THE MEXICO CITY POLICY/GLOBAL GAG RULE: ITS IMPACT ON FAMILY PLANNING AND REPRODUCTIVE HEALTH

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THE MEXICO CITY POLICY/GLOBAL GAG RULE: ITS IMPACT ON FAMILY PLANNING AND REPRODUCTIVE HEALTH

WEDNESDAY, OCTOBER 31, 2007

HOUSE OF REPRESENTATIVES,
COMMITTEE ON FOREIGN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10:02 a.m. in room 2172, Rayburn House Office Building, Hon. Thomas Lantos (chairman of the committee) presiding.

Chairman LANTOS. The committee will come to order.

Around the globe millions of women are fighting for their reproductive rights. They are fighting for the right to control how many children they bring into the world. They are fighting for the right to have ready access to contraceptives, and they are fighting for the right to obtain a safe and legal abortion.

In this battle, women are supported by the world's leading nongovernmental organizations specializing in reproductive health care, but the United States refuses to work with these world health leaders, thanks to the mindless Global Gag Rule first instituted by President Reagan, and reimposed after the Clinton years by our current President. This policy places restrictions on health care workers overseas that they would never have to face if they were based in the United States.

If these overseas groups spend even a dime of their own money advocating for changes in their own nation's abortion laws, they are ineligible to receive family planning funds from our own country. They can't spend their own money to do what they think is right for women without losing U.S. support.

These same hard working NGOs are not just sidelined in the policy debate, they cannot even counsel women about abortion. If a pregnant woman shows up at a family planning clinic in South Africa, the doctor cannot even tell her that abortion is an option without jeopardizing the clinic's financial support.

Without that support, many of these facilities would have to close their doors forever, depriving women of essential health care services, including screenings for HIV and cervical cancer, and especially the provision of contraceptives for the prevention of unwanted pregnancies and abortion. By gagging the world's most effective reproductive health care organizations, the President is hoping to reduce the rate of abortion, but that is not happening. The Global Gag Rule is just making abortion more unsafe.

Earlier this month the *Lancet*, the highly-respected British medical journal, published a major study of worldwide abortion rates conducted jointly by the U.N.'s World Health Organization and New York's Guttmacher Institute. The results of the study are as eye-opening as a jolt of caffeine in the morning.

The study found that in countries in which abortion is legal and countries in which it is illegal, abortion rates are pretty much the same, but there is a shocking difference. Where abortion is legal, it is provided in a safe manner. Where it is illegal, abortion is often performed under unsafe conditions by poorly trained providers.

In fact, an estimated 20 million unsafe abortions are performed every year, almost all of them in countries where abortion is illegal under most circumstances. An estimated 67,000 women die each year as a result of complications from these unsafe procedures. Let me repeat that. Sixty-seven thousand women dead from unsafe abortions each year, often leaving many children behind.

Given these staggering statistics, the United States should be actively supporting NGOs which are fighting to get rid of unjust laws banning or severely limiting abortion, not shunning them. We should be working with organizations like the Family Planning Association of Kenya, the Family Guidance Association of Ethiopia, the Planned Parenthood Association of Ghana, and the International Planned Parenthood Federation. All of these organizations have been barred from getting U.S. family planning funds.

If banning abortion doesn't lower the abortion rate, what does? The answer is clear—ready access to contraception.

In Eastern Europe, a place I know a little bit about, where the availability of effective contraception has greatly expanded since the fall of the Communist regimes, the abortion rate has dropped by more than 50 percent, but because of the punitive provisions of the Global Gag Rule, since 2001 the United States has stopped shipping contraceptives to 20 developing countries in Africa, Asia, and the Middle East, and many leading NGO family planning providers in other countries have stopped receiving contraceptives. While the Global Gag Rule is being promoted as anti-abortion, it remains at its core anti-family planning.

These are important issues and they demand from us a constructive response. My good friend from New York, the distinguished chairwoman of the House Foreign Operations Appropriations Subcommittee, Nita Lowey had done just that. I strongly endorse the contraceptives language in her bill that begins to unravel the Global Gag Rule and I hope that by the end of the legislative process it will become completely repealed.

The Global Gag Rule is bad policy, and it is doing enormous harm to women around the globe. The sooner we change it the better for everyone concerned.

I now turn to my friend, the distinguished ranking member of our committee, my colleague from Florida, Congresswoman Ileana Ros-Lehtinen, for any comments she may wish to make.

Ms. ROS-LEHTINEN. Thank you so much, Mr. Chairman, my friend. Welcome to our wonderful panelists today, and today as you said, Mr. Chairman, we will be discussing the Mexico City Policy which prohibits the provision of United States tax dollars to foreign

non-governmental organizations (NGOs) that promote or perform abortions as a method of family planning.

Unfortunately, we will not hear from the very body that bears primary responsibility for implementing this policy, the United States Agency for International Development (USAID) and this is a glaring omission. The fact that USAID has not been given the opportunity to respond to concerns that will be raised today limits this committee's oversight of the Mexico City Policy. And so without the administration present to dispel the myths associated with the Mexico City Policy, I will seek to address just a few of them now.

First, it has been asserted that Mexico City has led to cuts in both funding for and delivery of vital family planning services, and therefore has led to an increase in the number of abortions in developing countries. This is untrue.

U.S. funding for family planning abroad has not been cut. Actually, funding has increased steadily. Funds which were denied to groups that promote abortion as a means of family planning have been diverted to other implementers, which have proven both willing and able to deliver quality family planning services.

Further, demographic health surveys reveal that contraceptive prevalence has increased while fertility rates have decreased since the year 2001. A recent study published in *Lancet* by the World Health Organization and International Planned Parenthood's research affiliate confirms that abortion rates declined significantly between 1995, when Mexico City was not in effect, and 2003, 2 years after Mexico City was reinstated.

So while it is true that a few influential groups such as International Planned Parenthood and its affiliates have lost funding, U.S. funds for family planning have not been cut. Critical services have not been lost, and abortion rates have not increased.

A second popular myth is that the Mexico City Policy endangers the lives of women because it provides no exceptions and ultimately forces women to seek unsafe abortions. This also is not true. Mexico City does not apply to abortions or abortion referrals in cases of rape, incest or to protect the life of the mother.

Further, it does not block what is called "passive referrals," or the provision of information to a woman in response to direct questions if that woman is determined to have an abortion.

Finally, it allows organizations to provide compassionate care to women who require post-abortion services. It bears mentioning that abortion is illegal in many of these countries where the complaints by abortion advocates have been the loudest. I find it interesting that these groups attribute the performance of unsafe abortion with the Mexico City Policy rather than with their own efforts to perform and promote abortions, which are illegal and inherently unsafe in those countries. This is a confusing paradox indeed.

And an third myth increasingly advanced by abortion advocates is that Mexico City infringes upon the democratic rights of foreign NGOs to participate in the political process. A recent paper published by IPAS even asserts that the policy is only imposed upon foreign NGOs because they are not protected by the concept of freedom of speech engendered in our U.S. Constitution. This is perhaps the most absurd argument of all.

Money is fungible. To fund an organization engaged in lobbying efforts to legalize abortion, even when that organization uses private resources to do so, effectively subsidizes that lobbying effort. Mexico City does not prevent individuals from lobbying their government. It simply prevents groups from redirecting funds to pay for that effort.

It is important to note that current U.S. domestic policy prohibits funding for programs that support abortion as a method of family planning. Such a position is widely supported by a majority of Americans.

The Mexico City Policy, therefore, applies the same standard for domestic funding to global family planning assistance, and therefore reinforces the belief that the central goal of family planning programs should be to reduce abortions. To eliminate this policy would devalue the importance of other preventative methods of family planning, if not replace them with abortion.

At its core the Mexico City Policy represents an effort to protect basic human rights of each and every member of society, including women and children.

As a pro-life woman and a human rights advocate, I urge members to seriously consider the ramifications of any policy change which would compromise our ability to protect and promote respect for innocent human life and human rights worldwide. I look forward to hearing from our witnesses today, and thank you as always, Mr. Chairman

Chairman LANTOS. I thank my friend from Florida.

There is no Member of Congress with whom I have worked more intensely and more collegially on human rights than my friend from New Jersey, Congressman Chris Smith. On this issue we disagree, but I am delight to call on him to present his position.

Mr. SMITH OF NEW JERSEY. Mr. Chairman, thank you, and the respect is certainly mutual. For 27 years we have worked together as well as with Ileana Ros-Lehtinen, and I thank you for that kind introduction.

Mr. Chairman, let me say at the outset that some day future generations of Americans will look back on us and wonder how and why such a rich and seemingly enlightened society so blessed and endowed with the capacity to protect and enhance vulnerable human life could have instead so aggressively promoted death to children by abortion both here and overseas.

They will note that we prided ourselves on our commitment to human rights while precluding virtually all protections to the most persecuted minority in the world today, unborn children. Human life begins at conception. Every second thereafter is simply a stage of development. By 22 days after fertilization the heart is beating, as you can see on this ultrasound of a 10-week unborn child who is moving and kicking and catapulting in the womb. This is what life is before birth, very robust. The child wakes and sleeps, swallows the embryonic fluid. If you sweeten the embryonic fluid, he or she will swallow even more of it because of the sweetness.

By week 5, tiny hands and feet begin to develop. By week 7, the baby is already kicking and swimming in the womb. We know that second trimester babies have the capacity to feel pain, and last year more than 250 members of the House voted for legislation

that I sponsored called the Unborn Child Pain Awareness Act, to inform women that a child feels pain before birth.

Future generations will indeed wonder why we didn't get it. Unborn babies, even if they are unwanted, have dignity, inherent value and infinite worth, and because they are so vulnerable, governments must protect their human rights. They will wonder why it took so long for Congress, the President and the courts here in America to stop just one hideous and painful method of death, partial birth abortions. They will wonder how by dismembering a child with sharp knives, pulverizing a child with powerful suction devices or chemically poisoning a baby with any number of toxic chemicals failed to elicit as much as a scintilla of empathy, mercy or compassion for these tiny victims.

Abortion, Mr. Chairman, is violence against children. It is extreme child abuse. It is cruelty to children. Abortion treats pregnancy as a sexually transmitted disease, a parasite, a piece of junk to be destroyed, and the whole notion of wantedness and unwantedness turns a child into an objection. Feminists had it right; no human being can be construed to be an object.

I respectfully submit that the term "unsafe abortion" is the ultimate oxymoron. All induced abortion, whether it be legal or illegal, is unsafe for the baby. It is also unsafe for the mother who is at risk not only of physical injury but also of long-term psychological damage, including severe depression. All abortion is unsafe and a violation of fundamental human rights.

Now, as in previous years, some Members of Congress want to export the violence of abortion to Africa, Latin America, parts of Asia and Europe by reversing the Pro-Life Mexico City Policy, and by providing hundreds of millions of dollars to organizations that are obsessed with abortion, so obsessed that they insist on promoting and performing it as a method of family planning rather than accepting United States donations, and let us not forget this is grant money. We have an obligation to put human rights safeguards around it.

Mr. Chairman, today scores of countries throughout the world are literally under seize in a well-coordinated, exceedingly well-funded campaign to overturn the laws and policies of sovereign nations that protect women and children from the violence of abortion on demand, putting women and children at risk, and now they want us, the American taxpayer, to facilitate, enable and legitimize their deadly activities.

Finally, as humanitarians and as policymakers, the challenge we must meet is to always and at all times affirm, care for and tangibly assist both mother and unborn child. We must increase our access to maternal and prenatal care, and access to safe blood.

You will recall, Mr. Chairman, last year I held a hearing here in this room, and we heard from the World Health Organization who said that maternal mortality could be greatly mitigated with access to safe blood, and we have to provide for better nutrition.

No other country, I would also point out, donates more funds for family planning than the United States. We must expand essential obstetrical services, including skilled birth attendants, and improve transportation capabilities for emergency care to significantly reduce maternal mortality and morbidity, including obstetric fistula.

Expanding these measures will reduce deaths and injury to both mothers and children. No one is expendable. No one's life is cheap. I would respectfully submit that the way forward, the humane way forward, is to devise and implement policies that respect, protect and assist both women and their babies from all threats, including abortion.

I thank you, Mr. Chairman

Chairman LANTOS. Thank you very much, Mr. Smith.

Are there any other colleagues interested in making a brief opening statement?

Mr. Chabot.

Mr. CHABOT. Thank you, Mr. Chairman. I will be very brief. I just want to associate myself with the remarks of the gentlewoman from Florida and the gentleman from New Jersey who have been leaders in the movement to protect innocent unborn children for many years now, and as the principal proponent of the Partial Birth Abortion Act, I have been involved in this for many, many years, and I have looked up to them for their leadership, and also the gentlelady from Colorado, Mrs. Musgrave, who has also been a leader since she got here to Congress and prior to that as well, but I couldn't have stated it any better or more clearly or more articulately than the two folks that we just heard from up here, and there is no excuse.

It is bad enough the number of abortions that occur in this country year after year after year, and I think since *Roe* v. *Wade*, the number is about 50 million or so now. It is incredible. My birthday happens to be the day that *Roe* v. *Wade* came out, so it is something that hits me every year, my birthday, how many children have died because of that decision, but to use tax dollars to spread that around the world is just unconscionable to me. So I want to thank those that have once again led the debate in this area.

Thank you, Mr. Chairman, for holding the hearing. Even though we disagree on the issue, I want to thank you for holding the hearing.

Chairman LANTOS. Thank you very much.

Mr. Fortenberry.

Mr. FORTENBERRY. Thank you as well, Mr. Chairman, for convening this important hearing on the Mexico City Policy which I believe goes to the heart of the integrity of our foreign assistance programs.

The issue of abortion is one of the most pressing issues today. Abortion has caused a deep wound in the soul of our country and much of the pain has only come to light in recent years. Wherever it takes place, I believe, abortion is so often a decision that is brought about by emotional and physical abandonment.

I do look forward today, Mr. Chairman, to hearing the perspectives of our distinguished witnesses on this very sobering topic. It truly is my hope that one day soon we can all come to agree that women everywhere in the world deserve better than abortion. People around the world look to the United States for justice, hope, and compassion, and I believe we must be very careful as to what we export. The West should be highly sensitive to imposing its cultural norms onto other people in other places that perhaps do not share those norms.

Thank you, Mr. Chairman.

Chairman LANTOS. Thank you very much.

Ambassador Watson.

Ms. WATSON. Thank you, Mr. Chairman.

Reproductive health is one of the greatest public health issues facing women in poor countries. A woman's ability to maintain reproductive health, which is often tied to her ability to monitor and regulate her pregnancies, is key in many cases to regulating and monitoring her overall health and longevity.

As a Democratic staff brief notes, far too many poor women around the world unplanned childbirth is a life-threatening event. More than 529,000 women die from complications of pregnancy and childbirth every year. Ninety-nine percent of maternal deaths occur in the developing world. Pregnancy is the leading cause of death for girls ages 15 to 19 in developing countries. It is estimated that more than 100 million married women in developing countries have and unmet need for contraception. The official justification for the administration's gag rule, which denies U.S. funds to foreign nongovernmental organizations that perform or promote abortion as a method of family planning, even if the activities are undertaken with non-U.S. funds is that its imposition will reduce the number of abortions when in fact our current policies cause more unplanned pregnancies, unsafe abortions, and death of women and girls.

What is perhaps least understandable about the administration's present policy is its restricting the dissemination of contraceptives to leading indigenous family planning providers. These organizations have the most extensive supply networks, particularly to rural areas. Local family planning providers that decline the terms of the Global Gag Rule have been denied all U.S. family planning assistance.

What is very troubling to me is that the majority of HIV infections are transmitted during pregnancy, childbirth or breast feeding. HIV/AIDS rates, as we all know, continue to explode in poor countries, particularly in Africa and more specifically, the southern region of Africa.

So my question is does the administration's Global Gag Rule help or hinder the President's emergency plan for aid relief, and how does this policy fit into the administration's overall strategy in combatting HIV/AIDS around the world?

I look forward to hearing from our witnesses, and thank you, Mr. Chairman.

Chairman LANTOS. Thank you very much.

I now recognize my predawn swimming partner, the gentleman from South Carolina, Mr. Inglis.

Mr. INGLIS. Thank you, Mr. Chairman. Thank you for holding the hearing, and we look forward to hearing from our other swimming, predawn swimming partner here, Ms. Lowey.

I had a conversation a couple of years ago with a friend—somewhat supporter, not supporter. I said, "I know you have had trouble with my pro-life position." She said, "I am not as pro-choice as I used to be." And I said, "Really, what happened?" She said, "Ultrasound. The pictures show a baby."

I think that is what a lot people in the United States are coming to. They see the pictures and they have changed their mind.

I see that my friend, Ms. Lowey, is going to tell us what Ambassador Watson told us, that this gag rule, as they call it, forces our foreign partners to relinquish their free speech rights. I don't think so. I think what it just does is it says we are not going to pay them to speak about abortion. We are not going to pay them to advocate for abortion.

Now, I would acknowledge that we have an inconsistent policy. Here in the United States we do the opposite. We fund Planned Parenthood, which then goes out and uses fungible money to advance abortion services, and it seems to me that a logical and consistent application of the policy would be to apply the Mexico City Policy domestically, and that would make us very consistent so that we are not using taxpayers' dollars to do what many taxpayers find morally reprehensible.

So I think it is great that we are having the hearing. I hope that we get consistent and apply the Mexico City Policy domestically, and I thank the chairman for holding the hearing.

Chairman LANTOS. Thank you very much.

My good friend from Illinois, Mr. Manzullo.

Mr. MANZULLO. Thank you, Mr. Chairman.

I don't know of any topic as difficult to discuss as one involving abortion. My wife and I, 25 years ago when we were engaged, set up the Rockford, Illinois, Crisis Pregnancy Center that spawned centers in Freeport, Illinois, and in De Kalb, Illinois, and the purpose of those centers is to counsel women on making the choice, and if a woman decides to undergo an abortion, the crisis pregnancy centers are open for post-abortion counseling. Obviously the purpose of the centers is to encourage women to carry full term, and a lot of those decisions have been made because of the use of the ultrasound when women make up their own mind unfettered by propaganda and simply examine what is scientifically there.

So this issue has been very close to our hearts, but it is one in which we have been proactive because you can't just say you are opposed to abortion and then do nothing to help out the women that have to make this very difficult decision.

The Mexico City Policy in no way reduces by a single penny the $441 million that is provided for international family planning. In fact, the latest USAID data shows a dramatic increase in family planning dollars going to the countries that need it the most, such as Ethiopia, Uganda and Pakistan. There is absolutely no evidence to suggest that USAID has failed to spend the funds appropriate for family planning. By its definition and its mission, it is clear that the Mexico City Policy is not anti-family planning, it is anti-abortion. A policy against promoting abortion is only anti-family planning if one assumes that abortion itself is the method of family planning. We should draw a clear line that should represent the United States abroad, the Mexico City Policy ensures that the taxpayers' money is spent on newborn care programs and contraceptive education rather than the destruction of the life of a child.

I want to thank you, Mr. Chairman. You are always open for hearings on different topics. This again exemplifies your leadership on this committee, and I thank you very much.

Chairman LANTOS. I thank my friend.

My understanding is that all colleagues who wanted to speak at the outset have spoken, so I now turn to our first panel. We have two distinguished friends and colleagues, and it is my pleasure to introduce them.

Our first witness today is Congresswoman Nita Lowey who has earned for herself a well deserved reputation in Congress and in the nation at large as one of the great champions of women's rights. With boundless energy and keen intelligence, Nita Lowey, who was first elected to Congress in 1988, represents the 18th District of New York. Consistently she is on Congressional Quarterly's list of the most effective members of this body, and she is also on mine.

As chair of the State and Foreign Operations Subcommittee of the Appropriations Committee, Nita is taking steps that will begin to reverse the gag rule policy. For that effort, she has my strong and enthusiastic support.

Congresswoman Lowey is a former chair of the Congressional Women's Caucus and the House Pro-Choice Caucus. She is a graduate of Mount Holyoke College who before her election to Congress served as Assistant Secretary of State for the State of New York.

My friend from Colorado, Congresswoman Marilyn Musgrave, represents the 4th District of Colorado. She was first selected to the House in 2002. In her first term, she was identified by *National Journal* as one of the two freshmen members to watch, and I have been watching her ever since.

Congresswoman Musgrave is a member of the Republication Steering Committee and serves as policy chair for the Western Caucus. She serves on the Agriculture and Small Business Committees. She is a graduate of Colorado State University, and before her election was a teacher.

We are delighted to have both of you. Ms. Lowey, the floor is yours.

STATEMENT OF THE HONORABLE NITA LOWEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Ms. LOWEY. Well, I want to thank my dear friend, Chairman Lantos. I think we will have to appear before this committee more often. We don't usually get such an extensive, kind, generous——

Chairman LANTOS. We would be happy to have you here anytime.

Ms. LOWEY. So I thank you, and I thank my good friend, Ranking Member Ros-Lehtinen, and all my colleagues who are here today. I really do appreciate the opportunity to testify on the Global Gag Rule, and its tragic impact on poor women around the world.

The Global Gag Rule, which applies only to foreign non-governmental organization which have been referenced, although Mr. Inglis and I might take different positions as to where it should change, in my judgment has no place in our foreign policy. One of the goals of our foreign policy is spreading democracy which, to me, is completely inconsistent with what we are doing with the Global Gag Rule, applying it only to foreign NGOs. It forces our foreign partners to relinquish their right to free speech, a foundation of

four democratic governments, in order to participate in U.S.-supported family planning programs.

We must stop exporting this policy not only because it would be unconstitutional in the United States, but because it threatens the health of millions of vulnerable families worldwide.

Since its first enactment, as has been noted under the Reagan administration, the gag rule has starved reproductive health programs for resources in Ethiopia, Tanzania, Ghana, and the list goes on. Because many international health care providers refuse to give up their rights to counsel the world's poorest women on all of their legal health care options, many in the poorest, more remote regions of the globe lack reproductive health that can saves their lives, save the lives of their children and help prevent unwanted pregnancies and abortions.

There is no question the Global Gag Rule has magnified the tremendous need for contraceptives in the developing world. United States shipments of contraceptives have ceased to 20 developing nations in Africa, Asia, and the Middle East. In some areas the largest distribution centers for contraceptives have experienced decreased access for over 50 percent of the women they serve, and by filling the unmet need for contraceptives we can prevent 52 million unwanted pregnancies, 29 million abortions, 142,000 pregnancy-related deaths, and 505,000 children from losing their mothers every year. Playing politics with innocent lives is simply unacceptable.

The research proves one point: The way to prevent unintended pregnancies and abortion is to give women access to contraceptives. A study released this month by the World Health Organization and the Guttmacher Institute indicates abortion rates are higher in countries where contraceptives are not readily available even when abortion is illegal. I want to repeat that. In countries where contraceptives are not readily available, even when abortion is legal, the abortion rates are higher. Did I say when contraceptives are not readily available?

In fact, the world's lowest rate of abortion by far is found in countries were abortion is legal and contraceptive use is widespread.

Most significantly, the study found that abortion was not less prevalent in countries were it was illegal. It was only more dangerous. It is clear that withholding contraception does not reduce abortion. Yet many of our colleagues continue to oppose repeal of the Global Gag Rule, and as the chairman of the State and Foreign Operations Appropriations Subcommittee, I can assure the committee that ample protections, there are 15 provisions in the State and Foreign Operations Appropriations bill alone, 15 provisions, I have kept everyone of them in the bill. They are in place to ensure that none of our foreign assistance is used to provide abortion services, 15 provisions that various Members of Congress have placed in that bill still remain, not a dime, not a dime goes to provide abortion services.

It is clear that the Mexico City Policy is in fact thwarting our efforts to prevent unintended pregnancies, abortions, and the spread of HIV/AIDS. We must allow the provision of contraceptives to organizations that are most equipped to distribute them. That is the purpose of a provision that I have placed in the fiscal year 2008

State and Foreign Operations bill, to provide foreign NGOs with U.S. Government-donated contraceptives, not direct funding. Send the contraceptives, not the funding.

Yet the administration has threatened to veto this bill with the support of many in Congress instead of backing this common sense measure to help reduce unintended pregnancies and abortions.

The Global Gag Rule is unconstitutional, immoral, unsubstantiated, and dangerous. I urge your co-sponsorship of the Global Democracy Promotion Act which I authored to repeal this terrible policy. Until it is passed, I hope we can all agree that we must provide contraceptives to the world's poorest men and women through the fiscal year 2008 State and Foreign Operations Appropriations bill.

I do want to respond to my good friend from New Jersey, I would be delighted to join you to expand the money that we are investing in safe blood, maternal child care, obstetric fistula, and all the other good things you do. This is a priority of mine. I would also like to say as a mother of three and a grandmother of eight, I consider myself pro-life. I do respect life. We disagree on this critical issue and I believe so fervently that the way to respect life, that the way to prevent unintended pregnancies, that the way to prevent abortions is to provide contraceptives.

I thank you, Mr. Chairman, for your testimony.

[The prepared statement of Ms. Lowey follows:]

PREPARED STATEMENT OF THE HONORABLE NITA LOWEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Chairman Lantos, Ranking Member Ros-Lehtinen, my fellow colleagues, thank you for permitting me to testify today on the global gag rule and its tragic impact on poor women around the world.

The global gag rule, which applies only to foreign NGOs, has no place in our foreign policy for which one of the goals is spreading democracy. It forces our foreign partners to relinquish their right to free speech, a foundation of our democratic government, in order to participate in U.S. supported family planning programs. We must stop exporting this policy not only because it would be unconstitutional in the United States, but because it threatens the health of millions of vulnerable families worldwide.

Since its first enactment under the Reagan administration, the gag rule has starved reproductive health programs for resources in Ethiopia, Tanzania, Ghana, and the list goes on. Because many international health care providers refuse to give up their rights to counsel the world's poorest women on all of their legal health care options, many in the poorest, more remote regions of the globe lack reproductive health care that can save their lives, save the lives of their children, and help prevent unwanted pregnancies and abortions.

There is no question the global gag rule has magnified the tremendous need for contraceptives in the developing world. U.S. shipments of contraceptives have ceased to 20 developing nations in Africa, Asia, and the Middle East. In some areas, the largest distribution centers for contraceptives have experienced decreased access for over 50% of the women they serve.

By filling the unmet need for contraceptives, we can prevent 52 million unwanted pregnancies, 29 million abortions, 142,000 pregnancy-related deaths and 505,000 children from losing their mothers every year. Playing politics with innocent lives is simply unacceptable. The research all proves one point—the way to prevent unintended pregnancies and abortion is to give women access to contraception.

A study released this month by the World Health Organization and the Guttmacher Institute indicates abortion rates are higher in countries where contraceptives are not readily available, even when abortion is illegal. In fact, the world's lowest rates of abortion by far are found in countries where abortion is legal and contraceptive use is widespread. Most significantly, the study found that abortion was not less prevalent in countries where it was illegal; it was only more dangerous. It is clear that withholding contraception does not reduce abortion.

Yet many of our colleagues continue to oppose repeal of the global gag rule. As the Chairwoman of the State and Foreign Operations Appropriations Subcommittee, I can assure the Committee that ample protections—including 15 provisions in the State and Foreign Operations Appropriations bill alone—are in place to ensure that none of our foreign assistance is used to provide abortion services.

It is clear that the Mexico City Policy is in fact thwarting our efforts to prevent unintended pregnancies, abortions and the spread of HIV/AIDS. We must allow the provision of contraceptives to organizations that are most equipped to distribute them. That is the purpose of a provision I included in the fiscal year 2008 State and Foreign Operations bill to provide foreign NGOs with U.S. government-donated contraceptives—not direct funding. Yet the Administration has threatened to veto this bill—with the support of many in Congress—instead of backing this commonsense measure to help reduce unintended pregnancies and abortions.

The global gag rule is unconstitutional, immoral, unsubstantiated and dangerous. I urge your co-sponsorship of the Global Democracy Promotion Act, which I authored, to repeal this terrible policy. Until it is passed, I hope we can all agree that we must provide contraceptives to the world's poorest men and women through the FY08 State and Foreign Operations Appropriations Bill. Thank you.

Chairman LANTOS. Thank you, Ms. Lowey. I understand you have to leave.

Before introducing again my friend from Colorado, without objection I would like to submit the following items for the record: The written statement of Ms. Matilda Owusu-Ansah, Former Director of Research Mobilization, the International Planned Parenthood Association of Ghana. She was scheduled to testify earlier this month on October 11, on this scheduled hearing; statement of Steven Sindy, Senior Fellow at the Good Marker Institute who was also scheduled to testify; statement of Ms. Nancy Northrup, President of the Center for Reproductive Rights; statement of Ms. Sara Sipple, Acting Executive Director at the Center for Health and Gender Equity.

I am pleased, pleased to note that committee members and the U.S. Agency for International Development will be given 5 additional days to submit statements for the record.

I am now pleased to recognize my friend from Colorado, Congresswoman Musgrave.

STATEMENT OF THE HONORABLE MARILYN MUSGRAVE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. MUSGRAVE. Thank you, Mr. Chairman, for your very kind introduction. As I sit in this room today, I am thinking of our dear former colleague, Henry Hyde, and I think of his work on behalf of unborn children around the world, and I would just say that he was a hero to me long before I came to Congress, and I was privileged to serve with him for a brief time.

Getting a little emotional already this morning, that ultrasound Congressman Smith showed was very touching. My ninth grandchild will be born soon, and I recently saw that little baby in 3–D in the womb. The humanness and the preciousness of that child just washed all over me.

The Mexico City Policy is a pro-family policy protecting women and their children. Its principles enhance U.S.-funded international family planning by encouraging alternatives to terminating pregnancies. According to USAID, since reimplementation in 2001, the Mexico City Policy has not had a negative impact on United States-funded family planning and reproductive health. If anything, this

policy is positively impacting family planning programming and reproductive health.

For example, there is evidence that the closing clinics run by international organizations in Kenya resulted in the redirection of funding and training going to government and local non-government organizations that resulted in increased local capacity and sustainability of programming, two key goals of United States foreign assistance.

On a more fundamental level, women deserve better options than terminating their pregnancies. Abortion should not be exported overseas where many nations hold strong life-affirming principles and laws. Poor women in developing nations are not asking for help to abort their children. They are asking for food, housing, and medicine to care for themselves and their families. At $1 a course, an infant can be saved from dying of malaria. It costs roughly $5 to spray a house with the cheapest insecticide to protect entire families from being infected with malaria. The drug Navirapine reduces the risk of prenatal HIV infection by 50 percent. One dose of Navirapine is given to the mother and one to the baby. The two doses cost only $5.

According to USAID, most preventable child deaths are from malnutrition, diarrhea, pneumonia, and infections of newborns and malaria. The United States has contributed more than $1.5 billion in the last 5 years to treat almost 5 billion episodes of child diarrhea with life-saving oral rehydration therapy, reducing deaths from diarrheal disease by more than half since 1990.

Mr. Chairman, these are success stories of how U.S. tax dollars are saving lives. U.S. dollars need to continue to preserve life.

Many argue that repealing the policy will result in increased safe abortions and the occurrence of unsafe abortions will decrease. There is no such thing as a safe abortion. Abortion is always deadly for the unborn children whose lives are taken in the womb.

Abortion can be devastating to mothers as well. A study in the *Journal of Child Psychology and Psychiatry* just last year demonstrated that women who had an abortion had elevated rates of subsequent mental health problems, including depression, anxiety, suicidal behaviors, and substance abuse disorders. In addition, physical damage can be inflicted by abortion procedures.

Our concern for women should be addressed with life-affirming policies that help women have healthy pregnancies and deliver healthy babies. This can be best achieved by providing international aid for essential obstetric care such as safe blood and delivery assistance.

According to the World Health Organization, nearly 40 percent of the 128 million babies born worldwide every year are not officially registered and two-thirds of deaths also go undocumented. Only 31 of the WHO organizations, 193-member states are believed to have reliable cause-of-death statistics. The belief then must be questioned that 13 percent of maternal mortalities occur due to unsafe abortions.

Contrary to claims that it does not, the Mexico City Policy does contain an exception for rape and incest and the life of the mother. It has been said that countries with the highest demand for family planning are hurt by the Mexico City Policy when in fact the oppo-

site is true. Funding in the last 5 years has increased dramatically in countries where USAID has found the need for family planning to be greatest. Ethiopia's funding has increased by 298 percent between 2002 and 2007. Pakistan has seen over a thousand-percent increase in its funding, and the Democratic Republic of the Congo has seen an 800-percent increase.

Mr. Chairman, our foreign aid tax dollars should be spent in assisting developing countries with their needs and preserving lives. We must stand up for a culture that promotes life and continues to protect the great number of American taxpayers that ethically oppose abortion, and do not want their tax dollars spent on encouraging the practice overseas.

We need to export a life-saving policy that provides poor women with food, housing, and medicine, not policies that are destructive to women and their children.

As a pro-life woman in Congress, I want to do the very best for women and their children around the world. I believe that human rights begin in the womb and I support the Mexico City Policy, and I thank you, Mr. Chairman and committee.

[The prepared statement of Ms. Musgrave follows:]

PREPARED STATEMENT OF THE HONORABLE MARILYN MUSGRAVE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Thank you, Mr. Chairman.

The Mexico City Policy is a pro-family policy, protecting women and their children. Its restrictions enhance U.S. funded international family planning by encouraging alternatives to terminating pregnancies.

According to USAID, since reimplementation in 2001, the Mexico City Policy has not had a negative impact on U.S. funded family planning and reproductive health. If anything, this policy is positively impacting family planning programming and reproductive health. For example, there is evidence that the closing clinics run by international organizations in Kenya resulted in the re-direction of funding and training going to government and local non-government organizations that resulted in increased local capacity and sustainability of programming—two key goals of U.S. foreign assistance.

On a more fundamental level, women deserve better options than terminating their pregnancies. Abortion is harmful to women and should not be exported overseas, where many nations hold strong life-affirming principles and laws. Poor women in developing nations are not asking for help to abort their children. They are asking for food, housing, and medicine to care for themselves and their families.

At a dollar a course, an infant can be saved from dying of malaria. It costs roughly $5 to spray a house with the cheapest insecticide to protect entire families from being infected with malaria. The drug Nevirapine (ne-vir-a-pine) reduces the risk of prenatal HIV infection by fifty percent. One dose of Nevirapine is given to the mother and one to the baby. The two doses cost only $5. According to USAID most preventable child deaths are from malnutrition, diarrhea, pneumonia, infections of newborns, and malaria. The United States has contributed more than $1.5 billion in the last five years to treat almost five billion episodes of child diarrhea with life-saving oral rehydration therapy, reducing deaths from diarrheal disease by more than half since 1990. Mr. Chairman, these are success stories of how U.S. tax dollars are saving lives—U.S. dollars need to continue to preserve life.

Many argue that repealing the policy will result in increased "safe" abortions and the occurrence of "unsafe" abortions will decrease. There is no such thing as safe abortion. Abortion is always deadly for the unborn children whose lives are taken in the womb. Abortion is devastating to mothers as well. A study in the Journal of Child Psychology and Psychiatry just last year demonstrated that women who had an "abortion had elevated rates of subsequent mental health problems including depression, anxiety, suicidal behaviors and substance use disorders." In addition, the physical damage inflicted by abortion is extensive. Recent studies indicate that women who undergo an abortion are three to four times more likely to die within the following year compared to women who give birth.

The issue of maternal mortality should be addressed with life-affirming policies that help women have healthy pregnancies and deliver healthy babies. This can be best achieved by providing international aid for essential obstetric care such as safe blood and delivery assistance. According to the World Health Organization (WHO), nearly 40 percent of the 128 million babies born worldwide every year are not officially registered, and two thirds of deaths also go undocumented. Only 31 of the World Health Organization's 193 member states are believed to have reliable cause-of-death statistics. The belief, then, must be questioned that 13% of maternal mortalities occur due to "unsafe" abortions.

Contrary to claims that it does not, the Mexico City Policy does contain an exception provision for victims of rape and incest or when the life of the mother is at risk.

It has been said that countries with the highest demand for family planning are hurt by the Mexico City Policy, when in fact, the opposite is true. Funding in the last five years has increased dramatically in countries where USAID has found the need for family planning to be greatest. Ethiopia's funding increased by 298% between 2002 and 2007. Pakistan has seen a 1079% increase in its funding, and the Democratic Republic of the Congo has seen an 800% increase.

Mr. Chairman, as a nation, we must not export policies that are harmful to women. Our foreign aid tax dollars should be spent assisting developing countries with their needs and preserving lives. We must stand up for a culture that promotes life and continue to protect the great number of American taxpayers that ethically oppose abortion from having their tax dollar spent on encouraging the practice overseas. We need to export a life-saving policy that provides poor women with food, housing, and medicine—not policies that are destructive to women and children.

Thank you, Mr. Chairman.

Chairman LANTOS. Thank you very much. We very much appreciate your appearance.

We shall next hear from four distinguished witnesses, and I would like to ask them to take their places at the witness table. They include a leading American scholar in the field of population and health, and three experienced medical professionals who have traveled here from Africa in order to testify today.

Dr. Duff Gillespie is Senior Scholar at the Bill and Melinda Gates Institute for Population and Reproductive Health at Johns Hopkins University's Bloomberg School of Public Health, a position he has held since 2004. He has served for many years at the U.S. Agency for International Development after heading the Office of Population for 7 years. He became Senior Deputy Administrator of the Global Health Bureau. He has had 30 years of relevant experience and holds a Ph.D. Degree from Washington University in St. Louis.

Dr. Jean Kagia is an obstetrician and gynecologist from Kenya. Dr. Kagia is chairperson of the Protecting Life Movement, a group that opposed legalized abortion.

Dr. Joana Nerquaye-Tetteh is the immediate past Director of the Planned Parenthood Association of Ghana. Under her leadership, this organization evolved from a group concerned mainly with family planning to one focused on the larger issues of sexual and reproductive health, health with an emphasis on youth. She holds a B.S. and M.S. degree from the University of Ghana and a Ph.D. in reproductive biology from Oxford University. For 23 years, she was senior lecturer in physiology at the Quaum Kruma University of Science and Technology.

Dr. Ejike Oji from Nigeria works under the auspices of Ipas, an international woman's organization whose mission is to advance the cause of reproductive choice and to reduce the incidence of abortion-related death and injuries. Dr. Oji provides care for victims of unsafe abortion and works with government, civic and

faith-based organization in the struggle against this major cause of death and injury to women.

Before Joining Ipas 5 years ago, he was national coordinator for Nigeria's Program for the Prevention of Blindness. He has practiced medicine for more than 20 years.

We are delighted to have all four of you and we will begin with Dr. Gillespie.

STATEMENT OF DUFF G. GILLESPIE, PH.D., PROFESSOR AND SENIOR SCHOLAR, GATES INSTITUTE FOR POPULATION AND REPRODUCTIVE HEALTH, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

Mr. GILLESPIE. Good morning, Mr. Chairman. I must preface my comments by saying that you and representative Lowey are a hard act to follow, so I hope I can add some new light to the discussion. My testimony is a summary of the written statement submitted to the committee earlier.

Chairman LANTOS. Without objection, it will be entered in the record.

Mr. GILLESPIE. The Reagan administration presented a policy in 1984, during a conference in Mexico City, that for all non-governmental organizations receiving family planning funds must agree not to provide abortion services, to advocate changing anti-abortion laws, or to provide information about legal abortion services even if no USAID funds are used for these activities. Essentially, the United States was stating that they would not give family planning funds to NGOs for doing things that may be legal in their country and, of course, are legal in this country.

The Mexico City Policy is designed to ensure that USAID-recipient countries have laws making abortion illegal under the assumption that illegality will reduce the incidence of abortion. In this regard, the Mexico City Policy has been a dismal failure. After 15 years of existence, the Mexico City Policy has done nothing to stop the liberalization of abortion laws throughout the developing world.

An analysis of 97 developing countries' legal status of abortion in the 1980s and in 2007 found that, in 1989, 13 countries made no exception to the prohibition of abortion. This number dropped to just two countries by the year 2007. Contrastingly, the number of countries that allow for abortion on demand increased from eight to 12 countries. Perhaps more telling was the dramatic increase of countries from 15 to 38 that allow abortion for a range of socio-economic and health reasons.

The Mexico City Policy premise that reducing access to all abortions, safe and unsafe, legal and illegal, will reduce the incidence of abortion is based on faulty logic that is as perverse as it is wrong. Women do not get an abortion because of its legal status. They get an abortion because they have an unwanted pregnancy. What the legal status does do is guarantee that women will receive an unsafe abortion in countries where it remains illegal.

A recent study by the prestigious Guttmacher Institute found a modest decline in the number of abortions worldwide, from 45.6 million in 1995 to 41.6 million in 2003, a 9-percent decline. However, this entire decline took place in the developed world and

China. The number of abortions actually increased in the developing world from 24.9 to 26.4.

There is no evidence that I am aware of indicating the Mexico City Policy has reduced the number or rate of abortions in the developing world. If restricting access to abortion and reducing its incidence or rate is the ultimate goal of Mexico City Policy proponents, then the policy must be considered a dramatic failure.

It is perplexing that such an obviously ineffective policy is the hook by which anti-abortion activists want to deprive women of safe and unsafe abortion. If they really believe in blocking funds to organizations that provide or promote abortion, why restrict the policy to just USAID population funds. Certainly this approach would have a better chance of success if it encompassed all foreign assistance funds along with funds from CDC and NIH.

The most fundamental flaw in the Mexico City Policy is that it ignores the reasons women get an abortion. Abortion will not take place absent an unwanted pregnancy. The most effective way to prevent abortions is simply to prevent unwanted pregnancies, and one of the most effective ways to prevent unwanted pregnancies is through family planning.

The Mexico City Policy has undermined the United States' leadership. The policy is openly condemned and resisted by other donors. For example, in 2006, USAID withdrew support from a respected international research center in Bangladesh because it ran afoul of the Mexico City Policy. The British Government rushed to the center's support with a United States $15 million grant, and in 2006, the United Kingdom created the Global Safe Abortion Fund, an explicit response to what the U.K. Government refers to as the "Global Gag Rule."

