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Anticipated Effects of the U.S. Mexico City Policy on the
Attainability of the Millennium Development Goals and future
Development Efforts in sub-Saharan Africa

By:

Katherine Clare Alexander

In the low-income countries of sub-Saharan Africa, the performance of pyramidal reproductive health and family planning services with public outreach initiatives has not met the expectations or the needs of the communities they serve. Insufficient case management, limited management capacity and referral and communication failures are challenges faced on the delivery level, while on the policy level these health clinics face insufficient coordination among organizations and weak links between programs (Schneider, 2006). The Mexico City Policy, first introduced by President Reagan in 1984, only exacerbated these challenges for organizations that offer comprehensive contraception and family planning programs by denying any U.S. funding to any organization that performs abortions, provides abortion counseling or referrals, advocates for the legalization of abortion or seeks merely to inform women on this procedure. This U.S. policy was repealed by Democratic President Bill Clinton in 1993 only to be reinstated by Republican President George W. Bush in 2001 and repealed for a second time by President Obama in January 2009. The Mexico City Policy cut significant funding to reproductive health care facilities, thereby limiting their outreach program capabilities, their contraceptive supplies and their overall ability to cater to the health needs of the women of sub-Saharan Africa and their families, resulting in the severely compromised the progress of the Millennium Development Goals and present living conditions in sub-Saharan Africa.

In the year 2000, the global community created an over-arching framework for the eradication of extreme poverty by 2015. This framework, the United Nations Millennium Declaration, includes eight identifiable goals, 18 targets and 48 indicators. The eight goals, known as the Millennium Development Goals (MDGs), take a different approach to development than neoliberal economics by ensuring that human development indicators, alongside economic indicators, are used as measurements and targets in development strategies. The MDGs represent the only

international development agenda that has fully acknowledged the critical relationship between poverty and health. Health is represented in three of the eight goals and will greatly affect the achievement of all others, particularly those related to gender equality and education. The eight Millennium Development Goals are: the eradication of extreme poverty and hunger, the achievement of universal primary education, gender equality, reducing child mortality rates, improving maternal health, combating HIV/AIDS, promoting environmental sustainability and building a global partnership for development. Given recent studies, such as Care International's "The Girl Effect" it has become evident that the promotion of gender equality and the achievement of universal primary education will play a significant role in the eradication of global poverty.

In 2008, Care International led a study commonly known as the Girl Effect which produced tremendous results for the International Development community. This study found that an educated girl is more likely to have healthier children, participate in political processes, send her own children to school and is 50% less likely to become infected with HIV when compared to an uneducated girl. Care International concluded that the education of girls may be "the single highest return on investment in the developing world" (Burke, 2005) as female education consistently demonstrates a positive influence on national economies as educated women are more likely than men to spend discretionary resources on health, education and food, thereby positively contributing to the progress of the social conditions of her nation and moving forward in the achievement of the United Nations MDGs. However, unhealthy girls are unable to make the often hour long journey on foot to attend schools and so remain trapped in the cycle of poverty. Rural communities in sub-Saharan Africa rely heavily on clinics that, largely due to the

U.S. Mexico City Policy, lost funding and outreach capabilities, resulting in the restricted progress of nations in achieving not merely health related MDGs, but all eight of them.

By stagnating the developing world's progress in accomplishing the MDGs, the U.S. has compromised any progress towards the eradication of extreme poverty in sub-Saharan Africa and has further contributed to a process of circular and cumulative causation in these nation states.

Through suppressing the potential improvement of health standards in these developing nations, the U.S. has exercised a social development field test of Gunnar Myrdal's theory of circular and cumulative causation (Myrdal, 1957). Myrdal theorizes that one sector of a nation's economy or social strata affects all others, for example the earlier relation of health to education and can be perceived either optimistically with the faith that focused efforts in one sector will transform a nation's development overall or pessimistically with the knowledge that a downturn in one area, such as health, can lead to diminished economic growth by compromising the work force.

Transforming Myrdal's theory into a vicious cycle of poverty, the U.S. Mexico City Policy has condemned the people of sub-Saharan Africa to become sick because they are poor and to become poorer because they are sick (Dodd, 2006).

