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ISSUE BRIEF

The Expanded Mexico City Policy: Implications for the Global Fund

Overview

On January 23, 2017, President Trump signed a presidential memorandum reinstating the Mexico City Policy (MCP) and directing the Secretary of State to expand it to apply to all United States Global Health Assistance (U.S. GHA). The Expanded Mexico City Policy (EMCP or the Policy), which became effective in May 2017, restricts non-U.S.-based or foreign nongovernmental organizations (fNGOs) from receiving U.S. GHA if they perform, counsel on, or refer for abortion, or advocate for its liberalization outside of limited exceptions.[1] The EMCP restrictions apply only to fNGOs, meaning that U.S.-based organizations and multilateral institutions such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund or GF) are formally exempt from the Policy. However, because EMCP restrictions apply to the organization's activities as a whole while receiving U.S. GHA, private and multilateral investments can be impacted when implementing partner networks overlap. Indeed, it is common for the Global Fund and the U.S. government (USG) to fund the same NGO, which has implications for that prime recipient as well as its sub-recipients. This brief examines the effects of the EMCP on the Global Fund, specifically quantifying the proportion of Global Fund investments that are subject to the Policy globally.

Key Findings

- Approximately **12% ($1.08 billion) of Global Fund (GF) allocations** could be subject to the U.S. Expanded Mexico City Policy (EMCP).
- Countries with the greatest amounts of EMCP-restricted GF funding include: **Nigeria** ($198 million), **Tanzania** ($94 million), **South Africa** ($89 million), **Philippines** ($74 million), and **Ukraine** ($73 million).
- Five countries have greater than 60% of their GF funding restricted by EMCP: **Botswana** (61.7%), **Kosovo** (100%), **Nepal** (64.1%), **Philippines** (87.2%), and **Ukraine** (78.5%).
- GF investments in **key population disease prevention** are most likely to be restricted by the EMCP.
- The GF and other donors should assess their grant portfolios to be cognizant of when and how the **EMCP is impinging on their investments** and take steps to track and mitigate the effects in cases where quality sub-recipients would be excluded from participating.

Background on the EMCP: Timeline and Expansions

The exact language of the EMCP prohibits fNGOs from "providing or promoting abortion as a method of family planning"[1] even with non-U.S. government resources while receiving restricted funding. Under the Policy's definition, "abortion as a method of family planning"[1] includes abortions for any reason other than when the pregnancy arose from rape or incest or if carrying the pregnancy to term would endanger a woman's life. Abortions to protect the health of a pregnant woman or for fetal abnormalities are expressly included under the definition, and fNGOs are therefore prohibited from providing, counseling, or referring for abortions in these circumstances while receiving U.S. GHA.[1] Moreover, any fNGO subject to the Policy must include the same restrictions on any fNGO sub-recipient of funding.

Historically, the MCP was limited to United States Agency for International Development (USAID) Family Planning and Reproductive Health Funding. Under the EMCP, the restrictions attach to all U.S. GHA, approximately $8.8 billion in annual funding, including the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), Maternal and Child Health (MCH), and Tuberculosis (TB) funding, among others.

When the MCP was expanded to all GHA funding in May 2017, the State Department—then under Secretary Rex Tillerson—began a review of the effect the expansion would have on global health programming. The review, titled *Protecting Life in Global Health Assistance Six-Month Review*, was released on February 6, 2018, and included several clarifications to the Policy requested by organizations receiving U.S. GHA and other stakeholders.[2]

One clarification pertained to the interpretation of "Financial Support," specifically whether fNGOs that receive both U.S. GHA funding and funding from other sources would be required to enforce EMCP restrictions on their sub-recipients of **non-U.S. GHA funding**. In the review, the State Department clarified that the EMCP would only apply to sub-recipients of U.S. GHA, but would not attach to sub-recipients of non-U.S. GHA funding so long as fNGOs subject to the EMCP did not fund the provision or promotion of abortion as a method of family planning with their non-U.S. GHA funding.[2]

However, on March 26, 2019, Secretary of State Mike Pompeo announced the reversal of the Six-Month Review's interpretation of "Financial Support," stating that EMCP restrictions would, in fact, be enforced on all sub-recipients of fNGOs regardless of the source of funds. The announcement was further clarified on June 6, 2019, in a Frequently Asked Questions (FAQ) document issued by USAID.[3] Regarding sub-recipients of non-U.S. funding, the FAQ states:

