Impact of the Mexico City Policy: Literature Review

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Overview
There is an increasing literature assessing the impact of the Mexico City Policy over time and during different presidential administrations. We conducted a literature review to identify studies examining this impact, from 2001 to the present, with particular focus on capturing recent studies assessing the policy under the Trump administration. Overall, we identified 71 studies or documents for inclusion in our review. They employed a variety of methodological approaches (including more than one approach in a single study) with the majority using qualitative methods (48), followed by those using quantitative methods (27); seven were scoping or literature reviews. Most of the literature assessed the impact of the policy under the Trump administration (45), followed by the George W. Bush administration (31). Fewer studies looked at the policy under other presidential administrations. Taken together, the literature documents a range of impacts associated with the policy, including: increases in abortion rates and reductions in contraceptive prevalence (among other health outcomes); disruption and gaps in services; reduction in service integration; over-implementation and chilling effects; confusion about the policy; loss of civil society/NGO coordination and partnerships; and increased administrative burden. In addition, several studies sought to calculate or estimate the reach of the policy, as measured by amount of funding, countries, and/or NGOs affected.

Box 1: Impacts Associated with the Mexico City Policy in the Literature

- Increased abortion rates
- Increased pregnancy
- Decreased contraceptive prevalence
- Disruption in family planning and other services
- Gaps in family planning and other services
- Reduced service integration
- Over-implementation and chilling effect
- Confusion
- Loss of civil society/NGO coordination and partnerships
- Increased administrative burden
Snapshot of the Literature

We identified 71 studies, published since 2001, for inclusion in this review. Key characteristics are as follows:

Presidential Administration: The studies reviewed included those that assessed the impact of the policy over time and during different presidential administrations; these included times when the policy was not in place, generally to serve as a control or comparison period. Most of the studies reviewed assessed the impact of the policy under the Trump administration (45), followed by studies assessing the impact under the George W. Bush administration (31). Fewer studies looked at the impact under other presidential administrations, with 10 assessing the policy during the George H.W. Bush administration and 9 during the Reagan administration. A small number used the Obama (15), Clinton (13), and Biden (4) administration periods as comparisons.

Methodological Approach: The studies employed a variety of methodological approaches, often using more than one. The majority used qualitative methods, primarily key informant interviews and site visits (48), followed by those that used quantitative methods (27). Seven were scoping or literature reviews, included primarily to help identify additional studies and confirm overall findings.

Geographic Scope: Studies were largely split between those that were multi-country in their geographic scope (29) or single-country focused (29). The remainder did not include a specific geographical analysis (13).

Type of Literature: Twenty-nine studies were peer reviewed analyses, 38 were independent or organizational studies, and four were U.S. government-issued reports.

Findings

Below, we summarize the literature reviewed and provide findings in key areas (see Appendix Table for a complete list of studies, including their findings and other information).

Reach and Impacts of the Policy

Reach

The U.S. government has not routinely provided data (such as data on the amount of funding or number of recipients subject to the policy) when the Mexico City Policy has been in effect. As such, several studies have attempted to calculate or estimate its reach. Our analyses have found that the expanded policy during the Trump administration applied to a much greater amount of U.S. global health assistance, and a greater number of foreign NGOs, across many program areas than during prior periods when the policy was in effect. Specifically, we found that the Trump policy potentially encompassed $7.3 billion in global health assistance, a significantly greater amount than the $600 million in family planning funding that would have been subject to the policy under prior iterations (Moss & Kates 2021). Using prior periods...
as proxies, we also found that had the expanded Mexico City Policy been in effect during the FY 2013 – FY 2015 period, approximately 1,275 foreign NGOs would have been subject to the policy, and more than 460 U.S. NGOs recipients of U.S. global health assistance would have been required to ensure that their foreign NGO sub-recipients were in compliance (Moss & Kates 2017). Finally, we found that more than half (37) of the 64 countries that received U.S. bilateral global health assistance in FY 2016 allowed for legal abortion in at least one case not permitted by the policy, suggesting that the policy would be at odds with country law in many cases (Kates & Moss 2017).

A Congressionally-requested GAO (GAO 2020) study of the Trump administration’s policy analyzed U.S. government project data from May 2017 through FY 2018 (Sept. 2018) and found that the policy had been applied to more than 1,300 global health assistance awards (that is, grants or cooperative agreements), primarily at USAID and CDC. NGOs had declined to accept the policy in 54 instances, totaling $153 million in declined funding. These included seven prime awards totaling $102 million and 47 sub-awards totaling $51 million (more than two-thirds of sub-awards were intended for Africa).

**Effects on Abortion Rates, Contraceptive Prevalence, and Pregnancy**

Several studies have sought to estimate the association between the Mexico City Policy and a range of health outcomes among women, including abortion rates, contraceptive prevalence, and pregnancy:

- **Brooks et al. (2023)**, using data from eight countries in sub-Saharan Africa between 2014-2019, found that women were significantly less likely to be using any method of contraception when the Trump administration’s policy was in effect, equivalent to a 13% reduction in contraceptive prevalence. They also found that women appeared to be substituting traditional methods of family planning for modern methods. Finally, they found that women were 5.7% more likely to have given birth when the policy was in place.

- **Kavakli and Rotondi (2022)**, using data from 134 countries between 1990-2015, found that, when in place, the policy was associated with higher maternal and child mortality and HIV incidence rates. In addition, their analysis of individual data in 30 countries found that women had less access to modern contraception and were more likely to report that their pregnancy was not desired. Finally, they used their findings to estimate that reinstatement of the policy by the Trump administration could result in 108,000 maternal and child deaths and 360,000 new HIV infections over a four year period.

- **Brooks et al. (2019)**, using data from 26 countries in sub-Saharan Africa between 1995-2014, found that when the policy was in place, abortion rates rose by 40%, use of modern contraceptives declined by 14%, and pregnancies increased by 12%.

- **Rodgers (2018)**, using data from 51 countries between 1994-2008, assessed the impact of the policy on abortion rates before and after its reinstatement in 2001 by President George W. Bush, finding that the policy was associated with a threefold increase in the odds of women getting an abortion in Latin America and the Caribbean and a twofold increase in sub-Saharan Africa; there was no net change in the Middle East and Central Asia. They also found that there was no consistent relationship between strict abortion laws and abortion rates.
• Bendavid et al. (2011), using data from 20 African countries between 1994-2008, found that women had 2.55 times the odds of having an induced abortion after the policy’s reinstatement and that the prevalence of contraceptive use was almost 2% lower.