Mr. Chairman, it should be possible to find common ground between those who oppose safe abortion but not family planning and those who support greater access to safe abortion.

Unwanted pregnancies remain a serious problem in the developing world. Research clearly shows that the provision of family planning dramatically reduces unwanted pregnancies and abortion. Expanding USAID's family planning program is the surest way to reduce both safe and unsafe abortion in a developing world. Yet under the leadership of Secretary Rice, the Bush administration has significantly lowered its request levels from that during the tenure of Secretary Powell, from $425 million to $347 million.

If this administration and Congress is serious about reducing abortion, it should double its fiscal year 2007 appropriation figure of $435 million for fiscal year 2008. I have no doubt that this $870 million would be effectively and quickly spent, and that millions of unwanted pregnancies would be prevented.

Thank you.

[The prepared statement of Mr. Gillespie follows:]

PREPARED STATEMENT OF DUFF G. GILLESPIE, PH.D., PROFESSOR AND SENIOR SCHOLAR, GATES INSTITUTE FOR POPULATION AND REPRODUCTIVE HEALTH, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH

When the Reagan Administration unveiled its Mexico City Policy in 1984, I was the Deputy Director of the Office of Population. In the months following the announcement, much of my time was spent working with political and career colleagues within USAID and other federal agencies translating this complex policy

into regulations. At the time, I had no idea that this policy, soon to be derisively labeled the Global Gag Rule by its many critics, would consume so much of my professional life until my retirement from the Agency as the Senior Deputy Assistant Administrator for Global Health in 2002.

Much has been written about the Mexico City Policy. Indeed, it is hard to think of any other foreign assistance policy that has generated such a volume of commentary representing diverse political, legal, social and religious viewpoints. Considering that the policy concerns a small program, a rounding error in the Pentagon's budget, the remarkable attention it has received and the emotions it provokes are indicative of the fundamental values it challenges.

While this is not the place to examine in detail the many facets of this policy, it is necessary to remind ourselves that Mexico City is about much more than a policy on abortion, which continues to be the most emotive of all topics in this country. It is also about such things as freedom of speech, ideological imperialism, reproductive choice and national sovereignty. Lastly, one reason the Mexico City Policy remains such a lightening rod is that it is all about what the United States values. It is an instrument by which our country projects to others what we believe and, importantly, what we believe others should believe.

In this statement, I will address the failure of the Mexico City Policy to achieve its goals in preventing the liberalization of abortion laws and reducing the incidence of all abortions in the developing world, and I will identify and discuss the unstated goals of the policy. Finally, I will suggest a bipartisan effort to drastically reduce the number of abortions throughout the developing world.

THE MEXICO CITY POLICY IS A FAILURE

To fully understand the implications of the Mexico City Policy it is necessary to briefly review the Helms Amendment and its impact. In 1973, the year I joined USAID, Senator Jesse Helms introduced an amendment to the Foreign Assistance Act to prohibit the use of Agency funds to pay "for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortion as a method of family planning." The Helms Amendment put a stop to USAID's nascent and small efforts to promote safe abortion as well as to provide treatment in cases of incomplete abortions. The program largely consisted of training physicians how to use manual vacuum aspirators, MVA kits, along with the provision of the kits to trained medical personnel. Since abortion was illegal in almost all the countries USAID worked in at the time, and since this program was so small, its termination had little contemporaneous impact. Its importance lies in insuring that this and related programs would not grow in size and importance.

The Helms Amendment was easy to understand and implement. Very few of USAID recipients were in any way involved with abortion, so there was minimal change in accounting procedures and virtually no change in programs. For those few programs that were involved with abortion, principally the International Planned Parenthood Foundation (IPPF), an accounting or tracking system had to be installed to insure that no US funds paid for abortion-related activities.

Some anti-abortion activists considered the Helms Amendment seriously flawed, feeling that US funds would simply free-up other funds for abortion activities. Moreover, as a matter of policy, the US should not have any relationship with abortion providers or promoters since such relationships could be perceived as condoning, if not indirectly supporting, abortion. These accusations often took on a metaphysical quality since abortion activities among USAID-sponsored programs were virtually non-existent. For example, although IPPF was often characterized by its foes as being a large, organized provider of abortion services, less than one percent of its resources were directed towards abortion-related programs. Abortion was, of course, taking place in USAID recipient countries, but it was illegal and unsafe.

The Helms Amendment was, and remains, effective in preventing USAID funding for abortion activities. But, anti-abortion activists still found it wanting. First, they wanted to address the non-existent fungibility issue. Second, they wanted to eliminate any ambiguity for a US anti-abortion position. Lastly, and most importantly, they wanted others to stop the provision of abortion, safe or unsafe, legal or illegal, and to prevent any activities designed to make abortion legal and safe.

Because the reasons for a stronger, more comprehensive anti-abortion foreign assistance program existed only in the minds of its advocates in the 1970s and early 1980s, legislating for such a position seemed unlikely to be successful. However, there were sympathetic policy makers within the Reagan Administration who secretly crafted a policy which was presented to the world in 1984, during a UN conference in Mexico City. The boldness, some would say arrogance, of the policy was remarkable. Foreign non-governmental organizations (NGOs) that receive *family*

planning funds must agree not to provide abortion services, advocate changing anti-abortion laws, or provide information about legal abortion services, even if no USAID funds are used for these activities. Essentially, the United States was stating that they would not give family planning funds to NGOs for doing things that may be legal in their countries and, of course, are legal in this country. However, in reality the Mexico City Policy was a policy in search of a problem. The conditionalities the policy imposed sought to address conditions that simply did not exist among foreign NGOs receiving USAID funds. It is not surprising, then, that the Mexico Policy is ineffective. Where the policy does have an impact, as was found with the Helms Amendment, is in preventing NGOs in engaging in any future abortion activities.

The real measure of Mexico City's effectiveness is not whether NGOs' abortion programs changed, but rather if national policies kept or made abortion illegal under the assumption that illegality will reduce the incidence of abortion. In this regard, Mexico City has been a dismal failure. After 15 years of existence,[1] the Mexico City Policy has done nothing to stop the liberalization of abortion laws throughout the developing world. We examined 97 developing countries for which we had information on the legal status of abortion in the 1980s and in 2007.[2] As shown in Table 1, the trend is clear.

[1] The Reagan administration announced Mexico City in 1984. The administration of President George H.W. Bush continued the policy. President Clinton rescinded the policy in January 1993. President George W. Bush reinstated it in January 2001. Even under the eight years of the Clinton administration, the chilling effect of the Mexico City Policy continued and few foreign NGOs became engaged in "prohibited" activities either because they had no desire to or they feared future retribution from another anti-abortion administration. Such caution was justified not only with the election of George W. Bush but by President Clinton accepting for one year appropriation language that more-or-less imposed the Mexico City Policy of FY 2000 funds. This complex maneuver is too arcane to go into here. Within USAID, it was referred to as "Mexico City Lite."

[2] Most restrictive—illegal, no exceptions; Restrictive—exception to save a woman's life; Somewhat restrictive—legal for medical or socioeconomic reasons; Least restrictive—without restriction as to reason

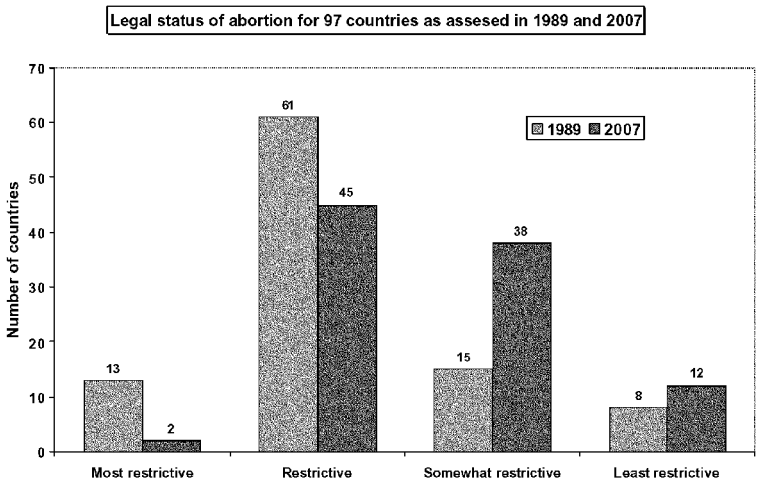

Table 1: Legal status of abortion in 97 countries as assessed in 1989 and 2007.

Sources: Abortion Policies: A Global Review, Volumes I, II, III. United Nations, Department of Economic and Social Affairs, Population Division, New York, 2001.

Ross, JA, Mauldin WP, Green SR, Cooke ER. Family planning and child survival program as assessed in 1991, The Population Council, New York, 1992.

The World's Abortion Laws, 2007 wallchart. Center for Reproductive Rights, New York.

The developing world is adopting more liberal laws. In 1989, 13 countries made no exception to the prohibition against abortion. This number dropped to just two countries by 2007. Contrastingly, the number of countries that allowed abortion on demand increased from eight to 12. Even more telling is the drop in the number of countries that allowed abortion only to save the life of the mother, 61 to 45 countries, and the dramatic increase in the number of countries that allowed abortion for a range of socio-economic and health reasons. Ironically, the greatest liberalization of abortion laws throughout the developing world has taken place during the reign of the Mexico City Policy.

One of the unfortunate hallmarks of the Mexico City Policy is the absolutism of its intent to reduce access to all abortions, safe and unsafe, legal and illegal, and as logic goes, thereby reducing the incidence of abortion. The logic is as perverse as it is wrong. Women do not get an abortion because of its legal status. They get an abortion because they have an unwanted pregnancy. What the legal status does do is guarantee that women will receive an unsafe abortion in countries where it remains illegal. A closer look at the incidence, or number of abortions, and the abortion rate, the number of abortions per 1,000 women 15–44 years of age will provide a clearer picture of abortion in the developing world.

Abortion statistics are hard to collect in countries were abortion is illegal. This difficulty is exacerbated by the fact that few donors, public or private, want to fund abortion research in countries were it is highly restricted or illegal. Fortunately, the Guttmacher Institute just completed a comprehensive study on abortion. Table 2 shows that, globally, there was a modest decline in the number of abortions, from 45.6 million in 1995 to 41.6 million in 2003, a 9 percent decline.

INCIDENCE AND RATES

Global and regional estimates of induced abortion, 1995 and 2003

Region and Subregion	No. of abortions (millions)		Abortion rate*	
	1995	2003	1995	2003
World	45.6	41.6	35	29
Developed countries	10.0	6.8	39	28
Excluding Eastern Europe	3.8	3.5	20	19
Developing countries†	35.5	35.0	34	29
Excluding China	24.9	26.4	33	30
Estimates by region				
Africa	5.0	5.6	33	29
Asia	26.8	25.9	33	29
Europe	7.7	4.3	48	28
Latin America	4.2	4.1	37	31
Northern America	1.6	1.5	22	21
Oceania	0.1	0.1	21	17

*Abortions per 1,000 women aged 15–44.
†Those within Africa, the Americas, excluding Canada and the United States of America, Asia, excluding Japan, and Oceania, excluding Australia and New Zealand

Table 2: Global and regional estimates of induced abortion, 1995 and 2003.

Source: Facts on induced abortion worldwide. In Brief. Guttmacher Institute, New York, October 2007.

While still modest, the decline in the abortion rate is more promising, from 35 to 29 per 1,000 women 15–44 years of age, a 17 percent decline. The most dramatic decline in the abortion rate took place in Europe, were legal and safe abortion is readily accessible and modern contraceptive use is high. Here, the rate plummeted from 48 to 28, a 42 percent decline. On the other hand, the abortion rate declined a modest 12 percent, from 33 to 29 in Africa, the region with the most restrictive abortion laws and low levels of contraceptive use. There is nothing in the Guttmacher report, or any other study I am aware of, that would suggest the Mexico City Policy has reduced the number or rate of abortions in the developing world. If restricting access to abortion and reducing its incidence and rate is the ultimate goal of Mexico City Policy proponents, then the policy must be considered a dramatic failure.

WHAT IS THE REAL GOAL OF PROPONENTS OF MEXICO CITY?

Supporters of Mexico City and other anti-abortion initiatives are not a homogenous, monolithic group and there are degrees of commitment within the anti-abortion movement. Still, one has to question the attainability of the overall goal of the group. It is curious that such an obviously ineffective policy is the hook by which they want to deprive women of safe *and* unsafe abortion. If, for instance, they really believed that blocking funds to organizations that are one way or another involved in providing or promoting safe abortion, why restrict the policy to just USAID population funds? Certainly this approach would have a better chance of success if it encompassed all foreign assistance funds, along with funds from CDC and NIH? For that matter, why not stop all foreign assistance to governments that provide abortion services? As discussed later, Mexico City has had some important consequences, but it cannot be considered a serious attempt to have had an impact on abortion policies and behavior throughout the developing world.

The most fundamental and telling flaw in a Mexico City-type of approach is that it ignores the reason women get an abortion. It is undeniable that an abortion will not take place absent an unwanted pregnancy.[3] To say it another way, the most effective way to prevent abortions is simply to prevent unwanted pregnancies. And, one of the most effective ways to prevent unwanted pregnancies is through family planning, a fact well documented in the research literature and recognized by the

[3] Anti-abortion activities sometimes attempt to distort the issue by throwing into the debate the red herring of coerced abortion, a totally repugnant but extremely rare event outside of China. Coercion of any kind is uniformly condemned by every pro-choice organization I am aware of in the developed and developing worlds. Ironically, women living in countries were access to abortion is legally restricted are legally coerced into an unsafe abortion.

George W. Bush White House.[4] Anti-abortion activists should be the strongest supporters of family planning programs. Instead, they are often openly hostile toward family planning. This hostility or indifference toward family planning under the Reagan and both Bush Administrations is well known and is totally inconsistent with their anti-abortion stances. Although the Mexico City Policy is not explicitly designed to negatively impact USAID's family planning efforts specifically and other programs generally, it has done so in ways outlined below. The Reagan and Bush Administrations' toleration of these negative consequences, coupled with more explicit anti-family planning actions,[5] leads one to conclude that the Mexico City Policy is implicitly anti-family planning in its intent.

Other witnesses will give examples of how Mexico City has negatively impacted their programs. Here, the focus will be on two large categories of negative impact. First, there are the disruptive and chilling enforcement tactics. These are numerous and seem to have grown in number and intensity under this Administration. It is not easy to provide documentation of these tactics because effected organizations fear retribution would follow any disclosure on their part. Therefore, the sampling given here are from those that I personally know of and which occurred under this Administration.

> Women Deliver Conference, London, 2007. Support for this international conference on maternal health was withdrawn. Organizers were pressured to change the agenda and disinvite speakers. The website of the principal organizer was deemed to promote abortion and to have links to other sites promoting abortion.
>
> Special Session of the Conference of African Union Ministers of Health, "Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa," Maputo, 2006. USAID withdrew support from the program and attempted to force organizers to change the meetings agenda and disinvite certain speakers.
>
> WHO Publication: *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2003. The US attempted to excise and modify parts of an earlier draft deemed to promote abortion.

The African Union and WHO cases technically do not fall under the Mexico City Policy since neither is a foreign NGO. But, the actions described reflect the spirit of the policy and the enthusiastic and comprehensive attempts to impose the policies' principles on others, albeit often in an embarrassingly visible, ham-fisted way. These efforts have had a chilling effect on recipients of USAID population funds and have lead to self-censorship and their isolation or exclusion from activities that may, however tenuously, leave them vulnerable to accusations of promoting abortion. The guiding beacon for organizations dependent on USAID funding is risk *avoidance*.

The second category of negative impact flows from the first. The most serious result of the Mexico City Policy is that it has undermined United States leadership. Since the late 1960s, this country has been the intellectual, technical, and programmatic leader in family planning. The blaring hypocrisy in promoting democracy as the lynchpin in our foreign policy and at the same time aggressively attempting to stifle public discourse on safe abortion is not lost on our counterparts. Recent and dramatic illustrations of the disgust and disdain come from our traditionally strongest friend and development partner, the United Kingdom.

In 2006, USAID withdrew support from the Centre for Health and Population, an internationally respected research center in Bangladesh, because they ran afoul of the Mexico City Policy. The British government rushed to the center's support with a US$15 million grant. The UK's International Development Secretary noted in slightly veiled reference to the US that, "Research related to sexual and reproductive health is especially important at a time when there has been a concerted effort to prevent key areas such as reproductive health and rights and unsafe abortion from getting proper attention."[6] Any ambiguity about the UK's stance is dispelled by its involvement in the creation of the Global Safe Abortion Programme in 2006.

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[4] "This policy recognizes our country's long history of providing international health care services, including voluntary family planning to couples around the world who want to make free and responsible decisions about the number and spacing of their children." (22 January 2001). *Statement by the Press Secretary, Restoration of the Mexico City Policy*.

[5] The latest and perhaps most heavy handed manifestation on this Administration's anti-family planning posture is the appointment of Susan Orr to head our domestic family planning program, a vocal and avid opponent of safe abortion and family planning. (Lee, C. (17 October 2007). HHS Appointment: Birth-Control Foe to Run Office on Family Planning. *The Washington Post*, p. A15.)

[6] UK Government Announces Support to Help Combat Threat to Women's Health in Developing World. (6 February 2006). *DFID Press Release*.

This initiative is being implemented by IPPF and is an explicit response to what the UK government refers to as the "Global Gag Rule."[7]

The loss of leadership is so pronounced today that the common impression of USAID is that it no longer supports family planning. Intentionally or unintentionally, one of the results of Mexico City Policy is the serious erosion of US leadership, especially its inability to effectively disseminate new lessons learned and to foster partnership with other donors.

A WAY FORWARD

It is doubtful that core members of the "pro-life" and "pro-choice" movement can ever find common ground on making safe and legal abortion readily available to women. There is no doubt that this debate will remain a dominate feature in this country's political and judicial landscapes for years to come. Perhaps there can be agreement that our domestic debate should not be imposed on other sovereign countries. Should not countries decide themselves what is legal and what is not legal? This is not to say that individuals and organizations in this country cannot speak out against or for safe abortion. And, it is proper if Congress decides that no taxpayer funds should pay for such advocacy. It is quite another matter, however, to have a policy, backed by the most powerful government in the world, designed to prevent such debate within sovereign countries. The US government should drop the Mexico City Policy. It is an arrogant, counterproductive policy that is an affront to the basic ideals of this country.

More optimistically, we turn to the objective of reducing the need for abortion. Here, finding common ground between those who oppose safe abortion, but not family planning, and those who support greater access to safe abortion seems possible. Unwanted pregnancies remain a serious problem in the developing world. Recent research by the Guttmacher Institute indicates that about a third of all pregnancies in the developed world are unwanted and the over half of these unwanted pregnancies will end in an abortion, as shown in Figure 1.

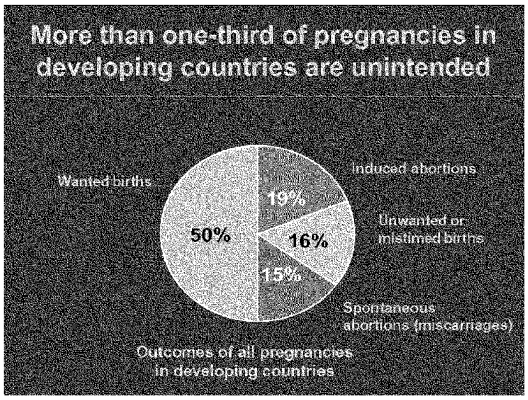

Figure 1: More than one-third of pregnancies in developing countries are unintended.

Source: AGI. Sharing responsibility: women, society and abortion worldwide, New York, 1999.

Sedgh G, Henshaw S, Singh S, Ahman E, Shah IH. Induced abortion: estimated rates and trends worldwide. Lancet 2007 October 13;370(9595):1338-45.

We also know that over 60 percent of unwanted pregnancies occur among women who are not using contraceptives, see Figure 2.

[7] Taking Science to Where the Problem Is. (31 August 2006). *DFID Press Release*.

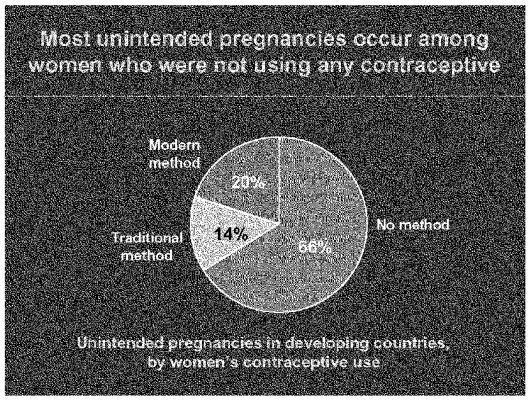

Figure 2: Most unintended pregnancies occur among women who were not using any contraceptive.

Source: Singh S, et al. Adding it up: the benefits of investing in sexual and reproductive health care. The Alan Guttmacher Institute and United Nations Population Fund, New York, 2003.

It follows, then, that a quick and effective way to reduce abortions is to reduce unwanted pregnancies through the provision of high quality, voluntary family planning programs. Research clearly shows that the provision of family planning dramatically reduces unwanted pregnancies and abortion. Greatly expanded USAID's family planning program is the surest way to reduce both safe and unsafe abortion in the developing world. Yet, under the leadership of Secretary Rice, the administration has significantly lowered its request levels from that during the tenure of Secretary Powell, from $425 million to $347 million. If this Administration and Congress is serious about reducing abortion, it should double its FY 2007 appropriation figure of $435 million for FY 2008. I have no doubt that this $870 million would be effectively and quickly spent and that millions of unwanted pregnancies would be prevented.

In accordance with clause 2(g) (4) of House Rule XI, I declare I have not received any Federal funds, directly or through subcontracts.

Chairman LANTOS. Thank you very much.

Dr. Ejike Oji. Could you please pull the microphone close to you and push the button.

STATEMENT OF EJIKE OJI, M.B.B.S., COUNTRY DIRECTOR, IPAS NIGERIA

Dr. OJI. Yes, Chairman Lantos and members of the House Committee on Foreign Affairs and distinguished colleagues. I bring you greetings from the men and women of Nigeria, and I feel privileged to be invited here today to speak on the issue of the Global Gag Rule.

The gag rule is a——

Chairman LANTOS. I am sorry to interrupt you. Could you pull the microphone a little closer?

Dr. OJI. The Global Gag Rule is a great barrier in Nigeria to our work to improve women's health and save women's lives.

I have spent the last 28 years of my life working to improve women's health. I have experience in medical practice and consultancy work, advocacy. I currently run the Nigerian Ipas program.

Ipas is a non-governmental organization based in Chapel Hill, North Carolina, with a mission of preventing death and injury from unsafe abortion and promoting women's reproductive rights globally. In Nigeria, we expand the availability of care for complications from unsafe abortion and comprehensible abortion care up to the limits of the law, including post-abortion family planning.

My passion for the work I do come from a personal tragedy in 1970. I lost a cousin, who was the most beautiful woman ever. I did not understand why she died. My mother told me she died trying to end a pregnancy and that didn't mean a thing for me then until I went into medical school to train to be a doctor. That was when I realized that she died from abortion complications. I cried, I wept, and I still do today.

Thirty-eight years later Nigerian women are still dying needlessly from lack of access to information and family planning services to manage their fertilities. They all too often resort with unintended pregnancies to unsafe abortion. U.S. policy of the Global Gag Rule is definitely at odds with efforts to try to address these threats to women's health.

Nigeria is a country with 140 million people, more than any other country in Africa. Seventy percent of Nigerians live on less than $1 a day. Women in Nigeria are confronted by insurmountable barriers in their pursuit of healthy, productive lives. The average Nigerian woman gives birth to around six children, and we have a high unmet need for contraception. One in 17 women in Nigeria will die from pregnancy-related causes.

High rates of abortion of individual women face a lack of family planning services and unwanted pregnancy. Unsafe abortion is a common and every Nigerian is aware of it. If this room were full of Nigerians and I asked the question, how many of you know someone who has died from unsafe abortion, there will not be a single person without his hand or her hand raised in this room.

In Nigeria, an estimated 760,000 induced abortions occur annually. Five years ago, Mr. Chairman, distinguished members of this great house, it was 600,000. It has increased by 160,000 within 5 years. Sixty percent of these are unsafe.

The most effective way to decrease the number of abortions is by preventing unwanted pregnancy. Expanding the use of family planning to prevent unwanted pregnancy is a major objective for USAID, and the programs for family planning reproductive efforts in Nigeria rely heavily on non-governmental organizations to implementation and achieving higher levels of contraceptive use.

However, the Global Gag Rule effectively blocks USAID from working with some of the organizations that are most effective in increasing the use of family planning. USAID can only choose among those organizations who pledge that they will not act to change the abortion law in Nigeria. The result is an increase in unwanted pregnancies which often lead to abortion deaths and disabilities.

Women will take drastic measures no matter the barriers to terminate a pregnancy that they do not want. Almost one-tenth of women in Nigeria say they have had an unwanted pregnancy and have attempted an abortion at some time. Tragically and ironically the Global Gag Rule is stemmed the flow of U.S. assistance and re-

sources that could prevent unwanted pregnancies and reduce the deaths of women from unsafe abortion.

The problem of unsafe abortion in Nigeria is made worse by the restrictive abortion laws, which deny women the opportunity to terminate a pregnancy safely. Advocates for women have long recognized this and Nigeria has a history of public debate around the abortion law. Restrictive abortion laws do not decrease the number of abortions, but they do increase the number of deaths and disabilities. An environment that promotes women's choice an options by improving access to contraception does in fact decrease the number of abortions over time and greatly reduces the consequences.

The crux of the matter is that women are dying and something needs to be done. However, the Global Gag Rule says that organizations that are working to affront the law are not eligible for USAID funding, even if a particular organization would be the most qualified to increase the use of family planning and decrease the number of abortions in Nigeria.

Mr. Chairman, in conclusion, more than 10,000 women die yearly from complications of unsafe abortion in Nigeria. For every woman that dies, 20 are maimed for life. Mr. Chairman and other members of this Committee on Foreign Affairs, if as much as half of these women died in America, it would be declared a national disaster and you will close ranks irrespective of your political divide.

I urge you to do so now for the rest of the women of the world, which includes my country women. Please, I urge you to repeal the Global Gag Rule. To my mind, and with great humility, the policymakers in the U.S. should spend less of their valuable time trying to debate about deadly abortion laws and more on helping women prevent unwanted pregnancy. We can reduce the risk of unwanted pregnancy and abortion, first and foremost, with increasing family planning. However, the Global Gag Rule hurts the efforts in Nigeria to reduce the number of unwanted pregnancies and reform the dangerous law. The Global Gag Rule exacerbates the situation in Nigeria whereby women have no choice about how to manage their own lives. That is what makes me so frustrated, because at the end of the day it is our women—our wives, daughters and sisters—who are dying. I urge you to repeal this policy.

I thank you, Mr. Chairman.

[The prepared statement of Dr. Oji follows:]

PREPARED STATEMENT OF EJIKE OJI, M.B.B.S., COUNTRY DIRECTOR, IPAS NIGERIA

HOW THE MEXICO CITY POLICY PERPETUATES THE HIGH RATE OF UNSAFE ABORTION IN NIGERIA

Chairman Lantos, members of the House Committee on Foreign Affairs and distinguished colleagues, I feel privileged to be invited here today to speak on the issue of the Global Gag Rule. The Global Gag Rule is a great barrier in Nigeria to our work to improve women's health and save women's lives. I am pleased that the Committee has chosen to spend this time considering the dangerous implications of this policy.

I am Dr. Ejike Oji and I have spent the last 28 years of my life working to improve women's health. I have extensive experience in medical practice and consultancy, advocacy, and project management. I have worked as a medical officer in a number of health facilities and was at one time National Coordinator for the National Program for Prevention of Blindness. I have organized and facilitated several national and international medical conferences, workshops and seminars to encourage exchange of medical and scientific knowledge. I have an MBBS degree and a postgraduate diploma in management. In 2005, I received the "Advocate for Ma-

ternal and Child Health" award from the National Council of Women's Societies in Nigeria due to the work I have been doing to reduce deaths from complications of unsafe abortion in the country. Currently I am the Country Director for Ipas Nigeria.

Ipas is a non-governmental organization based in Chapel Hill, North Carolina. Ipas implements programs aimed at preventing death and injury from unsafe abortion and promotes women's reproductive rights globally. In Nigeria we expand access to and availability of care for complications from unsafe abortion and comprehensive abortion care up to the limits of the law, including post-abortion family planning. Ipas Nigeria works to create and strengthen policies and alliances to support women's reproductive health and rights and we advocate for increased funding for reproductive health. We support the media to be strong advocates and empower them to educate the public on women's rights to health and life. Finally, we work with the community to get their participation in reproductive health issues and services.

Women in Nigeria are dying and are maimed daily and needlessly from lack of access to reproductive health care and the all-too-often resulting unsafe abortions. U.S. policy—the Global Gag Rule—is directly at odds with efforts to address these threats to maternal health. In Nigeria, we face more maternal deaths than all but one country in the world, and a major contributing factor to our high rates of maternal mortality is lack of access to basic reproductive health care, particularly family planning services. Complications from unsafe abortion are rendering women infertile, causing chronic health problems, and taking lives.

High rates of unsafe abortion are inevitable where women face unwanted pregnancy and a lack of safe abortion facilities. Unwanted pregnancy is a reality in Nigeria because of low use of contraception.

The most effective way to decrease the number of abortions is by preventing unwanted pregnancy. High rates of unwanted pregnancy generally correlate with low levels of contraceptive use. The majority of women in Nigeria who have obtained an abortion were not using family planning when they became pregnant.[1]

USAID plays an important role in increasing access to family planning services in Nigeria and throughout Africa. However, the effectiveness of USAID is undermined by the Global Gag Rule. The policy dictates that USAID can only choose implementing partners based on their support for the current restrictive abortion law, not on the basis of who can best provide the services. Organizations that do receive USAID funding are unable to voice their support for changing the law, which is a major contributing factor in the deaths and injuries of women in Nigeria.

Background on Nigeria

Nigeria is a country with a very large population and high levels of poverty. We have 137 million people, more than any other country in Africa.[2] One in every five Africans is a Nigerian. The average Nigerian born today will live to age 44 and at least 15% of Nigerian children die before reaching age five. Seventy percent of Nigerians live on less than $1 a day.[3]

Women in Nigeria are confronted by insurmountable barriers in their pursuit of full, healthy and productive lives. Forty-two percent of Nigerian women have never attended school.[4] The average Nigerian woman gives birth to around six children. We have a high unmet need for contraception and low rates of contraceptive use. According to the most recent official statistics, the 2003 Demographic and Health Survey, only 8.2% of currently married women of childbearing age are using modern methods of contraception.[5]

Maternal Mortality in Nigeria

Nigeria has the second highest number of maternal deaths in the world. According to the World Health Organization, the number of maternal deaths—59,000—is second only to India and India's population is ten times that of Nigeria. One in 17 women in Nigeria will die from pregnancy-related causes. As a comparison, in the United States the risk of dying from pregnancy-related causes is one in 4,800.[6]

Lack of access to reproductive health care is a major contributor to maternal mortality in Nigeria and across Africa. The Global Gag Rule exacerbates this public health crisis. Women seek abortion because they are faced with unwanted pregnancy. The majority of unwanted pregnancies can be prevented through family planning services. USAID has been working in Nigeria and across the African continent to increase access to family planning services through working with governments and with non-governmental organizations.

The most effective way to decrease the number of abortions is by preventing unwanted pregnancy. High rates of unwanted pregnancy generally correlate with low levels of contraceptive use. The majority of women in Nigeria who have obtained an

abortion were not using family planning when they became pregnant.[7] *According to USAID's Nigeria Country Strategic Plan for 2004–2009, expanding the use of family planning is a major objective, and USAID regards partnerships with effective in-country NGOs as essential to achieving higher levels of contraceptive use. However, the Global Gag Rule effectively prohibits USAID from working with some of the organizations that would be the most effective in increasing the use of family planning. Instead, USAID can only choose among those organizations who pledge that they will not act to change the restrictive abortion law in Nigeria. The result is an increase in unwanted pregnancies, which often lead to abortion.*

Unsafe abortion is common and every Nigerian is aware of it. If this room were full of Nigerians instead of Americans and I asked the question, how many of you know someone—a sister, a cousin, a friend of a friend—who has died of unsafe abortion, there would not be a single person without his or her hand raised. Unsafe abortion in Nigeria is a dangerous fact of life.

Unsafe abortion accounts for 14% of all maternal deaths in Africa.[8] In Nigeria, an estimated 760,000 induced abortions occur annually, 60% of which are unsafe.[9] More than 10,000 women die yearly from complications of unsafe abortion.[10] These are just estimates; the true numbers are probably much higher. Due to the stigma of abortion and because it is illegal in most cases, incidences of abortion go largely unreported.[11]

Women will take drastic measures, no matter the barriers, to terminate a pregnancy that they do not want. This is true in Nigeria and this is true everywhere in the world. *Almost one-third of women in Nigeria say they have had an unwanted pregnancy and half of these have attempted an abortion at some time.*

There are a host of reasons that women seek abortion in Nigeria—probably for many of the same reasons women seek abortion in the United States. The majority of women who procure an abortion in Nigeria are younger than 25.[12] Their reasons for not wanting to continue with their pregnancies are often because they are not married or they are too young. Some young people try to end their pregnancy because they want to finish their education, as pregnant girls in Nigeria are usually not allowed to continue with their education. Sometimes the pregnancy is a result of rape or the partner has abandoned the pregnant woman. Older women who are married and have children also seek abortion and their reasons typically include that they want more time between their most recent birth and their next, they do not want any more children or cannot afford to take care of an additional child. The majority of these unwanted pregnancies could have been prevented in the first place through the use of contraception.

For the typical Nigerian woman who is faced with unwanted pregnancy, her only choice for terminating her pregnancy involves dangerous methods and carries with it high risk of death or injury. A quarter of all women who obtain an abortion in Nigeria experience complications that are serious.[13] Women seek abortion from chemists' shops, where they get concoctions, tablets or injections from people with little or no medical training and who certainly are not trained in providing abortion. Women who live in rural areas and don't have easy access to health professionals turn to quacks or traditional healers. They otherwise try to induce an abortion on themselves or with the help of friends.

Methods of unsafe abortion involve the illicit and unthinkable use of chemicals, sticks, herbs and knives. Traditional healers will use ground ginger, alligator pepper, local chalk and native alum. A common method for quacks, traditional healers and that women use to self-induce abortion is the use of a sharpened stick from a cassava plant, or the sharpened edge of Bahaman grass. Untrained providers misuse medical equipment. These unsafe methods cause bleeding, septic shock, abdominal pain, fever, infection, uterine perforation, bowel damage, abdominal injury and death. Twenty-five percent of all women who obtain abortion report severe complications. Only one third of these women seek treatment.[14]

Treating complications from unsafe abortion pulls resources out of the already under-resourced health care system in Nigeria. Research in Africa has shown that treating complications from unsafe abortion in hospitals costs 10 times more than providing elective abortion in primary care facilities.[15] In Nigeria, women pay an average of almost $90 for care for abortion-related complications.[16]

USAID recognizes the need to do something to save women from losing their lives or experiencing long-term health consequences from unsafe abortion. USAID provides training to doctors and nurses in several states in Nigeria on treating complications from unsafe abortion. Training includes treatment for pain management, infection prevention and removal of any fetal tissue left after an unsafe abortion.

However, tragically—and ironically—the Global Gag Rule is hindering the flow of U.S. assistance and resources that could prevent unwanted pregnancies and the numerous deaths to women from unsafe abortion.

The Public Debate on the Abortion Law in Nigeria

The problem of unsafe abortion in Nigeria is exacerbated by our restrictive and antiquated abortion laws, which deny women the opportunity to terminate a pregnancy safely. Advocates for women's health and lives have long recognized this and Nigeria has a history of robust debate around the abortion law.

By limiting funding to organizations that comply with the Global Gag Rule, USAID effectively punishes organizations that are working to reform the abortion law. Some of these organizations could be the most effective at expanding access to contraception in Nigeria. At the same time, USAID supports organizations that are campaigning on the side of the current law, a law far more restrictive than the U.S. abortion law, and far more punitive than what the vast majority of Americans would support.

The law on abortion dates back to colonial times and is based on law that the British enacted in 1861. Abortion is criminal in Nigeria, except when a woman's life is at risk. However, because abortion is in the criminal law, it is understood widely to be completely banned in Nigeria. The major relevant statutes in relation to abortion are the Criminal Codes of the different southern states of Nigeria and the Penal Codes of the different Northern States and the Federal Capital Territory of Abuja. The laws of Nigeria state that an abortion provider shall be imprisoned for up to 14 years. Women who seek abortion are also imprisoned under the law for seven to 14 years.

Islamic law is in effect in Nigeria and where it conflicts with statutory law such as the Criminal and Penal Codes, the statutory law is applicable over Islamic law. However, Sharia criminal law has been codified in many of the northern states, and state penal codes are no longer the only criminal statutes applicable. There are in some states parallel Sharia-based Penal Statutes and in others where the Penal Codes remain the criminal legislation, they have been amended to reflect Sharia-based standards. Amnesty International has found cases in such states, where Islamic law is codified, of women sentenced to death for abortion-related offenses.[17]

The laws on abortion throughout Nigeria are complicit in the death and injury of women. We know that when abortion is restricted by law, women will turn to unsafe methods. When we look to other countries we can see clear evidence that making abortion laws less restrictive reduces rates of maternal mortality due to unsafe abortion. According to the World Health Organization, where abortion laws have become less restrictive and safe abortion available, death and injury from unsafe abortion decreases. For example, in South Africa, where abortion became legal in 1995, maternal deaths from unsafe abortion have reduced by 90% since the law was changed.18

It is largely due to the restrictive abortion law that abortions are offered clandestinely and unsafely. The government of Nigeria and non-governmental organizations cannot make services widely available because the law prohibits most abortions. The narrow law is a disincentive to training health professionals working at all levels of the Nigerian health system and providers therefore remain untrained in safe methods. Legitimate health care professionals refuse to offer services to comply with the law, sending women away only to have them return to their health care facility with complications.

The crux of the matter is that our women are dying and something needs to be done. Recognizing the contribution of the law to the high rates of unsafe abortion in Nigeria, medical practitioners, civil society organizations, women's rights advocates, legal professionals and grassroots activists have joined in an effort to work to reduce the number of unsafe abortions. They are campaigning for expanded use of family planning services and a change in the abortion law.

We have 760,000 cases yearly in Nigeria with a restrictive law. One thing is clear: in countries where abortion laws are more liberal, abortion will continue to occur but women will not die from it because they will get it done properly in an appropriate health care facility. When the law is restrictive, the same number of abortions will continue to occur and more deaths will occur because the women will instead go to unsafe providers. The law has no effect on number of the abortions that occur, but it does have effect on the consequences. Increased use of family planning services is the best way to prevent abortion in the first place.

The Global Gag Rule has silenced committed advocates for the reduction of unsafe abortion and has forced them into inactivity. Because of the Global Gag Rule, we have lost champions who were working to improve the reproductive health and save lives of women in Nigeria. Organizations in Nigeria that receive USAID funding for family planning and HIV related work do not even mention abortion as a leading cause of death in their public messages for fear of losing funding. The US government is even supporting the Catholic Secretariat of Nigeria and other groups who are working to retain the existing laws on abortion—laws that imprison women be-

tween seven and 14 years for obtaining an abortion and laws under which women have been sentenced to death.

Conclusion

The Global Gag Rule is one of the most negative international policies damaging public health in developing nations like Nigeria. US citizens who have an unwanted pregnancy have safe choices to make. They can choose to use contraception to avoid unwanted pregnancy. Pregnant women in the U.S. can keep their pregnancy and be supported with good antenatal services and a safe delivery of their babies. If they instead chose to terminate the pregnancy they have the option of a safe service and they can get on with their lives and live them to the fullest.

I cannot say this is true for my wife, daughter, sister, or my fellow country women. More often than not, a woman in Nigeria does not have information to make a choice in controlling her fertility. Being pregnant in Nigeria is like being a soldier on the frontlines. It is simply dangerous. Many, many women in Nigeria do not have the opportunity to avoid unwanted pregnancy with the use of contraception, to carry out a safe pregnancy or to safely terminate a pregnancy they do not want. For some women in Nigeria, in carrying out their choice, they pay the ultimate price.

Policy makers in the U.S. should spend less of their valuable time trying to stop debate about reforming our deadly abortion law and more on helping women prevent unwanted pregnancy. *We can reduce rates unwanted pregnancy and abortion first and foremost with increased use of family planning.*[19] However, the Global Gag Rule hurts the efforts in Nigeria to reduce the number of unwanted pregnancies and reform the dangerous law. The Global Gag Rule exacerbates the situation in Nigeria whereby women have no choice about how to manage their own lives. That is what makes me so angry, because at the end of the day it is our women—our wives, daughters, and sisters—who are dying.

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[13] Bankole, Akinrola, Boniface A. Oye-Adeniran, Susheela Singh, Isaac F. Adewole, Deirdre Wulf, Gilda Sedgh and Rubina Hussain. 2006. Unwanted Pregnancy and Induced Abortion In Nigeria: Causes and Consequences. New York and Washington, DC: Guttmacher Institute. Available online at http://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA.pdf, last accessed 22 October 2007.

[14] Bankole, Akinrola, Boniface A. Oye-Adeniran, Susheela Singh, Isaac F. Adewole, Deirdre Wulf, Gilda Sedgh and Rubina Hussain. 2006. Unwanted Pregnancy and Induced Abortion In Nigeria: Causes and Consequences. New York and Washington, DC: Guttmacher Institute. Available online at http://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA.pdf, last accessed 22 October 2007.

