out this huge group of people who are in need.” This representative also referenced the chilling effect of the APLO on PEPFAR’s programmatic activities by reporting that “it’s also a matter of interpretation, because for some [partners] it would say, ‘It doesn’t say we should not work with sex workers. We should still work with them.’ For others, they’ll say, ‘No, it’s a little bit tricky, because we just need to be careful how we work with them.’ So it leaves a lot of room for misunderstanding.”

**U.S. government engagement & partnerships**

Organizations working across the SRHR landscape—including those organizations who receive U.S. global health funds and those that do not—reported a lack of clear communication regarding U.S. global health policies from the U.S. government and prime partners. This lack of communication has a detrimental impact on partners’ engagement with the U.S. government. As reported by recipients of U.S. global health assistance, including prime partners like CHAM, FHI 360 Malawi, Pact, and sub-primes like VillageReach-Malawi and others, the communication, implementation, and rollout of Trump’s expanded GGR lacked clarity.

U.S. global health assistance policy requirements are also not fully explained through the application process. A community-based CSO applied and received approval for a U.S. Embassy PEPFAR small grant in 2019 for a program focused on AGYW, and the staff were elated. This organization, which also promotes access to safe abortion services in Malawi, was not aware of the requirements and stipulations attached to U.S. global health assistance, particularly Trump’s expanded GGR. Staff were unfamiliar with the policy because it had not been in place when they had last received U.S. funding. When CHANGE staff shared the details of Trump’s expanded GGR, the organization reported they would have to “decide which funds to accept”—U.S. global health assistance funds or funding from other donors—because their abortion advocacy activities would not be compliant with Trump’s expanded GGR.

Furthermore, recipients of U.S. global health assistance reported that there is no official mechanism through which partners can share feedback with the U.S. government about the impacts of policies and funding decisions on their work. Melchiade Ruberintwari from FHI 360 Malawi reported that they received requests from USAID to share examples of the impact of Trump’s expanded GGR on LINKAGES programming during the early implementation stages of the policy, but had no sense of how USAID used that information. Other prime and sub-primes reported a complete lack of opportunity to share feedback about the positive or negative impacts of U.S. global health assistance policies on their programming.
Prime partner and sub-prime partner relationships

Prime partners often reported receiving updated information about Trump’s expanded GGR from regular meetings with the U.S. government, either through PEPFAR partner meetings or project management meetings with staff from the U.S. government implementing agency.366,367

Sub-primes then rely on prime partners to ‘flow down’ the information about relevant policies like Trump’s expanded GGR. Sub-primes reported that policy information is sometimes shared with them during regular project management meetings, annual project reviews, or through public online training modules. One such online training module is the Protecting Life in Global Health Assistance and Statutory Abortion Restrictions – 2019 training that was developed by Knowledge for Health (K4Health) funded by USAID with technical guidance from USAID’s PLGHA policy compliance team.368

FHI 360 Malawi told CHANGE that USAID requested that all LINKAGES implementing partners complete the PLGHA online training module.369 A sub-prime of LINKAGES, described this process in detail. All staff whose salaries are paid either whole or in part by LINKAGES are required to complete the PLGHA online training course and submit a certificate of completion to FHI 360 Malawi as an annual requirement of their subaward.370

The Executive Director of this sub-prime described this process as “tedious” and did not complete the training, whereas the other sub-prime staff who work on LINKAGES completed the training and submitted their certificates to FHI 360 Malawi in 2019.371 The Executive Director reported to CHANGE that Trump’s expanded GGR “operates against [his] conscience” and negatively impacts the ability of LINKAGES to meet the needs of beneficiaries due to the high project management burden of the sub-prime’s subaward and restrictive management by FHI 360 Malawi as the prime partner.372

According to the Executive Director, his level of effort (LOE) on LINKAGES is low, but he believes the management of this award takes up at least three to four times more of his time than is currently budgeted due to the high project management burden placed on organizations that receive U.S. global health assistance.374 In addition to his primary duties to review annual workplans, programmatic reports, and financial reports as part of his LOE, the Executive Director is also expected to attend every LINKAGES in-country meeting and host every visitor to their sites (including DICs).375 Partners should be paid for this type of work, as it directly contributes to program management responsibilities. Expecting sub-prime staff to operate beyond the standard program management requirements of a subaward places an undue burden on organizations that have limited staff to manage a dynamic programmatic portfolio.

Second, FHI 360 Malawi does not actively facilitate interaction and collaboration between LINKAGES sub-primes. A sub-prime reported that sub-primes feel that they are discouraged from networking and collaborating with each other during regular LINKAGES partner meetings. During these meetings, sub-primes are expected to present their progress and challenges in implementing LINKAGES programming and are not allowed to engage “beyond what you are there for… [the meetings] are not for networking.”376 From their perspective, sub-primes do not feel they can network and engage with other organizations, which limits their ability to effectively strengthen their organizational capacity and create a functional network.
From his perspective as the FHI 360 Malawi Country Director, Melchiade Ruberintwari reported that the LINKAGES quarterly meetings are intended for FHI 360 Malawi and sub-primes to share program strategies, report quarterly achievements, and discuss relevant U.S. global health assistance policy updates. When asked if these meetings were also an opportunity for partners to collaborate with one another outside of the LINKAGES project, he said that sub-primes “usually talk without even having those meetings. They are in the same country, they have known each other for a while, they will always talk. But at the program level, the quarterly review meetings are used as an opportunity to share program successes and challenges.” These findings suggest that some sub-primes would appreciate more time to collaborate with each other, while the prime partner perceives that sub-primes work together regularly in other fora, so networking is not necessary during regular program management meetings. Clear expectations and objectives for such meetings are necessary to ensure that prime partners are meeting their responsibilities to the U.S. government and that sub-primes are receiving the support they need from the prime partner.

Sub-primes interviewed by CHANGE were largely unaware of the further expansion of Trump’s expanded GGR that was announced in a press statement by Secretary of State Mike Pompeo. Staff from one sub-prime were not aware of Pompeo’s expansion and reported only receiving information about Trump’s expanded GGR when signing their subcontract at the start of the project. Furthermore, staff from this sub-prime were unaware that Trump’s expanded GGR does not apply to their work because they have signed a subcontract (which is an acquisition mechanism), not a subaward (which is an assistance mechanism). Some sub-prime staff used the terms “cooperative agreement” and “contract” interchangeably throughout interviews with CHANGE. It is important for U.S. government and prime partner staff to explain the differences between the applicability of the expanded GGR to cooperative agreements and contracts given that the GGR applies to the former, not the latter.

### Acquisition versus Assistance Mechanisms: An Explainer

U.S. global health assistance falls into two categories: Acquisition and Assistance.  

**Acquisition:** This type of mechanism is used to purchase supplies or services, including commodities. Acquisition mechanisms include contracts, purchase orders, and Interagency Agreements.

**Assistance:** This type of mechanism engages public health stakeholders and implementing partners who work toward a shared goal in collaboration with the U.S. global health implementing agency. Cooperative agreements are a common type of assistance mechanism that requires the U.S. government implementing agency to actively engage in the program through a process called “substantial involvement.” Grants, another type of assistance mechanism, are used when substantial involvement is not required.
Based on the inconsistent and piecemeal communication they received from the U.S. government about Trump’s expanded GGR, implementing partners need clear, intentional communications to ensure that they fully understand the policies and contingencies that come with U.S. funding. Partners described this top-down approach of information sharing from the U.S. government and prime partners as a significant issue that leads to miscommunication and misunderstanding of how the GGR applies (or does not apply) to their programs. If implementing partners are not fully aware of all elements of Trump’s expanded GGR, they are at risk of not providing permissible services, violating the policy unintentionally, losing current funding, and potentially being disqualified from future funding opportunities.

These findings are consistent with CHANGE’s findings presented in past research on the implementation of Trump’s expanded GGR approximately one year after the policy was implemented. Two and a half years into the implementation of the Trump’s expanded GGR, U.S. government officials and prime partners are still not providing accurate and complete guidance to their partners regarding policy implementation and compliance.

**INGO-local partner relationships**

Multiple interviewees believe that the relationships between donors, INGOs, and local partners need to change for U.S. global health assistance to truly meet the needs of communities. The Executive Director of a sub-prime expressed the desire to “be partners as opposed to donors and recipients. Can we be partners? There is no partnership there. Actually, it’s unidirectional.”

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Eric Sambisa outside of the Nyasa Rainbow Alliance office in Blantyre, Malawi.

“After projects phase out, everything phases out. They’ve got good reports about sustainability of projects on paper, but not in the community.”

– Brown Mkandawire, Programs Coordinator, Malawi Rural Education Support and Rehabilitation Program

The Malawi Rural Education Support and Rehabilitation Program is a local NGO headquartered in Blantyre that does not receive U.S. global health assistance. Brown Mkandawire, the Programs Coordinator, told CHANGE that the organization tried to coordinate their AGYW programming with ongoing DREAMS work in Blantyre, but the DREAMS partners “implement projects themselves...”
without partnership with local organizations.” Mkandawire reported that this is an issue of sustainability across U.S. global health assistance because “after projects phase out, everything phases out. They’ve got good reports about sustainability of projects on paper, but not in the community.”

As a KP-led local organization that does not receive U.S. global health assistance, Nyasa Rainbow Alliance has a unique perspective about the complicated relationship between INGOs and local organizations in Malawi. The Nyasa Rainbow Alliance, along with other organizations who developed the Diversity Forum, had limited interaction with a prime partner of U.S. global health programs in Malawi. Eric Sambisa, the Director, reported to CHANGE that the prime partner asked Nyasa Rainbow Alliance to co-host an HIV testing day for LGBTQI+ beneficiaries in mid-2019. According to Sambisa, the prime partner wanted Nyasa Rainbow Alliance to “mobilize the community” and conduct an HIV testing event right away. The prime pushed back when Sambisa’s staff asked to draft a Memorandum of Understanding (MOU) before co-sponsoring such an event. Instead, the prime partner offered to fund the testing day and even offered to hire transportation to pick up beneficiaries at their homes or places of work to bring them to the testing location. Nyasa Rainbow Alliance staff refused to participate in the testing day because the prime partner refused to sign an MOU with Nyasa and the prime did not understand the added security risk that offering transportation would pose to LGBTQI+ beneficiaries, many of whom experience discrimination and violence due to their perceived or actual sexual orientation and/or gender expression.

Through this interaction, Sambisa’s staff got the impression that the prime partner “only came looking for data” and did not consider the security of the beneficiaries at all, particularly when offering transportation that would draw attention to these individuals within their communities. Beneficiaries from the Nyasa Rainbow Alliance also shared their experiences of violence and discrimination in a confidential interview with CHANGE researchers and confirmed that security is one of their primary concerns when accessing health services.

Access to U.S. global health assistance

Whether or not they receive U.S. global health assistance, many Malawian CSOs believe that the U.S. government prioritizes funding INGOs over smaller local organizations that are based within the community. Staff from Foundation for Civic Education & Social Empowerment (FOCESE), a young women-led organization in Malawi’s rural Balaka district, reported that the U.S. government focuses more on funding “organizations that are big... We have observed on our side that they prioritize NGOs – they give a lot of assistance to organizations that are big and maybe are implementing programs that are not relevant to meet the needs of communities. So maybe if they can also consider small organizations like ours because we are in the community, we know a lot of problems our people are facing, especially our girls and women.”

Staff from Disabled Women in Africa (DIWA) share their perspectives about the importance of creating programs to meet the needs of women living with disabilities at the DIWA office in Lilongwe, Malawi.
“We have observed on our side that they prioritize NGOs – they give a lot of assistance to organizations that are big and maybe are implementing programs that are not relevant to meet the needs of communities. So maybe if they can also consider small organizations like ours because we are in the community, we know a lot of problems our people are facing, especially our girls and women.”