**Disruption and Gaps in Family Planning Services**

Numerous studies have documented disruption and gaps in family planning services when the policy has been in place. For example, a recent quantitative analysis of the policy during the Trump administration, based on data from eight countries in sub-Saharan Africa, found that health facilities provided fewer family planning services, including fewer short-acting methods, long-acting reversible contraceptives (LARCs), and emergency contraception (Brooks et al., 2023). Studies in Ethiopia also found statistically significant declines in the use of LARCs and short-acting methods under the Trump administration’s policy (Sully et al., 2023) and decreases in the proportions of facilities reporting family planning provision through community health volunteers, mobile outreach visits, and family planning and postabortion care service integration, as well as increases in contraceptive stock-outs (Sully et al., 2022).

A recent GAO analysis (2022) documented delays, gaps, and disruptions in the provision of family planning services in Senegal, Uganda, and the West Africa region due to the Trump administration’s policy. Similarly, the Department of State (2020), in its second review of the expanded policy during the Trump administration, found that although agencies and departments made efforts to transition projects to another implementer to minimize disruption, gaps and disruptions were sometimes reported when recipients of U.S. funding declined to accept the policy. An analysis by Sherwood et al. (2020) found significant decreases in services offered by PEPFAR implementing organizations, including reductions in the delivery of information about sexual and reproductive health, pregnancy counseling, contraception provision, and HIV testing and counseling, due to the policy.

Qualitative analyses have also found disruptions and gaps in family planning and other services – including clinic closures, loss of staff, reduction in services, and increased commodity insecurity – during the Trump administration’s policy, including in: Ethiopia (Vernaelde 2022; PAI 2018), Kenya (Ushie et al., 2020; Human Rights Watch 2017), Madagascar (Ravaoarisoa et al., 2020; MSI 2018), Nepal (Puri et al., 2020; Adhikari 2019; PAI 2018), Nigeria (PAI 2018), South Africa (du Plessis et al., 2019), and Uganda (MSI 2018; PAI 2018; Human Rights Watch 2017).

Analyses of the impacts of the policy during prior administrations also found disruptions and gaps (see, for example, Jones 2015; GGR Impact Project 2003-2006).

**Reduction in Service Integration**

Studies have also examined how the policy might affect service integration and/or documented impacts on integration. For example, a study in PEPFAR countries found a high risk of disruption in integration of family planning and HIV services (Sherwood et al., 2018) under the Trump administration’s policy. Disruption of service integration was documented in Cambodia (Frontline AIDS & Watipa 2019), Ethiopia (Sully et al., 2022), and the West Africa region (GAO 2022).
Over-Implementation and Chilling Effect
Several studies have documented an “over-implementation” of the policy (that is, implementers, providers or others taking steps to curtail services beyond what was required by the Mexico City Policy), resulting in further limitations. This was found in a survey of PEPFAR implementers (Sherwood et al., 2020) as well as in qualitative research in Malawi (Iyer et al., 2022), Nigeria (Rios 2019), and interviews with broader groups of stakeholders (Planned Parenthood Global 2019), among other studies. Similarly, several studies cited a “chilling effect” among implementers and others, resulting in reluctance to provide services or partner with certain organizations even where abortion was legal. This was found in Kenya (Maistrellis et al., 2022), Nepal (Maistrellis et al., 2022; Tamang et al., 2020), Nigeria (PAI 2018), and Uganda (PAI 2018).

Confusion
Confusion about the policy, including what is required, has been documented throughout its history. For example, the Department of State (2018), in its initial six-month review of implementation of the Trump administration’s policy, found a number of areas needing clarification to reduce confusion. Specifically, the review directed agencies to provide greater support for improving understanding of implementation among affected organizations and provide additional guidance to clarify terms and conditions. A range of qualitative analyses have similarly documented confusion about the expanded Trump policy including among respondents in Cambodia (Frontline AIDS & Watipa 2019), Ethiopia (PAI 2018), Kenya (Rios 2019), Malawi (Frontline AIDS & Watipa 2019), Nepal (Puri 2020; Rios 2019), Nigeria (Rios 2019), and South Africa (Rios 2019), and among key informants in multiple other settings (PPFA, CHANGE).

Confusion about the policy has even been found during times when it was not in place. For example, one study found that even after the policy was rescinded by the Obama administration, interviewees in Nepal reported a range of misunderstandings from believing that all U.S. abortion restrictions were lifted to believing that the policy was still in place, and interviewees also often conflated the policy with the Helms Amendment, which prohibits U.S. funding for the performance of abortion (Ipas & Ibis Reproductive Health 2015). Similar confusion was found in Ethiopia after the policy was rescinded (Leitner Center for International Law and Justice 2010).

Loss of Civil Society/NGO Coordination and Partnerships
Several studies have documented negative impacts of the policy on civil society, including on partnerships and networks. This was found in Ethiopia (Vernaelde 2022; PAI 2018), Kenya (Maistrellis et al., 2022; Ushie et al., 2020; Rios 2019), Nepal (Dhakal et al., 2023; Maistrellis et al., 2022; Puri et al., 2020; PAI 2018), Senegal (PAI 2018) and South Africa (du Plessis et al., 2019). For example, organizations in Cambodia (Frontline AIDS & Watipa 2019) felt that the policy led to reputational risk and affected their partnerships, and coalitions in Malawi reported that the policy resulted in fragmentation, tension and mistrust.

Increased Administrative Burden
Finally, studies have documented the administrative and cost burden associated with implementing and monitoring compliance with the policy, including that it increased workload and required implementers
who refuse to agree to the policy to spend time and resources searching for new partners and training them. This was found, for example, in Kenya (Rios 2019), Nepal (Puri et al., 2020), Nigeria (Rios 2019; PAI 2018), South Africa (Rios 2019), and Uganda (PAI 2019; PAI 2018).

