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Exporting Despair: The Human Rights Implications of U.S. Restrictions on Foreign Health Care Funding in Kenya

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Exporting Despair: The Human Rights Implications of U.S. Restrictions on Foreign Health Care Funding in Kenya

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Abstract

This Report culminates a year-long project undertaken by the Joseph R. Crowley Program in International Human Rights to study the impact of the Mexico City Policy in Kenya and to analyze the applicable international human rights standards. This Report sets out the findings and legal analysis that resulted. Following this Introduction and a cataloguing of our recommendations, Part I examines those international human rights obligations that the Mexico City Policy most obviously implicates. In Part II, the Report turns to the impact of the Mexico City Policy upon these rights in Kenya. Part III of this Report turns to the understudied question of whether and to what extent donor nations, such as the United States, are or should be held responsible by the international community for the violations of international law that their policies promote. Here the Report concludes that there exists some basis for establishing such responsibility, but there are, nonetheless, significant gaps in current international law that the international legal community should consider and address.

SPECIAL REPORT

EXPORTING DESPAIR: THE HUMAN RIGHTS IMPLICATIONS OF U.S. RESTRICTIONS ON FOREIGN HEALTH CARE FUNDING IN KENYA

*Mehlika Hoodbhoy,**
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“After [the clinic] closed, I was stranded. When I went to another clinic, the services were not as good. It was discouraging because they always told me to come back another day.”¹

“We still see a lot of people, but we just don’t have the same supplies we used to. [They ask] ‘why have you abandoned us?’ [Our clients] liked our services, but not now.”²

“Clients were praying that we wouldn’t close [the clinic] but we had to.”³

INTRODUCTION

These voices, together with many others, speak to the impact in Kenya of a policy known as the “Mexico City Policy.” They tell a common story. In light of clinic closings and staff cutbacks resulting from the Mexico City Policy, the level of

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1. Interview with Marren Acheing, former client, Family Planning Association of Kenya [FPAK], in Kisii, Kenya (May 20, 2004) (on file with Crowley Program).

2. Interview with Hussein Marjan, Kenya Community Health Workers Program, in Embu, Kenya (May 20, 2004) (on file with Crowley Program).

3. Interview with Dr. Methuselah Ocharo, former FPAK Embu Clinic Manager, in Embu, Kenya (May 20, 2004) (on file with Crowley Program) [hereinafter Former FPAK Ocharo Interview].

health care in some areas has deteriorated dramatically in terms of availability, access, and quality.⁴ Nowhere has this decline been more significant than in poverty stricken areas and among poor women — where health care is needed the most.⁵

Often termed the “Global Gag Rule,” the Mexico City Policy is a regulation that issued not from Kenya, but rather the United States.⁶ On January 22, 2001, President George W. Bush issued an Executive Memorandum that formally reinstated a set of restrictions prohibiting foreign non-governmental recipients of U.S. family planning funds from, among other things, promoting or advocating abortion as either a means of family planning or, in all but potentially fatal cases, as a procedure to safeguard a woman’s health.⁷ These restrictions, in the first instance, bind the U.S. Agency for International Development (“USAID”), the principal conduit through which U.S. bilateral funding for health care flows to Kenya and to the developing world.⁸ First adopted in 1984 under the Reagan Administration,⁹ the Mexico City Policy was rescinded by President Clinton in 1993 for a period of seven years.¹⁰ In 1999, the policy was revived statutorily by Congress, which attached it as a condition to an appropriation act for the 2000 fiscal year.¹¹ President Bush restored it on

4. See Global Gag Rule Impact Proj., *Access Denied: The Impact of the Global Gag Rule in Kenya* [hereinafter *Access Denied: Kenya*], available at http://www.globalgagrule.org/pdfs/case_studies/GGRcase_kenya.pdf (last visited Sept. 9, 2005) (claiming that five family planning clinics closed as a result of the country’s two leading reproductive health organizations refusing to follow the restrictions, thus severely disrupting women’s access to vital services).

5. See *infra* Part II.

6. See *Access Denied: Kenya*, *supra* note 4, at 3.

7. See Memorandum on Restoration of the Mexico City Policy, 37 WKLY. COMP. PRES. DOC. 216 (Jan. 22, 2001).

8. See Memorandum for the Acting Administrator of the USAID: Restoration of the Mexico City Policy, 66 Fed. Reg. 17,303 (Mar. 28, 2001) [hereinafter USAID Memo].

9. See Policy Statement of the United States of America at the United Nations International Conference on Population (Mexico City, Aug. 6-14, 1984), reprinted in 10 POPULATION & DEV. REV. 574, 578 (1984) [hereinafter *Mexico City Policy*]; see also Sharon Camp, *The Impact of the Mexico City Policy on Women and Healthcare in Developing Countries*, 20 N.Y.U. J. INT’L L. & POL. 35, 37-38 (1987). The policy was initially enforced against the International Planned Parenthood Federation (“IPPF”) in 1984. *Id.* at 38. In 1985 it was officially implemented by the U.S. Agency for International Development (“USAID”) by inserting a “standard clause” in contract grants. *Id.*

10. See *Bush Moves to Outflank Democrats on Abortion Finance Limits*, N.Y. TIMES, Mar. 25, 2001, at 23.

11. See Foreign Operations, Export Financing and Related Programs Appropria-

an ongoing basis in 2001¹² and, two years later, extended it beyond USAID to all foreign population assistance programs within the purview of the U.S. Department of State.¹³ The Mexico City Policy became one point of difference during the 2004 presidential campaign when Senator Kerry stated that, if elected, he would revoke it.¹⁴ President Bush's reelection, however, virtually guarantees that the restrictions will continue at least until 2009.

This Report culminates a year-long project undertaken by the Joseph R. Crowley Program in International Human Rights to study the impact of the Mexico City Policy in Kenya and to analyze the applicable international human rights standards.¹⁵ As such, it is the first study to focus upon how the Mexico City Policy implicates international law and to do so with reference to a specific country. In this effort the Report has benefited greatly from a substantial literature on the impact of the Mexico City Policy upon the developing world. For the most part, this literature confirms predictions that U.S. restrictions on its development funding would undermine the goals of improving the provision of reproductive and general health care in countries where these services are lacking.¹⁶ Such studies, however, have documented the effects of the Mexico City Policy from the perspective of health care or development.¹⁷ Whether the documented effects violate international obligations such as the right to health have, for the most part, been addressed in passing. In addition, much of the existing literature examines the Mexico

tions Act, Pub. L. 106-113, §§ 599(C), 599(D), 113 Stat. 1501, app. 130, 130-33 (1999) [hereinafter Appropriations Act].

12. See USAID Memo, *supra* note 8, at 3.

13. See Memorandum from President George W. Bush for the Secretary of State Regarding Assistance for Voluntary Population Planning, 68 Fed. Reg. 52,323 (Aug. 22, 2003).

14. See *Reproductive Health: Ten Years' Hard Labor*, ECONOMIST, Sept. 4, 2004, at 65.

15. See Joseph R. Crowley Program in International Human Rights, Home Page, <http://www.crowleyprogram.org> (providing background information regarding the Crowley Program).

16. See, e.g., *Access Denied: Kenya*, *supra* note 4; see also Ctr. for Reproductive Rights, Expanded Global Gag Rule Limits Women's Rights and Endangers Their Well-Being (Dec. 2, 2003), http://www.crlp.org/hill_int_ggr_hiv.html (last visited Nov. 27, 2005); Global Gag Rule Impact Proj., The Impact of the Global Gag Rule in Ethiopia (Sept. 2003), http://www.globalgagrul.org/pdfs/case_studies/GGRcase_ethiopia.pdf; Global Gag Rule Impact Proj., The Impact of the Global Gag Rule in Kenya (Sept. 2003), http://www.globalgagrul.org/pdfs/case_studies/GGRcase_kenya.pdf.

17. See, e.g., *Access Denied: Kenya*, *supra* note 4.

City Policy on a regional basis and does so with a statistical emphasis. By contrast, this Report explores whether, and to what extent, the Mexico City Policy violates human rights obligations, in particular the rights to health, to free expression, and to be free from discrimination based upon gender. It considers the extent to which these obligations bind developing nations in the first instance, yet also addresses the novel issue of the responsibility of donor nations, such as the United States, when they encourage violations of these rights through their funding policies. To apply this legal analysis, this Report concentrates on the experience of a particular developing nation — in this case, Kenya — and highlights the personal testimony of individuals whose fundamental rights are at issue.

The Fordham delegation studying these issues was led by Professors Martin S. Flaherty and Tracy E. Higgins, and the 2003-2004 Crowley Fellow, Mehlika Hoodbhoy, and included six second-year Fordham Law students: Robin Boucard, Lindsay Ernst, Amy Howlett, Erin Kelly, Kenneth Powers, and Michael Yim.

Following the Program's established practice, the Crowley delegation undertook an intense program of academic study in the year leading up to the mission.¹⁸ This course of preparation included a seminar focusing on the Mexico City Policy in Kenya specifically. While in Kenya, from May 14 to May 31, 2004, the delegation met with Kenyan government health officials, representatives of USAID,¹⁹ health care administrators from non-gov-

18. See Maria McFarland Sanchez-Moreno & Tracy E. Higgins, *No Recourse: Transnational Corporations and the Protection of Economic, Social and Cultural Rights in Bolivia*, 27 FORDHAM INT'L L.J. 1663, 1666 (2004); Nicole Fritz & Martin S. Flaherty, *Unjust Order: Malaysia's Internal Security Act*, 26 FORDHAM INT'L L.J. 1345, 1347 (2003); Jeanmarie Fenrich & Tracy E. Higgins, *Promise Unfulfilled: Law, Culture, and Women's Inheritance Rights in Ghana*, 25 FORDHAM INT'L L.J. 259, 261 (2001); Crowley Program in Int'l Human Rights & Centro de Derechos Humanos Miguel Agustín Pro Juárez, *Presumed Guilty?: Criminal Justice and Human Rights in Mexico*, 24 FORDHAM INT'L L.J. 801, 804-05 (2001); Crowley Program in Int'l Human Rights, *One Country, Two Legal Systems?*, 23 FORDHAM INT'L L.J. 1, 3-4 (1999); Crowley Program in Int'l Human Rights & Lawyers Comm. for Human Rights, *Justice on Trial: State Security Courts, Police Impunity, and the Intimidation of Human Rights Defenders in Turkey*, 22 FORDHAM INT'L L.J. 2129, 2132 (1999).

19. Much of the information regarding USAID policy that we present here was gleaned from research on the agency's website and other documentary sources. Although we made many requests to interview USAID staff both in Washington, D.C. and Nairobi, those requests were either declined or ignored with few exceptions.

ernmental organizations (“NGOs”), human rights advocates, doctors, nurses, and health care clients throughout the country. The delegation conducted over 100 interviews in all.²⁰

This Report sets out the findings and legal analysis that resulted. Following this Introduction and a cataloguing of our recommendations, Part I examines those international human rights obligations that the Mexico City Policy most obviously implicates. Most important in this regard is the right to health, as set out in the International Covenant on Economic, Social and Cultural Rights (“ICESCR”), especially as elaborated by the Committee on Economic, Social, and Cultural Rights (“CESCR”) and the U.N. Rapporteur on the Right to Health.²¹ This Part will also make clear the relevance of the rights of free expression and the prohibition against gender discrimination set out in, among other instruments, the International Covenant on Civil and Political Rights (“ICCPR”).²² With respect to fulfillment of such rights, this Report begins by spelling out our recommendations to the U.S. Government, the Kenyan Government, and the international legal community.

In Part II, the Report turns to the impact of the Mexico City Policy upon these rights in Kenya. It first considers Kenya’s health care system, Kenya’s necessarily heavy reliance as a developing nation upon outside donors, and the historic role played by USAID in addressing Kenya’s systemic health care needs. Next, Part II sets out in detail how USAID policy changed under the complex restrictions on funding embodied in the Mexico City Policy. Finally, Part II sets out and summarizes the Crowley Program’s extensive interviews with individuals directly affected by the Policy. Taken together, these interviews suggest that the Policy has had a significant impact upon many communities in Kenya and confirm the findings of more general regional studies.

Part III of this Report turns to the understudied question of whether and to what extent donor nations, such as the United States, are or should be held responsible by the international

20. See *infra* Annex 1 (detailing Crowley delegation’s itinerary in Kenya).

21. See International Covenant on Economic, Social, and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) [hereinafter ICESCR] (Kenya acceded on May 1, 1972).

22. International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter ICCPR].

community for the violations of international law that their policies promote. Here the Report concludes that there exists some basis for establishing such responsibility, but there are, nonetheless, significant gaps in current international law that the international legal community should consider and address.

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The Crowley Program benefited from the contributions and assistance of many individuals and organizations in Kenya and the United States.

The Crowley delegation thanks guest speakers Kathy Hall-Martinez, Center for Reproductive Rights, then Director of the International Legal Program; Jacqueline Klopp, Adjunct Professor, School of Public and International Affairs, Columbia University; Lydiah Kemunto Bosire, Program Associate, International Center for Transitional Justice and Joanne Csete, former Director of the HIV/AIDS Program, Human Rights Watch. Special thanks to Patty Skuster, former consultant to the Center for Reproductive Rights, for providing contacts based on her previous research in Nairobi. Naomi Remis and Annemarie DeSimio provided valuable research assistance.

While in Kenya, the delegation met with members of the Kenyan government, academics, non-governmental and civil society organizations, United Nations specialized agencies, medical doctors, women's and human rights advocates, faith-based organizations and most importantly, former and present clients of the Family Planning Association of Kenya ("FPAK") and Marie Stopes International—Kenya ("MSI-Kenya") and the ordinary Kenyans whose access to health care has been affected by the Mexico City Policy.

Research for this Report was conducted in all five locations where FPAK and MSI-Kenya closed family planning clinics. The Crowley Program is indebted to FPAK and MSI-Kenya for working with Ms. Hoodbhoy as she planned the mission, permitting the delegation to interview members of their respective staffs and for arranging the numerous and informative site visits that gave the delegation access to those who have been affected by the clinic closures.

At FPAK, we thank Executive Director Godwin Z. Mzenge and Program Manager Dr. Linus I.A. Ettyang for their time and

assistance in arranging for delegation members to meet with staff and clients in Embu, Kisii, and the Eastleigh neighborhood in Nairobi. Dr. Methuselah M. Ocharo accompanied the Embu team. Ms. Heryne Ayiemba Dok served as escort and translator for the Kisii group. Ms. Ruth Wachira led the entire delegation on the Eastleigh visit, including a visit to the Nairobi Youth Centre.

Mr. Cyprian A.O. Awiti, Country Director of MSI-Kenya, briefed Ms. Hoodbhoy during her January visit and his colleague, Martha Mutunga, Manager of VSC Projects, escorted Ms. Hoodbhoy to Machakos to visit a rural health clinic. During the mission the Kisumu team was accompanied by Mr. Richard Olewe, Regional Manager for Western Kenya. Mr. Tom Chuma, Finance and Administration Manager, provided us with background information on FPAK's past and present financial status.

Ms. Pamela S.A. Onduso, Associate for Sexual and Reproductive Health at Pathfinder International in Nairobi, was instrumental in arranging several meetings in the city and with Pathfinder project partners in Eldoret, including Pathfinder staff, Anglican Church of Kenya and FPAK-Eldoret. Ms. Onduso kindly provided us with background reports and copies of relevant Kenyan health policies that would have been difficult to obtain without her assistance.

Heartfelt thanks to Juddy Kinuthia at Muthaiga Travel Ltd. at the Fairview Hotel for her invaluable logistical support that enabled safe travels within Kenya. Cheers to the staff of the Fairview Hotel for making us feel at home during our extended stay. Thanks to our taxi drivers, Cyrus, Joseph, Karoki and Rafael, who helped us navigate Nairobi traffic and answered our endless questions about Kenyan culture and society.

Finally, we are grateful to the former clients of FPAK and MSI-Kenya who took time from their hectic lives to share details of how they personally have been affected by the closure of the health clinics. Their stories are the heart of this Report.

RECOMMENDATIONS

A. To the United States Government

1. The Bush Administration should rescind the Mexico City Policy and direct that USAID funding be dispensed without re-

strictions concerning discussion of abortion as a means of family planning.

2. At a minimum, the Mexico City Policy should be modified so that it is no more restrictive than limits that obtain with regard to domestic health care funding within the United States.

3. The Bush Administration and USAID should undertake a comprehensive study with regard to the impact of the Mexico City Policy on the provision of reproductive and general health care in all countries in which the restrictions apply.

4. More generally, the U.S. government and USAID should consider whether and to what extent funding decisions would cause or facilitate the violation of the human rights obligations previously assumed by the recipient State. Toward that end, U.S. funding agencies should undertake "human rights impact assessments" in implementing funding decisions.

5. The United States should take a leading role in promoting, and at a minimum not impede, efforts by the international legal community to expand definitions of third-party State responsibility, especially in the context of developed States deploying their economic power in ways that pressure developing States to violate their human rights obligations.

6. The United States should ratify the International Covenant on Economic, Social, and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination Against Women.

B. *To the Kenyan Government*

1. To the greatest extent possible, the Kenyan government should adopt budgetary priorities that would better insulate reproductive health providers from dramatic shifts in donor policies.

2. The Kenyan government should seek to close the gap in reproductive health care funding that has resulted from the Mexico City Policy by soliciting donors who do not restrict the provision of health care in the same manner.

3. The Kenyan government should ensure that third parties do not interfere with the provision of services, supplies, and medically sound information in a manner that leads to retrogression in the level of health care.

4. The Kenyan government should fulfill its obligations under CEDAW Committee Recommendation 24 and the commitments

it made at the International Conference on Population and Development by allocating the resources necessary to implement its comprehensive national health strategy.

5. The Kenyan government should reallocate health care funding to emphasize preventative rather than curative care. With respect to reproductive care, it should upgrade existing health and family planning facilities that serve poor populations in order to improve access. It should also pay particular attention to providing reproductive health care in a manner that maximizes women's access to such services.

6. The Kenyan government should ensure that health facilities are equipped with the infrastructure, supplies, and medical personnel necessary to provide the highest feasible quality of care as per the General Comment Fourteen on the Right to Health.

7. The Kenyan government should ensure access to information about reproductive health services including contraceptives, family planning, safe abortions (as allowed by the Kenya Penal Code) and HIV/AIDS prevention.

8. The Kenyan government should ensure that adolescents have access to appropriate services, including information about reproductive health and HIV prevention.

C. To the International Legal Community

1. The international legal community generally should consider the problem of the state of international law in situations in which wealthy States use their wealth and influence to pressure developing countries in particular to violate their human rights obligations.

2. Where possible, transnational, government, and non-governmental bodies interpreting human rights instruments should seek to expand their extraterritorial effect, especially with regard to economic, social, and cultural rights.

3. The International Law Commission and relevant U.N. bodies should reconsider the Draft Articles on State Responsibility in light of third-party donor State actions that facilitate recipient State human rights violations.

4. Derivative responsibility under Draft Article 16 needs to be broadened and clarified. Specifically, the requirement that an assisting State must itself be bound by the human rights obligations the principal State has violated as a result of the assisting State's actions should be eliminated.

5. Likewise, the Article 16 standard for the assisting State's knowledge concerning whether its actions would result in human rights violations should be clarified to include situations in which the assisting State had objective reason to know of potential violations.

6. Derivative responsibility under Article 18 should be expanded by broadening the definition of coercion to include State actions that make it substantially or overwhelmingly difficult to take any other course.

7. Similarly, the Article 18 standard for the assisting State's knowledge concerning whether its actions would result in human rights violations should be clarified to include situations in which the assisting State had objective reason to know of potential violations.

8. The international legal community needs to recommit to the concept of an international duty to cooperate in the realization of economic, social, cultural, and development rights. Such an effort should be designed to complement the current Millennium Development Goals.

I. *INTERNATIONAL LAW*

The denial of foreign aid to organizations that "perform or actively promote abortion as a method of family planning"²³ implicates several fundamental rights recognized in international law. Foremost is the right to health.²⁴ Where a policy retards or reverses the progressive realization of adequate health care, a violation has presumptively occurred. Likewise, the Mexico City Policy further raises questions with regard to freedom of speech and expression to the extent it restricts health-related information and silences health care practitioners and providers. Given that any adverse effects on the provision of reproductive health care by definition affect women more than men, the Policy's funding constraints also potentially jeopardize core international prohibitions against discrimination based upon sex. This Part will analyze these three sets of rights and consider the obligations that they entail.

23. See *Mexico City Policy*, *supra* note 9, at 578.

24. See, e.g., The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. Comm. on Human Rights Res. 2003/28, 59th Sess., 56th mtg., U.N. Doc. E/CN.4/RES/2003/28 (Apr. 22, 2003).

The Mexico City restrictions raise further issues still — questions that approach the current frontiers of international human rights law. In conventional analysis, obligations to abide by human rights standards run to the nation within whose territory or jurisdiction violations occur. It follows that in the first instance, Kenya stands responsible for insuring the rights to health, free speech, and gender equality within its borders, especially since Kenya itself has acceded to various international instruments establishing these rights.²⁵ It is important to note, however that — to the extent that it accounts for violations of any or all of these rights — the Mexico City Policy issued not from Kenya, but from the United States. The Kenyan government in no way welcomed the imposition of the new funding restrictions.²⁶ As a practical matter, the United States, as a wealthy donor nation, can be understood to have caused any relevant human rights infringements — both directly and by pressuring Kenya as a developing recipient nation to violate its own human rights obligations. Nor is this framework limited to the health care context. A similar situation would arise, for example, if the United States or another prosperous nation conditioned its foreign aid to a heavily dependent developing nation upon the proviso that the recipient government subject detainees suspected of terrorism to interrogation methods that would violate at least that nation's treaty obligations to refrain from cruel, inhuman or degrading treatment.²⁷

This Report will defer to Part III the complex issue of potential U.S. legal responsibility for the effects of the Mexico City Policy in nations such as Kenya.²⁸ This Part will emphasize Kenya's obligations with respect to the rights at issue. It will do so for several reasons: First, these obligations do run to the govern-

25. See, e.g., ICESCR, *supra* note 21; see also *infra* note 30.

26. See, e.g., News Release, Population Council, Do Population Policies Matter? (Sept. 18, 1998), available at <http://www.popcouncil.org/mediacenter/newsreleases/jain.html> (stating that "in Kenya . . . external forces — principally the World Bank and the U.S. — [are] seen as having played [a] significant role in policy determination").

27. Such a situation is hardly fanciful, given the practice of "extraordinary rendition," through which the United States allegedly hands over detainees directly to nations in which illegal mistreatment is a significant concern. See Comm. on Int'l Human Rights & Ctr. for Human Rights and Global Justice, N.Y.U. School of Law, *Torture by Proxy: International and Domestic Law Applicable to "Extraordinary Renditions,"* 60 RECORD OF THE ASS'N OF THE BAR OF THE CITY OF NEW YORK 13, 28-34 (2004).

28. See *infra* Part III.

ment of Kenya as a formal matter. Second, though not a focus of this Report, it may be that Kenya could have taken measures to avoid or minimize the impact of the Mexico City Policy upon its human rights commitments, regardless of the magnitude of U.S. funding at stake. Finally, and most importantly, Kenya's formal violation of its human rights obligations potentially serves as a predicate for U.S. responsibility in ways that will be explored in Part III. This analysis cannot be done, however, without first considering the rights themselves.

A. *The Right to Health*

1. Substance and Objectives

The principal treaties setting forth the right to health generally, and reproductive rights in particular, are the ICESCR²⁹ and the Convention on the Elimination of all Forms of Discrimination Against Women ("CEDAW").³⁰ Kenya has acceded to both instruments.³¹ The general definitions of the rights set out in these documents have been clarified by treaty-implementation bodies, such as the Committee on Economic, Social and Cultural Rights ("CESCR"), through General Comments.³² CESCR General Comments Three³³ and Fourteen³⁴ address in detail matters affected by the Mexico City Policy. Further elaboration of health

29. See ICESCR, *supra* note 21, art. 12.

30. Convention on the Elimination of All Forms of Discrimination Against Women art. 11, Dec. 18, 1979, 1249 U.N.T.S. 13 (Kenya acceded on Mar. 9, 1984) [hereinafter CEDAW]. The right to health is also protected in the International Convention on the Elimination of All Forms of Racial Discrimination art. 5, March 7, 1966, 660 U.N.T.S. 195 (Kenya acceded on Sept. 13, 2001) and the Convention on the Rights of the Child art. 24, Nov. 20, 1989, 1577 U.N.T.S. 3 (Kenya acceded on July 30, 1990) [hereinafter CRC].

31. See Office of the U.N. High Comm'r for Human Rights, Ratification Status of the International Covenant on Economic, Social and Cultural Rights, <http://www.ohchr.org/english/countries/ratification/3.htm> (last visited Nov. 1, 2005); see also Div. for the Advancement of Women, Dep't of Econ. & Soc. Affairs, States Parties to the Convention on the Elimination of All Forms of Discrimination against Women, <http://www.un.org/womenwatch/daw/cedaw/states.htm> (last visited Nov. 1, 2005).

32. See U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. & Cultural Rights [CESCR], *Report on the Twentieth and Twenty-First Sessions*, ¶ 51, U.N. Doc. E/2000/22 (2000) (describing the role of General Comments).

33. ECOSOC, CESCR, *The Nature of States Parties Obligations*, CESCR General Comment 3, U.N. Doc. E/C.12/1990/4 (1990) [hereinafter General Comment Three].

34. ECOSOC, CESCR, *The Right to the Highest Attainable Standard of Health*, CESCR General Comment 14, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment Fourteen].

and reproductive rights appears in the Beijing Platform for Action ("Beijing Platform")³⁵ and the Cairo Programme of Action ("Cairo Programme")³⁶ declarations. The Beijing Platform and the Cairo Programme have been adopted by the world community, and Kenya is a party to both.³⁷ Finally, judicial decisions from other jurisdictions also bear upon the proper interpretation of international health care rights.³⁸ While none of these sources that lend additional definition to the Treaty text are binding in their own right, they do constitute persuasive authority and can serve as evidence of customary international law.³⁹

Article 12(1) of the ICESCR generally proclaims the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁴⁰ Article 12(2) specifies that full realization of this right requires, among other things, "[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness."⁴¹ Turning toward reproductive rights, Article 12(2) also requires "provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child."⁴² Also relevant is the further stipulation that governments provide for "[t]he prevention, treatment and control of epidemic, endemic, occupational, and other diseases."⁴³ CEDAW, in its own Article 12, takes up both

35. See Fourth World Conference on Women, Sept. 4-15, 1995, *Beijing Declaration and Platform for Action*, U.N. Doc. A/CONF.177/20 (Oct. 17, 1995) [hereinafter *Beijing Platform*].