–FOCESE Staff member

The capacity of local partners to fully engage with the U.S. global health assistance system and meet the eligibility requirements for U.S. global health funding should also be prioritized. Local partners across Malawi would be able to better engage in this process if they were more familiar with the application process and the mandatory reporting, monitoring, and evaluation requirements. Some partners like PCI/Malawi also suggested that program timelines be extended for multiple years to allow for partners to operationalize their programs and adapt them to the changing local context.395

Trump’s expanded GGR limits access to U.S. global health funds for local organizations that work in the SRHR space if they engage in any work related to abortion. CHANGE interviewed a number of organizations who expressed interest in applying for U.S. global health funds, but do not do so because they would have to eliminate abortion-related activities from their work.396,397

Staff from CSJ reported that the restrictions placed on U.S. global health assistance prevents them from addressing the immediate needs they encounter in communities. On numerous occasions, CSJ has been unable to apply for PEPFAR funding due to their advocacy around all areas of SRHR. Brian Ligomeka, the Director, shared that:

“The U.S. government has [released] calls for proposals. One was for PEPFAR funding, ... but one of the conditions was that all the organizations which are advocating for access to abortion should not apply. So, CSJ is affected. We go to the village where HIV and AIDS is a problem. And HIV and AIDS is also part of sexual reproductive health and rights. It’s an area which we work on, but we cannot get funding from the U.S. because ... as an organization, we advocate for comprehensive SRHR ... [we cannot] drop the whole idea of advocating for family planning, abortion law reform, or ending child marriages because we want to comply with the conditions that the U.S. government has set aside.”398

–Brian Ligomeka, Director, CSJ
In 2018, PEPFAR shared a goal of programming 70 percent of its funding through local indigenous partners by FY2020. There are potential benefits and harms to SRHR in Malawi as PEPFAR mandates this goal through the annual COP process. CHANGE met with many local organizations who do not receive U.S. global health assistance but are engaged in progressive SRHR work, including implementing holistic HIV prevention programming for AGYW (similar to DREAMS) as well as targeted services for KPs that would support the work of LINKAGES. The skills and expertise of these local organizations could strengthen PEPFAR’s programming in Malawi and increase community engagement as many of these organizations have direct ties with communities that are key and priority populations for PEPFAR. There would also be a cost-saving benefit because funding will not need to pass through multiple organizations through the standard prime-sub relationship to reach beneficiaries. However, more local organizations being funded by U.S. global health assistance also means that more organizations would be forced to comply with policies that impact SRHR, including Trump’s expanded GGR, which will harm populations across the country.

Some CSOs also reported that the application process for U.S. global health assistance is incredibly complicated, particularly for smaller local organizations that have not received funding from the U.S. government before. Richard Yohane, the Executive Director of RISE Malawi, one of CHANGE’s partners in this project, shared the following perspective:

“Most of the US government funding goes to big, big NGOs and you see that most of the money goes to vehicles and big salaries. I’m not saying they are doing a bad job; they’re doing good work as well. But that small amount of funding can reach a lot of people if it goes to a smaller organization at the community level.

They don’t need that vehicle, they don’t need a big salary, but they need the small funding to accelerate change at the community level … There are small organizations who struggle to come up with a proposal document, and for them to apply for USAID funding is almost impossible because it’s so complicated and so high level. It’s as if the application process is designed for specific organizations and not for others.”

One mechanism through which local partners in Malawi are encouraged to apply for U.S. global health assistance is through the U.S. Embassy small grant programs:

- U.S. Ambassador’s Special Self-Help Fund;
- U.S. PEPFAR Small Grants Program;
- U.S. Embassy Lilongwe Public Diplomacy Small Grants Program; and
- U.S. African Development Foundation.

Two small grants are particularly relevant to SRHR programming in Malawi: the U.S. Ambassador’s
Special Self-Help Fund and the PEPFAR Small Grants Program. These programs encourage applications from local organizations like FOCESE, which received a PEPFAR small grant of approximately US$20,000 in 2014. Using the grant money, FOCESE instituted a two-year program to promote the rights of people with disabilities and provide mobile HIV testing for people living with disabilities. Receiving these U.S. global health assistance strengthened FOCESE’s programming and increased their capacity to provide services at the community level. Once this project was over, FOCESE staff remained committed to continuing to build their capacity to “have an active role in the issues” and needs of the community.

These small grant programs allow for smaller local organizations to engage with the U.S. global health system in Malawi, often for the first time. The small grants are also required to include the same stipulations and conditions that are associated with other forms of U.S. global health assistance. As local organizations engage with the small grants programs, the U.S. Embassy or implementing agency staff should clarify such policies and conditions so that partners know explicitly what activities are permitted and which are restricted when they accept U.S. global health assistance.

DIN Malawi reported that they have applied for U.S. Embassy small grants at least three times in recent years. In 2017, DIN Malawi’s proposal for a PEPFAR Small Grant to implement a program for young people in Chikwawa was approved and the U.S. Embassy instructed DIN Malawi to register their organization in the System for Award Management (SAM) to access the funds. DIN Malawi told CHANGE that even though they are sure they completed their registration in SAM, the U.S. Embassy did not officially approve their small grant because DIN Malawi did not appear in the U.S. government system. This was a most unfortunate experience that prevented a local organization from addressing the needs they see in their community. DIN Malawi staff told CHANGE:

“We have the capacity. If we manage to utilize $1,000 and implement those funds directly in the community if we win this grant, we can make a great change, more than what these international NGOs can do. Because we are based here, we know the challenges of people here, while the other INGOs are travelling all the way from Lilongwe, they’re using the money which could be used by the project for allowances, they’re using for transport, fuel, and the like. But we are here. So that’s why we decided to take this challenge; that if we win this grant, definitely we can make a great change.”

The U.S. global health system should provide training programs and mentorship opportunities for local organizations to learn how to apply for and access U.S. global health funding.

In contrast, Pact staff successfully submitted a concept note to the U.S. Embassy in Malawi in 2017. During an interview with CHANGE, they described how the addition of U.S. global health assistance strengthened the organization’s Fisheries Integrations Society and Habitats (FISH) Project, a USAID-funded program. The FISH Project receives U.S. environment assistance to support “natural resource management, local governance, capacity development, climate change adaptation, and livelihood” activities. Since 2014, the FISH Project operates in the districts of Zomba, Machinga, and Mangochi, with a particular focus on fishing communities along Lake Malawi.

Pact’s concept note requested DREAMS funding through the PEPFAR COP process to support HIV testing and counseling among men, including young men and men in mobile populations (particularly men in fishing communities where the FISH Project
operates). The provision of additional PEPFAR funds to support Pact’s existing FISH Project is a success story for organizations accessing funding across programmatic and funding siloes to address a demonstrated gap, and it unfortunately stands in contrast to the experiences of other organizations interviewed by CHANGE.

**Community engagement**

To best meet the needs of beneficiaries, programs must be informed by the communities themselves, including through active participation of local CSOs in all stages of the program cycle. One partner, GENET, reported to CHANGE that “social norms are directly linked to girls’ access to SRHR services, because [social norms are] the backbone of SRHR. So, if girls and implementing partners are able to recognize those social norms [in] the communities, it will help us a great deal.”

Richard Yoahane, the Director of RISE Malawi, stated that U.S. global health assistance should “be more informed by the real needs of the people of a country or a community rather than only being informed by...the donor or government policies. The policy should be informed by actual context and the real needs of the people, because some donors just come in and say, ‘You can’t do this activity, you should do this activity.’ This is a top-down approach which doesn’t address the real needs of the community or the country.”

To make U.S. global health assistance programs more responsive to the needs of the community, beneficiaries themselves should be involved and compensated for their involvement in the design and implementation of programs intended to serve them. One community partner shared that “you can find the solutions right there in the community. Get their ideas and make sure that you apply their knowledge to address the issues that the communities are facing each and every day.”

Across interviews, CSOs and intended beneficiaries consistently reported feeling excluded from programming that is supposed to meet their needs. FSWs were no exception. The Female Sex Workers Association (FSWA) of Malawi is an FSW-led civil society organization that advocates for the rights of FSWs and advocates for decriminalization of sex work as well as access to health services. FSWA also provides case management services for FSWs who experience violence and is an active member of the Diversity Forum. Zinenani Majawa, the Founder and Executive Director of FSWA, shared that she and FSWA staff are frustrated that they have been excluded from PEPFAR programming across the board, including DREAMS and LINKAGES.

Majawa learned of a high-level PEPFAR meeting where FSW programming was to be discussed. FSWA had not been invited to the meeting—nor had any other FSW advocates—to her knowledge, so she decided to attend the meeting anyway and sat in the back of the room. When the discussion turned to programming for FSWs, she told CHANGE that she raised her hand, even though her hand was shaking from nerves, and asked the presenter, “Are you a sex worker?” When he said no, she followed up by asking, “So why are you discussing issues for sex workers? Where are the sex workers? You didn’t invite the sex workers. Sorry, you didn’t invite me; but I’m here.”

CHANGE researchers with members from the Female Sex Workers Association (FSWA) in Lilongwe, Malawi.
She explained to CHANGE that they have not been able to provide input on DREAMS programming for AGYW who engage in sex work, despite FSWA being the primary FSW-led CSO in Malawi. Majawa also explained that PEPFAR’s programming for FSWs through LINKAGES was lacking because they “don’t consult with FSWs, not in real life.”

The people who are impacted by U.S. global health policy should be actively involved in policy and program creation. Throughout the interviews with CHANGE, organizations reported that policies like Trump’s expanded GGR and the APLO cause negative effects for people that are already at-risk – whether it be due to their engagement in sex work, living in a rural area, lacking access to health care services, or identifying as LGBTQI+.

**Funding and programmatic siloes**

Integrated SRHR programs based on all human rights should be the standard for U.S. global health assistance. The structural elements of the U.S. global health assistance system, including funding silos, policy decisions, or programmatic priorities, should not limit the ability of programs to offer integrated services and strengthen novel partnerships to meet the needs of beneficiaries. Across interviews, local organizations repeatedly expressed to CHANGE researchers that they desired integrated SRHR programs and increased engagement with U.S. global health actors and prime partners.

The United Nations Children’s Fund (UNICEF) Malawi reported that the programmatic and funding siloes could be overcome if coordination increased among the numerous actors that have a role in U.S. global health assistance, from the government of Malawi to NGOs to the UN agencies. Kimanzi Muthengi, the Chief of Education and Adolescents, reported that the U.S. global health system is well-equipped to “deal with the boundaries and the silos amongst these actors. When we [as actors within the global health space] act separately, then it reduces our impact. For me, success is the ability to engage broadly in rolling out solutions in collaboration with other partners.”

Her Excellency Dr. Joyce Banda recommended that future U.S. global health programming address the needs of the African girl child before she reaches the age of 10. From her perspective, the current programming focuses on AGYW at 10 years old and this approach is siloed and may reach beneficiaries too late.

As has been discussed at length throughout this report, however, it is challenging for the U.S. global health system to promote integrated SRHR projects due to the complicated dynamics between the various actors, their priorities, and the funding available to implement programming. From her perspective as a prime implementing partner technical lead at Management Sciences for Health, Kate Ramsey reported that “it’s very hard for [U.S. implementing agencies] to manage it as an integrated project, because of the way the money works” across funding siloes and programmatic priorities.
Climate change & humanitarian assistance

U.S. humanitarian assistance is another category within U.S. foreign assistance that is intended to “alleviate suffering, and minimize the economic costs of conflict, disasters and displacement” through emergency operations and time-sensitive programming. The U.S. government can approve either global health assistance or humanitarian assistance to address issues caused by climate change in a particular country depending on the type of response and the sustainability of programming required to address the issue.

Beyond the expectations of the methodology, CHANGE researchers encountered the impact of climate change on the health needs of communities throughout Malawi across interviews. In recent years, Malawi has been impacted by a variety of natural disasters that have been exacerbated by climate change, including drought, flooding, cyclones, and fall armyworm infestations. Existing systems such as the health care system and agricultural economy are already overburdened, which makes recovering from these natural disasters even more challenging.