Methods

To identify literature documenting the impact of the Mexico City Policy, we employed a multi-pronged search strategy. First, we searched for literature using Google Scholar and targeted follow-up searches of key organizations websites for documents that had the keywords “Mexico City Policy” or “Global Gag Rule” and “impact.” We reviewed those documents for relevance and for additional references. We also used selected other scoping and literature reviews to identify additional documents for review. This yielded a total of 129 documents, of which 71 were included for analysis (we excluded documents that were only descriptive or speculative in nature and did not include findings of impact, or documents that reported on impacts from other studies). We included only resources published from 2001 through the present. For each document, we assessed: the method(s) employed; main findings; the presidential administration(s) assessed or studied; geographic scope; and the type of literature (e.g., peer reviewed, government document).
<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th>Citation</th>
<th>Main Findings</th>
<th>Methodological Approach</th>
<th>Geographic Scope (Countries)</th>
<th>Type of Literature</th>
<th>Link</th>
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</thead>
<tbody>
<tr>
<td>2023</td>
<td>Brooks, N., Gunther, M., Bendavid, E., et al.</td>
<td>U.S. global health aid policy and women's reproductive care in Sub-Saharan Africa. Science Advance, 9, 49 (2023); eabk2864.</td>
<td>(1) Health facilities provide fewer family planning services, including fewer short-acting methods, long-acting reversible contraceptives (LARCs), and emergency contraception. (2) Women less likely to use contraception (13% reduction in contraceptive prevalence) and appear to be substituting traditional methods for modern methods. (3) Women were 5.7% more likely to have given birth.</td>
<td>Analyzed data for 2014-2019 from Performance Monitoring for Action (PMA) national surveys and health service delivery site surveys, and HINE. Used a difference-in-difference study design.</td>
<td>Multi-country (Sub-Saharan Africa: 8 countries)</td>
<td>Peer-reviewed</td>
<td><a href="https://science.org/doi/full/10.1126/sciadv.adk2684">https://science.org/doi/full/10.1126/sciadv.adk2684</a></td>
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<td>2023</td>
<td>Dhakal, S., Pun, M., Gautam, P., et al.</td>
<td>Impacts of Protecting Life in Global Health Assistance policy in Nepal: a qualitative study. Health Res Pol Syst 21, 81 (2023).</td>
<td>(1) Policy created gaps in SRH services, affecting marginalized and underserved populations in Nepal. Family planning and safe abortion were most affected. (2) Participants reported that organizations lost funding, had to reduce staff. (3) Participants reported that the policy compromised the work of NGOs and civil society organizations posing additional risk to the sustainability of achievements.</td>
<td>Conducted in-depth interviews with 21 national-level stakeholders selected purposively on the basis of their experiences and expertise in sexual and reproductive health and rights (SRHR) in Nepal. Interviews were conducted two times: first between August and November 2021 when policy was in place, and then between July and August 2023 after policy was revoked. Interviews were digitally recorded, transcribed, translated and analyzed thematically.</td>
<td>Single country (Nepal)</td>
<td>Peer-reviewed</td>
<td><a href="https://healthpolicy-articles.biomedcentral.com/articles/10.1186/s12913-022-09017-8">https://healthpolicy-articles.biomedcentral.com/articles/10.1186/s12913-022-09017-8</a></td>
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<td>2023</td>
<td>Iyer, A., Cooper, B., Luffy, S., et al.</td>
<td>We are Completely Captured: The Global Gag Rule’s Impact on Malawi’s Sexual and Reproductive Health and Rights Landscape, Annales of Family Medicine 21, Supp 1 (2023): 4206.</td>
<td>(1) Policy stated passage of liberalized abortion law, cemented anti-abortion policies, and limited national sovereignty in Malawi. (2) Mis-implementation of the policy restricted access to SRH services globally but did not reverse national anti-abortion sentiments. (3) Threat of reinstatement by future U.S. president has created fear and hesitation to invest in SRH programs and advocacy and has contributed to a weakening of national sovereignty.</td>
<td>Conducted 17 semi-structured in-depth interviews with current and past recipients of U.S. global health assistance and organizations working in SRH in Malawi for 2017-2021 period. Recruited participants via purposive and snowball sampling. Transcribed interviews verbatim, and thematically analyzed transcripts in MAGI2020 using inductive and deductive coding.</td>
<td>Single country (Malawi)</td>
<td>Peer-reviewed</td>
<td><a href="https://www.annfammed.org/content/21/Supplement_1/4206.abstract">https://www.annfammed.org/content/21/Supplement_1/4206.abstract</a></td>
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<td>2023</td>
<td>Siilwan, M., Kibira, S.P.S., Shiferaw, S. et al.</td>
<td>Postabortion and safe abortion care coverage, capacity, and crossovers during the global gag rule policy period in Ethiopia and Uganda. BMC Health Serv Res 23, 104 (2023).</td>
<td>(1) PAC service coverage was high and improved over time, but facilities’ capacity to provide basic PAC services was low in Uganda (17.8% in 2019) and Ethiopia (15.0% in 2020). (2) PAC use was increased by 15.5% over time in Uganda and decreased by 7% in Ethiopia. Basic SAC capacity increased in Ethiopia from 49.7 to 82.8% overall, due in part to an increase in the provision of medication abortion, and the number of safe abortions increased in Ethiopia by 5.7%. (3) In Ethiopia, findings suggest that public health systems were able to maintain essential PAC/SAC services, including improvements. (4) In Uganda, PAC crossovers increased which could indicate that abortion became more stigmatized, less accessible and less safe.</td>
<td>Collected abortion care data from the Performance Monitoring for Action (PMA) platform between 2018 and 2020 from public health facilities in Ethiopia (N = 282) and Uganda (N = 223). Adapted signal functions approach to 82.8% overall, composite indicators of health facilities’ capacity to provide basic and comprehensive post (PAC) and safe (SAC) abortion care to assess service provision before and after policy went into effect. Also investigated trends in crossovers over the time-period.</td>
<td>Single country (Ethiopia, Uganda)</td>
<td>Peer-reviewed</td>
<td><a href="https://link.springer.com/article/10.1186/s12913-022-09017-8">https://link.springer.com/article/10.1186/s12913-022-09017-8</a></td>
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<td>2023</td>
<td>Sully EA, Sere, A., Shiferaw, S., et al.</td>
<td>Impact of the global gag rule on women’s contraceptive use and reproductive health outcomes in Ethiopia: a pre-post and difference-in-difference analysis. BJU Int 123 (2023): e03209.</td>
<td>(1) Statistically significant declines from 2018 to 2020 in the use of LARCs and short-acting methods. (2) In difference-in-difference analysis, women exposed to non-compliant organizations experienced greater declines in LARC and short-acting methods use compared with less-exposed women. (3) The policy seemed to result in a stagnation in the previous growth in contraceptive use in Ethiopia. (4) No statistically significant impacts on pregnancy and birth outcomes (potentially too soon to detect).</td>
<td>Using data from the Performance Monitoring for Accountability for Contraceptive use in Ethiopia (PMA) platform between 2018 and 2020, assessed impacts of the policy on contraceptive use, pregnancies, births and abortions. Used a pre-post analysis to investigate changes in women’s reproductive outcomes and difference-in-differences designs to measure the additional effect of MGAR rules’ refusal to comply with the policy and the resulting loss in funding; districts are classified as more exposed if organizations impacted by lost funding were providing services there and women are classified based on their district.</td>
<td>Single country (Ethiopia)</td>
<td>Peer-reviewed</td>
<td><a href="https://bjo.onlinelibrary.wiley.com/content/123/9/13/article-abstract">https://bjo.onlinelibrary.wiley.com/content/123/9/13/article-abstract</a></td>
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<td>2022</td>
<td>GAO</td>
<td>International Family Planning Assistance: USAID Has Faced Implementation Challenges Related to U.S. Policy and COVID-19. United States Government Accountability Office (2022); GAO-22-104228.</td>
<td>Country/regional assessment found: (1) Senegal: an implementing partner had to recruit all new personnel when a subaward declined the policy terms and conditions delaying delivery of family planning services by at least 6 months and causing gaps in mobile clinic services. (2) Uganda: subawardees declined policy terms and conditions which resulted in termination and large-scale interruptions of programs and services, including interruptions in introduction of new contraceptive, programs on male engagement in family planning, and research initiatives. (3) West Africa region: USAID struggled to find replacement partners in some cases, including to provide integrated, voluntary family planning through mobile outreach and local clinics. Because the region lacked adequate number of health care clinics, loss of funding could lead to a loss of FP/RH services, including access to contraceptives, in high-population areas. Providers couldn’t refer to youth friendly services, could not expand training for community health workers.</td>
<td>Reviewed USAID project documents from missions in Senegal and Uganda and the West Africa Regional Program. Conducted literature review of studies that were based on original research or that summarized a number of other studies. Interviewed USAID officials in Washington and at missions in Senegal, Uganda, and West Africa Regional Program implementing partners; former implementing partners who declined funding due to policy; representatives of other FP/RH donors working in Senegal, Uganda, and West Africa.</td>
<td>Multi-country (Senegal, Uganda, West Africa Region)</td>
<td>Report (government or Congress)</td>
<td><a href="https://www.gao.gov/products/22-104228">https://www.gao.gov/products/22-104228</a></td>
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(1) Long-lasting reversible contraceptive use increased more rapidly among women in less exposed districts after GGR implementation. D20 estimates for contraceptive use were small. 
(2) Results suggest that the policy may have reduced Uganda’s recent progress in improving SRHR outcomes, with women in less exposed districts continuing to benefit from this progress, while previously increasing trends for women in more exposed districts levelled off.