> *[F]oreign NGOs that receive U.S. global health assistance should take steps to ensure that they are not providing financial support, **with any source of funds and for any purpose**, to another foreign NGO that performs, or actively promotes, abortion as a method of family planning.* [emphasis original]

Under this new interpretation of the Policy, the EMCP applies to fNGOs as sub-recipients even if they do not receive any form of U.S. funding. Moreover, under this interpretation of the Policy, even funding that is formally exempt from the EMCP, such as from foreign governments, multilateral and parastatal organizations, and private U.S.-based donors can have U.S. funding restrictions attached to their own independent funding.

Timeline of Expanding the Mexico City Policy

- January 23, 2017 – President Trump reinstates the MCP and announces intention to expand it to include all U.S. GHA.
- May 22, 2017 – New Standard Provisions released, renaming MCP to Protecting Life in Global Health Assistance (PLGHA) and expanding to all U.S. GHA. Commitment made to review impact of the Policy within six months.
- February 6, 2018 – State Department Six-Month Review released. States intention to clarify the definition of "Financial Support" in the policy to be limited to sub-recipients of U.S. GHA. Recipients of U.S. GHA, as before, cannot provide any funding from any source of funds for the purpose of performing or actively promoting abortion as a method of family planning.
- March 26, 2019 – Secretary Pompeo holds press conference reversing the interpretation of "Financial Support" adopted by the Six-Month Review.
- May 22, 2019 – New Standard Provisions released reflecting changes recommended in the Six-Month Review except those related to "Financial Support."
- June 6, 2019 – USAID releases new FAQ stating that fNGO recipients of U.S. GHA cannot provide any funding from any source of funds for any purpose to another fNGO that performs or promotes abortion as a method of family planning.

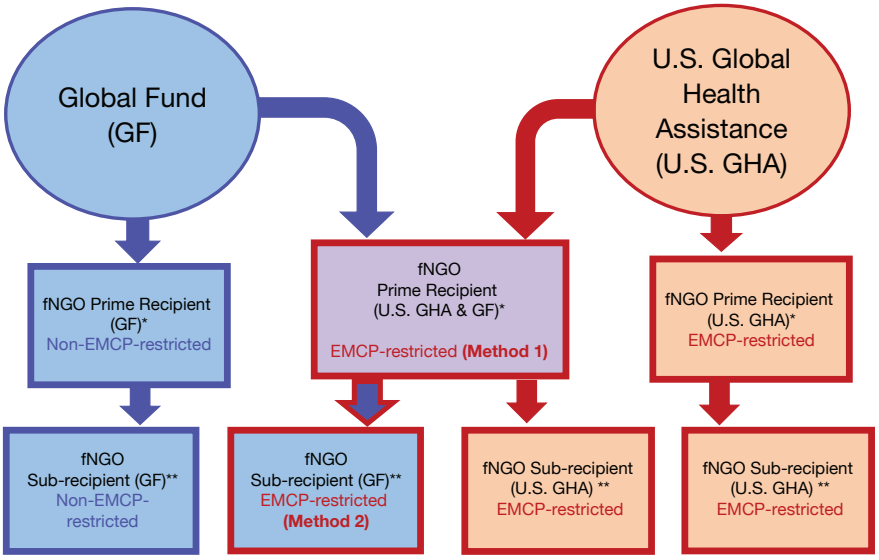
The Global Fund and the Expanded Mexico City Policy

Founded in 2002, The Global Fund is an independent, multilateral financing entity designed to raise resources to combat HIV/AIDS, TB, and malaria in low- and middle-income countries. The U.S. has played an integral role in the Global Fund since its inception and has contributed one-third of its total funding. The Global Fund recently completed its sixth replenishment, raising over $14 billion in contributions from 58 countries and 18 major private entities, as well as many smaller contributions. The U.S. government pledged $4.68 billion in support of this replenishment, which will support HIV, TB, and malaria programming through 2022.

"Under this new interpretation of the Policy, the EMCP applies to fNGOs as sub-recipients even if they ***do not*** receive any form of U.S. funding."