[15] Johnston, Heidi, Maria Gallo and Janie Benson. 2007. Reducing the costs to health systems of unsafe abortion: A comparison of four strategies. *Journal of Family Planning and Reproductive Health Care*, 33(4).

[16] Bankole, Akinrola, Boniface A. Oye-Adeniran, Susheela Singh, Isaac F. Adewole, Deirdre Wulf, Gilda Sedgh and Rubina Hussain. 2006. Unwanted Pregnancy and Induced Abortion In Nigeria: Causes and Consequences. New York and Washington, DC: Guttmacher Institute. Available online at http://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA.pdf, last accessed 22 October 2007.

[17] Amnesty International. 2004. Nigeria: The death penalty and women under the Nigerian penal systems. London: Amnesty International Press Release. Available online at http://news.amnesty.org/index/ENGAFR440072004, last accessed 22 October 2007.

[18] Jewkes, Rachel, Helen Rees, Kim Dickson, Heather Brown and Jonathan Levind. 2002. The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change. *British Journal of Obstetrics and Gynecology.* 112:355–359; World Health Organization, United Nations Children's Fund, United Nations Population Fund and The World Bank. 2007. Maternal Mortality in 2005 Estimates developed by WHO, UNICEF, UNFPA and The World Bank. Geneva: World Health Organization. Available online at http://www.who.int/reproductive-health/publications/maternal__mortality__2005/mme__2005.pdf, last accessed 22nd October, 2007.

[19] Sedgh, Gilda, Stanley Henshaw, Susheela Singh, Elisabeth Ahman, and Iqbal H Shah. 2007. *Lancet.* 370(9595):1338–1345.

Chairman LANTOS. Thank you very much.

Our next witness is Dr. Joana Nerquaye-Tetteh. Please pull the microphone close to you. Thank you.

STATEMENT OF JOANA NERQUAYE–TETTEH, PH.D., FORMER EXECUTIVE DIRECTOR, PLANNED PARENTHOOD ASSOCIATION OF GHANA

Ms. NERQUAYE-TETTEH. Thank you, Mr. Chairman.

My name is Joana Nerquaye-Tetteh, and I am honored to testify at this important hearing as a former Executive Director at the Planned Parenthood Association of Ghana, PPAG. I held this position for 11 years and it was during my tenure that the Global Gag Rule was implemented in Ghana. I personally witnessed the destructive impact the gag rule had on family planning and reproductive health efforts in the country, and it is my hope that by sharing PPAG's story, I can give voice to those people who are most affected, the women and young people.

P.P.A.G. was founded in 1967 by a small group of doctors and lawyers. Women were suffering and even dying from pregnancy-related ill health which they knew could be prevented by quality family planning services. Our founders believed in children by choice, not by chance. This was their motto and it has remained the motto of PPAG today.

We offered comprehensive voluntary family planning and contraceptives, including condoms. We provided a range of maternal and child health services, including child immunizations and pre- and postnatal care. We provided HIV prevention education and services to our clients. In family planning, we sometimes surpassed government efforts, especially in the rural areas. We introduced reproductive health initiatives in the country, including family life edu-

cation for young people, emergency contraception, reproductive health services, and community-based contraceptive services.

I need to underscore that PPAG has never performed abortions. We counsel women and refer them to government hospitals where abortion services are provided in accordance with Ghanian law. However, we provide care to a steady stream of women who suffer complications from unsafe abortion.

In 2003, PPAG wrestled with a decision of whether to sign the gag rule or not. It was thoroughly debated in our organization. Would we forego our 30-year partnership with USAID which helped us reach the poorest and most vulnerable people in Ghana, or would we violate the trust we had built with these same people and communities?

Signing the gag rule would have meant breaking with one of our greatest ongoing public health crisis, maternal death from unsafe abortion. We found the gag rule morally offensive and at odds with our mission and medical ethics, to improve the health and well being of our clients. To risk the lives of Ghanian women because of domestic policies in another country left us little choice.

So we refused the terms of the gag rule, and the impact was immediate and damaging. We lost nearly $600,000 annual funding which could have come from USAID, which was about a third of our budget. We had to lay off half of clinic staff and more than 1,000 community-based agents, the backbone of family planning outreach for rural Ghanaians. We also lost U.S.-donated contraceptive supplies, and began experiencing shortages.

Our once dependable system for delivering health information, contraceptives and condoms was collapsing, and we were no longer able to provide free contraceptives to our poorest clients.

So, Ghana's biggest rural outreach program by an NGO in family planning, providing nearly 20 percent of all contraceptives was seriously affected by the Global Gag Rule. In less than 1 year, our condom distribution fell by 40 percent. In 2004, 38,000 women who relied on us for family planning were no longer able to obtain the contraceptives from us.

I want to show you a map of Ghana indicating where we were before the gag rule and where we are now, and you would see that we lost a whole lot of communities that we were providing services to. Most disturbing of all, we saw 50 percent more women come to our clinics for post-abortion care in the year after we refused the terms of the gag rule. For us this was a clear and direct impact of the gag rule. The loss of family planning services and supplies resulted in more unintended pregnancies and more unsafe abortions.

Let me share the story of a young lady from a village in the northern part of the country. She was receiving contraceptives from one of these community health agents in her village, but in 2004, they noticed that the agent had no contraceptives to give them, and they were all directed to the Kparigu Clinic. Even though it was a few kilometers away, on foot it takes the greater part of the day.

Kolgu Inusah, this young mother of two, who became pregnant wanted to abort the pregnancy by using local herbs. After experiencing severe abdominal pains, she was rushed to our clinic. The medical team tried to save her but it was too late.

The death of Kolgu was entirely preventable. From where I sit, the gag rule has resulted in more abortion, not less. The policy undercuts family planning and contraceptives which help women avoid unplanned pregnancy and abortion. We will never know, Mr. Chairman, how many more women have shared Kolgu's fate, but I suspect the total is high and growing because in Kparigu alone where we have this clinic I have mentioned, four deaths have been recorded.

Life is life whether it is the life of the mother or the life of the child, and what we want to do is to save both the mother and the child. I humbly urge the U.S. Government to repeal the Global Gag Rule on behalf of women everywhere. We are asking for the rights of women in our country, especially women in rural areas, rights that others have in the developed world.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Nerquaye-Tetteh follows:]

PREPARED STATEMENT OF JOANA NERQUAYE-TETTEH, PH.D., FORMER EXECUTIVE DIRECTOR, PLANNED PARENTHOOD ASSOCIATION OF GHANA

Chairman Lantos, members of the House Committee on Foreign Affairs, Committee Staff and my esteemed colleagues, I would like to thank you for holding this hearing to assess the Mexico City Policy/Global Gag Rule and its impact on international women's reproductive health in US-funded programs. Additionally, Mr Chairman, we are very aware that only the strong support of Congress has prevented an even more serious erosion of the United States program in international family planning. On behalf of the volunteers and staff of the 150 Member Associations of the International Planned Parenthood Federation—and the women and families we serve—we thank you.

My name is Joana Nerquaye-Tetteh. Today, I speak to you as the former Executive Director at the Planned Parenthood Association of Ghana (PPAG) from 1995–2006. I held this position when the Global Gag Rule was being implemented in Ghana, a time of tremendous turmoil. I personally witnessed the destructive impact the Gag Rule had on our programs and on the clients we serve. It is my hope that by telling the story of PPAG, I can give voice to those people most affected—women and girls. The experience of PPAG mirrors the experience of IPPF around the world.

First, I will explain a little bit about how PPAG has come into existence, and then provide you with some overall context of Ghana. I will then describe the work of PPAG before we were affected by the Gag Rule and the impact the Global Gag Rule has had on the ground and in our clinics. Finally, I will offer some thoughts on the overall effect of the Gag Rule.

THE BIRTH OF A NATIONAL ORGANIZATION

Planned Parenthood of Ghana was founded in 1967 when a small group of doctors and lawyers came together to confront a persistent public health issue they faced on a daily basis. Women were suffering and even dying from pregnancy-related ill health which they knew could be prevented by quality family planning services. Our founders believed in "children by choice, not by chance." This was the motto in those early days and it remains the motto of PPAG today.

Over the years, PPAG grew into a national organization, reaching people in 63 districts, spanning seven of Ghana's ten regions. PPAG is a proud member of IPPF, a global service provider and leading advocate of sexual and reproductive health and rights. IPPF is a worldwide movement of national organizations working with and for communities. We envisage a world where women, men and young people have control over their own bodies, and therefore their destinies. IPPF's strong sense of solidarity and unified vision transcend political, economic, religious and ethnic boundaries.

ADVANCES AND CHALLENGES IN SEXUAL AND REPRODUCTIVE HEALTH IN GHANA

Ghana has a long history of voluntary family planning. We approved our first national policy on population and family planning in 1969—among the first in Africa—

and the total fertility rate (TFR)[1] has gradually declined. Since 1988, use of contraception among married women has doubled to 25.2 per cent and use of modern methods has more than tripled to 18.7 per cent[2].

While we are making some progress, the challenges facing us are daunting. There is a serious disparity between urban and rural areas—contraceptive use remains low and fertility rates are high in rural Ghana[3]. In addition, Ghana's population is young and 50 per cent of adolescents aged 12 to 19 live in rural areas[4]. The rural poor, including a large proportion of young people, cannot afford contraceptives and family planning services and also may not be able to afford the journey to the nearest service outlet because almost half of Ghanaians earn less than $1 a day. The pregnancy rate of young, rural girls aged 15 to 19 is double that of those living in cities[5] and many of those pregnancies are unintended.

In my country, one in 35 women will die during pregnancy or in childbirth[6]. (By comparison, only one in 2,500 women living in the United States will ever die of pregnancy-related causes[7].) For us, childbearing remains an important role for women. It is simply unacceptable that women face a real risk of dying every time they give birth merely because they do not have access to the reproductive health services and supplies that they need and want.

If you live in a rural area of Ghana, you may have to walk for miles for a prenatal examination or to buy contraceptives. Sometimes, when you arrive, there are none in stock. We are lucky that the prevalence rate of HIV/AIDS in Ghana is low at this point in time[8], but as long as access to condoms is limited, the rate could rise.

SNAPSHOT OF THE PLANNED PARENTHOOD ASSOCIATION OF GHANA PRE-GLOBAL GAG RULE

Let me take you back to the Planned Parenthood Association of Ghana, circa 2002, before we were faced with the Global Gag Rule.

At this time, PPAG offered a comprehensive range of sexual and reproductive health information and services. These included family planning methods, specialized youth-friendly clinics, mother-and-child health welfare services, such as child immunizations, and antenatal and post-natal services. We provided HIV/AIDS prevention, voluntary counseling and testing (VCT) for HIV/AIDS, sexually transmitted infection management, post-abortion care, fertility management, specialized male reproductive health services, laboratory services, treatment of minor ailments and referrals.

In 2002 we distributed more than 6.5 million condoms—twice the number reached by the government-run health service. We were the second largest distributor of contraceptives in rural areas (rural outreach is the hallmark of PPAG's services), and third in the country. The reach and extent of PPAG's family planning services was achieved, in part, with the generosity of US taxpayers and the long-standing cooperation and partnership we shared with USAID.

A $2.8 million USAID grant, from 1999 to 2004, gave PPAG the means to realize a long-desired plan: to implement an innovative community-based services project to reach the most vulnerable groups in rural areas. PPAG grew to include over 1,800 trained community-based volunteers and 13 staffed clinics. This project vastly increased the uptake of contraceptives[9].

Let me share with you the words used in an independent case study report:

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[1] Total fertility rate (TFR) is defined as the total number of births a woman would have by the end of her childbearing period if she were to pass through those years bearing children at the currently observed rates of age-specific fertility. The TFR is obtained by summing the age-specific fertility rates and multiplying by five. Source: *Ghana Demographic and Health Survey* (2003) USA: Measure DHS.

[2] Solo, J.,et al. *Ghana case study: 'Give them the power'* (2005) A case study report of the Repositioning family planning initiative. New York: ACQUIRE Project/Engender Health. P. 6.

[3] The total fertility rate in urban areas is 3.1, compared to 5.6 in rural areas. Source: "Ghana" in *Country Profiles for Population and Reproductive Health: Policy Developments and Indicators* (2005) USA: Population Reference Bureau. Pp 53.

[4] "Adolescents in Ghana" (2006) In Brief. USA: Guttmacher Institute.

[5] *Indicators for reproductive health: Ghana* (2006) USA: UNFPA.

[6] *State of the World's Mothers* (2007) USA: Save the Children. <www.savethechildren.org/jump.jsp?path=/publications/mothers/2007/Mothers-Index-2007.pdf> [Accessed 8 October 2007]

[7] Ibid.

[8] HIV/AIDS Among Adult Population, Ages 15–49, is 2.3%. Source: "Ghana: Demographic and health highlights" (2005/2006) USA: Population Reference Bureau. <www.prb.org/Countries/Ghana.aspx> [Accessed 8 October 2007]

[9] Couple-years of protection, achieved by PPAG, rose from 61,000 in 1995 to 96,000 in 1998, and more than 128,000 in September 2002.

"Since [1967], PPAG has been in the forefront of advocating for reproductive health and rights and delivering services at the clinic and community levels.

PPAG pioneered the introduction of a small community-based [services (CBS)] program in 1974. The program continued to expand with support from various sources, including USAID . . . The difference between the earlier distribution of contraceptives and [community-based services] was a more holistic approach to reproductive health. Volunteers and nurses took into account the needs of the clients, made more information available and increased referrals for clinical services beyond family planning (sexual health, maternal and child health, and STI prevention)." [10]

Galvanizing their combined expertise and resources, USAID and PPAG effectively prevented significant numbers of unwanted pregnancies and reduced maternal mortality among Ghana's women and girls

This USAID–PPAG initiative was, remember, just one example of collaboration between USAID and an IPPF Member Association. The achievements of the community-based services program in Ghana were echoed in many countries and communities across the IPPF network. A joint review of the USAID–IPPF partnership, completed in 2000, noted

"There is high interest on the part of USAID and IPPF in increased dialogue and mutual engagement. IPPF and USAID should seek opportunities to exchange information on their priorities, strategies, and field experiences . . . Both USAID and IPPF see the value of continuing the relationship (USAID 2000)." [11]

WHY WE COULD NOT SIGN THE GLOBAL GAG RULE

After the reinstatement of the Mexico City Policy in 2001, PPAG, along with many other IPPF Member Associations, faced a nearly impossible choice. We had to choose between losing our 30-year partnership with USAID, which helped us reach the poorest and most vulnerable people in Ghana with family planning services and supplies, or to violate the trust we painstakingly built with these same people and communities. If we signed the Global Gag Rule, we would breach the medical ethics of our staff by requiring them to withhold life-saving, medically-necessary information from our clients—requirements that were being imposed by a foreign government.

Let me explain further. The people of Ghana come to our clinics or seek out our community-based health workers because they trust us. They trust us because we give them full information and confidential counselling so they, in turn, can make their own reproductive health choices. Family planning and contraceptive distribution comprise the majority of our services because we know that the best way to prevent unintended pregnancies and to reduce the need for abortion is to make sure that women, couples and young people have information about and access to contraception.

At the time that we were faced with this decision, PPAG did not perform abortions. Rather, we counselled women and, if needed, referred them to our government hospitals where upon advice of a qualified doctor abortion services are provided according to Ghanaian law[12].

We wrestled with the decision of whether to sign the Global Gag Rule; it was deeply debated within PPAG as well as throughout all parts of IPPF. To sign it would have been to turn our back on women, consigning them to risk their lives and health through unsafe abortion. To sign the Global Gag Rule would have meant breaking with medical standards in our own country by not informing our clients about the full range of medical services legally available to them. It seemed to us that the Global Gag Rule was playing politics with women's lives. We found it morally offensive and totally at odds with our mission and medical ethics to risk the lives of Ghanaian women because of domestic politics in another country.

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[10] Solo, J.,et al. *Ghana case study: 'Give them the power'* (2005) A case study report of the Repositioning family planning initiative. New York: ACQUIRE Project/Engender Health. Pp 22.

[11] *Joint review of the International Planned Parenthood Federation and the U.S. Agency for International Development Partnership* (2000) A USAID-funded report. USA: POPTECH. Key findings and conclusions, pp (vi).

[12] Ghanaian law (1985) allows for safe abortion within certain circumstances: "Where pregnancy is the result of rape, defilement or incest; where continuance of the pregnancy will involve risk to the life of the pregnant woman or injury to her physical or mental health; or where there is substantial risk that the child, if born, may suffer from or later develop a serious physical abnormality or disease." Source: *Prevention and management of unsafe abortion: Comprehensive abortion care services* (2006) Accra: Ghana Health Service. 23.23.

From a completely different part of the world, Dr Nirmal Bista of the Family Planning Association of Nepal, in his testimony before the Senate Foreign Relations Committee in July 2001, expressed well the anguish we were experiencing:

> "Were we to accept the restricted U.S. funds, I would be prevented from speaking in my own country to my own government about a health care crisis I know first-hand. But by rejecting U.S. funds, I put our clinics—clinics addressing that same health care crisis—in very real jeopardy.
>
> It is an untenable situation. But, we simply could not stand by and watch countless women suffer and die without doing everything we could to prevent the misery[13]."

In the end, we chose to refuse to abide by the Global Gag Rule requirements as did the whole of IPPF. The Global Gag Rule endangers the lives and health of women and families around the world. It undermines the provision of family planning services and information; it causes more women and couples to face the reality of unwanted pregnancies; it exposes women to the dangers of unsafe abortions. As our founder and special adviser to the President of Ghana, Dr Fred Sai compellingly stated

> "A straightforward public health problem with a known solution has been allowed to become the killing fields of women in developing countries, particularly Africa." [14]

THE DETRIMENTAL IMPACT OF THE GLOBAL GAG RULE IN GHANA

Around the world, the imposition of the Global Gag Rule and the consequent loss of funding have had a dramatic impact on the ability of IPPF Member Associations, and many other organizations, to provide full sexual and reproductive health services. The impact on PPAG was immediate, deep and damaging. PPAG lost all of its in-country USAID funding as well as USAID funding received via IPPF headquarters. In one fell swoop, PPAG had to absorb budget cuts of nearly $2 million.

An independent evaluation developed for Repositioning Family Planning, an initiative funded by USAID, stated:

> "Losing PPAG as a cooperating agency, and the resulting dismantling of a huge operation of contraceptive services and distribution, certainly had a negative effect on family planning coverage in Ghana. In 2003, 17% of all contraceptive sales were from the PPAG system, and most importantly, from rural areas. More than half of PPAG's 192 staff members were laid off, and more than 1,000 volunteers were without the structure that kept them motivated and supplied." [15]

When PPAG lost USAID-donated contraceptive supplies, we experienced contraceptive shortages and stockouts in some regions, at times for several months. We were no longer able to provide free contraceptives to the poorest of the poor. In less than a year, PPAG's condom distribution of 6.5 million fell by 40 per cent.

We were compelled to create a new 'cash and carry' system to fund the purchase of contraceptives. Despite this attempt to bolster contraceptive availability, PPAG was able to provide only half the number of contraceptive supplies in 2004 that we provided in 2003. This shortage meant that 38,000 women who had come to rely on PPAG for contraceptives were no longer able to obtain them.

PPAG has kept in touch with some of its community-based volunteers. Six of them who live in the areas surrounding Kparigu, one of the poorest and most rural areas of Ghana, recently spoke with us. I will share with you their first hand experiences. Their names are James Manga from Boayili, Sam Duud and Kasim Sumani from Kparigu, Abraham Aduku from Zasilari, Haruna Mahamodu from Boamasa and Abubakir Yamusa from Guakudow. They keep in contact with the PPAG Kparigu clinic even though there is no money to pay them for their travels to and from the clinic and no contraceptives to distribute. James, Sam, Kasim, Abraham, Haruna and Abubakir were all trained to be community-based service volunteers about seven years ago with USAID funds.

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[13] Schlangen, Rhonda. "The Global Gag Rule: Playing politics with women's lives" (2 July 2007) USA: Planned Parenthood Federation of America. http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/international-issues/global-gag-rule-15079.htm [Accessed 27 September 2007]

[14] *Death and denial: Unsafe abortion and poverty* (2006) UK: IPPF.

[15] Solo, J.,et al. *Ghana case study: 'Give them the power'* (2005) A case study report of the Repositioning family planning initiative. New York: ACQUIRE Project/Engender Health. Pp 22–23.

Haruna said, "We are all ready to work, but we need the contraceptives."

Kasim said, "I need 60,000 cedis[16] to buy 600 condoms and another 60,000 cedis to buy 50 cycles of pills. In my community these will last about six weeks, but most of the time I do not have this money."

At the same time, 20,000 women and their babies who had maternal and child health care (including immunizations for the babies and family planning for the mothers) in the outreach programs could not get that anymore and over 8,000 people could no longer be reached with treatment for STIs.

Sam said, "We still refer women to the PPAG clinic but because we have stopped many of the community programmes there are fewer referrals."

Finally, and most tragically, we saw 50 per cent more women come to our clinics for post-abortion care. Some of these women died from self-induced post-abortion complications in one rural community in the North. "In Ghana complications of unsafe abortion contribute [to] 22 to 30 percent of all maternal deaths. This exceeds the World Health Organization estimate of 13% [worldwide]"[17]. The tragedy of unsafe abortion in Ghana is so heartbreaking that it inspired a British radio (BBC) program to document the situation and share the personal stories of Ghanaians whose lives have been changed as a result[18].

AFFECTING REAL PEOPLE, REAL LIVES

Perhaps the impact of the Global Gag Rule will become more real with a personal account of the tragedy it has brought about. Benjamin Baavugi, a 40-year-old farmer from Boayili village, is currently caring for his niece and nephew because their parents have been severely and directly affected by the impact of the Gag Rule. A few kilometres from the PPAG Kparigu Clinic, in Benjamin's village, he told me the story of his sister-in-law, Kolgu Inusah, who died of an unsafe abortion.

I will let Benjamin tell this tragic story of an unnecessary and preventable death of a young mother for lack of contraceptives:

"To understand what happened to Kolgu, I have to describe the situation in our village about seven years ago. We had a [community-based services] agent who was working in the village, regularly giving talks on family planning and the use of contraceptives, HIV/AIDS and environmental sanitation. The education was good for us, especially for the women, and many of them started using contraceptives to space their births . . . My wife used contraceptives and we spaced our children.

About the middle of 2004, we noticed that the frequency of the agent's house to house visits and talks had reduced and sometimes he did not have enough contraceptives, and then after some time he stopped everything. There was no education and no contraceptives. When the women visited him he informed them that they had to go to Kparigu Clinic. Since this was a few kilometres away it was easier said than done.

A few months after this we noticed that the number of pregnancies had increased and there were rumours of women having abortions. Kolgu and my brother, Kala Inusah, already had two children, Helene, 5, and Nurdee, 2. One day she started complaining of severe abdominal pains and when it became serious she confessed to her husband that she found out she was pregnant and went to a woman for some herbs to abort it. Kala rushed her to the PPAG clinic, but he did not tell anybody in the village the real problem. The medical team at the PPAG clinic tried to save her but it was too late.

After Kolgu's death there was a lot of trouble in the village because the elders interpreted this sudden death as coming from the ancestors. Somebody had to be blamed and Kolgu's sister, Abu Bahe, was accused of causing her sister's death and she was banished from the village. We reported the case to the Medical Assistant at the PPAG clinic and the issue has been resolved. However my brother is not very well so I am looking after his two children."

David Kansuk, the medical assistant and head of the PPAG team at Kparigu, is a tribal chief in Nalerigu. He understands his people and has their trust. He ex-

[16] This amount is approximately US $6

[17] Professor Agyeman Badu Akosa, Director General, Ghana Health Service, June 2006 (Foreword of *Prevention and management of unsafe abortion: Comprehensive abortion care services* (2006) Ghana Health Service)

[18] "Ghanaians risk death for abortion" (11 January 2006) BBC Radio Four: Crossing Continents. <http://news.bbc.co.uk/1/hi/programmes/crossing_continents/6246303.stm> [Accessed 3 October 2007]

plained that traditionally after childbirth the woman goes to stay with her parents for about two years. This naturally creates space between births. Although things have changed and most couples continue to stay together after having a baby, there is a lot of mocking if the woman becomes pregnant again before the child is two years old. The use of contraceptives had therefore become important and was gaining ground among both men and women. This explains the situation Kolgu found herself in.

David continued the story of Kolgu:

> "Before this lady died she told the nurses what she had done, using herbs to try and abort her pregnancy. We were surprised therefore to get a delegation from the village with the news that a woman had been banished because she had been accused for causing the death of Kolgu. We confronted Kala Inusah and after discussions he agreed to tell the community the truth. We went to the village and a meeting of the elders was arranged at which Kala told them what had happened. He confessed that he was ashamed of what his wife had done. It was agreed that Abu had been wrongly accused and she was brought back to the village. After this PPAG organized a sensitization seminar for the community and educated them on the dangers of unsafe abortion.
>
> In many of the communities where we had community-based service providers, reports of unsafe abortion have increased and we have had more post-abortion complications and deaths in this clinic since the Gag Rule and the end of our community-based services program which was supported by USAID. We see on average two to three women a month for post-abortion care. Those who can afford it travel to clinics in Bolgatanga and Walewale where they get safer abortion services. Unfortunately poor and young women are the ones who are at greatest risk for unintended pregnancies and who end up having the unsafe services and suffering through the consequences."

PPAG's community-based services program through which thousands of rural women, men and young people were given quality sexual and reproductive health services, including distribution of contraceptives, was the biggest rural outreach program in the area. PPAG is the only NGO providing sexual and reproductive health services through community volunteers in this district. The Ghana Health Service and some Christian organizations like the Baptist Mission have clinics in three towns. However, the extent to which we mobilize the community and the reach of our community-based service volunteers cannot be equalled, and a vacuum has been created that the public health service cannot fill.

The table below illustrates the magnitude of the reduction in PPAG's services to the poor and marginalized women of Ghana.

PPAG Service Statistics	Pre-Gag *		Post-Gag		
	2002	2003	2004	2005	2006
Number of clinical services for sexual and reproductive health**	2,482,487	2,679,638	1,035,780	664,176	958,608
Male Condoms distributed	6,518,572	4,411,437	2,755,060	3,506,479	3,190,861
Other contraceptives***	1,287,298	1,093,336	561,582	551,906	652,685
Facilities (service outlets)	17	16	15	14	12
No. of Community based Service Agents (volunteers)	1750	1685	760	650	761

* Though the Global Gag Rule was reinstated in January 2001, it did not immediately impact PPAG due to the fact that PPAG and USAID had a multi-year funding agreement which did not come up for review until 2003.

*** Clinical services include: post abortion care, MCH, infertility, family planning, treatment of minor aliments, HIV counseling, STI management, Male SRH services

*** other contraceptives includes: female condoms, injectables, oral contraceptive pills, norplant, IUD, Norigynon, emergency contraception

UNDERMINING FAMILY PLANNING AND PREVENTION OF HIV/AIDS

Reduced access to family planning—condoms specifically—was a clear result of the Global Gag Rule. With limited access to contraceptives and reproductive health

services, not only did the number of unintended pregnancies increase, but so did the number of new sexually transmitted infections.

In my country there are 7.5 million young people[19]. This is a group that is particularly vulnerable to HIV/AIDS but, unfortunately, many of them don't believe that HIV is a real threat to them and they do not protect themselves against it. Young people understand unwanted pregnancy, however. The Guttmacher Institute did a study in four sub-Saharan African countries, including Ghana, and they found that young people were more likely to use condoms to prevent pregnancy than to prevent HIV (only 5% of females used a condom for protection solely against STIs, including HIV/AIDS)[20]. In fact, Ghana has a high proportion of women living with HIV—64 per cent of HIV-infected adults in Ghana are women—the highest recorded rate among 16 West African countries listed by PRB[21].

Those of us working in the field of reproductive health know that integrating HIV prevention and family planning programs is one of the most effective ways of getting young people to protect themselves, against unintended pregnancy and sexually transmitted infections.

Partnering with local churches and mosques, PPAG runs a dedicated program for youth called 'Young and Wise'. At Young and Wise we educate young people to help them make informed choices, to prevent HIV infection and to prevent teenage pregnancy. By refusing to sign the Global Gag Rule, PPAG was unable to continue promoting condoms through Young and Wise. In an article published in the L.A. Times in June 2004, Barbara Crossette illustrates the loss felt by Young and Wise following the implementation of the Gag Rule. She writes

> "The problem is that the supplier to Ghana of the best condoms, the United States Agency for International Development, can no longer give any to this project. Does this make any sense? . . . Because Ghanaians—Christian and Muslim—are a religious people, the effect has been to undermine many programs that conservatives could support[22]."

The U.S. government maintains separate funding programs for family planning and HIV/AIDS, and integration is discouraged owing to funding and policy constraints. When PPAG lost funding from USAID, we hoped that we would be able to continue our HIV prevention programs at Young and Wise by applying to the President's Emergency Plan for AIDS Relief (PEPFAR). Sadly, this was not the case. Any partner that receives PEPFAR funds for integrated family planning/reproductive health—HIV/AIDS programs must comply with the restrictions on both U.S. family planning and HIV/AIDS assistance. This includes the Global Gag Rule. We know from years of experience that to get young people to pay attention—to really change their behaviour so that they are protecting themselves from sexually transmitted infections as well as unintended pregnancies—you have to promote condoms within family planning programs.

OUR CONCLUSIONS

In my country the Global Gag Rule has had the exact opposite effect of its stated intent. It did not reduce abortions. Indeed PPAG began to see a sharp rise (almost double) in post-abortion care services in our clinics, especially in the rural areas which is a reflection of the worsened access to reproductive health care and supplies. The Gag Rule undermined family planning and reproductive health services across the country. Fewer pregnant women were able to access much-needed care, and access to HIV/AIDS and STI prevention services, especially among young people, were reduced.

We will never know the real cost of this harmful policy because we can never know the total number of lives that have been irreversibly altered. It is the lives of poor and rural women, men and young people who were denied the right to make choices that could have improved their living conditions: an STI or maybe HIV infection that could have been prevented, a poor rural mother that could have received quality prenatal care to help her survive a pregnancy and deliver a healthy baby, a woman that could have avoided an unwanted pregnancy and therefore no need for an unsafe abortion and its related complications.

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[19] "Ghana: Demographic and health highlights" (2007) Population Reference Bureau. <www.prb.org/Countries/Ghana.aspx> [Accessed 3 October 2007]

[20] Awusabo-Asare K et al., "Adolescent sexual and reproductive health in Ghana: Results from the 2004 National Survey of Adolescents" (2006) Occasional Report No. 22, New York: Guttmacher Institute. <www.guttmacher.org/pubs/2006/06/08/or22.pdf> Pp 69.

[21] "Women of our World," Population Reference Bureau, 2005.

[22] "Commentary: U.S. Right Squeezes Lifesaving Aid to Africans" (10 June 2004) USA: Los Angeles Times.

When PPAG refused to sign the Gag Rule, USAID hoped to find another NGO to take over the program. This was not possible then and it's still not possible now. There was simply no local or international NGO with the structure and expertise that PPAG had built over 33 years to take over. Not only did PPAG lose a key funder for its core services, but USAID also lost an irreplaceable partner, and the women and children of rural Ghana were the most severely affected.

Ironically, the Global Gag Rule has resulted in an inefficient use of US tax-payers money. No other Ghanaian organization compares to our rural outreach and our youth programs nor the trust and credibility we have with the community we come from. By funding other organizations with smaller reaches into the community, you fund a piecemeal and less cost-effective approach to development.

If USAID-donated contraceptives were made available to PPAG, the effect would be immediate and thousands of women would once again be able to access the services and contraceptives they need most. PPAG could resume community outreach programs to the rural poor. In our experience, the increase in contraceptive provision would dramatically and directly reduce unwanted pregnancies and avert unsafe abortion—thereby saving women's and mother's lives.

Chairman LANTOS. Thank you very much.

Our next witness is Dr. Jean Kagia.

STATEMENT OF JEAN KAGIA, M.D. (KENYA), CONSULTANT, OBSTETRICIAN & GYNECOLOGIST

Dr. KAGIA. Mr. Chairman, I will summarize——

Chairman LANTOS. I am sorry. Would you move the microphone very close to you and push the button.

Dr. KAGIA. I have done so. Thank you.

Mr. Chairman, I will summarize my comments but I would ask that my complete statement be included in the record

Chairman LANTOS. Without objection.

Dr. KAGIA. Thank you.

Honorable Chairman, members of the committee, I am very honored to have this opportunity to address you on this important subject. I am consultant gynecologist and obstetrician born and brought up in rural Kenya. I have worked as a doctor for 31 years, and as a gynecologist for 26 years, both in private and public sector in Kenya. I have had the privilege of working for very many women who have had complications from abortion, some of them physical, and others are psychological.

This is why I have spent a lot of my time trying to find out solutions for these unplanned pregnancies. I am one of the founder and board members of the Institute of Family Medicine which trains doctors for a postgraduate degree in family medicine so as to improve the health care services in the rural areas. I am also a national coordinator of an American-based emergency obstetric care program called Advance Life Support in Obstetrics which helps already working health workers to improve their skills in managing emergency cases, and of course you mentioned that I am from the Protecting Life Movement of Kenya, an organization that teaches people about abortion, possible complications, and alternatives to abortion. We partner with organizations that teach skills both in behavior formation and behavior change for the youth.

Although figures point to high material mortality rates due to abortion in Kenya, the actual magnitude of the problem is not known. All the figures are hospital-based including the latest that were carried out by IPAS reported in 2004.

I wish to state that by imposing the Mexico City Policy the effect on family planning in Kenya has not been adversely affected be-

cause there are other sources and facilities that have continued to offer the services. The IPAS study of 2004 seems to indicate that not only had the abortion situation not gotten worse, but may have improved considering the differences in the population.

In 1982, Aggarwal and Mati did a survey and found that 62 percent of admissions to the hospitals were due to induced or likely induced abortions as compared to 44 percent of the study by Ipas. So there seems to be a bit of a drop, and out of the seven deaths reported by IPAS study, six were due to the use of manual vacuum aspirator in mid-trimester abortions, and this was done by trained medical personnel, showing that abortion is not safe even in the hands of trained health personnel.

The Protecting Life Movement is currently seeking funds so that we can carry out a National Knowledge and Practices of Abortion Survey that will give us reliable information of the magnitude of abortion. We would like this survey to be done by an independent organization which is the Department of Community Health at the University of Nairobi, so that there will be no potential conflict of interest or bias involved. Our hope is to take the results of this survey to create a program that includes education and behavior change programs to build on the successful HIV/AIDS behavior change programs already taking place in Kenya. We will also look for other ways to prevent abortion which would respect and recognize the rights of the life of the unborn child. And after an appropriate time we would be able to do another survey to study attitude and practices to see whether our intervention was practical and see how we can improve the strategy on preventing abortion.

The NGOs that have been affected by the Mexico City Policy do not seem to be conversant with the social, cultural and religious practice of the African woman. In order to attempt to reduce material mortality, one has to propose remedies that do not conflict with these practices, otherwise they will be met with a lot of resistance. Remedies need to take into account the realities and the faith of the African woman and not focus only on family planning—even when this woman is not assured of survival of her children or if she doesn't get any permission from her husband—to practice family planning, or even bring the issue of abortion, which will not only risk her health and the life of her unborn child, but it doesn't make her go against her faith and conscious.

This is actually confirmed by opinion polls carried out in Kenya regarding the legalization of abortion, and even though abortion occur in Kenya, many people, including women, said no to the legalization of abortion. In 2003, 81 percent said no, in 2004, 86 percent said no. These were done by a renowned research company called Steadman Research Group. And this year there was an SMS text message survey done by one of the media houses, and again 85 percent of the people said that they didn't want abortion legalized.

I have to ask why Congress wants to fund organizations that work against the will of the majority of the people of democratic countries.

In conclusion, Mr. Chairman, the promotion of and effort to legalize abortion in Africa is a foreign agenda and a form of recolonization. The Mexico City Policy together with the government, public,

private and some NGOs are going to lower maternal mortality within the African social, cultural and religious setup. I would plead with you to support these local programs that are run by people who respect African babies and women within the context of African culture, faith and real-life situation.

Thank you.

[The prepared statement of Dr. Kagia follows:]

PREPARED STATEMENT OF JEAN KAGIA, M.D. (KENYA), CONSULTANT, OBSTETRICIAN & GYNECOLOGIST

Hon. Chairman, Hon members of the committee, I am very honored to have this rare opportunity to address you on this important subject.

I am a consultant Obstetrician Gynaecologist who was born in rural Kenya and trained in Kenya for both undergraduate and postgraduate. I have worked as a doctor in both public and private sectors for the last 31 years and as a gynaecologist for the last 26 years. In my career I have treated very many women who have had complications from pregnancy and childbirth including women who have suffered physical and psychological injury from abortions. I realized that the indirect causes of maternal mortality include ignorance, poverty, lack of economic empowerment, inadequate health care services in terms of materials and manpower. After seeing their suffering I decided to dedicate my time and resources in getting involved in programs that reduce maternal mortality. This service I give *free of charge*.

I am one of founder and board members of Institute of Family Medicine which trains doctors for a postgraduate degree in Family Medicine so as to improve health services in rural areas. I am the National Coordinator of an American based emergency obstetric care program called Advanced Life Support in Obstetrics. I am also the chairperson of the Protecting Life Movement of Kenya which educates the public on what abortion is, possible complications of abortion and alternatives to abortion, through public meetings and the media. Our organization also partners with organizations that teach skills in both behavior formation and behavior change for the youth.

Although figures point to high maternal mortality rates due to abortion in Kenya, the actual magnitude of the problem is not known. All the figures are hospital based including the latest that were carried out by IPAS in 2005. I wish to state that by imposing the Mexico City Policy the effect on Family planning in Kenya has not been adversely affected because there are other sources and facilities that have continued to offer the service. The IPAS study in 2005 seems to indicate that not only has the abortion situation not gotten worse, but may have improved considering the differences in the national population. In 1982 Aggarwal and Mati found that 62% of admissions due to abortion were induced or likely to be induced[1] as compared to 44% in 2005 by IPAS[2]. Out of the 7deaths reported by the IPAS study, 6 were due to use of the manual vacuum aspirator (MVA) in mid trimester abortion by trained medical personnel, showing that abortion is not safe even in the hands of trained health personnel[3].

The Protecting Life Movement is currently seeking funds so that we can carry out a national 'Knowledge, Attitude and Practices of Abortion' survey that will give us reliable information of the magnitude of abortion. We would like this survey to be done by the Department of Community Health at the University of Nairobi, so that there is no potential conflict of interest or bias involved. Our hope is to take the results of this survey to create a prevention program that includes education and behavior change programs that build on the successful HIV/AIDS behaviour change programs already taking place in Kenya. We will also look for other ways to prevent abortion that respect women and recognize the right to life of the unborn child. After an appropriate period we would want to do a second survey to determine the success of the prevention program and to change it if necessary, so that we can create the most effective abortion-prevention strategy.

The NGOs that have been affected by the Mexico City Policy do not seem to be conversant with the social, cultural and religious practices of the African woman. In order to attempt to reduce maternal mortality, one has to propose remedies that do not conflict with her social-cultural and religious practices; otherwise they will be met with a lot of resistance. Remedies need to take into account the realities and faith of the African woman and not focus only on family planning (when she is not assured of the survival of her children or if she does not have consent from the husband) or abortion (which not only risk her health and the life of the unborn baby but would also make her go against her faith and conscience).

This is confirmed by 'Opinion polls' in Kenya regarding legalization of abortion. Even though abortions occur, the number of people—including women—who said 'NO' to legal abortion were 81% in 2003, 86% in 2004 (Steadman Research Group) and 85% in 2007 (SMS text message survey by a media house). I have to ask why Congress wants to fund organizations that work against the will of the majority of the people of democratic countries.

In considering the solution of the abortion issue one has to remember some very important facts:

1. An Unplanned pregnancy is a social problem and not a medical one.
2. By treating a social problem medically complications do occur even under the best medical conditions both in developed and developing countries.
3. Abortion whether legal or illegal kills babies (wiping out future generations), injures and sometimes kills the mothers.

What the African woman needs is:

1. Education so that she can understand issues particularly those pertaining to reproduction.
2. Economic empowerment to be able to reach health facilities.
3. Provision of accessible, affordable and good quality health care services, including emergency obstetric ones.
4. Prevention of unplanned pregnancies through behavior change programs and family planning services whether they artificial or natural.
5. Transport to health care service.

Enforcing the Mexico City Policy has NOT adversely affected the over all health of the Kenyan women because:

1. 60% of family Planning services are provided by the government up to health center level. 30% is by Faith based health facilities and the rest by private hospitals, clinics and NGOs. This means that the effect of the closed clinics is almost negligible[4]
2. Our two medical schools produce over 350 doctors per year and these are deployed in rural areas thereby improving the healthcare services[5]. The first group of family physicians graduates at the end of this year.
3. Prevention of unplanned pregnancies among the youth is being successfully addressed through behavior formation and behavior change programs such as Life Skills, Worth The Wait, Why Wait, Cross roads, True Love Waits, Wholistic Caring and Counseling Services and Inter Varsity Peer Counseling Association and many more.
4. Free Primary school education which is empowering the girl child.
5. Improving economy (6% growth within the last 4 years).
6. Free ante and post natal care, family planning and delivery services by the government. Free delivery services are given in health centers and dispensaries where most of the poor women are.

In conclusion, the promotion of and effort to legalise abortion in Africa is a foreign agenda and a form of recolonisation. The Mexico City Policy together with the government, public, private and some NGOs are going to lower maternal mortality within the African social, cultural and religious setup. I would plead with you to support those local programs that are run by people who respect African babies and women within the context of African culture, faith and real-life situation.

Thank you.