The combination of Malawi’s growing population, overburdened health care system, and reliance on rain-fed agriculture and subsistence farming place pressures on the health and well-being of Malawians on top of food insecurity and lack of access to health care services. Constantly responding to the negative impacts of climate change has become “the new normal in Malawi; we have to prepare communities to be resilient to those shocks.”

According to Kurt Henne of PCI/Malawi, USAID’s Food for Peace (FFP) program is an ideal mechanism through which U.S. global health assistance can respond to climate change in Malawi. The FFP program is a global initiative to reduce hunger and malnutrition and ensure all people have access to the food they need to lead healthy and productive lives through emergency activities, development activities, and nutritional support activities. In Malawi, FFP focuses on the impacts of climate change by helping farmers think through the changes they are experiencing and identifying solutions to address those challenges because “every farmer out there knows about and discusses climate change; everyone is very acutely aware of climate change and what it means to them at a personal level.” Henne provided the following example of helping farmers make “the choices of seeds [based on] what type of crops seem to be more resilient to climate change; which types of seed are faster maturing; which reduce risk of failing due to drought that comes very frequently here; helping farmers with installing irrigation systems so that they can produce food throughout the year, rather than depending on rain-fed agriculture.”

DIN Malawi recognizes the impacts of climate change on farmers in the rural Chikwawa region outside Blantyre. DIN Malawi staff described the challenges faced by farmers in this way: “People are highly vulnerable to impacts of climate change on

“[Responding to the negative impacts of climate change is] the new normal in Malawi. We have to prepare communities to be resilient to those shocks.”

–Kurt Henne, Malawi Country Director, Project Concern International
agriculture because here in Chikwawa, most people face floods and, if not floods, then it’s going to be drought. So, most people have a lack of adequate land for farming and no irrigation system, so some farmers are highly vulnerable. To assist farmers experiencing these challenges, DIN supports food security activities to improve farming techniques, raise awareness of pest-resistant crops, and promote better food storage practices during both floods and drought. These types of activities should be promoted through other forms of U.S. foreign assistance related to food production and farming in Malawi, especially because the vast majority of Malawians rely on rain-fed subsistence farming.

As an organization that supports health systems strengthening in Malawi, VillageReach-Malawi reported that the impact of these disasters on the health system is most concerning because “it takes so long to build up health systems; [disasters] did not only affect households, they also affected hospitals and health centers, which were flooded and destroyed.” Rebuilding the health system to support the needs of communities impacted by such disasters is expensive and time intensive, especially in resource-limited communities.

More global attention is also being paid to the impact of climate change and humanitarian emergencies on SRHR specifically. Caroline Mvalo, Executive Director of CECOWDA, reported that women may experience sexual violence when gathering firewood or water in more rural areas:

“Women need firewood to make sure they have energy at home, they cook for the children and their husbands and their families. They also need water to have at home so that they’re able to work, to do their domestic chores. But you’ll find because of climate change they don’t have water or firewood near them; they will have to walk long distances to get water or firewood. In between, they might encounter men who rape them along the way and they might come back home late and then their husband says, ‘Where were you?’ And then issues of violence start emerging.”

U.S. foreign assistance that supports climate change programming should include activities related to SRHR, including violence prevention and health systems strengthening.

During an interview with CHANGE, one sub-prime Executive Director shared that women’s “access to sexual and reproductive health services becomes limited” when they enter camps after a natural disaster. As “women become poorer” while staying in these camps, they may “seek sex in exchange of services,” which puts them at higher risk of negative health outcomes, including HIV, STIs, and unintended pregnancy.

Multilateral organizations like the United Nations Population Fund (UNFPA) play a vital role in supporting SRHR in emergencies in Malawi. After Cyclone Idai in 2019, 15 out of the 28 districts in Malawi experienced flooding that severely restricted people’s access to health care services, especially SRH services. UNFPA distributed reproductive health kits to communities impacted by the flooding to ensure women had access to supplies to assist with safe labor and delivery, treatment of STIs, and management of complications arising from miscarriage or abortion. The U.S. government is a founding member of UNFPA, but the political support for UNFPA in the United States is complex. The U.S. government had been a long-term strategic partner in support of UNFPA’s voluntary family planning programs worldwide until the Trump administration invoked the Kemp-Kasten amendment and willfully misinterpreted it to justify eliminating U.S. foreign assistance for UNFPA every year since March 2017.
Climate change is an important issue that organizations across Malawi have recognized in their communities and want to address through their programming, though few organizations have received direct U.S. foreign assistance to do this work. An Executive Director of a sub-prime reported that even though climate change negatively impacts SRHR, the U.S. government “doesn’t realize that climate change is an issue.” Until climate change mitigation efforts are assimilated into the U.S. global health assistance framework, reactionary U.S. humanitarian assistance will be required to address the immediate needs of communities in Malawi.

**Sexual Well-being**

Sexual well-being is a key component of sexual health, which is defined by the WHO as including “pleasurable and safe sexual experiences, free of coercion, discrimination and violence.” Sexual well-being is an essential factor to sexual health and is grounded within sexual rights, which recognizes well-being as part of one’s right to the highest attainable standard of health. Furthermore, an individual’s sexual well-being can change throughout one’s life and plays a critical role in one’s physical, psychological, emotional, social, and spiritual health.

Caroline Mvalo, the Executive Director of CECOWDA (an organization in Blantyre that does not receive U.S. global health assistance), recounted that even among Malawian women who have children, many “really haven’t enjoyed sex” or experienced an orgasm. Culturally enforced gender roles can prevent women in Malawi from feeling comfortable initiating sex and also reinforce societal expectations that they should have sex any time their husband wishes, “whether they like it or not.” CECOWDA encourages discussions of sexual pleasure and autonomy in their Girls Power groups, believing that “for women to enjoy sex, they have to be prepared in their head...and know that sex is for pleasure. It’s not a forced thing.”

“For women to enjoy sex, they have to be prepared in their head...and know that sex is for pleasure. It’s not a forced thing.”

- Caroline Mvalo, Executive Director, CECOWDA

Beneficiaries of CECOWDA’s programming engaged CHANGE researchers in a lively discussion about sexual well-being and the challenges of...
taking ownership of one’s sexuality given Malawi’s conservative culture. The beneficiaries stated that regardless of cultural taboos, “We should be proud of ourselves, because we are expensive.”448

Numerous partners shared that it is challenging to discuss sexual well-being in general because, according to Chance Mwalubunju, Senior Policy Consultant at Ipas Malawi, “Malawi is very conservative; there are some issues that some people don’t want to be spoken in public, so they would rather be silent about such issues.”449 RISE Malawi reported that “changing mindsets takes time, so in most places, you still cannot discuss openly even about condoms. You cannot share them openly because they will label you as if you’re promoting promiscuity, or immoral behavior, so you look at the context, and then you try to contextualize whatever message” to make it as appropriate as possible.450,451,452,453,454

Across the board, U.S. global health partners including PCI Malawi, Pact, VillageReach-Malawi, PSI Malawi, and CHAM reported that sexual well-being, including autonomy, pleasure, and satisfaction, is not actively promoted through U.S. global health assistance policies or programs.455,456,457,458,459 Technical staff from a prime partner of U.S. global health programming in Malawi explained that:

“I don’t believe that the U.S. government has any policies or processes around any of those topics [related to sexual well-being]. The U.S. government cannot promote sexual well-being if it does not identify it. It does not actively go against it, but I would say that they don’t recognize any of those things as being part of sexual and reproductive health and rights.”460

Kurt Henne from PCI/Malawi reported that sexual well-being is “not as an explicit objective” in PCI’s programs funded by the FFP program. Instead, PCI focuses on a number of other women’s empowerment strategies that challenge traditional gender norms, which are deeply ingrained in Malawian culture and daily life.461 Numerous organizations that spoke with CHANGE do not explicitly focus on sexual well-being but do try and promote the positive aspects of health and well-being in women’s lives. However, in discussing sexual well-being, VillageReach-Malawi reported that U.S. global health assistance increases women’s access to health services overall—including a range of contraceptive methods—which indirectly contributes to sexual well-being. Alinafe Kasiya believes that “having access to a whole range of methods and comprehensive information on a range of methods is a great thing for a woman to have. To be able to decide what you want for yourself is critical.”462 Kasiya also reported that FPAM and BLM are the primary private organizations that actively promote sexual well-being in Malawi.463 Tazirwa Chipeta, the Director of Programs at FPAM, confirmed that FPAM actively
promotes sexual well-being by offering a range of services and community programs that focus on the positive, as well as the negative, aspects of sexual health. As an organization, FPAM believes in supporting dialogue around SRHR issues as a means to promote sexual health and well-being. Chipeta reported that FPAM clinics are “open-minded. Someone can walk in [a clinic] and talk about anything related to SRHR. We promote people talking about the goodness of a small family, the goodness of contraceptives, the goodness of openness between parents and children, the goodness of staying in school.”

Since both FPAM and BLM no longer receive U.S. global health assistance, they were forced to close certain clinics and programs, which now limits their capacity to promote sexual well-being for the people of Malawi.

Maxwell Kasonga, the Director of Centre for Youth Development, an organization that does not receive U.S. global health assistance, shared that the organization focuses on promoting women’s autonomy to decide when to have sex, their preferred contraceptive method, and child spacing. It is challenging for women who live in rural areas with limited access to SRHR information and services to exercise their autonomy because family planning is culturally taboo. According to Kasonga, “there is a need for quite a lot of interventions to cover the gap” that exists between service provision and the promotion of sexual well-being that takes into account cultural practices and taboos.

Young women-led local organizations like FOCESE and GENET reported that they offer SRHR services including HIV prevention, GBV counseling, and self-defense training, but do not have a specific focus on sexual well-being. The organizations approached the issue differently: GENET mentioned that their organization may address sexual well-being indirectly by providing external condoms and services, whereas FOCESE recognized that the positive aspects of sexual health are a vital area that they want to intentionally focus on moving forward.

With regard to the specific needs of Malawians who identify as LGBTQI+, Nyasa Rainbow Alliance shared that their programming focuses more on the mental health and overall well-being of their beneficiaries instead of sexual well-being because of the stigma and discrimination they experience.
Conclusion

U.S. global health assistance must involve the communities that the programs are intended to serve. To be most effective and meet the needs of beneficiaries, key stakeholders must be engaged at every step of the program cycle. Community partners and experts in the field should be involved across procurement, design, implementation and monitoring, and evaluation to ensure programs and interventions are responsive to the needs of communities.

Trump’s expanded GGR is a primary example of the ways in which U.S. global health assistance can be used by a powerful few to export narrow American ideologies with impunity. Unless advocates, researchers, global health experts and the American public continue to draw attention to the impacts of such policies, U.S. global health assistance could be used as a weapon to infringe upon the sovereignty of other nations and harm the health and well-being of beneficiaries.

Research conducted by Lake Research Partners and American Viewpoint on behalf of CHANGE and PAI found that according to American voters in focus groups, the United States should not be imposing stipulations on foreign aid and health care providers based on religious or moral grounds. Some respondents called it bullying or controlling behavior. When it comes to the GGR, according to national polling, “over half (59 percent) of likely American voters oppose banning U.S. global health assistance to health care organizations in other countries that provide abortions or referrals to women even if they use their own funding.”

Brian Ligomeka from CSJ shared his perspective that “sometimes our leaders tend to forget that the ‘American Aid’ is not aid that one president raises. These are tax [dollars] of all Americans, ... so why should one president control taxes that are being contributed by all sorts of different people, just because of their personal values? It is a tragedy that the personal values of one individual are negatively affecting millions of people.”