As a multilateral organization, the Global Fund is not directly implicated by the EMCP restrictions. This means that even though the U.S. contributes directly to the Global Fund, organizations receiving Global Fund grants are not required to sign the EMCP as a condition of receiving Global Fund funding. However, because the EMCP dictates what an organization can do as an entity while receiving U.S. GHA, if an organization receives both U.S. GHA and a Global Fund grant, the organization will be bound by the EMCP restrictions even on what it can do with Global Fund resources. Additionally, in light of the interpretation of the Policy announced by Secretary Pompeo, an organization would also become subject to the EMCP if it is a sub-recipient of Global Fund funding from an fNGO that receives EMCP-restricted U.S. GHA. This is true even if that sub-recipient does not itself accept any U.S. funding. These potential pathways are outlined in Figure 1.

Figure 1: How the EMCP can bind organizations receiving Global Fund funding by two methods: 1) As a prime recipient that receives U.S. and GF funds, and 2) As a sub-recipient that receives GF funding from an EMCP-restricted prime recipient.



*Prime Recipient refers to a Global Fund or U.S. GHA-funded implementing partner that receives funding directly from the funder.
**Sub-recipient refers to an implementing partner that receives a Global Fund or U.S. GHA grant from a prime recipient.

It is important to note that the Global Fund does not primarily choose the partners it funds. Rather, government-led Country Coordinating Mechanisms (CCMs) prepare funding proposals and nominate prime recipients and sub-recipients to be funded by the proposals. The CCM itself is not bound by the EMCP, but the expansion has important implications for CCMs to consider when nominating prime and sub-recipients in the 2020—2022 funding round.

Study Methods and Findings

Aims

The current research study aims to:

1. Estimate the proportion of Global Fund funding going to organizations that also receive U.S. GHA directly by country and sector (Method 1)
2. Estimate the proportion of Global Fund funding going to sub-recipient organizations whose prime recipient also receives U.S. GHA funding by country and sector (Method 2)

Methods

This analysis was conducted from June to September, 2019. Data on Global Fund recipients and allocations were drawn from Global Fund Concept Notes from the 2017—2019 allocation period. Global Fund recipient lists included all identifiable prime recipient/sub-recipient names from grants with proposed budgets in 2017 or 2018 (n=2,199 grant/partner pairs). Global Fund recipient lists were then matched manually for overlap with lists of recipients of U.S. GHA from www.USASpending.gov.

Global Fund recipients were counted as being subject to the EMCP if they were an fNGO (non-U.S.-based) that either 1) directly received U.S. GHA, or 2) received Global Fund funding from a prime recipient that directly received U.S. GHA. This analysis is likely to undercount the amount of Global Fund EMCP-restricted partners and funds for several reasons. First, this analysis does not capture Global Fund sub-recipients that may be EMCP-restricted because they are also a sub-recipient of other types of private funding (e.g., from the Bill & Melinda Gates Foundation) from an EMCP-restricted prime recipient. Second, only Global Fund recipients with identifiable names could be cross-referenced for overlap with U.S. GHA. Finally, Global Fund recipients and sub-recipients could only be cross-referenced against U.S. GHA prime recipients, but not against sub-recipients of U.S. GHA, substantially limiting the level of partner overlap that could be assessed.

As these findings are based on recipient lists and allocations from 2017 and 2018, this analysis is meant to estimate the proportion of Global Fund funding implicated by the EMCP if Global Fund and U.S. GHA recipients remain consistent, rather than provide projections of EMCP-implicated Global Fund funding in the current or next cycle of grant-making.

Results

Approximately 12% ($1.08 billion of $8.98 billion) of total GF allocations to known recipients in 2017 or 2018 would be subject to the EMCP by the two methods described. The majority (81%, $876 million of $1.08 billion) of EMCP-restricted GF funding is

bound by the EMCP because it is allocated to an organization that also receives some form of U.S. GHA (Method 1). The remaining 19% of EMCP-restricted GF funding ($208 million of $1.08 billion) is bound by the EMCP because it flows to an fNGO sub-recipient that does not receive U.S. GHA but whose prime partner receives U.S. GHA (Method 2). There is wide variation in the proportion of GF investments that are EMCP-restricted across countries, ranging from 0% in some areas where the U.S. is not investing heavily bilaterally, to 100% in some countries with fully overlapping partner networks between recipients of GF and U.S. Government funding.