Data from panel of women surveyed in 2018 and 2019 in Uganda and from meetings with key stakeholders used to create a detailed map of exposure to the policy within Uganda, classifying districts as more or less exposed. Multivariate regression models were used to assess changes in contraceptive use, all births, unplanned births, and abortion from before to during implementation and differences-in-differences estimates were calculated.


(1) In 134 countries between 1990-2015, MCP associated with higher maternal and child mortality and HIV incidence rates. 
(2) In 30 countries, based on individual data, women found to have had less access to modern contraception and are less exposed to information on family planning and AIDS via in-person channels. 
(3) In 30 countries, pregnant women more likely to report that their pregnancy is not desired. 
(4) Estimate that reinstating the MCP between 2017 and 2021 could result in an additional 108,000 maternal and child deaths and 360,000 new HIV infections.


Once the policy was rescinded in 2009, countries with high exposure to the policy had significant improvements in infant, neonatal, and under-five mortality, lower fertility rates, and improvements in birthweights.

Multi-country Peer-reviewed https://www.economicsbulletin.org/content/42/3/1908752


(1) Observed greater breakdown of NGO coordination and chilling effects in countries where abortion is legal and there is a sizeable community of non-US-based NGOs working on SRH. 
(2) Policy weakened SRH service delivery in all countries, irrespective of the legal status of abortion. Contraceptive service availability, accessibility and training for providers were particularly damaged. 
(3) In Kenya and Nepal, evidence of a ‘chilling effect’, whereby certifying NGOs applied unnecessary restrictions to their work to ensure compliance and prevent assistance from USG.

Multi-country (Kenya, Madagascar, Nepal) Peer-reviewed https://bmj.com/content/57/7/e007152


(1) Found reductions in the proportions of facilities reporting family planning innovation through community health volunteers, mobile outreach visits, and family planning and postabortion care service integration, as well as increases in contraceptive stock-outs over the past three months. 
(2) No additional impacts in facilities more exposed to noncompliant organizations observed.


(1) U.S. policy disrupted activities and service delivery, threatened the closure of private clinics, stunted mobile outreach, and impacted safe abortion training of health personnel. 
(2) Dismantled partnerships, affected non-U.S. government donors’ investments, and caused confusion and over-imitation of activities permissible under the policy.


(1) U.S. aid for family planning was 48% higher under Democratic presidential regimes. 
(2) A switch from Democratic to Republican party, for an aid-receiving country with above-median reliance on US family planning aid, associated with an 8% increase in maternal deaths.

Multi-country (49 countries) Independent https://ideas.repec.org/p/iza/izadp/2021-14915.html


Scoping review found that the policy was associated with:

(1) Increase in abortion rate. 
(2) Negative impact on maternal health, STIs, and the health of marginalized groups. 
(3) Loss of funding for organisations. 
(4) Chilling of staff who lead to closing of lines of services. 
(5) Negatively impacted integration of services and partnerships between organizations, leading to fragmented and inefficient health systems. 
(6) Chilling effect, with organizations feeling censored and reluctant to engage in discussion around their work for fear of losing U.S. funding.

Confidential regarding policy.


2021 Lane, S. Ayeh- Karikson, S., and Shavivi, A. Scoping review found that the policy was associated with:

(1) Increase in abortion rate. 
(2) Negative impact on maternal health, STIs, and the health of marginalized groups. 
(3) Loss of funding for organisations. 
(4) Chilling of staff who lead to closing of lines of services. 
(5) Negatively impacted integration of services and partnerships between organizations, leading to fragmented and inefficient health systems. 
(6) Chilling effect, with organizations feeling censored and reluctant to engage in discussion around their work for fear of losing U.S. funding.

Administrative burden of compliance.