Bypassing local institutions, civil society, and advocates has been all too common, particularly given the numerous specific examples that CHANGE partners described in Malawi. The U.S. government must remain actively engaged with local institutions to ensure that programs are responsive to the unique and dynamic cultural, social, political, and economic landscapes in each country context.
Recommendations

- The Global Gag Rule is having devastating impacts across global health in Malawi. The White House and Congress must end the GGR.

- U.S. global health implementing agencies must ensure that prime partners are communicating clear, concise, consistent, and accurate information to sub-primes on what is and is not allowable under Trump’s expanded GGR.

- Congress and implementing agencies must take steps to mitigate the harm of funding silos on global health programs by actively promoting the integration of SRHR services across funding streams and programs.

- U.S. implementing agencies must ensure that organizations that receive U.S. global health assistance provide beneficiaries equitable access to services regardless if the individual comes to the clinic alone or with their partner.

- U.S. implementing agencies should proactively engage communities in the design and implementation of U.S. global health programs to ensure that the needs of the community are being met.

- DREAMS programming must provide targeted services for AGYW living with disabilities, engaged in sex work, identifying as (LGBTQI+), and those who are seeking abortion services.

- PEPFAR must continue to promote the implementation of innovative programming beyond what is already included in DREAMS since the DREAMS-IC has ended. Engagement with partners who are developing innovative programming is vital to ensuring that U.S. global health assistance programs are responsive to the needs of communities.

- Congress and implementing agencies must continue to fund innovative programming like the DREAMS-IC and KPIF but ensure that impacted populations are included in program planning and design, and that funds are routed to local partners with specific funding intended to build capacity.

- As PEPFAR transitions 70 percent of PEPFAR funding to indigenous organizations by FY2020, the U.S. implementing agencies must:
  - Rigorously assess the legitimacy of “indigenous organizations” to make sure they are not simply newly locally registered INGOs; and
  - Build the capacity of sub-primes and local orgs to apply for and receive U.S. government funding, and not rely on prime assessments to determine which local organizations are most appropriate and experienced partners.

- PEPFAR and USAID must procure high quality internal and external condoms that are acceptable to intended beneficiaries by ensuring they are known brands with recognizable packaging with no unsavory smells.

- Sexual well-being is a critical component of health. The U.S. government must take steps towards including sexual well-being in programs meant to address SRHR.

- Implementing agencies and partners implementing global health programs in Malawi must consider the impact of climate change on SRHR in their programming.
Methodology

This report is based on a two-part data collection model.

1. CHANGE conducted a scoping review of peer-reviewed articles and grey literature to explore the history of U.S. global health assistance. CHANGE also interviewed 14 stakeholders with expertise in U.S. global health assistance to further explore the changes in U.S. global health assistance policies, funding actions, and programs related to SRHR over time, including current and former U.S. government officials; representatives from civil society organizations; implementing partner staff at organizational headquarters; and global health researchers and advocates. In lieu of an interview, representatives from USAID’s Office of HIV/AIDS and the Office of Population and Reproductive Health submitted written responses to CHANGE’s interview questions.

2. CHANGE, in partnership with RISE Malawi and MANET+ (two local Malawian organizations), conducted an independent 12-day fact-finding mission in late July and early August 2019 in five districts in Malawi: Blantyre, Chikwawa, Lilongwe, Machinga, and Zomba. Over the course of the fact-finding, CHANGE researchers interviewed 72 representatives from 39 civil society organizations, U.S. global health implementing partners, advocacy forums, and U.S. government staff to document their perspectives about the impact of U.S. global health assistance on SRHR in Malawi. Some of the organizations receive U.S. global health assistance and others do not. CHANGE also met with 56 beneficiaries from three different organizations during the fact-finding mission. For the first time in the history of CHANGE fact-finding trips, CHANGE attempted to meet with the USAID and PEPFAR country teams in Malawi and was unable to do so. The USAID and PEPFAR teams in Malawi shared brief, written responses to a subset of CHANGE’s interview questions via email in November 2019.

   a. CHANGE had the privilege of meeting with politicians, traditional authorities, and religious leaders to discuss their unique perspectives on the needs of their communities. In particular, CHANGE met with Her Excellency Dr. Joyce Banda, Former President of the Republic of Malawi, to discuss her experience and expertise as an advocate for the health and well-being of women and girls across the African continent, particularly through economic empowerment.

   b. The photos included in this report are part of a photography project intended to provide the interviewees the opportunity to self-direct their own photo shoots and visually represent themselves as they desired. Most partners took the opportunity to be photographed and CHANGE shared the photos with partners for their personal use. A few partners abstained from the photography for confidentiality and safety reasons.

3. The interviews for both parts of data collection were audio recorded for the purposes of transcription. CHANGE researchers coded each transcript and analyzed themes across interviews using MAXQDA 2018 software (VERBI Software, 2018). The staff writers developed the Malawi case study using common themes and detailed quotes from the interviews that most comprehensively explain the impact of U.S. global health assistance policies, funding decisions, and programs on SRHR in Malawi.
Acknowledgements

CHANGE would like to thank the following organizations and individuals for sharing their experiences, perspectives, and expertise: AVAC - Maureen Luba Milambe; Centre for Conflict Management and Women Development Affairs - Caroline Mvalo; Centre for Human Rights Education, Advice and Assistance (CHREAA) - Victor Mhango, Eddah Nyirenda, Francis Mataya, Lisa Tembo, and Thandiwe Kaunda; Centre for Solutions Journalism (CSJ) - Brian Ligomeka, Peter Montfort, Gloria Chimpikizo, and James Kalulu; Centre for Youth Development - Maxwell Kasonga; Chipembere Development Foundation - Boniface Mbewe; Christian Health Association of Malawi (CHAM) - Michael Phiri and Edna Kankhwali; Civil Society Advocacy Forum - David Kamkwamba and Eric Mcheka; Development Initiative Network (DIN Malawi) - Anderson Frey Billiati, Rittah Chawala, Connor Michalek, Lucia Olesi, and Joshua Malunga; Disabled Women in Africa (DIWA) - Rachel Kachaie, Ruth Mkutumula, and Rejoice Masebo; Female Sex Workers Association (FSWA) - Zinenani (Lucy) Majawa, Florence Chimpoyo, and Chiletso Chikawga; Family Planning Association of Malawi (FPAM) - Tazirwa Chipeta; FHI 360 Malawi - Melchiade Ruberintwari (via Skype); Foundation for Civic Education & Social Empowerment (FOCESE) - Christie Banda and Esther Harawa (via Skype); Girls Empowerment Network (GENET) - Twambilile Kayuni, Taonga Kachilonda-Phiri, Blessings Phiri; IPAS Malawi - Chance Mwalubunju and Luke Tembo; Kachere Progressive Women's Group - Malango Maganga; Kawale Health Centre - Andrew Mphongolo; Malawi Human Rights Resource Centre (MHRRC) - Emma Kaliya; Malawi SRHR Alliance - Hastings Saka; Management Sciences for Health (MSH) - Kate Ramsey (via phone); MANET+ - Lawrence Khonyongwa; Mapanga Community Development Organization - Lawrence Zuzu; Nyasa Rainbow Alliance (NRA) - Eric Sambisa and George H. Kachimanga; Pact - Sarah Ellison; Passion for Women and Children - Mackson Harawa; PEPFAR/Malawi (via phone and email); Populations Services International (PSI) Malawi - Tamara Mwenifumbo; Project Concern International (PCI)/Malawi - Kurt Henne (via Skype); RISE Malawi - Richard Yohane and Michael Mwandira; Rural Education Support and Rehabilitation Program - Brown Mfekala Mkaudawire; Save the Children-Malawi - Gomezgani Jenda; SRHR Africa Trust (SAT) - Kondwani Nathaniel Mwenda, Foster Mafiala, Robert Phiri, Mwiza Msowoya, and Loyce Chomba; Timvance Community Organization - Bright Simbi; Umodzi Youth Organization - Shy Ali; United Nations Children’s Fund (UNICEF) - Kimanzi Muthengi; VillageReach-Malawi - Alinafe Kasiya and Hope Ngwira; and Women and Law in Southern Africa Research and Educational Trust (WLSA-Malawi) - Clara M. Lungu.

CHANGE would like to thank the following beneficiaries from The Centre for Conflict Management and Women Development Affairs (CECOWDA) - Magret Alfred, David Elson Banda, Margret Bodza, Rodrina Bodza, Chisomo Chamasowa, Glory Chamasowa, Loice Chaweza, Jane Chikafa, Rose Chikoko, Jessie Chinyama, Siva Chinyama, Gertrude Chirwa, Maria Dash, Mai Faison, Memory Fonseca, Esnart Gwiriza, Niya James, Chifundo Jobvu, Esnart Kachingwe, Mercy Kamwendo, Rose Kangale, Mai Kapyepe, Anjella Khanyepe, Elizabeth Kwatani, Mary Makiyi, Fanny Manda, Grace Mandelumbe, Major Manyenje, Liness Manyong’onya, Bertha Mkanda,
Ellen Mthepeiya, Madalitso Mzunga, Anasitantia Namakhwa, Atameje Njilima, Meria Nkhoma, and Elizabeth Starford. CHANGE would also like to thank the 15 PSI Malawi’s DREAMS beneficiaries and three anonymous beneficiaries from the Nyasa Rainbow Alliance who bravely shared their personal experiences.

CHANGE extends a special thanks to Her Excellency Dr. Joyce Banda, Former President of the Republic of Malawi, for taking the time to share her experiences and expertise as a lifelong advocate for the rights of women and girls across the African continent. CHANGE would also like to express gratitude to the traditional authorities and religious leaders who provided critical information for this report during interviews, including: Pastor Evock Banda, Alton Chikaoneka, Nancy Kafamuaka (GVH Mngwangwa), GVH Kamangita, Steve Kamphinda, GVH Kudooka, BSV Lutere, Loti Nyomi, Enock Mbeke, GVH Mvugo, Rev. Nixon Nzunga, and Dorotay Phiri.

CHANGE was awarded a small grant for a photography project to accompany this report. The project provided the interviewed partners an opportunity to self-direct their own photo shoots and visually represent themselves as they desired. CHANGE thanks photographers George Ntoya and Zikomo Mbwana for capturing images of the fact-finding trip in Malawi, and for supporting the project through navigation and in-country coordination with drivers and partner organizations.

CHANGE would like to thank the peer reviewers for their insightful guidance and edits to this report.

This report would not be possible without the collective efforts of CHANGE staff, interns, and volunteers: Samantha Luffy, Policy Research Associate, and Zoë Bulls, Advocacy and Partnerships Associate, conducted the fact-finding and authored the report; Ebonie Megibow, Policy Research Intern, Deekshita Ramanarayanan, Policy Research Intern, Natalie Rowthorn, Public Policy Intern, and Victoria Watson, Policy Research Fellow, conducted background research for the report and provided editing support; Bergen Cooper, Director of Policy Research, designed, led, and directed the fact-finding and report; Beirne Roose-Snyder, Director of Public Policy, provided policy guidance; and Serra Sippel, President, provided writing guidance. The views expressed and conclusions drawn in this report are those of CHANGE.
Annexes

Annex 1: Malawi History & Context

The Republic of Malawi gained independence from more than eighty years of formal British colonial rule on July 6, 1964. Prior to independence, the British colonized modern-day Malawi during a period of aggressive European colonial expansion into mainland Africa at the end of the 19th century. During this period, Malawi was called the ‘British Central Africa Protectorate’ and ‘Nyasaland’.

Malawi’s current governmental structure

Malawi’s current constitution was put in place in 1994 and established a system of government that mirrors Britain and the United States with three equal branches: Executive, Legislative, and Judicial. Within the Executive Branch, the President and Vice President are elected to five-year terms. Each President appoints ministers to coordinate and supervise the 18 ministries within the government of Malawi. While sexual and reproductive health and rights (SRHR) and international development are cross-cutting issues coordinated by numerous ministries, the two primary ministries discussed throughout the fact-finding relevant to SRHR are the Ministry of Health & Population and Ministry of Gender, Children, Disability and Social Welfare.