Ref:

[1] Aggarwal VP, Mati JGK.Epidemiology of induced abortion in Kenya.J Obst Gyn East Cent Afric 1982; 1:54–7

[2] A national Assessment of the magnitude and consequences of unsafe abortion in Kenya page 15 by IPAS 2005

[3] A National Assessment of magnitude and consequences of unsafe abortion in Kenya page 18 by IPAS 2005

[4] Division of Reproductive health and CHAK 2007

[5] Dean of Medical School University of Nairobi

Chairman LANTOS. I want to thank all four of our distinguished witnesses. Your testimony is extremely helpful to this committee. We will begin the questioning with Ms. Ileana Ros-Lehtinen.

Ms. ROS-LEHTINEN. Thank you as always, Mr. Chairman, for your fairness and your kindness to our side. Thank you to all of the panelists. Excellent testimony. Thank you for being here with us today.

I wanted to direct my statements and my questions to Dr. Kagia. Am I saying the name correctly?

Dr. KAGIA. That is quite right. Thank you.

Ms. ROS-LEHTINEN. I have a very difficult name myself so I can identify with that problem.

But thank you for your work, especially with the Protecting Life Movement of Kenya in which you serve as the chair. I think that that is a very important mission, to educate the public on what abortion is and the complications, and you make an interesting statement in your testimony. You say that "by imposing the Mexico City Policy, the effect of family planning in Kenya has not been adversely affected because there are other sources and facilities that have continued to offer the service." That is a very important part of your testimony.

I also wish you much success with the completion of the knowledge, attitude and practices of abortion survey. That seems like a very necessary instrument that is going to give us the reliable information that we are all seeking.

Another important statement that you make in your testimony is that "the NGOs that have been affected by the Mexico City Policy do not seem to be conversant with the social, culture and religious practices of the African woman," and I think that is interesting to point out, and that is why you state that it is a form of recolonization of Africa.

The opinion polls that you cited are very clear about how the people in your country feel about abortion. You then question, "I have to ask why Congress wants to fund organizations that work against the will of the majority of the people of democratic countries." And you conclude by saying, "I would plead with you to support those local programs that are run by people who respect African babies and women within the context of African culture, faith and real-life situations."

So thank you for that testimony. I know that because of the limited time that each panelist has you were not able to elaborate on some other key issues of your testimony, and I wanted to give you the opportunity to do so now.

You discuss here, "In considering the solution of the abortion issues, one has to remember some very important facts." I wanted to give you the opportunity to state those facts. You also have a segment in your testimony about what the African woman needs, and then the statement, "Enforcing the Mexico City Policy has not adversely affected the overall health of the Kenyan woman," and then you point out six reasons why that is so, and I wanted to see if you could have the opportunity to elaborate on that.

Thank you, Dr. Kagia.

Dr. KAGIA. Okay, thank you very much.

Some of the issues that I wanted you to remember include three facts: I want to emphasize that an unplanned pregnancy is not a medical problem. It is a social problem, and by treating a social problem with the wrong treatment you are about to get complica-

tions, and this is why we have complications of abortion, whether you are in developed countries or in developing countries.

The other point is that whether abortion is legal or illegal, it will kill the babies and it will injure and sometimes kill the mothers in whatever setup. In fact, by legalizing abortion you don't improve the skills of the person who is performing the abortion, so abortion will still go on with complications.

Then on the question of what an African woman needs is I think the African woman needs to be educated. She needs to be educated about herself, about her health and particularly the productive health so that if she gets a complication with a pregnancy she looks for solutions, look for help in the medical services.

She needs economic empowerment. Many women, as somebody said, are looking for food to put on the table, and they need to have some money so that they can be able to look after themselves and go to the hospital or healthy facilities.

She needs accessible, affordable and good-quality health care services, and this includes the obstetrical services, and this is why our organization is trying to educate a lot of people on how to improve their skills so that when these women go to the health services they don't die for lack of good care.

And of course, the prevention of the unplanned pregnancies using behavior change and behavior formation programs, and family planning services, and may I state here that family planning services can be both artificial or natural, but as long as you educate that woman, let her know within the context of her faith what she can use, and I do give contraceptives to women and educate them about it.

Ms. ROS-LEHTINEN. And if you could just tell us—Mr. Chairman, thank you for the time—why the enforcement of the Mexico City Policy has not adversely affected the overall health of the Kenyan woman.

Dr. KAGIA. Okay, thank you very much.

This is because the Kenya Government supplies over 60 percent of family planning services for the country free of charge. Thirty percent is given by faith-based organizations, and the 10 percent is from private organizations, private hospitals, NGOs, private doctors and all that. We are producing about 350 doctors per year from our two medical schools, and these are deployed in rural areas so they are improving the health service, and the family physicians whom we are training right now are coming out. The first group is going to come out this year.

The other thing is we have very many programs that are involved in behavior change information in the country. We have free primary education in our country, which is helping the woman to be given a bit of education empowerment so that she can be able to solve her own problems. The economy is improving.

We have free ante-natal and postnatal and family planning clinic services in our country up to the health centers and dispensaries.

Ms. ROS-LEHTINEN. Thank you very much.

Dr. KAGIA. And this is where 80 percent of our women live.

Ms. ROS-LEHTINEN. Thank you, Doctor, and again thank you to the other panelists as well for wonderful testimony. Thank you, Mr. Chairman.

Chairman LANTOS. Thank you very much.

Ambassador Watson.

Ms. WATSON. Mr. Chairman, I really want to thank you so much for bringing these witnesses in. There is nothing like hearing from the people impacted by our policies as to how those policies fit into cultural and social patterns.

I have sat in this committee and I have listened to people on the committee try to impose their cultural beliefs on people who don't even understand what they are talking about, and having lived in foreign countries you have to come at these issues from a point of view and a perspective of people who are being impacted and served by these programs, and I want to thank all of the panelists for enlightening us.

I would like this question to go to you, Dr. Gillespie. In your statement you showed evidence that globally more countries are adopting less restrictive abortion laws in spite of the Mexico City Policy. Is that because of an increasing demand of women in the developing countries or because American organizations push abortion?

Mr. GILLESPIE. The former. When the Mexico City Policy was first pronounced in 1984, we examined what the activities were of USAID-recipient organizations in the countries we worked in. One of the things we found, and we were a little bit surprised and some of us disappointed, was that there were essentially no activities going on, even in the case of IPPF, which is often cited as the principal advocate for changing abortion laws. Only 1 percent of their funds actually were going toward advocacy for safe abortion.

So this is very much an indigenous change brought upon the legislation in the same process that it comes in this country too. It is something that has not been imposed on by outside forces.

Ms. WATSON. Thank you. You also cite instances of how aggressively USAID personnel have been in their attempts to implement the Global Gag Rule. Specifically, it has been used to inhibit a wide range of speech about family planning, and could you speak more about the levels of coercion that have taken place in public forums where reproductive health has been on the agenda?

Mr. GILLESPIE. I didn't mean, and I hope I didn't say, that my former colleagues at USAID were the strongest enforcers of Mexico City. Although there are some overly aggressive enforcers within the agency, enforcement also encompasses State and various other parts of the Federal Government, including HHS.

There is a chilling effect when I hear comments that the Mexico City Policy has not influenced family planning programs. Let me tell you as someone who has spent most of his entire professional life dealing with and working with and enforcing the Mexico City Policy that it affects every recipient of USAID funds. There are many, many examples where there has been coercion in terms of the content of technical articles. This has actually affected me and some of my staff, and we have had to censor articles that we have done. It has stifled free discourse not only in foreign countries but in this country as well.

When you are, as pointed out, the largest donor in this area, and USAID is, and you are in an organization which is highly dependent upon funds from USAID, you have to make a Faustian pact,

and that is what most people have done. They have made a decision, unlike our colleagues in the IPPF affiliate in Kenya, most organizations have caved and said the provision of family planning services takes precedent over the principle of choice.

Ms. WATSON. Dr. Gillespie, my time is almost up and we are probably going to have to break to go to the floor, but on our own time what would you recommend as common ground between two widely opposing groups, those that support choice in family planning and those who are pro-life and don't want any contraceptive activities?

Mr. GILLESPIE. We have heard this morning from both sides of the aisle, including the ranking member and other Republican representatives here, and on the Democratic side, the effectiveness of USAID's family planning program, and USAID has, I am very proud to say to this day, a very effective family planning program. We have also heard from both sides that family planning does prevent pregnancies which may lead to abortion.

Therefore, why not significantly increase funds going to a very effective organization, USAID's population program. That would in fact be common ground and would have a demonstrable impact on unwanted pregnancies and abortion. I would also like to point out that the decline of the administration's request for population funds is taking place. It has been mentioned that there hasn't been any decline. In fact, there has been a decline in the last couple of years.

Chairman LANTOS. The gentlelady's time has expired. It is the intention of the chair to give every member of the committee his or her full 5 minutes. We have votes on the floor. The committee will stand in recess, after which we will resume with Mr. Smith of New Jersey.

[Recess.]

Mr. PAYNE [presiding]. Let me thank the witnesses for your patience. Our voting has concluded for an hour or 2 so I believe we will be able to conclude the hearing before the next series of votes.

Welcome, good to see all of you. I heard most of your testimony, but at this time we will hear from the ranking member of the African subcommittee, Congressman Smith.

Mr. SMITH OF NEW JERSEY. I thank my good friend and colleagues for yielding.

Just let me begin, earlier in the hearing, and each of you were here during it, we showed a video of ultrasound, including 3–D ultrasound of unborn babies, but the ultrasound that we began with was that of a 10-week unborn child moving robustly within the embryonic fluid within the womb, very clearly delineated as a person.

I think those who believe that we are not talking about a human being, a human person, might better believe in a flat earth policy, that somehow the world isn't round. With modern technology, and as my good friend Mr. Inglis said earlier today, increasingly, we are finding that men and women—especially women—who consider themselves pro-choice upon seeing an ultrasound begin to revise, if not radically alter and change their view and become pro-life.

There was a doctor who founded NARAL, Bernard Nathanson, who wrote in the *New England Journal of Medicine*, "I have come

to the agonizing conclusion that I have presided over 60,000 deaths." He was a leading abortionist, and ran the largest abortion clinic in New York City. In the 1960s and 1970s, he went through the state promoting abortion. He has said, "If wombs had windows," and certainly the ultrasound is a window to the womb, that "women would get out of those abortion mills, run out because they would realize that their baby is about to be destroyed."

I was recently with some women from the group known as "Silent No More," women who have had abortions who now deeply regret it. Several of those women told stories about having abortions and once they saw an ultrasound realized what it was that the doctor did to their baby. One woman talked about how, while the abortion was going on, the doctor said, "It's trying to get away," and it immediately crystallized in her mind by "it," the doctor meant the boy or girl, and she wanted to get up off that operating table but obviously she was partially sedated and the abortion was completed.

Dr. Alveda King, a woman who is known for her civil rights work, her uncle was the late Martin Luther King, Jr., has had two abortions, and now is a passionate right to lifer, believing that not only are babies destroyed, but women are injured with each and every abortion. Very often it does not show itself until later on through delayed PTSD or some other psychological manifestation, all to the negative.

So I would ask the panelists first, you saw the ultrasound, and very briefly if you saw a 10-week unborn child moving freely throughout the womb—and again technology improves by the day in terms of our ability to diagnose and treat individuals like that baby before birth. I believe we ought to be looking at these children as the littlest patients who might need micro surgery, not chemical poisoning, not a manual vacuum aspiration suction that literally destroys the child by ripping the limbs and the body and pulverizing the child, and certainly not by toxic chemicals which badly burn and kill and destroy the child. To me that is violence against children.

But I would be interested in knowing, you saw a 10-week unborn child moving. Do you believe it is a person? We will begin with our friend from Ipas.

Dr. OJI. Thank you, Congressman, for the photograph. I am a medical doctor myself for 28 years now.

What we are talking about—all of us agree that life is sacred, we want to save lives, both the life of the child and the life of the mother.

In Nigeria, most women—most women, I want to emphasize—don't have this choice. What I mean is that when they want to manage their fertility they don't have the means, they don't have the rights, the rights are taken away from them. They can't even be able to say, "I want to have two children," and have those two children. So at the end of the day they get pregnant, and when they get pregnant it is a question of, I don't want this pregnancy.

I come from a family of six children. I am the only boy, and I do know how resolute women can also be, and I take a lot of learning from my sisters. Any women that is pregnant from rape or incest, I have tried to counsel other women on that issue. When you

counsel and counsel, they said, "Okay, let me do what I want to do." They go out and have a termination, the end of the pregnancy. If I can show you some of the slides of some young women trying to self-induce abortion.

Mr. SMITH OF NEW JERSEY. If the gentleman would yield. The point is, and I tried to make this point, and we try to make it over and over again, it is affirming them both, helping women with crisis pregnancies. Mr. Manzullo talked about how a quarter of a century ago he and his wife founded a pregnancy care center. We are all about saying there are two people involved here. A humane, just, social justice requires that we look at both and help both. When we abandon the baby, I believe we also abandon the mother.

Let me say on point that the Mexico City Policy permits abortion in rape, incest and life of the mother. Those three exceptions are contained. It is abortion as a method of birth control that is explicitly excluded from funding, and organizations that will not agree to that are the ones who lose their funding.

Dr. OJI. Well, if I could complete——

Mr. SMITH OF NEW JERSEY. Do you think it is a person? That was my question.

Dr. OJI. No, what I am trying to say is that these exceptions of rape, incest and health conditions, these are actually what the Nigerian women are asking for right now, but the law is only to save the life of the woman. A Nigerian woman is not even getting those rights because most of the people who are also working in the country cannot even speak up based on what the women want because the gag rule makes it impossible for them to speak freely even in the case of rape, incest and health conditions. That is the issue, My Honorable Congressman.

Ms. NERQUAYE-TETTEH. Thank you, Mr. Chairman.

I think I agree with you, sir. We are all concerned about life, and the ultrasound shows that, yes, this is a baby in there. We accept that. I accept it. Even in the condition of rape and incest what we are saying is that we want to take away the situation where a woman will have to take that decision to go through an abortion, and therefore we would in that case give emergency contraception if the woman can get to our clinic before 72 hours.

What we are now saying is that we don't even have that opportunity because the contraceptives are not there for us to be able to do that, and that is the whole essence of our experience in Ghana with the gag rule.

Abortion is not legal in Ghana. It is only in those conditions that you have mentioned. But we decided not to sign the gag rule because you are taking away that fundamental opportunity for us to be able to tell a woman, counsel a woman that these are the options that you have, and therefore you can go ahead and take a decision. That was being taken away from us, and we wouldn't succumb to that.

Mr. SMITH OF NEW JERSEY. Just if I could, Mr. Chairman, just briefly to make it very clear that Ghana has seen a 50-percent increase between 2002 and 2007 in contraceptive commodities being provided. If one NGO does not agree to the Mexico City clause, another NGO is there to take the funding. Just like any grant money even for our own districts, for any group that applies, there are

usually three or four or five who would like to have the money. So, if a group does not want to abide by a bright line in the sand, that abortion is not family planning, we will find another NGO.

Dr. Gillespie. Sure.

Ms. NERQUAYE-TETTEH. I think that money might be going to Ghana for other NGOs, but they are not covering the areas that we have left. Those areas are still there and they are not getting the contraceptives, and that is why I decided to come and talk about this.

Mr. SMITH OF NEW JERSEY. With all due respect, Doctor, you have chosen to put abortion above the provision of contraception. It is the abortion choice on your part as an NGO that has precluded those women from receiving contraceptives.

Dr. Gillespie.

Mr. GILLESPIE. When a fetus becomes a person is a philosophical question and I am afraid, Congressman, that your philosophy and my philosophy will never overlap. No, I do not consider that to be a person.

Mr. SMITH OF NEW JERSEY. Then when?

Mr. GILLESPIE. Pardon?

Mr. SMITH OF NEW JERSEY. When? Anytime before birth?

Mr. GILLESPIE. Well, I think that is not germane to this particular discussion.

Mr. SMITH OF NEW JERSEY. With all due respect, if there is a child there, and birth is merely an event that happens to a person before birth, an event, that is all it is——

Mr. GILLESPIE. Well, you have——

Mr. SMITH OF NEW JERSEY [continuing]. It seems to me this is not a philosophical question, otherwise, in the past——

Mr. GILLESPIE. Of course it is.

Mr. SMITH OF NEW JERSEY. It's a fundamental human rights question as to whether——

Mr. GILLESPIE. No, that is——

Mr. SMITH OF NEW JERSEY [continuing]. Or not there is a human being there. You can say that about 1-year-olds and 2-year-olds then because philosophically you may disagree that they are persons, and certainly Dr. Singer in Princeton takes that view. Crick and Watson, the unravelers of the DNA, said we ought to wait 3 days after birth to confer personhood, and that way if an anomaly like Downs Syndrome is detected, the child can be destroyed.

Human rights are for everybody, including the disabled, and age and dependency should not preclude a human right to an individual.

Doctor?

Dr. KAGIA. Can you hear me?

Mr. SMITH OF NEW JERSEY. Yes.

Dr. KAGIA. Yes, thank you. I quite agree with you. We know that life starts at conception and must be protected at all times. I have looked after very many women some of whom have been raped, others have gone through incest, and after taking a lot of time in counseling them they have come back, many of them, many of them have come back carrying their babies to thank me for having helped them.

What I am trying to emphasize is that the African women love babies, and I wish we would just spend some time thinking of how we can help this African woman achieve that aspect of getting a baby in a safe way so that she too does not die.

Mr. SMITH OF NEW JERSEY. Am I out of time?

Mr. PAYNE. Unfortunately, you are on your third 5 minutes, though. Thank you. I know that you have strong interests, and that is why I did allow you to go but we do have to move on.

Thank you very much, the witnesses, and it is good to have you here. I would just ask the question to anyone here who might want to answer. Many of the pro-life movement have stated that abortion is a practice that has been imported from the United States and other western countries, so I have just a general question. You probably can answer it better than we.

Did African women have abortions before United States support for comprehensive planning services came to the continent or was it something that was imposed and said, you know, that it began with the spread of family planning?

Ms. NERQUAYE-TETTEH. Thank you, Mr. Chairman. I think it is not quite right, you know, that abortion in Africa is a foreign thing, it has been brought down to us by any country for that matter. Abortion has been in the African system for ages and ages, and women were using all sorts of concoctions that perhaps our grandmothers know about, which are inserted in the vagina to cause abortion. There are grandmothers who have the experience of massaging the abdomen to get rid of babies.

There are young girls, and this has come up in research in my own organization, young girls who grind bottles to drink, and they think that this will go into the womb to kill their baby because they don't have any idea about the distinction between the digestive system and their reproductive system.

So we have had these issues from time immemorial, and the whole issue though we are talking about is that we want to avoid these things. We want to teach the women to have the right knowledge, to have the right education, and use contraceptives so that they will not have unintended pregnancies.

Dr. OJI. Mr. Chairman, sir.

Mr. PAYNE. Yes.

Dr. OJI. I would like to use some photographs to confirm what she has just said. Can I have those slides up, please?

In the southern part of the country, what you see on the screen there, sir, is a Cassava plant. Anybody that has been to Africa will know that is one of the tubers that is edible. What the young women do is that they sharpen, remove the leaf, sharpen the Cassava plant, lie in an autonomy position, and use a mirror to self-induce by puncturing the embryonic sac with the stem.

The next slide, please. The next one, she just mentioned concoctions. You can see pepper, native chalk and native alum, they grind all those together, they drink it, they insert it into their vagina, and they end up with chemical shock, and they die.

The last one is Bahamian grass. They don't need to sharpen it. They just remove the leaves, and they do the same and insert into the vagina to self-induce abortions. This is not imported from the U.S.A., Mr. Chairman. This is what is happening in our country

right now. These people don't have any information about reproductive health services. That is why they are doing this. It is not a modern thing. It has been happening in our society, and it will always continue to happen.

Thank you, Mr. Chairman.

Mr. PAYNE. Thank you. Yes?

Dr. KAGIA. Thank you. I want to put up this suggestion that in the real African culture there are systems that are laid out to help young people not get pregnant before they are married. In other words, not to get involved in sexual activities before they are married.

With modernization, media changes, you find this is breaking down, and this is why you find young girls are getting pregnant before they are married. That brings an issue because they are not supposed to get pregnant, and this is why I am saying that behavior change programs, where these young people are going to be taught and be brought back to their original state where Africans are able to stay without having sex before they are married. But you see they are bombarded with a lot of media, things in the newspapers, pornography, internet, everything is coming round, and they are being destroyed. We have to find a way of bringing them back to where they originally were.

Mr. PAYNE. Well, thank you very much. I will ask Mr. Fortenberry from Nebraska.

Oh, excuse me, Dr. Gillespie, was there another statement that—oh, Dr. Oji.

Dr. OJI. What I just want to add here, Mr. Chairman, is that regardless of what we all see either in this room or anywhere that anyone is discussing in rooms the fact here remains that women are dying out there, Mr. Chairman, and it behooves all of us to see how we can get around this issue and not make it a personal or a moral issue, but knowing that women are dying, and it has been shown very well that contraception reduces unintended pregnancies, and also reduces the chance that a woman has a pregnancy she doesn't want to keep.

In Nigeria, in the work that we do, we are working in 17 states, we have seen post-abortion care sites where we have integrated post-abortion family planning. We are getting more clients for family planning than abortion complication clients which shows that the women want contraception. There is always this idea that Nigerian women do not want contraception. There is high unmet need.

We have seen in some post-abortion care sites, we have integrated post-abortion family planning. After these services, women are counseled to make sure they know the methods of family planning. Women are now coming directly to those sites without any abortion complications, so we are seeing more women getting methods from a site that was not originally planned for family planning.

So this is what I just want to get across to you, Mr. Chairman, and the honorable members of this House today.

Mr. PAYNE. Thank you very much. And I might just ask real quickly again, the gag rule was, of course, intended to prevent U.S. dollars from being used for abortion, and therefore going to family planning organizations.

Have you seen any reduction because, first of all, in your family planning you highlight the ways to have healthy children and spacing and those things, and correct me if I am wrong, and then only when it is necessary to hear all options then you talk about an option of adoption, but I am sure that most of your counseling is to try to see how a person can have a healthy child, et cetera? Could you respond to that real quickly?

Ms. NERQUAYE-TETTEH. Yes, Mr. Chairman. Thank you very much. And the whole essence of our program is as you are saying, to educate the woman, keep the necessary support so that they would have a child when they want to have that child, so that that child will be loved and cared for, and before many women would go to the extent of saying that they want an abortion, at least in my country, it will be because they have been—they are in a desperate situation. Usually it is partly the economy that they are not able to get out from the emotional drain. Sometimes it is also their health, especially those who also have a lot of children at very short intervals.

So every time there is something which is driving this woman to take such a decision, and our aim is to help them to take the right decision so that the first choice is always not abortion, and abortion has never been a family planning method. The methods are the contraceptives.

Abortion is an end thing that a woman does because out of the desperation she is not able to make that decision that, look, I will have another child.

Mr. PAYNE. Thank you very much.

Jeff, the gentleman from Nebraska.

Mr. FORTENBERRY. Thank you, Mr. Chairman.

Dr. Kagia, I don't think I have heard a more uplifting, hope-filled message or phrase since I have been in Congress in regards to what you just said. African women love babies. What a beautiful, simplistic way of describing your commitment, your work, and I want to unpack the question a little further in regards to what you said after that.

If we spent our resources on aggressive efforts to look at the way in which—if we are not actually participating in a cultural imperialism in your country, in the West and other places in the world, and imposing a Western paradigm, and therefore potentially undermining traditional norms that try to keep the innocence of children and the family system in tact, try to stand against the assaults on human dignity, that try to create a mechanism or a mindset that resisted the modern forms that have taken place through aggressive globalization, the sexual saturation of messages through the internet or the widespread use of pornography, and use the limited resources that we do have there to preserve the norms that have protected against this malaise in the past and try to change behaviors so that we can get underneath the root of the problem instead of watching people fall off a cliff, and then trying to figure out what we do with them, this is my concern.

I just was very uplifted by what you said because I think it goes to the heart of what should be the integrity of our foreign assistance policies, upholding the dignity and value of a life and children, promoting the ideals of a nurturing mother, a caring protec-

tive father being sensitive to the cultural indigenous norms of the populations that we are actually trying to help. I just congratulate you on that vision, but I would welcome input as well from the other panelists who have a comment on what I said.

Dr. OJI. Mr. Chairman, Congressman, thank you for your inputs.

We do agree that African women love children and I also just showed you some slides of women who also wanted to terminate the pregnancies that they have gotten. We are talking in terms of people getting pregnancies they don't really want, Mr. Congressman.

Obviously, within marriage people want children, but at the same time that is declining because of the economics of population and development. In the U.S., the average population size in terms of your fertility rate is about two; two kids per family. In Nigeria, it is about 5.8, and 70 percent of the population of 440 million earn less than $1 a day.

So even if there are some traditional values that are very, very good, as time moves on or as people move on in the society and there is a lot of development, there are certain things people also want to make sure that they improve their well-being. A man who earns $1 with six children; how would he be able to manage those six children? That is the problem.

Mr. FORTENBERRY. Okay. That is a reasonable point but I think it is a point for common ground. Is there interest in abortion or is there interest in child survival? Is there interest in isolation and abandonment and hopelessness that takes place when somebody has to turn to the methods that you talked about or is there interest in reforming the community so that no matter how difficult the circumstance a person never feels abandoned to such a tragic decision, which I think I hear everyone agreeing that it takes a life, it should be avoided by the means if possible?

So I agree that are we talking—is there another component to this, of child survival, promoting opportunity, other forms of health that allow for hope and don't force someone into a decision that has so many health care ramifications and very often leads to despair?

Ms. NERQUAYE-TETTEH. Mr. Chairman, I just want to say something briefly on that. Several years ago, around 1968, I was at the U.N. as a very young girl, and it was a U.N. meeting for young people, and I remember that one of the things that the African countries were all shouting about was that we don't need any family planning because we have vast lands in our continent. We can grow the food that we need and we can, you know, spread as much as we want.

Several years after that, I am seeing in my own country a place where the population has become so high that we are having challenges in using the very scare resources for our education, for our health system, and so on and so forth. And you know, yes, we are talking about child survival, but we are also talking about a system where things are going overboard if we do not have the right systems, and this is where we are very happy with the sort of help that we have had from USAID for so many years, that we have been able to build our systems to sustain that. Now a number of people can use contraceptives to prevent having unwanted children.

What we are trying to say here is that bringing in the gag rule and forcing us to take a decision that we would not sign such a document is sending us back, and is more or less a waste of all the huge resources that USAID has pumped into our countries, not only Ghana, Kenya is one, Ethiopia is one, and my friend from Kenya mentioned earlier on that.

You know, the fact that the gag rule has affected Kenya, I mean, it is not true that it is not really affecting Kenya because other NGOs are doing the work. There is information from the DHS that the CPR, the contraceptive prevalence rate is stagnating. It is there in a document in 2003, and I can assure you that it is because the largest family planning organization is not contributing what it was contributing before to what the government was doing, and this is happening in all our countries.

So we are talking about survival of our children. We are talking about survival of our women. We do not want abortion in our countries, we don't, but we also don't want to be forced to sign anything which will prevent us from giving the necessary counseling and information to our women, and as Congressman Smith said earlier, it is our fault that we didn't sign it. It is. But the point that we are making is that no country should be forced to do something which is against the ethic of that country, and this is the point that we are making.

Thank you.

Mr. PAYNE. Thank you very much. As a matter of fact, 18 countries in Africa have received less funding from the family planning reproductive health out of 34 countries on the list, so it is certainly a sad decline because we are really not helping many countries that, as you mentioned, many people live on less than $1 a day providing for six and eight people in a family, and like the Congressman said, you didn't sign it so it is your fault. You are right.

Ms. Jackson Lee.

Ms. JACKSON LEE. Let me thank you, Mr. Chairman, and let me thank Mr. Crowley as well, and I apologize to the witnesses. We are both in between meetings. But I want to thank each of you, and I really sincerely mean that from my heart. You are speaking from your heart, and from your experience, and from the needs that you perceive that have been impacted by the Mexico City Policy.

And I want to say to my colleagues who I disagree with vigorously on the other side of the aisle, I understand that they are speaking from their heart and their beliefs, but allow me to just do a line of questioning that I think speaks to the horror, the nightmare that women face when they don't have reputable family planning, and I want to applaud Kenya for finding resources that address their policies.

I think the bottom line is that countries who desire a certain policy should have that opportunity. Others who believe in a different approach to helping women should not be stifled in their medical determination. So when you look at the horror of 67,000 women die each year because of unsafe abortions, I begin to see medical issues being raised. So in this country many times, most of the time we allow a physician to make a medical decision so that life can go on as the mother, the woman desire it to be.

I always say that it goes on for a woman to have life again, to give birth again, to have a better situation so that the idea of child survival is a reality as opposed to it being simply a visual or a concept.

So I want to ask, is it Dr. Tetteh, or is it Dr. Nerquaye-Tetteh? Thank you very much, Doctor. And you may have some knowledge of the situation in northern Uganda where women have been left unattended. It is both conflict there but more importantly they are totally without, as I understand it, workable family planning. So I want you to speak to this from the medical perspective, and the medical impact that comes about, one, in successive births, the toll on the mother, the woman, toll on prospective or future children at birth, the response or the treatment of those who have tried to self-abort and what happens to them, and the cost to the nation, to the health system in your country or in Africa broadly, if you have some concept, on what happens when we don't provide medical care and options for women. Doctor.

Ms. NERQUAYE-TETTEH. I will just say something and then Dr. Oji will add on.

Ms. JACKSON LEE. Thank you.

Ms. NERQUAYE-TETTEH. I don't know too much about Uganda because I haven't worked there, but I have been in Ghana, I have also worked in Zambia and Ethiopia.

Ms. JACKSON LEE. Yes.

Ms. NERQUAYE-TETTEH. And in all these countries the issue you are talking about is very true. If women are not able to space their children and have children at very short intervals, then what happens is that it does affect their health. The womb itself grows weaker with each successive pregnancy, and we all know what can happen.

We also have the situation where early pregnancy in young who are married too early, like 15, 16, has its own complications to the mother as well as the child who is born. The children are usually of low birth weight, for example. The young women also end up in some cases having issues of fistula, which Mr. Smith had mentioned earlier on. So there are a whole lot of complications if we do not give the necessary support for both young women and older women in either not having children too early or spacing their children, or having too many children.

I think that in all these cases the supply of contraceptives and the necessary education is very, very useful.

Ms. JACKSON LEE. And do you believe that sometimes family planning can equate to a medical decision, that it is sometimes based upon the medical needs of the patient, the woman?

Ms. NERQUAYE-TETTEH. Yes, I think so, but I will leave that to Dr. Oji.

Ms. JACKSON LEE. Dr. Oji, if you would. Thank you very much, Doctor.

Dr. OJI. Thank you, Congresswoman, for the question. The contraception is actually a key medical decision for some women who have a condition that will make it difficult for them to have children too often. Like she said, having children too early in life in a place like Nigeria. I am glad that Mr. Smith is familiar with obstetric vaginal fistula. The average age of all the young women who

have obstetric vaginal fistula in Nigeria is about 16, so having children too early leads to a lot of problems: Obstructed labor, eclampsia, and of course the morbidity aspect of the vaginal fistula, and of course too often it also makes it impossible for the woman, for her reproductive health organs to completely recover for her to be able to continue in good health for the next pregnancy.

Also, too late, having children beyond 30 years old, and then also with inadequate medical attention, that is also prevalent in the country which makes it also difficult, and of course having more than four children also makes pregnancy much more dangerous for the women, especially in the areas where they don't have good prenatal care.

So family planning becomes a major issue because it is family planning and good contraceptive counseling that will make it possible for women to avoid these four areas that make women die so much in those countries that we are talking about, especially in a place like Nigeria.

But in a place where there are good medical care services, some of this might not be so important but in a situation where there are not services which also makes it much more difficult because the family planning services are not there so the woman can get pregnant in all these other conditions, it becomes a medical decision.

Ms. JACKSON LEE. My time is up, Mr. Chairman.

Mr. PAYNE. Dr. Kagia wanted to respond, yes.

Ms. JACKSON LEE. I am sorry.

Dr. KAGIA. Yes, thank you, Mr. Chairman.

It is true that the family planning services look like they have stagnated in Kenya, but I want to emphasize what has been discussed in many meetings I have been to.

One of the major issues of family planning not being taken up is the fact that the man, the African man was not involved in family planning. This I can speak about my country. But when women go to the clinics to talk about the pills, the condoms, everything, and they have to take them to the African man who does not understand what you are talking about, and he is the main deciding factor whether they will be taken or not taken, he will not give the permission. To him it doesn't matter whether he makes this woman pregnant the tenth time or whether his children have food or not, the fact remains that unless he gets educated we are still in trouble.

He is still the same man who will make a little girl of 16 to be the wife. He is the same man who will not be able to get enough resources to take those children to school, and therefore the poverty, the lack of education, all those things will continue going on.

So I think I want to emphasize that in education we need to educate the man, and educating the man you will be able to reach the woman's health and that is a big problem in the African culture that must be addressed without failure. Thank you.

Ms. JACKSON LEE. If I may just put on the record on my time, Mr. Chairman, we appreciate that, but I think it is very important to note it is a medical decision and the Mexico City Policy is denying the doctors from making medical decisions to save the lives of women.

I thank the witnesses and I thank the chairman, and I yield back.

Mr. PAYNE. Thank you very much.

Mr. Inglis.

Mr. INGLIS. Thank you, Mr. Chairman.

Dr. Gillespie, under the Mexico City Policy NGOs can distribute contraceptives, right?

Mr. GILLESPIE. If they had signed on——

Mr. INGLIS. Would you use the microphone? We can't hear you, Dr. Gillespie.

Mr. GILLESPIE. Do you mean if they had signed on to the Mexico City Policy?

Mr. INGLIS. If an NGO wants to distribute contraceptives, they can, right?

Mr. GILLESPIE. Yes.

Mr. INGLIS. And they can do that with U.S. dollars?

Mr. GILLESPIE. If they have not signed the Mexico City Policy, then they can't——

Mr. INGLIS. Right, can use U.S. dollars.

Mr. GILLESPIE. If they have, then they obviously can.

Mr. INGLIS. So if an NGO wants to, they can use American dollars, American resources, and they can do contraceptive education, distribution in their countries, correct?

Mr. GILLESPIE. Yes, if they sign on.

Mr. INGLIS. So what is your problem?

Mr. GILLESPIE. What is my problem?

Mr. INGLIS. Yes.

Mr. GILLESPIE. My problem is the conditionalities that are imposed by the Mexico City Policy which prevent them from doing things that are probably legal in their countries, and which deprive them of access to USAID dollars.

Mr. INGLIS. You want them to do abortions. You want them to be able to do abortions. That is your problem, right?

Mr. GILLESPIE. That is your projection, not mine. I didn't say that.

Mr. INGLIS. We just established an NGO, if it wants to, can draw down American dollars and distribute contraceptives. Now you are saying that you have a problem. Your problem is simply that they can't provide abortion services or counsel for abortion services. Isn't that right? That's your problem?

Mr. GILLESPIE. Well, my problem is that, like many people in this room, I have a notion of freedom of speech.

Mr. INGLIS. Well, no, no, this isn't a question of freedom of speech. If I want to——

Mr. GILLESPIE. No, I beg to differ with you. It is.

Mr. INGLIS. It is not a question of free speech because I don't have the right to reach into your pocket and get money out to go run my campaign commercials, do I? No, I don't have the right to use your money to exercise my right to speak. I do have a right to speak. That means freely on the street corner, or if I want to pay for it, I have got to use my money to do that.

Mr. GILLESPIE. Well, they want to use their money too, and if you are referring to the fungibility issue, is that what you are referring to?

Mr. INGLIS. That is what we are getting to next, yes.

Mr. GILLESPIE. Okay. Well, then why do you allow CDC funds to go to these organizations? Why do you allow USAID HIV/AIDS funds to go to these organizations? Why do you allow other U.S. Government funds to go to these organizations if this pervasive fungibility exists?

Mr. INGLIS. That is a good question. I think we should look into it.

Mr. GILLESPIE. Well, first of all, I don't think the fungibility issue is much of an issue. Secondly, if it is——

Mr. INGLIS. Well, do you not think it isn't an issue because it clearly is the objection. As one of the witnesses said——

Mr. GILLESPIE. No, it is more the rationale of the Mexico City Policy, and it is a bogus one.

Mr. INGLIS. No, no. One of the witnesses said a second ago that it should be consistent with the ethics of that country, and of course it seems to be the ethics of many people in this country, quite contrary to your ethics, that earlier you declared that there is no personhood in the person in the womb.

Mr. GILLESPIE. And we can debate that issue, and that is our right.

Mr. INGLIS. But there are a good number of us who decided that that is a moral question that we have answered. In fact, the trouble for you is that most American really are answering that the way that—in seeing the ultrasounds, they are deciding it is a person. They are coming to a very different conclusion than you are. So you——

Mr. GILLESPIE. The fact is, survey data doesn't show that, but go ahead.

Mr. INGLIS. Well, I think it does.

Mr. GILLESPIE. No, it doesn't. It doesn't show that.

Mr. INGLIS. In fact, what you look at is—well, we're dueling pollsters.

Mr. GILLESPIE. We can have this discussion. If I were a foreign NGO representative, in order to get USAID funds, we could not have this discussion if we lived in Ghana or wherever.

Mr. INGLIS. You can get those funds though to distribute contraceptives, to do education programs, and do all those things. The one thing that you want them to have the ability to do is what many people in this country find morally repugnant, and that is to use taxpayer dollars, American taxpayer dollars, to kill children.

Mr. GILLESPIE. That is totally wrong. I object to that. I have worked for USAID for 30 years. Once the Helms Amendment was enacted in 1973, I can guarantee you there was no taxpayers' money being used to support or promote abortion as family planning, so that's just inaccurate.

Mr. INGLIS. If I have a budget where I am going to spend some dollars on abortion services and some dollars on contraceptives, and you flow money, and I am on my own, and suddenly I get a source of outside dollars, it fills up the bucket that I was going to give to contraceptives, doesn't it make sense that that money just flowed over into the other bucket? It is clearly money is fungible. I don't know how you could assert otherwise. The money is clearly fungible. Once you give it to an organization that does this other

work that you so much want done, which is the provision of abortion, they are using the other money in that—the pot has just flowed over into the other one, are they not?

Mr. GILLESPIE. Well, you could make funds fungible. What I am saying is that in my experience very few organizations do do that. If you feel that that is a major problem, then Congress should pass legislation that does not allow us to give foreign assistance to governments in the developing world that provide abortion services, or NGOs.

Mr. INGLIS. Sounds like a good idea.

Mr. GILLESPIE. Well, I think that follows the logic, however illogical it is.

Mr. INGLIS. The other logic is here domestically the Planned Parenthood does the same thing with U.S. taxpayer dollars here in the United States. Takes money that flows into one pot, causes money to flow into the pot that they really want to provide, which is abortion services, right?

Mr. GILLESPIE. I can't speak to that. I don't know the domestic thing.

Mr. INGLIS. Of course, I agree. As I said to Ms. Lowey earlier, I think we should have a consistent policy here domestically and internationally, and I hope we get to it.

Mr. GILLESPIE. And I think in order to also be consistent, as has been stated by many people today, is that no one, I don't think, is really pro-abortion in the sense that they would like to see more abortions. I think everybody on this panel would certainly like to see fewer abortions, fewer safe abortions, fewer unsafe abortions, no matter what kind of tag you want to put to it. So why not significantly increase the amount of funds going for family planning to a good, excellent family planning program that everybody seems to agree upon? USAID has a good family planning program. If you want to prevent abortions, then why not double it? Why not triple it?

Mr. INGLIS. I think my time has expired. Thank you, Mr. Chairman.

Mr. PAYNE. The gentleman's time has expired, and as he indicated, this issue will be decided again. The people of America will have an opportunity in November 2008, so I agree.

Ms. ROS-LEHTINEN. Mr. Chairman, if I could make an inquiry about the procedure of our committee. It is certainly the chairman's right to comment after every member has his question and answer period, but is that going to be what we will continue to be doing? And if so, I would like to have another opportunity then to also comment. But I think it is better if we just moved from member to member.

Mr. PAYNE. Okay, although if——

Ms. ROS-LEHTINEN. If it is possible.

Mr. PAYNE. I am the type that really allows time to go on, so anytime that you would like to——

Ms. ROS-LEHTINEN. No, that is great. I totally agree.

Mr. PAYNE. Right.

Ms. ROS-LEHTINEN. It is that editorial comment after someone makes a point with which you don't agree that I am just saying I would like to also have that opportunity——

Mr. PAYNE. Okay.

Ms. ROS-LEHTINEN [continuing]. If you are going to have it.

Mr. PAYNE. I don't want to change his style. That just happens to be mind. But we will take your interest.

Mr. Crowley.

Mr. CROWLEY. Thank you, Mr. Chairman.

I have a steering committee meeting, in the interest of time that is why I was a little concerned and shuffling my papers a little bit here. I know we are under the 5-minute rule in terms of questions and answers, so I appreciate you recognizing me at this point.

I would just like to say that I also was heartened by what Dr. Kagia said about African women loving their babies. I don't think that probably was a scientific poll that she was referring to but I would imagine let us for the sake of argument say that it is. I would imagine if you polled women in America or polled them in Europe or South America, or Asia or anywhere, they would probably come out as a statistical dead heat in terms of them all loving their babies and wanting the best for them.

I would just note that also I think women in Africa probably love themselves as well, and I think a prerequisite to loving another individual is to love oneself, and they would probably like to live a little longer as well if they could. If we take into consideration in Ghana, one out of every 35 women dies as a result of a pregnancy-related cause, whereas in the United States it is one in 2,500 women.

Our women in the United States don't love themselves any more, I don't think statistically, than women in Africa do either, and I would hope that all children who are born throughout the world would have conditions that are improving for not only those babies and those children so they can grow up and have an opportunity to access good health care and have a healthy and good life, and that for children everywhere we would like to see that happen.