"There is wide variation in the proportion of GF investments that are EMCP-restricted across countries."

Expansive Geographic Reach of the EMCP on Global Fund Investments

The majority of countries/regions receiving Global Fund funding (56%, or 69 of 124) have at least one recipient that is subject to the EMCP. Countries with the greatest amounts of GF funding subject to EMCP restrictions include: **Nigeria** ($198 million, or 27.4% of GF investments), **Tanzania** ($94 million, 20.6%), **South Africa** ($89 million, 38.9%), **Philippines** ($74 million, 87.1%), and **Ukraine** ($73 million, 78.5%) [Table 1].

When ranking countries by the proportion of GF funds, as opposed to the overall dollar amount, subject to the EMCP, a different set of countries/regions emerges as the most affected. These include countries where GF investments may be smaller but where most or all of those investments are subject to the EMCP. These include: **Kosovo** (100% of GF investments), **Multicounty Asia** program (100%), **Multicounty South Asia** program (98%), **Philippines** (87%), **Ukraine** (78%), and **Nepal** (64%). The full set of country data is available at www.amfar.org/EMCP.[4]

Global Fund funding for HIV/TB most restricted by the EMCP

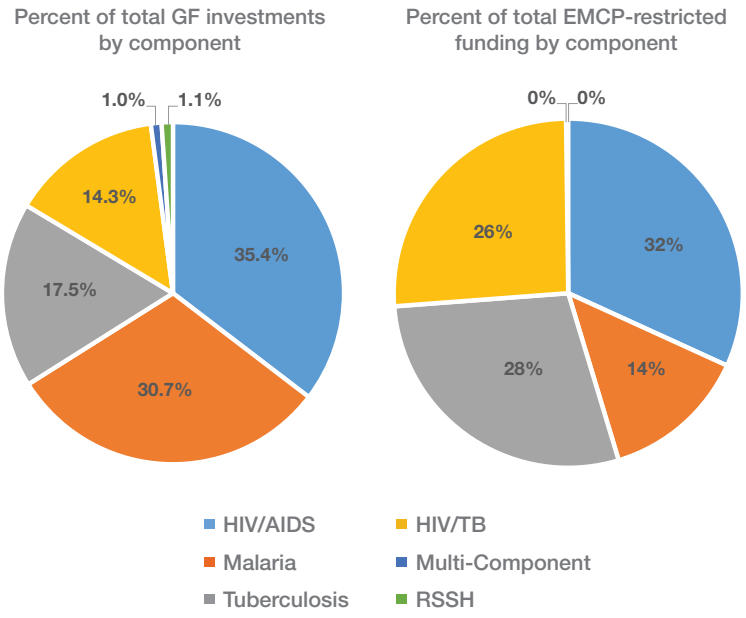
Global Fund funding is divided into different components based on the intended target of the funding: HIV/AIDS, Malaria, TB, HIV/TB (for combined HIV and TB programs), and Resilient and Sustainable Systems for Health (RSSH). Countries may also apply for multi-component grants incorporating multiple components.

Table 1: Fifteen countries with the highest amounts of EMCP-restricted GF funding by method, ranked highest to lowest based on total GF amount that is EMCP-restricted

Country	Total GF funding 2017 & 2018 in millions	Total GF EMCP-restricted funding in millions (%)	EMCP-restricted GF funding by Method 1* (%)^	EMCP-restricted GF funding by Method 2** (%)^
Nigeria	$ 724	$ 198 (27.4)	$ 165 (83.3)	$ 33 (16.7)
Tanzania	$ 455	$ 94 (20.6)	$ 87 (92.4)	$ 7 (7.6)
South Africa	$ 228	$ 89 (38.9)	$ 67 (75.5)	$ 22 (24.5)
Philippines	$ 85	$ 74 (87.1)	$ 70 (94.1)	$ 4 (5.9)
Ukraine	$ 93	$ 73 (78.5)	$ 60 (82.4)	$ 13 (17.6)
Myanmar	$ 242	$ 64 (26.4)	$ 25 (39.6)	$ 39 (60.4)
Zambia	$ 222	$ 58 (26.1)	$ 52 (90.4)	$ 6 (9.6)
Bangladesh	$ 98	$ 55 (56.3)	$ 49 (88.6)	$ 6 (11.4)
Niger	$ 108	$ 45 (41.7)	$ 40 (88.9)	$ 5 (11.1)
Malawi	$ 359	$ 41 (11.5)	$ 41 (100)	$ 0 (0.0)
Kenya	$ 257	$ 34 (13.4)	$ 17 (50.4)	$ 17 (49.6)
Nepal	$ 43	$ 28 (64.1)	$ 17 (61.5)	$ 11 (38.5)
India	$ 595	$ 24 (4.0)	$ 11 (44.5)	$ 13 (55.5)
Uganda	$ 243	$ 23 (9.7)	$ 20 (85.1)	$ 3 (14.9)
Mozambique	$ 224	$ 23 (10.3)	$ 21 (92.8)	$ 2 (7.2)