36. See Int'l Conference on Population and Dev., Sept. 5-13, 1994, *Cairo Programme of Action*, U.N. Doc. A/CONF.171/13 (Jan. 1, 1995) [hereinafter *Cairo Programme*].

37. See U.N. DEV. PROGRAM [UNDP], *HUMAN DEVELOPMENT REPORT: KENYA NATIONAL HUMAN DEVELOPMENT REPORT 28-29* (1999) [hereinafter *KENYA HDR 1999*].

38. See Statute of the International Court of Justice, June 26, 1945, art. 38(1)(d), 59 Stat. 1055, 1060, 3 Bevans 1153, 1187 (stating that national court decisions can be used to interpret international laws); see also Vienna Convention on the Law of Treaties, *opened for signature* May 23, 1969, art. 31(3)(b), 1155 U.N.T.S. 331, 8 I.L.M. 679 (stating that "subsequent practice in the application of the treaty which established the agreement of the parties regarding its interpretation" should be used for treaty interpretation) [hereinafter *Vienna Convention*]; Mary Ann Torres, *The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: A Case Study from Venezuela*, 2 CHI. J. INT'L L. 105, 108-09 (2002) [hereinafter *Venezuela Case Study*] (noting ways in which national court decisions can "inform international legal analysis").

39. See RESTATEMENT (THIRD) OF THE FOREIGN RELATIONS LAW OF THE UNITED STATES §§ 102, 103 cmt. c (1986) [hereinafter *RESTATEMENT (THIRD)*].

40. ICESCR, *supra* note 21, art. 12(1).

41. *Id.* art. 12(2)(d).

42. *Id.* art. 12(2)(a).

43. *Id.* art. 12(2)(c).

discrimination against women and reproductive rights by requiring State Parties to “take all appropriate measures to eliminate discrimination in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.”⁴⁴ The second part of CEDAW Article 12 sets out further reproductive rights, including “appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”⁴⁵

General Comment Fourteen breaks down the general right to health into several components.⁴⁶ It details that health services, goods, and facilities must be made: 1) available, 2) accessible, 3) acceptable, and 4) medically appropriate and of high quality.⁴⁷ First, General Comment Fourteen stipulates that health care “facilities, goods and services, as well as programmes,” should be available in “sufficient quantity.”⁴⁸ Second, government health care must be accessible in terms of ease of physical access and provided on a non-discriminatory basis and cost to everyone, including marginalized and vulnerable groups.⁴⁹ Accessibility also encompasses access to information, which implies the “right to seek, receive, and impart information and ideas concerning health issues.”⁵⁰ Third, acceptable health care must be provided through a system that is “respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals . . . and communities [and] sensitive to gender and lifecycle requirements.”⁵¹ Lastly, General Comment Fourteen unequivocally states that it is not enough to simply build facilities. Fulfilling the provision of health care “requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment and reproductive health.”⁵²

Expository sources also shed light on reproductive health

44. CEDAW, *supra* note 30, art. 12(1).

45. *Id.* art. 12(2).

46. *See* General Comment Fourteen, *supra* note 34, ¶ 12.

47. *See id.* ¶ 12(a).

48. *Id.* ¶ 12(a).

49. *See id.* ¶ 12(b).

50. *Id.*

51. *Id.* ¶ 12(c).

52. *Id.* ¶ 12(d).

rights in particular.⁵³ According to the Beijing Platform, “reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.”⁵⁴ Thus, reproductive rights encompass a broad span of health issues.⁵⁵ They include issues surrounding conception, such as the right to access contraceptives, to space births, to have adequate information about contraceptive choices, and to enjoy safe sex.⁵⁶ They also involve pregnancy-related issues such as access to quality pre- and post-natal care, and they stress the importance of delivering healthy babies who will have adequate chances for survival.⁵⁷ The ICESCR grants the right to prevention, treatment, and control of epidemic and endemic diseases.⁵⁸ As the Cairo Programme clarifies, this subsection is relevant to protecting reproductive rights, as many diseases are directly related to reproductive health — for example, AIDS and other sexually transmitted diseases (“STDs”).⁵⁹

In addition, CEDAW ensures equal access to family planning services for women and “appropriate services in connection with pregnancy, confinement, and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”⁶⁰ CEDAW Recommendation Twenty-Four also imposes specific obligations on governments to create comprehensive national health strategies,⁶¹ to commit the required budgetary, human and administrative resources,⁶² to apply a gender perspective in the creation of policy;⁶³ to remove

53. ECOSOC, Comm’n on Human Rights, *Report of the Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health*, ¶ 41, U.N. Doc. E/CN.4/2003/58 (Feb. 13, 2003).

54. Beijing Platform, *supra* note 35, ¶ 94.

55. See Cairo Programme, *supra* note 36, ¶ 7.2.

56. See *id.*

57. See *id.*; see also THE RIGHT TO KNOW: HUMAN RIGHTS AND ACCESS TO REPRODUCTIVE HEALTH INFORMATION, ch. 2 (Sandra Coliver ed., 1995).

58. See ICESCR, *supra* note 21, art. 12(2)(c).

59. See Cairo Programme, *supra* note 36, ¶¶ 7.27-7.33.

60. CEDAW, *supra* note 30, art. 12(1).

61. See U.N. Comm. on the Elimination of Discrimination Against Women, *Report of the Committee on the Elimination of Discrimination Against Women*, ¶ 29, U.N. GAOR, 54th Sess., Supp. No. 38, U.N. Doc. A/54/38/REV.1 (Aug. 20, 1999) [hereinafter CEDAW Recommendation Twenty-Four].

62. See *id.* ¶ 30.

63. See *id.* ¶ 31(a).

barriers to access to care for women;⁶⁴ to prevent unwanted pregnancies and liberalize abortion laws;⁶⁵ to monitor the provision of health care;⁶⁶ to provide conditions that ensure privacy and informed choice;⁶⁷ and to ensure personnel are given training on health and human rights.⁶⁸ CEDAW extends reproductive health rights to the work place, requiring provisions for maternity leave, prohibitions on discrimination in hiring and firing due to pregnancy, and special protection to women from harmful work conditions during pregnancy.⁶⁹

2. Implementation and Obligations

The ICESCR sets out in Article 2 the extent to which State Parties are legally obligated to observe the rights it specifies:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.⁷⁰

This provision raises the familiar challenges associated with so-called “affirmative” or “second generation” rights.⁷¹ In contrast to the ICCPR, the ICESCR requires State Parties, “to take steps . . . to achieve progressively” the full realization of Covenant rights, “to the maximum of its available resources.”⁷² An older view contrasts a right to health with, for example, a prohibition on torture, insofar as a nation may in the first instance fulfill that obligation by simply refraining from a practice rather than by providing a service. Yet, as has long been recognized,

64. *See id.* ¶ 31(b).

65. *See id.* ¶ 31(c).

66. *See id.* ¶ 31(d).

67. *See id.* ¶ 31(e).

68. *See id.* ¶ 31(f).

69. *See* CEDAW, *supra* note 30, art. 11(2).

70. ICESCR, *supra* note 21, art. 12(1). Article 2 also includes a broad non-discrimination provision, stating that “[t]he States Parties . . . undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.” *Id.* art. 2(2).

71. *See infra* Part I.A.2.a.

72. ICESCR, *supra* note 21, art. 12(1).

the dichotomy between negative and affirmative rights in international law is easily overstated.⁷³ As an initial matter, CESCRC provisions, such as the right to health, establish obligations that are binding in law, and which have been treated as justiciable.⁷⁴ In addition to establishing affirmative duties, the right to health establishes negative obligations upon State Parties.⁷⁵ Moreover, significant affirmative aspects of the right to health must be established immediately; the balance cannot be rolled back or indefinitely deferred on account of national resources. As with the underlying substantive rights, the obligations set forth under the ICESCR and CEDAW have been elaborated in official commentary and case law.⁷⁶

a. Obligations Elaborated

i. Negative Obligations

Though often characterized as affirmative in nature, the right to health, and the reproductive rights that follow, impose prohibitions as well as duties upon State Parties.⁷⁷ These negative obligations, in part, arise from the Covenant's requirement that States *respect* the rights involved — a concept more akin to a civil or political right barring State action.⁷⁸ General Comment Fourteen confirms this idea, stating that: “The right to health contains both freedoms [negative rights] and entitlements [positive rights].”⁷⁹ Accordingly, most rights to health entitlements have negative analogues, prohibiting States from *interfering* with health care and reproductive rights. Unlike obligations to “take steps,” which are subject to progressive realization, negative prohibitions are immediately enforceable. The ICESCR and complementary documents make specific mention of certain ar-

73. Catherine Powell, *Lifting the Veil of Ignorance: Culture, Constitutionalism, and Women's Human Rights in Post-September 11 America*, 57 HASTINGS L.J. (forthcoming 2005) (manuscript at 8 n.29, on file with author) (citing HENRY SHUE, BASIC RIGHTS: SUBSISTENCE, AFFLUENCE AND U.S. FOREIGN POLICY 35-40 (1980)).

74. See *infra* Part I.A.2.a.

75. See *id.*

76. See *id.*

77. General Comment Fourteen, *supra* note 34, ¶ 8. See generally *Treatment Action Campaign and Others v. Minister of Health and Others* 2002 (4) BCLR 356 (T) (S. Afr.), *aff'd*, *Minister of Health and Others v. Treatment Action Campaign and Others* 2002 (10) BCLR 1075 (CC) (S. Afr.).

78. See *supra* notes 41-42, 48 and accompanying text.

79. See *supra* note 77.

reas where such affirmative commissions of rights violations are prohibited.⁸⁰

First, the CSECR has made clear that “the obligation to protect requires States to take measures that prevent third parties from interfering with [right to health] guarantees.”⁸¹ This can be accomplished, *inter alia*, “through the adoption of legislative measures . . . to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services.”⁸² In this way, a State must not only ensure it is not violating the right to health, but must also ensure others are not violating the right to health of its citizens. This obligation will be of particular importance in the present study of Kenya, because it is USAID, and through it the United States as a third party, rather than the Kenyan government, that has instituted the Mexico City Policy.

Second, General Comment Fourteen prohibits interference with “the right to control one’s health and body, *including sexual and reproductive freedom* . . . and the right to be free from . . . non-consensual medical treatment.”⁸³ It also requires States to “*refrain from* limiting access to contraceptives and other means of maintaining sexual and reproductive health.”⁸⁴ The Cairo Programme affirms these rights, recognizing the right “to *decide freely* . . . the number, spacing, and timing of . . . children.”⁸⁵

Third, General Comment Three makes clear that “undertaking to guarantee . . . rights [that] will be exercised without discrimination” is immediately enforceable.⁸⁶ This prohibition on discrimination stems from: ICESCR Article 2(2), providing that “rights will be exercised without discrimination of any kind,”⁸⁷ Article 3, confirming “the equal right of men and women to the enjoyment of . . . [reproductive health] rights,”⁸⁸ and Article 12 of CEDAW, requiring “all appropriate measures to eliminate discrimination against women . . . in access to . . . fam-

80. See generally ICESCR, *supra* note 21.

81. General Comment Fourteen, *supra* note 34, ¶ 33.

82. *Id.* ¶ 35.

83. General Comment Fourteen, *supra* note 34, ¶ 8 (emphasis added).

84. *Id.* ¶ 34 (emphasis added). See also Beijing Platform, *supra* note 35, ¶ 97.

85. Cairo Programme, *supra* note 36, ¶ 7.3. (emphasis added).

86. General Comment Three, *supra* note 33, ¶ 1.

87. ICESCR, *supra* note 21, art. 2(2).

88. *Id.* art. 3.

ily planning.”⁸⁹ The positive aspect of the right — “*undertaking to guarantee*” — connotes a State action requirement, such as requiring States to enact policies to ensure reproductive health services are delivered without discrimination.⁹⁰ But on a negative level, if it is clear that access to, or the delivery of, health facilities, goods, or services is occurring in a discriminatory fashion, either *de facto* or *de jure*, this constitutes a violation of the right to health.⁹¹ Thus, States should not only pursue non-discriminatory health policies based on the minimum core content, but also, they cannot discriminate in the delivery or access to health services.

Finally, though not a minimum core obligation like the prohibition on discrimination, access to information is an obligation of comparable priority.⁹² It too has a negative analogue. Governments must not only undertake to make information and education available, but they must also not deliberately “ *censor or withhold . . . health-related information, including sexual education and information.*”⁹³ Of relevance to this paper, the Global Gag Rule prohibits clinics receiving U.S. family planning funds from dispersing information on abortion. If Kenya is found responsible for effectively prohibiting the dissemination of information, it could constitute a deliberate withholding of information and therefore violate the right to health.

ii. Minimum Core Content

The thirty years in which the ICESCR has been in force have foreclosed the argument that every right it specifies is subject to gradual implementation. To the contrary, the CESCR has made clear that certain rights together have ripened into an immediately enforceable “*minimum core content*” from which States cannot derogate.⁹⁴ General Comment Three first set out the

89. CEDAW, *supra* note 30, art. 12. *See also* General Comment Three, *supra* note 33, ¶ 34.

90. *See* General Comment Fourteen, *supra* note 34, ¶ 50; *see also* Beijing Platform, *supra* note 35, ¶ 96-97.

91. *See* General Comment Fourteen, *supra* note 34, ¶ 50; *see also* Beijing Platform, *supra* note 35, ¶ 96-97.

92. *See* General Comment Three, *supra* note 33, ¶ 10.

93. General Comment Fourteen, *supra* note 34, ¶¶ 34, 50 (emphasis added).

94. *See id.* ¶ 30. *See generally* *Treatment Action Campaign and Others v. Minister of Health and Others* 2002 (4) BCLR 356 (T) (S. Afr.), *aff'd*, *Minister of Health and Others v. Treatment Action Campaign and Others* 2002 (10) BCLR 1075 (CC) (S. Afr.).

concept of minimum core obligations in 1990:

[O]ver a period of more than a decade . . . a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every state party [F]or example, a State party in which any significant number of individuals is deprived of . . . *essential primary healthcare . . . is, prima facie, failing to discharge its obligations*⁹⁵

Ten years later the Committee reaffirmed this idea and set out specific core obligations:

[E]nsur[ing] access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; . . . to provide essential drugs; to ensure equitable distribution of all health facilities, goods and services; to adopt a national public health strategy and plan of action . . . [which] shall give particular attention to all vulnerable or marginalized groups.⁹⁶

The CESCR stresses that “a State party cannot, under any circumstances whatsoever, justify its non-compliance with the[se] core obligations . . . , which are non-derogable.”⁹⁷

In addition to this minimum, non-derogable core, General Comment Fourteen outlines several rights of “comparable priority.”⁹⁸ The first right obliges States to “ensure reproductive, maternal (pre-natal as well as post-natal) and child healthcare.”⁹⁹ The second and third rights, which are closely related, require States to “provide immunizations against major infectious diseases occurring in the community,” and they further obligate States to “take measures to prevent, treat and control epidemic and endemic diseases.”¹⁰⁰ Taken in tandem, these rights of comparable priority require a country to make available measures for prevention and treatment of any diseases that affect reproductive rights, such as healthy child birth, infant mortality, and safe pregnancies. Such obligations have special salience in a nation such as Kenya, where AIDS and other STDs are epidemic. The fourth obligation of comparable priority requires States to “pro-

95. General Comment Three, *supra* note 33, ¶ 10 (emphasis added).

96. General Comment Fourteen, *supra* note 34, ¶ 43.

97. *Id.* ¶ 47.

98. *Id.* ¶ 44.

99. *Id.*

100. *Id.*

vide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.”¹⁰¹ Accordingly, the Kenyan government faces a present international obligation to provide education and information on significant problems in reproductive health such as unsafe abortions¹⁰² and AIDS.

iii. Prohibition on Retrogressive Measures

The most sweeping express prohibition on incompatible State action is the prohibition on retrogressive measures — in other words, States cannot backslide with regard to their right to health obligations. According to the CESCR, “any deliberately retrogressive measures . . . would require the most careful consideration and would need to be fully justified”¹⁰³ A retrogressive measure that is “incompatible with the [minimum] core obligations [is] . . . a violation of the right to health” that cannot be justified.¹⁰⁴ For example, if a government repeals or suspends right to health legislation or adopts “legislation or policies which are manifestly incompatible with pre-existing domestic or international . . . right to health [obligations],” such government action constitutes an impermissible retrogressive measure.¹⁰⁵

Here again, the minimum core obligations will be useful in assessing whether Kenya has violated the right to health. Put simply, if Kenya has taken steps backward in an area governed by a minimum core standard, it has per se violated the right to health. Thus, the twin concepts of retrogressive measures and minimum core content will be powerful tools in analyzing whether the Mexico City Policy has resulted in backsliding in Kenya’s reproductive health care policies.

iv. Steps To Respect, Protect, and Fulfill Health care and Reproductive Rights

Both the ICESCR and CEDAW require that States employ all appropriate means, including and especially legislative measures, to realize the health care and reproductive rights they set

101. *Id.*

102. In Kenya, about 700 women die each week from unsafe abortions. See Caroline Karobia, *Kenya Divided Over Abortion*, B.B.C. NEWS (London), July 17, 2003.

103. General Comment Three, *supra* note 33, ¶ 9.

104. *Id.*

105. *Id.* ¶ 48.

forth.¹⁰⁶ As a general matter, the CESCR has stated that legislation may be “indispensable . . . [in] fields such as health [and] the protection of children and mothers.”¹⁰⁷ Further, “appropriate means” include “administrative, financial, educational and social measures.”¹⁰⁸ These means should ensure the availability, accessibility, acceptability, and quality of health facilities, goods and services.¹⁰⁹

The Beijing Platform and the Cairo Programme detail the more specific steps implicit in these general requirements:

a. Make Information Available and Accessible

Access is a prerequisite for the realization of reproductive and health rights.¹¹⁰ The Cairo Programme requires States to “enable and support” voluntary choices about methods of family planning and contraception,¹¹¹ through access to quality information, in order to make informed choices.¹¹² States should therefore “ensure that comprehensive and factual information” on reproductive and other health services is “accessible, affordable, acceptable and convenient to all users.”¹¹³ They must further facilitate access to information on all methods for fertility regulation that are not illegal.¹¹⁴ Beyond this, the Beijing Platform stresses the importance of disseminating information to adolescent girls, because “the trend towards early sexual experience, combined with the lack of information and services, increases the risk of unwanted and [too-early] pregnancies, HIV infection and other sexually transmitted diseases, as well as unsafe abortions.”¹¹⁵ In addition, States “should ensure that third parties do not limit people’s access to health-related informa-

106. See ICESCR, *supra* note 21, art. 2(1); see also CEDAW, *supra* note 30, art. 2.

107. General Comment Three, *supra* note 33, ¶ 3.

108. *Id.* See also Cairo Programme, *supra* note 36, ¶ 7.3.

109. See General Comment Fourteen, *supra* note 34, ¶ 12(a)-(d); see also Cairo Programme, *supra* note 36, ¶ 7.5(a). Access to health care must also be granted in a non-discriminatory fashion, encompass physical and economic access, and include information on reproductive health. See Beijing Platform, *supra* note 35, ¶ 30.

110. See Young Mi Kim et al., *Informed Choice and Decision-Making in Family Planning Counseling in Kenya*, 24 INT’L FAM. PLAN. PERSP. 4, 4 (1998).

111. See Cairo Programme, *supra* note 36, ¶ 7.5(b); see also CEDAW, *supra* note 30, art. 10(h).

112. See Cairo Programme, *supra* note 36, ¶ 7.5(a).

113. *Id.*

114. See *id.*

115. Beijing Platform, *supra* note 35, ¶¶ 95-96.

tion.”¹¹⁶

b. Take Steps to Reduce Infant Mortality and Still-Births

The ICESCR expressly requires states to make “provision[s] for the reduction of still-birth rate[s] and infant mortality [rates] and for the healthy development of the child.”¹¹⁷ A primary method for doing so is enhancing the quantity and quality of pre and post-natal care. Such care is also crucial for preventing maternal death. Accordingly, reproductive health care should include “education services for pre-natal care, safe delivery, and post-natal care,”¹¹⁸ giving particular attention to maternal and emergency obstetric care. Another specific method for doing so is the promotion of breastfeeding through education and support services.

c. Promote Contraception and Family Planning

Governments should promote voluntary choice in family planning.¹¹⁹ This task first requires that States make information and education available concerning the “widest possible range” of family planning methods.¹²⁰ Health care workers, in turn, must also receive expanded and upgraded training in family planning issues to learn how to more effectively counsel and communicate with patients.¹²¹ Secondly, individuals acting upon this information, should have access to a “continuous supply of essential, high-quality contraceptives.”¹²² Governments should therefore also “ensure a reliable, continuous supply of high-quality . . . contraceptives” and other necessary reproductive supplies, “using the [World Health Organization] Model List of Essential Drugs as a guide,”¹²³ which the ICESCR has made a minimum core obligation. As an alternative to, or in conjunction with other forms of contraception, programs should promote breastfeeding as a mechanism to enhance birth spac-

116. General Comment Fourteen, *supra* note 34, ¶ 35.

117. ICESCR, *supra* note 21, art. 12(a).

118. Cairo Programme, *supra* note 36, ¶ 7.6.

119. *See id.* ¶ 7.15.

120. *Id.* ¶ 7.23(c).

121. *See id.* ¶ 7.23.

122. *Id.* ¶ 7.23(c).

123. Beijing Platform, *supra* note 35, ¶ 106(u) [hereinafter WHO Model List] (citing World Health Organization (“WHO”) Model List of Essential Drugs, (14th ed., Mar. 2005)).

ing.¹²⁴ Third, governments should ensure “appropriate follow-up care, including treatment for side effects of contraceptive use . . . and availability of related reproductive health services on-site through a strong referral system.”¹²⁵

Although neither the Cairo Programme nor the Beijing Platform states that abortion should be promoted as a method of family planning, they require “humane treatment and counseling of women” who have had abortions.¹²⁶ Further, they call upon States to “recognize and deal with the health impact of unsafe abortion as a major public health concern.”¹²⁷ Women with unwanted pregnancies should have access to “reliable information and compassionate counseling,” and “in circumstances where abortion is not against the law, such abortion should be safe.”¹²⁸ Moreover, any decisions about abortion policy should be made at the national or local level through appropriate legislative processes.¹²⁹

The Cairo Programme pays special attention to the family planning needs of adolescents, because “motherhood at a very young age entails a risk of maternal death much greater than average, and the children of young mothers have higher levels of morbidity and mortality.”¹³⁰ Therefore, the provision of age-suitable services should be made available with the aim of preventing “pregnancies, unsafe abortion, STDs and HIV/AIDS,” and information and services should be made available to adolescents.¹³¹

d. Prevent and Treat Diseases Related to Reproductive Health

The ICESCR requires measures to prevent and treat epidemic and endemic diseases — an obligation that the CESCR commentary has affirmed. In this regard, HIV/AIDS has tragic salience in both Kenya and Africa generally. Other STDs and reproductive tract infections are diseases directly linked to reproductive health in particular. Women are especially vulnera-

124. See Cairo Programme, *supra* note 36, ¶¶ 7.14(f), 7.23(h).

125. *Id.* ¶ 7.23.

126. *Id.* ¶ 7.24; see also Beijing Platform, *supra* note 35, ¶ 107(k).

127. Beijing Platform, *supra* note 35, ¶ 107(i).

128. *Id.* ¶ 106(k).

129. See *id.*

130. Cairo Programme, *supra* note 36, ¶ 7.41.

131. *Id.* ¶¶ 7.41, 7.44.

ble to all of these diseases.¹³² The ICESCR, Cairo Programme, and Beijing Platform all stress the importance of accessibility to health services, especially for marginalized or vulnerable groups of society.¹³³ Treatment for severe reproductive health problems should be made available and accessible, especially with regard to the reproductive health of women.¹³⁴ Given that the provision of essential drugs is a minimum core obligation, governments are immediately obligated to make medications available and accessible for the treatment of AIDS, STDs, and reproductive tract infections to the extent that these are on the WHO Model List.

The Cairo Programme and the Beijing Platform also require that information on family planning methods include a discussion of health risks and effectiveness in the prevention of AIDS and other STDs.¹³⁵ To this end, the Cairo Programme requires special outreach efforts to those who do not have access to services and specialized training for health care workers in the prevention and detection of STDs, AIDS, and reproductive tract infections.¹³⁶ Similarly, information and counseling should be made available for “responsible sexual behavior and effective prevention of sexually transmitted diseases and HIV.”¹³⁷ As part of this disease prevention program, the government should promote a “reliable supply and distribution of high-quality condoms.”¹³⁸

e. Involve Women and the Community

The Cairo Programme and the Beijing Platform require participation by women and other members of the community

132. *See id.* ¶ 7.28. This is due to their:

[E]xposure to high risk sexual behavior by partners . . . and for women the symptoms of infections are often hidden . . . and consequences are often greater, including increased risk of infertility and ectopic pregnancy. The risk of transmission from infected men to women is also greater than from infected women to men, and many women are powerless to take steps to protect themselves.

Id.; *see also* WHO Model List, *supra* note 123.

133. *See generally* Beijing Platform, *supra* note 35; *see also* Cairo Programme, *supra* note 36.

134. *See* Beijing Platform, *supra* note 35, ¶ 107(m).

135. *See* Cairo Programme, *supra* note 36, ¶ 7.23(c).

136. *See id.*

137. *Id.* ¶ 7.32.