Specifically targeting foreign NGOs that provide abortion as a method of family planning, the Mexico City Policy had three basic restrictions. First, it withheld USAID family planning grants and technical assistance from foreign NGOS, including but not limited to private hospitals, clinics and research centers, which used U.S. or non-U.S. funding to perform abortions, actively promote abortions, or to conduct research to improve abortion methods. Second, the Mexico City Policy forbade these NGOs from lobbying, even with non-U.S. funding, for the decriminalization or liberalization of abortion or for conducting a public education campaign on abortion. Further, the U.S. policy prohibited health workers from referring women to an abortion provider or for

counseling women, even those with HIV/AIDS or those already seeking an abortion, on the procedure. Those agencies that refused to be limited by the Mexico City Policy restrictions were further unable to engage in partnerships with agencies that did receive USAID funding, including U.S. NGOs (Motluk, 2004).

If the U.S. was a minor donor, the repercussions of this policy on public health and development efforts might have been minimal. However, as the U.S. is the largest single donor to international population assistance, and contributes roughly 43% of all funds in this category (Cincotta, 2001), this hard-line abortion policy and its continued effects on public health have undermined international development efforts substantially. The International Planned Parenthood Federation, a leading provider of reproductive health care, contraceptive methods and sexual education, lost more than 20% of its funding (Motluk, 2004). Likewise, many reproductive health organizations in sub-Saharan Africa, such as the Family Guidance Association of Ethiopia, Marie Stopes Tanzania and the Family Planning Association of Kenya, refused Mexico City Policy restrictions and lost not only USAID funding, but also key U.S. NGO partnerships. Many of these partnerships were not intended to benefit family planning services, but to aid the struggle against HIV/AIDS and to improve maternal health.

A study by the center for Reproductive Rights found that Africa was the continent most affected by the Mexico City Policy (Medical News Today, 2009). These effects were particularly exacerbated by the already slow progress of sub-Saharan Africa in achieving the Millennium Development Goals (Indian Journal of Medical Sciences, 2004). Although the loss incurred by the organizations that refused the restrictions of the Mexico City Policy was immense, the reasons for this refusal reflect a loyalty to the communities of sub-Saharan Africa, not just a different social agenda. For many organizations, the refusal was based on the knowledge that for

many women and children in sub-Saharan Africa, family planning clinics are their sole contact with health care professionals and basic health services (Motluk, 2004). Further, 80% of sub-Saharan Africa's population lives in rural areas that would be without basic health services if not for the outreach programs of reproductive health clinics. These same clinics, which counsel, perform abortions and educate people about the procedure, also provide prenatal care, childhood immunizations, protection against malaria, contraception materials and education on and medication for HIV/AIDS. When the funding to these clinics was compromised by the Mexico City Policy, it wasn't abortion services, but these critical health services, that were being primarily affected; using U.S. funds to pay for abortion procedures overseas has been illegal since the Helms Amendment of 1973 (Klink, 2004). The Mexico City Policy was implemented not in the interests of internationally agreed upon development goals or in the interests of improving public health, but like other imposed policies that carry economic and social ramifications the Mexico City Policy was used by Reagan and Bush to push their ideological agenda onto developing nations, even if it meant playing politics with women's lives.

The Mexico City Policy, referred to as the Global Gag Rule by opponents, would be unconstitutional in the United States because of its severe restrictions on what health care clinics can say on the topic of abortion. Family planning organizations that rejected the restrictions of the Mexico City Policy were forced to close clinics, cut back services and increase fees in some of the poorest nations of the world. Many of these nations subsequently experienced a collapse of established health care referral networks as key family planning organizations struggled to cope with budget cuts and rapidly declining stocks of contraceptive supplies. The 1990 Blane-Friedman report, using data collected from six developing nations, warned that the policy was having negative effects on women's health issues because of the budgeting restrictions it

imposed on foreign NGOs (Cincorra, 2001). After the reinstatement of the Mexico City Policy by U.S. President George W. Bush in 2001, shipments of U.S. donated condoms and other contraceptive supplies ceased entirely to 16 developing nations, primarily in sub-Saharan Africa (Myths and Realities, 2003). Condoms are the most effective method used globally to stop the spread of HIV/AIDS among people who are sexually active, making this particular cutback unforgivable to the 22 million people in Africa who are living with this disease and their partners who risk infection (UNAIDS, 2008).