(1) Provided an overview of the history of the policy, including the changes made by President Trump, as well as the implications of the Biden administration rescinding the policy for programs going forward. 
(2) Found that the Trump administration’s application of the policy to the vast majority of U.S. bilateral global health assistance, including funding for HIV under the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), maternal and child health, malaria, nutrition, and other programs, marked a significant expansion of its scope, potentially encompassing $7.3 billion in FY 2020 alone, to the extent that such funding was ultimately provided to foreign NGOs directly or indirectly (family planning assistance accounted for approximately $600 million of that total).


(1) Conducted a scoping review for articles between 1984 and 2020; 48 articles that met eligibility criteria, and were analysed thematically, noting effects on: (1) the operations of governmental organizations; (2) maternal health; (3) sexually transmitted infections; (4) marginalized social groups; (5) reproductive rights.

Neither (n/a) Peer-reviewed https://kff.org/issue-brief/impacts-of-the-mexico-city-policy/


(1) Provided an overview of the history of the policy, including the changes made by President Trump, as well as the implications of the Biden administration rescinding the policy for programs going forward.

Analyzed USG funding data to quantify the amount potentially subject to the expanded MCP during the Trump administration; conducted a literature review of impacts of MCP.

Neither (n/a) Peer-reviewed https://kff.org/global-health-issues/issue-brief/the-mexico-city-policy/

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(1) Understanding of policy very limited among participants from non-USG funded organizations and did not improve over time. (2) Participants who had heard about the policy had very negative attitudes about it. The policy is perceived to be restricting women’s empowerment, putting women at risk of gender-based violence and affecting the rural, poor, forest-dwelling and marginalized communities. (3) Early termination of a large USG supported program resulted in phasing out of family planning programs in 22 districts of Nepal, which provided family planning information, counselling, services and activities to reduce stigma on family planning to unreached populations, and supported improving the capacity of public sector service providers at the district level for delivering family planning and other sexual and reproductive health services. (4) Service coverage in rural and remote areas was reduced due to reduced funding. (5) Policy negatively affected coalition work and networking between organizations, resulting in lost partnerships or difficulty in finding suitable partners for program implementation, and silencing the voices of civil society organizations. A few programs scaled down their programs and are struggling to find alternative grants to allow them to continue their programs when there is a need. Even USG prime recipients had some concern about the policy and felt an additional burden.

(1) Loss of funding due to policy led to fewer contraceptive service delivery points, including mobile outreach services, a critical component of care in rural areas. (2) Public and private health providers reported increased contraceptive stockouts and fees charged to clients.

Conducted semi-structured interviews with 259 representatives of the Ministry of Health and NGOs, public and private health providers, community health workers and contraceptive clients in Antananarivo and eight districts between May 2019 and March 2020; after coding of the interview transcripts, conducted thematic content analysis to identify emerging themes related to how the policy impacted NGOs, providers and clients.

Effect of the Mexico City Policy: Literature Review

(1) Awards declined spanned a variety of program areas, including family planning and reproductive health (FP/RH), HIV and AIDS (HIV/AIDS), maternal and child health (MCH), tuberculosis (TB), and nutrition, in addition to cross-cutting awards. (2) Awards declined spanned geographic areas but many were for activities in sub-Saharan Africa. (3) Agencies and departments made efforts to transition projects to another implementor in order to minimize disruption; but, among USAID awards involving health service delivery where prime and sub-award recipients declined to accept the policy, gaps or disruptions in service delivery were sometimes reported.

The policy had been applied to over 1,300 global health projects, with the vast majority of these USAID and CDC projects. The estimated total value of these awards was almost $29 billion across multiple fiscal years, of which about $12 billion was planned funding that had yet been obligated as of September 30, 2018, and is subject to the PLGHA policy. NGOs declined to accept the policy in 54 instances, totaling $153 million in declined funding. The Department of State and DoD did not identify any instances where NGOs declined to accept the policy conditions.

Obtained data from U.S. departments and agencies on all relevant awards active when the policy was first implemented in May 2017 or awarded through September 30, 2018. Created data collection instrument to further assess information from agencies. Calculated amount of funding and awards subject to policy and identified those that declined the policy's terms and conditions. Met and corresponded with USAID, CDC, and other USG officials, as well as interviewed representatives from two prime awardees that publicly declined to accept the policy to discuss their declined awards and accuracy of USAID's data provided on them. Conducted performance audit from April 2018 to March 2020 in accordance with generally accepted government auditing standards.

Conducted data collection from field teams during the period the policy was in effect through the end of the data collection period May 8, 2019. Additional information collected via qualitative survey on awards and sub-awards under which an organization declined to agree to the policy, as well as more in-depth information on the transition of activities under affected awards.

(1) The policy had been applied to over 1,300 global health projects, with the vast majority of these USAID and CDC projects. The estimated total value of these awards was almost $29 billion across multiple fiscal years, of which about $12 billion was planned funding that had yet been obligated as of September 30, 2018, and is subject to the PLGHA policy. NGOs declined to accept the policy in 54 instances, totaling $153 million in declined funding. (2) Awards declined spanned geographic areas but many were for activities in sub-Saharan Africa. (3) Agencies and departments made efforts to transition projects to another implementor in order to minimize disruption; but, among USAID awards involving health service delivery where prime and sub-award recipients declined to accept the policy, gaps or disruptions in service delivery were sometimes reported.

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(1) Loss of funding due to policy led to fewer contraceptive service delivery points, including mobile outreach services, a critical component of care in rural areas. (2) Public and private health providers reported increased contraceptive stockouts and fees charged to clients.

Conducted semi-structured interviews with 259 representatives of the Ministry of Health and NGOs, public and private health providers, community health workers and contraceptive clients in Antananarivo and eight districts between May 2019 and March 2020; after coding of the interview transcripts, conducted thematic content analysis to identify emerging themes related to how the policy impacted NGOs, providers and clients.

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Survey results showed that 28 percent (56 of 198) of organizations reported stopping or reducing at least one service in response to the policy. Reported reductions often occurred as a result of decreased patient flows or implementation of the expanded policy beyond what is required. Reductions disproportionately harmed pregnant women, youth, and key populations such as sex workers and men who have sex with men.

(1) Low policy awareness.
(2) Chilling effect.
(3) Undermining of the ecology of SRH service delivery in Nepal as well as undermining of national sovereignty.