138. *Id.* ¶ 7.33.

in designing reproductive and health care programs.¹³⁹ They further recommend that States decentralize public health management and partner with local NGO private health clinics.¹⁴⁰

f. Monitoring

In addition to taking the steps outlined above, State Parties are required to submit reports every five years to the relevant treaty-monitoring bodies, such as the CECSR and the CEDAW Committee, regarding reproductive rights.¹⁴¹ The committees respond to State reports with recommendations and observations. This reporting procedure is the primary international enforcement mechanism for health rights. But, as one commentator points out, the CEDAW Committee has “little if any power to criticize or condemn what appears in these reports.”¹⁴² Others have noted similar deficiencies in the CEDAW Committee’s enforcement powers.¹⁴³ The Cairo Programme adds an additional layer by requiring not only periodic reports, but also that an institutionalized system of monitoring be put into place in each State to ensure the quality of services and to control abuses in family planning services.¹⁴⁴

g. Resource Constraints

Finally, Article 2(1) of the ICESCR permits States to “take steps . . . to the *maximum of its available resources*.”¹⁴⁵ This adds a possible hindrance to the enforcement of reproductive rights under the right to health umbrella, to the extent that poorer nations, such as Kenya, can simply defend violations by citing a lack of available resources. Even dubious retrogressive measures, such as those which have potentially occurred in Kenya,

139. See Cairo Programme, *supra* note 36, ¶¶ 7.1(e), 7.7-8; see also Beijing Platform, *supra* note 35, ¶ 106; General Comment Fourteen, *supra* note 34, ¶ 11 (suggesting that community participation is appropriate); Amy Kaler & Susan Cotts Watkins, *Disobedient Distributors: Street-Level Bureaucrats and Would-Be Patrons in Community-Based Family Planning Programs in Rural Kenya*, 32 *STUD. IN FAM. PLAN.* 254, 256-58 (2001).

140. See Cairo Programme, *supra* note 36, ¶ 7.9; see also Beijing Platform, *supra* note 35, ¶ 107(c).

141. See ICESCR, *supra* note 21, art. 16(1); see also BRIGIT C.A. TOEBES, *THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW* 140-158 (1999).

142. See *Venezuela Case Study*, *supra* note 38, at 108.

143. See LOUIS HENKIN ET AL., *HUMAN RIGHTS* 359 (1999).

144. See Cairo Programme, *supra* note 36, ¶ 7.17.

145. General Comment Fourteen, *supra* note 34, ¶ 47 (emphasis added).

will be heavily scrutinized “in the context of the full use of the maximum available resources.”¹⁴⁶ Yet the resource-constraints defense is not a panacea for State inaction. It, too, has limits.

First, “inability” to allocate necessary funds must be distinguished from an “unwillingness” to do so.¹⁴⁷ Unwillingness is not justifiable. The State bears the burden of establishing that derogations have resulted from inability rather than unwillingness.¹⁴⁸ Instead, “it must demonstrate that every effort has been made to use all resources . . . at its disposition.”¹⁴⁹ Second, the State’s obligations to monitor the realization of health rights “and to devise strategies . . . for their promotion, are not in any way eliminated as a result of resource constraints.”¹⁵⁰ Third, the resource-constraints defense cannot be used for violations of the ICESCR’s minimum core obligations. Paragraph forty-seven of General Comment Fourteen says that the minimum core obligations are non-derogable, and a State “cannot, under any circumstances whatsoever, justify its non-compliance.”¹⁵¹ Accordingly, “retrogressive measures incompatible with core obligations . . . constitute a violation.”¹⁵²

Recent cases have confirmed this limitation.¹⁵³ In *Cruz Bermúdez, et al. v. Ministerio de Sanidad y Asistencia Social*,¹⁵⁴ the Venezuelan Supreme Court in 1999 held that access to essential antiretroviral (“ARV”) drugs for HIV/AIDS is a minimum core obligation¹⁵⁵ and implicates reproductive health rights.¹⁵⁶ The Court so held, notwithstanding the government’s main defense

146. General Comment Three, *supra* note 33, ¶¶ 9, 13, 32.

147. *See* General Comment Fourteen, *supra* note 34, ¶ 47.

148. *See* General Comment Three, *supra* note 33, ¶ 10; *see also* General Comment Fourteen, *supra* note 34, ¶ 47.

149. General Comment Three, *supra* note 33, ¶ 10.

150. *Id.* ¶ 11.

151. General Comment Fourteen, *supra* note 34, ¶ 47.

152. *Id.* ¶ 48.

153. Because there has been a dearth of cases dealing with reproductive health rights on the international level, these cases, though not from a Kenyan jurisdiction, shed light on how the Covenant should be interpreted, and provide a hint of how courts will deal with future resource-constraints defenses. *See supra* note 79 and accompanying text; *see also Venezuela Case Study, supra* note 38, at 108.

154. In the Matter of Cruz Bermúdez, et al. v. Ministerio de Sanidad y Asistencia Social (MSAS) (1999), Case No. 15789, *reprinted in* DAVID P. FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH: MATERIALS ON AND ANALYSIS OF GLOBAL HEALTH JURISPRUDENCE 316-26 (2000).

155. *Id.*

156. *Id.*

of a lack of available resources. The Court explicitly rejected this defense.¹⁵⁷ In 2001, the High Court of South Africa, in *Treatment Action Campaign*, rejected the resource-constraints defense under similar circumstances.¹⁵⁸ The High Court held that South Africa had violated the right to health of its citizens by limiting distribution of ARVs to prevent mother-to-child AIDS transmissions. The government's contention that it lacked the resources to provide the services "because of the lack of trained counselors . . . , counseling facilities . . . and budgetary constraints"¹⁵⁹ was rejected by the court.¹⁶⁰

Finally, the resource-constraints defense cannot be used for violations against "vulnerable members of society [who] can, and indeed must, be protected by the adoption of relatively low-cost targeted programmes."¹⁶¹ Because women are more vulnerable to certain reproductive health diseases, and arguably more vulnerable when it comes to reproductive health issues in general, the possibility for successful use of this defense is weakened. Nations such as Kenya must also protect any other "vulnerable" groups — perhaps those living in rural or poor urban areas — despite resource constraints.

B. Other Relevant Rights

With respect to the right to health, Kenya has an obligation to respect, protect, and promote the right to health of its citizens.¹⁶² Therefore, Kenya must take steps to ensure the core content of the right against threats from whatever source, including U.S. domestic politics. The analysis of the Mexico City Policy with respect to the rights of expression and against gender discrimination is somewhat different. In connection with these rights, the responsibility of Kenya is less direct. First, it should be noted that, were a State Party to implement the restrictions contained in the Mexico City Policy directly on individuals within its jurisdiction, the restrictions would almost certainly vio-

157. *Id.*

158. See *Treatment Action Campaign and Others v. Minister of Health and Others* 2002 (4) BCLR 356 (T) (S. Afr.), *aff'd*, *Minister of Health and Others v. Treatment Action Campaign and Others* 2002 (10) BCLR 1075 (CC) (S. Afr.).

159. *Id.* ¶ 54.

160. See *id.* ¶¶ 68, 71, 73.

161. General Comment Three, *supra* note 33, ¶ 12.

162. See ICESCR, *supra* note 21, art. 2(1); see also CEDAW, *supra* note 30, art. 2.

late both the rights to freedom of expression and against gender discrimination. Second, Kenya has an obligation to ensure that these rights are protected from interference by others. Both of these claims, and the legal standards upon which they are based, are explored further in this section. The more difficult question, whether a donor State may be held liable for violations of these rights, is deferred to Part III.

1. Freedom of Expression

The ICCPR's provisions on freedom of expression are generally modeled after the Universal Declaration of Human Rights ("UDHR").¹⁶³ The UDHR states that "everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive, and impart information and ideas through any media and regardless of frontiers."¹⁶⁴ Article 19 of the ICCPR secures for individuals the right to form his or her own opinions free from outside influence and to defend them without fear of external repression.¹⁶⁵ Specifically, Article 19(2) includes the rights to seek, receive, and impart ideas. It does not distinguish between expression and seeking of information. In effect, Article 19(2) protects the free flow of ideas, identifying speech rights of both the conveyer and the seeker of information.

163. See ICCPR, *supra* note 22, art. 19; see also Universal Declaration of Human Rights art. 19, G.A. Res. 217A(III), at 74, U.N. GAOR, 3d Sess., 183d plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948) [hereinafter UDHR].

164. See UDHR, *supra* note 163, art. 19. For purposes of this paper, "Article 19" refers to provisions under the ICCPR and not the UDHR. Article 19 of the ICCPR states:

1. Everyone shall have the right to hold opinions without interference.
2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or imprint, in the form of art, or through any other media of his choice.
3. The exercise of the right provided for in paragraph 2 of this Article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary:
 - a. For respect of the rights or reputations of others;
 - b. For the protection of national security or of public order (ordre public), or of public health and morals.

ICCPR, *supra* note 22, art. 19.

165. See SCOTT N. CARLSON & GREGORY GISVOLD, PRACTICAL GUIDE TO THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS 119 (2003).

Given the broad scope of Article 19, the Mexico City Policy potentially affects two groups of rights-bearers — NGO recipients of USAID funds and their clients. Insofar as the Mexico City Policy restricts not only how the NGO may use USAID funds to communicate information and ideas, but also how it may use non-USAID funds, the policy represents a serious threat to the NGO's freedom of expression.¹⁶⁶ Second, to the extent that the Mexico City Policy reduces the availability of information concerning reproductive health to the clients of such NGO's, it may compromise their rights under Article 19 as well.

Assuming that the restrictions of the Mexico City policy would have violated Article 19 had they been implemented directly by the Kenyan government, what is the scope of Kenya's obligations with respect to the *impact* of the U.S. policy on individuals within its jurisdiction? Here Kenya's obligation stems from its commitment not only to *respect* the rights guaranteed under Article 19 but to *ensure* their enjoyment by persons under Kenyan jurisdiction.¹⁶⁷ The obligation to ensure enjoyment of the right includes an obligation to protect that enjoyment from interference by third parties, including other States.¹⁶⁸ This obligation to ensure the right may not correspond directly to the obligation to respect the right. In other words, just because an action taken by a State toward individuals within its jurisdiction would violate Article 19 does not *necessarily* mean that the State's failure to prevent the same action by a third party constitutes a violation of the obligation to ensure.¹⁶⁹ Such a broad interpretation would greatly expand State responsibility for third party ac-

166. It is worth noting in this connection that the Mexico City Policy goes further than its domestic counterpart under Title X, which limits the scope of the "gag" to the federal funds, leaving U.S. NGOs free to use other funds as they see fit, so long as they segregate the funding streams. Moreover, in upholding this "domestic gag rule" in *Rust v. Sullivan*, the U.S. Supreme Court implied that this limitation in scope might well be required by the U.S. Constitution. See *Rust v. Sullivan*, 500 U.S. 173, 197 (1991) (stating that domestic cases involving "situations in which the Government has placed a condition on the *recipient* of the subsidy rather than on a particular program or service" may be unconstitutional because it "thus effectively [prohibits] the recipient from engaging in the protected conduct outside the scope of the federally funded program.").

167. See ICCPR, *supra* note 22, art. 2(1).

168. See Sarah Joseph, *A Rights Analysis of the Covenant on Civil and Political Rights*, 5 J. INT'L LEGAL STUD. 57, 74 (1999) (noting that "the general obligation to 'respect and ensure' treaty rights implies an obligation to protect people from human rights abuses by private entities with regard to all civil and political rights").

169. See *id.* (noting that "the extent to which States are required by international human rights law to control private human rights abuse is very uncertain. Presumably

tions. Nevertheless, if the actions taken by a third party have a significant impact upon the enjoyment of the rights guaranteed by the ICCPR, the State's failure to respond may represent a breach of its obligation to ensure enjoyment under Article 2.¹⁷⁰

2. Gender Discrimination

In both the ICESCR and in CEDAW, the right to health and the right to gender equality overlap and reinforce one another. As described above, the ICESCR protects against gender discrimination with respect to the right to health, and CEDAW specifically addresses the right to health, particularly reproductive health, as an important aspect of women's equality.¹⁷¹ Yet, apart from and in addition to this right to health, Kenya is obligated to respect and protect the broader right of its citizens to be free from gender discrimination. CEDAW mandates this in very broad terms. First, CEDAW defines gender discrimination as:

Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.¹⁷²

Second, according to Article 2, State Parties must "take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise."¹⁷³

CEDAW's definition of gender discrimination has been interpreted to include policies that expressly classify on the basis of gender and policies that, although facially gender-neutral, have a disparate impact on the basis of gender.¹⁷⁴ Insofar as it has affected the availability of reproductive health services sought exclusively or primarily by women, the Mexico City Policy, *at a*

their duties to control private entities are not as strict as their duties to control public agents.").

170. See, e.g., Carlos M. Vasquez, *Direct v. Indirect Obligations of Corporations Under International Law*, 43 COLUM. J. TRANSNAT'L L. 927 (2005) (noting that human rights treaties do not generally bind private actors directly, rather they obligate States to regulate certain types of conduct by private actors).

171. See *supra* notes 40-45 and accompanying text (discussing the protections afforded to women under the ICESCR and CEDAW).

172. CEDAW, *supra* note 30, art. 1.

173. *Id.* art. 2.

174. See General Comment Fourteen, *supra* note 34, ¶ 43.

minimum, implicates the latter form of discrimination. In addition, to the extent that the reduction in the availability of reproductive health services has led to unwanted pregnancy, early motherhood, and/or inadequate spacing among children, it may undermine women's equality more generally by reducing women's ability to engage in market work or acquire education. Thus, had the policy been implemented directly by the Kenyan government, it almost certainly would violate broad obligations undertaken in connection with CEDAW.

Given that the policy was imposed on the Kenyan government by an outside donor, what is the scope of Kenya's obligations with respect to the *impact* of the U.S. policy on individuals within its jurisdiction? Here the text of CEDAW addresses this issue, at least at a general level, by imposing on Kenya a clear obligation to eliminate discrimination against women by third parties.¹⁷⁵ As in the context of freedom of expression, this obligation does not translate every instance of private (or third party) gender discrimination into a violation of international human rights by virtue of a State's failure to prevent it. Nevertheless, it does oblige States, at a minimum, to address discrimination by third parties that is widespread and persistent.¹⁷⁶ Thus, the discriminatory impact of the Mexico City policy on Kenyan women may give rise to an obligation on the part of Kenya to remedy, or at least ameliorate, its effects.

II. HEALTH CARE IN KENYA, USAID, AND THE MEXICO CITY POLICY

A. Health Care in Kenya

This Part examines the impact of the Mexico City Policy on the provision of reproductive health care in Kenya. The first section provides a brief overview of health care in Kenya — tracking the development of the health care system and particularly Kenya's reliance on outside donors, including USAID. The first section also emphasizes the degree to which Kenya has relied on

175. See CEDAW, *supra* note 30, art. 2.

176. See, e.g., U.N. Comm. on the Elimination of Racial Discrimination [CERD], Communication No. 4/1991, L.K. v. Netherlands, U.N. Doc. A/48/18, Annex IV, at 130 (1993) (finding that the Netherlands had breached its duty under Article 4(1) of the International Convention on the Elimination of All Forms of Racial Discrimination by failing to investigate and punish acts of racial discrimination and violence against the plaintiff).

such donors, not simply to fund expansion of the system, but also to participate in the development of national health care policy. The second section provides a very brief overview of USAID and its work in Kenya. It then goes on to describe in some detail the Mexico City Policy — a policy first adopted in 1983, then suspended under President Clinton's Administration, and, finally, reinstated in 2001 by the Bush Administration. Finally, the third section documents the experiences of two of the most important family planning NGOs in Kenya — the Family Planning Association of Kenya and Maries Stopes International — both of which lost substantial USAID funding as a result of their decision to not agree to the restrictions imposed by the Mexico City Policy.

1. Overview

Since attaining independence in 1963, the Kenyan government has made efforts both to modernize its health care system and expand access to care. Indeed, a pledge to provide “free” health services was part of the government of Kenya's initial development and poverty-alleviation plan.¹⁷⁷ The overall strategy was to “alleviate poverty and ensure social equity” by developing a network of government subsidized services, staffed by government trained health personnel, within walking distance for most of the population.¹⁷⁸ Consistent with this commitment, Kenya's health care system grew rapidly and access to health care expanded in the latter part of the twentieth century. For example, the quantity of health institutions rose from 861 in 1964 to 4557 in 2003,¹⁷⁹ and the number of hospital beds and cots increased from 11,344 in 1964 to 60,657 in 2003.¹⁸⁰ The number of medical personnel also rose. In 1965, Kenya had 710 doctors, 26 dentists and 148 pharmacists.¹⁸¹ By 1996, there were 3971 doctors,

177. See Wasunna Owino & Maureen Were, *Enhancing Healthcare Among the Vulnerable Groups: The Question of Waivers and Exemptions 2* (Inst. of Policy Analysis and Research Discussion Paper No. DP/014/98, 1998), available at <http://www.ipar.or.ke/DP14.pdf>.

178. *Id.*

179. See *id.*; see also Gov't of Kenya, Cent. Bureau of Statistics, Ministry of Planning and Nat'l Dev., Health Institutions and Hospital Beds and Cots by Province, 2003 [hereinafter Bureau of Statistics], http://www.cbs.go.ke/health_summary.html (last visited Sept. 23, 2004).

180. *Id.*

181. See Germano Mwaba et al., Health Service Provision and Health Status in Africa: The Case of Kenya and Cameroon 22 (Feb. 2003) (revised version of paper

685 dentists and 1447 pharmacists,¹⁸² and by 2002 there were 4740 doctors, 761 dentists and 1866 pharmacists.¹⁸³ This reflects an improved ratio of providers per 100,000 people from 7.8 doctors, 0.3 dentists and 1.6 pharmacists in 1964 to 15.1 doctors, 2.6 dentists and 5.9 pharmacists in 2002.¹⁸⁴

Nevertheless, these increases have not resulted in a substantial improvement in the delivery of health services for at least two reasons. First, the HIV/AIDS crisis in Kenya has placed serious constraints on the health care system, diverting resources from other types of services.¹⁸⁵ Indeed, despite these increases in capacity, the Kenyan government itself estimates that 30% of hospital beds in urban areas and 50% to 55% of all beds at the district hospital level are occupied by AIDS patients.¹⁸⁶ Second, the facilities and personnel have not been distributed in a way that ensures access for the largest number of Kenyans. For example, medical personnel are heavily concentrated in Nairobi.¹⁸⁷ Nairobi residents have 21.6 beds and cots per 100,000 people compared with the Northeastern Province, which has 14.2.¹⁸⁸ Indeed, on a national basis, fewer than half of all Kenyans live within four kilometers of a health care facility.¹⁸⁹ Because many poor Kenyans, in both urban and rural settings, cannot afford to pay for transportation to health facilities, health services must be located within walking distance in order to provide meaningful access. It is not surprising, therefore, that one recent study found that 40% of the rural population had no access to health services of any kind.¹⁹⁰

presented at the Global Development Network Conference, Prague, Czech Republic, Apr. 2002), available at http://www.gdnet.org/pdf2/gdn_library/global_research_projects/MERCK_health/Kenya_Cameroon_study.pdf.

182. See Paul K. Kimalu et al., *A Review of the Health Sector in Kenya* 67 (Kenya Inst. for Pub. Policy Research and Analysis Working Paper No. 11, Mar. 2004) [hereinafter *Review of the Health Sector*], available at <http://www.kippra.org/Download/WPNo.11.pdf>.

183. See Bureau of Statistics, *supra* note 179.

184. See *id.*

185. See *Review of the Health Sector*, *supra* note 182, at 49.

186. See KENYA HDR 1999, *supra* note 37, at 54.

187. See *Review of the Health Sector*, *supra* note 182, at 31.

188. See Bureau of Statistics, *supra* note 179.

189. See KENYA HDR 1999, *supra* note 37, at 50.

190. See Wasunna Owino, *Delivery and Financing of Health Services in Kenya: Critical Issues and Research Gaps* 23 (Inst. of Policy Analysis & Research Discussion Paper No. DP/002/97, 1997) [hereinafter *Research Gaps*], available at <http://www.ipar.or.ke/dp02.pdf>.

Recognizing this problem of access to health care among the poor, the Kenyan government has established a goal to “increase accessibility to appropriate health care facilities and services, particularly in informal urban settlements, rural areas, arid and semi-arid areas, with emphasis on promoting healthy behavior and better provision of services for the poor.”¹⁹¹ Yet, its recent budget allocations and spending patterns reflect a failure to implement such a policy.¹⁹² Indeed, government spending on rural health services has fallen below even its own planned budget allocations.¹⁹³ Spending was budgeted to grow from 14% of all recurrent expenditures in 1999-2000, to 31% in 2000-2001 and to 34% in 2001-2002.¹⁹⁴ However, actual spending was only 9% of all recurrent expenditures in 1999-2000, 10.2% in 2000-2001, and only 10.8% in 2001-2002.¹⁹⁵ Particularly problematic is the government’s failure to allocate development funds to rural health centers and dispensaries; only 27% of the approved budget for this category was actually spent, and only 15.8% of the overall development budget was spent on rural health centers and dispensaries.¹⁹⁶

Even when some form of health care is available, the quality of care is often poor. For example, one measure of the quality of care is access to essential medicines.¹⁹⁷ According to a recent

191. Office of the Vice-President of Kenya, Ministry of Home Affairs, Heritage and Sports, *National Gender and Development Policy* § 7.2.2.d (Feb. 2000) [hereinafter *Gender and Development Policy*].

192. Currently, the Ministry of Health is headed by Hon. Charity Ngulu, an appointee of President Kibaki. She is assisted by a permanent secretary and a Director of Medical Services, who are responsible for administration and technical coordination, respectively. Headquartered in Afya House in Central Nairobi, the Ministry of Health sets policies; oversees the activities of NGOs; and manages, monitors, and evaluates health policies on the national level. Guidelines from the headquarters flow through to the provincial level, which serves as an intermediary between the central ministry and the district level. At the district level, the focus is on the provision of health services and creating budgets and expenditure plans based on the guidelines that come from above. See *Research Gaps*, *supra* note 190, at 2.

193. See Henry J. Kaiser Family Found., *Kenyan Government to Lobby United States for Antiretroviral Drug Funding* (Apr. 7, 2004), available at http://www.thebody.com/kaiser/2004/apr7_04/kenya_hiv.html (last visited Oct. 18, 2005).

194. See GOV'T OF KENYA, MINISTRY OF HEALTH, *PUBLIC EXPENDITURE REVIEW 2003 15-16* (2003), available at http://www.ministryofhealth.go.ke/pdf/publicexp_2003.pdf [hereinafter *PUBLIC EXPENDITURE REVIEW*].

195. See *id.* at 16.

196. See *id.* at 15.

197. Gro Harlem Brundtland, Director-General, World Health Org. [WHO], *Access to Essential Medicines as a Global Necessity*, Address Delivered at the 25th Anniversary of

report by a Kenya-based NGO, only 36% of Kenyans have access to even these most basic drugs.¹⁹⁸ The Kenyan government reports that it spent only US\$0.70 per person to guarantee access to essential drugs — less than half of the level of spending recommended by the WHO.¹⁹⁹

Even apart from the inadequate level of expenditure on health, the Kenyan government has not allocated its expenditure in a way that maximizes effectiveness. A widespread consensus exists that, given scarce resources, allocating funds to preventative care rather than curative care results in a more equitable and efficient use of those resources.²⁰⁰ For example, General Comment Fourteen states that “[i]nvestments should not disproportionately favor expensive curative services which are only accessible to a small privileged fraction of the population, rather than primary and preventative health care, benefiting a far larger part of the population.”²⁰¹ And yet, although the government has recognized the importance of preventive care, analysis of actual spending levels of the 2001-2002 budget reveals that 48.5% of the overall budget was spent on curative care as compared to only 5.2% of preventative and promotive care.²⁰² The Kenya Institute for Public Policy Research and Analysis (“KIPPRA”), a leading Kenyan policy research institute, warns that “failure to adequately fund preventative and promotive services in a sustainable manner implies that the existing facilities will continue to be burdened with cases of illness than could have been averted.”²⁰³

Although misallocation of existing resources has contributed to Kenya’s failure to achieve its goals of improving access to health care, an overall lack of resources to expend on health

the WHO (Oct. 20, 2002), available at <http://www.who.int/dg/brundtland/speeches/2002/whoessentialmedicines/en/index.html> (last visited Oct. 18, 2005).

198. Ken Opala, *Ministry Loses Millions in Irregular Tendering*, NATION (Kenya), Jan. 10, 1999.

199. See PUBLIC EXPENDITURE REVIEW, *supra* note 194.

200. See, e.g., General Comment Fourteen, *supra* note 34, ¶ 19.

201. General Comment Fourteen, *supra* note 34, ¶ 19.

202. See PUBLIC EXPENDITURE REVIEW, *supra* note 194, at 8. This is true, despite draft budgets requesting a shift from curative to both preventive and rural health care. The Public Expenditure Review admits that the 2001/2002 budget “overshoots” allocations to curative care by 180%. It does not offer an explanation of how this came to be. See *id.* at 9.

203. *Review of the Health Sector*, *supra* note 182 at 37.

care has, of course, limited its progress as well.²⁰⁴ In 2001-2002, the Ministry of Health spent 17.6% of the GDP on health.²⁰⁵ As of 2001, health spending per capita was approximately US\$6.20.²⁰⁶ Moreover, over 90% of the Ministry of Health's budget is devoted to supporting existing capacity,²⁰⁷ including paying salaries and maintaining facilities.²⁰⁸ The balance, less than 10%, makes up the development budget, which goes toward the creation of new programs and the expansion of existing ones.²⁰⁹ This allocation of concededly limited resources favors the maintenance of service to relatively better-served areas at the expense of developing new programs in underserved areas.

The government of Kenya has attempted to increase its health care resources through user fees and cost-sharing programs. Most recently, the government reintroduced cost-sharing at the district level in 1991 by funding the USAID Healthcare Financing Project.²¹⁰ Overall, cost-sharing has made a significant contribution to financing health in Kenya and has generated funds to cover non-wage recurrent expenditures, thereby enabling government hospitals to remain open during times of economic crisis.²¹¹ However, there is ample evidence that the imposition of user fees effectively prevents the poorest of the poor from being able to access health care.²¹² Moreover, al-

204. *See id.*

205. *See* WHO, WORLD HEALTH REPORT 2004 — CHANGING HISTORY 139 (2004) [hereinafter CHANGING HISTORY]. According to the 1999 Kenya Human Development Report, the most recent and only such report, government spending only covers about 60% of what is needed to provide minimum health services. *See* KENYA HDR 1999, *supra* note 37, at 52.