*Method 1: GF funding allocated to a partner that also receives U.S. GHA directly
**Method 2: GF funding allocated to a sub-recipient whose prime partner receives U.S. GHA
^ Percentages are calculated out of the total GF funding that is EMCP-restricted

Figure 2: Total GF investments by component compared to total EMCP-restricted funding by component



Overall, funding for HIV/TB was most likely to be restricted by the EMCP at 21.9% of total GF HIV/TB investments, followed by TB alone (19.6%), and HIV/AIDS alone (10.9%). Funding for TB and HIV/TB was disproportionately more likely to be subject to the EMCP, with TB consisting of about 17.5% of total GF investments, but 28% of total EMCP-restricted funding. The same was true of HIV/TB funding, which constitutes 26% of total EMCP-restricted funding despite being just 14% of the GF's total allocations [Figure 2].

Global Fund funding for priority and key population programming most restricted by EMCP

Global Fund modules indicate the specific area of Global Fund investment within each of the larger components, including areas such as programming for key and priority populations, strengthening the health system, policy and governance, and others. All modules include some funding that is subject to the EMCP, with the highest proportion of EMCP-restricted funds in program modules for comprehensive prevention programming for men who have sex with men (MSM), at 40.9%, prevention programs for adolescents and youth in and out of school, at 38.1%, and programs to reduce human rights-related

Table 2: EMCP-restricted funding by select Global Fund funding module and method

Module Group	Total GF Funding (millions)	Total amount EMCP-restricted in millions (%)	Amount EMCP-restricted by Method 1* (%)^	Amount EMCP-restricted by Method 2** (%)^
HIV treatment, care, and support	$ 2,017	$ 183 (9.1)	$ 149 (81.4)	$ 34 (18.6)
TB programming	$ 1,390	$ 249 (17.9)	$ 211 (84.8)	$ 38 (15.2)
Vector control	$ 1,255	$ 57 (4.6)	$ 57 (99.5)	$ 0.3 (.5)
Health systems strengthening	$ 1,141	$ 136 (11.9)	$ 113 (83.0)	$ 23 (17.0)
KP prevention	$ 527	$ 100 (19.0)	$ 57 (57.8)	$ 42 (42.2)
➢MSM prevention	$ 31	$ 13 (40.9)	$ 8 (59.4)	$ 5 (40.6)
➢PWID prevention	$ 101	$ 29 (29.1)	$ 16 (55.2)	$ 13 (44.8)
➢SW prevention	$ 223	$ 31 (13.9)	$ 20 (63.2)	$ 11 (36.8)
➢TG prevention	$ 3	$ 0.4 (13.1)	$ 0.3 (58.7)	$ 0.2 (41.3)
➢Adolescent prevention	$ 110	$ 42 (38.1)	$ 30 (71.3)	$ 12 (28.7)
General population prevention	$ 216	$ 21 (9.7)	$ 19 (91.2)	$ 2 (8.8)
PMTCT	$ 114	$ 8 (7.3)	$ 4 (50.6)	$ 4 (49.4)
HIV testing	$ 51	$ 2 (3.2)	$ 1 (81.3)	$ 0.3 (18.7)
Human rights	$ 40	$ 13 (33.1)	$ 9 (66.8)	$ 4 (33.2)

*Method 1: GF funding allocated to a partner that also receives U.S. GHA directly
**Method 2: GF funding allocated to a sub-recipient whose prime partner receives U.S. GHA
^ Percentages are calculated out of the total GF funding that is EMCP-restricted

barriers to HIV services, at 33.1% [Table 2]. These relatively high percentages indicate higher levels of fNGO implementing partner overlap between the USG and the Global Fund for the delivery of these programs. In general, programs for key and priority populations were more likely to be EMCP-restricted than other types of more general modules such as HIV testing services (3.2%) and vector control (4.6%), where fNGO networks were likely to be larger.