Reduced service provision

(1) Organizations reported critical funding loss resulting in the fragmentation of sexual and reproductive health and HIV services, and closure of some service delivery programmes.
(2) At public and private health facilities, participants reported staffing shortages and increased stock-ups of family planning and safe abortion commodities.
(3) The expanded policy's effects also disrupted collaboration and health promotion activities, strengthening opposition to sexual and reproductive health and rights in some segments of Kenyan civil society and government.

(1) One of biggest NGOs in country lost US funding resulting in 150 staff and 45 partner community volunteers having to leave their jobs before their contracts ended.
(2) Organization had to close four new branches, and the remaining 29 clinics operating on minimal budgets.
(3) Although abortion legal in country, government not likely to be able to fill the gap.
(4) Organization expects to provide only half the services it has provided in previous years.

Conducted 205 semi-structured in-depth interviews in 3 phases (August–September 2018, and June–September 2019), and across 22 districts. Interview participants included NGO programme managers, government employees, facility managers, and service providers in the NGO and private sectors, and service providers in public sector facilities. Transcripts of the interviews were coded for thematic content analysis.

Conducted semi-structured interviews with representatives of US- and non-US-based NGOs, as well as managers and health providers at public and private health facilities, between September 2018 and March 2019.

Conducted interviews with staff of an NGO in Nepal; description and analysis.

Conduct analysis of data on Global Fund recipient subject to the policy.

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Examined patterns of modern contraception use, pregnancies, and abortion among women in 26 countries in 2015--2018.

During periods when the policy was in place, in countries with high exposure compared to low exposure:
(1) Abortion rates rose by 40% in countries with high exposure.
(2) Use of modern contraceptives declined by 14%.
(3) Pregnancy rates increased by 12%.
(4) Policy's effect reverses after repeal.


(1) Some funding cuts, closure of clinics.
(2) Change of focus of organizational work (away from abortion).
(3) New culture of secrecy.
(4) Reduction in coalition space, affecting civil society.
(5) While policy should not affect government services, most felt it was doing so.

Conducted media tracking and analysis and key stakeholder interviews with members of South African government agencies, SRH civil society and healthcare providers.

Impact of the Mexico City Policy: Literature Review
2019 Frontline AIDS and Watipa


X  X  X

Concluded between April and November 2019 and combined quantitative and qualitative components. Service-level data from Cambodia on outreach activities and referrals to HIV testing and counseling. STI services and family planning clinics for female entertainment workers, transgender people and men who have sex with men was analyzed. A range of perspectives about the impact of the policy were sought and analyzed: stakeholders – including policy makers, donors, service providers and representatives of constituency groups such as sex people living with HIV, men who have sex with men, and sex workers – were interviewed individually and in groups in both countries.

Multi-country (Cambodia, Malawi)  Independent


2019 IPPF


X  X

Documentation of funding losses, loss of staff, and closure of clinics as well as of individuals turned away from services in 31 IPPF Member Associations.

Multi-country  Independent

https://www.ippf.org/sites/default/files/publications/Policy%20Briefing%20-%20The%20Impact%20of%20the%20Global%20Gag%20Rule%202019.pdf

2019 Menicka, C. Goldman R., and Cooper, B.


X  X  X  X  X  X

1) Misunderstanding, miscommunication, and chilling effect of the policy.
2) Frequently reported impacts on family planning delivery systems (34 articles) and the loss of U.S. funding (31 articles) were often related.
3) Sources reported on the impact of the policy on HIV programs, advocacy and coalition spaces, and maternal and child health.
4) Three studies quantified associations between the policy and abortion rates, concluding that the policy does not decrease rates of abortion.
5) The policy’s development and implementation was consistently associated with poor impacts on health systems’ function and outcomes.
6) Previous iterations of the policy deterred health system functions beyond family planning programs.

NA  Peer-reviewed


2019 PAI


X  X

1) Organizations that chose not to comply with policy forced to close clinics and end services as a result of funding deficits, disproportionately affecting vulnerable groups including youth, people living with HIV/AIDS and rural populations.
2) NGOs compliant with policy must often discontinue critical initiatives with noncompliant organizations expected to advance health care access and quality.
3) Stigma and technical complexities of the policy also led NGOs to self-sense and overly restrict activities out of caution.
4) Created heavy operational burden for NGOs—both compliant and noncompliant and need to spend resources on unanticipated overhead, time seeking clarification from funders and costs other, which detracts from service provision and directly impacts clients and beneficiaries.

Multi-country (Burkina Faso, Ethiopia, India, Kenya, Nepal, Nigeria, Senegal, Uganda)  Independent


2019 Planned Parenthood Global


X  X

1) Widspread confusion on policy application, due to limitations in information and guidance.
2) Over-implementing by complying organizations driven by fear of losing funding.
3) Chilling effects of the policy felt from health facilities to national civil society dialogues and policy development.
4) Loss of funding led to discontinued programs and reductions in services, size of staff.

Multi-country (7 countries)  Independent

https://www.plannedparenthood.org/documents/4002-011514423-2019.03.11.213753.pdf


X  X

1) Many stakeholders had no or very limited knowledge of policy.
2) Participants thought that the policy threatened recent improvements Nepal has made in women’s health.
3) Policy created funding gaps and halted implementation of programs.
4) Negatively affected partnerships and coalitions.
5) Policy creating gaps which would mainly affect marginalized and underserved populations.

Single country (Nepal)  Independent


2019 Rios, V.


X  X

1) The policy was harmful to the health and well-being of women, young people, and marginalized communities, such as LGBTQI, rural, poor, and religious minority communities.
2) The policy exacerbated existing barriers to accessing care including comprehensive abortion care, contraceptive services, HIV/AIDS testing and treatment, screening for cervical cancer, breast cancer, prostate cancer, and support for survivors of gender-based violence.
3) The policy created funding gaps, causing the fragmentation of health services, and halting critical health programs, including those strengthening the delivery of government services.
4) The policy created burden for organizations, shrank civil society spaces, silenced voices, and created distrust.

Multi-country (Kenya, South Africa, Nigeria)  Independent

https://www.iwhc.org/content/criticalstudies/trump-s-global-gag-rule


X  X  X  X  X

Reviews findings from studies assessing the impact of the policy. Hypothesize that health systems impacts will be significant.

NA  Peer-reviewed

https://bmj.bmj.com/content/4/5/e001785

Impact of the Mexico City Policy: Literature Review

11
Provides overview of policy over time and documents challenges associated with Trump expansion including confusion and overinterpretation, lack of information, restrictions or unwillingness to partner with certain organizations, chilling effect, and impacts in multiple areas of health.