206. *See* CHANGING HISTORY, *supra* note 205, at 139; *see also* Interview with Dr. Richard O. Muga, Director, Nat'l Council on Population and Dev., in Embu, Kenya (May 19, 2004) (on file with Crowley Program). Health services are financed from three sources. Approximately half of all healthcare funding comes directly from the government to the Ministry of Health and indirectly through other agencies with health-related portfolios — for example, the National Council on Population and Development and the Ministries of Water and Home Affairs. Another one-third is provided by multilateral and bilateral donors, with the balance coming from the private sector and non-governmental organizations. *See* KENYA HDR 1999, *supra* note 37, at 52.

207. *See* PUBLIC EXPENDITURE REVIEW, *supra* note 194.

208. *See id.*

209. *See id.* at 5.

210. *See* Kenya KENYA HDR 1999, *supra* note 37, at 54; *see also* USAID, SUMMARY OF USAID PROJECT 6150245: HEALTHCARE FINANCING, available at <http://www.dec.org>.

211. *See* Owino & Were, *supra* note 177, at 4.

212. One analyst of the Kenyan healthcare system notes:

though Kenya's Health Policy Framework emphasizes strengthening the waiver system in cost-sharing for the poor, the program is poorly administered and inadequately publicized. Studies have revealed that providers are not well trained about the purpose of the waiver and exemption system, nor on how to administer the system.²¹³ One study found that a majority of the administrative staff interviewed did not want to encourage further loss of revenue and opposed publicizing the system to the intended beneficiaries.²¹⁴ As a result, potential users were "ill-informed" about the system and how to best benefit from the waiver scheme. The same study found that only one in three patients seemed to have any information about the waivers and exemptions system and uncovered differences between the information held by inpatients and outpatients as well as between men and women.²¹⁵

2. Reproductive Health

These problems with the overall provision of health care in Kenya are equally apparent in the area of reproductive health, the focus of this study. Reproductive health includes family planning, maternal/child health (including pre-natal, maternity, and post-natal care) and the prevention and treatment of STDs. This section provides an overview of each area, giving particular attention to gender issues and adolescents.

a. Family Planning

Although Kenya was the first African State to undertake a family planning initiative and made some progress in reducing overall fertility in the 1980's and 1990's, progress in the area has either slowed or reversed in recent years.²¹⁶ For example, the

With the lack of a clear 'fee policy' in the Public Health Sector, the [District Health Management Boards] are likely to continue increasing fees arbitrarily without due regard to the vulnerable. Indeed, declines in utilisation have been evidenced in poverty stricken areas and/or facilities serving farmers, nomads, squatters and land clash victims.

Wasunna Owino, *Public Health Sector Pricing Policy: The Question of Fee Adjustments* 19 (Inst. of Policy Analysis Discussion Paper No. DP/013/98, 1998).

213. Owino & Were, *supra* note 177, at 7.

214. *See id.*

215. *See id.* at 17 (noting that 16% of inpatients were aware of the waiver system, as opposed to 27% of outpatients).

216. *See* GOV'T OF KENYA, CENT. BUREAU OF STATISTICS, KENYA DEMOGRAPHIC AND

2003 Kenya Health and Demographic Survey (“KDHS”) reports that while total fertility had declined to 5.4 births per woman in 1990-92 and reached a low of 4.7 in 1995-97, it increased to 4.9 in 2000-2003.²¹⁷ The percentage of contraceptive users among currently married women rose from 33% in 1993, peaked at 39% in 1998 but remained flat in 2003.²¹⁸ The 2003 KDHS points out that the unmet need for family planning remains high.²¹⁹ The recent findings echo the 1998 KDHS, which indicated that “if all women who wanted to space or limit child-bearing were to use family planning, the contraceptive prevalence rate would increase from the current level of 39% to about 66%.”²²⁰

The family planning and reproductive health care system in Kenya has long been plagued by the lack of a coordinated system to obtain and distribute contraceptive supplies. At present, the public sector drug supply system is centrally managed by the Ministry of Health and the Kenya Medical Supplies Agency, which, by the Kenyan government’s own admission, are “unable to meet the challenges of providing quality services in the procurement, warehousing and distribution of drugs and medical supplies due to organizational and operational problems.”²²¹ Although Kenya is in the process of revamping the system, prospects for reform seem bleak; the Medical Supplies Coordination Unit received only 0.3% of the total Ministry of Health budget.²²² In addition, management of the system has been decentralized to a non-government entity — the Kenya Medical Supplies Agency (“KEMSA”) — which, the government admits, is severely underfunded.²²³ By extension, this affects the provision of reproductive health commodities at government-run facilities and at the NGO clinics that rely upon the Kenyan government to distribute these supplies obtained from donor agencies. A circular dated January 14, 2004, released by the logistical unit of the KEMSA and copied to the Reproductive Health Division

HEALTH SURVEY 54 (2003) [hereinafter KDHS], available at <http://www.cbs.go.ke/pdf/KDHS2003%20Full%20Report.pdf>.

217. *Id.*

218. *See id.* at 68 tbl.5.4.

219. *See id.* at 105-07.

220. GOV'T OF KENYA, CENT. BUREAU OF STATISTICS, KENYA DEMOGRAPHIC AND HEALTH SURVEY 107 (1998), available at <http://www.cbs.go.ke/pdf/>.

221. *See* PUBLIC EXPENDITURE REVIEW, *supra* note 194, at 28.

222. *See id.* at 8.

223. *See id.* at 19.

of the Ministry of Health, shows that the government ran out of stock of Norplant, progesterone-only pills (contraceptive), and female condoms in May 2003.²²⁴

Apart from problems of supply, the contraceptive distribution scheme often fails to ensure that women are able to make fully informed decisions about contraceptive use.²²⁵ For example, the first point of care for almost half of Kenyan women is either a government or private dispensary.²²⁶ Yet these women are often unable to obtain appropriate information and counseling when they choose a contraceptive method. Despite evidence that unanticipated side effects of contraception are the main reason women discontinue their use, only 57.1% of women who visit government dispensaries and 32.2% who use private chemists are informed of the side effects of the family planning method they purchased.²²⁷ In contrast, 77.4% of women who go to FPAK for contraceptives report having been informed of side effects.²²⁸ Although NGO-run family planning clinics are able to provide far better counseling and information, they currently serve only a small percentage of the population.

b. Maternal/Child Health

Data from the 2003 KDHS indicate that 88% of Kenyan women reported having received pre-natal care at some point during pregnancy.²²⁹ Yet, this high percentage masks potential problems with the adequacy of care. For example, only 18% received care from doctors, with 70% getting care from only a nurse or midwife.²³⁰ Moreover, Kenyan women, on average, seek care relatively late in pregnancy—during the fifth month.²³¹ Finally, of those obtaining care, only 36% reported having been informed of the signs of pregnancy complications,²³² and only

224. See *Alarm Over Birth Pills Shortage*, NATION (Kenya), Feb. 4, 2004.

225. The Kenyan government reports that 20.7% of women obtain contraceptives from a government facility and 21.9% from a private dispensary. See KDHS, *supra* note 216, at 75.

226. See *id.*

227. See *id.* at 77.

228. See *id.*

229. See *id.* at 123-24.

230. See *id.* at 124.

231. See *id.* at 126.

232. See *id.* at 127.

32.8% reported that they were given information about HIV.²³³

With respect to childbirth itself, only two out of five births in Kenya take place in a health facility, while the rest are home deliveries.²³⁴ This high proportion of home births is problematic in view of the fact that only one out of five of the women receives any post-natal care, care that is essential to address delivery-related complications, especially for births that occur at home. Only half of those obtaining care did so within two days of delivery.²³⁵ Moreover, whether taking place at home or in a health care facility, the proportion of births in Kenya attended by skilled health personnel has been declining in the past decade, 51% in 1989, 45% in 1993, 44% in 1999, down to about 42% in 2003.²³⁶ Data from the 2003 KDHS show that nationwide, only 11.4% of babies were delivered under the supervision of a doctor and 30.2% by a nurse or midwife.²³⁷ Traditional birth attendants, both trained and untrained, conducted 28% of all deliveries in 2003,²³⁸ a significant increase from 21% of all deliveries in 1999.²³⁹

c. Abortion

Kenyan abortion law is quite restrictive, allowing abortion only when it is necessary to save the life of the mother.²⁴⁰ Kenya's Penal Code also criminalizes any attempt to induce miscarriage,²⁴¹ and punishes a woman who attempts to induce abortion herself.²⁴² Yet, the Penal Code also provides that:

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, upon an unborn child for the preservation of the life of the mother, if the performance of the operation is reasonable, having regard to the patient's

233. *See id.*

234. *See id.* at 130-31.

235. *See id.* at 135.

236. *See* U.N. DEV. GROUP & GOV'T OF KENYA, MILLENNIUM DEVELOPMENT GOALS: PROGRESS REPORT FOR KENYA 132 (2003) [hereinafter 2003 MDG], available at <http://www.undp.org/mdg/kenya.pdf>; *see also* KDHS, *supra* note 216, at 131-32.

237. *See* KDHS, *supra* note 216, at 132.

238. *See id.*

239. *See id.*; *see also* 2003 MDG, *supra* note 236, at 22.

240. *See* Penal Code, Laws of Kenya, ch.63, §§ 158-60.

241. *See id.* § 158.

242. *See id.* § 159.

state at the time and to all circumstances of the case.²⁴³

In some cases this has been interpreted to permit abortion when necessary to preserve the women's physical or mental health.²⁴⁴

As a practical matter, the criminalization of abortion has meant that abortion in Kenya is not uncommon, but simply unregulated. Health care facilities may perform abortions under the euphemism of "menstrual extraction,"²⁴⁵ or legally, under circumstances that accord with the exceptions in the penal code.²⁴⁶ Although difficult to document, illegal abortions performed by licensed and unlicensed practitioners appear to be common. Indeed, one indication of the prevalence of abortion is that complications from botched abortions account for approximately 45% of hospital admissions for women in Kenya.²⁴⁷

The legal status of abortion continues to generate political controversy in Kenya. For example, the draft constitution has been criticized by some women's groups and advocates of the legalization of abortion as constitutionalizing restrictions on abortion.²⁴⁸ Nevertheless, the government has also shown some awareness of the serious problem created by the prevalence of unsafe abortion. For example, the National Population Policy for Sustainable Development states that, while "abortion will not be used as a method of family planning in Kenya," women who undergo the procedure "will not be discriminated against and will have access to quality services for management of complications arising from abortion."²⁴⁹

d. Sexually-Transmitted disease

The AIDS virus was first reported in Kenya in 1984.²⁵⁰ In

243. *Id.* § 240.

244. See Ctr. for Reproduc. Law & Policy, *WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES, FRANCOPHONE AFRICA* 62-63 (1999).

245. See generally Penal Code, Laws of Kenya, ch.63.

246. See *id.* § 240.

247. See MINISTRY OF HEALTH, KENYA MED. ASS'N, *A NATIONAL ASSESSMENT OF THE MAGNITUDE AND CONSEQUENCES OF UNSAFE ABORTION IN KENYA* 23-25 [hereinafter *National Assessment*] (on file with Crowley Program).

248. *Id.*

249. OFFICE OF THE PRESIDENT OF KENYA & NAT'L AIDS CONTROL COUNCIL, *KENYA NATIONAL HIV/AIDS STRATEGIC PLAN 2000-2005* § 5.6.1 (Oct. 2000) [hereinafter *HIV/AIDS STRATEGIC PLAN*].

250. See Boniface O. K'Oyugi & Jane Muita, *Impact of a Growing HIV/AIDS Epidemic on the Kenyan Children*, in *AIDS, PUBLIC POLICY AND CHILD WELL-BEING*, ch.3 (Giovanni Andrea Cornia ed., 2002).

1999, President Daniel Arap Moi declared AIDS a National Disaster,²⁵¹ recognizing that by the year 2000, over two million Kenyans, out of a total population of twenty-nine million, were HIV positive and more than 1.5 million Kenyans had already died of AIDS.²⁵² According to the United Nations Human Development Report, life expectancy in Kenya has dropped from 53.6 years in 1994²⁵³ to 45.2 years in 2002.²⁵⁴

In 1999, the government established the National AIDS Control Council ("NACC") in the Office of the President to "provide policy and strategic framework for mobilizing and coordination of resources for the prevention of HIV transmission and provision of care to those infected and affected by the disease."²⁵⁵ The National HIV/AIDS Strategic Plan 2000-2005 was issued in October 2002, with an estimated cost of 14.06 billion Kenyan Shillings (KSH), approximately US\$180 million for the five year period.²⁵⁶ As part of prevention efforts, the government put in place the National Condom Policy and Strategy in 2001 to "ensure adequate national supply and access to condoms, coupled with public education and advocacy to increase use among those who need to use condoms but are not doing so."²⁵⁷

Much like the Family Planning Implementation Plan, the National HIV/AIDS Strategic Plan 2000-2005 relies on non-governmental and community-based organizations for implementation. The HIV/AIDS Strategic Plan states that NGOs have been "actively involved in the fight against HIV/AIDS since the onset

251. See HIV/AIDS STRATEGIC PLAN, *supra* note 249, at iv.

252. See *id.*; see also UNAIDS Website, Kenya, <http://www.unaids.org/en/geographical+area/by+Country/kenya.asp>, (last visited Aug. 16, 2004).

253. See UNDP, HUMAN DEVELOPMENT REPORT 1997 148 (1997).

254. See UNDP, HUMAN DEVELOPMENT REPORT 2004 141 (2004), available at http://www.undp.org.in/hdr2004/HDR2004_complt.pdf (last visited Oct. 10, 2005).

255. See PUBLIC EXPENDITURE REVIEW, *supra* note 194, at 2. In 2004, the National AIDS Control Council ("NACC") was at the center of allegations that the former NACC chief embezzled NACC funds for her personal benefit. See *Gachara to Stand Trial for Fraud, City Court Rules*, NATION (Kenya), Feb. 4, 2004. The World Bank has refused to release some US\$21 million until it receives an audit report for 2002-2003. See *Kenya: Withheld Funds Cripples AIDS Planning*, U.N. INTEGRATED REGIONAL INFORMATION NETWORKS, June 23, 2004.

256. See HIV/AIDS STRATEGIC PLAN, *supra* note 249, at 47.

257. MINISTRY OF HEALTH (KENYA) & NAT'L AIDS COUNCIL, NATIONAL CONDOM POLICY & STRATEGY 6 (2001), available at http://www.policyproject.com/pubs/countryreports/Kenya_Condom_Policy.pdf.

of the epidemic.”²⁵⁸ Such groups are heavily supported by international donors. As of 2000, an estimated US\$90 million, or 90% of the donor funds for Kenya’s HIV/AIDS related efforts, with the exception of World Bank funding,²⁵⁹ were disbursed through NGOs.²⁶⁰

It is too early to assess the effectiveness of the NACC and the National HIV/AIDS Strategic Plan. To its credit, the government has recognized the severity of the crisis and has devoted available resources to combating the spread of the disease. Nevertheless, it is clear that the HIV/AIDS epidemic has been a major contributing factor to the precipitous decline in life expectancy among Kenyans and has created further strains on the already fragile Kenyan health system. The 1999 Kenya Human Development report states unequivocally: “The HIV/AIDS pandemic has compounded deteriorating health standards, in some instances reversing the earlier gains. In its wake, the pandemic has caused a steep rise in the number of orphans, growing destitution and unprecedented levels of poverty.”²⁶¹

e. Adolescents

The Kenyan government estimates that 20% of all reported AIDS patients are young people ages 15 to 24.²⁶² However, 88% of girls ages 15 to 19 and 89.1% of boys believe they face either “no” or “small” risk of becoming infected with HIV.²⁶³ Additionally, 46.7% of girls and 97.1% of boys ages 15 to 19 report engaging in high-risk sex in the past twelve months.²⁶⁴ During high-

258. HIV/AIDS STRATEGIC PLAN, *supra* note 249, at 44.

259. In 1995 the World Bank gave the Kenyan government a US\$40 million credit to be used for capacity building to treat sexually transmitted infections. The project financed the preparation of a Sessional Paper on AIDS, institutional development of NASCOP and the creation of the National AIDS Control Council. It also provided funds for nationwide interventions on blood safety; syndromic management of STDs; treatment of opportunistic infections including tuberculosis; surveillance; education and publicity and policy dialogue at the district level. Key implementing agencies include the Ministry of Health, NGOs, municipalities (local government), the Department of Defense and the Kenyan Police. *See id.* at 14.

260. *See id.* at 13.

261. *See* 2003 MDG, *supra* note 236, at 9.

262. *See* REPUB. OF KENYA, ADOLESCENT REPRODUCTIVE HEALTH & DEVELOPMENT PLAN 11 (2003).

263. *See* KDHS, *supra* note 216, at 194 tbl.12.6.

264. *See id.* at 201 tbl.12.12 (demonstrating that in 2003, pre-marital sex was considered high-risk).

risk sex, only 23.4% of girls and 41.3% of boys report using condoms.²⁶⁵ The lack of condom use is also reflected in the fact that by age nineteen, 45.6% of Kenyan girls have begun childbearing.²⁶⁶ A May 2004 study of unsafe abortion in Kenya revealed that women and girls ages fourteen to twenty-four accounted for 48% of all abortions.²⁶⁷

Despite the crisis reflected in these statistics, Kenyan adolescents continue to face significant obstacles to obtaining appropriate information about sexual health and reproductive health services. Because of the social stigma attached to adolescent sexuality, reproductive health services for young people ideally should be provided in a context that is both private and highly accessible (for example, schools).²⁶⁸ Centers designed especially to serve adolescent patients are most effective.²⁶⁹ Yet, as of 2001, only seven such clinics were located in government-owned health care facilities.²⁷⁰ Moreover, mission hospitals, which provide a large part of the health care particularly in rural areas, are even less likely to provide specialized reproductive health services and information to adolescents because of religious proscription of adolescent sexuality.²⁷¹ The most effective programs for youth are often those created and run by NGOs, including FPAK. FPAK-affiliated centers provide family planning information to young people and sponsor outreach efforts and training to reach populations unlikely or unable to visit the centers themselves.²⁷² These programs, while laudable, are underfunded and have had to curtail outreach programs in recent years.²⁷³

265. *Id.*

266. *Id.* at 62 tbl.4.10.

267. See Ministry of Health, Kenya Medical Association, FIDA-Kenya & IPAS, *A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya* 26 (May 6, 2004) [hereinafter *National Assessment*]; see also FIDA-Kenya *Report of a Baseline Survey Among Women in Nairobi* 10 (March 2002) [hereinafter *Baseline Survey Among Women in Nairobi*]. The survey sites were Aga Khan Hospital, Kangemi Health Centre, Kenyatta National Hospital and Pumwani Maternity Hospital. *Id.*

268. See Peter McIntyre, WHO, *Adolescent Friendly Health Sources — An Agenda for Change*, at 27-28, WHO Doc. WHO/FCH/CAH/02.14 (Oct. 2002), available at http://www.who.int/reproductive.health/publications/can_docs/can_02_14.pdf.

269. See *id.*

270. See *id.*

271. See KENYA HDR 1999, *supra* note 37, at 51.

272. See Former FPAK Ocharo Interview, *supra* note 3.

273. See *infra* Part II.B. (discussing the impact of the Global Gag Rule on FPAK).

f. Gender and the Provision of Reproductive Health Services

Most Kenyan women report that they do not enjoy complete autonomy with respect to their own health seeking behavior, including their use of contraception.²⁷⁴ According to the Kenyan government, only 39.8% of married women have the final say in decisions relating to their own health care.²⁷⁵ Perhaps even more striking is the finding that only 41.6% of *unmarried* women in Kenya, which includes never married, divorced, separated and widowed women, say they make their own health decisions.²⁷⁶ Even fewer adolescent women (20%) reported that they have *any* say in health care decisions.²⁷⁷ Predictably, the regions in which the fewest adult women report having decision-making power with respect to their health care are the regions where HIV is the most prevalent — Nyanza and the Western Provinces.²⁷⁸

One result of women's lack of control over their reproductive health care decisions is that 25% of all pregnancies in Kenya are mistimed and 20% are unwanted.²⁷⁹ According to government data, the overall preferred number of children is 3.6 whereas the actual number is 4.9.²⁸⁰ This gap between wanted and observed fertility is greatest among poor women, those living in rural areas, and those with less than secondary education.²⁸¹

When a woman does decide to seek reproductive health care on her own, the decision is not without potential consequences. Health care is not free, and often women have to negotiate with their husbands to obtain the money required for routine health care, including family planning. The necessity of such negotiation, of course, undermines a woman's ability to seek health care without her spouse's knowledge or over his objections. In addition, a woman's decision to seek health care, including the decision to use family planning, may precipitate

274. See KDHS, *supra* note 216, at 42-50.

275. See *id.* at 42 tbl.3.10. Of married women, 42.9% say their husband has final say with 14.3% reporting that such decisions are made jointly. *Id.*

276. See *id.*

277. See *id.* at 43 tbl.3.10.

278. See *id.*

279. See *id.* at 110 tbl.7.6.

280. See *id.*

281. *Id.* at 110.

domestic violence. According to the 2003 KDHS, the first to include questions about domestic violence, almost one-fifth (19%) of married women experienced violence within the first two years of marriage, and one-third (32%) experienced violence in the first five years of marriage.²⁸² According to the KDHS, 18.1% of urban women and 27.3% of rural Kenyan women have experienced violence during the past twelve months.²⁸³ The 2003 KDHS found that 29.4% of women and 24.6% of men felt that a woman's refusal to have sex was a justification for wife-beating.²⁸⁴ With respect to the link between reproductive health and domestic violence, a 2002 study conducted by FIDA-Kenya found that, among Nairobi women seeking care at either prenatal clinics or emergency rooms at a mix of private and public facilities,²⁸⁵ women seeking pregnancy and OB/GYN services reported the highest rate of domestic violence.²⁸⁶

Finally, polygamy, which is legal and reasonably widespread in Kenya, affects women's health care decisions in subtle but important ways.²⁸⁷ For example, a woman might be reluctant to use birth control to limit the number of children, because her husband might assume that she is infertile and seek a second wife. Similarly, a woman might be reluctant to seek other kinds of medical care because to do so might signal to her husband that she is weak or ill, again prompting him to take another wife.

In sum, women's subordination in Kenyan society creates particular obstacles to their access to health care and requires a system of delivering health care that takes into account these obstacles. In the area of reproductive health, the Kenyan government has recognized the importance of a gender-sensitive health policy, particularly with respect to family planning.²⁸⁸ Among the most effective modes of delivery are those developed in partnership with NGO's such as FPAK and Marie Stopes — both of which have lost funding as a result of the Mexico City Policy described below.

282. *See id.* at 247 tbl.15.5.

283. *See id.* at 242 tbl.15.1.

284. *See id.* at 46 tbl.3.12.1.

285. *See Baseline Survey Among Women in Nairobi, supra* note 267, at 10.

286. *See id.* at 17.

287. *See, e.g.,* Catherine A Hardee, *Balancing Acts: The Rights of Women and Cultural Minorities in Kenyan Marital Law*, 79 N.Y.U. L. REV. 712 (2004) (discussing the prevalence of polygamy and the effect upon women's power in the marital relationship).

288. *See Review of the Health Sector, supra* note 182, at 35, 38.

3. USAID in Kenya

The development of modern health policy in Kenya has always been influenced by the policy agendas of donor countries and institutions, such as the International Monetary Fund (“IMF”) and the World Bank. In fiscal terms, the influence is clear: Multilateral donors contribute 16% of all health care funding in Kenya and over 28.4% of the Ministry of Health’s development budget.²⁸⁹ This influence has been felt to an even greater extent in the area of reproductive rights. In fact, the Reproductive Health Program, which falls under the Department of Preventative and Promotive Health Services, does not even have a line item in the budget.²⁹⁰ Rather, reproductive health, including family planning and HIV/AIDS, depends entirely upon the support of donors, including USAID, the United Kingdom, the European Union, Canada, Sweden, Belgium, Finland, Germany, Japan, Denmark, United Nations Family Planning Association and the World Bank.²⁹¹

Throughout the development of Kenya’s reproductive health program, the single most significant donor has been USAID.²⁹² This section provides a very brief description of USAID’s history and mandate and an overview of its involvement in Kenya.

Created during the Kennedy Administration, USAID has promoted and funded international family planning since 1965.²⁹³ In Kenya, USAID has supported activities in the population, health, and nutrition sectors since the early 1970’s.²⁹⁴ USAID funded the roll-out of Kenya’s family planning program in the 1970s by supporting the creation of 590 service delivery points, 400 full-time and 190 part-time, served by 17 mobile units and the training of personnel at the district and provincial levels

289. See KENYA MINISTRY OF HEALTH, KENYA NATIONAL HEALTH ACCOUNTS 21-24 (2001-02) (on file with Crowley Program).

290. Interview with Dr. Solomon, Program Manager, Reproductive Health Programs, in Nairobi, Kenya (May 26, 2004) (on file with Crowley Program).

291. See USAID, USAID/KENYA INTEGRATED STRATEGIC PLAN 2001-2005, at 111 (2000), available at http://pdf.dec.org/pdf_docs/PDABU260.pdf [hereinafter USAID/KENYA INTEGRATED STRATEGIC PLAN].

292. See *id.*

293. See USAID, FAMILY PLANNING FUNDING 2001 ¶ 1 (Nov. 2001) available at http://www.usaid.gov/our_work/global_health/pop/publications/docs/fpfund.pdf.