One of the things I think about having a good and healthy life is to make sure that your mother is still alive, at least through your adolescent years, and that your father is still around as well. What is happening in parts of Africa is that the father is not alive any more because he has died as a result of AIDS. The mother, if she doesn't die as a result of AIDS, they die as a result of giving birth to the very child we are talking about helping to nurture. How can that child go on and have the ability to nurture his or her own children without having had a mother, and what denied them that health care, quite frankly, in respect to this policy as it pertains to women across the board, not just women reproductive health care.

One of the issues that I think that needs to be brought attention is that USAID, for the great work that it does and it does wonderful work, it is not in every country in the world today. It just simply isn't. And for the work that it does do in terms of reproduction health, I know that they are doing great work, but they are not everywhere.

I would just harken back to the first day the President took office in January 2001, when President Bush started the enforcement of the Mexico City Policy against NGOs overseas, the President's

spokesperson at the time, Harry Fleisher said that he was doing so to "make abortion more rare." That was January 22, 2001.

It is now 6½ years later, and I would like to ask each of the panelists if you would respond, if you can give your perspectives in the public health arena, if you think the Mexico City Policy has succeeded in making abortion more rare, and I would also like to know if you think it has helped to save the lives of women.

Dr. OJI. Thank you, Congressman. I can speak for Nigeria. The Guttmacher Institute did a study in 1997 and they found that there were an estimated 600,000 induced abortions every year and 60 percent of those abortions were unsafe. They repeated the study in 2005, and they found that it has actually increased to 760,000. So abortion rates are not reducing. They are actually increasing.

And that if you look at the maternal mortality rate of Nigeria also, it is also undergoing exponential growth. So for Nigeria, I don't see how the Global Gag Rule has reduced the number of abortions. They are there. They are all increasing, and there are a lot of resources, I must say to the United States Government and the people of America, Africa is really grateful for all the work that USAID does in Africa and other places.

But the point still remains that some of the large grants that come into Nigeria do not address some of these issues that would reduce maternal deaths in terms of we are talking about increasing funds for family planning, and at the same time some people also who work within the USAID can't even speak up on one of the causes of maternal deaths, which is abortion, because of the gag rule.

So these are some of the issues that come up, and then I am quite glad that you made the very clear point that every where, anywhere in the world women love children. They want to take care of the children everywhere, so also is in Africa, but a lot of women also are finding it very difficult to really give the care and love they need to give to those children because they are having too many of them, and their resources are not that they can make sure they can give the real love they want to give to those children.

Thank you, sir.

Ms. NERQUAYE-TETTEH. Mr. Chairman, before I answer that question, I mentioned something about Kenya that I would like to give the definite information on. The fact that FPAK care, which is the IPPF affiliate, was instrumental in Kenya's success in increasing the use of family planning services, and Kenya's story of success in expanding access to family planning services in 2003.

The 2003 demographic and health survey showed that for the first time in 25 years the contraceptive prevalence rate had stagnated at 39 percent, and until these statistics were revealed Kenya boasted steady and dramatic improvement in the use of family planning services. Thank you very much.

So the family planning associations which are affiliated to IPPF have done most of the family planning work in several African countries. I think this is something which cannot be argued. USAID can testify to that.

Coming back to your question, in Ghana, for example, it is very difficult to get the actual figures for abortion because it is a topic that people don't want to talk about very much. If you are asking

in a survey how many abortions do people have caused, it is very difficult to get such information. So we usually get it from estimates from hospital records of cases which have been brought as complications of unsafe abortion, and usually you will get about 20-percent-plus in most hospitals of gynecological cases which have been brought there as being due to unsafe abortion.

So the point that I would like to make is that the gag rule may have been brought in to make abortions more rare, but it has not. It has, rather, made abortion, it has increased abortion. In my own organization, we had 50 percent increase in post-abortion case. That is people who were coming to our clinics for complications of abortion increased by 50 percent after the gag rule. So the gag rule did not get the necessary results that I think was being looked for, and we are asking that if the gag rule is removed we can do a lot more work and avoid more abortions.

Mr. GILLESPIE. Globally, there has been a slight decline over the last 8 years, from 45 million to 41 million, as you probably know, Representative Crowley. But in terms of developing countries there has been a slight increase. If you take into consideration population increase and do it as a rate of 1,000 women of reproductive age, there is about a 9 percent decline.

The people that examine this more closely feel that it has little to do with the law, the legal status of abortion. It has to do more with the increase of contraceptive use over that period of time, which a number of people during this meeting have commented on, both Republicans and Democrats. I think this is a theme we should return to. Both sides of the debate have cited the Guttmacher Institute's *Lancet* article which indicates that the legal status of abortion in a country does not influence the incidence of abortion. It does influence, obviously, the safety of abortion, whether it is safe or not safe. I think that is a very important finding, perhaps the most important finding of the *Lancet* article.

Dr. KAGIA. Thank you. It is good for you to comment and say that the abortion seems to be getting down globally, but again this causes to see the very, very important issue of being able to get the proper statistics of abortion which you are not getting from most of the developing countries.

May I also add here that when you talk here about, for example, the research that was done by Ipas, you talk about 20,000 abortions who went to hospital. If you go to the breakdown, you find that 56 percent of those were miscarriages, and therefore they were not induced by anybody. Sixteen percent were probably miscarriages probably induced. The only ones that you can say were actually induced were the 28 percent.

What am I saying? I am saying that we need to get proper statistics of abortion before we get worked up about figures, and this I think we can do if we do something like a knowledge attitude and practices abortion survey in a country that will give you national outlook, and Kenya is ready to do it so that we can have a baseline which other countries can copy.

Thank you, Mr. Chairman.

Mr. CROWLEY. Mr. Chairman, before I yield back, let me thank you for your indulgence, and I also am interested in the second part of that question as to whether or not they are thinking it is

helping to save women's lives, but if they can respond to us in writing, I would appreciate that as well.

I yield back the balance of my time.

[The information referred to follows:]

WRITTEN RESPONSE FROM DUFF G. GILLESPIE, PH.D., TO QUESTION SUBMITTED FOR THE RECORD BY THE HONORABLE JOSEPH CROWLEY

U.S. Funding Trends for International family planning, and reproductive health

Total U.S. financial assistance for population, family planning, and reproductive health programs, both bilateral and multilateral, peaked in FY 1995 when Congress appropriated $577 million, including $542 million through the U.S. Agency for International Development and a $35 million contribution to the United Nations Population Fund. However, bilateral funding suffered a congressionally-imposed 35 percent cut the following year and remained precipitously low in the late 1990s before recovering modestly and then stagnating at less than $450 million since 2001. At the same time, the U.S. contribution to UNFPA has been withheld since FY 2002.

It is important to note that while the funding allocations for selected individual countries may increase in any given year, the amount of overall funding available for USAID FP/RH programs worldwide has remained stagnant during the Bush administration. In addition, total funding would have likely declined each year were it not for successful congressional efforts to protect the program from the funding cuts proposed annually in the President's budget request. Most notably, in his latest budget request, the President proposed a 25 percent cut to FP/RH funding for FY 2008, a $111 million reduction from the FY 2007 appropriated level of $436 million.

When adjusted for inflation, current U.S. bilateral funding for FP/RH programs is 41 percent less than in FY 1995. At the same time these steep funding reductions have taken place, the number of women of reproductive age in the developing world alone has increased by approximately 275 million women. As a result of inflation, the level of assistance has remained basically flat since the inception of U.S. funding of international FP/RH programs in 1965 if measured in constant 1974 dollars—the fiscal year that a separate population account was first added to the Foreign Assistance Act. This flat funding has occurred despite a major increase in the need and demand for FP/RH care and services. Just in demographic terms alone, the number of women of reproductive age in the developing world grew by 852 million women, from 527 million to 1.379 billion, between 1965 and 2005.

Impact of the Gag Rule on Maternal Mortality

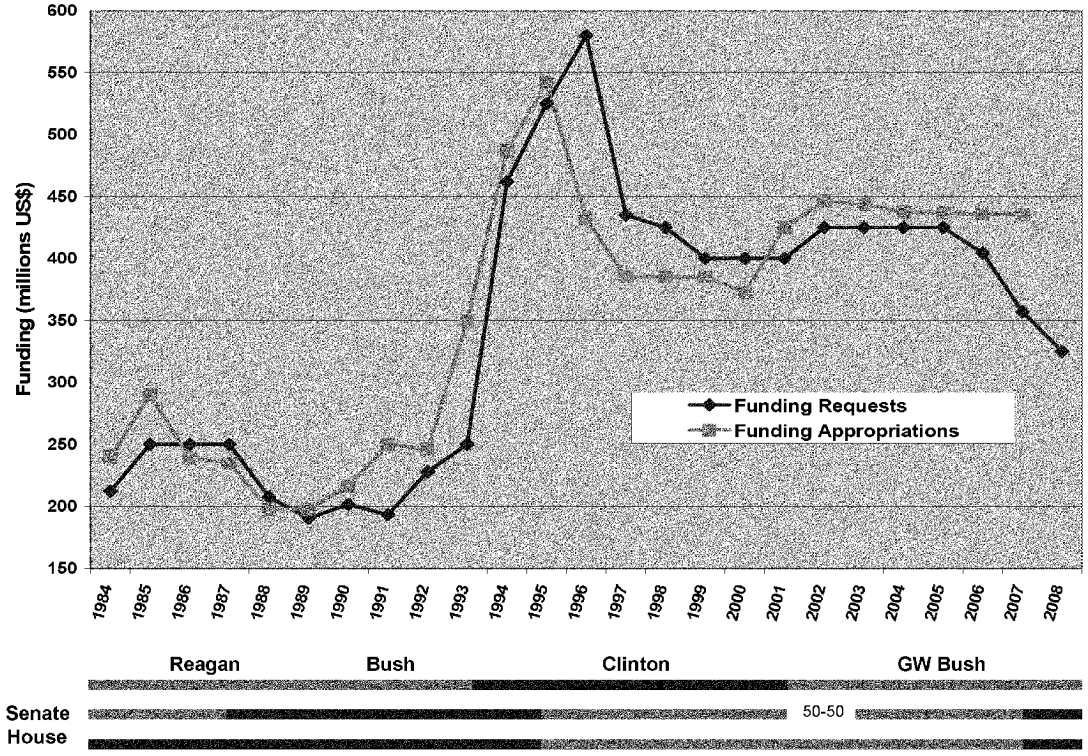
Worldwide, an estimated 529,000 women die of pregnancy and childbirth complications each year. The overwhelming majority of these deaths (86 percent) occur in sub-Saharan Africa and South Asia and are entirely preventable. A variety of interventions taken together—such as training trained birth attendants, scaling up emergency obstetric care, improving access to contraception, among others—are widely acknowledged as essential to reducing maternal mortality.

The World Health Organization estimates that up to 100,000 maternal deaths could be avoided each year if unintended pregnancies were prevented. A recent study published in British medical journal, The Lancet, projects that between a quarter and two-fifths of maternal deaths could be eliminated if unplanned and unwanted pregnancies were prevented. We know that the best way to do this is through comprehensive, voluntary family planning and reproductive health services that reach women where they live. Yet the Mexico City Policy / Global Gag Rule has undermined and weakened family planning efforts throughout sub-Saharan Africa since it was reimposed by the United States—historically, the largest source of family planning/reproductive health assistance and supplies. More than any other region of the developing world, sub-Saharan Africa has been harmed the most by the restrictive policy, where demand for family planning is very high in most countries—including Uganda, where "demand for family planning has increased substantially since the 2000/2001 Uganda Demographic and Health Survey (DHS)" or since the Gag Rule took effect. (Source: Preliminary 2006 Uganda DHS)

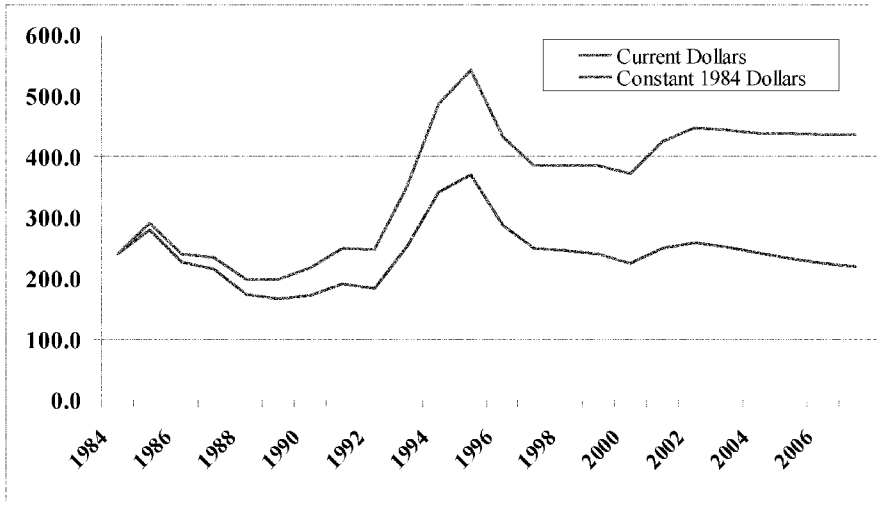
The combined effect of 1) declining financial support for family planning/reproductive health globally; and 2) the Mexico City/Gag Rule restrictions have likely contributed to very weak progress in reducing maternal deaths in sub-Saharan Africa. The latest 2005 maternal mortality figures from the WHO, UNICEF, UNFPA and the World Bank point to a decline in maternal mortality of a mere 0.1% annually between 1990 and 2005 in Africa. Alarmingly, in some countries, maternal and infant health indicators appear to have stalled or taken a turn for the worse. Kenya is one such country where steady progress has suffered in recent years due to de-

clining reproductive health funding and the Mexico City/Gag Rule restriction, which caused 10 family planning clinics to close across the country. Rates of maternal death do not appear to have dropped in Kenya, while infant and under-five child mortality has increased, according to the last demographic and health survey conducted (2003).

Request and Appropriation Levels for USAID Population Funds by Party in Control of White House, Senate and House



U.S. POPULATION, FAMILY PLANNING & REPRODUCTIVE HEALTH ASSISTANCE
FY 1984 — 2007
(in millions of dollars)



Mr. PAYNE. Thank you very much.

Mr. Manzullo.

Mr. MANZULLO. Thank you and I want to commend the witnesses, especially those of you who have traveled a long distance to come here and testify before our Congress. I have a question for Dr. Tetteh, is that correct? Is that close enough? Thank you. And I am going to read it because I just want to make sure all the elements are in it so just bear with me.

In your testimony you stated that signing the Mexico City Policy would have forced your staff to withhold life saving medically-necessary information from your clients and would have prevented you from informing them about the full range of medical services available to them.

You are aware that the Mexico City Policy expressly provides for abortion in cases of rape, incest or when the life of the mother is at stake, and you are fully aware, I am sure, that the policy allows abortion referrals to other agencies when a woman makes clear her intention to have an abortion and asks where a safe legal abortion can be obtained.

Given this, how can you justify your claim that the Mexico City Policy withholds life-saving medically-necessary information?

Ms. NERQUAYE-TETTEH. One of the areas which I have not talked about is when you give contraceptives to women the majority might use it according to the instructions which are given, but in a few cases we have had people with contractive failure. Now that condition or that situation doesn't fall in the rape, it doesn't fall in the incest, and it doesn't fall in the life of the mother. But you have got contraceptive failure; it is because something didn't go right. The person did not either go according to the instructions or sometimes they did everything and you still get a contraceptive failure.

So in the situation like that, what do you do? We still need to give the information to that woman that she has a choice to make.

Mr. MANZULLO. Under the Mexico City Policy, Doctor, if a woman comes to you and says, "I would like an abortion," then you can, under the Mexico City Policy, refer her to an abortion provider in the case of rape, incest or the life of a mother, isn't that correct?

Ms. NERQUAYE-TETTEH. It is correct that you can refer the person, and I am giving an instance where——

Mr. MANZULLO. No, I understand.

Ms. NERQUAYE-TETTEH [continuing]. It doesn't fall into any of those.

Mr. MANZULLO. No, I understand that.

Ms. NERQUAYE-TETTEH. Yes.

Mr. MANZULLO. But you had made the statement that the Mexico City Policy withholds life-saving medically-necessary information.

Ms. NERQUAYE-TETTEH. Yes, because that for us is a life-saving medical information——

Mr. MANZULLO. Right.

Ms. NERQUAYE-TETTEH [continuing]. That we need to give to that woman. Our program is holistic.

Mr. MANZULLO. Right, but it——

Ms. NERQUAYE-TETTEH. We do not leave parts out, so that when we are giving information, we give information about everything.

Mr. MANZULLO. But what you want to be able to counsel is that in that case where the contraceptive has failed and the person comes back to you, you want to be able to say that abortion is an option of birth control.

Ms. NERQUAYE-TETTEH. It is not abortion of birth control because it is a birth control which has failed the person. The woman has used a birth control and it has failed, so she is now faced with a medical situation. If she doesn't want to continue with that pregnancy, then what is she to do? And we are bound to give all the necessary information to her as to what can happen. Counseling in an abortion is telling the positives and the negatives, and therefore we do everything, and of course because we don't do the abortion ourselves we will refer the person in the end, yes.

Mr. MANZULLO. In Ghana, under what conditions is abortion legally allowed?

Ms. NERQUAYE-TETTEH. Rape, incest and the health of the mother.

Mr. MANZULLO. Okay. So it's similar to the United States.

Ms. NERQUAYE-TETTEH. Yes.

Mr. MANZULLO. The health of the mother is determined pretty liberally.

Ms. NERQUAYE-TETTEH. Yes.

Mr. MANZULLO. Isn't that correct?

Ms. NERQUAYE-TETTEH. Yes.

Mr. MANZULLO. So all the woman has to do is simply mention to you that she would be interested in having an abortion, then you can legally under the law of your country and also under the regulations of the Mexico City Policy refer her to somebody else who would be able to give her further advice on abortion. Isn't that correct?

Ms. NERQUAYE-TETTEH. But we were being told that we cannot even do the counseling. We cannot give any information on abortion. We cannot do——

Mr. MANZULLO. But if she asks, if she brings up that she would like to have an abortion, at that point, then you say, well, you can go to such and such a clinic down the street where they could give you more counseling and provide for a legal abortion, isn't that correct? Under the Mexico City Policy, that is allowed.

Ms. NERQUAYE-TETTEH. Well, if you put it that way, I would say yes, we should be able to do that, but under the period where we were being made to sign this document or not to sign it, one of the things which came out very clearly for us was that you cannot even talk about abortion. You cannot do anything about abortion.

Mr. MANZULLO. Well, Doctor, I would encourage you to take a look at the legal document itself that states very specifically that you can passively respond to a question regarding where a safe legal abortion may be obtained, but that is allowed under the Mexico City Policy.

Ms. NERQUAYE-TETTEH. Well, thank you very much. I will study that, but the point I am making is that at the time when this issue was coming up, these were the conditions that we were given. You cannot talk about it, you cannot do any counseling about it, and therefore we felt that we cannot be imposed upon. We wanted to

be free to be able to give all the necessary information to our clients even though we wouldn't do the abortion ourselves.

Mr. MANZULLO. Now that you are aware of this would you consider signing onto the Mexico City Policy?

Ms. NERQUAYE-TETTEH. Well, I think I would like time to study that a bit more and to really get the understanding because maybe there are some people out there who are not giving the correct interpretation to some of the policies that you are talking about now.

Mr. MANZULLO. Doctor, thank you for your patience.

Ms. NERQUAYE-TETTEH. You are welcome.

Mr. MANZULLO. Do we have time for more responses, Chairman Payne?

Mr. PAYNE. Sure. I don't want to cut you off. Really quickly.

Mr. MANZULLO. I don't want to be cut off but it is up to you.

Mr. PAYNE. All right. Yes, real quickly.

Dr. OJI. Thank you, sir, for bringing up these very excellent issues that are engrained in the document. But I still want to also have clarification on the fact that USAID post-abortion care training, due to the Mexico City Policy, doesn't fund the instrument the World Bank and WHO have said is the best instrument to be able to manage abortion complications. The fund the training of the doctors and nurses that will provide the services, but they say they can't fund the instrument. So it is just like family planning, no product, no services.

Then also for post-abortion care services, no instrument, no services. In Nigeria, they are training a lot of doctors and nurses in post-abortion care skills, but they are not giving them instruments to work with, so they train them, they lie around, they don't offer any services. So this is one of the clarifications that we want to have on this Mexico City Policy. USAID funds training but it doesn't fund instruments.

Mr. MANZULLO. Thank you. Dr. Gillespie, very quickly.

Mr. GILLESPIE. Very quickly, and as someone who has studied the language and has implemented the language and has give deposition in a lawsuit saying basically the same thing you have, I can shed some light on what may seem very clear here within the Beltway, but is not necessarily very clear outside the Beltway, and especially outside this country.

For example, what does it mean to "passively respond"? Lawyers within USAID and the Department of Justice spent much time defining what "passively respond" means. What does a woman have to say that falls within the guidelines of the Mexico City Policy?

I submit to you, sir, that if you are in a clinic in rural Ghana or rural Nigeria, that those subtleties, those nuances are very difficult to actually operationalize. So what happens, and this is documented, what happens is that there is an overreaction, and people do avoid doing things under the Mexico City Policy that they technically could, but they do that at their own risk. They do that with the risk of being defunded because their interpretation could be wrong and our interpretation.

The second point has nothing to do with referral services, but it is talking about abortion, and what happens if a client asks a question, a technical question about abortion, does the counselor say, "I

am sorry, I can't answer that question because it falls outside the guidelines for us to receive funds"?

So technically, narrowly, you are correct. Practically, you are wrong.

Mr. MANZULLO. Well, have you ever attempted to clarify these regulations?

Mr. GILLESPIE. Absolutely.

Mr. MANZULLO. In what manner?

Mr. GILLESPIE. Well, one was a deposition and one was periodically sending out guidance to contract officers, program officers. Yes, of course we did.

Mr. MANZULLO. I mean, this clearly says that if a woman clearly states that she has already decided to have a legal abortion, then Mexico City Policy does not disallow it. It even uses the word "clearly" which is——

Mr. GILLESPIE. Well, it sounds clearly too, but what if a woman comes in and says, you know, "I have been feeling very, very sick and my heart seems to be beating faster, and I know I am pregnant, what should I do?"

Mr. MANZULLO. Well, if it is medically necessary.

Mr. GILLESPIE. No, I mean, if she asks that, what should I do as a physician or as a nurse counselor? In fact, she says, "I don't know what you should do."

What you are saying is if I want to have an abortion, I have decided to have an abortion or I feel that if I continue this pregnancy to term, I might die, then they can say, "We don't do abortions here. It is legal in the government clinic down the road."

Mr. MANZULLO. That is correct.

Mr. GILLESPIE. But the first time, which is more likely to happen when a woman comes in and seeks advice, when they go to a medical facility most women go there with the idea that they are going to get some information.

Mr. MANZULLO. Well, I guess we could go around and around on this all the time.

Mr. GILLESPIE. Well, when I go to my internist, I don't go there with all the answers. I go with questions.

Mr. MANZULLO. I understand that but this is——

Mr. GILLESPIE. So a woman who is pregnant and she has some concerns about the pregnancy, she probably will have some questions about that.

Mr. MANZULLO. The first option should not be abortion.

Mr. GILLESPIE. It may not be the first option for her but she may want to know that it is an option. She may want to ask questions whether or not that is something she should consider.

Mr. MANZULLO. If she——

Ms. ROS-LEHTINEN. Mr. Chairman, you have been very fair but I think that——

Mr. MANZULLO. Thank you. Thank you.

Mr. PAYNE. All right. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. My microphone finally works.

Dr. Kagia, thank you so much for your enlightening testimony and the years of dedicated service you have provided to Kenyan women and children born and unborn. You are a beacon of hope

and inspiration as far as I am concerned for your whole country. You provide this committee with unique insight as to not only the medical, social infrastructure of your country, but also the cultural/religious workings.

In your testimony you provide some pretty amazing poll numbers regarding legalization of abortion, and I know that they have been said, but I think it is worth emphasizing. In 2007, a poll revealed that 85 percent of women in Kenya oppose legalized abortion. Yet despite that statistic, according to Joseph Afasi, a Kenyan doctor now studying in the United States, doctors were targeted by International Planned Parenthood Federation and paid to attend a "extravagant conferences in 5-star hotels where the abortion agenda was pushed and doctors taught the techniques of abortion procedure."

As I understand it, these conferences were not advertised as abortion training conference, but rather as a forum to learn "new techniques and reproduction health." According to Dr. Afasi, doctors who promote the abortion agenda in clinics in their villages are paid three times as much as doctors who provide legitimate health services to Kenyans. They are also paid by the number of abortions they commit.

Obviously this creates an incentive to increase the prevalence of abortion in a country where the majority of the population opposes abortion and the law forbids it.

In addition since the majority of Kenyans oppose abortion, it is my understanding that doctors have developed tactics to dupe women into having abortions. A procedure disguised as a "menstrual regulation services" is suggested by unscrupulous doctors, it is my understanding.

The patient is informed that a minor surgery must be done to correct the problem of missing menstrual cycle. The doctor then performs a D&C abortion on a woman who believed she was having a minor operation to correct her menstrual cycle.

If this is not true, I would like to hear. Quite shockingly, in my opinion, these clinics received funding from IPPF and the United Nations Family Planning Association whose mission it was to "control" Kenya's population.

I was absolutely outraged and appalled to learn this. My guess is that most Members of Congress are not aware of this disturbing fact that U.S. tax dollars could be used in this fashion.

This is my question. Has your experience as an OB–GYN in Kenya, including facing Planned Parenthood's coercive tactics such as the economic incentives to perform abortions? If so, how did you combat it and how can other doctors combat it?

Also, is the fact pattern articulated by Dr. Afasi prevalent in Kenya still? If so, how big a role does the United Nations Family Planning Association and IPPF play in duping women into unwanted abortions?

Finally, has the Mexico City Policy helped to defund abortions in Kenya while at the same time improving the quality of life?

Dr. KAGIA. Thank you very much. It is a common knowledge that inducing abortion has the terminology of menstrual regulation. You can't control menstruation, you don't have menstruation when

somebody is already pregnant, so it is a termination of pregnancy, and that is what is usually done, and goes into patients' records.

Remember that in Kenya abortion is illegal, so nobody wants to be caught up with the law that they performed abortions, and this is why they write that it is menstrual regulation.

Two, because it is illegal, nobody is supposed to perform abortions, but as long as they come and put up a poster like they are giving reproductive health services, then they can easily do the menstrual regulation out of the guise of reproductive health services, and I think this is what they use to circumvent the legal aspect of it.

And they will give other services, like family planning services, and even try to deal with infertility problems, but you can see that their core business is termination of pregnancy in a country where abortion is already illegal. But because they have a license to do it, you find them doing it.

When the Mexico City Policy came into be, and funds were not released to these organizations, they had to close some of the clinics, and I remember being interviewed by BBC in my office and they asked me, what do you think we should do? Do you think you should stand up as a gynecologist and say that they should revert that rule because many people are suffering?

And I said, I take great offense that somebody would come into a country where there is a law which should be obeyed, and they are still disobeying it, and this law is actually killing babies. That is exactly what I told them.

So I think what we need to see is that if there is a country that has good laws, and the law is against abortion, then somebody shouldn't circumvent the law and come and kill the babies under the guise of giving reproductive services. This is what is going on, and I think it is very wrong. Even if they are giving funds, they shouldn't bring funds to kill the people, and this is why we are trying to talk about it.

What you find is that these people who have these organizations, they will be able to have meetings. Of course they go to big hotels, they have a lot of funds, but at the end of the day that baby who was killed is of great value to the family where it was, and that is what is very important to me.

Mr. PAYNE. Thank you very much.

Mr. Pence. Or excuse me. Yes.

Ms. NERQUAYE-TETTEH. Mr. Chairman, I just wanted to say that because IPPF has been mentioned, I would like to make a point that all the IPPF affiliates are independent entities in our own countries, and every country works according to the laws of the country, and therefore if abortion is illegal in Kenya, the family planning affiliate in Kenya will not go against the law. This is something which the organization is very adamant on; that you work according to the regulations and the laws of your own country, and that is why in Ghana, for example, we do not do abortions. We could if we wanted to for incest, rape and so on, but we don't because we prefer to just refer them.

I think that this needs to be substantiated. This is an accusation which is being made against the Family Planning Association in

Kenya, and I think it is very serious. As far as I know, they work according to the laws of the country.

Mr. PAYNE. Thank you.

Mr. Pence.

Mr. PENCE. Thank you, Mr. Chairman. I want to thank all the witnesses for your testimony and your sincerity and purpose. I actually want to focus—I very much appreciate hearing from our witnesses from elsewhere in the world, Ghana, Nigeria and Kenya, but I want to maybe have a conversation with Dr. Gillespie about our interest as Americans.

Let me say categorically I am pro-life. I think abortion is morally wrong. But it seems to me the issued tied up here is a separate moral wrong. It seems to me the Mexico City Policy, as first established first by President Reagan and then put back and restored, in effect, in 2001 by President Bush, was born of the notion not so much that millions of Americans believe that abortion is morally wrong, as I do, but rather that an overwhelming majority of Americans think it's morally wrong to take the taxpayer dollars of millions of pro-life Americans and use it to promote abortion.

And that in effect, Dr. Gillespie, it seems to me, and I know President Clinton did away with this for awhile, and President Bush, thankfully, put it back, it seems to me that while there have been—I think in your statement you referred to this program as a "dismal failure." I think another one of our witnesses refereed to it as a "great barrier."

The truth is that the Mexico City Policy has allowed for an enormous expansion of family planning funding by the American people to the world community because we essentially took out of it the argument that we have in this committee the argument that we are having as a nation about funding of abortion.

I authored an amendment on the floor of the House this summer essentially to have a Mexico City Policy in the United States. With all due respect to Dr. Tetteh, I don't understand why in our country Planned Parenthood doesn't face the same barriers as you face. I think they should. I think that would be appropriate. I don't think the largest abortion provider in America should be the largest recipient of Title X family planning funding, but that is an issue for another day.

My question to Dr. Gillespie has to do with—do you have, and very sincerely, because we have a fundamental difference of opinion on aspects of this, but I would like to see this family planning funding continue, which is a lot for me as a fiscal conservative. I would like to see it continue.

Dr. Kagia, you said, profoundly, that African women love babies. Well, the American people love African babies, obviously. I mean, while there has been some statements that I can't comprehend by members of the committee today that there has been a decline in USAID funds. I mean, according to USAID statistics, family planning services have increased dramatically under Mexico City Policy. USAID has found over 200 organizations willing to accept policy in Nigeria where the funding level was $11.8 million in 2002, under this abortion-free policy that has doubled to more than $20 million. I mean, $446 million per year for family planning can hardly be described as a failure of commitment.

And I won't even bring up PEPFAR. I mean, the President of the United States just called for a $30 billion plan over 5 years. The American people have committed nearly $50 billion to fight global HIV and AIDS. I mean, the American people, and this humble Congressman from the Midwest, are deeply interested in the health and well being of the people of Africa, and that with which they struggle.

My question, Dr. Gillespie, is by having this hearing and characterizing a policy which I believe the Mexico City Policy is one of the policies that is overwhelmingly supported by the American people. I think a recent survey showed some 74 percent of American do not want their tax dollars to be used to pay for abortions, and that means that many millions of Americans who support abortion rights understand that second moral issue that I raise.

And so I guess my question is are you not at all concerned, Dr. Gillespie, as someone who has a commendable interest in world health, has a distinguished career in USAID, are you not at all concerned that however well-intentioned that abortion rights advocates in Congress who would seek to bring back the Mexico City Policy might actually well be endangering the family planning funding that has flowed nearly $.5 billion in family planning funding under this plan?

Because I really, and I say that very sincerely. It seems to me the focus here ought to be on how can we continue to expand this program given the inherent limitations of the American domestic political debate on this issue, and I just have to believe that part of the genius of people like Henry Hyde and others who have advanced this issue over the years was the very essence of political compromise. I just wonder if you might speak to that and whether returning this policy and injecting the issue of abortion into it might actually jeopardize the ongoing vitality of this kind of family planning funding.

Mr. GILLESPIE. Well, thank you for your comments. I think the issue goes to the fungibility issue. As I indicated in my written statement, the Helms Amendment actually was very, very effective in ensuring that no taxpayer funds go directly for the support or promotion of abortion as a method of family planning, and it has withstood the test of time in terms of implementation and I think that that addresses at one level your concern.

Yes, Congress and the American people have every right to say our money shouldn't be spent on this activity, whatever it is.

Mr. PENCE. Right. But Mexico City goes to your point, to the indirect funding.

Mr. GILLESPIE. Then there is the fungibility issue.

Mr. PENCE. It is a fungibility question. But does injecting that issue back into that question, does that give you any pause about jeopardizing the funding broadly?

Mr. GILLESPIE. Anything that would jeopardize the funding of family planning would cause me concern, and you indicate that you would like to see the continuing funding of this area. I would like to see the increase of funding for family planning, and I hope that that would be possible for those like you and I who have very fundamental disagreement on the abortion issue, and I think it does fall into, How do we want to present our image to the rest of the

world?, and I can tell you that many people who have traditionally been strong supporters of USAID, both in developed and developing world, find it wrong. In my years of defending as a civil servant, defending and implementing the Mexico City Policy for 15 years, and I did that faithfully as a servant should even though I disagreed personally with the policy, that they felt that this did not represent the best of the United States. They felt that this imposed a conditionality that was on un-American and that conditionality——

Mr. PENCE. But would it be——

Mr. GILLESPIE [continuing]. Had to do more with——

Mr. PENCE. Yes.

Mr. GILLESPIE [continuing]. The freedom of speech.

Mr. PENCE. Let me reclaim my time for a moment, and I understand that, and I understand your concern about conditionalities. I look at conditionalities as the terms and conditions under which the American people are willing to provide this type of family planning funding, and it does seem to me that, and I just would urge to my Democratic colleagues on the committee, to those that might be looking in and respectfully to leading voices outside of Congress on this like yourself, Dr. Gillespie, that be careful what you wish for on this issue because I have to believe that the Mexico City Policy, which as you said follows in the Helms Amendment, no Federal funding overseas for abortion, but also no Federal funding for organizations that essentially represents an indirect support for abortion as a family planning service, I urge caution that to bring this issue back in I think ultimately could jeopardize the ongoing vitality of the commitment of the American people to family planning globally because, again, and I will yield back in a moment, Chairman, be open to any comments, but to me it is not just the issue—you know, I am one of those millions of Americans who believes abortion is morally wrong, but the Mexico City Policy, it seems to me, masterfully deals with the larger question, which is the overwhelming majority of American believe it is also morally wrong to take the taxpayer dollars of people like me and use it to fund directly or indirectly abortion overseas, and I just—I urge caution on this, and I hope we will be able to sustain this policy, because I think it is ultimately in the interest that were—Dr. Gillespie, I know, regardless of our difference of opinion, I can tell your heart to this committee, and I know you have a heart for this program and I would use any comments.

Mr. GILLESPIE. Thank you for those comments. Mr. Chairman, several times in this discussion, the increase of funds for family planning has been mentioned. It might be useful to submit—I know you have this access, but I could easily send it to you—what the request levels have been under the various administrations since 1985 to the present, and what the appropriation has been for the population program because, in fact, it has gone up and done, and it is now in a downward trajectory. I would be very keen and interested to see if that downward spiral could be corrected by members on both sides of the aisle.

Mr. PENCE. Thank you, Mr. Chairman.

Mr. PAYNE. Thank you very much, and although I have been told about editorializing, the numbers that I gave did say that U.S.

funding has gone down in general, there is no question, PEPFAR, $15 billion over a 5-year period. I just said U.S. funding for family planning and reproductive health, a very narrow part of our overseas funding has gone down.

Mr. Burton has the last word. We have to be out of here by two o'clock, so you are restricted, unfortunately, to 5 minutes.

Mr. BURTON. Mr. Chairman, you can't do that.

Mr. PAYNE. All right, that is right, not to you. As much time as you can make another hearing.

Mr. BURTON. I will try to be brief.

Mr. PAYNE. All right.

Mr. BURTON. First of all, I want to enter into the record an article, this is *National Breast Cancer Month*, and this article goes into great detail in scientific research that shows that women who have abortions have a greater chance of having breast cancer, and I would like to have this as part of the record.

Mr. PAYNE. Without objection.

[The information referred to follows:]

Abortion and Breast Cancer: The Missing Link in Awareness Campaign

By Joel Brind, Ph.D.

You can tell it's October. Up north, the leaves are turning to their festive fall reds and yellows. All over the country, pink ribbons are sprouting everywhere, from jacket lapels and bumper stickers to storefronts and billboards. As everybody knows, October is National Breast Cancer Awareness Month. It is good that everybody is indeed aware of breast cancer and the epidemic swath of destruction it has cut through American society.

The not-so-good thing is that breast cancer awareness is often coupled with misinformation about the disease, its causes, its detection, its treatment, and its cure.

In its October 1 edition, the *Chicago Tribune* reported on the results of a survey commissioned by the National Breast Cancer Coalition (NBCC). "There's a lot of misinformation out there," said NBCC president Fran Visco told the *Tribune*. "In order to take meaningful action, we need to educate, not just raise awareness."

Unfortunately, some of the very people who are publicly decrying the misinformation are busy themselves spreading it around.

For example, according to the *Tribune*, the NBCC survey reported that "most women believe breast cancer can be prevented."

Tribune reporter Judy Peres insists, "In reality, there are only a few things women can do to reduce, but not eliminate, the risk of developing the disease, such as not drinking alcohol and not taking hormones. The biggest risk factors are being female and getting older."

One wonders just what "reality" Peres is talking about. Asian women, for example, have breast cancer rates four or five times lower than American women, even though they are still women and still getting older. And we know it's not genetic because when they immigrate to the U.S., within a generation, the risks of women of Asian parentage are just as high as those in the U.S. for many generations. Clearly there are risk factors.

Joel Brind, Ph.D.

But that doesn't stop Christopher Wanjek, writing for Live Science's *Bad Medicine* web site this month, from saying that the number 1 myth about breast cancer is that "Risk factors are mostly to blame." Says Wanjek, "More than two-thirds of women with breast cancer have no known risk factors."

Let's tackle this nonsense from two directions. First, no single factor so increases a woman's breast cancer risk than the avoidable act of having an abortion. This elevates a woman's overall risk of developing breast cancer by 30%.

That doesn't mean that most women who have an abortion will get breast cancer, or that most women who get breast cancer have had an abortion. It does mean that the effect of abortion is so *strong* that choosing abortion even once increases breast cancer risk.

Of course, there is nothing more politically incorrect than a claim that abortion is unsafe (in any way). **NRL News** readers are well familiar with the informational battles waged in medical journals and the media over the abortion-breast cancer link (ABC link). The battle continues to rage.

For example, Wanjek calls "Abortions cause breast cancer" his number 5 "myth." To read his description is to get the distinct impression that it's all a battle over statistical correlations among epidemiologists (the scientists who study such statistics).

Trouble is, it isn't just a battle of arcane statistics. In recent years, biologists have gotten a pretty good handle on where breast cancers start, and why. The basic biology demonstrates clearly why disrupting a normal pregnancy heightens breast cancer risk.

When a woman gets pregnant, her estrogen and progesterone levels begin to rise within days of conception. The estrogen stimulates the production of more and more immature, cancer vulnerable Type 1 lobules: more places for cancer to start. Estrogen levels continue to rise—up 2,000% by the end of the first trimester—stimulating growth day by day.

But at about 32 weeks gestation, other hormones cause differentiation of the lobules to Type 3 and Type 4—lobules that can actually produce milk. The cells of these mature lobules are no longer able to multiply. Hence, even if affected by a carcinogen, they cannot grow into cancer.

By 32 weeks gestation, 85% of the lobules have matured to Type 4. That means there are fewer places for cancer to start than there were even before the pregnancy began.

That's why abortion increases a woman's overall risk of breast cancer by 30%. Pregnancy greatly increases the number of cancer-vulnerable lobules, a problem that is naturally cured in a full-term pregnancy.

However, if her pregnancy is aborted, she is left with many more primitive, cancer-vulnerable breast cells than before she became pregnant.

Second, about half the breast cancer in the U.S. is attributable to a woman delaying first childbirth until after age 25 or 30, or forever.

That is because by the end of a 40-week pregnancy, 85% of a woman's breast lobules have become mature, cancer-resistant Type 4 lobules. The younger a woman is when she has her first child, the lower her lifetime risk.

By contrast the breasts of a girl or woman who has never had a child consist 75% of Type 1 lobules and 25% of Type 2 lobules. The longer the interval between puberty and first childbirth, the more the effects of carcinogens (some known, like cigarette smoke; some unknown) build up as abnormal, potential cancer-forming cells. This is not controversial. All experts agree that the longer a woman waits to have her first full-term pregnancy, the greater is her breast cancer risk.

As my esteemed colleague, breast surgeon Angela Lanfranchi, is fond of saying to those who continue to deny the reality of the ABC link: "It's the biology, stupid."

Joel Brind, Ph.D., is a professor of human biology at Baruch College, City University of New York; president of the Breast Cancer Prevention Institute in Poughkeepsie, New York; and a regular contributor to NRL News.

Mr. BURTON. Thank you.

Dr. Gillespie, do you believe that a child or a fetus in a woman's womb is a living being? You just answer yes or no. Do you believe it is alive?

Mr. GILLESPIE. I won't want to engage—we will disagree on that, and I don't want to engage on my personal beliefs because I don't think it is particularly germane to——

Mr. BURTON. Well, this is a question that needs to be answered because what you have been saying dances all around it. Do you believe that a fetus in a woman's womb is a living thing?

Mr. GILLESPIE. I don't want to get engaged in what I consider to be a philosophical question.

Mr. BURTON. It is not philosophical.

Mr. GILLESPIE. Well, of course it is. Of course it is.

Mr. BURTON. Okay. Well, let me ask you this. Do you believe that in the last trimester of a woman's pregnancy and they decide to have an abortion where they stick a tube into the baby's brain and suck the brains out, do you believe that is a living being?