In 1997, the Directorate for Reproductive Health, also known as the Department for Reproductive Health, was established in response to the International Conference on Population and Development (ICPD) in Cairo, Egypt in 1994.

The National Assembly, also known as Parliament, is a unicameral legislative body with 193 seats. Members of Parliament are directly elected by their constituencies and serve five-year terms.

From 1964–1994, Hastings Kamuzu Banda led a one-party dictatorship before Malawi’s first democratic elections in 1994. During this time, Banda was known for jailing or executing his political opponents and controlling all aspects of government. In response to domestic protests and the withdrawal of funding from donor governments in 1993, Banda legalized other political parties and was voted out of office in 1994.

In 2004, Bingu wa Mutharika was elected president as part of the United Democratic Front party. In 2005, he resigned from this political party over “hostility to his anti-corruption campaign” and formed the Democratic Progressive Party. From 2009 – 2012, President Mutharika faced controversy after proposing a bill to set the retirement age above the average life expectancy of Malawian citizens and supporting the jailing of a same-sex couple for breaching Malawi’s strict anti-homosexuality laws. In 2011, Mutharika called on members of his party at a rally to beat up those who insulted him, and expelled a British high commissioner over a leaked diplomatic cable describing the president as “increasingly autocratic.”
Malawi’s economy suffered during Mutharika’s presidency due to strained foreign relations. Within the last year of Mutharika’s presidency, Britain, Germany, Norway, the European Union, the World Bank, and the African Development Bank suspended all financial aid to Malawi. They expressed concern about Mutharika’s attacks on democracy domestically and his increasingly erratic policies.

Mutharika died in 2012 and was succeeded by Vice President Dr. Joyce Banda, Malawi’s first female president, who served in office from April 7, 2012 to May 31, 2014. Her Excellency Dr. Joyce Banda has no relation to Hastings Kamuzu Banda. Prior to assuming office, Dr. Banda had served in numerous public offices as a Member of Parliament, the Minister of Gender and Child Welfare from 2004–2006 and Foreign Minister from 2006–2009. She was—and continues to be—a champion for women and children’s rights throughout her career. Of note, Dr. Banda led the enactment of The Prevention of Domestic Violence Bill in 2006 during her time as the Minister of Gender and Child Welfare. This legislation serves as the foundation of Malawi’s efforts to prevent and eliminate all forms of violence against women and girls.

**Malawi’s engagement on global progress toward SRHR**

Malawi sent its first Ambassador to the United Nations (UN) upon independence in 1964. Since that time, Malawi has ratified or provided accession to the following UN Human Rights treaties:

- **CAT:** Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment.
- **CCPR:** International Covenant on Civil and Political Rights.
- **CED:** Convention for the Protection of All Persons from Enforced Disappearance.
- **CEDAW:** Convention on the Elimination of All Forms of Discrimination against Women.
- **CERD:** International Convention on the Elimination of All Forms of Racial Discrimination.
- **CESCR:** International Covenant on Economic, Social and Cultural Rights.
- **CRC:** Convention on the Rights of the Child.
- **CRPD:** Convention on the Rights of Persons with Disabilities.
### Annex 2: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AGYW</td>
<td>Adolescent girls and young women</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>APLO</td>
<td>Anti-Prostitution Loyalty Oath</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>AU</td>
<td>African Union</td>
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<tr>
<td>BLM</td>
<td>Banja La Mtsogolo</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CECOWDA</td>
<td>Centre for Conflict Management and Women Development Affairs</td>
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<tr>
<td>CEDEP</td>
<td>Centre for the Development of People</td>
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<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
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<tr>
<td>CHREAA</td>
<td>Centre for Human Rights, Education, Advice and Assistance</td>
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<tr>
<td>COP</td>
<td>Country Operational Plan</td>
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<td>COPUA</td>
<td>Coalition of Prevention of Unsafe Abortion in Malawi</td>
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<tr>
<td>CSJ</td>
<td>Centre for Solutions Journalism</td>
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<td>CSO</td>
<td>Civil society organization</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<td>DICs</td>
<td>Drop-in Centers</td>
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<td>DIN</td>
<td>Development Initiative Network</td>
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<td>DIWA</td>
<td>Disabled Women in Africa</td>
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<tr>
<td>DMPA</td>
<td>Depot medroxyprogesterone acetate</td>
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<td>DoD</td>
<td>Department of Defense</td>
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<tr>
<td>DREAMS</td>
<td>Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe</td>
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<tr>
<td>DREAMS-IC</td>
<td>DREAMS Innovation Challenge</td>
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<tr>
<td>EGPAF</td>
<td>Elizabeth Glaser Pediatric AIDS Foundation</td>
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<td>FAA</td>
<td>Foreign Assistance Act</td>
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<td>FFP</td>
<td>Food for Peace</td>
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<td>FOCES</td>
<td>Foundation for Civic Education &amp; Social Empowerment</td>
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<tr>
<td>FPAM</td>
<td>Family Planning Association of Malawi</td>
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<tr>
<td>FSW(s)</td>
<td>Female sex worker(s)</td>
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<td>FSWA</td>
<td>Female Sex Workers Association</td>
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<tr>
<td>FY</td>
<td>Fiscal year</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GENET</td>
<td>Girls Empowerment Network</td>
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<td>GGR</td>
<td>Global Gag Rule</td>
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<td>GNI</td>
<td>Gross National Income</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>INGO</td>
<td>International non-governmental organization</td>
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<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<tr>
<td>IUD</td>
<td>Intrauterine device</td>
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JH-CCP | Johns Hopkins Center for Communication Programs
K4Health | Knowledge for Health
KPs | Key populations
KPIF | Key Populations Investment Fund
LGBT(QI+) | Lesbian, gay, bisexual, transgender (queer, intersex)
LINKAGES | Linkages across the continuum of HIV services for key populations affected by HIV
LOE | Level of Effort
MDG | Milenium Development Goals
MOU | Memorandum of Understanding
MSH | Management Sciences for Health
MSI | Marie Stopes International
MSM | Men who have sex with men
NGO | Non-governmental organization
ONSE | Organized Network of Services for Everyone’s Health Activity
OSARC | Office of Southern Africa Regional Cooperation
PAC | Post-abortion care
PCI | Project Concern International
PEPFAR | President’s Emergency Plan for AIDS Relief
PLGHA | Protecting Life in Global Health Assistance
PLHIV | People living with HIV
PMI | President’s Malaria Initiative
PrEP | Pre-Exposure Prophylaxis
PSI | Population Services International
SAM | System for Award Management
SIFPO2 | Support for International Family Planning Organizations 2
SRHR | Sexual and reproductive health and rights
STI(s) | Sexually transmitted infection(s)
TB | Tuberculosis
TLD | tenofovir/lamivudine/dolutegravir
UN | United Nations
UNFPA | United Nations Population Fund
UNICEF | United Nations Children’s Fund
USAID | United States Agency for International Development
VMMC | Voluntary medical male circumcision
WHO | World Health Organization
YONECO | Youth Net and Counseling
Endnotes


8. Id.

9. CONSTITUTION OF THE REPUBLIC OF MALAWI (as amended up to Act No. 38 of 1998), art. 4 [hereinafter MALAWI CONST.].

10. Id., arts. 83(1)-(2).


12. The Ministry of Health & Population directs the government's policies on health matters and is responsible for the overall functioning of the health system in Malawi. The Ministry of Health also operates directives that work in unique health areas, such as HIV and AIDS, preventative health, reproductive health, safe motherhood, and nutrition. For more information, see Directories, MINISTRY OF HEALTH & POPULATION, REPUBLIC OF MALAWI, http://www.health.gov.m mw/index.php/directories (last visited Oct. 27, 2019) [hereinafter Directories, MINISTRY OF HEALTH & POPULATION].


15. Interview with Her Excellency Dr. Joyce Banda, in Lilongwe, Malawi (July 2019) [hereinafter Interview with Her Excellency Dr. Joyce Banda].

16. Id.

17. For additional details about Her Excellency Dr. Joyce Banda’s political career in Malawi, see Annex 1.


23. One hundred and ninety-one governments gathered in New York City at the UN Millennium Summit in 2000 to set eight development goals to accomplish within 15 years. Such goals were termed the Millennium Development Goals (MDGs) and included commitments to promoting gender equality and the empowerment of women, improving maternal health, combating HIV and AIDS, malaria, and other diseases, and prioritizing environmental sustainability. For more information, see Millennium Development Goals (MDGs), WORLD HEALTH ORGANIZATION (WHO), https://www.who.int/topics/millennium_development_goals/about/en/ (last visited Oct. 27, 2019).


31 Id.


35 Malawi, History, USAID, supra note 33.

36 JULIE SOLO, ROY JACOBBSTEIN & DELIWE MALEMA, MALAWI CASE STUDY: CHOICE, NOT CHANCE: A REPOSITIONING FAMILY PLANNING CASE STUDY 8 (2005).

37 U.S.-Malawi Relations, U.S. Embassy in Malawi, supra note 34.

38 Id.

39 Id.

40 The Executive Branch of the United States Government consists of the Executive Office of the President, Executive Agencies (e.g., Department of Defense, Department of State, etc.), Independent Agencies (e.g., USAID, Peace Corps, etc.), and Boards, Commissions, and Committees. The Executive Branch is responsible for submitting a budget request to U.S. Congress each fiscal year for review and approval. The U.S. government’s fiscal year runs from October to September, so FY2020 would run from October 2019 to September 2020. Congress has the authority to approve and disburse funds to implementing agencies, including those listed here: Offical US Executive Branch Web Sites, THE LIBRARY OF CONGRESS, http://www.loc.gov/rr/news/fedgov.html (last visited Oct. 27, 2019).


42 Significantly smaller amounts were requested for the other funding categories, such as economic development, education and social services; environment; and democracy, human rights, and governance. For more information, see id.


44 UNFPA, PROGRAMME OF ACTION OF THE ICPD, supra note 22.


50 Id. at 2.


52 See KFF, BREAKING DOWN THE U.S. GLOBAL HEALTH BUDGET BY PROGRAM AREA, supra note 46.


55 Id.


A Powerful Force: U.S. Global Health Assistance and Sexual and Reproductive Health and Rights in Malawi


60 “Comprehensible” information is defined by USAID as explanations on “the health benefits and risks, including conditions that might make the method chosen inadvisable and known adverse side effects, for the specific FP method being provided to an acceptor.” The health benefits and risks of alternative methods are not required by the Tiahrt Amendment. USAID, Guidance for Implementing the “Tiahrt” Requirements for Voluntary Family Planning Projects (Apr. 1999), at 6-7 (1999), available at https://www.usaid.gov/sites/default/files/documents/1864/tiahrtq.pdf.


62 USAID’s family planning programs are guided by the principles of voluntarism and informed choice. Under these principles: people have the opportunity to choose voluntarily whether to use family planning or a specific family planning method; individuals have access to information on a wide variety of family planning choices, including the benefits and health risks of particular methods; clients are offered, either directly or through referral, a broad range of methods and services; and the voluntary and informed consent of any clients choosing sterilization is verified by a written consent document signed by the client. Additional details can be found at: Voluntarism and Informed Choice, Family Planning, USAID, https://www.usaid.gov/global-health/health-areas/family-planning/voluntarism-and-informed-choice (last visited Nov. 30, 2019).