294. See USAID/KENYA INTEGRATED STRATEGIC PLAN, *supra* note 291, at vi.

to staff them.²⁹⁵ Grant funds also went toward the establishment of a National Family Welfare Center which was to have “day to day responsibility for the administration [and] coordination of all [family planning and maternal and child health] clinics in Kenya.”²⁹⁶ Contemporaneously, USAID provided funds to establish a Population Studies and Research Institute at the University of Nairobi that would conduct multi-disciplinary research and publish a professional journal to generate data to be used by government planners to better design family planning programs.²⁹⁷

In the late 1970s and early 1980s, USAID funded several pilot projects in rural areas.²⁹⁸ USAID intended for these projects to demonstrate the efficacy of providing family planning services at the rural level and in combination with maternal/child health services.²⁹⁹ The projects also provided an opportunity for officials in the Ministry of Health to gain hands-on experiences with project design and management, with the goal that the Ministry would eventually assume full responsibility for the management of the projects.³⁰⁰ USAID, through a contracting agency, provided consulting services to Ministries of Health and Planning so that a Division of Planning and Implementation could be created to oversee rural health programs and services over the long term.³⁰¹

These early projects were only partially successful. It quickly became apparent to USAID and other donors that the Government of Kenya lacked the technical expertise and experience to staff and manage new projects.³⁰² Thus, in the early to mid-1980s, USAID, the World Bank, and other donors adopted a

295. See USAID, SUMMARY OF USAID PROJECT 6150161: FAMILY PLANNING (1992), available at <http://www.dec.org>.

296. *Id.*

297. See *id.* This project also provided scholarships for Kenya scholars to obtain advanced graduate degrees abroad and the international organization the Population Council was heavily involved as a project partner. *Id.*

298. See USAID, SUMMARY OF USAID PROJECT 6150179: KIBWEZI PRIMARY HEALTH CARE (1979), available at <http://www.dec.org>; see also USAID, SUMMARY OF USAID PROJECT 6150206: KITUI RURAL HEALTH (1982), available at <http://www.dec.org>.

299. See USAID, EVALUATION OF THE KENYA HEALTH PLANNING AND INFORMATION PROJECT (1979), available at <http://www.dec.org>.

300. *Id.*

301. See USAID, SUMMARY OF USAID PROJECT 6150193: FAMILY PLANNING II (1992) [hereinafter USAID FAMILY PLANNING II], available at <http://www.dec.org>.

302. See USAID, POPULATION DYNAMICS — HEALTH EDUCATION (June 1975), available at <http://www.dec.org>.

strategy of creating new government entities, supported by a hand-picked advisory staff, to implement family planning projects.³⁰³ This strategy resulted in the creation of the National Council on Population and Development under the Ministry of Home Affairs³⁰⁴ and the National Family Welfare Center ("NFWC") in the Ministry of Health.³⁰⁵ The former coordinated activities among public and private agencies working on family planning,³⁰⁶ and the latter provided training to community nurses and clinical officers to work in dispensaries, health centers and sub-centers across Kenya, as part of a strategy to decentralize the health system.³⁰⁷

At the same time, donors began to collaborate more extensively with the private sector to create and administer programs. For example, in 1983, USAID started the Family Planning Private Sector Project which created smaller scale projects to do the same work of project design and community health worker training.³⁰⁸ In contrast with government efforts, this project exceeded program targets and implementation time frames, and became a successful model for implementing family planning projects in Kenya.³⁰⁹ By the mid-1980s, under the Family Planning Services and Support project, USAID began giving direct support to NGOs, including the Family Planning Association of Kenya (FPAK), the Christian Health Association of Kenya (CHAK) and the Christian Organizations Research Advocacy Trust.³¹⁰ These grants were intended to expand further the successful community health worker system and to create more inte-

303. See USAID, POPULATION STUDIES AND RESEARCH INSTITUTE (Sept. 1984), available at <http://www.dec.org>; see also USAID, SUMMARY OF PROJECT 6150216: FAMILY PLANNING MANAGEMENT AND RESEARCH PROJECT (1983), available at <http://www.dec.org>.

304. See USAID FAMILY PLANNING II, *supra* note 301.

305. See *id.* The National Family Welfare Center ("NFWC") later became the Division of Family Health. *Id.*

306. See USAID, SUMMARY OF PROJECT 6150223: PRIVATE SECTOR FAMILY PLANNING (1988) [hereinafter PRIVATE SECTOR FAMILY PLANNING], available at <http://www.dec.org>.

307. See *id.* Training was provided by the International Training in Health Program at the University of North Carolina. *Id.*

308. See PRIVATE SECTOR FAMILY PLANNING, *supra* note 306. .

309. *Id.* Lessons learned included: 1) service providers which provided integrated care were more successful than those with solely FP interventions, 2) local IEC subcommittees increased service provider success, 3) contraceptives should be promoted and distributed by non-threatening persons rather than senior managers, and 4) better contraceptive supply and logistics systems are needed. *Id.*

310. See USAID, SUMMARY OF USAID PROJECT 6150241: CHILD SURVIVAL AND FAMILY PLANNING (Feb. 1987), available at <http://www.dec.org>.

grated primary health and family planning service delivery locations.³¹¹ During this time, USAID funded contraceptive marketing efforts that, in 1990, became the Contraceptive Social Marketing Project.³¹² Under the 1991-1997 Private Sector Family Planning II project, a follow-up project to the 1983 Family Planning Services and Support effort, USAID continued to work with many small organizations, including religious groups, and stated that: "all organizations assisted under this project will be helped to access contraceptive supplies available from the Ministry of Health."³¹³

In 1995, USAID launched the AIDS Population and Health Integrated Assistance (APHIA) project to "consolidate all USAID support to public healthcare" to "reduce fertility and the risk of HIV/AIDS transmission in Kenya through integrated health and family planning service delivery."³¹⁴ This effort, implemented by Kenyan NGOs and the Ministry of Health, in collaboration with the Japan International Cooperation Agency and several USAID Washington-based projects, combined past efforts in public and private service delivery and sustainable financing (aimed at reducing dependency on outside support) with district-level activities.³¹⁵ On the government side, new elements of USAID efforts included strengthening the Ministry of Health Reproductive Health Logistics Unit and upgrading the Ministry of Health Rural Health Training Centers.³¹⁶ On the NGO side, USAID earmarked funds to help FPAK, CHAK, and Chogoria Hospital become financially stable.³¹⁷ The focus on HIV/AIDS resulted in funds being directed to Nyanza, Western and Coast Provinces "where the need is the greatest."³¹⁸

In 1998, USAID began working with the Government of Kenya to shape a new health strategy that would aid in the imple-

311. See USAID, EVALUATION OF THE FPPS PROJECT: FAMILY PLANNING PRIVATE SECTOR (May 1990), available at <http://www.dec.org>.

312. See USAID, SUMMARY OF USAID PROJECT 6150251: CONTRACEPTIVE SOCIAL MARKETING (July 1990), available at <http://www.dec.org>.

313. See USAID, SUMMARY OF USAID PROJECT 6150254: PRIVATE SECTOR FAMILY PLANNING II, available at <http://www.dec.org>.

314. See USAID, SUMMARY OF USAID PROJECT 6150264: AIDS POPULATION AND HEALTH INTEGRATED ASSISTANCE (May 1999), available at <http://www.dec.org>.

315. See *id.*

316. See *id.*

317. See *id.*

318. See *id.*

mentation of the 1994 Health Policy Framework and make good on Kenya's commitments to fulfill the International Conference on Population and Development's Program of Action in a way that was consistent with USAID's Integrated Strategic Plan for Kenya.³¹⁹ This included providing major funding — with contributions from the United Kingdom's Department for International Development and the United Nations Population Fund — for the 1998 Kenya Demographic and Health Survey³²⁰ and collaborating with government and private actors to develop an HIV/AIDS strategy.³²¹ The Center for Disease Control, which had been working in Kenya on efforts with a bio-medical slant, especially in malaria, also at this time began to shift into HIV/AIDS activities with an emphasis on hard-hit Kisumu in Nyanza Province.³²²

This brief history of USAID's work on reproductive health in Kenya suggests that outside donors have had a profound influence not just on the quality and accessibility of health care in Kenya, but also on the structure of the health care delivery system.³²³ For example, in recent years, grants from outside donors, including USAID, have shifted from family planning to HIV/AIDS.³²⁴ This shift in donor priorities may or may not reflect the policy priorities of the government of Kenya. In any event, they inevitably precipitate a shift in focus among grantees — both governmental and nongovernmental. Whatever the merits of such a shift in terms of public health policy, they have the unintended consequences of undermining the coherence of health policy at the national level and creating transition costs in

319. See USAID/KENYA INTEGRATED STRATEGIC PLAN, *supra* note 291, at 107.

320. See *id.*

321. See *id.*

322. See *id.* at 110.

323. See BETSY HARTMANN, REPRODUCTIVE RIGHTS AND WRONGS: THE GLOBAL POLICIES OF POPULATION CONTROL 87 (1995). For example, in 1982, the World Bank made the release of part of Kenya's Second Structural Adjustment Loan contingent on the establishment of a National Council on Population & Development (NCPD) to be housed outside the Ministry of Health, despite the Ministry's opposition to the creation of a "donor driven" entity. *Id.* at 87 (citing Ronald Ridder, World Bank, *Population and the World Bank: Implications from Eight Case Studies* 54 (Operations Evaluations Study, World Bank, 1992)). The implication here is that the Ministry of Health was considered incapable of making the required reforms and implementing the spending cuts mandated by the structural adjustment loan. See Warren C. Robinson, *Kenya Enters the Fertility Transition*, 46 POP. STUD. 455 (1992).

324. See USAID, SUMMARY OF PROJECT 6150264: AIDS POPULATION AND HEALTH INTEGRATED ASSISTANCE (1995), available at <http://www.dec.org>.

a highly under-resourced system. Thus, one commentator from the International HIV/AIDS Alliance stated:

[T]he significant increase in resources is welcome, however donor ambitions and frequent changes in international financing mechanisms are absorbing much needed human capacity and forcing structural changes. A case study of Kenya shows that the Ministry of Health has profoundly changed its role from being focused on policy-making, planning and quality assurance, technical support and coordination to one of resource mobilization activities and managing multiple relationships with donors In addition, there is no mechanism to prevent duplication of effort.³²⁵

As a result, Kenya's control over the provision of health care is undermined even while Kenya remains accountable under international law for ensuring the right to health of its citizens.

With respect to the delivery of health care services, donor support has shifted toward NGO's and away from block grants at the national level.³²⁶ For example, the USAID Kenya Integrated Strategic Plan 2001-2005 outlines a plan to "reduce fertility and the risk of HIV/AIDS transmission through sustainable, integrated family planning and health services."³²⁷ Specifically, the Integrated Plan states that USAID/Kenya

[W]ill combine and refocus its separate clinic, community-based, and quality improvement [reproductive health] activities to take a more facility-based, comprehensive approach to service delivery at the district level. An NGO, or consortium of NGOs, will be selected to work with USAID/Kenya and its cooperating agencies . . . [to increase the] availability of community-level family planning . . . , reproductive health . . . , and child survival . . . services [I]ncluding HIV/AIDS/

325. Alvaro Bermejo, *HIV/AIDS in Africa: International Responses to the Pandemic*, 11 *NEW ECONOMY* 125, 165-66 (2004).

326. See USAID/KENYA INTEGRATED STRATEGIC PLAN, *supra* note 291, at 111 (explaining that, with regard to the health sector, "due to difficulties of tracking donor funds through the public sector, particularly at the national level, donor support has shifted toward NGOs or toward district-level activities").

327. See *id.* at 112. The components are: 1) recognizing HIV/AIDS as a multi-sectoral crisis, 2) integrating HIV/AIDS and STI services into family planning, maternal and child health services, 3) integrating private sector (including NGO) programs in targeted geographic areas, 4) recognition of the need for behavior change and positive health-care-seeking behavior, 5) giving young people priority attention, and 6) enhancing efforts to strengthen the policy environment and manage sector resources. *Id.*

STI prevention.³²⁸

Although this strategy of reliance on NGO's may have resulted in more efficient use of donor funds, whether it has resulted in a more efficient use of health care dollars overall is less clear. More importantly for the purposes of this Report, the strategy helped to create a system that is particularly vulnerable to restrictions imposed by the United States through the Mexico City policy described in the next section.

4. Mexico City

The early years of USAID's reproductive health policymaking were characterized by a position of political neutrality toward the regulation of family planning. For example, a 1967 Guideline for Assistance to Population Programs stated "[USAID] does not advocate any specific population policy for another country, nor any particular method of family planning. Its aim is to provide needed assistance upon request so that people everywhere may enjoy the fundamental freedom of controlling their reproduction, health, and welfare as they desire."³²⁹ According to President Johnson, "The United States cannot and should not force any country to adopt any particular approach [of population control]. It is a matter of individual and national conscience."³³⁰

During the 1970's, however, the domestic politics of abortion in the United States began to influence its international family planning agenda. The earliest example of this influence was the Helms Amendment adopted in the wake of the Supreme Court's landmark decision, *Roe v. Wade*,³³¹ striking down a criminal abortion statute and limiting the degree to which abortion could be regulated in the United States.³³² The Helms Amendment prohibits the use of population assistance either to pay for the performance of abortions or to coerce any woman to have an

328. *Id.* at 123.

329. R. T. Ravenholt, *The A.I.D. Population and Family Planning Program — Goals, Scope, and Progress*, 5 *DEMOGRAPHY* 561, 562 (1968) (quoting U. S. AGENCY FOR INT'L DEV., *GUIDELINES FOR ASSISTANCE TO POPULATION PROGRAMS*, M.O. 1612.57 (1967)).

330. Lyndon B. Johnson, Special Message to Congress on the Foreign Aid Program (Feb. 1, 1966), in *PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES, LYNDON B. JOHNSON*, Vol. I at 119 (1967).

331. *Roe v. Wade*, 410 U.S. 113 (1973).

332. See Foreign Assistance Act of 1961, 22 U.S.C. § 2151b(f)(1) (2000).

abortion.³³³

One year after the enactment of the amendment, the United States attended the 1974 Bucharest Conference on Population, where it formally recognized family planning as a basic human right.³³⁴ Along with this ideological rhetoric came tactical change. USAID began to modify its approach to population programming, shifting from "supply-side" theory, which emphasized the use of contraceptive supplies as a means of limiting births, to "demand-side" or "developmental" theory, entailing economic reforms aimed at reducing demand for children.³³⁵ But with the election of Ronald Reagan, neither human rights nor a demographic-economic imperative would be the guiding principle of population assistance.³³⁶ By 1983, with a cooperative leader in the White House, anti-abortion advocates were paying more attention to what they could accomplish on an international level.³³⁷ Thus, at the United Nations International Conference on Population in Mexico City, James L. Buckley, the U.S. delegate, recited the position of the United States: "The United Nations Declaration of the Rights of the Child (1959) calls for legal protection for children before birth as well as after birth. In keeping with this obligation, the United States does not con-

333. *See id.* The Amendment states:

(f) Prohibition on use of funds for performance or research respecting abortions or involuntary sterilization.

(1) None of the funds made available to carry out subchapter I of this chapter may be used to pay for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions.

(2) None of the funds made available to carry out subchapter I of this chapter may be used to pay for the performance of involuntary sterilizations as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations.

(3) None of the funds made available to carry out subchapter I of this chapter may be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning.

Id.

334. *See* Jeannie L. Rosoff, *The Politics of Birth Control*, 20 *FAM. PLAN. PERSP.* 312, 313 (1988).

335. *See generally* Ruth Dixon-Mueller, *U.S. International Population Policy and "the Woman Question"*, 20 *N.Y.U. J. INT'L L. & POL.* 146, 155 (1987).

336. *See id.* at 166.

337. *See* Barbara B. Crane & Jason L. Finkle, *The United States, China, and the United Nations Population Fund: Dynamics of US Policymaking*, 15 *POPULATION & DEV. REV.* 23, 30 (1989).

sider abortion an acceptable element of family planning programs."³³⁸

More critically, the United States would cut off USAID funding to foreign non-governmental organizations ("FNGOs") that "perform or actively promote abortion as a method of family planning," even with non-USAID funds.³³⁹ Foreign governments would be permitted to receive USAID funding while supporting abortion, as long as USAID funds were not used for abortion-related activity. Furthermore, the funds were to be kept in a segregated account.³⁴⁰

In providing its statement to the conference, known popularly as the "Mexico City Policy,"³⁴¹ the United States declared that population growth was "not necessarily good or ill," but became problematic in conjunction with other factors.³⁴² According to the U.S. argument, where the effects of population were

338. *Mexico City Policy*, *supra* note 9, at 578 (citing Declaration of the Rights of the Child, *supra* note 30); see also Rebecca J. Cook, *U.S. Population Policy, Sex Discrimination, and Principles of Equality Under International Law*, 20 N.Y.U. J. INT'L L. & POL. 93, 125 (1987) (criticizing U.S. reliance on the Declaration on the Rights of the Child to justify an anti-abortion stance as contrary to the substance of international human rights law).

339. *Mexico City Policy*, *supra* note 9, at 578. The Statement says that first, where U.S. funds are contributed to nations which support abortion with other funds, the U.S. contribution will be placed into segregated accounts which cannot be used for abortion; second, the United States will no longer contribute to separate non-governmental organizations which perform or actively promote abortion as a method of family planning in other nations; and third, before the U.S. will contribute funds to the United Nations Fund for Population Activities ("UNFPA"), it will first require concrete assurances that the UNFPA is not engaged in, and does not provide funding for, abortion or coercive family planning programs. Should such assurances not be possible, and in order to maintain the level of its overall contribution to the international effort, the United States will redirect the amount of its intended contribution to other, non-UNFPA family planning programs. See *id.* This softer governmental requirement was a late concession to the policy. See ACLU REPROD. FREEDOM PROJECT, U.S. POPULATION POLICY AS ANNOUNCED IN MEXICO CITY, 1984, at 2 (1984) [hereinafter PROJECT]. The original pre-conference draft circulated by the White House in May, 1984, applied the advocacy restriction to governments as well as FNGOs. See *id.* But in response to criticism, and to reconcile the new restrictions with foreign policy and sovereignty considerations, the U.S. position amended the policy. See *id.*; see also Camp, *supra* note 9, at 36; Cook, *supra* note 302, at 98-99 (reasoning that the Administration recognized that compelling other States to refuse to support abortion services would violate their sovereignty).

340. See *Mexico City Policy* *supra* note 9, at 574.

341. The policy is also known pejoratively as the "global gag rule" because of its effect of silencing abortion recommendation and advocacy. See discussion *infra* Part III.B.1.

342. *Mexico City Policy*, *supra* note 9, at 576. See VERNON RUTTAN, UNITED STATES DEVELOPMENT ASSISTANCE POLICY: THE DOMESTIC POLITICS OF FOREIGN ECONOMIC AID

detrimental they could be relieved by rapid economic growth.³⁴³ The Reagan Administration was essentially identifying economic underdevelopment as the real problem, and excessive population growth as merely a symptom.³⁴⁴ This perspective signaled an explicit abandonment of a position advocated for two decades: that slowing population growth is essential to economic development.³⁴⁵

Following the U.S. policy statement in Mexico City, USAID promulgated agency guidelines to administer the new funding restrictions.³⁴⁶ Essentially, into each new grant and each renewal grant for population assistance USAID inserts a “standard clause,” or a boilerplate contractual provision detailing the relevant restrictions.³⁴⁷ Funding is contingent on a recipient’s ratification of the clause.³⁴⁸

USAID population assistance grants are administered in three ways: (1) directly to foreign governmental agencies, (2) directly to FNGOs, or (3) indirectly to FNGOs through U.S.-based family planning intermediaries known as Office of Population Cooperating Agencies (“Cooperating Agencies”).³⁴⁹ Cooperating Agencies enter into cooperative agreements to issue sub-

125 (1996). Population growth was actually characterized as a “neutral phenomenon” in the pre-conference draft. See Mexico City Policy, *supra* note 9, at 575.

343. See Mexico City Policy *supra* note 9, at 578-79.

344. See Mueller, *supra* note 335, at 166. Michael S. Teitelbaum notes that, ironically, pressure from the New Right was significant enough to force Ronald Reagan, the quintessential Cold Warrior, to embrace planned economic development policies thereby “trad[ing] ideological places on population issues with . . . communist adversaries.” Michael S. Teitelbaum, *The Population Threat*, FOREIGN AFF., Winter 1992-1993, at 70.

345. See Rosoff, *supra* note 334, at 317.

346. See A.I.D. HANDBOOK #13, Trans. Memo. 13:43, at 4C-47 to 4C-53, 4D-53 to 4D-60 (June 19, 1987)) [hereinafter HANDBOOK 13] cited in John Blane & Matthew Friedman, *Mexico City Policy Implementation Study*, app. A (Population Technical Assistance Proj. Occasional Paper No. 5, 1990) [hereinafter *Study*]. The restrictions contained in the handbook are virtually identical to the restrictions currently in effect. Compare HANDBOOK 13, *supra* at 4C-47 to 4C-53; 4D-53 to 4D-60 with USAID Memo, *supra* note 8, at 17,303-13. The single substantive difference between the policy provisions as enacted by USAID and President Bush’s memo in 2001 is that the latter document exempts from the restrictions the performance or advocacy of post-abortion care. See *id.* at 17,306, 17,311.

347. See Camp, *supra* note 9, at 38 (detailing the development of the standard clause, including negotiation with the first affected parties).

348. See generally *id.*

349. See *Study*, *supra* note 346, at 1.

grants to FNGOs on behalf of USAID.³⁵⁰ Foreign NGO's receiving funds either from USAID directly or through a Cooperating Agency may further grant portions of funds received to "sub-recipients" and "sub-subrecipients."³⁵¹

In any case, all cooperative agreements with U.S. domestic Cooperating Agencies and all grant contracts to FNGO recipients and subrecipients must contain the appropriate standard clause rendering any recipient ineligible for USAID funding if they perform or actively promote abortion as a method of family planning.³⁵² USAID funds may be provided to government family planning programs that perform or promote abortion but none of the USAID money may be used for such purpose and must be maintained in a segregated account.³⁵³ The government exemption also extends to government-sponsored entities such as universities and research facilities.³⁵⁴ Because they are U.S.-based, Cooperating Agencies are likewise eligible for USAID population assistance without regard to their non-USAID-funded abortion activities, but they must agree not to provide U.S. funds to FNGOs "unless the foreign NGO certifies in writing that it does not currently and will not during the term of a cooperative agreement perform or actively promote abortion as a method of family planning" or provide funds to any NGO that conducts such activities.³⁵⁵

Under the Mexico City Policy, "to perform abortion" means to operate a facility in which abortions are performed as a "method of family planning."³⁵⁶ To promote abortion "actively"

350. See *Study*, *supra* note 346, at 1. Some examples of Cooperating Agencies include the Pathfinder Fund and the International Planned Parenthood Federation/Western Hemisphere Region. See *id.* at app. D.

351. See USAID Memo, *supra* note 8, at 17,304.

352. See *Study*, *supra* note 346, at 1.

353. See *id.* (citing HANDBOOK 13, *supra* note 346 at 4C-47 to 4C-53; 4D-53 to 4D-60).

354. See *Camp*, *supra* note 9, at 36. An example of this exemption might entail funding to a national university which sponsors a publication advocating abortion or provides abortion-related medical training. See *id.*

355. See *Study*, *supra* note 346, at 2 (quoting HANDBOOK 13, *supra* note 311 at 4D-53 to 4D-55).

356. USAID Memo, *supra* note 8, at 17,311. The memo defines what constitutes abortion in the context of family planning:

Abortion is a method of family planning when it is for the purpose of spacing births. This includes, but is not limited to, abortions performed for the physical or mental health of the mother but does not include abortions performed if the life of the mother would be endangered if the fetus were carried to term

means to commit financial resources “in a substantial or continuing effort to increase the availability or use of abortion.”³⁵⁷ In signing this agreement, an FNGO grantee agrees to permit USAID to check for compliance at any time by inspecting virtually any documents or evidence.³⁵⁸ If an FNGO violates its agreement while receiving USAID funds, the FNGO’s grantor Cooperating Agency must terminate the subgrant and withhold further disbursement.³⁵⁹

The major exceptions to the restriction on abortion performance or promotion are where the life of the mother would be endangered by the fetus being carried to term and where a pregnancy is the result of rape or incest.³⁶⁰ The policy also stipulates that “passive” referral for abortion services, or response to an inquiry, is sometimes acceptable.³⁶¹ A final exception, in the

or abortions performed following rape or incest (since abortion under these circumstances is not a family planning act).

Id.

357. *Id.* The memo further specifies:

This includes, but is not limited to, the following:

(I) Operating a family planning counseling service that includes, as part of the regular program, providing advice and information regarding the benefits and availability of abortion as a method of family planning;

(II) Providing advice that abortion is an available option in the event other methods of family planning are not used or are not successful or encouraging women to consider abortion (passively responding to a question regarding where a safe, legal abortion may be obtained is not considered active promotion if the question is specifically asked by a woman who is already pregnant, the woman clearly states that she has already decided to have a legal abortion, and the family planning counselor reasonably believes that the ethics of the medical profession in the country requires a response regarding where it may be obtained safely);

(III) Lobbying a foreign government to legalize or make available abortion as a method of family planning or lobbying such a government to continue the legality of abortion as a method of family planning; and

(IV) Conducting a public information campaign in USAID-recipient countries regarding the benefits and/or availability of abortion as a method of family planning.

Id.

358. *See id.* at 17,304.

359. *See id.* at 17,305. A refund of amounts already disbursed is not required unless fraud was involved in obtaining the subgrant. *See id.*

360. *See id.* at 17,306.

361. *Id.* The term “response” is discussed further:

[P]assively responding to a question regarding where a safe, legal abortion may be obtained is not considered active promotion if the question is specifically asked by a woman who is already pregnant, the woman clearly states that she has already decided to have a legal abortion, and the family planning

context of advocacy, is that an individual acting on her own and not as part of an organization may be involved in lobbying or advocacy for abortion rights provided that the organization for which she works neither endorses nor provides funding for the action and takes reasonable steps to ensure that the individual does not improperly represent the organization.³⁶²

The Mexico City Policy was initiated by executive order under President Reagan and remained in place during the administration of his successor, President George H. W. Bush.³⁶³ President Clinton suspended the policy during his administration.³⁶⁴ President George W. Bush reinstated the Mexico City Policy as one of his first executive acts upon taking office in 2001.³⁶⁵

B. *The Impact of the Mexico City Policy on Kenya*

Two NGO's, Marie Stopes International (MSI) and the Family Planning Association of Kenya (FPAK), formerly important partners of USAID in Kenya, refused to sign the pledge required under the Mexico City Policy when President Bush reinstated it in 2001.³⁶⁶ As a result, both NGO's lost significant funding and were forced to close clinics, curtail services, impose or raise fees, and reduce outreach and education efforts.³⁶⁷ This section describes some of the consequences of the loss of funds, including the impact on individual women in some of the poorest sections of Kenya.