The effect of the Mexico City Policy on the availability of contraceptive supplies further creates results contrary to Reagan's purpose in creating the policy, which was to limit abortions. This intention, while ensuring continued support for the policy from a primarily politically conservative base, contradicts the real world effects of the Mexico City Policy. Multiple studies have shown that increased contraceptive usage is essential in reducing the number of unintended pregnancies and consequently helps to reduce the incidence of abortion overall (Population Action, 2005), including the incidence of unsafe, unhygienic abortions, and the incidence of high-risk childbirth. Simply put, contraceptives save women's lives. In Ethiopia, the rate of maternal death is exceedingly high and women are desperate for contraceptives. However, Mexico City Policy restrictions made many rural clinics ineligible to receive USAID contraceptives and supplies were exhausted in multiple clinics. One rural clinic ran out of Depo Provera, a long acting contraceptive used by 70% of its clients. In Lesotho, one in four women is infected with HIV/AIDS; before President Obama's repeal of the Mexico City Policy in 2009, 2000 was the last year that USAID had shipped family planning supplies, including condoms, to Lesotho (Cohen, 2003).

Given that HIV/AIDS in sub-Saharan Africa is transmitted primarily through sex, a crucial link exists between reproductive healthcare and HIV/AIDS preventative efforts. Family planning providers play a key role in HIV prevention, so by undermining the funding of these organizations, the U.S. sentenced the developing nations of sub-Saharan Africa, already crippled by HIV/AIDS, to feel the worst consequences of the Mexico City Policy. Even as the U.S. continued to publically express a strong commitment to address the HIV/AIDS crisis globally, the Mexico City Policy rendered these promises false. The verity of this statement can be seen in the case of Kenya. Here, Mary Stopes International (MSI) Kenya was forced to shut down two clinics in 2002, one of which was the only health facility in the Mathare Valley, an area of 300,000 people (Cohen, 2003). The Family Planning Association of Kenya (FPAK) was forced to shut down three clinics which together served nearly 19,000 clients in hard-to-reach areas of Kenya. These trials only showcase a fraction of the effects of the Mexico City Policy on development efforts in sub-Saharan Africa. Further repercussions were felt throughout this region, as will now be examined using as examples the nations of Zambia, Ethiopia, Tanzania and Ghana.

In Zambia, the Mexico City Policy contributed to increased numbers of unintended pregnancies and increased numbers of HIV/AIDS infections (Access Denied: Zambia, 2006). The Planned Parenthood Association of Zambia (PPAZ), the primary reproductive health provider in the nation, was the only health clinic in Zambia to specifically reach out to educate young people and provide them with reproductive health and HIV/AIDS preventative services. This organization refused the Mexico City Policy restrictions and, as a result of lost funding, lost nearly 40% of its staff, scaled back services and was forced to end vital community-based distribution programs that provided health information and condoms to hard-to-reach areas of

Zambia (Fillinger, 2007). This system of distribution gave away roughly 2.8 million condoms at its peak in 1998. The loss of funding closed these booths and rendered PPAZ unable to meet the growing demand of reproductive health services in Zambia, which has proved to be the most enduring impact of the Mexico City Policy in Zambia as this infrastructure is not easily rebuilt.

In Ethiopia, family planning services were scaled back and contraceptive supplies were severely diminished because of the Mexico City Policy (Access Denied: Ethiopia, 2001). Further, as was seen in Zambia, innovative community-based distribution projects, which have proved to be essential to HIV/AIDS prevention efforts around the world, were compromised. The already limited access of women to adequate health care services in Ethiopia has resulted in high fertility rates, rampant numbers of unsafe abortions, and an incredibly high maternal death rate of 1,800 deaths per 100,000 live births. Based on this and other reproductive health indicators, Ethiopia ranks highest in the world in reproductive health risk. Given these challenges faced by women in Ethiopia, and the estimate that 25% of these maternal deaths could be prevented by family planning services (Klink, 2004), the two leading reproductive health care providers in the nation (Mary Stopes International (MSI) Ethiopia and the Family Guidance Association of Ethiopia) refused to accept Mexico City Policy restrictions. MSI Ethiopia was able to keep all but one of its facilities, but did have to downsize distribution operations and lay off employees in order to cope with financial restrictions. However, FGAE paid much more dearly for its choice and lost nearly 25% of its operating budget as well as all access to USAID contraceptives and technical assistance. Further, the Mexico City Policy hampered the capacity of FGAE and MSI Ethiopia to provide comprehensive HIV services, including testing, medication and condoms, just as the infection rate was peaking. Overall, health care services were curtailed by the Mexico City

Policy as it crippled an already destitute reproductive health and HIV preventative network in Ethiopia.