64 Id. at 733.


70 USAID, STANDARD PROVISIONS (2017), supra note 69, at 75-80.


72 Id.


82 The Penal Code (1930), arts. 149-151, 231, 243 (Malawi).

83 Id., arts. 149-150.
84 Chelsea B. Polis et al., Incidence of induced abortion in Malawi, 2015, 12(4) PLoS ONE 1, 9 (2017), available at https://doi.org/10.1371/journal.pone.0173639.
85 Brooke A. Levandowski et al., Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma, 118 INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTetrics 5167, 5169-5170 (2012).
86 Interview with Twambilile (Twambie) Kayuni, Gender Program Officer, Blessings Phiri, Project Coordinator, and Taonga Kachilonda-Phiri, Project Officer, Girls Empowerment Network (GENET), in Lilongwe, Malawi (July 2019) [hereinafter Interview with GENET].
87 Interview with Shy Ali, Program Director, Umodzi Youth Organization, in Blantyre, Malawi (July 2019) [hereinafter Interview with Shy Ali].
88 Interview with Luke Tembo, Programs Manager/Consultant, and Chance Mwalubunju, Senior Policy Consultant, Ipas Malawi, in Lilongwe, Malawi (July 2019) [hereinafter Interview with Ipas Malawi].
89 Interview with Brown Mkandawire, Programs Coordinator, Malawi Rural Education Support and Rehabilitation Program, in Blantyre, Malawi (July 2019) [hereinafter Interview with Brown Mkandawire].
90 Interview with Brian Ligomeka, Director, Peter Montfort, Media Producer, Gloria Chimpikizo, Accounts Officer, and James Kaulu, Community Liaison Officer, Centre for Solutions Journalism (CSJ), in Blantyre, Malawi (July 2019) [hereinafter Interview with CSJ].
93 Interview with Tamara Mwenifumbo, SIFPO and DREAMS Manager, PSI Malawi, in Blantyre, Malawi (July 2019) [hereinafter Interview with Tamara Mwenifumbo].
96 Id.
99 Interview with Emma Kaliya, Director, Malawi Human Rights Resource Centre and Chairperson, Coalition of Prevention of Unsafe Abortion (COPUA), Malawi Human Rights Resource Center (MHRRC), in Lilongwe, Malawi (July 2019) [hereinafter Interview with Emma Kaliya].
100 Chasukwa & Banik, Bypassing Government, supra note 20, at 107.
101 Interview with CSJ, supra note 90.
102 Interview with anonymous U.S. global health sub-prime staff, in Lilongwe, Malawi (July 2019).
104 Daire, Kloster & Storeng, Political Priority for Abortion Law Reform in Malawi, supra note 95, at 226.
105 The Coalition for the Prevention of Unsafe Abortion (COPUA) receives funding from AmplifyChange to advocate and advance abortion law reform in Malawi. COPUA consists of more than 45 civil society organizations representing diverse stakeholders, including: women, youth, health care providers, lawyers, media, community partners, traditional authorities, and religious leaders. CHANGE interviewed a number of COPUA members, including CSJ, Malawi Human Rights Resource Center (MHRRC), Family Planning Association of Malawi (FPAM), Kachere Progressive Women’s Group, the Centre for Conflict Management and Women Development Affairs (CECOWDA), and Ipas Malawi. For more information, see The Coalition for the Prevention of Unsafe Abortion, AMPLIFYCHANGE, https://amplifychange.org/news/-the-coalition-for-the-prevention-of-unsafe-abortion-copua-malawi_24/ (last visited Oct. 28, 2019).
106 Interview with Ipas Malawi, supra note 88.
107 Daire, Kloster & Storeng, Political Priority for Abortion Law Reform in Malawi, supra note 95, at 226-233.
108 Interview with Ipas Malawi, supra note 88.
109 Daire, Kloster & Storeng, Political Priority for Abortion Law Reform in Malawi, supra note 95, at 229-231.
110 Interview with CSJ, supra note 90.
111 Daire, Kloster & Storeng, Political Priority for Abortion Law Reform in Malawi, supra note 95, at 228.
112 Id. at 231-232.
113 Interview with CSJ, supra note 90.
114 Id.
115 Interview with Ipas Malawi, supra note 88.
116 Interview with CSJ, supra note 90.


119 Interview with CSJ, supra note 90.

120 Id.

121 Interview with Shy Ali, supra note 87.

122 Focus group discussion with traditional authorities and religious leaders, in Lilongwe, Malawi (July 2019) [hereinafter Focus group discussion with traditional authorities and religious leaders].


124 Interview with Hastings Saka, Secretariat, Sexual and Reproductive Health and Rights (SRHR) Alliance, in Lilongwe, Malawi (July 2019).


126 Email from Richard Yohane, Executive Director, RISE Malawi (Nov. 2019).

127 Focus group discussion with traditional authorities and religious leaders, supra note 122.

128 Eggen, Chiefs and Everyday Governance, supra note 125, at 313.

129 Interview with Her Excellency Dr. Joyce Banda, supra note 15.


134 Interview with David Kamkwamba, Civil Society Advocacy Forum Chair, and Eric Mcheka, Civil Society Advocacy Forum Member, in Lilongwe, Malawi (July 2019) [hereinafter Interview with Civil Society Advocacy Forum].


136 Carlos Varela et al., TRANSPORTATION BARRIERS TO ACCESS HEALTH CARE FOR SURGICAL CONDITIONS IN MALAWI a cross sectional nationwide household survey, 19 BMC PUBLIC HEALTH 1, 2 (2019), available at https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6577-8 [hereinafter Varela et al., TRANSPORTATION BARRIERS TO ACCESS HEALTH CARE FOR SURGICAL CONDITIONS IN MALAWI].


140 Interview with CSJ, supra note 90.


142 MSI, Re-enactment of the Mexico City Policy, supra note 138.

143 Interview with CSJ, supra note 90.

144 Interview with Tazirwa Chipeta, Director of Programs, Family Planning Association of Malawi (FPAM), in Lilongwe, Malawi (July 2019) [hereinafter Interview with Tazirwa Chipeta].

145 FPAM, GLOBAL GAG RULE HURTS MALAWIANS, supra note 97, at 2.

146 Id. at 4.

147 Interview with Emma Kaliya, supra note 99.

148 Interview with CSJ, supra note 90.

149 See, e.g., CHANGE, PRESCRIBING CHAOS IN GLOBAL HEALTH, supra note 71.

150 See, e.g., AMFAR, THE EFFECT OF THE EXPANDED MEXICO CITY POLICY ON HIV/AIDS PROGRAMMING, supra note 73.
2030, but there are very few countries that are poised to achieve these targets. All of PEPFAR’s programming is dictated by a country’s progress toward these goals. For example, Namibia’s progress is as follows: 91-95-95 and Eswatini’s progress is 92-95-94 for all ages as of the 2019 UNAIDS data report. In Malawi, progress was 90-87-89. For more information, see UNAIDS, UNAIDS Data 2019 26 (2019), available at https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf [hereinafter UNAIDS Data 2019]. See also 90-90-90: Treatment for all, UNAIDS, https://www.unaids.org/en/resources/909090 (last visited Oct. 29, 2019); UNAIDS, FAST TRACK: ENDING THE AIDS EPIDEMIC BY 2030 (2014), available at https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf [hereinafter UNAIDS Data 2019].


TLD is considered the preferred first-line antiretroviral (ARV) regimen that will support countries as they strive to reach the 95-95-95 targets. This regimen contains dolutegravir, a drug that is superior to other ARV regimens because it is well tolerated and has low side effect profiles. As a result, people taking TLD (which contains DTG) are more likely to stay on treatment and achieve viral load suppression faster than those taking other regimens. For WHO guidelines, see WHO, Dolutegravir (DTG) and the fixed dose combination (FDC) of tenofovir/lamivudine/dolutegravir (TLD), Briefing note (Apr. 30, 2018), available at https://www.who.int/hiv/pub/arv/DTG-TLD-2018.pdf?ua=1.

Malawi’s COP19 is currently awaiting Congressional approval to program this amount of funds in FY2020 to advance the country’s PEPFAR program. Memorandum from S/GAC – Ambassador Deborah L. Birx, MD to Ambassador Palmer, Malawi (Jan. 16, 2019), at 1, available at https://www.state.gov/wp-content/uploads/2019/08/Malawi.pdf.

The Global Fund is a partnership designed to accelerate the end of AIDS, tuberculosis and malaria as epidemics. As an international organization, the Global Fund mobilizes and invests more than US$4 billion a year to support programs run by local experts in more than 100 countries. In partnership with governments, civil society, technical agencies, the private sector and people affected by the diseases, we are challenging barriers and embracing innovation.” For more information, see Global Fund Overview, THE GLOBAL FUND, https://www.theglobalfund.org/en/overview/ (last visited Nov. 30, 2019).

The HIV and AIDS continuum of care, also known as the treatment cascade, outlines the steps of HIV medical care from initial diagnosis to viral suppression. PEPFAR often collects data regarding the proportion of people living with HIV who are engaged at each stage as a means of measuring progress toward the UNAIDS 90-90-90 goals, which are: 90 percent of people living with HIV know their status, 90 percent of people who know their status are on treatment, and 90 percent of people on treatment have suppressed viral loads by 2030. These global goals have been increased to 95-95-95 by 2030, but there are very few countries that are poised to achieve them. Rapid scale-up of HIV prevention and treatment approaches are the primary methods by which countries are expected to achieve these targets. All of PEPFAR’s programming is dictated by a country’s progress toward these goals. For example, Namibia’s progress is as follows: 91-95-95 and Eswatini’s progress is 92-95-94 for all ages as of the 2019 UNAIDS data report. In Malawi, progress was 90-87-89. For more information, see UNAIDS, UNAIDS Data 2019 26 (2019), available at https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf [hereinafter UNAIDS Data 2019]. See also 90-90-90: Treatment for all, UNAIDS, https://www.unaids.org/en/resources/909090 (last visited Oct. 29, 2019); UNAIDS, FAST TRACK: ENDING THE AIDS EPIDEMIC BY 2030 (2014), available at https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf [hereinafter UNAIDS Data 2019].
The 15 African countries implementing DREAMS are Botswana, Côte d’Ivoire, Eswatini, Haiti, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. 175


PEPFAR, DREAMING OF AN AIDS-FREE FUTURE, supra note 175, at 6-7.

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Skype interview with Kurt Henne, Country Director, Project Concern International (PCI)/Malawi, PCI (Aug. 2019) [hereinafter Interview with Kurt Henne].

Interview with Gomezgani Jenda, Senior Technical Advisor for Health and Nutrition, Save the Children, in Lilongwe, Malawi (Aug. 2019).

PEPFAR, DREAMING OF AN AIDS-FREE FUTURE, supra note 175, at 2.

One Community is a USAID-funded project led by JH-CCP with sub-primes Project HOPE and Plan International. Go Girl Clubs are a key element of One Community’s programming in Malawi. These clubs encourage AGYW to remain in school or re-enter school if they have left. They provide AGYW with the space to discuss HIV and STI prevention, experiences with gender-based violence (GBV), and ways to address early marriage or unintended pregnancy. Members of Go Girl Clubs also engage in economic empowerment activities including savings and loan programs and sewing programs. For more information, see One Community, JH-CCP, https://ccp.jhu.edu/projects/one-community/ (last visited Oct. 29, 2019); #YOUNGANDPOWERFUL: YOUTH EMPOWERING YOUTH, PLAN INTERNATIONAL (May 22, 2018), https://www.planusa.org/youngandpowerful-youth-empowering-youth.

Interview with Tamara Mwenifumbo, supra note 93.

Id.

“DREAMS Ambassadors are selected from within the DREAMS program based on demonstrated leadership or leadership potential. They are responsible for generating heightened public awareness of DREAMS and issues affecting the lives of AGYW within their communities. They are regularly engaged by designated partners and chaperones with auxiliary support from the National DREAMS Project Team through workshops on leadership and facilitation (DREAMS Ambassadors are also present during speaking engagements, public events, and media campaigns). They are leveraging existing structures, such as homework clubs, and local media outlets to share information and resources, serve as positive role models and provide mentorship to others.” For more details about DREAMS Ambassadors in South Africa, see DREAMS, DREAMS AMBASSADORS 1 (2016), available at https://za.usembassy.gov/wp-content/uploads/sites/19/2016/12/DREAMS-AMBASSADORS-26Oct2016-3.pdf.