1. The Family Planning Association of Kenya (FPAK)

The Family Planning Association of Kenya (FPAK) is the oldest family planning organization in Africa and was registered as an affiliate of the International Planned Parenthood Federa-

counselor reasonably believes that the ethics of the medical profession in the country requires a response regarding where it may be obtained safely.

Id.

362. *See id.* at 17,307.

363. *See* Marc Lacey, *House Panel Blocks Order Linking Money to Abortion*, N.Y. TIMES, May 3, 2001, at A1.

364. *See id.*

365. *See id.*

366. *See Access Denied: Kenya*, *supra* note 4, at 3.

367. *See id.*

tion (IPPF) in 1962.³⁶⁸ Originally a loose network of volunteer organizations working on family planning,³⁶⁹ FPAK grew into a professional health organization that set the “standard as family planning associations across the continent.”³⁷⁰ Prior to the reinstatement of the Mexico City Policy, FPAK operated thirteen conventional family clinics and three male clinics.³⁷¹ In addition to family planning, FPAK provides pre- and post-natal obstetric care as well as routine health check-ups for mothers and infants.³⁷² Several of these clinics also served as centers for the Ministry of Health to train doctors and nurses to insert Norplant and intrauterine devices, perform sterilization procedures, and run STI/HIV/AIDS counseling programs.³⁷³ FPAK clinics do not perform abortions, although FPAK offers comprehensive post-abortion care to women requiring emergency treatment³⁷⁴ and counseling to those who want the procedure.³⁷⁵

When the Mexico City Policy was reinstated in 2001, the International Planned Parenthood Foundation (“IPPF”) headquarters in London reviewed the conditions and subsequently advised all of its affiliates not to sign.³⁷⁶ However, each country office had the autonomy to make its own decision.³⁷⁷ FPAK senior staff presented the matter to its Board which, according to Dr. Godwin Mzenge, Executive Director of FPAK, made its decision with “its eyes wide open” with regard to financial implications.³⁷⁸ According to Mzenge, Board Members had several reasons for choosing not to sign; some cited FPAK’s mission and obligation to its clients; some felt that, as a family planning organization, complete avoidance of abortion as a medical issue was impossi-

368. See Family Planning Association of Kenya [FPAK] Website, Brief History, <http://www.fpak.org/history.html> (last visited Sept. 23, 2005).

369. See *id.*

370. *Access Denied: Kenya*, *supra* note 4 at 3.

371. See FPAK Website, Clinics, <http://www.fpak.org/Clinics1.html>.

372. Global Gag Rule Impact Proj., *Access Denied: U.S. Restrictions on International Family Planning*, Executive Summary (Sept. 2003), at 3, available at http://www.globalgagrule.org/pdfs/executive_summary/GGR_exec_summary.pdf.

373. See *Access Denied: Kenya*, *supra* note 4, at 3.

374. See *id.*

375. Interview with Dr. Godwin Mzenge, Program Manager, and Dr. Linus I.A. Etyyang, Executive Director, FPAK, in Nairobi, Kenya (May 18, 2004) [hereinafter FPAK Mzenge and Etyyang Interview] (on file with Crowley Program).

376. *Id.*

377. See *id.* (explaining that Ghana, 99% dependent on USAID, and Tanzania, who later did not get approval for funds, have signed).

378. *Id.*

ble; and in the end a decision was made to “stay with one position” rather than “hop from one erratic U.S. funding policy to the next.”³⁷⁹ As a result of this decision, FPAK lost an average of KSH21 million annually (US\$276,300).³⁸⁰ IPPF London also declined to sign, and, as a result, lost core support from USAID.³⁸¹ FPAK annual core funding from IPPF-London was therefore reduced by an additional KSH16 million.³⁸² Overall, the losses comprised almost 60% of its annual budget.³⁸³

Faced with this substantial loss of funds, FPAK had to make difficult decisions about eliminating staff and services. The Association had to balance its competing obligations as a service provider to poor Kenyans, as an employer, and as an organization with an international reputation earned over decades of work. Executive Director Mzenge and Program Manager Dr. Linus I.A. Etyyang called the decision regarding which clinics to close “contentious and painful.”³⁸⁴ They explained that senior staff reviewed service provision statistics including the volume of clients served, the ability of the clinic to recover costs, the number of staff who would have to be relocated, and whether FPAK owned or rented the facility.³⁸⁵ This combination of factors, while reasonable from an economic standpoint, led to the closing of clinics in some of the poorest communities, including Eastleigh, Embu and Kisii.

a. The Closures

The FPAK Eastleigh clinic, which closed in 2002, had been operating since 1984 in a densely populated slum neighborhood that is home to many refugees from the Republic of Congo, Ethiopia and Somalia.³⁸⁶ The neighborhood has no government-run

379. *Id.* See Former FPAK Ocharo Interview, *supra* note 3 (commenting after one day of contact with healthcare clients, “[a] day will come when we can see the light. Funding will have to come back. We have to fight for our cause. We cannot be for the immediate benefit. We have lost temporarily but in the end we will win.”).

380. FPAK, Brief on Financial Position 2004, at 1 [hereinafter FPAK Financial Brief] (on file with Crowley Program).

381. *Id.*

382. *Id.*

383. See *Access Denied: Kenya*, *supra* note 4, at 375.

384. FPAK Mzenge and Etyyang Interview, *supra* note 375.

385. See *id.*

386. MSI-Kenya, who did not close their Eastleigh clinic, provides pamphlets (on file with the Crowley Program) with family planning information in Amarric and Somali. While MSI-Kenya provides services to all, regardless of refugee background, they

health clinic.³⁸⁷ Clients visited the Eastleigh clinic for STD screening and treatment, family planning, pre- and post-natal obstetric services and check-ups for infants.³⁸⁸ The clinic also served women who live in Mathare Valley, one of the poorest sections of Nairobi.³⁸⁹ The Eastleigh clinic provided important services directed at adolescents as it was located very near the Eastleigh Youth Counseling Center (YCC), also sponsored by FPAK.

The FPAK Embu Town Clinic was located in the capital of Eastern Province and in the heart of Kenya's tea plantations and rice farms. Opened in 1978, the clinic provided various forms of family planning, check-ups, Pap Smears, treatment for STDs and HIV/AIDS counseling and testing.³⁹⁰ FPAK was the only NGO providing reproductive health services to the community.³⁹¹ Dr. Methuselah M. Ocharo, former FPAK Embu Clinic Manager, stated that the clinics used to serve between 200 and 300 clients per month.³⁹² FPAK Embu also ran an extensive outreach program to tea plantation and rice irrigation workers.³⁹³ Dr. Ocharo explained that clinic staff conducted outreach at three sites, with about seventy-five clients per site adding another 200

do not require their clients to state their status or nationality when they come for services. As such, they could not provide statistics on the proportion of refugees in their client base, but the fact of the multi-lingual materials strongly suggests a significant presence. *See* Interview with MSI-Eastleigh staff, in Nairobi, Kenya (Feb. 3, 2004) (on file with Crowley Program); *see also* Interview with Tom Chuma, Finance and Administration Manager, in Nairobi, Kenya (Feb. 5, 2004) (on file with Crowley Program).

387. *See Access Denied: Kenya*, *supra* note 4, at 4.

388. *Id.*

389. A photograph book of Nairobi states:

[The people of] Mathare, Nairobi's largest and poorest slum, survive with many things we take for granted. They do not have toilets, running water, electricity or a good pair of shoes. Working people are lucky if they earn sixty Kenyan shillings (roughly US\$1) a day. Cramped into one-room shacks with sheets hanging from the ceiling as room dividers, families are large, with five to ten children. Single mothers run the majority of the households. Many fathers have left or died, perhaps from AIDS or one of the other illnesses that plague the slum. This is the Nairobi that most tourists do not see.

SHOOTBACK: PHOTOS BY KIDS FROM THE NAIROBI SLUMS, Epilogue (Lana Wong ed., 1999).

390. *See* Former FPAK Ocharo Interview, *supra* note 3.

391. *See* Effects of the Gag Rule on FPAK Programme, Summary Version, 2004 [hereinafter Effects on FPAK (Summary)] (on file with Crowley Program).

392. *See* Former FPAK Ocharo Interview, *supra* note 3.

393. *See* Effects on FPAK (Summary), *supra* note 391.

to 300 persons served per month.³⁹⁴ Dr. Ocharo was involved in the process that led to the closure. He said that from a business perspective, FPAK Embu was performing poorly. He agreed to the closure, although the decision was “very, very difficult,” and acknowledged that “clients were praying we wouldn’t close but we had to.”³⁹⁵

Kisii is a densely populated town in the center of a vast rural and agricultural area. Fifty-two percent of the people in Kisii live below the poverty level.³⁹⁶ Also, 95.9% of all women of the Kisii ethnic group have had genital surgery performed.³⁹⁷ FPAK Kisii had functioned as a regional training for doctors and nurses to learn how to perform tubal ligations, vasectomies, and Norplant insertion and removal.³⁹⁸ FPAK Kisii also had a youth program and, when it was open, partnered with an area high school teacher to distribute reproductive and sexual health information to some 100 students for four hours on Saturday mornings.³⁹⁹ A community health worker program was launched in 2000 with FPAK providing an extensive three-week training program to prepare the workers to serve youths, pregnant women, and mothers who want family planning.⁴⁰⁰

Most directly, the closures of the clinics in Eastleigh, Embu, and Kisii have made it more difficult — and in some cases impossible — for their former clients to obtain basic family planning services. Members of the Crowley delegation visited all three sites and interviewed members of the community, many of whom were former clients of the FPAK clinics. These interviews, though anecdotal, suggest that the closings had a substantial impact on the availability of reproductive and basic health services in these communities.

394. See Former FPAK Ocharo Interview, *supra* note 3.

395. *Id.*

396. Central Bureau of Statistics, Ministry of Planning and Nat’l Dev., *Geographical Dimensions of Social Well-Being in Kenya, Where are the Poor? From Districts to Locations: Volume I, Rural Poverty Rates Summary Table*, at 73 [hereinafter *Geographical Dimensions*].

397. See KDHS, *supra* note 216, at 251.

398. Norplant is particularly popular with rural women whose access to healthcare facilities is limited and irregular.

399. Interview with Margaret, high school teacher, in Kisii, Kenya (May 20, 2004) (on file with Crowley Program).

400. Interview with Ben Giseemba, Kennedy Nyakundi Nyandoro and Linet Osebe, Gusii Community Health Workers, in Kisii, Kenya (May 20, 2004) [hereinafter FPAK Gusii Volunteers] (on file with Crowley Program).

As an initial matter, the economic circumstances of many of their clients made it difficult for FPAK to prepare them for the closure and help them to arrange for an alternative source for reproductive health care. Because most clients lacked postal addresses, FPAK could not notify them by mail. Instead, FPAK kept each clinic open for at least four months so that clients could be told in person and be made aware of the alternatives. In some cases, these clients chose to switch to longer term contraceptive methods such as Norplant.

The “face to face” strategy worked with clients using methods such as the pill and injections as they are required to come in every three months for a check-up and to obtain a new supply.⁴⁰¹ Patients already on longer term methods were still learning of the closures at the time of the Crowley mission. For example, Zipporah Kuamboka, a twenty-four-year-old woman and mother of three, only found out that the clinic had closed the day before she was interviewed by the Crowley delegation.⁴⁰² She had visited the FPAK clinic on the recommendation of her sister and her aunt, who also heard about FPAK from “people satisfied with the services.”⁴⁰³ In addition to receiving Norplant, she obtained basic health care services such as weight and blood pressure monitoring and a Pap Smear. Her last visit was in 2001. On the day before the interview, Kuamboka paid KSH100 to travel to the FPAK clinic in Kisii because the clinic near where she lives in Bomochoge “gives limited services.”⁴⁰⁴ She wanted to have her Norplant removed because she was bleeding. Instead, she went to the Aries Medical Clinic which opened in the office where FPAK had operated. Kuamboka paid KSH600 to have the Norplant removed, twice the amount FPAK had charged. When interviewed by the delegation, Kuamboka complained not only that the new clinic was “too expensive” but that the staff had simply given her pills and “not told [her] about when to take the pills or about side effects.”⁴⁰⁵

FPAK’s strategy of switching patients to long-term methods such as Norplant helped to alleviate some of the immediate

401. See FPAK Mzenge and Etyyang Interview, *supra* note 375.

402. See Interview with Zipporah Kuamboka, former FPAK Kisii client, in Kisii, Kenya (May 20, 2004) (on file with Crowley Program).

403. *Id.*

404. *Id.*

405. *Id.*

problems created by the clinic closings. But long-term methods also require monitoring and, eventually, removal. One client, Angela Owino used to pay KSH70 and travel for an hour from her village to FPAK Kisii because she felt the clinic was more “reputable” than what she could find “back home.”⁴⁰⁶ Heryne Ayiamba Dok, who used to work in the FPAK Kisii clinic and has since been relocated to FPAK Eldoret, explained the problems that Norplant users face. “The [Kisii District] hospital only does [Norplant removal] on one day [a week.] FPAK did it every day. People get discouraged when they show up and can’t get the services they came for. . . . One woman kept her Norplant in for seven years because she did not want to go somewhere else to have it removed.”⁴⁰⁷ With the FPAK clinic closure, Ms. Owino will have to find an alternative for the removal of her Norplant in 2005. She said simply: “I hope there will be a solution by next year.”⁴⁰⁸

Ms. Dok’s observations highlight that, in order to serve poor women effectively, making services available on multiple days and according to a predictable schedule is essential. Many FPAK clients have no reliable way to contact the clinic to make or confirm appointments or to check whether services will be available on a given day. Moreover, they often must travel long distances and bear significant costs to obtain the services. If they are unable to obtain the services on the day they arrive at the clinic, they may simply be unable to reschedule and return on another day. For example, Esther Mutui, a forty-five-year-old mother of four, used to go to the FPAK clinic in Eastleigh, a ten-minute walk from her home in Mathare Valley. She now travels two hours each way to get services at the FPAK Ribeiro clinic, a trip she is able to make, at most, once a year. Mutui said, “I used to get a check-up every three months in order to get the pills so I would go to the clinic. Now I only get a check-up once a year.”⁴⁰⁹ In the meantime, she tries to obtain pills from outreach workers

406. Interview with Angela Owino, former client of FPAK Kissi, in Kisii, Kenya (May 20, 2004) [hereinafter Owino Interview] (on file with Crowley Program).

407. Interview with Heryne Ayiamba Dok, formerly of FPAK Kisii, Kenya (May 20, 2004) [hereinafter Dok Interview] (on file with Crowley Program).

408. *Id.*

409. Interview with Esther Mutui, former client of FPAK Eastleigh, in Eastleigh, Kenya (May 18, 2004) [hereinafter Mutui Interview] (on file with Crowley Program).

but notes “sometimes the volunteers do not have any pills.”⁴¹⁰ Because of the proximity of the Eastleigh clinic, Mutui also brought her children when they were sick. Now she explains, “[I]t is hard. If they get sick I usually just go to the chemist for medicine.”⁴¹¹

Some women like Veronica Ngina, an Eastleigh widow and a mother of two children, have been cut off completely. She used to go the FPAK clinic in Eastleigh but says, “now I never go anywhere.”⁴¹² She used to receive contraceptive injections at FPAK but, since she cannot access the clinic, Veronica buys her pills at the pharmacy for KSH30 a month. At the time of the interview, Veronica was out of work. “I used to sell cabbages, then I got a new job cooking, but now I am unemployed. I get some financial help from the government. . . . So far, I still have money because I have not been unemployed too long, but if I don’t find a job soon, I don’t know how I will pay.”⁴¹³

In addition to reproductive health services, the FPAK clinics also served as an affordable—and sometimes the only—source of primary health care for women. For example, Petwnila Masimiyu Wanyama, who is twenty-nine and works as a clerk with Kenya Power, had been visiting FPAK in Embu for five years. She is neither married nor using contraceptives but went to the clinic when she was “having trouble with [her] periods.”⁴¹⁴ She had her hormones checked, got a Pap Smear and medicine. A private clinic staffed by FPAK nurses has opened in the site of the former FPAK office, and Wanyama compared her past and present experiences. “Before it was cheaper . . . it was quicker.”⁴¹⁵ She used to pay KSH50 per visit. With regard to the new clinic, she said, “I came once and there was no doctor so I stopped coming. I went to see a gyn[ecologist]. He was private and charged KSH300. I will go to him if there is no other option, but it is very expensive.”⁴¹⁶

410. *Id.*

411. *Id.*

412. Interview with Veronica Ngina, former client of FPAK Eastleigh, in Eastleigh, Kenya (May 18, 2004) [hereinafter Ngina interview] (on file with Crowley Program).

413. *Id.*

414. Interview with Petwnila Musimiyu Wanyama, former client of FPAK Embu, in Embu, Kenya (May 20, 2004) [hereinafter Wanyama Interview] (on file with Crowley Program).

415. *Id.*

416. *Id.*

Similarly, Marren Achieng, a former client of FPAK Kisii, a forty-year-old woman who planned her two pregnancies, complained about the quality of services she obtained when the clinic closed. Achieng, comparing her past and present experiences with seeking health care, said, "I went to the [FPAK] clinic every three months and when necessary. I got Pap Smears and check-ups. It was not difficult to pay for the Pap Smear. When I was at the clinic, they did counseling, blood pressure, HIV/AIDS counseling. They offered the services, I did not have to ask. FPAK provided family planning counseling too."⁴¹⁷ Achieng continued,

After they closed, I was stranded. . . . I did not want to switch to another doctor. When I went to another clinic, the services were not as good. They were expensive and they were not offered every day. It was discouraging because they always told me to come back another day. There was not as much counseling.⁴¹⁸

Almost to the person, former clients of the closed clinics complained about the additional time and financial costs associated with finding alternatives. Some continue to visit other FPAK sites at considerable inconvenience. According to Nurse Imbadi, formerly based at FPAK-Eastleigh and now based at FPAK-Ribeiro House, "I had a relationship with many clients. And now those clients travel here to follow me. They know me, but it is very difficult for them to come here to me now. Some have to walk very far—even to get to the [bus]."⁴¹⁹

At the time of the publication of this Report, FPAK was considering closing two additional clinics that had been funded primarily by USAID. A statement prepared by FPAK's Finance and Administration Officer regarding the possibility of closing these two clinics predicted that, based on past levels of service, some 8600 clients would be left without access to services including, on an annual basis, 17,200 family planning visits, contraceptive supplies for 2900 couples, 5000 Pap Smear tests for early diagnosis of cervical cancer, and counseling for some 900 STD cli-

417. Interview with Marren Achieng, former client of FPAK Kisii, in Kisii, Kenya (May 20, 2004) [hereinafter Achieng Interview] (on file with Crowley Program).

418. *Id.*

419. Interview with Sarah Imbadi, Registered Nurse, FPAK Ribeiro Clinic, in Nairobi, Kenya (May 18, 2004) [hereinafter FPAK Imbadi Interview] (on file with Crowley Program).

ents.⁴²⁰

b. Reduced Services and Higher Fees

Beyond the closing of these three clinics, the loss of USAID funding also forced FPAK to reduce staff and services at the clinics that have remained open. In total, FPAK laid off forty staff, including thirty who were directly associated with service provision.⁴²¹ According to FPAK Executive Director Mzenge, “I have lost most of my senior staff. . . . In 2001, the program-officer level fell to sixty percent and we have not been able to replace these people. We have redeployed less-experienced staff back to headquarters to replace these people.”⁴²² Salary increases were being planned prior to the 2001 reinstatement of the Mexico City Policy but fell through and experienced staff people left seeking higher wages at international organizations which have recently begun to hire more Kenyan nationals.⁴²³ Mzenge says that remaining staff are demoralized because they “can’t implement plans or achieve goals.”⁴²⁴

In Nairobi, FPAK Supervising Physician Dr. J. Osur Odour, divides his time between FPAK’s Phoenix House and Ribeiro Clinic where the staff has been “cut in half.”⁴²⁵ Dr. Odour works at Phoenix House once a week and at Ribeiro House twice a week. In addition, he said that “many volunteer doctors used to come and can’t come anymore.”⁴²⁶ Ribeiro House Registered Nurse Sarah Imbadi complained that “[r]etrenchment made it difficult for even the staff to travel to the new clinics, so many of them chose to retire early. I continued to work even though it is more difficult for me to get here.”⁴²⁷

420. Effect of the Global Gag Rule on the Programme of Family Planning Association of Kenya 2002, at 2 [hereinafter Effects on FPAK] (on file with Crowley Program).

421. Interview with Tom Chuma, Fin. and Admin. Manager, FPAK, in Nairobi, Kenya (May 24, 2004) [hereinafter FPAK Chuma Interview] (on file with Crowley Program).

422. FPAK Mzenge and Etyyang Interview, *supra* note 375.

423. *Id.* For example, the FPAK communications person got a job at the Joint U.N. Program on HIV/AIDS (UNAIDS), the most senior doctor went to the Center for Disease Control and an advocacy person moved on to Pathfinder. Mzenge asserts that FPAK’s inability to provide competitive salaries is a “direct result of the Gag Rule.” *Id.*

424. *Id.*

425. Interview with Dr. J.A. Osur Odour, Supervising Physician, FPAK Ribeiro Clinic, in Nairobi, Kenya (May 18, 2004) (on file with Crowley Program).

426. *Id.*

427. FPAK Imbadi Interview, *supra* note 419.

Director Mzenge described the situation at FPAK in Kakamega in Western Kenya:

[B]ecause of the Gag Rule, the staff has been reduced to one third of the pre-Gag Rule number. This has resulted in reducing the number of patients. The lab in that location is not able to do simple tests. Consequently, patients have to be referred to the general hospital. When the clients are referred to the hospital, they tend not to come back to FPAK.⁴²⁸

Similarly, FPAK Kisumu had a clinical officer and three nurses on staff prior to the funding cuts. Now, Nurse in Charge Martha Achesi doubles as nurse and clinical officer and says that many of her former patients go to government hospitals. Nurse Achesi also reported that all eight Kisumu-based community health workers are dormant as are an additional twenty-five community health workers between the towns of Ugunja and Ukwala. FPAK had started to build a new clinic in Ukwala but had to stop construction due to a lack of funds. Nurse Achesi suggested that the rate of family planning has gone down and that the rate of STIs, botched abortions, and unwanted pregnancies has gone up.⁴²⁹

In order to maintain services at the remaining clinics, FPAK has been forced to reevaluate its fee structure. Although FPAK originally provided family planning services free of charge, it eventually began to impose fees for some services. At the time it lost USAID funding, FPAK was in the process of implementing a fee structure under which clients outside of poor neighborhoods would pay near-market rates for services, and those funds would be used to subsidize services for the poor. In the wake of the cuts, FPAK has found that the cross-subsidization scheme does not generate enough income to fund clinics located in rural and poor urban communities. Thus, FPAK must now consider introducing higher fees across the board in order to remain in operation.⁴³⁰ If FPAK cannot add new services to underwrite family planning, the ability of Kenya's poorest people to access health care may be further compromised.

428. FPAK Mzenge and Ettyang Interview, *supra* note 375.

429. Interview with Martha Achesi, Nurse in Charge, FPAK Kisumu, in Kisumu, Kenya (May 20, 2004) (on file with Crowley Program).

430. See FPAK Mzenge and Ettyang Interview, *supra* note 375.

c. Cuts in Outreach and Education

One of the less obvious but perhaps more devastating effects of the loss of USAID funding has been to undermine FPAK's well-developed system for the community-based distribution of contraceptives. With the financial and technical support of USAID, FPAK recruited and trained a large network of community health workers to provide reproductive health education, contraceptive supplies, and referrals for medical services. In 2001, FPAK's community health workers reached 56,000 people with reproductive health information, education and counseling, made 30,000 referrals, provided 75,000 persons with contraceptives and distributed 89,600 condoms.⁴³¹ This network allowed FPAK to reach women whose geographic location or personal circumstances made it difficult for them to visit a clinic for care. According to an international consortium of NGOs monitoring the effects of the Mexico City Policy, FPAK reduced the number of community-based distribution agents by fifty percent.⁴³² Finance and Administration Officer Tom Chuma reported that the community health worker component of FPAK is now only about "twenty percent effective" and operating with only a "minimal structure."⁴³³

The Crowley delegation interviewed FPAK community health workers in Eastleigh, Embu, and Kisii and found that, although they were acutely short on contraceptive supplies, many were still doing their best to provide counseling and referrals. For example, a former FPAK community health worker in Embu explained that, in the past, "USAID gave us bicycles, an allowance, and bags," but that now, "we do not have the supplies we need like we used to."⁴³⁴ They estimated that the twenty-five Embu community health workers used to serve 500 people every two weeks. One volunteer, Hussein Marjan, complained, "We still see a lot of people, but we just don't have the same supplies we used to."⁴³⁵ He added that clients "liked our services before

431. See Effects on FPAK, *supra* note 391, at 3.

432. See *Access Denied: Kenya*, *supra* note 4, at 5.

433. FPAK Chuma Interview, *supra* note 386.

434. Interview with Nancy W. Kamav, Muchoki Kithinji, Hussein Marjan, Mary W. Nyagah and Halima S. Shaban, members of the Kenya Cmty. Health Volunteers Program, in Embu, Kenya (May 20, 2004) [hereinafter Embu Volunteers Interview] (on file with Crowley Program).