(1) Need for more central and field-based training and implementation tools. (2) Need for clearer explanation of termination of awards for NGOs found to be in violation of the policy. (3) Need clarification of “financial support” in context of policy. (4) Identified number of awards subject to the policy and number that declined to accept terms and conditions.

Elegant funding from the USA between 2003 and 2007, and particularly the drop in funding in 2004, are consistent with the re-introduction in 2001 of the Mexico City Policy.

Identifies impacts in several countries: (1) Malawian: voucher programme, delivering sexual and reproductive health services to women and adolescents living in poverty has already been forced to close and a further 22 outreach teams and 150 public sector franchises are at risk. (2) Uganda: Five of our 35 outreach teams closed and another 12, covering nearly half the country’s most hard-to-reach populations, are at risk. If new funding is not identified, team visits to all of the country’s 117 districts will be reduced to just 47 districts. (3) Zimbabwe: Halved the number of outreach sites visited from 1,200 to 600.

(1) Key populations who rely on the private sector—such as adolescents and youth, people living with HIV/AIDS and sex workers—are directly being affected by the closure of previously U.S.-supported health clinics. (2) Loss of key U.S. partners for service delivery. (3) Dismantling of partnerships between compliant and noncompliant organizations. (4) Undermining of other donors’ health programs and projects. (5) Uncertainty of securing future funding for sexual and reproductive health commodities.


(1) Foreign NGO implementers leading outreach with mobile clinics and social franchises have been hit hardest by loss of U.S. funding and the rupture of partnerships with U.S. NGOs. (2) The policy is also having chilling effects to revive a long-awaited sexual and reproductive health law that would allow for termination of pregnancy in the instance of rape or incest.

Impact of the Mexico City Policy: Literature Review
2018 PAI


X X Conducted a fact-finding trip to Kampala, Uganda, in October 2017 to document the preliminary impacts of the Trump administration’s expanded Global Gag Rule on women’s sexual and reproductive health and rights. PAI held interviews and meetings with representatives from over 20 organizations and agencies including Uganda, U.S. and other foreign non-profit NGOs providing sexual and reproductive health services or advocacy; officials from the Uganda Ministry of Health; bilateral and multilateral donors; and health professionals. Single country (Uganda) Independent

https://globalgagrule.org/resource-access-denied-uganda

2018 Rodgers, V. VOM


X X X X Policy associated with a threshold increase in the odds of women getting an abortion in Latin America and the Caribbean, a twofold increase in sub-Saharan Africa, and no net change in the Middle East and Central Asia. (2) Results also indicate no consistent relationship between strict abortion laws and abortion rates. (3) In the majority of developing countries exposed to the global gag rule, the policy failed to achieve its objective of discouraging women from getting an abortion. Multi-country (51 countries) Independent


X X Quantified the likelihood of FP/HIV service de-integration in 37 PEPFAR-funded countries and finds high risk of potential impact on integration. Multi-country (21 countries) Independent

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5964247/

2017 Human Rights Watch


X X Conducted research on early implications of Trump administration policy through interviews with representatives of 45 organizations in Kenya and Uganda that were formerly funded by U.S. international health funding, many of whom had planned to apply for renewals or new funds in the coming year. Multi-country (Kenya, Uganda) Independent


2017 Kates, J. and Moss, K.


X X Using data from the U.S. government, identified all countries that received bilateral U.S. global health assistance in FY 2016. Examined their abortion laws in at least one case not permitted by the policy. Multi-country (64 countries) Independent


2017 Moss, K., and Kates, J.

How Many Foreign NGOs Are Subject to the Expanded Mexico City Policy?. KFF (2017).

X X Using data from the U.S. government, identified the number of NGO prime recipients and sub-recipients of U.S. global health assistance in FY 2013–FY 2015 to approximate the number of foreign NGOs that would have been subject to the expanded MCP if the policy had been in effect during that time period. Multi-country (64 countries) Independent


2015 Ispa and Ispa


X X Ispa sponsored fact-finding projects in Ghana, Nepal and Kenya (between 2009 and 2011) and consulted with partner organizations in the United States and eight countries to document how U.S. restrictions on U.S. funding for abortion are applied. Conducted over 200 interviews with staff of reproductive health organizations, health care providers, government officials, multilateral agencies, bilateral donors, and opinion leaders. Multi-country (Ghana, Nepal, Kenya) Independent


2015 Jonas, X.M.


X X X X X X Conduction analysis on fertility outcomes in Ghana between 1989-2008 using 2009 DHS data. Single country (Ghana) Peer-reviewed

https://www.journals.uchicago.edu/doi/abs/10.1086/658184

2015 Asefvi, E., Narevane, M., and Naai, M.


X X X X X X Created panel data of 151 developing countries over the period of 1986-2010 to examine the effect of the MCP on the allocation of family planning aid to developing countries. The data are from the World Development Indicators (WDI) and the Organization for Economic Co-operation and Development (OECD). Multi-country (151 countries) Independent


Impact of the Mexico City Policy: Literature Review

13

Discussion of policy over time and review of studies. Found limited empirical findings and no studies examined the policy longitudinally to determine the impacts of the GGR.


X X X X X Literature review based on searches of several databases were explored for GGR-relevant information. The keywords ‘global gag rule’ and ‘Mexico City Policy’ were searched in the Social Science Abstracts database, WELINE, and Gender Studies Database. Additionally, a search was conducted of three organization websites for literature pertaining to the GGR. These organizations included Population Action International (PAI), a non-profit organization with a reproductive health care focus, the Guttmacher Institute, and the Center for Reproductive Rights.


Although the Obama administration rescinded the policy, confusion remains; residual effects of years of strict enforcement remain an obstacle to addressing unsafe abortion in Ethiopia.


X X X Conducted mapping exercise of the standards of prevention and access to care in seven Phase 2B and 3 monobolide and cervical barrier trials, conducted in three phases: a desk review of key documents, interviews of key international and local staff and study sponsors by phone, and visits to trial sites in four African countries.


X Examines implications of George W. Bush administration’s reinstatement of the MCP, and other U.S. policies, caused confusion among trial staff about what sites could provide with respect to counseling on pregnancy options, including information or referral for termination.


X X X Conducted interviews with key stakeholders and affected organizations during the George W. Bush administration. Created and analyzed panel data on expenditures of OECD donors for three types of aid agencies (multilateral, NGOs, and bilateral aid) for the years 1983–2002.