In Tanzania, Mexico City Policy restrictions jeopardized the future of family planning as critical technical support was cut short just before family planning services could be integrated into government facilities (Access Denied: Tanzania, 2005). Two local organizations, Chama Cha Uzazi na Malezi Bora Tanzania (UMATI) and Mary Stopes Tanzania (MST) have been the primary reproductive health care providers in Tanzania since the 1990s. MST lost nearly 65%, about \$170,000, of its annual budget when it refused to accept Mexico City Policy restrictions and had to close three clinics which were located in critical, hard-to-reach spots where poor infrastructure has made it difficult for women in these areas to receive any kind of care. The loss of USAID funding forced UMATI to lose 13% of its staff, which destabilized the entire program. Both of these organizations were responsible for estimating contraception needs, and without the capacity to create these estimates, the supply system has lagged behind. Further, the insecurity triggered by the Mexico City Policy has compromised potential partnerships between family planning providers and HIV/AIDS organizations.

In Ghana, The Planned Parenthood Association of Ghana (PPAG), the major family planning organization of the nation, was forced to cut back essential outreach programs and clinic services substantially, resulting in the deterioration of crucial partnerships and important HIV/AIDS initiatives (Access Denied: Ghana, 2005). PPAG lost \$200,000 in USAID funding, and an additional 1,700 community-based agents were denied the financial support needed to provide family planning services to rural areas of Tanzania. Three clinics serving rural communities lost funding and were forced to reduce their nursing staff by over 40% in order to remain open, even though it meant limiting the number of clients they are able to serve. Mexico City Policy

restrictions prematurely ended the Community-Based Services (CBS) project which, prior to the Mexico City Policy, was an adolescent reproductive health program and the largest program directed by PPAG. PPAG also served as an essential partner for a number of smaller reproductive health organizations in Ghana; the effects felt by all of these organizations led to over 1,327 communities in Ghana being directly affected by the Mexico City Policy. PPAG dismissed 67 staff members, reorganized 40% of its remaining staff and saw as early as 2004 a 40% reduction in the use of family planning services since the previous year. Further, post-abortion care services were made unavailable. Since 30% of all maternal deaths are a result of unsafe abortion complications, this has proved detrimental to Millennium Development Goal #5: improve maternal health. HIV/AIDS efforts were crippled in Ghana and while former U.S. President George W. Bush was reaffirming our commitment to address the HIV/AIDS crisis, the U.S. Mexico City Policy cut all access to HIV/AIDS preventative services to over 700,000 Ghanaians (Germain, 2004).

The MDGs aimed at reducing child mortality, improving maternal health and combating HIV/AIDS are the goals whose progress was most directly impeded by the Mexico City Policy. However, as stated by UN Secretary-General Kofi Annan in 2002, all of “the Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be addressed if questions of population and reproductive health are not squarely addressed” (Burke, 2005). While these questions are not easily answered, they cannot be summarily dismissed because of the pivotal role they play in women’s health, empowerment and the development of sub-Saharan African nations. When a poor woman becomes ill, much is at stake as her entire family will often become trapped in a Myrdal-described downward spiral of lost income and high health-care costs. Without sufficient attention to women’s health, especially reproductive

health, economic and social progress is sure to stagnate. In effect, maternal mortality will not be reduced, HIV/AIDS will continue to proliferate, women will not achieve equality, the Millennium Development Goals will fail and global poverty will never be eliminated; these are the risks we face in evading issues of reproductive health rights and family planning services.

Reproductive health rights are supported by several internationally recognized human rights because the initiative encompasses not only the right to reproductive health care, but the right to reproductive self-determination. Both of these rights were impeded by the Mexico City Policy restrictions on family planning services. Improved accessibility of effective family planning methods allows people to obtain a higher standard of health and living. A couple with access to contraceptives and other family planning methods is able to limit their family size according to their child support capabilities, allowing them the ability to lessen their likelihood of poverty and hunger while increasing the opportunities for education and employment for both themselves and the number of children they choose to bear.