Discussion

There is extensive overlap between Global Fund and U.S. GHA recipients, resulting in substantial amounts of multilateral funding being subject to the EMCP. This overlap becomes especially pronounced due to the expanded interpretation of the EMCP, which can bind Global Fund sub-recipients to the restrictions of the Policy even if they do not accept any U.S. funding.

This analysis shows important geographic variation in the countries and regions where Global Fund funding is most likely to be affected by the EMCP. This geographic prioritization is influenced by several major factors. First, in some countries, Global Fund investments may be highly restricted by the EMCP because the NGO networks capable of delivering specialized services are limited. In these settings, international funders, including the Global Fund and USG, often work with the same implementing partners to deliver quality programs. In countries such as the Philippines and Ukraine, the vast majority of GF investments (87% and 78%, respectively) are subject to the EMCP due to the nearly perfect overlap of fNGO partners. This means that there are few qualified NGOs for the GF or other non-USG private donors to partner with that are not funded by U.S. GHA.

Second, in some countries, the mere size of the GF's investments means that large amounts of GF money are bound by the EMCP. In countries such as Nigeria, Tanzania, and South Africa, 20—40% of GF investments are restricted by the EMCP. Due to the size of their programs, this equates to more than $381 million of GF-restricted money in these countries alone. In South Africa, for example, where about 70% of USG bilateral investments for HIV are granted to fNGOs, partner overlap with the GF is far reaching.

Third, there are several countries for which the expanded interpretation of the EMCP (Method 2) captures substantially larger amounts of GF investments. In countries such as Myanmar, India, and Kenya, the additional restrictions of the newly expanded interpretation more than double the amount of EMCP-restricted GF funding ($53 million to $122 million). This implicates millions of additional GF dollars and hundreds of GF partners that may not receive any U.S. GHA funding directly.

The specifics of the Global Fund programs implicated by the expansion are also critically important. While no GF programming module remains untouched by the EMCP, several areas have emerged as the most heavily implicated, including key and priority population HIV prevention and investments to reduce the human rights barriers to obtaining HIV services. Overall, 19% of GF funding for key population prevention programming is estimated to be subject to the EMCP, compared to around 10% for general population prevention. This difference is especially stark when comparing the proportion of EMCP-restricted GF funding for comprehensive prevention programming for MSM (41%) and adolescents both in and out of school (38%). These data support the previously observed pattern that when an NGO network is less expansive (either in terms of available partners in a country or in a programmatic sector) there is higher saturation of U.S. funding in those networks and proportionately more EMCP-restricted funding. In the case of key populations, organizations that are equipped to provide services for the world's most-at-risk populations, such as MSM, people who inject drugs, sex workers, and transgender populations, are relatively rare. Fewer available partners that can deliver key population-competent HIV services means higher levels of GF and USG implementing partner overlap in these program areas and subsequently wider reach of the EMCP.

> "The current version of the Policy is more expansive than any previous version, and mounting data indicate that the EMCP excludes effective implementing partners and negatively affects health outcomes."

While other Global Fund modules, such as general HIV treatment, care, and support, TB programming, and vector control have relatively lower proportions of funding bound by the EMCP (9%, 18%, and 5%, respectively), these are also the largest GF modules. These programs mostly direct funding to support government programming through ministries of health, which are explicitly exempt from the EMCP restrictions. Nevertheless, the size of these programs still results in more than $489 million of GF resources becoming restricted by the EMCP. Of note, 7.3% of GF investments for the prevention of mother-to-child transmission (PMTCT) of HIV are bound by the EMCP. While this is lower than other modules, under the reinterpretation of the EMCP (Method 2) the amount of EMCP-restricted funds doubles from $4 million to $8 million, making GF investments in PMTCT among the most impacted by the recent reinterpretation of the Policy.