Interview with Tamara Mwenifumbo, supra note 93.

Id.

The DREAMS annual oral PrEP target 1,452 AGYW aged 15-24 in Malawi during the COP19 implementation year, FY2020 (October 2019 through September 2020). MALAWI COP 2019 STRATEGIC DIRECTION SUMMARY, supra note 170, at 56.

Interview with Tamara Mwenifumbo, supra note 93.

The family planning component of DREAMS programming is supported through Support for International Family Planning Organizations 2 (SIFPO2). PSI’s family planning strengthening program that is also funded by USAID’s Office of Population and Reproductive Health. Additional details can be found at: Support for International Family Planning Organizations 2 (SIFPO2), PSI, https://www.psi.org/projects/support-for-international-family-planning-organizations-2-sifpo2/ (last visited Oct. 29, 2019).

Focus group with DREAMS beneficiaries, in Machinga, Malawi (July 2019).

Interview with Tamara Mwenifumbo, supra note 93.

Interview with Tamara Mwenifumbo, supra note 93.
203 Interview with Tamara Mwenifumbo, supra note 93.
204 Id.
205 Interview with Shy Ali, supra note 87.
206 Interview with Anderson Biliati, Director, Joshua Malunga, Programmes Manager, Lucia Olesi, Field Officer, and Ritkah Chawala, Field Officer, Development Initiative Network (DIN) Malawi, in Chikwawa, Malawi (Aug. 2019) [hereinafter Interview with DIN Malawi].
207 Interview with GENET, supra note 86.
209 Interview with GENET, supra note 86.
211 PEPFAR & JSI, DREAMS Innovation Challenge, supra note 181, at 18-19.
212 Id. at 1.
213 Details from the VillageReach-Malawi website: “In remote and rural communities, distance often prevents people from seeking health care when they need it. In a country like Malawi with one of the highest rates of maternal, child, and infant mortality in the world, knowing where and when to seek care is critical to reducing maternal and child mortality rates. Chipatala cha pa Foni (CCPF) is a toll-free health hotline in Malawi that creates a link between the health center and remote communities. CCPF is staffed by trained health workers who provide information and referrals over the phone. Originally developed as a maternal and child health innovation, CCPF has evolved to become a general health hotline, covering all general health topics including nutrition and sexual and reproductive health in accordance with Ministry of Health guidelines. Through CCPF, women and caregivers can also sign up to receive voice reminders on maternal and child health topics specific to their month of pregnancy or their child’s age. CCPF for Adolescents extends the platform for HIV prevention with youth friendly health services and information for sexual and reproductive health.” For more information, see Chipatala cha pa Foni (CCPF), VillageReach, https://www.villagereach.org/impact/ccpf/ (last visited Nov. 30, 2019).
214 Interview with Alinafe Kasiya, Country Director, and Hope Ngwira, Senior Manager, Advocacy and Communications, VillageReach-Malawi, in Lilongwe, Malawi (July 2019) [hereinafter Interview with VillageReach-Malawi].
215 Id.
216 “In 2018, DREAMS will be integrated into each country’s core COP activities...There were concerns that by moving DREAMS into COP activities, some of the smaller projects funded through the Innovation Challenge would not continue.” CHANGE, The U.S. DREAMS PARTNERSHIP (2017), supra note 181, at 25.
217 Interview with VillageReach-Malawi, supra note 214.
218 Skype interview with Melchiade Ruberintwari, Malawi Country Director, FHI 360 Malawi (Oct. 2019) [hereinafter Interview with Melchiade Ruberintwari].
219 Id.
220 Written responses from PEPFAR/Malawi to CHANGE interview questions, supra note 201.
221 Malawi, PROJECT CONCERN INTERNATIONAL (PCI), https://www.pciglobal.org/malawi/ (last visited Oct. 29, 2019) [hereinafter Malawi, PCI].
222 Interview with Kurt Henne, supra note 182.
223 Id.
224 Id.
225 Id.
227 LINKAGES was originally awarded until 2020 but has been extended until 2021. According to FHI 360 Malawi staff, all LINKAGES activities in Malawi are being transitioned to another award entitled EpiC (Epidemic Control), with FHI 360 Malawi continuing as the prime partner. These details were collected during a Skype interview with Melchiade Ruberintwari, supra note 218.
228 LINKAGES, FHI 360, supra note 226.
230 Interview with Eric Sambisa, Director, and George Kachimanga, Administration Officer, Nyasa Rainbow Alliance, in Blantyre, Malawi (Aug. 2019) [hereinafter Interview with Nyasa Rainbow Alliance]; Interview with CSJ, supra note 90.
232 Interview with CSJ, supra note 90.
234 FPAM, GLOBAL GAG RULE HURTS MALAWIANS, supra note 97, at 2.
236 Interview with CSJ, supra note 90.
238 “Section 377 was, and is, a model law in more ways than one. It was a colonial attempt to set standards of behavior, both to reform the colonized and to protect the colonizers against moral lapses. It was also the first colonial ‘sodomy law’ integrated into a penal code-and it became a model anti-sodomy law for countries far beyond India, Malaysia, and Uganda. Its influence stretched across Asia, the Pacific islands, and Africa, almost everywhere the British imperial flag flew. … In Africa, countries that inherited versions were: Botswana, Gambia, Ghana, Kenya, Lesotho, Malawi, Mauritius, Nigeria, Seychelles, Sierra Leone, Somalia, Swaziland, Sudan, Tanzania, Uganda, Zambia, and Zimbabwe.” HUMAN RIGHTS WATCH, THIS ALIEN LEGACY: THE ORIGINS OF “SODOMY” LAWS IN BRITISH COLONIALISM 5-6 (2008), available at https://www.hrw.org/sites/default/files/reports/gbtl2008_web2cover.pdf.
240 Interview with Her Excellency Dr. Joyce Banda, supra note 15.
241 Id.
242 Id.
243 Interview with Nyasa Rainbow Alliance, supra note 229.
244 James Stannah et al., HIV testing and engagement with the HIV treatment cascade among men who have sex with men in Africa: a systematic review and meta-analysis, 6 THE LANCET HIV e769, e781 (2019).
245 LINKAGES, FHI 360, supra note 226.
246 A ‘hotspot’ is a location where key populations commonly congregate. These locations can be opportunities for peer education, service provision, or community outreach – particularly for key populations that are served by PEPFAR programming. For more details on hotspots, see generally Justin Lessler et al., What is a Hotspot Anyway?, 96 AM J TROP MED HYG. 1270, 1270-1273 (2017). For more information on the importance of hotspots in PEPFAR programming, see PEPFAR 2019 COP GUIDANCE, supra note 176, at 52, 163-164, 402, 404, 407, 447.
247 MALAWI COP 2019 STRATEGIC DIRECTION SUMMARY, supra note 170, at 75.
249 FPAM, GLOBAL GAG RULE HURTS MALAWIANS, supra note 97, at 2-3.
250 Id. at 2.
251 Id.
252 Id.
253 Id.
254 Interview with Tazirwa Chipeta, supra note 144.
255 FPAM, GLOBAL GAG RULE HURTS MALAWIANS, supra note 97, at 4.
256 Interview with Tazirwa Chipeta, supra note 144.
257 Id.
258 Interview with anonymous U.S. global health implementing partner staff (Oct. 2019).
259 Interview with Melchiade Ruberintwari, supra note 217.
261 Interview with Melchiade Ruberintwari, supra note 217.
262 Id.
263 Email from Maureen Luba Milambe, African Region Advocacy Advisor, AVAC (Nov. 2019).
264 Interview with Melchiade Ruberintwari, supra note 217.
265 Interview with Tazirwa Chipeta, supra note 144.
266 Id.
267 Id.
268 FPAM, GLOBAL GAG RULE HURTS MALAWIANS, supra note 97.
269 Id. at 2.
270 Interview with anonymous U.S. global health sub-prime staff, in Malawi (Aug. 2019).
271 Varela et al., TRANSPORTATION BARRIERS TO ACCESS HEALTH CARE FOR SURGICAL CONDITIONS IN MALAWI, supra note 136, at 2.
272 Martha T. Makwero, Delivery of primary health care in Malawi, 10 AFR J PRIM HEALTH CARE FAM MED. 1, 2 (2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6018651/.
273 Varela et al., TRANSPORTATION BARRIERS TO ACCESS HEALTH CARE FOR SURGICAL CONDITIONS IN MALAWI, supra note 136, at 2.
274 Id.
277 Malawi, PCI, supra note 221.
279 Interview with Andrew Mphongolo, Clinician, Kawale Health Center, in Lilongwe, Malawi (July 2019).
280 Id.
281 Id.
282 Varela et al., TRANSPORTATION BARRIERS TO ACCESS HEALTH CARE FOR SURGICAL CONDITIONS IN MALAWI, supra note 136, at 2.
283 Interview with Michael Phiri, Communications and Resource Mobilization Officer, and Edna Kankhwali, Health Services Officer, Christian Health Association of Malawi (CHAM), in Lilongwe, Malawi (July 2019) [hereinafter Interview with CHAM].
285 Interview with CHAM, supra note 283.
286 Id.
287 Within PEPFAR, key populations (KPs) include men who have sex with men, transgender individuals, sex workers, people who inject drugs (PWID), and people in prisons and other closed settings. For more details, see Key Populations, U.S. DEPARTMENT OF STATE, https://www.state.gov/key-populations/ (last visited Oct. 28, 2019).
288 Interview with CHAM, supra note 283.
289 Id.
290 Id.
291 Id.
292 Id.
293 Id.
294 Id.
297 PAGE, DEVELOPMENT, SEXUAL CULTURAL PRACTICES AND HIV/AIDS IN AFRICA, supra note 6, at 53.
299 For context, the National Survey of Family Growth 2001-2015 reports that the average age of sexual intercourse is 17.3 for females and 17.0 for males in the United States. Sexual activity between males and females, Key Statistics from the National Survey of Family Growth - S Listing, NATIONAL CENTER FOR HEALTH STATISTICS, CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), https://www.cdc.gov/nchs/nsfg/key_statistics/s.htm#sexualactivity (last visited Oct. 28, 2019). Approximately 6.5 percent of women in the United States reported forced sexual initiation and the mean age of forced sex was 15.6 years of age as of 2017. Laura Hawks et al., Association Between Forced Sexual Initiation and Health Outcomes Among US Women, JAMA INTERN MED. 1, 1 (2019), available at https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2751247.
300 Interview with Boniface Mbewe, Programs Coordinator, Chipembere Development Foundation, in Blantyre, Malawi (July 2019).
301 Interview with CHAM, supra note 283.
302 Interview with GENET, supra note 86.
303 Id.
304 Id.
305 Interview with Civil Society Advocacy Forum, supra note 134.
306 Interview with CHAM, supra note 283.
308 Current PEPFAR guidance indicates that PEPFAR funds should not support public clinics that administer user fees. Details can be found on page 35 of the COP 2019 Guidance: “Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention [required in COP17 and COP18].” Full COP19 Guidance can be found here: PEPFAR 2019 COP GUIDANCE, supra note 176.
309 Interview with CHAM, supra note 283.
310 Interview with Maxwell Kasonga, Director, Centre for Youth Development, in Blantyre, Malawi (July 2019) [hereinafter Interview with Maxwell Kasonga].
312 Aisling Walsh et al., The role of the traditional leader in implementing maternal, newborn and child health policy in Malawi, 33 HEALTH POLICY AND PLANNING 879, 883 (2018) [hereinafter Walsh et al., The role of the traditional leader in implementing maternal, newborn and child health policy in Malawi].
313 Id. at 881.
315 Id.
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316 Walsh et al., The role of the traditional leader in implementing maternal, newborn and child health policy in Malawi, supra note 311, at 884.