435. *Id.*

but not now.”⁴³⁶ Marjan reported that his clients ask, “Why have you abandoned us?”⁴³⁷ Another community health worker from Embu, Michoki Kithinji elaborated on the specific case of HIV patients: “It has reached a point where people with HIV — who would not go to hospitals because of the fear of the scourge — began to trust us. Some would be frank about HIV. But we can’t give people pills when we have none.”⁴³⁸ He felt that in the past “taking services to people really produce[d] results” but that some clients “are becoming careless now.”⁴³⁹

Community health workers in Eastleigh also described the effects of the shortage on their clients. According to Charles Kanyi, “[We] could be walking down the street and people would ask me for contraceptives.”⁴⁴⁰ He added, “Some stopped taking pills because they can’t get it elsewhere.”⁴⁴¹ When asked whether their clients had other alternatives, Virginia Njue reported that “some end up getting abortions.”⁴⁴² Grace Adams added that women “go to bushmen [or] overdose on drugs.”⁴⁴³

Kennedy Nyakundi Nyandoro, a Gusii community health volunteer who was trained by FPAK, told Crowley delegation members, “[w]e want to reach out to youth but we do not have the resources. We haven’t been able to get them. We want to start a program because the FPAK center closed. FPAK clinic served our youth. We have worked for 2000 youths in [the] year [before] the program . . . closed.”⁴⁴⁴ Linet Osebe, another volunteer said, “The community is still asking us what we did with the clinic.”⁴⁴⁵

Apart from undermining the community-based distribution of contraceptives, the loss of funding has also undercut the educational function of the community health workers. As Assistant Program Officer Gertrude Akolo explained, “we used to get re-

436. *Id.*

437. *Id.*

438. *Id.*

439. *Id.*

440. Interview with FPAK Eastleigh Youth Center Volunteers, in Nairobi, Kenya (May 18, 2004) [hereinafter FPAK Eastleigh Youth Center Volunteers] (on file with Crowley Program).

441. *Id.*

442. *Id.*

443. *Id.*

444. FPAK Gusii Volunteers, *supra* note 400.

445. *Id.*

ferrals from clients in the village for Norplant, Pap Smears, tubal ligations. We used to send FPAK staff to the municipal hospital to do tubal ligations once a month, but we don't do this anymore. . . . It was easier for some clients to get to the hospital, so FPAK would offer services there."⁴⁴⁶ Akolo also said that discontinuing the outreach program has eliminated access for "women from rural towns [who are] are not allowed to go to town. Their husbands forbid them."⁴⁴⁷

Finally, the loss in funding has also led to cuts in educational programs including those targeting youth. For example, the FPAK Youth Counseling Center (YCC) is located in Eastleigh, near the former site of the FPAK clinic. The Crowley delegation visited the center and spoke with a group of fifteen volunteer "Peer Educators." Some forty-eight Peer Educators are affiliated with the YCC and conduct trainings at schools throughout Nairobi as well as at the YCC. They explained their work: "We keep HIV/AIDS, family planning, and reproductive health books here, as well as brochures. We also have books on developing life-support skills. . . . We do counseling — peer education and counseling."⁴⁴⁸ The volunteers also use a technique they call "Invisible Theater" which involves staging accurate and detailed conversations about sexual health on public transportation so that other passengers may overhear and learn.⁴⁴⁹

Although the Youth Center still operates, its effectiveness has been reduced due to the closing of the Eastleigh clinic. The clinic had provided important support for the educational efforts concerning family planning. As one Eastleigh volunteer explained, the FPAK clinic "was a help to the YCC [Youth Center]. People could be referred there and sent over right away. . . . [FPAK] also provided us with publications and we had physicians nearby."⁴⁵⁰

The Youth Center in Eastleigh is but one example of FPAK's efforts to design outreach programs with messages that are both understandable to and appropriate for their target groups of adult women and men and adolescents. For example, Linet

446. Interview with Gertrude Akolo, Assistant Program Officer, FPAK-Eldoret, in Eldoret, Kenya (May 19, 2004) (on file with the Crowley Program).

447. *Id.*

448. FPAK Eastleigh Youth Center Volunteers, *supra* note 440.

449. *See id.*

450. *Id.*

Osebe, a community health worker in Kisii, explained that local chiefs “pick people from the community” to be interviewed for the positions.⁴⁵¹ Her co-worker, Kennedy Nyakundi Nyandoro, said that once the community health workers were selected and trained, “the chief assists us . . . [and] tells the men of the community that they need to care about family planning.”⁴⁵² She added, “we also work with elders . . . [and] have theater on many health emergencies including malaria, HIV/AIDS, [and] family planning.”⁴⁵³ The reduction in resources due to the loss of USAID funding has undermined the effectiveness of these innovative programs.

2. Marie Stopes International-Kenya

Marie Stopes International (MSI) is a U.K.-based family planning organization, which grew out of an organization founded by Dr. Marie Stopes in 1921.⁴⁵⁴ The first overseas office was established in 1977.⁴⁵⁵ Today, the MSI Global Partnership has offices in thirty-nine countries and provides sexual and reproductive health services to some 4.3 million people worldwide.⁴⁵⁶ The MSI-Kenya office opened in 1985.⁴⁵⁷ Until 2001, MSI-Kenya ran twenty-one clinics and two outreach projects that offered a wide range of services including screening and treatment of malaria, cervical cancer screening, immunizations, HIV/AIDS testing and routine primary care for clients and their children.⁴⁵⁸

MSI-Kenya had received funds from USAID from its inception. Between 1998 and 2001, MSI Kenya received some US\$1.6 million from USAID to train professionals to provide contraceptive services and reproductive health care.⁴⁵⁹ Nevertheless, the

451. FPAK Gusii Volunteers, *supra* note 400. Those who are nominated for these positions are those who command respect from others and are expected to be models of altruism and concern. See Kaler & Watkins, *supra* note 139, at 258.

452. *Id.*

453. *Id.*

454. Marie Stopes International, About Us, <http://www.mariestopes.org.uk/about-us.htm> (last visited Nov. 14, 2003) (on file with Crowley Program).

455. *Id.*

456. *Id.*

457. See Marie Stopes Website, Kenya, <http://www.mariestopes.org.uk/ww/kenya.htm> (last visited Oct. 18, 2005).

458. See Marie Stopes Website, About Us, *supra* note 454.

459. See *Access Denied: Kenya*, *supra* note 4, at 3.

organization refused to agree to the terms of the Mexico City Policy when President Bush reinstated it in 2001. MSI-London and some country offices provide abortions in countries where abortion is generally legal or permitted when necessary to save the life of the mother. MSI-London therefore decided not to agree to the Mexico City Policy requirements and lost over US\$3 million for MSI Partners in Africa. MSI-London convened Country Directors in London to discuss the implications of the policy but left it up to Country Offices to decide whether to sign.⁴⁶⁰ In East Africa, decisions taken at the country level led to the closure of two centers in Kenya, an outreach program servicing poor communities in Ethiopia, and additional centers in Tanzania.⁴⁶¹

In Kenya in 2001, MSI was running twenty-one clinics in various parts of the country. Surplus income from the high-volume clinics in Nairobi subsidized services for low income clients in rural and poor urban areas. The MSI website notes that “although some clients, like those in Mathare Valley and Kibera districts and the rural communities of Western Kenya, may not be in a position to contribute towards the costs of their care, services are not denied for lack of resources, and these clients are subsidized by the majority who can afford to pay an appropriate fee.”⁴⁶² Because of its large network of clinics, MSI-Kenya was better insulated from the loss of USAID funding than FPAK, which was only in the preliminary stages of developing an internal cross-subsidization strategy when the Mexico City Policy came into effect. Nevertheless, with the loss of USAID funding, MSI was forced to close two clinics that had been operating at a loss. These clinics, serving some of the poorest communities, were closed by September 2001.⁴⁶³

Despite the consequences, MSI-Kenya Country Director

460. Interview with Richard Olewe, Marie Stopes Kenya Reg. Manager-Western, in Kisumu, Kenya (May 19, 2004) [hereinafter Olewe Interview]. See Notes from Site Visit to MSI-Kenya Machakos-Kyawalia, Feb. 6, 2004 [hereinafter MSI-Kenya Machakos-Kyawalia Notes] (on file with Crowley Program); see also Interview with Martha Mutunga, Manager VSC Projects, in Nairobi, Kenya (February 6, 2004) [hereinafter Mutunga Interview] (on file with Crowley Program).

461. Marie Stopes Website, Current Global Campaigns, <http://www.mariestopes.org.uk/ww/advocacy-cur-glob-camp.htm> (last visited Oct. 18, 2005).

462. Marie Stopes Website, *supra* note 457.

463. See *Access Denied: Kenya*, *supra* note 4, at 4.

Cyprian Awitti said, “[w]e are confident with our decision.”⁴⁶⁴ Regional Manager Western Richard Olewe echoed “[w]e have our own beliefs to protect.”⁴⁶⁵ Martha Mutunga, Manager of Community Outreach, agreed that “[i]t is important to stand up in the hopes that the policy will eventually be overturned.”⁴⁶⁶

When Marie Stopes-Kenya lost USAID funding, the organization laid off eighty employees, or about one-fifth of its staff, most of whom were associated with the outreach program as well as some of the least senior staff members.⁴⁶⁷ Salaries were cut and only an “immediate and massive internal reorganization” and an increase in fees “ensured [MSI’s] continued operation.”⁴⁶⁸ MSI-Kenya has survived the cuts but not without having to abandon many of its most vulnerable health care clients.

a. The Closures

The Mathare Valley clinic opened in 1987 and was located in a sprawling slum neighborhood in Nairobi.⁴⁶⁹ For ten years, the MSI clinic in Mathare Valley was the only source of health care for some 300,000 people until a Doctors Without Borders center opened in 1998.⁴⁷⁰ The Mathare Valley clinic was located only a short distance by car from the MSI Eastleigh clinic, which remains open. Nevertheless, because it is too far to walk easily, the distance to the well-equipped clinic prevents most women from Mathare Valley from accessing its services. No bus service exists and the cost of a taxi ride, approximately KSH500, is prohibitive. For Dorothy Akimyi, who makes her living selling vegetables, it is the equivalent of ten days work.⁴⁷¹

As a practical matter, women who live in this part of Nairobi usually do not leave the area and tend to seek health care only in the case of emergencies.⁴⁷² According to Nurse Grace Otiemo,

464. Interview with Mr. Cyprian Awitti, Country Director, Marie Stopes-Kenya, in Nairobi, Kenya (May 27, 2004) [hereinafter Awitti Interview] (on file with Crowley Program).

465. Olewe Interview, *supra* note 460.

466. Mutunga Interview, *supra* note 460.

467. *See Access Denied: Kenya*, *supra* note 4, at 6.

468. *Id.* at 5.

469. *See id.* at 4.

470. *See id.*

471. Interview with Dorothy Akimyi, former client, Marie Stopes-Mathare Valley, in Nairobi, Kenya (May 28, 2004).

472. *See Access Denied: Kenya*, *supra* note 4, at 4.

“Since Mathare Valley closed, slum girls just stay there.”⁴⁷³ Grace Achewa and Henrietta Asistu, community health workers who used to do outreach for the FPAK Eastleigh clinic stated:

Eastleigh is too far away for the women to travel — especially when they are in labor in the middle of the night. There is no vehicle to refer the clients to Eastleigh. The women have to use their own money for transport and they don’t have that much money. People are suffering and women who were delivering babies [at the Mathare Valley Clinic] here have nowhere to go.⁴⁷⁴

Twenty-four year-old Virginia Wambui first learned about Marie Stopes from community health workers who came to Mathare Valley and went from house to house to do education. She noted, “Now that the clinic has closed, I do not see them.”⁴⁷⁵ Although she gave birth to her first child at MSI-Mathare Valley, the clinic had closed by the time her second child was due. Instead, she gave birth at Pumwani, a government hospital. When asked to compare the two experiences, she said, “Marie Stopes can be expensive and sometimes they have no supplies. [But] the treatment is good. . . . The government hospital has [supplies] but the staff verbally abuse clients and sometimes they beat you.”⁴⁷⁶ As for her ongoing contraceptive needs, Wambui cannot afford the transportation costs to MSI-Eastleigh and now buys her contraceptives from a chemist.⁴⁷⁷ It is worth noting that Wambui pays for her reproductive health care, including her contraceptives, from her own earnings and cannot rely on her husband’s contribution. She said simply: “Husbands do not tell you how much they earn.”⁴⁷⁸

Kisumu, the third largest city in Kenya, is the capital of Nyanza Province.⁴⁷⁹ In Kisumu, 63% of the rural population lives

473. Interview with Grace Otiemo, Facility Manager, Nurse, Marie Stopes Int’l, Nairobi Women’s Clinic in Eastleigh, in Nairobi, Kenya (May 26, 2004) [hereinafter former MSI-Kenya Otiemo Interview] (on file with Crowley Program).

474. FPAK Eastleigh Youth Center Volunteers, *supra* note 440.

475. Interview with Virginia Wambui, former client, Marie Stopes Mathare Valley, in Nairobi, Kenya (May 28, 2005).

476. *Id.*

477. *Id.*

478. *Id.*

479. See Nationmaster.com, Encyclopedia: Kisumu, <http://www.nationmaster.com/encyclopedia/kisumu> (last visited Sept. 24, 2005).

below the poverty line,⁴⁸⁰ as does 67% of the urban population.⁴⁸¹ The highest rate of HIV infection in Kenya is here, 18.3% for women and 11.6% for men.⁴⁸² The National AIDS Program and the Population Council estimated that, in 1999, 8.6% of nineteen-year-old boys were infected with HIV and 33.3% of nineteen-year-old girls.⁴⁸³ The prevalence of HIV is especially high among the fishing communities that live and work along the shores of Lake Victoria. Most of the fish, which are caught by women, are sold to middlemen. With little fish left for community consumption, many women are vulnerable to men's demands for "sex for fish."⁴⁸⁴ In short, conditions of poverty in the region leave women with very little control over their sexual activity. Given the prevalence of HIV, effective contraception is essential to women's health.

Before it closed in 2001, the MSI clinic in Kisumu served some 400 clients, including HIV/AIDS patients, per month. The clinic also supported a mobile team which provided services to women who could not travel to town on a regular basis.⁴⁸⁵

b. Cuts in Outreach and Education

One of the most distinctive and important features of MSI-Kenya's operation is its mobile clinic program in which medical personnel make scheduled visits to underserved areas to perform tubal ligations, vasectomies and Norplant insertions on a quarterly or bi-monthly basis.⁴⁸⁶ Unlike their FPAK counterparts, MSI-Kenya community health workers do not distribute contraceptives. Rather, their main objective is to encourage clients to make use of the mobile clinic network by sharing information about the importance of reproductive health and the ser-

480. See *Geographical Dimensions*, *supra* note 396, at 73.

481. *Id.* at 76.

482. See KDHS, *supra* note 216, at 223.

483. Johnathan Brown, Multi-Country HIV/AIDS Program (MAP), at 7 (July 1, 2003) (citing National AIDS Programme, Kenya, & Population Council, 1999), available at http://www.worldbank.org/afr/aids/workshops/fiduciary/MAP%20Presentation_jonathan_dcjune30.ppt#7.

484. International Family Health UK Website, Sex for Fish Project, Summary of Findings, <http://www.ifh.org.uk/sexforfish.html> (last visited Sept. 23, 2005).

485. See *Access Denied: Kenya*, *supra* note 4, at 4.

486. See MSI-Kenya Machakos-Kywalia Notes, *supra* note 460; see also Mutunga Interview, *supra* note 460.

vices that are offered.⁴⁸⁷ MSI-Kenya develops the mobile care schedule based on knowledge about when and where it is most convenient for women to access services. For example, the mobile team plans visits around market days, harvest and rainy seasons as well as around school holidays.⁴⁸⁸ For many women in rural areas, the mobile unit is their only source not just of reproductive health services but also of primary health care.

This Mobile Clinic program was severely affected by the USAID funding cuts. Currently, two medical teams service the entire network of outreach sites. Plans to add a third team had to be abandoned after the loss of USAID funding.⁴⁸⁹ Even without the additional unit, rising fuel and transportation costs threaten the economic viability of the program. With an annual cost of servicing an outreach site of approximately US\$4500,⁴⁹⁰ MSI has been forced to scale back the program.⁴⁹¹ Mr. Awitti, Country Director of MSI-Kenya, told the Crowley delegation that only 94 of the 161, or 58%, of outreach sites in operation before 2001 are currently offering services.⁴⁹² Moreover, even at previous levels, the services provided were inadequate to meet demand. Women seeking tubal ligations sometimes become pregnant between the bi-monthly or quarterly mobile clinic visits.⁴⁹³

c. Affordability and Quality of Care

MSI-Kenya's strategy of self-financing through cross-subsidization has helped to insulate the operation from changing donor policies. Yet, notwithstanding the organization's commitment to ensure that the fee structure is affordable to the majority of potential clients, higher fees have meant that the services are unavailable to the poorest women.⁴⁹⁴ According to one father whose first child was born at MSI-Eastleigh in 1999, he was

487. See Awitti Interview, *supra* note 464; see also MSI-Kenya Machakos-Kywalia Notes, *supra* note 460; Mutunga Interview, *supra* note 460.

488. See MSI-Kenya Machakos-Kywalia Notes, *supra* note 460; see also Mutunga Interview, *supra* note 460.

489. See Awitti Interview, *supra* note 464; see also MSI-Kenya Machakos-Kywalia Notes, *supra* note 460; Mutunga Interview, *supra* note 460.

490. See Awitti Interview, *supra* note 464.

491. See *id.*

492. See *id.*

493. See MSI-Kenya Machakos-Kywalia Notes, *supra* note 460; see also Mutunga Interview, *supra* note 460.

494. See generally FPAK Website, *supra* note 368.

pleased with both the pre-natal and post-natal services his wife received there. Yet, he added, “The very poor cannot afford Marie Stopes. The prices at Marie Stopes seem to have gone up since we had the baby there.”⁴⁹⁵

The difference between the pricing strategies of FPAK and Marie Stopes, with the latter more effectively self-financed than the former, illustrates the stark choice facing the organizations following the loss of USAID funds. FPAK’s more affordable pricing left a much higher percentage of its facilities vulnerable, forcing it to close three of its thirteen family planning clinics. In contrast, after laying off staff, cutting salaries, outreach, and services, and reorganizing its clinic structure, MSI limited the number of clinic closings to two out of twenty-one in operation in 2001. The remaining clinics, however, are less affordable and offer a more limited range of services.

MSI officials acknowledge that although most clinics remain open, the loss of funding has in some cases compromised the quality of care MSI is able to provide. Mr. Richard Olewe, Regional Director of MSI-Western Kenya, who accompanied the delegation in Kisumu, told the Crowley delegation:

Of late, sometimes we have no space to admit patients. . . . It makes things precarious for clients so sometimes they stop coming. Previously this center had lagged behind in numbers of clients, but today we only have one bed open. Yesterday we turned two clients away and last night we turned others away. They go away as dissatisfied clients.⁴⁹⁶

Olewe showed the delegation a room used by clients under observation, and explained:

The occupancy rate here is almost full—the rate is usually fifty-to-eighty percent. Here is a ward meant to accommodate post-delivery patients, but we are not able to have any facilities so that babies are accommodated. It is essential to continue to monitor babies, but now it is not possible. Ideally, we would not mix the mothers and the babies together, but we have to because space is limited. We really need a pediatric unit but we don’t have the funding. We only have one resident doctor here, but ideally we should have two. We can’t

495. Interview with Karoki Elicide, Taxi Driver and Client of Marie Stopes Kenya, in Nairobi, Kenya (May 17, 2004).

496. See Olewe Interview, *supra* note 460.

because of the lack of funding.⁴⁹⁷

Olewe noted the pressure to reduce costs in order to maintain the viability of the remaining clinics and admitted, “[t]he reduction of costs sometimes sacrifices quality. People work extra time. We use cold water instead of hot.”⁴⁹⁸

Clients have noticed the quality of care in the remaining clinics has suffered due to internal staff cuts and reduced funds. When we interviewed her, Elizabeth Bunei had been a client of Marie Stopes Kisumu for five years. Ordinarily she obtained physical examinations and contraceptive injections at the clinic. On the day of the interview she was seeking care for her infant who was vomiting. Bunei told the delegation that she had walked “some distance” and then paid KSH20 to take a *matatu* (public transport vehicle) to the clinic.⁴⁹⁹ She reported:

Last year [2003], the management was not very good. . . . You would come here and wait and nobody was asking you why you were here. I came here last year with a miscarriage at 10 p.m. and waited for half an hour and there was nobody at the reception. Then, from January of this year things started getting better. But some of my friends gave up last year when things started getting bad, and they started going to the public hospital. . . . They don’t like the [public] hospitals, [and] there’s nobody there to guide you.⁵⁰⁰

3. The Impact of the Mexico City Policy on Overall Strategies to Improve Care

Although it is impossible to measure with precision the effect of the Mexico City Policy on the delivery of reproductive services nationwide, the dramatic impact on perhaps the two most important NGO providers is clear. As documented above, these NGOs provide vital services to women throughout Kenya and often serve as the sole source of health care for poor and rural women. The closure of the clinics has therefore had a severe impact upon the women in the communities they served. But the significance of FPAK and Marie Stopes goes beyond the populations directly served by their clinics. These NGOs provide

497. *Id.*

498. *Id.*

499. Interview with Elizabeth Bunei, client, Marie Stopes, Kisumu, in Kisumu, Kenya (May 19, 2004) [hereinafter Bunei Interview] (on file with Crowley Program).

500. *Id.*

integrated outreach and education designed to cultivate clients who might not be able to access important health services. In so doing, they have developed a highly effective model of reproductive health care delivery, one which foreign donors, including USAID, have promoted for the past two decades in Kenya. The loss of funding for FPAK and MSI undercuts the further development and replication of this model in underserved areas.

Perhaps ironically, USAID itself felt the impact of the Mexico City Policy through the loss of the expertise of FPAK and MSI in its own project. At the time the Mexico City Policy was reinstated by the Bush Administration, USAID had just initiated the "AMKENI" project, which means "new awakenings" in Kiswahili.⁵⁰¹ AMKENI was to be a five-year, 16 million dollar program integrating family planning, reproductive health and child survival services based in part on the model already followed by FPAK and Marie Stopes (and encouraged by USAID through grants to these programs). Both FPAK and Marie Stopes were to have been key participants in AMKENI. Yet, in the wake of the decision to reinstate the Mexico City Policy, FPAK and MSI could not be included, depriving the project of their expertise, their clinics, and their trained networks of community outreach volunteers. As a result, the effectiveness of the overall project has been compromised.

The AMKENI experience is just one example of the inefficiencies in the provision of health care caused by the Mexico City Policy. Another problem results from the artificial separation of family planning funds from a larger health policy agenda. Although from a medical perspective the advantages of combining information about HIV/AIDS prevention and treatment with family planning seems obvious, the fact of separate funding streams for family planning (restricted) and HIV/AIDS (unrestricted) programs forces organizations to maintain distinct programs and information campaigns. Margaret W. Gatei, Project Manager of Pathfinder PMCT Program expressed frustration with having to maintain this division. She said:

It is critical to tell women that even if they are on the pill they must still use condoms to avoid the transmission of HIV. . . . You cannot separate family planning from HIV. You must encourage women to take the test before having more children.

501. *See Access Denied: Kenya*, *supra* note 4, at 5.

Counseling will be a big part of this service. Once the decision is made they will choose a method of family planning and that method must be maintained. . . . We give information and counseling and emphasize the importance of knowing one's HIV status.⁵⁰²

Although the overall impact of the Mexico City Policy may defy precise quantification, these examples confirm its direct impact on some of Kenya's most vulnerable people. More broadly, the policy has created significant inefficiencies in the delivery of care in a country that has not a single health care dollar to waste.

C. *The Right to Health: An Assessment of Kenya's Legal Obligations*

1. The Right to Health and the Government of Kenya

Since Kenya gained independence from British colonial rule in 1963,⁵⁰³ the government has been working to expand and improve the Kenyan health care system through a combination of public and private efforts. As described in preceding sections, the process has entailed a number of different strategies for health care delivery, a variety of institutional actors, both domestic and international, and many sources of funding. As a result, the Kenyan government has never exercised anything approaching complete control over its national health care strategy. Nevertheless, international human rights law on the right to health, while recognizing the complexities of the provision of public health care, places responsibility squarely on States for respecting, protecting, and fulfilling their legally binding obligations regarding the right to health.⁵⁰⁴ Thus, an assessment of the human rights implications of the Mexico City Policy must begin with an examination of Kenya's obligations with respect to reproductive health.

As the first part of this Report has already elaborated, Article 12(1) of the ICESCR generally proclaims the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁵⁰⁵ Article 12(2) specifies that among the

502. See Interview with Margaret W. Gatei, Project Manager of Pathfinder PMCT Program, in Nairobi, Kenya (May 19, 2004).

503. See Nationmaster.com, Africa: Kenya: Background, <http://www.nationmaster.com/country/ke/Background> (last visited Sept. 23, 2005).

504. See *supra* Part I.

505. ICESCR, *supra* note 21, art. 12(1).

steps necessary to achieve the full realization of this right are “[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness.”⁵⁰⁶ With respect to reproductive rights, the provision also requires “provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child.”⁵⁰⁷ Also relevant is the further stipulation that governments provide for “[t]he prevention, treatment and control of epidemic, endemic, occupational, and other diseases.”⁵⁰⁸ CEDAW, in its own Article 12, takes up both discrimination and reproductive rights by requiring State Parties to “take all appropriate measures to eliminate discrimination in the field of health care to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.”⁵⁰⁹ The second part of this Article sets out further reproductive rights, including “appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”⁵¹⁰

Under the ICESCR, Kenya must “undertake to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the [right to health] by all appropriate means.”⁵¹¹ Although the framework of progressive realization allows countries — particularly poor countries such as Kenya — a degree of latitude in allocating resources to meet their obligations under the treaty, this discretion is not unlimited. Moreover, the ICESCR imposes certain obligations that are immediately enforceable. In evaluating the degree to which Kenya may be in violation of its obligations under the ICESCR, this section focuses on these immediately enforceable components together with the issue of retrogression.

2. Obligation to Respect

A State’s obligation to respect the right to health can be restated as an individual’s right to be free from State interfer-

506. *Id.* art. 12(2)(d).

507. *Id.* art. 12(2)(a).

508. *Id.* art. 12(2)(c).

509. CEDAW, *supra* note 30, art. 12(1).

510. *Id.* art. 12(2).