The World Health Organization estimates that there are some 20 million unsafe abortions performed each year, resulting in the deaths of over 70,000 women annually, primarily in sub-Saharan Africa, due to complications from the procedure (Cincotta, 2001). A review of four major hospitals in Uganda estimates that 5,000 women and girls are admitted to the hospitals for incomplete abortions every year, making unsafe abortions the cause of one-third of all maternal deaths (Klink, 2004). The Mexico City Policy silenced the women of Uganda from speaking up for their bodies and their basic right to survival, ultimately intertwining women's health with women's rights. Each year, more than half a million women die from pregnancy and childbirth complications. Meanwhile, 60% of the HIV/AIDS population in sub-Saharan Africa is female (UNAIDS, 2008). In Kenya, there are 45 HIV/AIDS infected women for every ten men with the

disease (Motluk, 2004). Despite this disproportionate suffering, women work two-thirds of the world's working hours and produce half of the global food supply (Heyzer, 2005). Eliminating the health challenges faced by these women by supporting the clinics that cater to their basic health care needs will empower and enable women to become more involved in and integrated into their local communities, which has the potential to result in a turning point in recently stalled development trends.

It is a crucial recognition that is being made by international financial institutions, policy makers, NGOs and microloan agencies that women's equality and rights, including reproductive rights, are key in achieving the economic and social priorities of the Millennium Development Goals as well as any future development efforts in sub-Saharan Africa and throughout the world (Heyzer, 2005). Unfortunately, the progress of the MDGs, despite their unprecedented global consensus and commitment, has been slow. However, with the repeal of the Mexico City Policy, progress towards the achievement of these goals may depend on the commitment of women, a commitment whose strength stems from the depth of a community's investment in females. The value of this investment has been argued by well respected economists; Nobel-prize winning economist Amartya Sen has argued that nothing is more important for development today than the economic, political and social participation of women. Similarly, Lawrence Summers, former Chief Economist of the World Bank, concluded that girls' education may be the investment that yields the highest return in the developing world (Coleman, 2004); empowering women by giving them access to contraceptives and family planning opens the door to these school houses. By allowing women to control when and how often they bear children, the global community can contribute directly to the achievement of four millennium development goals, and as the goals are mutually self-sustaining, it can contribute indirectly to the achievement of the other four

goals. However, when the U.S. impeded the reproductive rights of women in sub-Saharan Africa, it stalled and often reversed progress in achieving each of the MDGs.

Educating women has proved to yield higher returns than educating men. Empowering women through education leads to lower child mortality rates, healthier newborns, improved child nutrition and it does more to ensure that the women's children will be educated (Coleman, 2004). Those educated girls will then have lower birth rates, improving per-capita income in developing nations. To further improve national economies, female education has been proven to boost agricultural productivity more effectively than increased access to land or fertilizer usage. In the last half century, the regions that have most successfully closed gender gaps have also achieved the most progress socially and economically (Coleman, 2004).

Empowering and educating women further enhances the performance of a nation's economic sector by attracting foreign direct investment. It is becoming increasingly common for microloan agencies to extend loans primarily to women, a trend that has very recently developed into a powerful tool for development. Based on the idea that "millions of small people with their millions of small pursuits could add up to the biggest development wonder," Mohammed Yunus founded the Grameen Bank and popularized microfinance lending. His institution started the trend of catering to women in order to improve women's access to family monetary resources and because women pay back their loans more consistently than men. Women now account for 80% of the world's 70 million micro borrowers (Coleman, 2004), who in 2007 borrowed \$17 billion (Swibel, 2008), a sizeable contribution to sub-Saharan African developing nations and a powerful stimulus toward the achievement of the MDGs for the eradication of extreme poverty.

By constraining women's access to vital family planning, reproductive health and HIV/AIDS preventative services, the Mexico City Policy became a barrier to improvements in overall public health in sub-Saharan Africa. In limiting these vital health services, the Mexico City Policy hurt long standing efforts to promote women's security and achieve the Millennium Development Goals. President Obama's repeal of the Mexico City Policy in January 2009 was publicized as the end of a long struggle, conducted primarily by U.S. and foreign NGOs, to ensure for women their reproductive rights; but this step, although momentous, is just the beginning. The Mexico City Policy, though no longer in effect, tore down reproductive and HIV/AIDS preventative healthcare infrastructure in sub-Saharan Africa that will take an incalculable amount of time to rebuild. By denying women the means to make their own health care decisions, the Mexico City Policy also contributed to perpetuating the unequal status of women in developing nations, confining a force which is critical in the battle to eliminate extreme poverty. The Mexico City Policy broke down key initiatives that were working to improve the living conditions of this and the next generation. Efforts to undo the damage inflicted by the U.S. onto sub-Saharan Africa through this policy have only just begun, even as the MDG end date draws near.

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