Implications and Recommendations

The full implications of the EMCP in terms of reach, health impact, and effect on multilateral investments remain to be seen. However, the current version of the Policy is more expansive than any previous version, and mounting data indicate that the EMCP excludes effective implementing partners and negatively affects

health outcomes.[5] Indeed, the Policy is linked to decreased national contraception coverage in areas affected by the Policy (which increases abortion rates)[6] and disruptions in HIV programming—including basic HIV prevention services such as condom distribution, HIV testing, and voluntary medical male circumcision programming to prevent HIV.[7]

While this analysis does not assess the health impact of the EMCP, it adds to the body of literature showing the broad scope of the EMCP and helps to quantify the number of organizations globally that are restricted by the Policy—some while not receiving any U.S. GHA. Among the goals of multilateralism is that countries do not dictate individual restrictions on multilateral institutions. The results of this analysis clearly show that not only are Global Fund investments affected by the EMCP globally, but in some settings the majority of the Global Fund's funding and available NGO partner networks are likely to become bound by the EMCP, if they aren't already. This may have implications for the success of these public health investments and runs counter to the goals of multilateralism.

Importantly, while this analysis focuses on the reach of the EMCP into GF investments, similar analyses could be run for other sets of non-U.S. funders whose investments may become restricted under the expanded interpretation of the EMCP. This includes domestic government investments from ministries of health or social development in their own domestic NGO networks, bilateral funding from other donor governments such as the United Kingdom Department for International Development, and private entities such as the Bill & Melinda Gates Foundation, whose funding can become bound by the Policy under the same mechanisms as the GF. This raises substantial questions of interfering with the sovereignty and democratic functioning of other countries when U.S. policy restrictions are attaching to a foreign government's own appropriations and expenditures in their own countries through domestic health organizations. Funders of global health should actively investigate and assess the ramifications and changes being made to their own programming as a result of the EMCP.

Recommendations

All donors and affected organizations should proactively seek technical assistance to understand the potential exposure of their funding, programs, and partner networks as a result of the EMCP, and to devise ways to mitigate disruptions to programmatic activities, partnerships, and service delivery. Funders should be aware that disruptions to programming are not isolated to abortion provision, advocacy, or family planning funding, but can also be seen in the delivery of basic health services, HIV testing, circumcision programming, TB programs, and other areas.

The Global Fund Secretariat:

- Be transparent regarding the networks of organizations receiving Global Fund resources, including all sub-recipients of Global Fund grants.
- Provide informational materials regarding the EMCP, its restrictions, and the potential ramifications for Global Fund funding and partner selection throughout the Global Fund's network of organizations.

Global Fund Country Coordinating Mechanisms:

- In nominating prime recipients for Global Fund grants, be cognizant of the implications of choosing a prime recipient that is or may become restricted by the EMCP and how that may affect sub-recipients that can be partnered with to perform grant activities.
- Where possible, directly identify sub-recipients for each grant in the Concept Note/Funding Request.
- Where possible, make use of dual-track grants, ensuring that at least one prime recipient of Global Fund resources—and therefore their sub-recipients—is not bound by the restrictions in the EMCP.

Other Global Health Donors:

- Proactively assess your grant portfolios to determine when funding may become subject to EMCP restrictions under the expanded interpretation of the EMCP.
- Add a reporting requirement to grant agreements requiring that grant recipients report if they receive funding restricted by the EMCP and whether they have lost or excluded other organizations as potential partners or sub-recipients of funding as a result of the EMCP. It should be expressly clear that this reporting requirement is for data collection purposes only and is not a condition of funding. Counter-conditionalities that refuse funding to organizations restricted by the EMCP should be avoided.
- Consider developing alternative funding structures to allow direct funding to sub-recipients in circumstances where the EMCP would attach to your organizational grant funds.

Recipients of U.S. GHA:

- To avoid over-implementation of the EMCP, know the provisions of the EMCP and your organization's continued rights and obligations while subject to the Policy.
- Document the effects of the EMCP on the organization, including loss of qualified sub-recipients due to the EMCP.
- Report to non-U.S. government funders when potential sub-recipients are being excluded from partnering opportunities due to EMCP-related restrictions.

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