Mr. GILLESPIE. I think my personal beliefs on something like this are not germane to the topic of this discussion.

Mr. BURTON. Yes. Well, okay, let me just say this.

Mr. GILLESPIE. So I am not going to answer the question, with all due respect.

Mr. BURTON. If you really believe one way or the other, then you are not showing much intestinal fortitude right now. You have got all this expertise but when it comes right down to it you don't want to answer the question.

Mr. GILLESPIE. I don't answer that question. I can answer other questions.

Mr. BURTON. All right. All right. All right.

Mr. GILLESPIE. By the way, I can also submit for the record other research indicating that——

Mr. BURTON. Well, if you are going to give an opinion on that, why won't you give an opinion on whether it is a living being?

Mr. GILLESPIE. Because that is——

Mr. BURTON. I did not ask for your opinion.

Mr. GILLESPIE. Because——

Mr. BURTON. I did not ask for your opinion on this and I don't want it. I want you to tell me whether or not a fetus in a woman's womb is a living being, and you don't have the guts to say one way or the other. Okay, so let us just let that lie, okay?

Now I want to ask one question of Dr.——

Mr. GILLESPIE. So you are not interested to know whether or not abortion does relate to a higher incidence of breast cancer or not?

Mr. BURTON. No, you can't because I am not going to ask that question of you. I asked a question of you that you won't answer, so let us just stick to the ones I do ask.

Mr. GILLESPIE. Okay.

Mr. BURTON. Now, Dr. Kagia, I would like to ask you a question. Can you give us a breakdown of primary causes of maternal deaths notified since June 2004?

Dr. KAGIA. Thank you. The reports that we got from the Ministry of Health is that the direct causes are hemorrhage, 30 percent; eclampsia, 14 percent; obstructed liver, 11 percent; sepsis after deliv-

ery, 10 percent; and abortion complications for that period was less than 1 percent. The indirect causes were HIV/AIDS, 11 percent; anemia, 4 percent; and other causes, 8 percent.

Mr. BURTON. I'm sorry. My staff, I was talking to. I yield the balance of my time to——

Dr. KAGIA. Do you want me to repeat them?

Mr. BURTON. I beg your pardon, ma'am?

Dr. KAGIA. Do you want me to repeat?

Mr. BURTON. No, no, that is all right. I want to yield the balance of my time to the hero in the Congress of the United States like Henry Hyde was of the Right to Life Movement.

Mr. SMITH OF NEW JERSEY. And I appreciate that, and I would ask the chairman, you know, I chaired the Human Rights Committee for 8 years, and I know that we want to get out of here pretty soon. There will be a vote about 2:15, but I do have some additional questions, and when he was the ranking member as well as a member of the committee, never, not once did I ever cut him off, so I do hope I would have the opportunity to raise these questions.

Mr. PAYNE. Well, there is a hearing that starts at 2 o'clock. The chairman is coming in, so in all due respect the Subcommittee on International Organizations, Human Rights and Oversight, and Mr. Delahunt is here. He has been waiting outside.

Mr. SMITH OF NEW JERSEY. Well, let me just ask a couple of questions if I could.

Mr. PAYNE. All right.

Mr. SMITH OF NEW JERSEY. I mean, you and I have done this back and forth for years.

Mr. PAYNE. Absolutely, but Mr. Burton's time had expired, but go right ahead.

Mr. SMITH OF NEW JERSEY. I appreciate that indulgence.

Mr. PAYNE. Just briefly.

Mr. SMITH OF NEW JERSEY. Let me just say when we talked about the incidence in that this false image that is being portrayed that illegal or legal in numbers will stay the same. Stanley Henshaw from the Guttmacher Institute, whether you want to believe him or not, who also is a writer or an author of this most recent *Lancet* study, said back in 1994, and I quote:

> "In most countries, it is common after abortion is legalized for abortion rates to rise sharply for several years, then stabilize just as we have seen in the United States."

That is why the lobby provision of Mexico City is so important. If it is legalized, if we are enablers and facilitators of that legalization, the number of dead children and wounded mothers will rise sharply.

Secondly, statistics, we need to be very wary of statistics. Statistics drive policy, and the lack of peer review that is rampant in the abortion area when it comes to numbers, two examples. When we were dealing with partial birth abortion, there was a letter that was signed by a number of NGOs, including the Guttmacher Institute, including Planned Parenthood, that said that partial birth abortion is used only in rare cases, fewer than 500 per year. That was an unmitigated lie. The Guttmacher people signed it, and yet that is a lie.

How do I know that? Even the head—Ron Fitzsimmons of the National Coalition of Abortion Providers, large number of abortion clinics under his auspices, said we have lied through our teeth about the incidence as regards to partial birth abortion. Flippant.

Bernard Nathanson, founder of NARAL, former abortionist, said repeating the big lie oft enough convinces the public, and he said annually in the United States 10,000 women were dying from illegal abortions. He says that too was an absolute lie, had no basis in truth, but a gullible press picked up on it, repeated it over and over again.

Just this week, this week, WHO said that only 31 of WHO's 193-member states are believed to have reliable cause of death certificates. So even the *Lancet* study says: "There is a degree of uncertainty and imprecision in country-specific estimates." And yet we get numbers that then people pass around here as if to suggest those numbers are credible, that they are based in fact. We have had a past where there have been lies and distortions, and I am very concerned that it is being used today to drive this policy.

We need honest data, real honest data. UFBA have not been known for it, there are some at the U.N., particularly their statistical branch that does a good job. The U.S. Census Bureau does a good job, but this kind of manufactured number designed to drive policy raises serious questions, and again it could lead to more children, more babies and more mothers being hurt by abortion.

I know we are out of time so I yield back.

Mr. PAYNE. Let me thank all of the witnesses for your very important testimony. We are out of time. The meeting stands adjourned. Thank you.

[Whereupon, at 2:04 p.m., the committee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF THE HONORABLE SHEILA JACKSON LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Thank you, Mr. Chairman, for convening today's important hearing. The Mexico City Policy, also known as the global gag rule, prevents organizations which provide or promote services related to abortion from receiving federal funding. This policy has been extremely controversial since its inception in 1984, and I believe that it is imperative that we seriously reexamine the efficacy and impact of this policy.

Let me also take this opportunity to thank the Ranking Member of the Committee, and to welcome our distinguished panel of witnesses: Ejike Oji, Country Director, Ipas Nigeria; Dr. Joana Nerquaye-Tetteh, Former Executive Director, Planned Parenthood Association of Ghana; Dr. Duff G. Gillespie, Professor and Senior Scholar, Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health; and Dr. Jean Kagia, Consultant, Obstetrician, and Gynecologist. I look forward to your informative testimony.

Mr. Chairman, the Mexico City Policy, denying U.S. funds to any non-governmental organization (NGO) performing or promoting abortion as a method of family planning, is a relic of the Reagan Administration. The gag rule extends to all activities conducted by an organization, even those undertaken with non-U.S. funds. Though President George H.W. Bush reversed the Mexico City policy in 1993, George W. Bush reapplied the restrictions immediately upon taking office.

The Bush Administration has also halted the U.S. practice of providing contraceptives to indigenous family planning providers, even in those countries where the U.S. continues to supply contraceptives to government health ministries. Since 2001, the U.S. government has suspended shipments of contraceptives to 20 developing countries in Africa, Asia, and the Middle East. This reversal has exacerbated the shortages of contraceptives in many nations, where the NGOs now being denied supplies are often the organizations with the most extensive distribution networks, particularly in rural areas. As a result, it is the people, and particularly the women, of these poor, rural areas of developing nations that suffer.

Mr. Chairman, I believe that the Mexico City policy has had a significant and negative consequence, particularly for the women of developing countries. In particular, poor, rural women have suffered as local and community-based planning providers have lost U.S. funding, technical assistance, and donations of contraceptives. Because of the Administration's focus on abortion, many organizations providing comprehensive family planning services have had to eliminate many of their programs, including those providing counseling, contraceptives, and referrals to health services.

As Dr. Oji testified today, the denial of funding to organizations providing or promoting abortion or related services does not keep women safe. Dr. Oji's testimony describes how numerous women in Nigeria die or are maimed each day, due to a lack of reproductive health care and unsafe abortions. Women who lack access to contraceptives are more likely to have unwanted pregnancies, and, by extension, to seek abortions. Consequently, this policy of denying funding to some of the programs best equipped to meet the reproductive health needs of women, and to provide contraception, is directly harming the health of many poor women.

Mr. Chairman, this policy has not, and will not, eliminate the practice of abortion in developing nations. In fact, since 1989, the global trend has been toward less restrictive abortion policies. Women continue to seek abortions because they have unwanted pregnancies; where abortion is illegal or not available from safe providers, they will still seek to terminate their pregnancy, but they will be forced to go about it in an unsafe manner.

In the best case scenario, there are numerous organizations able to deliver the needed services to women. The Mexico City policy works under the presumption that if one organization chooses not to sign on to this policy, another organization will, with the help of U.S. funds, be able to provide the contraceptives and other services permitted under the policy.

Unfortunately, this is not always the case. For example, as Dr. Nerquaye-Tetteh has described, in Ghana there is a large discrepancy between the rural areas and urban centers, which is reflected in contraceptive use and fertility rates. A full 50% of girls and young women ages 12–19 live in rural areas, and the pregnancy rate of rural girls between 15 and 19 years of age is double that of those living in cities. Women in rural areas of Ghana are now without many reproductive health services, previously provided by her organization, before the loss of U.S. funding necessitated large scale-backs. The tragic result of this is, as reported by Dr. Nerquaye-Tetteh, one in 35 women in Ghana will die in childbirth.

In addition to women who happen to live in rural areas, women in conflict zones also suffer from a lack of access to reproductive services. In the northern regions of Uganda, a nation often cited as a triumph of abstinence-based AIDS prevention, the ongoing conflict and resulting humanitarian crisis continues to keep women from receiving necessary health care, including reproductive health services. Organizations active in the area cited a lack of clinics, a dearth of supplies, and the need for better education for both men and women.

Mr. Chairman, we can endlessly debate the ideology behind the Mexico City Policy. However, I believe that the health of women, particularly the poor women in rural areas of developing nations who suffer as a result of this policy, is too important to allow ideology to trump efficacy. I believe that we must look at the reality of the situation, of what works and what really serves the needs and interests of women, what promotes women's reproductive health. I believe that this Congress has the responsibilities to U.S. taxpayers to ensure that their money is going to truly benefit the recipients of U.S. grants and assistance. I believe it is time to seriously take stock of the negative impacts of the Mexico City policy, both on the organizations working to assist women in developing nations, and on the women these organizations serve.

Thank you, Mr. Chairman. I yield back the balance of my time.

PREPARED STATEMENT OF THE HONORABLE CHRISTOPHER H. SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. Chairman, some day future generations of Americans will look back on us and wonder how and why such a rich and seemingly enlightened society, so blessed and endowed with the capacity to protect and enhance a vulnerable human life, could have instead so aggressively promoted death to children by abortion both here and overseas.

They will note that we prided ourselves on our commitment to human rights while precluding virtually all protection to the most persecuted minority in the world today, unborn children.

Human life begins at conception. Every second thereafter is simply a stage of development. By 22 days after fertilization, the heart is beating. As you can see on this ultrasound of a 10-week unborn child who is moving and kicking in the womb; this is what life is before birth. Very robust. The child wakes and sleeps, swallows the amniotic fluid. If you sweeten the amniotic fluid, he or she will swallow even more of it because of the sweetness.

By week five, tiny hands and feet begin to develop. By week seven, the baby is already kicking and swimming in the womb. We know that second trimester babies have the capacity to feel pain. And last year more than 250 members of the House voted for legislation that I sponsored called The Unborn Child Pain Awareness Act to at least inform women that a child feels pain before birth.

Future generations will indeed wonder why we didn't get it. Unborn babies, even if they are unwanted, have dignity, inherent value and infinite worth. And because they are so vulnerable, governments must protect their human rights. They will wonder why it took so long for Congress, the President and the Court here in America to stop just one hideous and painful method of death, partial birth abortion. They will wonder why dismembering a child with sharp knives, pulverizing a child with powerful suction devices or chemically poisoning a baby with any number of toxic chemicals failed to illicit so much as a scintilla of empathy, mercy or compassion for these tiny victims.

Abortion, Mr. Chairman, is violence against children. It is extreme child abuse. It is cruelty to children. Abortion treats pregnancy as a sexually transmitted dis-

ease, a parasite, a piece of junk to be destroyed, and the whole notion of wantedness and unwantedness turns a child into an object. Feminists had it right: no human being can be construed to be an object.

I respectfully submit that the term "unsafe abortion" is the ultimate oxymoron. All induced abortion, whether it be legal or illegal, is unsafe for the baby. It is also unsafe for the mother who is at risk not only of physical injury but also of long-term psychological damage, including severe depression.

All abortion is *unsafe* and a violation of fundamental human rights.

Now, as in previous years, some members of Congress want to export the violence of abortion to Africa, Latin America and parts of Asia and Europe by reversing the pro-life Mexico City policy and providing hundreds of millions of dollars to organizations that are obsessed with abortion—so obsessed that they insist on promoting and performing it as a method of family planning rather than accepting U.S. donations. And let's not forget this is grant money. We have an obligation to put human right safeguards around it.

First announced by the Reagan administration at a 1984 U.N. Population Conference held in Mexico City, hence its name, the current policy simply requires that foreign nongovernmental organizations agree, as a condition of their receipt of Federal assistance for family-planning activities, to neither perform nor actively promote abortion as a method of family planning. The three exceptions in the Mexico City policy are rape, incest and life of the mother.

Mr. Chairman, today scores of countries throughout the world are literally under siege in a well-coordinated, exceedingly well-funded campaign to overturn the laws and policies of sovereign nations that protect women and children from the violence of abortion on demand, putting women and children at risk. And now they want us, the American taxpayer, to facilitate, enable and legitimize their deadly activities.

Finally, as humanitarians and as policy-makers, the challenge we must meet is to *always* and at all times affirm, care for and tangibly assist both mother and unborn child. We must increase our access to maternal and prenatal care, including better nutrition and access to safe blood. You'll recall, Mr. Chairman, last year I held a hearing and we heard from a representative of the World Health Organization, who said that maternal mortality could be greatly mitigated with access to safe blood.

NO other country, I would also point out, donates more funds for family planning than the United States. We must expand essential obstetrical services, including skilled birth attendants and improved transportation capabilities for emergency care to significantly reduce maternal mortality and morbidity—including obstetric fistula.

Expanding these measures will reduce deaths and injury to both mothers and children. No one is expendable. No one's life is cheap. I would respectfully submit that the way forward, the humane way forward, is to devise and implement policies that respect and assist *BOTH* women and their babies from all threats, including abortion.

I will submit my statement for the record, and ask that the following documents be considered part of my statement.

I thank you, Mr. Chairman.

PREPARED STATEMENT OF THE HONORABLE RUSS CARNAHAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. Chairman, thank you for hosting this hearing to discuss the impact of the Global Gag Rule on family planning and reproductive health. International family planning is one of the few policy issues in Congress that has implications across a multitude of policy areas. From health care to women's rights to national security, the positive impact of sufficient international family planning should not be underestimated.

Planned Parenthood of Ghana (PPAG) offers an example of the negative impact the Gag Rule has had on family planning and reproductive health. For years, PPAG was able to provide extensive family planning services in both urban and rural areas throughout Ghana. When the Gag Rule was reinstated by President Bush, PPAG suffered massive shortages and cutbacks—a direct result of the elimination of USAID funding. This policy change affected all aspects of family planning services.

Access to family planning resources in rural communities has been hit the hardest. Prior to the reinstatement of the Gag Rule, organizations like PPAG were the largest and often sole providers of family planning and reproductive health services in rural areas. In Ghana, it had taken PPAG over 30 years to build the infrastruc-

ture and distribution networks required to reach the poorest and most rural areas of the country. Since the removal of USAID funding, no other NGO has been able to fill that gap.

The Gag Rule is a flawed policy that does not produce the effect President Bush intended and as a direct result of this policy, innocent women are being denied much needed assistance. It is time that we increase funding to international family planning and lift the current restrictions placed on how this money is spent. From various population studies by the U.N. and organizations like Population Action International, we know that proper family planning can control population surges in developing countries and help reduce the possibility of conflict, which have direct links to both international terrorism and our own domestic security.

Proponents of the Global Gag Rule maintain that this policy will decrease the number of abortions; however, I am interested in hearing our witnesses' first hand experiences as to the impact this policy has actually had on abortion rates. Thank you for taking the time out of your busy schedules to appear before us today. I look forward to hearing your testimonies.

PREPARED STATEMENT OF THE HONORABLE DONALD A. MANZULLO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Thank you, Mr. Chairman, for the opportunity to review the benefits of the Mexico City Policy, also pejoratively labeled by opponents as the "global gag rule." I look forward to hearing from today's witnesses, as I believe that this policy continues to protect women abroad from risky procedures as well as to protect the United States taxpayer from becoming an implicit partner in the funding of abortions overseas.

The Mexico City Policy was initiated in 1984 and requires international Non-Governmental Organizations (NGOs) receiving federal funding to agree that they will not perform or actively promote abortion as a form of family planning. I would like to be very clear about something that I hear commonly misstated about the Mexico City Policy: the policy in *no way* reduces by a single penny the $441 million that is provided for international family planning services or contraceptives. Contrary to what many of my colleagues suggested on the House floor during our debate on this policy in June, no country with a high demand for family planning has been denied money on the basis of the Mexico City Policy. In fact, the most recent USAID data shows a dramatic increase in family planning dollars going to the countries that need it most. Ethiopia, a country with great need for funding, has shown a 298 percent increase in family planning funds since 2002. Similarly, Uganda has shown an 80 percent increase in family planning funding since 2002. Likewise, Pakistan has shown a 1079 percent increase in funding between 2002 and 2007. There is absolutely no evidence to suggest that USAID has failed to spend the funds appropriated for family planning programs because of the Mexico City Policy.

By its definition and its mission, it is clear that the Mexico City Policy is not anti-family planning—it is anti-abortion. A policy against promoting abortion is only "anti-family planning" if one assumes that abortion itself is a method of "family planning." By simply providing guidance as to the types of organizations that should represent the United States abroad, the Mexico City Policy ensures that the taxpayer's money is spent on newborn care programs and contraceptive education rather than on destructive abortion procedures destroying the life of the child and harming women.

Thank you, Mr. Chairman, for the opportunity to issue a statement. I look forward to continuing with the proceedings today.

PREPARED STATEMENT OF THE HONORABLE MIKE PENCE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

The Mexico City Policy is a policy implemented by President Reagan in 1984. Ronald Reagan said it wisely in that same year: "We cannot diminish the value of one category of human life, the unborn, without diminishing the value of all human life." The purpose of this policy is to prevent international family planning funding from going to organizations that promote or perform abortions.

This policy improves the credibility of international family planning programs by ensuring that they are entirely separated from abortion activities. During the debate this summer, I was proud to support the bi-partisan Smith/Stupak amendment, in which my friend, Mr. Stupak wisely said, "This policy is a vital, pro-life provision intended to protect the integrity of U.S. family planning programs around the world by establishing a clear wall of separation between abortion and family planning."

Interestingly enough, I'm working to do the same thing here at home, but we'll save that for a later date.

Many will criticize this policy, calling it the Global Gag Rule. The Foreign Operations appropriations bill spends approximately $446 million per year on family planning—hardly a gag rule. According to USAID's own statistics, Family Planning services have actually increased dramatically under the Mexico City Policy. USAID was able to find over 200 organizations that were willing to accept this policy while providing family planning. Take for example Nigeria, where the funding level was at $11.8 million in 2002 and under this abortion—free policy family planning funding has almost doubled to $20 million. Likewise for countries like Uganda, Kenya and Pakistan.

As everyone will recall, the Lowey amendment, which is attached to the FY08 State, Foreign Operations Appropriations bill in the house, would allow valuable in-kind contributions of contraceptive commodities to flow to organizations that refuse to accept the conditions of the Mexico City Policy. If foreign nongovernmental organizations put their desire to perform and promote abortion above their desire to receive USAID family planning support that is their decision. However, these organizations do not have a right to USAID support.

The US government currently funds family planning services around the world, and funding organizations that perform abortions is not necessary. Most Americans do not want to fund abortions, much less use their hard earned tax dollars to fund abortion providers overseas. According to a recent Zogby poll, 74% of Americans do not want their tax dollars to be used to pay for abortions. It's unfortunate enough that we continue to fund Planned Parenthood here in the US; we don't need to export a pro-abortion ideology overseas.

Furthermore, the Mexico City Policy protects family planning services by drawing a clear line between family planning services and abortion. According to USAID, under Mexico City Policy, US funding for family planning has increased in countries around the world, especially in Africa.

Funding international abortion providers will undermine pro-life laws in other countries, especially in developing countries.

We should fund health care that helps treat HIV/AIDs, malaria, and care that helps pregnant women to reduce maternal morbidity, not spend money on promoting or performing abortion. This lack of restrictions will allow our tax-payer-funded, foreign assistance to fund abortions as an official U.S. policy.

I find the discussion of the removal of the Mexico City Policy to not only be a travesty, as is the loss of each innocent life to an abortion, but also a terrible message to be sending our neighbors around the world regarding the United State's position on the importance of a LIFE. I call on my colleagues to stand up in support of the continuation of the Mexico City Policy.

I submit my statement for the record and ask that the following documents be considered part of my statement.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF THE HONORABLE LINDA T. SÁNCHEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you Chairman Lantos for your leadership and interest in bringing this important topic up for discussion.

As we will hear today, the global gag rule, also known as the Mexico City Policy has prohibited international family planning organizations from receiving federal funding unless they certify that they do not provide abortions or referrals for abortions.

I was deeply saddened when this Administration elected, as one of its first orders of business, to reinstate this oppressive rule. Non-Governmental Organizations (NGOs) are now faced with the difficult choice of rejecting much needed aid money from the United States or denying the women and families they work with medical care.

The Global Gag rule does not just affect the services women and their families are receiving. This rule restricts the rights of private organizations that receive USAID family planning funding to speak out and participate in the political process.

The bans on lobbying and awareness-raising and educational activities are particularly intrusive in countries with active public debates. This type of restriction would immediately be declared unconstitutional in our own country as an abridgement of freedom speech. I do not understand how any American politician can support a policy in direct contravention to our Constitution.

There is no evidence that this rule reduces the number of abortions occurring or improves general health care around the world.

On the contrary there is less contraception available worldwide; fewer clinics are open to deliver a wide range of services; HIV/AIDS prevention efforts are compromised; and family planning providers are unable to participate with their governments and their colleagues to provide the best and most cost-effective solutions to health care problems, most significantly HIV/AIDS.

I believe a woman's reproductive rights should be protected. I strongly maintain that the ability to determine one's own biological choices is fundamental to a person's rights—regardless of what country one lives in.

Women, whether pregnant or simply seeking counseling for reproductive health concerns, should have access to the full range of support and options available.

Every individual deserves access to needed contraceptive services and fair and equitable health care coverage for these services.

I will continue to fight to make sure that women all over the world have access to the most appropriate medical treatment available.

WRITTEN RESPONSES FROM EJIKE OJI, M.B.B.S, COUNTRY DIRECTOR, IPAS NIGERIA, TO QUESTIONS SUBMITTED FOR THE RECORD BY THE HONORABLE J. GRESHAM BARRETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA

Question:

Like all of you, I am very interested in reducing the number of dangerous and unsafe abortions worldwide. Some have argued, I believe incorrectly, that the Mexico City Policy imposes a dangerous "gag rule" on organizations that seek to assist women who are victims of rape or incest, or who have suffered complications as a result of an abortion. Are there any exceptions included within the Mexico City policy for the above situations?

Response:

In practice the Mexico City Policy is a ban on USAID family planning funding to any foreign nongovernmental organization that works on abortion-related issues. Within the reproductive health community in Nigeria, any organization that receives USAID funding effectively feels that it cannot work on abortion in any circumstance. USAID-funded reproductive health organizations in Nigeria also have the perception that they cannot support efforts to reform the abortion law, even in an effort to expand the law to include legal abortion in cases of rape or incest. We have received no indication or information from USAID to the contrary. No written guidelines exist that we are aware of for NGOs under the policy to make distinctions between abortion in different circumstances or to give organizations a mandate to provide abortion counselling or services in cases of rape, incest, or danger to the life of a woman.

Under the Mexico City Policy, organizations that receive USAID funding technically can do work to expand access to abortion in cases of rape, incest or when the life of the woman is in danger. However, these exceptions are not well known, and there is no evidence that any USAID family planning grantee in Nigeria has guidelines in place or is equipped to diagnose, counsel, refer, or treat a woman in these circumstances.

I am aware that USAID funds organizations that work to treat women for complications from unsafe abortion.

Question:

Furthermore, from what I understand, the Mexico City policy does not even restrict non-directive counselling or "passive" referrals even in the case of family-planning abortions if the mother states that she intends to pursue an unsafe abortion. Does the Mexico City Policy ban NGOs from making these passive abortion referrals to women who would otherwise seek an unsafe abortion? (Page 17306 10 (iii)(A)(II) of the Policy)

Response:

In practice there is no evidence that NGOs under the Mexico City Policy are prepared to counsel or refer clients to an abortion provider, even if the client were to ask for an abortion. In Nigeria, USAID-funded organizations are fearful and will over-interpret the policy to be sure that they will not lose funding.

From the perspective of a health care provider, "passive" referral is not a familiar concept. When a patient is in front of you, your ethical duty as a health care provider is to evaluate that patient's situation and discuss the treatment options with him or her. In the case of unwanted pregnancy, it would be unethical to purposely

deny a patient information on abortion, particularly when that pregnancy is a risk to her health—yet this ethical duty of a provider cannot be met under the restrictions imposed by the Mexico City Policy.

Question:

Outside of your respective organizations, are you aware of other NGOs who are providing family planning services within the framework of the Mexico City Policy in the countries you serve/once served?

Response:

Ipas does not receive USAID funding. I am aware of other NGOs that are funded by USAID and providing family planning in Nigeria under the restrictions of the Mexico City Policy. USAID could provide the names.

WRITTEN RESPONSES FROM JOANA NERQUAYE-TETTEH, PH.D., FORMER EXECUTIVE DIRECTOR, PLANNED PARENTHOOD ASSOCIATION OF GHANA, TO QUESTIONS SUBMITTED FOR THE RECORD BY THE HONORABLE J. GRESHAM BARRETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA

Question:

Like you, I am very interested in reducing the number of dangerous and unsafe abortions worldwide. Some have argued, I believe incorrectly, that the Mexico City Policy imposes a dangerous "gag rule" on organizations that seek to assist women who are victims of rape or incest, or who have suffered complications as a result of an abortion. Are there any exceptions included within the Mexico City policy for the above situations?

Response:

While the Gag Rule makes exceptions for rape, incest and saving life of the woman, it is highly unlikely that a woman would report a rape or case of incest as the reason for her pregnancy. In Ghana, both rape and incest are taboo issues and women do not feel comfortable talking about such issues. In addition, the policy 'gags' organizations by preventing them from working with other NGOs and even their own governments. While the Gag Rule allows post abortion care (PAC), health care providers would rather prevent an unintended pregnancy than have to treat a woman in need of life-saving PAC.

Question:

Futhermore, from what I understand, the Mexico City policy does not even restrict non-directive counselling or "passive" referrals even in the case of family-planning abortions if the mother states that she intends to pursue an unsafe abortion. Does the Mexico City Policy ban NGOs from making these passive abortion referrals to women who would otherwise seek an unsafe abortion? (Page 17306 10 (iii)(A)(II) of the Policy)

Response:

While the policy allows for such a referral if a woman "clearly states that she has already decided" to have an abortion, most women who seek health services have questions about their health, not answers. It has been our experience that very few women come in to our clinics knowing they want an abortion. Typically, women come in seeking medical services and advice. (Note: Please see statement of Dr. Gillespie during Q&A with Rep. Manzullo on the unlikelihood that a woman would visit a clinic to request an abortion)

Question:

Dr. Nerquaye-Tetteh in your written testimony you said that the Mexico City Policy requires your staff to "withhold life-saving, medically-necessary information from our clients." If the answers to my last questions are true, what kinds of medically-necessary information are you referring to in your testimony?

Response:

As mentioned in the first question, if a woman comes into our clinic with an unwanted pregnancy and wants information/counseling on what to do, we have to give her all the information she requires, including the option for abortion. If we cannot give the counseling because her pregnancy is not due to rape, incest or it cannot be proved that it is life threatening, then we are withholding life-saving, medically necessary information. In my experience, women will then seek an unsafe abortion. Healthcare providers have an ethical responsibility to provide clients with all the medical information available to allow then to make a decision. The Gag Rule pre-

vents healthcare professionals from fulfilling this ethical necessity in a large number of cases by censoring the information available to women. This is an effective gag on healthcare providers that will undermine trust and force women to seek alternatives, including unsafe abortion, from non-medical persons.

Question:

Outside of your respective organizations, are you aware of other NGOs who are providing family planning services within the framework of the Mexico City Policy in the countries you serve/once served?

Response:

I am not aware of any National NGO providing family planning services within the framework of the policy in my country. My organization, PPAG, fulfilled a particular role in provision of services in rural areas—where need and demand for services is highest—that complimented the Government of Ghana's services. No one has stepped in to fill the gap, nor was their any agency that could have done so that had the reach, networks and trust amongst clients and communities of PPAG.

QUESTIONS SUBMITTED FOR THE RECORD TO JEAN KAGIA, M.D. (KENYA), CONSULTANT, OBSTETRICIAN & GYNECOLOGIST, BY THE HONORABLE J. GRESHAM BARRETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA

WRITTEN RESPONSE RECEIVED FROM , TO QUESTION ASKED DURING THE HEARING BY THE HONORABLE J. GRESHAM BARRETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA

Question:

Like all of you, I am very interested in reducing the number of dangerous and unsafe abortions worldwide. Some have argued, I believe incorrectly, that the Mexico City Policy imposes a dangerous "gag rule" on organizations that seek to assist women who are victims of rape or incest, or who have suffered complications as a result of an abortion. Are there any exceptions included within the Mexico City policy for the above situations?

Response:

No Answer received

Question:

Futhermore, from what I understand, the Mexico City policy does not even restrict non-directive counselling or "passive" referrals even in the case of family-planning abortions if the mother states that she intends to pursue an unsafe abortion. Does the Mexico City Policy ban NGOs from making these passive abortion referrals to women who would otherwise seek an unsafe abortion? (Page 17306 10 (iii)(A)(II) of the Policy)

Response:

No Answer received

Question:

Do you believe the Mexico City Policy is undermining the ability of NGOs to provide family planning services to women in need in Kenya where you serve? According to your estimates, have family planning services decreased in the country you serve since the Mexico City Policy was reinstated in 2001? Do you foresee any health benefit for the women in Kenya if the Mexico City Policy were to be rescinded?

Response:

No Answer received

WRITTEN STATEMENT SUBMITTED FOR THE RECORD BY SERRA SIPPEL, ACTING EXECUTIVE DIRECTOR FOR THE CENTER FOR HEALTH AND GENDER EQUITY (CHANGE)

Chairman Lantos, distinguished Members of the House Committee on Foreign Affairs, and Committee Staff, first let me thank you for holding this hearing on such an important matter. The Center for Health and Gender Equity is a U.S.-based nongovernmental organization focused on the effects of U.S. foreign policies on the health and rights of women and girls in the developing world. We believe that every individual has the right to the basic information, technologies and services needed to make informed choices about their sexual and reproductive health. On behalf of

the Center for Health and Gender Equity, I am pleased to provide testimony regarding the impact of the Mexico City Policy on women's health and the ability of the U.S. to deliver on its international development promises and priorities. It is our position that in order to ensure that U.S. foreign assistance for global health is used most effectively to prevent HIV infection and unintended pregnancies, health care facilities and organizations on the ground must be free to deliver reproductive health services and information without the restraints of the Mexico City Policy.

The U.S. Role as A Global Leader in Foreign Assistance

The U.S. has supported international family planning assistance for more than forty years. We have been a global leader in ensuring that millions of individuals and couples in developing countries have a full range of information and services necessary to plan, space, and limit their births free from coercion or violence. In 2006, forty-two percent of international donor support for contraception and family planning supplies, including male and female condoms for STI/HIV prevention, came from the U.S. Agency for International Development[1]. Furthermore, the U.S. has demonstrated outstanding leadership in fighting the global HIV/AIDS pandemic with the President's Emergency Plan for AIDS Relief (PEPFAR). Considering such successful U.S. foreign policy and development assistance, we must also take into account restrictive U.S. international policies such as the Mexico City Policy. This policy, also known as the Global Gag Rule, has undermined the leadership of the United States in supporting and expanding access to sexual and reproductive health services, including the means to prevent HIV infection, in developing nations.

The Mexico City Policy undercuts the very principles on which U.S. international family planning assistance is based—effective access to information on family planning options, counseling and services—by stifling information U.S.-supported organizations would normally provide to their clients regarding pregnancy options. The policy also prohibits organizations that provide information and services related to abortion from receiving essential U.S. *contraceptive supplies*. Instead of diminishing the need and incidence of abortion worldwide, the Mexico City Policy limits access to information and services that help prevent unintended pregnancy. Without access to life-saving information and services that address unintended pregnancy, women die: there are more than 70,000 deaths each year due to unsafe abortion, and some 500,000 deaths each year due to pregnancy complications.

The Mexico City Policy Undermines U.S. Global AIDS Response

Worldwide, an estimated 200 million women lack access to basic family planning services and contraceptive supplies. Not only does the Mexico City Policy aggravate women's limited access to these services, it also threatens the effectiveness and scope of our nation's global HIV/AIDS interventions. An estimated 4.3 million people were infected with HIV in 2006. Although the Mexico City Policy does not apply to funds issued under the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (legislation authorizing PEPFAR), the policy nevertheless obstructs integration of HIV/AIDS and reproductive health services on the ground.

Eighty percent of infections worldwide are transmitted sexually. The same factors placing women and girls at risk for HIV, which include the inability to negotiate safer sex practices and the lack of access to prevention information and methods such as male and female condoms, also place them at increased risk for unintended pregnancy. Additionally, the majority of HIV-infected men and women are of reproductive age[2], and antiretroviral treatment has helped restore fertility options for those who are infected. The integration of HIV/AIDS services and reproductive health services has the dual effect of reaching men and women with effective HIV prevention and treatment interventions and safe and informed reproductive health choices. However, the Mexico City Policy hinders this integration because organizations barred from U.S. family planning funding under the Policy, yet are eligible for U.S. HIV/AIDS assistance, cannot use their extensive experience and expertise in the reproductive health field to deliver integrated HIV/AIDS and family planning services.

In resource-poor countries, women often lack the means to access separate facilities or providers for various health services. Failure to integrate reproductive health and HIV/AIDS programming places many women in a position where they must choose between HIV/AIDS services and family planning services, ultimately choosing between knowledge of HIV status and treating that condition or preventing un-

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[1] Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2006. UNFPA. Pg 7

[2] Nancy Eriksen, MD, *Reproductive Options for HIV-Infected Patients*, The Body—The Complete HIV AIDS Resource. November 2001.

wanted pregnancy and attaining other reproductive health services. Furthermore, the separation of HIV services and family planning services may invoke a disincentive for women to seek testing and treatment due to stigma and discrimination against HIV infection. This disjunction puts women at increased risk of preventable death and illness related to sex and reproduction. Therefore, not only is the Mexico City Policy harmful at the individual level, but it also interferes with global health efforts to prevent new HIV infections and to treat those living with HIV/AIDS.

The Mexico City Policy as an Indicator of U.S. Foreign Policy

The Mexico City Policy is not simply a restriction on U.S. international family planning assistance; it guides U.S. foreign policy on sexual and reproductive health and informs the way in which our nation interacts with civil society and foreign governments. Though the U.S. remains the largest donor of international family planning funding and supplies, the Mexico City Policy undermines the goals of this assistance and our leadership in expanding global access to comprehensive family planning and sexual and reproductive health services. *Without a full repeal of this policy, U.S. international family planning assistance will continue to exacerbate the morbidity and mortality that resource-poor countries are experiencing as a result of HIV/AIDS and lack of access to comprehensive and integrated family planning services.* In order to ensure that U.S. foreign assistance for global health is used most effectively to prevent HIV infection and unwanted pregnancies, health care facilities and organizations on the ground must be free to deliver reproductive health services and information without the restraints of the Mexico City Policy.

The Center for Health and Gender Equity asks that you consider our testimony as you reflect on the harmful effects of the Mexico City Policy on women's health in the developing world. *It is our hope that the U.S. Congress will act swiftly on this policy by fully repealing the measure.* Should you have any questions or comments, feel free to contact me or Jamila Taylor, Legislative and Policy Analyst, The Center for Health and Gender Equity, 6930 Carroll Avenue, Suite 910, Takoma Park, MD 20912; (301) 270–1182; jtaylor@genderhealth.org. Thank you very much.

Ms Matilda Owusu-Ansah
Former Director of Resource Mobilization
Planned Parenthood Association of Ghana,
a Member Association of the International Planned Parenthood Federation

Hearing of the House Committee on Foreign Affairs,
US House of Representatives

The Mexico City Policy/Global Gag Rule:
Its Impact on Family Planning and Reproductive Health

October 11, 2007

Chairman Lantos, members of the House Committee on Foreign Affairs, Committee Staff and my esteemed colleagues, I would like to thank you for holding this hearing to assess the Mexico City Policy/Global Gag Rule and its impact on international women's reproductive health in US-funded programs. Additionally, Mr Chairman, we are very aware that only the strong support of Congress has prevented an even more serious erosion of the United States program in international family planning. On behalf of the volunteers and staff of the 150 Member Associations of the International Planned Parenthood Federation – and the women and families we serve - we thank you.

My name is Matilda Owusu-Ansah. Today, I speak to you as the former Director of Marketing and Resource Mobilization at the Planned Parenthood Association of Ghana (PPAG). I held this position when the Global Gag Rule was being implemented in Ghana, a time of tremendous turmoil. I personally witnessed the destructive impact the Gag Rule had on our programs and on the clients we serve. It is my hope that by telling the story of PPAG, I can give voice to those people most affected – women and girls. The experience of PPAG mirrors the experience of IPPF around the world.

First, I will explain a little bit about how PPAG has come into existence, and then provide you with some overall context of Ghana. I will then describe the

work of PPAG before we were affected by the Gag Rule and the impact the Global Gag Rule has had on the ground and in our clinics. Finally, I will offer some thoughts on the overall effect of the Gag Rule.

The Birth of a National Organization

Planned Parenthood of Ghana was founded in 1967 when a small group of doctors and lawyers came together to confront a persistent public health issue they faced on a daily basis. Women were suffering and even dying from pregnancy-related ill health which they knew could be prevented by quality family planning services. Our founders believed in "children by choice, not by chance". This was the motto in those early days and it remains the motto of PPAG today.

Over the years, PPAG grew into a national organization, reaching people in 63 districts, spanning seven of Ghana's ten regions. PPAG is a proud member of IPPF, a global service provider and leading advocate of sexual and reproductive health and rights. IPPF is a worldwide movement of national organizations working with and for communities. We envisage a world where women, men and young people have control over their own bodies, and therefore their destinies. IPPF's strong sense of solidarity and unified vision transcend political, economic, religious and ethnic boundaries.

Advances and Challenges in Sexual and Reproductive Health in Ghana

Ghana has a long history of voluntary family planning. We approved our first national policy on population and family planning in 1969 – among the first in Africa – and the total fertility rate (TFR)[1] has gradually declined. Since 1988, use of contraception among married women has doubled to 25.2 per cent and use of modern methods has more than tripled to 18.7 per cent[2].

While we are making some progress, the challenges facing us are daunting. There is a serious disparity between urban and rural areas - contraceptive use remains low and fertility rates are high in rural Ghana[3]. In addition, Ghana's population is young and 50 per cent of adolescents aged 12 to 19

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[1] Total fertility rate (TFR) is defined as the total number of births a woman would have by the end of her childbearing period if she were to pass through those years bearing children at the currently observed rates of age-specific fertility. The TFR is obtained by summing the age-specific fertility rates and multiplying by five. Source: Ghana Demographic and Health Survey (2003) USA: Measure DHS.

[2] Solo, J.,et al. Ghana case study: 'Give them the power' (2005) A case study report of the Repositioning family planning initiative. New York: ACQUIRE Project/Engender Health. P. 6.

[3] The total fertility rate in urban areas is 3.1, compared to 5.6 in rural areas. Source: "Ghana" in Country Profiles for Population and Reproductive Health: Policy Developments and Indicators (2005) USA: Population Reference Bureau. Pp 53.

live in rural areas[4]. The rural poor, including a large proportion of young people, cannot afford contraceptives and family planning services and also may not be able to afford the journey to the nearest service outlet because almost half of Ghanaians earn less than $1 a day. The pregnancy rate of young, rural girls aged 15 to 19 is double that of those living in cities[5] and many of those pregnancies are unintended.

In my country, one in 35 women will die during pregnancy or in childbirth[6]. (By comparison, only one in 2,500 women living in the United States will ever die of pregnancy-related causes[7].) For us, childbearing remains an important role for women. It is simply unacceptable that women face a real risk of dying every time they give birth merely because they do not have access to the reproductive health services and supplies that they need and want.

If you live in a rural area of Ghana, you may have to walk for miles for a prenatal examination or to buy contraceptives. Sometimes, when you arrive, there are none in stock. We are lucky that the prevalence rate of HIV/AIDS in Ghana is low at this point in time[8], but as long as access to condoms is limited, the rate could rise.

Snapshot of the Planned Parenthood Association of Ghana Pre-Global Gag Rule

Let me take you back to the Planned Parenthood Association of Ghana, circa 2002, before we were faced with the Global Gag Rule.