X X Conducted narrative analysis of qualitative information on emergency contraceptive shifts in USAID/Peru’s policy on emergency contraception in Peru since 1982. The information is drawn from ongoing monitoring conducted by the authors of reproductive health and rights policies in Peru over a number of years.


X X X Conducted interviews with key stakeholders and affected organizations during the George W. Bush administration.


X X X Conducted interviews with key stakeholders and affected organizations during the George W. Bush administration.

Impact of the Mexico City Policy: Literature Review
2005 Global Gag Rule Impact Project

...The sole NGO to operate reproductive health clinics in Zambia has lost nearly 80 percent of its staff members, scaled back services, and ended vital community-based distribution of contraceptive supplies and health information. Financial losses caused by the gag rule have made it impossible for Zambia's primary family planning provider to expand and meet the rapidly growing demand for reproductive health services in the country.

X X Conducted interviews with key stakeholders and affected organizations during the George W. Bush administration.

Single country (Zambia) Independent

2005 Global Gag Rule Impact Project

Ethiopia’s pioneer family planning organizations have experienced significant budget cuts, which caused them to scale back services. The Family Guidance Association of Ethiopia (or FAGE), an affiliate of the International Planned Parenthood Federation (or IPPF) and Marie Stopes International Ethiopia (or MSIE) both reduced their activities in early 2002. As a result, FAGE lost 35 percent of its budget, while MSIE lost 10 percent.

X X Conducted interviews with key stakeholders and affected organizations during the George W. Bush administration.

Single country (Ethiopia) Independent

2005 Global Gag Rule Impact Project

Three clinics serving peri-urban and rural communities lost funding in 2003. While these clinics remain open, the nursing staff has been reduced by more than 40 percent, severely limiting the number of clients served.

X X Conducted interviews with key stakeholders and affected organizations during the George W. Bush administration.

Single country (Ghana) Independent

2005 Global Gag Rule Impact Project

A loss of US$200,000 in funding has forced a major family planning organization to significantly reduce its rural outreach activities. Approximately 1,700 community-based agents have been denied the support needed to provide important family planning services to rural areas. Three clinics serving peri-urban and rural communities lost funding in 2003. While these clinics remain open, the nursing staff has been reduced by more than 40 percent, severely limiting the number of clients served.

X X Conducted interviews with key stakeholders and affected organizations during the George W. Bush administration.

Single country (Tanzania) Independent

2005 Global Gag Rule Impact Project

Funding constraints are exacerbated and have limited the expansion of at least two major family planning organizations, at a time when access to reproductive health services is crucial.

X X Conducted interviews with key stakeholders and affected organizations during the George W. Bush administration.

Single country (Zimbabwe) Independent

2005 Sikkawasjaja, S.T.

Examines the impact of the MCP on programs that serve men who have sex with men and sexual minorities.

X X Provides examples of how the MCP impacts support for groups working with sexual minorities such as MSM in Ghana during the George W. Bush administration.

A/a Independent

2004 Center for Reproductive Rights

Policy and legal analysis, drawing on country examples from prior studies. Cambodia: Despite the landmark reform of the abortion law that legalized abortion on broad grounds in 2002, NGO reproductive health-care providers—many of whom are U.S.-funded—cannot lobby the government of Cambodia to provide safe and accessible abortion services.

X X Includes various examples including CRR-supported country studies that were published earlier; in 2001.

Multi-country Independent

Impact of the Mexico City Policy: Literature Review

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<table>
<thead>
<tr>
<th>Year</th>
<th>Study Title</th>
<th>Authors</th>
<th>Summary</th>
<th>Methodology</th>
<th>Country(ies)</th>
<th>Access</th>
<th>URL</th>
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<tbody>
<tr>
<td>2004</td>
<td>Advocacy in Whispers: The Impact of the Unpaid Global Gag Rule Upon Free Speech and Free Association in the Context of Abortion Law Reform in Three East African Countries.</td>
<td>Skuster, P.</td>
<td>(1) The ability of stakeholders to communicate with lawmakers is restricted by the policy. (2) The policy infringes upon the free speech and free association of reproductive health advocates. (3) The policy splinters the work of reproductive health providers, creating a division within the community.</td>
<td>Based on field research in 2002 in East Africa to study the effect of the GGR upon the free speech and free association of advocates of access to safe abortion through interviews with stakeholders and a desk review of information about stakeholders and legal and health system data and information for Uganda, Ethiopia, and Kenya.</td>
<td>Multi-country (Ethiopia, Kenya, Uganda)</td>
<td>Peer-reviewed</td>
<td><a href="http://repository.law.umich.edu/cgi/viewcontent.cgi?article=1100&amp;context=mjgl">http://repository.law.umich.edu/cgi/viewcontent.cgi?article=1100&amp;context=mjgl</a></td>
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<tr>
<td>2003</td>
<td>The Global Gag Rule &amp; Contraceptive Supplies.</td>
<td>Global Gag Rule Impact Project</td>
<td>By 2002, the Global Gag Rule had ended shipments of USAID-donated contraceptives to 16 developing countries: Burundi, Cape Verde, Chad, Comoros, Gabon, Gambia, Lesotho, Mauritius, Sierra Leone, Solomon Islands, Sri Lanka, Swaziland, Togo, Vanuatu, Western Samoa and Yemen. The local family planning associations (FPAs) in each of these countries, affiliates of International Planned Parenthood Federation, declined to sign the policy. They were the only recipients of USAID contraceptives in their respective countries. Several of these countries have not received USAID supplies for the last three years because of the Global Gag Rule. Leading family planning agencies in another 13 countries are unable to receive USAID contraceptives because of their refusal to abide by the restrictions. The FPAs in Bangladesh, Benin, Cameroon, Ivory Coast, Ethiopia, Mozambique, Dominican Republic, Nicaragua, Togo, Uganda, Nepal, Zambia and Zimbabwe were major recipients of USAID supplies.</td>
<td>Conducted interviews with key stakeholders and affected organizations during the George W. Bush administration.</td>
<td>Multi-country</td>
<td>Independent</td>
<td><a href="https://www.abpl.org/i/b22e-4505-image.pdf?153737651130520077/1/The-Global-Gag-Rule-and-Contraceptive-Supplies.pdf">https://www.abpl.org/i/b22e-4505-image.pdf?153737651130520077/1/The-Global-Gag-Rule-and-Contraceptive-Supplies.pdf</a></td>
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