317 Focus group discussion with traditional authorities and religious leaders, supra note 122.

318 Walsh et al., The role of the traditional leader in implementing maternal, newborn and child health policy in Malawi, supra note 312, at 881.

319 Focus group discussion with traditional authorities and religious leaders, supra note 122.

320 Varela et al., Transportation Barriers to Access Health Care for Surgical Conditions in Malawi, supra note 136, at 2.


322 Reena Sethi et al., The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labor and delivery, 14 REPRODUCTIVE HEALTH 1, 4-8 (2017), available at https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0370-x.


325 Id. at 98, 107.


327 USAID’s family planning program in Malawi promotes “awareness of the importance of family planning and the impact of rapid population growth on development through advocacy and social behavior change and communication. Other efforts expand voluntary, quality family planning services within health facilities and through outreach and community-based distribution.” These programs were not discussed as stand-alone programs during the fact-finding — instead, the organizations CHANGE interviewed referenced family planning services provided by specific clinics, including public clinics, CHAM, BLM, and FPAM. Details available through: Malawi, Family Planning, USAID, https://www.usaid.gov/malawi/global-health-family-planning (last visited Oct. 29, 2019).


329 Interview with Zinenani (Lucy) Majawa, Founder/Executive Director, Chiletso Chikaunga, Peer Educator, and Florence Chimphoyo, Peer Educator, Female Sex Workers Association (FSWA), in Lilongwe, Malawi (July 2019) [hereinafter Interview with FSWA].

330 MALAWI COP 2019 STRATEGIC DIRECTION SUMMARY, supra note 170, at 70.

331 Id. at 69.

332 Id. at 70.

333 Id. at 69.

334 Id. at 81.


338 Interview with FSWA, supra note 329.

339 Interview with Nyasawa Rainbow Alliance, supra note 228.


341 CHANGE interviewed representatives from the Nyasawa Rainbow Alliance and FSWA. The other members of the Diversity Forum include LITE, Gender Links, CheRa, and Ivy Foundation. Additional details can be found in the Diversity Forum’s June 2019 letter to PEPFAR/Malawi here: Letter from Diversity Forum to Cynthia Mambo, PEPFAR Malawi Senior Program Advisor (June 18, 2019), available at https://www.avac.org/sites/default/files/u81/Final_Letter_to_PEPFAR.pdf.

342 Id.

343 Id.

344 Letter from PEPFAR Malawi to Diversity Forum Members (July 15, 2019) (on file with CHANGE).

345 Id.

346 Id.

347 The applicability of the APLO to US-based groups was found to be unconstitutional in AOSI v. USAID (2013), supra note 66.

For more detailed information on the impacts of the APLO on the health and rights needs of female sex workers, please see CHANGE’s report, All Women, All Rights, Sex Workers Included: U.S. Foreign Assistance and the Sexual and Reproductive Health and Rights of Female Sex Workers at: CHANGE, ALL WOMEN, ALL RIGHTS, SEX WORKERS INCLUDED, supra note 65.

Id.


USAID, PEPFAR, LINKAGES, UNC PROJECT, CEDEP & THE GLOBAL FUND, PLACE REPORT: MALAWI, supra note 228, at 19.


Interview with Victor Mhango, Executive Director, Lisa Tembo, Paralegal, Francis Mataya, Paralegal, Eddah Nyirenda, Sex Worker, and Thandiwé Kaunda, Sex Worker, Centre for Human Rights Education, Advice, and Assistance (CHREAA), in Blantyre, Malawi (July 2019).

Mphatso Kamndaya et al., The role of material deprivation and consensualism in the decisions to engage in transactional sex among young people in the urban slums of Blantyre, Malawi, 11 GLOBAL PUBLIC HEALTH 295, 295 (2016).


Interview with anonymous U.S. global health sub-prime staff, in Lilongwe, Malawi (July 2019).

Id.

Id.

Interview with Melchiade Ruberintwari, supra note 218.

Interview with anonymous U.S. global health sub-prime staff, in Malawi (Aug. 2019).

Id.

Id.

Interview with anonymous U.S. global health sub-prime staff, in Lilongwe, Malawi (July 2019).

Id.

Interview with anonymous SRHR organization staff, in Blantyre, Malawi (July 2019).

Interview with Sarah Ellison, former Technical Operations Manager, Pact, in Lilongwe, Malawi (July 2019) [hereinafter Interview with Sarah Ellison].

Interview with Melchiade Ruberintwari, supra note 218.

Interview with CHAM, supra note 283.

Interview with Melchiade Ruberintwari, supra note 218.

Interview with Sarah Ellison, supra note 360.

Interview with VillageReach-Malawi, supra note 214.

Interview with Sarah Ellison, supra note 360.

Interview with Melchiade Ruberintwari, supra note 218.


Interview with Melchiade Ruberintwari, supra note 218.

Interview with anonymous U.S. global health sub-prime staff, in Malawi (Aug. 2019).

Id.

A common project management term is Level of Effort (LOE), which represents the percentage of a staff person’s salary that is paid by a particular subaward. This percentage should reflect the amount of time that staff person should spend on related work for that subaward.

Interview with anonymous U.S. global health sub-prime staff, in Malawi (Aug. 2019).

Id.

Id.

Interview with Melchiade Ruberintwari, supra note 218.

Id.

Interview with anonymous U.S. global health sub-prime staff, in Lilongwe, Malawi (July 2019).

Id.

About CDC Funding, CDC, https://www.cdc.gov/funding/about-cdc-funding/index.html (last visited Oct. 29, 2019) [hereinafter About CDC Funding, CDC].

Id.


About CDC Funding, CDC, supra note 381.

See CHANGE, PRESCRIBING CHAOS IN GLOBAL HEALTH, supra note 71.

Interview with anonymous U.S. global health sub-prime staff, in Malawi (Aug. 2019).

Interview with Brown Mkandawire, supra note 89.

Id.

Interview with Nyasa Rainbow Alliance, supra note 229.

Id.

Id.
Focus group discussion with anonymous beneficiaries of Nyasa Rainbow Alliance programming, in Blantyre, Malawi (Aug. 2019).

Skype interview with Esther Harawa, Gender and Protection Coordinator, and Christie Banda, Executive Director, Foundation for Civic Education & Social Empowerment (FOCESE) (Aug. 2019) [hereinafter Interview with FOCESE].

Interview with Kurt Henne, supra note 182.

Interview with FOCESE, supra note 394.

Interview with CSJ, supra note 90.

Id.

Id.

“To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations – regardless of current ART coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term, local partner engagement and impact. This action is a priority for all OUs, Regional Programs, and Country Pairs. PEPFAR has set a 70 percent goal by agency by the end of FY20, and must meet 40 percent by the end of FY19 (see Figure 2.3.12); each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services.” PEPFAR 2019 COP GUIDANCE, supra note 176, at 79-80.

Interview with Richard Yohane, Executive Director, and Michael Mwandira, Programs Manager, RISE Malawi, in Lilongwe, Malawi (July 2019) [hereinafter Interview with RISE Malawi].


Interview with FOCESE, supra note 394.

Interview with DIN Malawi, supra note 206.

Id.

Environment funds are a category of U.S. foreign assistance that are intended to “support the sustainability of a productive and clean environment.” More information can be found here: Environment, FOREIGNASSISTANCE.GOV, https://www.foreignassistance.gov/categories/Environment (last visited Oct. 29, 2019).

Interview with Sarah Ellison, supra note 360.


Interview with Sarah Ellison, supra note 360.

The program cycle often includes the following stages: strategic planning, procurement, design, implementation, monitoring, and evaluation. The USAID Program Cycle, LEARNING LAB, https://usaidlearninglab.org/program-cycle-overview-page (last visited Oct. 29, 2019).

Interview with GENET, supra note 86.

Interview with RISE Malawi, supra note 400.

Interview with Shy Ali, supra note 87.

Interview with FSWA, supra note 329.

Id.

Id.

Id.

Interview with Kimanzi Muthengi, Chief of Education and Adolescents, UNICEF Malawi, in Lilongwe, Malawi (July 2019).

Interview with Her Excellency Dr. Joyce Banda, supra note 15.

Phone interview with Kate Ramsey, former Principal Technical Advisor, Management Sciences for Health (MSH) (July 2019).


The fall armyworm is an invasive crop pest that can feed on 80 different crop species that are prevalent across the African continent, including maize. The fall armyworm can cause severe devastation to maize crops and has caused significant damage in Malawi numerous times since 2016.


Interview with anonymous U.S. global health implementing partner staff, in Blantyre, Malawi (July 2019).


Interview with Kurt Henne, supra note 182.

Id.

Interview with DIN Malawi, supra note 206.
441 Interview with anonymous U.S. global health sub-prime staff, in Malawi (Aug. 2019).

442 Id.

443 IAWG INTER-AGENCY FIELD MANUAL ON REPRODUCTIVE HEALTH IN HUMANITARIAN SETTINGS, supra note 430, at 218.


445 Id.

446 Id.

447 Id.

448 Focus group discussion with beneficiaries of CECOWDA programming, in Blantyre, Malawi (Aug. 2019).

449 Interview with Ipas Malawi, supra note 88.

450 Interview with RISE Malawi, supra note 400.

451 Interview with CSJ, supra note 90.

452 Interview with Shy Ali, supra note 87.

453 Interview with GENET, supra note 86.

454 Interview with FOCESE, supra note 394.

455 Interview with Kurt Henne, supra note 182.

456 Interview with Sarah Ellison, supra note 360.

457 Interview with VillageReach-Malawi, supra note 214.

458 Interview with Tamara Mwenifumbo, supra note 93.

459 Interview with CHAM, supra note 283.

460 Interview with anonymous prime partner staff (July 2019).

461 Interview with Kurt Henne, supra note 182.

462 Interview with VillageReach-Malawi, supra note 214.

463 Id.

464 Interview with Tazirwa Chipeta, supra note 144.

465 Id.

466 Interview with Maxwell Kasonga, supra note 310.

467 Interview with GENET, supra note 86.

468 Interview with FOCESE, supra note 394.

469 Interview with Nyasa Rainbow Alliance, supra note 229.


472 CHANGE & PAI, AMERICAN ATTITUDES ON THE GLOBAL GAG RULE, supra note 470, at 1.

473 Interview with CSJ, supra note 90.


A Powerful Force: U.S. Global Health Assistance and Sexual and Reproductive Health and Rights in Malawi


478 Malawi Const., supra note 9, art. 4.
479 Id. arts. 83(1)-(2).
480 Id. art. 94(1); Ministries, MALAWI GOVERNMENT, supra note 11.
481 The Ministry of Health & Population (referred to in this report as the Ministry of Health) directs the government’s policies on health matters and is responsible for the overall functioning of the health system in Malawi. The Ministry of Health also operates directives that work in unique health areas, such as HIV and AIDS, preventative health, reproductive health, safe motherhood, and nutrition. see Directorates, MINISTRY OF HEALTH & POPULATION, supra note 12.

482 MINISTRY OF GENDER, CHILDREN, DISABILITY AND SOCIAL WELFARE, supra note 13.

486 Id.
488 Id.
489 Id.
490 PAGE, DEVELOPMENT, SEXUAL CULTURAL PRACTICES AND HIV/AIDS IN AFRICA, supra note 6, at 47-49.
492 Id.
About CHANGE

CHANGE is a U.S.-based nongovernmental organization that promotes sexual and reproductive health and rights as a means to achieve gender equality and empowerment of all women and girls, by shaping public discourse, elevating women’s voices, and influencing U.S. and global policies. We are guided by our vision of a world that respects, protects, and honors sexual and reproductive rights for all. Our four-pronged impact model—advocacy, research, partnerships, and communications—is grounded in and driven by a human rights framework at the intersection of multiple sectors including women’s rights, human rights, family planning, maternal health, HIV/AIDS, and gender-based violence.