At this time, PPAG offered a comprehensive range of sexual and reproductive health information and services. These included family planning methods, specialized youth-friendly clinics, mother-and-child health welfare services, such as child immunizations, and antenatal and post-natal services. We provided HIV/AIDS prevention, voluntary counseling and testing (VCT) for HIV/AIDS, sexually transmitted infection management, post-abortion care, fertility management, specialized male reproductive health services, laboratory services, treatment of minor ailments and referrals.

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[4] "Adolescents in Ghana" (2006) In Brief. USA: Guttmacher Institute.
[5] Indicators for reproductive health: Ghana (2006) USA: UNFPA.
[6] State of the World's Mothers (2007) USA: Save the Children. <www.savethechildren.org/jump.jsp?path=/publications/mothers/2007/Mothers-Index-2007.pdf> [Accessed 8 October 2007]
[7] Ibid.
[8] HIV/AIDS Among Adult Population, Ages 15-49, is 2.3%. Source: "Ghana: Demographic and health highlights" (2005/2006) USA: Population Reference Bureau. <www.prb.org/Countries/Ghana.aspx> [Accessed 8 October 2007]

In 2002 we distributed more than 6.5 million condoms – twice the number reached by the government-run health service. We were the second largest distributor of contraceptives in rural areas (rural outreach is the hallmark of PPAG's services), and third in the country. The reach and extent of PPAG's family planning services was achieved, in part, with the generosity of US taxpayers and the long-standing cooperation and partnership we shared with USAID.

A $2.8 million USAID grant, from 1999 to 2004, gave PPAG the means to realize a long-desired plan: to implement an innovative community-based services project to reach the most vulnerable groups in rural areas. PPAG grew to include over 1,800 trained community-based volunteers and 13 staffed clinics. This project vastly increased the uptake of contraceptives[9].

Let me share with you the words used in an independent case study report:

> "Since [1967], PPAG has been in the forefront of advocating for reproductive health and rights and delivering services at the clinic and community levels.
>
> PPAG pioneered the introduction of a small community-based [services (CBS)] program in 1974. The program continued to expand with support from various sources, including USAID... The difference between the earlier distribution of contraceptives and [community-based services] was a more holistic approach to reproductive health. Volunteers and nurses took into account the needs of the clients, made more information available and increased referrals for clinical services beyond family planning (sexual health, maternal and child health, and STI prevention)."[10]

Galvanizing their combined expertise and resources, USAID and PPAG effectively prevented significant numbers of unwanted pregnancies and reduced maternal mortality among Ghana's women and girls

This USAID-PPAG initiative was, remember, just one example of collaboration between USAID and an IPPF Member Association. The achievements of the community-based services program in Ghana were echoed in many countries and communities across the IPPF network. A joint review of the USAID-IPPF partnership, completed in 2000, noted

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[9] Couple-years of protection, achieved by PPAG, rose from 61,000 in 1995 to 96,000 in 1998, and more than 128,000 in September 2002.

[10] Solo, J.,et al. Ghana case study: 'Give them the power' (2005) A case study report of the Repositioning family planning initiative. New York: ACQUIRE Project/Engender Health. Pp 22.

> "There is high interest on the part of USAID and IPPF in increased dialogue and mutual engagement. IPPF and USAID should seek opportunities to exchange information on their priorities, strategies, and field experiences... Both USAID and IPPF see the value of continuing the relationship (USAID 2000)."[11]

Why We Could Not Sign the Global Gag Rule

After the reinstatement of the Mexico City Policy in 2001, PPAG, along with many other IPPF Member Associations, faced a nearly impossible choice. We had to choose between losing our 30-year partnership with USAID, which helped us reach the poorest and most vulnerable people in Ghana with family planning services and supplies, or to violate the trust we painstakingly built with these same people and communities. If we signed the Global Gag Rule, we would breach the medical ethics of our staff by requiring them to withhold life-saving, medically-necessary information from our clients – requirements that were being imposed by a foreign government.

Let me explain further. The people of Ghana come to our clinics or seek out our community-based health workers because they trust us. They trust us because we give them full information and confidential counselling so they, in turn, can make their own reproductive health choices. Family planning and contraceptive distribution comprise the majority of our services because we know that the best way to prevent unintended pregnancies and to reduce the need for abortion is to make sure that women, couples and young people have information about and access to contraception.

At the time that we were faced with this decision, PPAG did not perform abortions. Rather, we counselled women and, if needed, referred them to our government hospitals where upon advice of a qualified doctor abortion services are provided according to Ghanaian law[12].

We wrestled with the decision of whether to sign the Global Gag Rule; it was deeply debated within PPAG as well as throughout all parts of IPPF. To sign it would have been to turn our back on women, consigning them to risk their

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[11] Joint review of the International Planned Parenthood Federation and the U.S. Agency for International Development Partnership (2000) A USAID-funded report. USA: POPTECH. Key findings and conclusions, pp (vi).

[12] Ghanaian law (1985) allows for safe abortion within certain circumstances: "Where pregnancy is the result of rape, defilement or incest; where continuance of the pregnancy will involve risk to the life of the pregnant woman or injury to her physical or mental health; or where there is substantial risk that the child, if born, may suffer from or later develop a serious physical abnormality or disease." Source: Prevention and management of unsafe abortion: Comprehensive abortion care services (2006) Accra: Ghana Health Service.

lives and health through unsafe abortion. To sign the Global Gag Rule would have meant breaking with medical standards in our own country by not informing our clients about the full range of medical services legally available to them. It seemed to us that the Global Gag Rule was playing politics with women's lives. We found it morally offensive and totally at odds with our mission and medical ethics to risk the lives of Ghanaian women because of domestic politics in another country.

From a completely different part of the world, Dr Nirmal Bista of the Family Planning Association of Nepal, in his testimony before the Senate Foreign Relations Committee in July 2001, expressed well the anguish we were experiencing:

> "Were we to accept the restricted U.S. funds, I would be prevented from speaking in my own country to my own government about a health care crisis I know first-hand. But by rejecting U.S. funds, I put our clinics — clinics addressing that same health care crisis — in very real jeopardy.
>
> It is an untenable situation. But, we simply could not stand by and watch countless women suffer and die without doing everything we could to prevent the misery[13]."

In the end, we chose to refuse to abide by the Global Gag Rule requirements as did the whole of IPPF. The Global Gag Rule endangers the lives and health of women and families around the world. It undermines the provision of family planning services and information; it causes more women and couples to face the reality of unwanted pregnancies; it exposes women to the dangers of unsafe abortions. As our founder and special adviser to the President of Ghana, Dr Fred Sai compellingly stated

> "A straightforward public health problem with a known solution has been allowed to become the killing fields of women in developing countries, particularly Africa."[14]

The Detrimental Impact of the Global Gag Rule in Ghana

Around the world, the imposition of the Global Gag Rule and the consequent loss of funding have had a dramatic impact on the ability of IPPF Member Associations, and many other organizations, to provide full sexual and

[13] Schlangen, Rhonda. "The Global Gag Rule: Playing politics with women's lives" (2 July 2007) USA: Planned Parenthood Federation of America. http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/international-issues/global-gag-rule-15079.htm [Accessed 27 September 2007]
[14] Death and denial: Unsafe abortion and poverty (2006) UK: IPPF.

reproductive health services. The impact on PPAG was immediate, deep and damaging. PPAG lost all of its in-country USAID funding as well as USAID funding received via IPPF headquarters. In one fell swoop, PPAG had to absorb budget cuts of nearly $2 million.

An independent evaluation developed for Repositioning Family Planning, an initiative funded by USAID, stated:

> "Losing PPAG as a cooperating agency, and the resulting dismantling of a huge operation of contraceptive services and distribution, certainly had a negative effect on family planning coverage in Ghana. In 2003, 17% of all contraceptive sales were from the PPAG system, and most importantly, from rural areas. More than half of PPAG's 192 staff members were laid off, and more than 1,000 volunteers were without the structure that kept them motivated and supplied."[15]

When PPAG lost USAID-donated contraceptive supplies, we experienced contraceptive shortages and stockouts in some regions, at times for several months. We were no longer able to provide free contraceptives to the poorest of the poor. In less than a year, PPAG's condom distribution of 6.5 million fell by 40 per cent.

We were compelled to create a new 'cash and carry' system to fund the purchase of contraceptives. Despite this attempt to bolster contraceptive availability, PPAG was able to provide only half the number of contraceptive supplies in 2004 that we provided in 2003. This shortage meant that 38,000 women who had come to rely on PPAG for contraceptives were no longer able to obtain them.

PPAG has kept in touch with some of its community-based volunteers. Six of them who live in the areas surrounding Kparigu, one of the poorest and most rural areas of Ghana, recently spoke with us. I will share with you their first hand experiences. Their names are James Manga from Boayili, Sam Duud and Kasim Sumani from Kparigu, Abraham Aduku from Zasilari, Haruna Mahamodu from Boamasa and Abubakir Yamusa from Guakudow. They keep in contact with the PPAG Kparigu clinic even though there is no money to pay them for their travels to and from the clinic and no contraceptives to distribute. James, Sam, Kasim, Abraham, Haruna and Abubakir were all trained to be community-based service volunteers about seven years ago with USAID funds.

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[15] Solo, J.,et al. Ghana case study: 'Give them the power' (2005) A case study report of the Repositioning family planning initiative. New York: ACQUIRE Project/Engender Health. Pp 22-23.

> Haruna said, "We are all ready to work, but we need the contraceptives."
>
> Kasim said, "I need 60,000 cedis[16] to buy 600 condoms and another 60,000 cedis to buy 50 cycles of pills. In my community these will last about six weeks, but most of the time I do not have this money".

At the same time, 20,000 women and their babies who had maternal and child health care (including immunizations for the babies and family planning for the mothers) in the outreach programs could not get that anymore and over 8,000 people could no longer be reached with treatment for STIs.

> Sam said, "We still refer women to the PPAG clinic but because we have stopped many of the community programmes there are fewer referrals."

Finally, and most tragically, we saw 50 per cent more women come to our clinics for post-abortion care. Some of these women died from self-induced post-abortion complications in one rural community in the North. "In Ghana complications of unsafe abortion contribute [to] 22 to 30 percent of all maternal deaths. This exceeds the World Health Organization estimate of 13% [worldwide]"[17]. The tragedy of unsafe abortion in Ghana is so heartbreaking that it inspired a British radio (BBC) program to document the situation and share the personal stories of Ghanaians whose lives have been changed as a result[18].

Affecting Real People, Real Lives

Perhaps the impact of the Global Gag Rule will become more real with a personal account of the tragedy it has brought about. Benjamin Baavugi, a 40-year-old farmer from Boayili village, is currently caring for his niece and nephew because their parents have been severely and directly affected by the impact of the Gag Rule. A few kilometres from the PPAG Kparigu Clinic, in Benjamin's village, he told me the story of his sister-in-law, Kolgu Inusah, who died of an unsafe abortion.

I will let Benjamin tell this tragic story of an unnecessary and preventable death of a young mother for lack of contraceptives:

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[16] This amount is approximately US $6

[17] Professor Agyeman Badu Akosa, Director General, Ghana Health Service, June 2006 (Foreword of Prevention and management of unsafe abortion: Comprehensive abortion care services (2006) Ghana Health Service)

[18] "Ghanaians risk death for abortion" (11 January 2006) BBC Radio Four: Crossing Continents. <http://news.bbc.co.uk/1/hi/programmes/crossing_continents/6246303.stm> [Accessed 3 October 2007]

> "To understand what happened to Kolgu, I have to describe the situation in our village about seven years ago. We had a [community-based services] agent who was working in the village, regularly giving talks on family planning and the use of contraceptives, HIV/AIDS and environmental sanitation. The education was good for us, especially for the women, and many of them started using contraceptives to space their births... My wife used contraceptives and we spaced our children.
>
> About the middle of 2004, we noticed that the frequency of the agent's house to house visits and talks had reduced and sometimes he did not have enough contraceptives, and then after some time he stopped everything. There was no education and no contraceptives. When the women visited him he informed them that they had to go to Kparigu Clinic. Since this was a few kilometres away it was easier said than done.
>
> A few months after this we noticed that the number of pregnancies had increased and there were rumours of women having abortions. Kolgu and my brother, Kala Inusah, already had two children, Helene, 5, and Nurdee, 2. One day she started complaining of severe abdominal pains and when it became serious she confessed to her husband that she found out she was pregnant and went to a woman for some herbs to abort it. Kala rushed her to the PPAG clinic, but he did not tell anybody in the village the real problem. The medical team at the PPAG clinic tried to save her but it was too late.
>
> After Kolgu's death there was a lot of trouble in the village because the elders interpreted this sudden death as coming from the ancestors. Somebody had to be blamed and Kolgu's sister, Abu Bahe, was accused of causing her sister's death and she was banished from the village. We reported the case to the Medical Assistant at the PPAG clinic and the issue has been resolved. However my brother is not very well so I am looking after his two children."

David Kansuk, the medical assistant and head of the PPAG team at Kparigu, is a tribal chief in Nalerigu. He understands his people and has their trust. He explained that traditionally after childbirth the woman goes to stay with her parents for about two years. This naturally creates space between births. Although things have changed and most couples continue to stay together after having a baby, there is a lot of mocking if the woman becomes pregnant again before the child is two years old. The use of contraceptives had therefore become important and was gaining ground among both men and women. This explains the situation Kolgu found herself in.

David continued the story of Kolgu:

> "Before this lady died she told the nurses what she had done, using herbs to try and abort her pregnancy. We were surprised therefore to get a delegation from the village with the news that a woman had been banished because she had been accused for causing the death of Kolgu. We confronted Kala Inusah and after discussions he agreed to tell the community the truth. We went to the village and a meeting of the elders was arranged at which Kala told them what had happened. He confessed that he was ashamed of what his wife had done. It was agreed that Abu had been wrongly accused and she was brought back to the village. After this PPAG organized a sensitization seminar for the community and educated them on the dangers of unsafe abortion.
>
> In many of the communities where we had community-based service providers, reports of unsafe abortion have increased and we have had more post-abortion complications and deaths in this clinic since the Gag Rule and the end of our community-based services program which was supported by USAID. We see on average two to three women a month for post-abortion care. Those who can afford it travel to clinics in Bolgatanga and Walewale where they get safer abortion services. Unfortunately poor and young women are the ones who are at greatest risk for unintended pregnancies and who end up having the unsafe services and suffering through the consequences."

PPAG's community-based services program through which thousands of rural women, men and young people were given quality sexual and reproductive health services, including distribution of contraceptives, was the biggest rural outreach program in the area. PPAG is the only NGO providing sexual and reproductive health services through community volunteers in this district. The Ghana Health Service and some Christian organizations like the Baptist Mission have clinics in three towns. However, the extent to which we mobilize the community and the reach of our community-based service volunteers cannot be equalled, and a vacuum has been created that the public health service cannot fill.

The table below illustrates the magnitude of the reduction in PPAG's services to the poor and marginalized women of Ghana.

PPAG Service Statistics	Pre-Gag[19]		Post-Gag		
	2002	2003	2004	2005	2006
Number of clinical services for sexual and reproductive health*	2,482,487	2,679,638	1,035,780	664,176	958,608
Male Condoms distributed	6,518,572	4,411,437	2,755,060	3,506,479	3,190,861
Other contraceptives**	1,287,298	1,093,336	561,582	551,906	652,685
Facilities (service outlets)	17	16	15	14	12
No. of Community based Service Agents (volunteers)	1750	1685	760	650	761

* Clinical services include: post abortion care, MCH, infertility, family planning, treatment of minor aliments, HIV counseling, STI management, Male SRH services

** other contraceptives includes: female condoms, injectables, oral contraceptive pills, norplant, IUD, Norigynon, emergency contraception

Undermining Family Planning and Prevention of HIV/AIDS

Reduced access to family planning – condoms specifically – was a clear result of the Global Gag Rule. With limited access to contraceptives and reproductive health services, not only did the number of unintended pregnancies increase, but so did the number of new sexually transmitted infections.

In my country there are 7.5 million young people[20]. This is a group that is particularly vulnerable to HIV/AIDS but, unfortunately, many of them don't believe that HIV is a real threat to them and they do not protect themselves against it. Young people understand unwanted pregnancy, however. The Guttmacher Institute did a study in four sub-Saharan African countries, including Ghana, and they found that young people were more likely to use condoms to prevent pregnancy than to prevent HIV (only 5% of females used a condom for protection solely against STIs, including HIV/AIDS)[21]. In fact, Ghana has a high proportion of women living with HIV - 64 per cent of

[19] Though the Global Gag Rule was reinstated in January 2001, it did not immediately impact PPAG due to the fact that PPAG and USAID had a multi-year funding agreement which did not come up for review until 2003.

[20] "Ghana: Demographic and health highlights" (2007) Population Reference Bureau. <www.prb.org/Countries/Ghana.aspx> [Accessed 3 October 2007]

[21] Awusabo-Asare K et al., "Adolescent sexual and reproductive health in Ghana: Results from the 2004 National Survey of Adolescents" (2006) Occasional Report No. 22, New York: Guttmacher Institute. <www.guttmacher.org/pubs/2006/06/08/or22.pdf> Pp 69.

HIV-infected adults in Ghana are women – the highest recorded rate among 16 West African countries listed by PRB[22].

Those of us working in the field of reproductive health know that integrating HIV prevention and family planning programs is one of the most effective ways of getting young people to protect themselves, against unintended pregnancy and sexually transmitted infections.

Partnering with local churches and mosques, PPAG runs a dedicated program for youth called 'Young and Wise'. At Young and Wise we educate young people to help them make informed choices, to prevent HIV infection and to prevent teenage pregnancy. By refusing to sign the Global Gag Rule, PPAG was unable to continue promoting condoms through Young and Wise. In an article published in the L.A. Times in June 2004, Barbara Crossette illustrates the loss felt by Young and Wise following the implementation of the Gag Rule. She writes

> "The problem is that the supplier to Ghana of the best condoms, the United States Agency for International Development, can no longer give any to this project. Does this make any sense? ... Because Ghanaians – Christian and Muslim – are a religious people, the effect has been to undermine many programs that conservatives could support[23]."

The U.S. government maintains separate funding programs for family planning and HIV/AIDS, and integration is discouraged owing to funding and policy constraints. When PPAG lost funding from USAID, we hoped that we would be able to continue our HIV prevention programs at Young and Wise by applying to the President's Emergency Plan for AIDS Relief (PEPFAR). Sadly, this was not the case. Any partner that receives PEPFAR funds for integrated family planning/reproductive health – HIV/AIDS programs must comply with the restrictions on both U.S. family planning and HIV/AIDS assistance. This includes the Global Gag Rule. We know from years of experience that to get young people to pay attention - to really change their behaviour so that they are protecting themselves from sexually transmitted infections as well as unintended pregnancies – you have to promote condoms within family planning programs.

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[22] "Women of our World", Population Reference Bureau, 2005.
[23] "Commentary: U.S. Right Squeezes Lifesaving Aid to Africans" (10 June 2004) USA: Los Angeles Times.

Our Conclusions

In my country the Global Gag Rule has had the exact opposite effect of its stated intent. It did not reduce abortions. Indeed PPAG began to see a sharp rise (almost double) in post-abortion care services in our clinics, especially in the rural areas which is a reflection of the worsened access to reproductive health care and supplies. The Gag Rule undermined family planning and reproductive health services across the country. Fewer pregnant women were able to access much-needed care, and access to HIV/AIDS and STI prevention services, especially among young people, were reduced.

We will never know the real cost of this harmful policy because we can never know the total number of lives that have been irreversibly altered. It is the lives of poor and rural women, men and young people who were denied the right to make choices that could have improved their living conditions: an STI or maybe HIV infection that could have been prevented, a poor rural mother that could have received quality prenatal care to help her survive a pregnancy and deliver a healthy baby, a woman that could have avoided an unwanted pregnancy and therefore no need for an unsafe abortion and its related complications.

When PPAG refused to sign the Gag Rule, USAID hoped to find another NGO to take over the program. This was not possible then and it's still not possible now. There was simply no local or international NGO with the structure and expertise that PPAG had built over 33 years to take over. Not only did PPAG lose a key funder for its core services, but USAID also lost an irreplaceable partner, and the women and children of rural Ghana were the most severely affected.

Ironically, the Global Gag Rule has resulted in an inefficient use of US tax-payers money. No other Ghanaian organization compares to our rural outreach and our youth programs nor the trust and credibility we have with the community we come from. By funding other organizations with smaller reaches into the community, you fund a piecemeal and less cost-effective approach to development.

If USAID-donated contraceptives were made available to PPAG, the effect would be immediate and thousands of women would once again be able to access the services and contraceptives they need most. PPAG could resume community outreach programs to the rural poor. In our experience, the increase in contraceptive provision would dramatically and directly reduce unwanted pregnancies and avert unsafe abortion – thereby saving women's and mother's lives.

WRITTEN STATEMENT SUBMITTED FOR THE RECORD BY STEVEN W. SINDING, PH.D., SENIOR FELLOW, GUTTMACHER INSTITUTE, AGENCY DIRECTOR FOR POPULATION, USAID, 1983–1986

Good morning. My name is Steven Sinding. I am a senior fellow of the Guttmacher Institute, having retired last year as Director General of the International Planned Parenthood Federation (IPPF), a position I occupied during the four years from 2002 to 2006. I have also taught population and development courses as a member of the faculty of Columbia University, served as Director of the Population Sciences program at the Rockefeller Foundation, and as Senior Population Adviser at the World Bank. During a nearly 20-year career at the U.S. Agency for International Development (USAID) between 1971 and 1990, I worked as a population program officer overseas and as Mission Director in Kenya. Most relevant to today's hearing, I was the Agency Director for Population and head of USAID's Office of Population between 1983 and 1986, the period during which the so-called Mexico City Policy (now more frequently dubbed the Global Gag Rule) was announced and implemented by the Reagan Administration. (It was termed the Global Gag Rule because of its similarity to the domestic Title X gag rule on family planning organizations promulgated in the late 1980s. Both, to varying degrees, sought to silence family planning providers from counseling, referring for or advocating legal or safer abortion. President Clinton rescinded both the domestic and international gag rules on his first day in office; President George W. Bush reimposed the global gag rule on his first day in 2001.)

This morning I would like to explain the origins and purposes of the Mexico City Policy and to tell you something about its impact. I have seen it from the vantage point of USAID/Washington, field missions, and an affected nongovernmental organization—IPPF

I would like to begin by explaining what the Mexico City Policy is. Its name derives from the fact that the policy was announced at a UN international population conference in Mexico City in the summer of 1984. The policy stated that with immediate effect "foreign (non-U.S.) nongovernmental organizations [would be required] to certify that they will not perform or actively promote abortion as a method of family planning as a condition for receiving USAID assistance for family planning." The policy did not apply to the use of U.S. funds. It applied to the foreign organizations themselves, regardless of the sources of their funding. Thus, the Mexico City Policy goes well beyond the 1973 Helms Amendment to the Foreign Assistance Act, which stipulates that "no U.S. [foreign aid] funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions."

The purpose of the Mexico City Policy, expressed by its advocates at the time, was to punish most of the longstanding NGO family planning partners of USAID on the grounds that they also might support decriminalizing abortion or enabling access to safer abortion services. Their sights were set most particularly on the International Planned Parenthood Federation, a long-time USAID grantee and the primary funding channel to national family planning associations around the world.

I worked very closely with M. Peter McPherson, the USAID Administrator from 1981 to 1987, as the Mexico City Policy was being developed in the White House and elsewhere in the Reagan Administration. Thus, while I did not participate directly in them (and, indeed, argued that they would damage many programs), I was informed about the internal administration discussions that preceded the final policy declaration at Mexico City. I know, for example, that the original draft would have applied not only to foreign NGOs but also to U.S. NGOs and to foreign governments. Legal experts within the administration counseled, however, that court challenges would probably confirm that domestic NGOs would be protected by the First Amendment and by the Roe decision. Diplomats argued that foreign governments would probably claim that applying the policy to them represented a violation of sovereignty and the application of a double standard, inasmuch as abortion was legal in the United States.

Following the announcement of the policy, it fell to me and my USAID colleagues to implement it. Implementation basically involved the attachment of new clauses to all USAID contracts and cooperative agreements. The agencies involved were in many cases U.S. NGOs that supported foreign NGOs by sub-granting the U.S. funds to them, providing technical assistance, and monitoring the use of the funds. The clauses required the recipients of USAID funds to receive certification from the sub-grantees that they would not provide, refer, or advocate on behalf of abortion. The policy required these recipients to set up accounting systems that enabled them to track the funds in order to ensure compliance with the policy. And it required the U.S. organizations to monitor how the sub-grantees used their own funds in order

to ensure that none were used to pay for any abortion-related activity. I think it is clear why the lawyers and diplomats thought such restrictions would not be acceptable to foreign governments or the U.S. NGOs themselves.

During my tenure as head of the USAID population program, two major grantees, Family Planning International Assistance (FPIA), the international program of the Planned Parenthood Federation of America; and IPPF, refused to accept the Mexico City Policy and, therefore, to accept USAID funding. Many other US cooperating agencies protested the policy and some did challenge it in court, but the courts, which have always granted wide discretion to the Executive Branch in foreign policy matters, upheld the right of the Administration to decide who could or should receive foreign assistance dollars. Meanwhile, under protest the cooperating agencies other than FPIA and IPPF accepted the policy and complied with it. All were confronted with a truly agonizing choice: oppose the policy as a matter of principle and lose all the USAID money they were spending on family planning and related services; or accept the policy in order to continue their vitally important work. What is especially noteworthy is that none of the cooperating agencies were spending even a penny of their own funds on abortion and very few of their grantees were either. Even the Planned Parenthood agencies overseas were spending less than one percent of *their own funds* on abortion-related activities—and then only in countries where it was legal. Indeed, numerous government audits over the years confirmed consistent compliance with the Helms amendment prohibition on spending any U.S. funds on abortion as a method of family planning.

We in the Agency, as best we could, redirected the funds that would have gone to IPPF and FPIA to other cooperating agencies, and to bilateral country programs. In some cases the other cooperating agencies were able to get the funds to sub-grantees that were willing to sign the Mexico City clauses but in other cases, particularly in countries where abortion was legal, the erstwhile sub-grantees refused to take the funds. Later in this testimony I elaborate on how disruptive the policy was to the USAID program.

I believe that the Mexico City Policy, which remained in force until early1993 (i.e., through the Reagan Administration and that of George H.W. Bush), initially achieved many of the purposes for which it was designed. First, because of the enormous influence of the United States in all matters pertaining to population and family planning, it had a profoundly chilling effect on international discussion about abortion, where in the developing world clandestine abortion kills or maims millions of women each year. Second, and just as importantly in my opinion, it denied U.S. funds to some of the most important providers of *family planning services* in the developing world, in particular, the primary target, IPPF, the foremost nongovernmental provider of services and advocate for reproductive health and rights.

This latter issue is more important than it might appear to be on its surface, for two reasons. First, the U.S. was then and still is far and away the largest provider of financial support to family planning programs around the world. At the time of the Mexico City Policy's promulgation in the mid-1980s U.S. support accounted for around 50 percent of all international assistance available to population programs. Second, in the population and family planning field, nongovernmental organizations were, and still are, inordinately important in providing services. Even today, more than half of all family planning services in the developing world (outside of China) are provided by NGOs, including many that are faith-based. Thus, the denial of U.S. funding to a substantial fraction of the most effective foreign NGOs clearly resulted in a curtailment in the availability of vitally needed family planning services to hundreds of thousands, if not millions, of women and their partners. *And this denial of resources for family planning services certainly did nothing to reduce the numbers of unwanted pregnancies and abortions.*

Because abortion statistics are difficult to amass and because it is almost as difficult to estimate the numbers of clients of family planning services who were affected by the Mexico City Policy, I cannot provide you with numbers on the effect of the policy on unwanted pregnancies and abortions. But I can say with considerable confidence that the Mexico City Policy deeply undermined the USAID family planning assistance program—the most important and effective program of its kind in the world—and that it denied to many thousands of clients contraceptive and other important services that were utterly unrelated to abortion.

The Mexico City policy was overturned as President Bill Clinton's first official act and for the next eight years the U.S. once again assumed a position of global leadership on population matters. But following the election of George W. Bush as President in 2000, he reinstated the policy as his first official act in January 2001. Then White House spokesman Ari Fleischer explained that the president did this to "make abortion more rare." Now dubbed by its opponents the Global Gag Rule

(GGR), the policy has been in force ever since. It is nearly identical to the original version of the Mexico City Policy.

While I was responsible for implementing the Mexico City Policy for a period of time following its initiation in 1984, my relationship to its reincarnation as the George W. Bush Global Gag Rule in 2001 was from the receiving end. In 2002 I became Director General of IPPF, joining shortly after IPPF made its decision to reject U.S. funding as long as USAID required adherence to the GGR. This was a very difficult but principled decision on IPPF's part, difficult because it cost IPPF around $23 million a year in USAID funds and donated contraceptives. The decision not only denied the Federation its USAID grant, it also demanded that the 150 individual national member associations of IPPF refuse to accept USAID funds offered through bilateral country programs—a major issue for many member associations which had direct funding relationships with USAID field missions. At the time, USAID funds represented more than 20 percent of all the IPPF income that was channeled through its central secretariat. Overall, IPPF estimates that the Global Gag Rule cost it and its members at least $116 million between 2002 and 2006.

Naturally, the loss of the U.S. money came as a major blow. IPPF was required to cut its grants to its members by some 20 percent. In countries where the members received additional U.S. funds directly, the percentage cut was even greater. In Kenya, for example, the Family Planning Association of Kenya (as it was then called) was forced to close six clinics that served over 9,000 regular clients. This phenomenon of clinic closures, curtailed community-based outreach programs, and contraceptive shortages was repeated across the entire IPPF network, affecting some 150 countries, thousands of facilities, and millions of clients.

I can tell you that IPPF's decision was politically wrenching. Many IPPF member associations had enjoyed longstanding and close relationships with USAID and, because they were in countries where abortion was illegal, had no abortion services. Had it not been for the decision by European donors to come to the rescue by attempting to compensate to some degree for the loss of U.S. funds, I think it's quite possible that IPPF would have collapsed. This is but one example among many where committed professional organizations providing vitally needed services were forced by U.S. policy to make an agonizingly difficult choice: a choice between being able to continue to serve their clients by knuckling under to a policy they considered ethically wrong and morally repugnant; or rejecting that policy at the cost of severe curtailment of services or even going out of business altogether. In the case of several large USAID-dependent U.S. cooperating agencies, such as Pathfinder International and Engender Health, a decision not to accept the restrictions imposed by the Global Gag Rule would almost certainly have meant going out of business and shutting down the family planning services they support in the dozens of countries where they operate.

There is a view that funds that are rejected by one agency can be quickly reprogrammed to others that are willing to abide by the U.S.-imposed restrictions, with no loss in the effectiveness of these programs. That is wrong. Service delivery programs are built up over a long period of time through trusting relationships between organizations. They often include a lot of technical support and training. One couldn't cut off an FPIA-supported NGO one day and simply shift the funding to another U.S.-based organization. It takes months and years to rebuild those relationships and, in the meantime, programs languish, clients drop out, and momentum is lost. When USAID could no longer fund FPIA after 1985, many strong programs in developing countries, often administered by faith-based groups, were weakened, sometimes even beyond the point of recovery.

Let me conclude by saying to this Committee that I believe the Mexico City Policy, or Global Gag Rule, has been extremely costly in terms of:

- its impact on the people living in developing countries who depend on U.S. reproductive health and family planning assistance;
- its perverse effect of making contraceptive services even harder to obtain in certain local areas, increasing the likelihood of unwanted pregnancies and, perhaps, abortions ? including a great many risky and unsafe abortions that threaten women's health and lives;
- its negative impact on U.S. credibility and stature around the world, and the ability of the U.S. to provide political and moral leadership in reproductive health and family planning;
- its chilling effect on rational discussion internationally about unsafe abortion as a significant public health problem which is heavily concentrated in the developing world; and

- its ultimate impact on the cause of helping countries reduce very high fertility, achieving eventual population stabilization, reducing poverty, and promoting social and economic development.

Finally, I would like to congratulate the House of Representatives for taking the first stand against the Global Gag Rule in 16 years with its vote in June during consideration of the Foreign Operations Appropriations bill. I hope the President will reconsider his threat to veto that bill because of the provision that would nullify the Global Gag Rule or even over the provision making contraceptives easier to distribute to poor countries.

Thank you very much for giving me this opportunity to testify.

WRITTEN STATEMENT SUBMITTED FOR THE RECORD BY JOACHIM OSUR, MBCHB, MPH, SENIOR ADVISOR FOR TRAINING AND SERVICE DELIVERY IMPROVEMENT, IPAS AFRICA ALLIANCE, NAIROBI, KENYA

HOW THE MEXICO CITY HAS INCREASED UNSAFE ABORTION IN KENYA

Chairman Lantos and distinguished members of the House Committee on Foreign Affairs, I am honored to be invited here today to speak on the issue of the U.S. Mexico City Policy – also referred to as the Global Gag Rule. As an African, I am deeply grateful for the Committee's attention to this issue of great significance to the lives of African women.

My name is Dr. Joachim Osur and I have been working in Kenya and throughout Africa to expand access to family planning and reproductive health services for the past ten years. I am first and foremost a medical doctor and a provider of reproductive health services. Secondly I have managed reproductive health programs provided by both government and non-governmental organizations (NGOs). Finally I have contributed to policies that affect family planning, reproductive health and HIV/AIDS in Kenya and in Africa as a whole. I therefore bring to the committee today the experiences and perspectives of a service provider, a program manager and a policy maker. Currently I am based in Kenya and I serve as Senior Advisor for Training and Service Delivery Improvement for Africa with Ipas, an international organization based in Chapel Hill, NC. I am also a member of the Kenya Government Technical Committee on the Implementation of Sexual Offences Act. I am privileged to be consulted on and to contribute to policy on an on-going basis on matters of reproductive health and HIV/AIDS by the government and civil society organizations in Kenya.

Ipas, the organization for which I currently work, implements programs aimed at preventing death and injury from unsafe abortion and promotes women's reproductive rights globally. Before I joined Ipas, I worked at the Family Planning Association of Kenya (FPAK), an affiliate of the International Planned Parenthood Federation, as a National Director in charge of clinical and community based reproductive health services. The Mexico City Policy had just been reinstated when I joined FPAK and it became my duty to try to cope with the disastrous effects of this policy that reverberated across the health services provided by NGOs and the government throughout the country. It is from this perspective that I will speak to you today.

From my experience, the Mexico City Policy has had many unintended consequences. I understand that the policy provided an opportunity for decision makers in the United States to demonstrate their opposition to abortion. However, in Kenya and across Africa the policy has greatly harmed the health and lives of women—young and old, married and unmarried, mothers and mothers-to-be.

The Mexico City Policy's purported intent is to stop abortion, but it has actually debilitated efforts to meet Kenyan women's demand for family planning and modern contraception, to prevent unintended pregnancy and prevent unsafe abortion. Although it applies only to local, indigenous NGOs, it has severely affected family planning services provided by both the Kenyan government and NGOs. President Bush has made clear that the Mexico City Policy does not apply to apply to U.S. HIV/AIDS assistance, yet it is adversely affecting HIV prevention efforts for

women and young people. Lastly, the policy was based on moral principles, the desire to save lives, yet it has proved to be against those same moral principles and it has resulted in many lives being lost. My duty today is to explain how these paradoxes have occurred in Africa using Kenya as a case study.

The History of Family Planning in Kenya

Before I address the Mexico City Policy specifically, I would like to present a picture of Kenya and the evolution of the family planning programming and policy development in the country. Kenya has made many gains over the past 50 years, but still remains today a country with a great need for family planning services. Nearly 60% of Kenyans live on less than two dollars per day and our life expectancy at birth is only 47 years. The number of women of reproductive age has more than doubled since the 1980s. Currently, only 61% of married women of reproductive age are using contraceptives.[1]

The story of family planning in Kenya dates back to 1962 when the Family Planning Association of Kenya was formed. At this time, communities were largely unaware of modern family planning methods and the government had no role in providing family planning services. Five years after FPAK established family planning services however, the Kenyan Government became the first African government to develop a population policy which embraced family planning. Since its inception, FPAK has remained a major service provider and advocate for family planning in the country.

Prior to 2001, partnerships between NGOs like FPAK and the Kenyan government were essential to providing effective family planning services in Kenya, with the government and NGO sectors each providing 50% of services.[2] FPAK educated and mobilized communities on family planning thereby creating demand for services. FPAK also supported community health workers who worked with rural women who otherwise had no access to health facilities to educate and distribute contraceptives, provide counseling and referrals to health clinics and provide information on sexually transmitted infections, including HIV/AIDS. Further, the organization trained health workers for both government and NGOs to offer family planning services. In addition, FPAK operated family planning clinics in parts of the country that lacked public health facilities. In this relationship, the government acquired and distributed contraceptives to NGOs and through public health facilities. The government operated public family planning clinics and ensured an enabling policy environment for services to be provided.

FPAK clinics provide a range of health care services including contraceptives, counseling and testing for sexually transmitted diseases, care for complications of unsafe abortion, as well as pre- and post-natal care. In most FPAK clinics women receive comprehensive infant care, immunizations, malaria tablets, and vitamin A supplements for their infants and children. FPAK clinics were the first reproductive health clinics in Africa to fully integrate HIV/AIDS services, including counseling and testing, prevention of HIV transmission from mother to child, anti-

retroviral treatment and psychological support. Prior to the loss of funding from the Mexico City Policy, FPAK ran 16 family planning clinics.

Beginning in 1982, with support from USAID, FPAK established a community-based distribution program for contraceptives. Community-based distribution (CBD), emblematic of USAID-funded programs, may be the only way to reach specific communities, particularly in slum areas and rural villages. The CBD agents distributed condoms and contraceptive pills and offered counseling and referrals for maternal and child health services. FPAK's CBD agents, beginning in the 1990s, also disseminated information about HIV/AIDS. For some Kenyans, CBDs represented their only interaction with a health care professional and they were therefore vital to promoting access to family planning and HIV/AIDS information and services.

In partnership with the Kenyan government, FPAK succeeded in drastically improving the ability of Kenyans to choose whether and when to have children. This success was most evident in official statistics collected between 1978 and 1998. Over the course of those twenty years, the average number of children born to each woman nearly halved from 8.3 in to 4.6. Between 1978 and 1998 Kenya experienced dramatic increases in the use of contraceptives – contraceptive rates among married women rose more than five-fold from 6.7% to 39%.[3]

USAID in Kenya

The United States has been the leading donor for family planning and other reproductive health services in Kenya. USAID provides technical and financial support to NGOs and the Kenyan government for Kenya's national programs in family planning and HIV/AIDS. Unlike other governmental donors, USAID provides funds to NGOs directly and has built the capacity of Kenyan organizations like FPAK to provide quality health care.

From 2001-2005, USAID undertook the AMKENI Project, a five year, $16 million package of services that included family planning and reproductive health. Through AMKENI, the Ministry of Health of Kenya and NGOs would work in partnership to implement family planning services at the local level through public and private clinics, with an initial emphasis on the development of NGO and private sector services.[4] Two NGOs were expected to lead the implementation of the AMKENI project: Marie Stopes International Kenya (MSI) and FPAK.

However, FPAK and MSI didn't sign the Mexico City Policy and the AMKENI project therefore had to revise its approach. No other entity in Kenya – neither NGOs nor government – had the capacity to provide family planning services and reach clients as well as FPAK and MSI. Because of the Mexico City Policy and the loss of irreplaceable partners, AMKENI entirely revised its strategic focus and shifted toward working with the government sectors in Kenya, as USAID was not able to find NGOs to replace FPAK and MSI.[5]

The Impact of the Mexico City Policy on NGOs in Kenya

The Mexico City Policy was implemented just as AMKENI was getting underway. FPAK (along with MSI) was faced with a difficult decision: either sign the terms of the Mexico City Policy or sever their long-time partnership with USAID.

FPAK ultimately decided that it could not abide by the restrictions of the Mexico City Policy. If it signed the policy, the health and rights of the patients the organization serves would be compromised. Kenyan's abortion law is restrictive and FPAK provided no abortion services. However, the ban on counseling and referrals under the policy goes against the rights of our patients to receive proper care and would prevent health care providers from upholding their ethical obligations. Also, the ban on advocacy with our private, non-U.S. funds would have compromised FPAK's ability to work with other NGO's, professional associations and government officials in Kenya to change the restrictive abortion law, which leads to unsafe abortion and the death and injury of women.

FPAK lost a total of 58% of its annual budget due to the Mexico City Policy. In addition to the loss of direct funding from USAID, FPAK lost US$325,000 from support from the International Planned Parenthood Federation. I took over management of clinic and community based family planning services at the Family Planning Association of Kenya at this bad time in the history of the organization. We had to act urgently to save the organization from collapsing.

Clinics closed

Because of the funding cuts, FPAK immediately closed thee clinics. Since losing USAID funding, FPAK has closed a total of eight clinics and retrenched 50 percent of its staff, not including CBD agents. The clinic closures resulted in a loss of FPAK services to between 80,000 and 100,000 Kenyans. For many of these Kenyans, FPAK was the only source of affordable health care in their area.

I will describe some of the clinics that are now closed because of the Mexico City Policy to help illustrate what it means to lose these health facilities that provide a range of comprehensive health care services:

- Kekewenga clinic, the only specialized family planning clinic in Western Province in Kenya (an area with a population of around 4 million), was closed and with it went the community based distribution program that served six districts in the province.

- Two Nyeri clinics, based in the Mount Kenya region, were closed. Some patients from these clinics, who for many years received services from FPAK, have had to travel 250KM to Nairobi to receive services.

- Nkumbi clinic, situated in a rural setting in Eastern province, was closed. Community leaders from the province petitioned FPAK and sent delegations to talk to the executive director to reverse the decision. Due to the funding cuts, this was not possible.

- Mombasa clinic, based in the second largest city in Kenya, was closed. This clinic was special because it provided services in a way that was culturally sensitive to the Muslim community who inhabit the Coast Province. There was a big outcry among the community when the clinic was closed. In an effort to please the community, FPAK decided to integrate clinic services in its youth center in Mombasa. However, this model is not appropriately culturally sensitive and has failed to attract the women of this area who previously benefitted from the FPAK clinics.

Because of the cuts, FPAK also had to lay off staff, cut salaries and raise fees in their existing clinics. The cost of family planning services became too high for some Kenyans. The FPAK staff members that we were able to keep were stretched to the limit. Just as USAID has been unable to find NGOs to replace the work of FPAK and MSI, both NGOs have been unable to find funds from other donors to replace what was lost from USAID. The once strong FPAK, the leader in family planning services in Kenya, has never fully recovered.

Community-Based Services Scaled Back

By 2006, FPAK's community-based distribution of information and contraceptives was completely stopped. Community-based distribution agents were advised to stop their services because there were no funds to support their activities. Many Kenyans, particularly rural women, lost their only access to affordable family planning services in their community. Kenya's success with increasing the use of family planning services is largely due to the use of FPAK's CBD agents, which numbered 1,000 before the Mexico City Policy was implemented.

Government Family Planning Services Interrupted

The ability of the public sector to deliver family planning services was severely hampered without the crucial role of the NGOs in service provider training and community mobilization. The capacity of FPAK was diminished with the loss of USAID funds. FPAK staff and community workers could no longer train government health providers, mobilize communities to use government health services and distribute government contraceptives. The demand for contraceptives as well as the capacity to provide services in the public and private sectors has gone down. Because of the interruption of the system for distributing family planning services, contraceptives expired on the shelves at government stores in 2003 and 2004.

Growth of Family Planning Stagnates

Kenya's story of success in expanding access to family planning services ended in 2003. The Mexico City Policy had exacerbated a crisis in family planning in Kenya that was also a result of massive cuts in funding for family planning and reproductive health services in the mid-1990's followed by a shift of resources by the Kenyan government and the donor community to HIV/AIDS. The system for providing family planning services in Kenya is now deteriorating, as is starkly illustrated by the latest official survey of demographics and health in Kenya. The 2003 Demographic and Health Survey showed that, for the first time in 25 years, the contraceptive prevalence rate had stagnated at 39%.[6] Until these recent statistics were revealed, Kenya boasted steady and dramatic improvement in the use of family planning services. The climb in the rate of contraceptive use has stagnated, representing a turning point in the history of family planning in Kenya and a very disturbing trend.

Since 2001, Kenya has experienced shortages of contraceptives at the national level and locally– what is referred to as contraceptive insecurity. Like many African countries, Kenya is dependent on outside donors to provide contraceptives and major donors decreased their donations of supplies. An evaluation of USAID's family planning program in Kenya recommends that USAID work to ensure contraceptive security at the national level and at facilities.[7] Donations of contraceptives are needed. Also needed is the capacity of organizations such as FPAK and MSI who are able to ensure that contraceptives get to the people who need them. Increasing supplies of family planning without concomitant increase in community mobilization and service provision in both the public and private sectors will not increase access to services.

Efforts to Reduce Unsafe Abortion Harmed

The Mexico City Policy harms our work to combat unsafe abortion in Kenya in two distinct ways. By crippling leading organizations that provide family planning services, the Mexico City Policy is contributing to unintended pregnancy and unsafe abortion. In addition, the Mexico City Policy prohibits USAID funded organizations from participating in the debate on unsafe abortion in Kenya.

Unsafe abortion in Kenya is a major public health problem. A recent study by the Ministry of Health and its partners showed that 300,000 abortions occur in Kenya annually. The same study revealed that 20,000 women are admitted to hospital with complications of unsafe abortion each year. Complications from unsafe abortion account for up to 50% of gynecological admissions.[8] The United Nations Development Program estimates Kenya's maternal mortality rate to be 1,000 per 100,000 live births[1] and Kenya is in the bottom 15% of countries

[1] This figure is adjusted from official government estimates to account for well documented problems of underreporting and misclassification of maternal deaths.

worldwide.[9] One-third of these maternal deaths in Kenya are due to unsafe abortion.[10] These are intolerable statistics. We as health care providers cannot stand by and allow women to die.

Where women do not have access to contraception, they are more likely to have an unplanned pregnancy. Global statistics tell us that over half of unplanned pregnancies end in abortion.[11] There are many reasons women face unwanted pregnancy. Women may feel they are too young or too poor to raise a child. They may not want a child while they are in school or they may be unable to keep their job if they continue with the pregnancy. Women may not want to continue with a pregnancy because of health problems, because they are estranged from their partner or because their pregnancy has resulted from sexual violence.[12]

Wherever women face unwanted pregnancy and do not have access to safe abortion, they will take desperate measures to end their pregnancies. In Kenya, safe abortion is not available and the law allows abortion only to save the life of the mother. Women in Kenya faced with unwanted pregnancy self-induce abortion or obtain clandestine abortion from untrained medical workers, traditional healers or laypeople. Women try to end their pregnancies by ingesting laundry bleach or turpentine, through the insertion of objects like sticks and wires or by jumping from a dangerous height.[13]

A wide range of stakeholders, including the Kenya Medical Association, Federation of Women Lawyers and health care providers have made a commitment to work to change the dangerous law on abortion. The Vice President of Kenya and the Deputy Minister of Health have recently expressed concern over deaths from unsafe abortion and called for commitment to abolish these deaths. Parliamentarians in Kenya have begun to work toward liberalizing the abortion law.

Because of the Mexico City Policy organizations that receive USAID funding are silent in the debate on abortion in Kenya and in the face of so many tragic deaths. The side of the debate in favor of changing the abortion law is stifled as reproductive health care providers – supportive of legal change in private – are gagged by the U.S. government and cannot voice their support or even discuss the problem of unsafe abortion. Shortly after the Mexico City Policy was reinstated, a coalition of Kenyan organizations held public debates on the topic of abortion. Though they were invited to the debates, no USAID-funded Kenyan organization participated because they were not permitted by the Mexico City Policy. As the public conversation on abortion continues in Kenya, USAID-funded organizations are notably absent. By signing the Mexico City Policy, USAID-funded NGOs have made a pledge to the United States government that they will not participate in the democratic process on the issue of abortion – within their own country, with their own government.

Combined Efforts to Provide Family Planning and HIV/AIDS Services Curtailed

Reproductive health care providers play a key role in HIV prevention. Reproductive health services, such as counseling on family planning methods, screening and treatment for sexually transmitted infections (including HIV/AIDS) and condom distribution are all integral components to any HIV prevention strategy. Many family planning providers are significant sources of HIV/AIDS information and provide prevention, care and treatment to their clients. FPAK was a leader in integrating HIV/AIDS activities into their reproductive health services. FPAK's community based agents provided information on HIV prevention to Kenyans in rural areas. Because the Mexico City Policy has weakened Kenya's infrastructure to deliver information and services, HIV/AIDS programs funded by USAID and other donors is less effective.

Separate programs for preventing HIV have been established and these programs cannot collaborate with the major family planning organizations because of the Mexico City Policy. I personally know people who feared they were risking their jobs at a USAID-funded organization by simply talking about collaboration with organizations who have not signed the Policy.

The Morality Paradox and the Mexico City Policy

I have heard it said repeatedly that the Mexico City Policy is a creation of people who value morality. As a medical doctor, I took an oath to save life. I find it very immoral whenever I come across a dying woman who has undergone unsafe abortion. I feel sad that I have to sign the death certificates of such women. I know that it is within our means to prevent these deaths and suffering yet the world has decided that African women are not worth saving. This depressing experience has made me move out of the hospital wards and to talk to audiences such as this and I pray that you will bring the needed change.

Conclusion

Nearly every Kenyan knows a story of a friend, relative, sister or classmate who has risked her life by undergoing an unsafe abortion. Recently the Assistant Minister of Health for Kenya, who is supportive of safe and legal abortion, relayed to the newspapers a story of a bright young girl from his region who had performed well in secondary school and had been admitted to university. However, the family of this girl could not pay the cost of her tuition at university. The Assistant Minister himself had organized a fundraiser for her in the city that would cover all of her tuition. The day before the event, the Assistant Minister received a call. The girl had died at the hands of a quack while seeking an abortion. Why did that girl need to die with all of the ambitions of a bright future?

WRITTEN STATEMENT SUBMITTED FOR THE RECORD BY NANCY NORTHUP, PRESIDENT OF THE CENTER FOR REPRODUCTIVE RIGHTS

Chairman Lantos, Ranking Member Ros-Lehtinen, distinguished Members, thank you for the opportunity to submit this statement on the distressing and repressive Mexico City Policy, also known as the Global Gag Rule. The Center for Reproductive Rights is a nonprofit legal advocacy organization dedicated to promoting and defending women's reproductive rights worldwide. We are opposed to the Global Gag Rule as a direct infringement on not only reproductive rights, but also the fundamental right to freedom of speech.

As you know, the Global Gag Rule prohibits any non-governmental organization (NGO) overseas that receives U.S. Agency for International Development (USAID) family planning funds from using their own money to provide abortion services; to advocate for changes in abortion laws; or even to provide full and accurate medical information about legal abortion services to their patients.

The Global Gag Rule forces health care organizations to make an immoral choice: either give up desperately needed funds for family planning and other reproductive health-care services, or give up their right to free speech and to provide patients with full and accurate medical information. Either conclusion harms the women and families who are most in need. They are left with either incomplete information and medical care or insufficient resources for full access to comprehensive services.

Zambia is one example of the devastating effects of the Gag Rule. There is only one NGO operating reproductive health clinics for the whole country, and its choice not to accept the terms of the Rule caused the loss of its USAID family planning funding. Since then, it has lost 40% of its staff, reduced services, and eliminated distribution programs due to lack of funding.

Not only has the policy had harmful and widespread effects on women throughout the world by shutting down health facilities and limiting the full range of reproductive health services, it has stifled debate and the ability of foreign NGOs to lobby their governments—in effect undermining their right to exercise freedom of speech.

The gag rule would be unconstitutional if it were applied to NGOs here in the U.S. and therefore, creates a double standard. As then-appellate court judge Ruth Bader Ginsburg articulated in a 1989 case challenging the gag rule:

If our land is one "of freedom, of equal opportunity, of religious tolerance, and of good will for other peoples who share our aspirations," it is in no small measure because our Constitution restrains all officialdom from infringing on fundamental human rights; just as our flag "carries its message . . . both at home and abroad," so does our Constitution and the values it expresses.

The Global Gag Rule is government censorship of political speech that President Bush disagrees with: speech that promotes abortion law reform and public education. Organizations working to criminalize abortion or to increase restrictions on abortion access are not censored by the U.S. government, but groups like the Center for Reproductive Rights and its foreign partners who support abortion rights as human rights are gagged.

This oppressive policy has hindered family planning organizations abroad for far too long. Certain champions in Congress have repeatedly taken steps to repeal or reduce the impact of the Global Gag Rule, and it is time that these efforts came to fruition. I have provided the Center's 2003 report entitled *"Breaking the Silence: The Global Gag Rule's Impact on Unsafe Abortion."* I hope that it will serve as yet another indication that the Rule is not only oppressive and hypocritical, but also contradictory to its stated aims. I thank the Committee again for taking up this important issue, and welcome any questions or comments you may have.

WRITTEN STATEMENT SUBMITTED FOR THE RECORD BY DR. KENT R. HILL, ASSISTANT ADMINISTRATOR FOR GLOBAL HEALTH, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

The Administration is firmly committed to protecting the lives of both the unborn and their mothers by reducing the incidence of abortion. President Bush, in his January 22, 2001 statement on the restoration of the Mexico City Policy, noted his "conviction that taxpayer funds should not be used to pay for abortions or advocate or actively promote abortion, either here or abroad." U.S. support for voluntary family planning assistance has not been reduced as a result of full restoration of the Mexico City Policy.

The United States Government is the world's largest family planning bilateral donor. USAID delivers voluntary family planning assistance in more than 60 countries through bilateral, regional, and centrally-managed programs to help families plan the timing and spacing of their children. In fiscal years 2002 through 2007,

U.S. global family planning programming averaged about $440 million—an increase over the $427 million average annual funding during the previous Administration. Congress's on-going commitment and support for voluntary family planning programming has been and is critically important. Our success in family planning has been very much the result of a partnership between the Administration and Congress.

Each year, U.S.-supported voluntary family planning programs abroad serve more than 20 million women, through both clinical as well as non-clinic-based approaches aimed at reaching the hard-to-reach populations. It is important to note that in addition to addressing maternal health through family planning, USAID supports a range of maternal health interventions that reduce suffering and deaths related to pregnancy and childbirth.

USAID's family planning program is designed to expand access to and use of high-quality, voluntary family planning services and information and reproductive health care, with the objective of reducing unintended pregnancy, decreasing abortion, and improving maternal and child health and survival.

Voluntary family planning programs that emphasize counseling, repeated contact with clients, and a broad range of methods from which a client can choose can help couples determine whether, when, and how often they will have children. While USAID does not fund abortion, post-abortion care, which includes both emergency treatment for abortion complications as well as provision of family planning, is part of our family planning portfolio and makes an important contribution to saving women's lives. When the Mexico City Policy was restored, it was made clear that post-abortion care should be an important aspect of USAID programming.

Since the restoration of the Mexico City Policy in 2001, USAID has worked hard to ensure that women have access to voluntary family planning programs. All family planning funds provided have been successfully programmed with an emphasis on the countries where the need is greatest. The vast majority of foreign non-governmental organizations in all of the countries where USAID provides family planning assistance have accepted the Mexico City Policy, and continue to participate in USAID-funded family planning programs.

The Ghana program provides an example of USAID's success in finding new partners after the restoration of the Mexico City Policy. Between 1998 and 2001, USAID shipped contraceptives purchased with family planning funds valued at $1.5 million annually to Ghana, translating to 344,000 couple-years protection from pregnancy, annually. About $380,000 worth of these donations on average were provided annually to the local International Planned Parenthood Federation (IPPF) affiliate. Although USAID no longer provides contraceptives to the Planned Parenthood Association of Ghana, the average annual value of commodities shipped to Ghana over the 2002–2007 period (that is, since the restoration of the Mexico City Policy) is $2.3 million. The number of couple-years protection over this period averaged about 600,000 annually, or about a 75 percent increase over the earlier period. Local implementing organizations in Ghana include Ghana Health Services (GHS), a government entity; the Centre for the Development of People; the Nurses and Midwives Council; Exp Momentum, based in South Africa; and local affiliates of Plan International, the Red Cross Society, Adventist Development Relief Agency, and World Vision International, all of whom have certified under the Mexico City Policy. The GHS, in particular, has a network of health clinics nationwide. GHS has also invested, with USAID support, in the establishment of Community Health Planning and Services zones to increase access of rural Ghanaians to basic health services including family planning and provision of condoms for HIV/AIDS prevention.

USAID's voluntary family planning program is a success story. Since the program began in 1965, the use of modern family planning methods in the developing world, excluding China, has increased by a factor of four, from less than 10 percent on average to 43 percent. In the 39 countries with the largest USAID-supported programs, the average number of children per family has dropped from more than 6 to 4.1. The program's continued success is shown by an increase in modern family planning use from 33 percent to 38 percent between 2001 and 2006 in these same countries.

The program has also had success in reducing abortion as evidenced by data in the Eastern Europe and Eurasia region. This success has continued since the restoration of the Mexico City Policy.

The Agency works directly with hundreds of non-governmental organization partners, the majority of which are foreign NGOs, to provide technical assistance to voluntary family planning programs at the local level. Since the restoration of the Mexico City Policy, the vast majority of organizations has been fully willing to comply and we have continued to be able to provide quality, voluntary family planning services through these organizations.

Further, the Mexico City Policy has not interfered with our ability to provide family planning services through a variety of channels. For example:

- Our efforts have made voluntary family planning accessible to people in hard-to-reach areas through door-to-door distribution, clinic-based service delivery and employee-based programs.
- USAID introduced contraceptive social marketing. These programs privatize contraceptive distribution and marketing, using the commercial pharmaceutical sector to reach more people at lower cost, decreasing countries' dependence on the donor community for supply and distribution of affordable commodities.
- USAID has always given high priority to providing contraceptive supplies and related assistance in logistics and quality assurance. We have worked hard over the past decade to encourage other donors to get involved in contraceptive procurement and to encourage more manufacturers to supply to the developing-world market. Over the past five years, USAID provided between one-third and two-fifths of all donated contraceptives and condoms and nearly all logistics management assistance.

Thanks to the unwavering support of Congress, USAID has been able to continue to address unmet need for family planning in these priority countries. U.S. support for international family planning programs has not been reduced as a result of the Mexico City Policy. The resources allocated to USAID for family planning since 2001 have been second only to those allocated for HIV/AIDS. This sustained high level of funding has allowed USAID to continue as a leader in the family planning sector and to work with both new and long-standing partners to bring women and families in the developing world the high-quality voluntary family planning programs they have said they want.

Family Planning/Contraception rises dramatically under Mexico City Policy*

Country	2002 funding	2007 funding	Increase
Ethiopia	$ 4.9 million	$19.5 million	298%
Haiti	$ 4.5 million	$11.0 million	144%
Pakistan	$ 1.4 million	$16.5 million	1079%
Uganda	$ 5.2 million	$9.8 million	88%
Nigeria	$11.8 million	$20.05 million	70%
DR Congo	$ 1.0 million	$9.0 million	800%
Kenya	$ 6.0 million	$11.40 million	90%
Tanzania	$ 4.0 million	$9.6 million	140%
Afghanistan	$ 0	$14.50 million	up from $0
India	$11.9 million	$17.0 million	43%

*According to data provided by USAID, June 2007

International Planned Parenthood Federation: Making abortion a universal right throughout the world

- IPPF's Abortion Goal: "A universal recognition of a woman's right to choose and have access to safe abortion, and a reduction in the incidence of unsafe abortion." [IPPF's Strategic Framework 2005-2015, p. 12 (2006)].

- "IPPF's second goal is to make abortion legal and safe everywhere." [IPPF, Death and Denial: Unsafe Abortion and Poverty, p. 9 (2006)].

- "IPPF's Member Associations are adopting more proactive advocacy strategies rather than simply responding to anti-choice tactics. Their aims are to protect existing liberal laws, and to make abortion safe and legal everywhere." [IPPF Annual Performance Report 2005, p. 67 (2006)].

- "In 2004, IPPF conducted a research initiative on abortion among all of its Member Associations. . . . The questionnaire was sent to 171 countries in which IPPF works and was completed by 165, representing a 96 per cent response rate. . . . Seventy-eight per cent of the total number of respondents indicated an interest in implementing abortion-related advocacy activities while 54 per cent expressed an interest in engaging in the provision of abortion-related services." [IPPF Annual Performance Report 2005, p. 66 (2006)].

EUROPE

- **Portugal:** "The Portuguese Family Planning Association, Associação Para o Planeamento da Familia (APF)[an IPPF Member Association], hailed today's results of Portugal's referendum on liberalizing its abortion laws as 'a victory for sexual and reproductive health and rights in Portugal.' As one member of a vital coalition . . . (APF) has campaigned tirelessly to change Portugal's abortion law, . . . Duarte Vilar, Executive Director of APF, said, 'We sincerely hope that these results can give inspiration to Ireland, Malta and Poland."[IPPF News Release, "IPPF Member Association plays crucial role in shaping abortion debate in Portugal (Jan. 12, 2007)].

- **Ireland:** The role of the IPPF Member in the ongoing battle over abortion in Ireland is described in an article on Planned Parenthood's website: "But when it comes to women's reproductive health and rights, Ireland is among the most restrictive and oppressive legal regimes in the world. If the Irish Family Planning Association (IFPA) [an IPPF Member] has anything to do with it, however, women will realize full reproductive rights in the foreseeable future. . . . IFPA launched the 'Safe and Legal Ireland' Campaign, a multi-layered approach to legalizing abortion. ["Ireland's Battle for Women's Rights," by Meg DeRonghe, senior program officer, Planned Parenthood Global Partners (2006)].

  -- In 2005, the Irish Family Planning Association issued a news release announcing the

campaign, and stated: "The Irish Family Planning Association, today (9.08.05), launched a major campaign for the introduction of legal abortion services in Ireland. The 'Safe and Legal in Ireland' campaign will comprise a range of activities, including a legal initiative to challenge the status quo on abortion; a political lobbying campaign and sustained programme of national and international advocacy. . . ." [IFPA News Release, "IFPA Launches Campaign for Safe and Legal Abortion in Ireland (Aug. 9, 2005)].

LATIN AMERICA

- "We, diverse members of U.S.-based NGOs, join with our allies in the Latin America and Caribbean region in calling on our governments to eliminate all legal and political obstacles to adequate reproductive health services and technical assistance in order to guarantee women's access to safe and legal abortion in the region. We join millions of women from Latin America and around the globe to demand the right women have to decide for themselves, to call upon societies to respect their decision, and governments to guarantee safe and legal abortion services for all women who need them." [International Planned Parenthood Federation/Western Hemisphere Region was a cosignatory to a statement by U.S.-Based NGO's on the occasion of the "Day for the Decriminalization of Abortion in Latin America and the Caribbean," (Sept. 28, 2004), posted on Ipas website].

- In 2003, the IPPF's Western Hemisphere Region initiated a new initiative with its Member Associations in Bolivia, Brazil, Guyana, Mexico, Peru, Venezuela (and Barbados and Puerto Rico in 2005) by which "[w]orking with partners such as Catholics for a Free Choice, board members and staff of Member Associations have been sensitized on pro-choice catholic perspectives on sexual and reproductive health and rights. This has proved to be an effective internal advocacy strategy, and there have been important institutional shifts in the participating Member Associations with staff . . . beginning to take on a public advocacy role to promote the liberalization of abortion laws." [IPPF Annual Performance Report 2005, p. 70 (2006)].

AFRICA

- "In most African countries, abortion laws are overwhelmingly restrictive and modelled closely on the laws of the major colonial powers that governed them at independence . . . . Member Associations, including Kenya and Mauritius, work bravely to advocate for restrictive abortion laws to be reviewed." [IPPF Annual Programme Review 2003-2004, p. 48].

- **Mauritius:** "The objective of the Mauritian Member Association's [MFPA] advocacy programme is to make abortion legal in the country through a successful change in the abortion law. The battle began back in March 1994 when MFPA organized an international conference on abortion. . . . In 2002, MFPA formed a national advocacy

team, . . . The Prime Minister, to commemorate International Women's Day on 8 March 2004, declared that the solution to the problem of abortion would be found shortly in consensus with all stakeholders. Since then, the Mauritian Government has made a commitment to legalize abortion in certain specific cases. MFPA and the pro-choice movement advocate for full freedom for the woman to decide freely whether she wants an abortion. The assertion is that abortion should be legalized not only in 'specific cases', and that a more proactive, pragmatic and practical approach needs to be adopted. This remains a long-term strategy and the battle is yet to be won." [IPPF Annual Programme Review 2003-2004, p. 49].

- **The Gambia:** "In May 2004, an orientation workshop was organized in The Gambia with staff, senior volunteers and youth peer educators of the Gambia Family Planning Association (GFPA) to advocate for the right to safe abortion. . . . 'Advocating for liberal abortion laws is not about encouraging abortions but about saving women's lives,' Medical Officer, GFPA." [IPPF Annual Programme Review 2003-2004, p. 46].

- **Uganda:** "Using evidence to support the case for reducing rates of unwanted pregnancy through improved access to safe abortion, IPPF's Member Association has appealed to the Government for repeal of the current restrictive abortion laws on public health grounds . , , ," [IPPF, Death and Denial: Unsafe Abortion and Poverty, p. 12 (2006)].

- **Kenya:** "In July 2004, following a workshop entitled 'Advancing women's access to safe abortion' organized by Ipas, the Kenyan Reproductive Health Steering Committee was established. . . . The IPPF Africa Regional Office and the Family Planning Association of Kenya (FPAK) have been regular and active participants in the Committee meetings and have made financial contributions to support publicity activities. . . . A draft motion on increasing the grounds upon which safe abortion is permissible will soon be tabled in the Kenyan parliament, and the IPPF Africa Regional Office is providing technical and financial support to the advocacy and media sub-committee which is publishing articles on various aspects of abortion in partnership with a pro-choice journalist. In less than a year, the Reproductive Health Steering Committee has brought together nearly all organizations that provide reproductive health services in the country, as well as many legal, medical and human rights organizations. This is undoubtedly the largest partnership lobbying for safe abortion services and the review of outdated abortion laws in the Africa Region." [IPPF Annual Performance Report 2005, p. 73 (2006)].

  -- "The president of the International Planned Parenthood Federation (IPPF), Dr Jacqueline Sharpe, is calling for legalization of abortion in the country. Dr. Sharpe said women should have the right to control their fertility and be at liberty to decide whether to have babies or not. . . . Legalising abortion in a country like Kenya, she said, would reduce the number of lives lost through unsafe methods." ["IPPF president calls for legalization of abortion," The Standard (online edition of this Kenyan newspaper)(July 6, 2007)].

ASIA

- **Sri Lanka and Indonesia:** "In **Sri Lanka**, where abortion is currently illegal except when a mother's life is in danger, the Family Planning Association of Sri Lanka (FPASL), in collaboration with women's rights groups and pro-choice lobbyists, introduced a new Bill in June 2004 to promote and protect women's rights, including their right to safe abortion. Similarly, in **Indonesia**, the Indonesian Planned Parenthood Association (IPPA) has worked for several years with the Indonesian Government, parliamentarians, and religious and community organizations to review and liberalize the abortion law." [IPPF Annual Programme Review 2003-2004, p. 47].

- **Nepal:** "The advocacy campaign led by the Family Planning Association of Nepal (FPAN) [an IPPF Member] since 1995 resulted in the legalization of abortion in 2002." [IPPF Annual Programme Review 2003-2004, p. 50]. A detailed history of this campaign for legalized abortion in Nepal can be found on the International Planned Parenthood Federation's website's profile of Nepal.

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Dr. Beverly LaHaye, Chairman

POLICY CONCERNS

President Bush's Policies Save Lives in Kenya
By Sarah Rode
June 11, 2007

President Bush's commitment to upholding the Mexico City Policy has stripped funding from pro-abortion groups in Kenya. International Planned Parenthood Federation (IPPF) and other groups received government funds during the Clinton administration to provide "health and reproductive services" which they used to monetarily entice Kenyan doctors to defy their nation's laws by committing abortions in a country which outlaws them.

According to Joseph Ofisi, a Kenyan doctor now studying in the U.S., doctors were targeted by IPPF and paid to attend "extravagant conferences in 5 star hotels where the abortion agenda was pushed and doctors taught the techniques of abortion procedure." These conferences are not advertised as abortion training seminars, but rather as a forum to learn "new techniques in reproductive health." According to Dr. Ofisi, doctors who promote the abortion agenda in clinics in their villages are paid three times as much as doctors who provide legitimate health services to Kenyans. They are also paid by the number of abortions they commit. This creates an incentive to increase the prevalence of abortion in a country where the majority of the population opposes abortion and the law forbids it.

Since the majority of Kenyans oppose abortion, doctors developed tactics to encourage women to have abortions which ignore the issue of choice altogether. When a woman missed her period, she would go to a clinic that provided "menstrual regulation" services. There, she was informed that a minor surgery must be done to correct the problem. The doctor then performed a dilation and curettage (D & C) abortion on a woman who believed she was having a minor operation to correct her menstrual cycle. There is no pregnancy test; the doctor does not even know if the girl is actually pregnant. These clinics received funding from IPPF and the United Nations Family Planning Association (UNFPA) whose mission it was to "control" Kenya's population.

President Bush is accused of denying funds to clinics that also combat AIDS and other diseases in developing countries. An article in Reuters from 2003 reports, "President Bush's anti-abortion policy has hit clinics in poor countries hard, forcing some to close and leave entire communities without healthcare." What

Dr. Beverly LaHaye, Chairman

POLICY CONCERNS

they do not report is that these clinics have the choice to keep their doors open with U.S. funds if they drop just one "service": abortion.

These "health care providers" are making the deliberate decision to stop providing services to women if they cannot promote their pro-abortion agenda. A congressional advisor told the BBC news, "Marie Stopes (an abortion provider based in the United Kingdom) had to make a decision if they wanted to continue receiving U.S. government funds," he says. "They made the decision that it was more important for them to be in the abortion business." Clearly, the abortion agenda is more important to Planned Parenthood than women's health.

Wendy Wright, President of Concerned Women for America, commended President Bush for his commitment to protecting life: "The Mexico City Policy is more effective than many of us knew. Dr. Ofisi provides a first-hand account of how President Bush's policy of protecting life by not allowing tax-dollars to subsidize organizations that promote abortion has a multi-fold effect. It saves lives and leads doctors to moral, life-affirming, Hippocratic-oath honoring careers."

Bush's policies have directed U.S. funding to programs that actually improve quality of life in developing countries. Whereas the U.N. and Planned Parenthood are intent on decreasing the population in certain countries through dangerous and illegal procedures, the President has upheld the right of women to choose life.

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THE MEXICO CITY POLICY (MCP): FALSE CRITICISMS AND THE FACTS

On March 28, 2001, the Bush administration reinstated the Mexico City Policy (MCP) that guided U.S. foreign aid for family planning from 1984 through 1992. This policy, first announced at the U.N.'s 1984 Conference on Population in Mexico City, requires foreign non-governmental organizations receiving these funds to certify that they will not perform or promote *abortion* as a method of family planning.

Fact: The MCP does not apply to abortions or abortion referrals in cases of rape, incest, or danger to the life of the mother.

During Senate debate in 2007, Senator Boxer focused primarily on this issue, using the word "rape" 12 times during her remarks (*Cong. Record*, Sept. 6, 2007, S11181-82, 11191). The truth is that the policy explicitly excludes abortions for rape, incest or life endangerment from its definition of abortion as "a method of family planning."[1]

Fact: The MCP places no restrictions on lobbying for legalized abortion in cases of rape, incest, or danger to the life of the mother.

Senator Boxer stated that MCP "gags" NGOs that want to advocate legalizing such abortions (*Id.*, S11182). But the MCP's restrictions on intervening to change foreign countries' abortion laws do not apply to such cases, because they do not involve promoting abortion as a "method of family planning." [2]

Fact: The MCP allows passive abortion referrals when women may otherwise seek an "unsafe" abortion.

Senator Boxer said the MCP prevents NGOs from protecting the lives of women determined to have an abortion (*Id.*). But the MCP does not ban non-directive counseling or "passive" referrals (giving information in response to questions) even in the case of "family planning" abortions. It bans "actively promoting" such abortions, to prevent U.S.-funded foreign NGOs from encouraging and persuading women to use abortion as a family planning method.[3]

Fact: The MCP is necessary because other laws do not prevent such abortion promotion.

Senator Leahy said the MCP is unnecessary, because current statutory law already prohibits the use of U.S. funds for abortion or to promote abortion. "Somebody should have told that to President Bush," Sen. Leahy stated (*Id.*, S11192). But these statutes only prevent *direct* use of U.S. taxpayer funds for abortion – they allow these funds to subsidize organizations, build clinics, and pay the salaries of officials who then use their newfound access to Third World women to promote abortion to them. This enormous loophole in existing law is the reason why the United States announced at the UN Population Conference in 1984 that "the United States does not consider abortion an acceptable element of family planning programs and will no longer contribute to those of which it is a part."[4]

Fact: The MCP encourages compassionate care for women injured by abortion.

Senator Boxer stated that maternal deaths from childbirth and botched illegal abortions are a "result" of the MCP (*Id.*, S11181). Senator Leahy urged opposition to the policy "to make lifesaving services available to the world's poorest women" (*Id.*, S11193). However:

- ***The MCP explicitly allows treatment for women who have complications from an abortion.***[5] When the U.N. Conference on Population in Mexico City issued its resolution against abortion as a method of family planning in 1984, it was the U.S. delegation that urged adding language specifically on this point, so that the final resolution

urged governments "to take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and whenever possible, provide for the humane treatment and counseling of women who have had recourse to abortion."[6] This commitment to compassionate care is in full accord with the MCP.

- ***The MCP does not increase "unsafe" abortions.*** Five years after the Mexico City Policy was first implemented in 1984, according to the *New York Times*, "even the most fervent opponents of the policy" were unable to find clear evidence of increased illegal abortions or abortion complications.[7]

- ***Rates of "unsafe" abortions decreased worldwide between 1995 (when the MCP was not in effect) and 2003 (two years after it was reinstated).*** This is confirmed by a recent study in *The Lancet* conducted by the Guttmacher Institute (Planned Parenthood's research affiliate) and the World Health Organization. During this time, the rate of unsafe or illegal abortions decreased because the total abortion rate declined so significantly.[8]

- ***Some organizations that lost funding under the MCP have a history of promoting abortions even where they are illegal.***[9] The International Planned Parenthood Federation (IPPF), the largest organization to lose funds under the MCP, has even instructed its affiliates: "Family Planning Associations [IPPF affiliates] and other non-governmental organizations should not use the absence of a law or the existence of an unfavourable law as an excuse for inaction; action outside the law, and even in violation of it, is part of the process of stimulating change."[10] If illegal abortions are inherently unsafe for women, the fact that these organizations promote illegal abortion is another reason it would be irresponsible to fund them.

Fact: The MCP neither reduces family planning funding nor increases abortions.
Sen. Leahy argued that the MCP reduces the availability of family planning worldwide, and that this leads to increased abortions (*Id.*, S11192-93). However:

- ***The MCP does not reduce the amount of family planning funds by one penny.*** The money is redirected to groups agreeing to the MCP's terms. In fact, under the MCP, U.S.-funded family planning has increased the most in countries where the need was said to be the greatest, such as Ethiopia and Uganda. Contrary to claims that these countries lost support under the MCP, family planning funding increased by almost $15 million in Ethiopia and by $4.6 million in Uganda.[11]

- ***Including abortion as a substitute or back-up for contraception undermines the goals of family planning programs.*** This has long been known, and is a reason why Congress has excluded abortion from its major domestic family planning program since 1970.[12] In general, numerous studies have shown that programs increasing access to contraceptives do not necessarily reduce unintended pregnancies or abortions.[13] But this is especially true of programs that include abortion as a family planning method. You cannot reduce abortion by promoting abortion.

Fact: People in developing nations support the MCP because it respects their sovereignty and their values.

Sen. Boxer claimed that the MCP "feeds into the stereotype of America" around the world (*Id.*, S11181). Sen. Leahy said rescinding MCP will "restore U.S. credibility and leadership" on global health (*Id.*, S11193). However:

- ***As U.S.A.I.D. has noted, "a principal purpose of the policy is to avoid the hostility to the U.S. resulting from U.S. identification with abortion."***[14] The agency added: "Abortion is a controversial issue in many countries, especially those with large Catholic or Moslem populations. The U.S. has been criticized in developing countries for its funding of groups (such as IPPF and some of its affiliates) which perform abortion with their own funds."[15]

- ***The UN Population Conference's Mexico City Policy of 1984 has been supported by the great majority of developing nations.***[16] This policy, rejecting any use of abortion as family planning, has been reaffirmed by the UN several times since it was approved.[17]

- ***The great majority of the nations affected by the MCP have laws against abortion as a method of family planning.*** The MCP shows due regard for these nations' legal and cultural values by preventing U.S.-funded groups from attacking, undermining and violating these laws.[18]

[1] Restoration of the Mexico City Policy, 66 *Federal Register* 17303 (Mar. 29, 2001) at 17306, Secs. (e)(10)(i) and (e)(10)(iii)(B).
[2] *Id.* at 17306, Secs. (e)(10)(i) and (e)(10)(iii)(A)(III).
[3] *Id.* at 17306, Sec. (e)(10)(iii)(A)(II).
[4] "U.S. Policy Statement for the International Conference on Population," 10 *Population and Development Review* 574 (1984).
[5] *See fn. 1 above* at 17306, Secs. (e)(10)(ii) and (e)(10)(iii)(B).
[6] United Nations, Department of Technical Co-operation and Development, "Report of the International Conference on Population, 1984" at 21, Recommendation 18(e).
[7] T. Lewin, "Abortion-Aid Cutoff Still Being Judged," *New York Times*, February 27, 1989 at A16.
[8] Gilda Sedgh, Stanley Henshaw, and Susheela Singh, et al., "Induced abortion: estimated rates and trends worldwide," 370 *The Lancet* 1341 (October 13, 2007) at 1341, 1344.
[9] Donald Warwick, "Foreign Aid and Abortion," 10 *Hastings Center Report* 30 (April, 1980) at 30, 33-35 (IPPF and other NGOs have distributed abortion equipment and conducted abortion training in countries where abortion is illegal, sometimes calling them "menstrual regulation kits" to skirt abortion prohibitions).
[10] International Planned Parenthood Federation, "Report of the Working Group on the Promotion of Family Planning as a Basic Human Right," November 1983 at 28-29.
[11] *Cong. Record*, June 21, 2007, H6893 (Rep. Bart Stupak citing data provided by U.S.A.I.D.).
[12] *Cong. Record*, Nov. 16, 1970, H10286-9.
[13] Fact Sheet, "Greater Access to Contraception Does Not Reduce Abortions," USCCB Secretariat for Pro-Life Activities, *available at* www.usccb.org/prolife/issues/contraception/contrafactsheet0207.shtml; *see also* Fact Sheet, "Emergency Contraception Fails to Reduce Unintended Pregnancy and Abortion," USCCB Secretariat for Pro-Life Activities, *available at* http://www.usccb.org/prolife/issues/abortion/factsheetec21607.shtml.
[14] United States Agency for International Development (U.S.A.I.D.), "Population Assistance Fact Sheet," May 1985.
[15] *Id.* (also cited in Fact Sheet, "The Mexico City Policy," National Committee for a Human Life Amendment, at 3, *available at* http://www.nchla.org/datasource/ifactsheets/mexico%20city%204.23.01.PDF [accessed 10/23/07]).
[16] Testimony of Bishop James T. McHugh before the House Appropriations Subcommittee on Foreign Operations, April 24, 1989 at 5-6, *available at* www.usccb.org/prolife/issues/abortion/McHugh1989.pdf.
[17] *See:* United Nations, "Report of the International Conference on Population and Development" (1994), paragraph 7.24, *available at* www.un.org/popin/icpd/conference/offeng/poa.html; "Report of the Fourth World Conference on Women in Beijing" (1995), paragraph 106 (k), *available at* www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en; "Report of the Ad Hoc Committee of the Whole of the twenty-third special session of the General Assembly" (2000), paragraph 72 (o), *available at* www.un.org/womenwatch/daw/followup/as2310rev1.pdf [all web sites accessed 10/23/07].
[18] Center for Reproductive Rights, International Fact Sheets, "The World's Abortion Laws," *available at* http://www.reproductiverights.org/pub_fac_abortion_laws.html (listing worldwide abortion policies by country); *see also* "List of Developing Countries", The World Bank, 2007, *available at* http://web.worldbank.org/WBSITE/EXTERNAL/OPPORTUNITIES/GRANTS/DEVMARKETPLACE/0,,contentMDK:20666605~menuPK:2895744~pagePK:180691~piPK:174492~theSitePK:205098,00.html (listing which nations the World Bank considers 'developing nations' as of 2007) [all web sites accessed 10/23/07].

10/26/07

DATE: November 1, 2007

FROM: Kevin Moore

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FOR IMMEDIATE RELEASE

U.S. CATHOLIC BISHOPS' PRO-LIFE SECRETARIAT TO CONGRESS: SUPPORT THE MEXICO CITY POLICY

WASHINGTON—On October 31, 2007, as the House Committee on Foreign Affairs convened a hearing on the Mexico City Policy, the United States Conference of Catholic Bishops (USCCB) ran ads in four Capitol Hill publications urging members of Congress to support "that sensible policy." The Mexico City Policy, currently under attack, ensures that the U.S. does not fund foreign non-governmental organizations that promote abortion as family planning abroad.

The USCCB's full-page ad in Roll Call, The Hill, CQ Today, and Congress Daily AM features the image of a woman from the developing world holding her child, paired with a quotation from Grace Olivarez, dissenting member of John D. Rockefeller III's federal advisory commission on population: "The poor cry out for justice and equality and we respond with legalized abortion."

Yesterday's hearing included pro-life testimony from Kenyan obstetrician and gynecologist Jean Kagia, MD, who compared efforts to legalize abortion in Africa with an earlier era's damaging and long-lasting influence by non-African outsiders. "The promotion of and effort to legalise abortion in Africa is a foreign agenda and a form of recolonisation," Dr. Kagia said.

Deirdre A. McQuade, Director of Planning & Information at the Secretariat, commented on the ad in light of Dr. Kagia's testimony. "Just as Latina activist Ms. Olivarez spoke out in 1972 against abortion as family planning in the U.S., Dr. Kagia spoke out courageously for today's African women," she said.

"Poor women around the world need help providing for their children, not eliminating them," Ms. McQuade said, "They deserve authentic help, not the phony substitute of more abortions."

Made possible by a grant from the Knights of Columbus, the ad appeared on October 30 and 31, and may be found on the Pro-Life Secretariat's website along with information on the Mexico City Policy at: www.usccb.org/prolife/MexicoCityPolicyAd.pdf.

###

SEC,DD,CATHPRESS,CNS,RNS.Crux

"The poor cry out for justice and equality and we respond with legalized abortion."

Grace Olivarez, dissenting member of John D. Rockefeller III's federal advisory commission on population

Some people have long been tempted to see abortion as a "quick fix" for the problems of the poor.

But poor women need help providing for their children, not eliminating them.

For many years the Mexico City Policy has ensured that our tax dollars do not fund groups that promote abortion as "family planning" to vulnerable women abroad.

But now, that sensible policy is under attack.

Dear Senators and Representatives:
The poor women of the world deserve authentic help, not the phony substitute of more abortions. ***Support*** *the Mexico City Policy. Please vote* ***against*** *any bill to overturn it.*

Secretariat for Pro-Life Activities

Made possible by the generous support of the Knights of Columbus

Support the Mexico City Policy.