511. ICESCR, *supra* note 21, art. 2(1).

ence in the exercise of the right to health. A State must refrain from acting in a way that contravenes access to health services that its citizens would otherwise enjoy. Thus, General Comment Fourteen prohibits interference with “the right to control one’s health and body, *including sexual and reproductive freedom . . . and the right to be free from . . . non-consensual medical treatment.*”⁵¹² It also requires States to “*refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health.*”⁵¹³ Importantly, this obligation of noninterference is immediately enforceable.⁵¹⁴

Applying this standard to Kenya’s record on reproductive health care suggests that Kenya may be in violation of its obligation to respect the right. First, although Kenya has made efforts to expand access to reproductive health and, in particular, to increase the use of contraception, its budgeting priorities have left reproductive health care entirely donor-funded. As a result, the provision of reproductive health services is highly vulnerable not only to the domestic politics of abortion in the United States but to other changes in donor priorities. This violation can be understood either as an interference in the right to health by the government or, alternatively, as a failure on the part of the government to protect the right from interference by third parties.⁵¹⁵

Second, Kenya has a very restrictive abortion law that permits abortions to be performed legally only under narrow circumstances.⁵¹⁶ Although international law leaves the legal status of abortion up to individual States, General Comment Fourteen defines as a violation of the obligation to respect the right to health “those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable

512. General Comment Fourteen, *supra* note 34, ¶ 8 (emphasis added).

513. *Id.* ¶ 34 (emphasis added). See Beijing Platform, *supra* note 35, ¶ 96.

514. See General Comment Fourteen, *supra* note 34, ¶ 30 (“various obligations . . . of immediate effect”); see also *id.* ¶ 34 (specific legal obligation of noninterference); *id.* ¶ 44 (obligation to “provide education and access to information concerning the main health problems in the community”).

515. See General Comment Fourteen, *supra* note 34, ¶ 33. The ICSECR has made clear that “the obligation to *protect* requires States to take measures that prevent third parties from interfering with [right to health] guarantees.” *Id.*

516. See *supra* note 512 and accompanying text (discussing Kenyan abortion law).

mortality.”⁵¹⁷ The impact of illegal abortions on women’s health in Kenya has been widely documented, including by the Kenyan government.⁵¹⁸ The current abortion policy in Kenya makes safe abortions difficult for women to obtain even in the circumstances under which they are permitted under Kenyan law. Moreover, fear of legal penalties or harassment may prevent women who have obtained illegal abortions from seeking post-abortion care in the event of complications, or prevent doctors who have performed such abortions from referring women for needed care. In sum, although Kenya is under no international obligation to legalize abortion on demand, it does have an obligation to adopt an abortion policy that does not contribute unnecessarily to the suffering, sterility, and death of women.

3. Nondiscrimination Obligation

General Comment Three makes clear that the obligation to “guarantee [that rights] will be exercised without discrimination” is immediately enforceable.⁵¹⁹ This prohibition on discrimination stems from ICESCR article 2(2), which provides that “rights . . . will be exercised without discrimination of any kind.”⁵²⁰ In this connection, the closing of the clinics and the resulting loss of services has had a discriminatory impact on two, and perhaps three, vulnerable groups. As documented above, the closure of two MSI clinics and three FPAK clinics because of their refusal to sign the Mexico City Policy has left reproductive health clients in Embu, Kisii, Kisumu and two neighborhoods of Nairobi (Eastleigh and Mathare Valley) with diminished or no access to affordable and quality health care. All of the closed clinics served poor communities, and, in the cases of the Eastleigh and Mathare Valley clinics, refugees comprised a significant part of the patient population.

To be clear, this Report does not suggest that the closing of these clinics was motivated by discriminatory animus towards the poor or refugee populations. Nevertheless, the government of Kenya has an obligation to ensure that a reduction in available health services does not have a disparate impact on these vulner-

517. General Comment Fourteen, *supra* note 34, ¶ 50.

518. *See, e.g., National Assessment*, *supra* note 247.

519. *See* General Comment Three, *supra* note 33, ¶ 1.

520. ICESCR, *supra* note 21, art. 2(2).

able groups.⁵²¹ Such a discriminatory impact may constitute a violation of the right to health whether or not the reduction in health services represents a retrogression in the State's obligation to protect the right to health, an issue discussed below. Insofar as the government of Kenya has created a scheme for providing reproductive health care that is virtually entirely dependent on the largesse of outside donors, it has helped to create and reinforce the vulnerability of these groups to the changing budgetary priorities and political agendas of donor entities.

The reduction in access to reproductive health services, particularly access to contraception, also has had a discriminatory impact on women. Although both men and women require and benefit from reproductive health services, the loss of such services affects women more severely than men. This is true for several reasons. Even when women enjoy control over their health care decisions and share decision-making about reproduction with their partners, the inability effectively to control reproduction affects women's health more profoundly because women bear the physical burden of pregnancy and nursing. Yet, as noted above, many Kenyan women, particularly poor women, lack such control either over health care or sexual decisions.⁵²² In such cases, the only way a woman can protect herself from unwanted pregnancy or sexually-transmitted disease is through access to contraception. Put differently, women are less able than men to control the degree to which they engage in high-risk sexual activity even when they are in long-term relationships.⁵²³ They may be unaware of their partner's sexual liaisons and, even if they are aware, they lack the right to decline sexual intercourse with their spouses.⁵²⁴

521. See General Comment Three, *supra* note 33, ¶ 1.

522. See *supra* notes 274-288 and accompanying text (discussing women's lack of control over health care decisions); see also *Gender and Development Policy*, *supra* note 191, at 24.

523. See Gender & HIV/AIDS Technical Sub-Comm., Nat'l AIDS Control Council, *Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan, 2000-2005*, at 2-3 (2002).

524. Although the Kenyan rape statute does not include a marital exemption, refusal of intercourse is grounds for divorce. See The Penal Code, Laws of Kenya, ch. 139 (rape statute); see also EUGENE COTRAN, *CASEBOOK ON KENYA CUSTOMARY LAW* 121 (describing grounds for divorce under Kenyan law).

4. Obligation to Fulfill Right to Health

a. Minimum Core Content

As discussed above, the CESCR has determined that certain affirmative obligations in connection with the right to health have ripened into “minimum core content,” and are therefore immediately enforceable.⁵²⁵ In addition to the nondiscrimination obligation, these include the obligation “to provide essential drugs. . . ; to ensure equitable distribution of all health facilities, goods and services; to adopt and implement a national public health strategy and plan of action . . . [which] shall give particular attention to all vulnerable or marginalized groups.”⁵²⁶ In addition, General Comment Fourteen outlines several rights of “comparable priority.”⁵²⁷ The first obliges States to “ensure reproductive, maternal (pre-natal as well as post-natal) and child healthcare.”⁵²⁸ The second and third require States to “provide immunizations against major infectious diseases occurring in the community,” and further obligates them to “take measures to prevent, treat and control epidemic and endemic diseases.”⁵²⁹ Taken together, these rights require a country to make available measures for prevention and treatment for any diseases that affect reproductive rights. The fourth obligation of comparable priority requires States to “provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.”⁵³⁰

When they were in operation, the five clinics described in this Report were responsive to the rights included as “minimum core content” and rights of “comparable priority.”⁵³¹ They provided basic medications and screening as well as an array of child birth and reproductive health services. In addition, through youth centers and community outreach volunteers, they served as an important source of basic and reproductive health information to poor communities. With the closing of these clinics, the fulfillment of Kenya’s core and comparable obligations has

525. See ICESCR, *supra* note 21, ¶ 14.

526. General Comment Fourteen, *supra* note 34, ¶ 43.

527. *Id.* ¶ 44.

528. *Id.*

529. *Id.*

530. *Id.*

531. U.N. ECOSOC, 9th Sess., 42nd mtg. 14, U.N. Doc. E/C.12/1993/SR.42 (Dec. 6, 1993).

been compromised. Again, although the Kenyan government is not responsible for the reinstatement of the Mexico City Policy, it is nevertheless responsible for fulfilling the right to health, notwithstanding the U.S. policy. Moreover, insofar as Kenya's scheme of health care financing relies heavily on private health care providers and NGOs, particularly in the area of reproductive health care, the Kenyan government helped to create the conditions under which the provision of such services could easily be compromised by changes in donor priorities or donor country politics.

With respect to the realization of core or comparable obligations on a national scale, Kenya has adopted various national health plans, including the Kenya Health Policy Framework. Yet, the effectiveness of such plans is unclear. As explained above, the Kenyan government has failed to make budget allocations that reflect a commitment to better serving the rural and urban poor, to preventative as opposed to curative services and to improving the distribution of reproductive health commodities. Over the years, Kenya has been collecting valuable benchmark data through the Kenya Demographics and Health Surveys and recently has begun monitoring progress toward meeting the Millennium Development Goals. Yet, by the government's own admission, its capacity to incorporate statistical analysis into policy planning and resource allocation mechanisms is mixed in key areas.⁵³² This capacity is rated as "weak" with regard to monitoring gender equity;⁵³³ "fair" on reducing child mortality;⁵³⁴ "fair" on maternal mortality;⁵³⁵ and "fair" with regard to tracking HIV/AIDS, malaria and other diseases.⁵³⁶ As described above, Kenya has failed to provide health care facilities, goods, and services on a scale that keeps up with the population growth rate. Finally, Kenya has failed to make significant progress in reducing maternal and child mortality.

532. See generally 2003 MDG, *supra* note 236. Capacity is rated "strong" if new information is systemically fed into policy making, planning and resource allocation; "weak" if this does not happen; and "fair" if this happens irregularly. *Id.* at 7.

533. *Id.* at 17.

534. *Id.* at 20

535. *Id.* at 23

536. *Id.* at 26.

b. Nonretrogression

The principle of nonretrogression simply means that a State may not backslide with respect to the realization of rights protected under the ICESCR.⁵³⁷ Particularly problematic are measures that are either deliberately retrogressive and/or bear on the minimum core obligations. With respect to the right to reproductive health, the Kenyan government cannot fairly be charged with deliberate retrogression, though its funding priorities have resulted in the vulnerability of reproductive health service providers as described above. Nevertheless, with the clinic closings, the availability of reproductive health services to several poor communities has either declined or been eliminated altogether. This constitutes retrogression—whether deliberate or not—in an area of core or comparable obligation and therefore a violation of the ICESCR.

5. Freedom of Expression

As described above, the Mexico City Policy penalizes NGOs outside the United States based on the point of view they express about abortion. Even putting aside the issue of whether limiting the use of USAID funds to projects unrelated to abortion advocacy would violate the NGOs' freedom of expression, the Mexico City Policy goes further: It restricts the uses to which an NGO may put non-USAID funds as well. To be clear, an FNGO receiving funding from USAID may not expend funds *from any source* to advocate for the legalization of abortion. Whether the United States can be held accountable for this regulation of speech is addressed in the next section.

With respect to Kenya's responsibility, the critical question is whether this burden on the expressive rights of individuals and organizations within its jurisdiction violates Kenya's affirmative obligation to ensure the enjoyment of the right, protecting it from interference by third parties. There are several reasons to answer this question in the affirmative. First, although the Kenyan government is not responsible for imposing the Mexico City Policy, it does exercise control over the structure of its health care delivery system and the funding of private providers. In the context of reproductive health, and especially family plan-

537. See ICESCR, *supra* note 21, art. 5(1).

ning, Kenya relies heavily on private providers for the delivery of services and on outside donors for funding. The government's policy and funding choices have thus rendered NGOs more vulnerable to the changing priorities of donors. Put differently, Marie Stopes' and FPAK's decision to decline USAID funding rather than agree to the Mexico City Policy had more severe financial consequences because of Kenya's decision to rely almost exclusively on outside funding to support reproductive health. Second, USAID funding directed to the government of Kenya itself is not subject to the full restrictions of the Mexico City Policy — such funds cannot themselves be used to support abortion but the government may allocate other funds for such purposes. In short, this means that the government of Kenya could allocate non-USAID funds to Marie Stopes and FPAK to make up for their lost funding without jeopardizing any agreement it might have directly with USAID. Third, the Mexico City Policy has been in place periodically since 1984. Its impact on freedom of expression is ongoing and could be anticipated and addressed through the budgeting process. For these reasons, we conclude that Kenya has not fully met its obligation to ensure the freedom of expression of NGOs subject to the Mexico City Policy.

III. DONOR NATION RESPONSIBILITY UNDER INTERNATIONAL LAW

Holding Kenya responsible for the effects of a policy instituted by the United States may appear beside the point in any setting other than international law. As this Report notes, Kenya has assumed binding obligations to realize the right to health, the elimination of discrimination based upon gender, and freedom of expression.⁵³⁸ As this Report further documents, the impact of the Mexico City restrictions within the country suggest that, in the first instance, the Kenyan government has failed to make good on these legal obligations.⁵³⁹ This legal conclusion, however, begs the practical reality. But for the Mexico City Policy, the reductions in health and reproductive care, disproportionate impact on women, and attempted censorship of reproductive medical information described here would not have occurred. This is not to say the Kenyan government was powerless

538. *See supra* Part I.

539. *See supra* Part II.

to anticipate and mitigate these effects. Yet at the end of the day, the effective causes for the challenges under review comprise the funding restrictions, USAID, and the United States. This part of the Report examines whether and to what extent the current international human rights regime captures this reality.

These questions go well beyond the current case study and implicate underappreciated limits of international law. As an initial matter, potential U.S. responsibility for facilitating human rights violations in Kenya logically runs to any State in which the Mexico City Policy has resulted in similar effects.⁵⁴⁰ Nor would possible third-State responsibility end with the United States were any other donor nation to institute comparable aid restrictions with comparable results. Most importantly, nothing limits the problem of donor State responsibility to the Mexico City Policy as opposed to restrictive aid in general. Consider, for example, a so-far hypothetical case in which a developing State over decades has become dependent on a donor nation for the bulk of both its military and social services. Then suppose the donor nation informs the dependent State that it will withdraw all aid to the government or domestic NGOs unless the developing country agrees to violate its obligations under treaties and *jus cogens* and subject persons suspected of terrorism to interrogation practices amounting to torture.⁵⁴¹ Can and should wealthy and powerful States be held accountable for the human rights violations effectively forced upon weak and developing nations in such a situation?

Within the context of the Kenyan example, this Report sets out three lines of legal argument that point toward third-State responsibility. The first looks to the specific treaties and related law that set out the relevant human rights obligations in the first place. In particular, the ICESCR general provisions require respect and promotion of the rights it establishes, including respect and promotion through international cooperation. These

540. See generally, *Access Denied: Kenya*, *supra* note 4.

541. In less stark form, something like this dynamic was at work when the United States announced that it would withhold military aid for allies signing the Statute of Rome establishing the International Criminal Court unless they took out a reservation agreeing not to extend ICC jurisdiction to U.S. personnel. See Elizabeth Becker, *U.S. Suspends Aid to 35 Countries Over New International Court*, N.Y. TIMES, July 2, 2003, at A12. Of course in this instance, the United States was deploying restrictions on aid to prevent other States from assuming new international obligations rather than to pressure them into violating obligations already assumed.

provisions directly bind the United States as a signatory to the extent it must refrain from frustrating the object and purpose of the Covenant. The second line builds upon recently articulated concepts of State responsibility under the Draft Articles on Responsibility of States for Internationally Wrongful Acts and their related Commentaries.⁵⁴² Among other things, these sources map out ways in which a State is responsible with another State in the commission of an internationally wrongful act through either aid and assistance, or actual coercion.⁵⁴³ The final approach centers upon the international obligation to cooperate in the promotion of human rights and development as set out in the general provisions of major treaties as well as in the U.N. Declaration on Friendly Relations.⁵⁴⁴

None of these approaches, however, compels the conclusion that the United States bears any responsibility for the human rights violations resulting from the Mexico City Policy. To the contrary, each line of argument reflects the ongoing strength of classical notions of State sovereignty despite the facts of increasing State interdependence and persistent inequality of power and wealth. These resulting limits obtain, moreover, even though the question of formal enforcement is not at issue and all that is at stake is the implementation through shaming. Identifying the limits of fixing legal responsibility on the United States therefore marks a critical and often overlooked border of current international law. Nonetheless, only by marking off the current territory of human rights can it be expanded.

A. *Direct U.S. Treaty Obligations*

The most immediate way to fix U.S. responsibility for the impact of the Mexico City Policy is also the most evasive. The United States in theory could have signed and ratified an international instrument expressly assuming responsibility for violations of standards it had undertaken even when committed outside its own borders. State responsibility in these circum-

542. Report of the International Law Commission, U.N. GAOR, 56th Sess., Supp. No. 10, UN Doc. A/56/10 (2001) [hereinafter ILC 2001 Report — Draft Articles].

543. *See id.* arts. 16-19.

544. *See* Declaration on Principles of International Law Concerning Friendly Relations and Co-operation Among States in Accordance with the Charter of the United Nations, G.A. Res. 2625, U.N. GAOR, 25th Sess., Supp. No. 18, at 124-25, U.N. Doc. A/8082 (Oct. 24, 1970).

stances would be the direct result of a solemn treaty obligation. In practice, however, few treaties prescribe extraterritorial obligation in this manner, even with regard to fundamental human rights.

The Vienna Convention on the Law of Treaties sets forth the established rule that “a treaty is binding on each party in respect of its total territory” unless “a different intention appears . . . or is otherwise established.”⁵⁴⁵ The rule’s apparent concern against reading treaties as having less than full territorial effect stems not from an implicit acceptance of an extraterritorial presumption but instead from the reality that States typically seek to reduce rather than extend the international obligations they undertake. The presumption of full territorial scope, in other words, means interpreting treaties as extending to no less, but to no more, than the extent of a country’s borders.⁵⁴⁶

However revolutionary in other ways, human rights instruments fall under this rule. Some human rights treaties do rebut the general presumption, but only to the extent that they refer to a State party’s territory and “jurisdiction,”⁵⁴⁷ which is generally defined as the authority of a State to prescribe, adjudicate, and enforce its domestic law.⁵⁴⁸ Rarely, if ever, do human rights agreements go further. Some, to the contrary, expressly set forth the standard territorial and jurisdictional limits. Others leave these constraints implicit by simply failing to provide for extraterritorial operation. Even human rights theory, which might clear the way for further evolution of legal principles, generally declines to conceive of fundamental obligations as crossing borders, whether these standards be civil and political rights, or social and economic.⁵⁴⁹

The three main human rights treaties that bear upon the Mexico City Policy confirm the traditional practice. To some extent the United States has agreed to abide by the ICESCR, the ICCPR, and CEDAW. None of these instruments, however, rebuts the general presumption against extraterritoriality.⁵⁵⁰

545. Vienna Convention, *supra* note 38, art. 29.

546. *Cf.* RESTATEMENT (THIRD), *supra* note 39, § 322(2) & reporter’s Note 3.

547. *Id.* § 322, reporters’ Note 3.

548. *See id.* § 401.

549. *See* Martin S. Flaherty, *Rights, Reality, and Utopia*, 72 *FORDHAM L. REV.* 1789 (2004).

550. *See generally* EXTRATERRITORIAL APPLICATION OF HUMAN RIGHTS TREATIES (FONS

1. International Covenant on Economic, Social and Cultural Rights

President Clinton signed the ICESCR in 1992, but the Senate has yet to give its consent, and so U.S. ratification remains pending. By signing the Covenant the United States has nonetheless assumed a basic legal obligation not to undermine it. Article 18 of the Vienna Convention on the Law of Treaties codifies the established international law rule that when a State has signed a treaty, it “is obliged to refrain from acts which would defeat the object and purpose” of the instrument.⁵⁵¹

To this extent, the key question becomes whether U.S. obligations under the ICESCR apply only within its borders and jurisdiction, or whether they extend to the nation’s relevant actions abroad. Without more, the text of the Covenant might appear to leave open the possibility that State Parties undertake to fulfill the rights set forth both domestically and extraterritorially. Article 2, which sets out the general obligations that a State assumes, notes that each Party undertakes to take steps, to the maximum of its available resources and with a view to achieving progressively the full realization of the recognized rights, but with no language limiting this undertaking to realizing the rights within its territory alone.⁵⁵² Indeed, the provision states that a State Party shall take steps both “individually and through international cooperation.”⁵⁵³ None of the specific provisions of the Covenant, moreover, expressly limits operation of the obligations set forth to a State Party’s territory.⁵⁵⁴

Coomans & Menno T. Kammiga, eds., 2004) (discussing broad and narrow views of applying human rights treaties in an extraterritorial fashion).

551. Vienna Convention, *supra* note 38, art. 18. It was to avoid this obligation that President George W. Bush “unsigned” the Statute of the International Criminal Court, which President Clinton had signed in the waning days of his Administration. See Christopher Marquis, *U.S. is Seeking Pledges to Shield its Peacekeepers from Tribunal*, N.Y. TIMES, Aug. 7, 2002, at A1.

552. See ICESCR, *supra* note 21, art. 2(1).

553. *Id.* Similarly, Article 11(1) refers to the “essential importance of international co-operation based on free consent” in each State Party’s obligation to take steps to realize an adequate standard of living, while Article 11(2) provides that each State Party agrees to take steps “individually and through international co-operation” to fulfill the right to be free from hunger. *Id.* arts. 11(1) and 11(2).

554. ICESCR, *supra* note 21, *passim*. Conversely, Article 2 does signal a preference for State Parties adopting legislative measures to fulfill the relevant rights. *Id.* art. 2(1). Elsewhere the provision accords developing countries some latitude in distinguishing between nationals and non-nationals in the full provision of the rights. *Id.* art. 2(3). Yet

Despite the text's potential breadth, the prevailing view has always been that the Covenant's rights obligations do not run beyond a State Party's territory and jurisdiction. First, no wording in the treaty expressly commits a State Party to act otherwise or otherwise rebuts the usual presumption that treaties do not apply extraterritorially. Second, the context and *travaux* confirm that extraterritorial application was not contemplated, especially given that the idea of international law regulating a State's behavior toward those within its jurisdiction was a radical enough departure for its time.⁵⁵⁵ Third, subsequent commentary with few exceptions has not addressed the question of general extraterritorial application, concentrating instead on the problems of resource constraints and progressive realization.⁵⁵⁶

At most, some commentators have suggested that the ICECSR imposes an obligation on wealthy States, not to take steps to realize such rights as health or education in equal measure at home and abroad, but at least to provide assistance to developing nations to realize such rights for their citizens when they cannot otherwise do so due to lack of resources. Even this more limited proposition has proved to be "difficult, if not impossible, to sustain."⁵⁵⁷ On one hand, references to international cooperation in Articles 2 and 11 better support some duty to aid than they do for extraterritorial application in general.⁵⁵⁸ On the other hand, however, the *travaux* and general subsequent understandings show only marginal support for deriving a legal obligation for aid. Such a position is distant even among theorists. This is not to say that under certain circumstances an obligation to provide assistance might not be plausibly asserted. It remains, however, a long way off before the plausible becomes the generally accepted.⁵⁵⁹

For these reasons, the ICESCR does not yield substantial

even these provisions could be read in an extraterritorial fashion. In the first instance, there is no reason why domestic legislation that promotes the specified rights could not do so abroad as at home, as in a foreign aid appropriation. In the second instance, the developing country provision may be read as an exception to both the principle of non-discrimination based on nationality and a principle of extraterritorial application.

555. See generally LOUIS HENKIN, *THE AGE OF RIGHTS* (1990).

556. See *supra* Part I.

557. Philip Alston & Gerard Quinn, *The Nature and Scope of State Parties' Obligations Under the ICESCR*, 9 HUMAN RIGHTS Q. 156, 186 (1986).

558. See *supra* note 553 (discussing Article 11).

559. *Id.*

promise in constructing an argument that the United States has violated its obligations under the Covenant. In practical terms, the Mexico City Policy may well not simply fail to promote, but significantly undermine, the full realization of health and reproductive rights among Kenyans. Yet absent a substantial shift in prevailing interpretations, the direct responsibility of the United States under the ICESCR runs to those within the country, not generally to each and every State Party. More plausibly, if Article 2's injunction to international assistance and cooperation is to have any binding meaning, then the case of a vastly wealthy nation such as the United States adopting aid restrictions that lead to retrogression in specified rights in a developing country such as Kenya would be a strong candidate for finding the violation of such a duty. Increased attention to this and other such cases, it is hoped, will prompt interpretation of the Covenant further in this direction.

2. International Covenant on Civil and Political Rights

In contrast with the application of the ICESCR, the United States has assumed the obligations of the ICCPR more fully. However, the Covenant itself sharply limits its extraterritorial reach. President Carter signed the ICCPR in 1978, though the Senate did not submit its approval until 1992. Accordingly, the United States has fully ratified the ICCPR and is bound by its provisions in international law.⁵⁶⁰

The Senate nonetheless insisted upon several reservations, understandings, and declarations, as is typical of the American approach to ratification of most international human rights treaties.⁵⁶¹ Two such conditions bear upon possible application of the ICCPR to the Mexico City Policy in Kenya. The first is a reservation concerning freedom of expression. This condition states that nothing in Article 20 shall authorize restrictions of freedom of speech under the Constitution of the United States.⁵⁶² Aimed to foreclose overbroad regulation of propa-

560. See generally ICCPR, *supra* note 22 (ratified by the United States on Sept. 8, 1992).

561. See Peter J. Spiro, *The States and International Human Rights*, 66 *FORDHAM L. REV.* 567, 574-75 (1997).

562. U.S. Reservations, Understandings, and Declarations to the International Covenant on Civil and Political Rights, no. I(1), 138 *CONG. REC.* 8068 (1992) [hereinafter ICCPR Reservations].

ganda and other hate speech, the reservation would not limit the ICCPR's general Article 19 free speech protections in this instance: first, because they expand the right rather than constrict it, and second, since the Mexico City Policy does not implicate propaganda or hate speech in any event.

The second relevant U.S. condition is an understanding concerning discrimination, including gender classifications. Here, the United States indicated that it would read the ICCPR's Article 2 anti-discrimination provisions as requiring no more than that a classification based upon gender, race, religion, or like factors be deemed lawful if it is rationally related to a legitimate governmental end.⁵⁶³ Further, the understanding states that under Article 4(1), discrimination cannot be inferred merely on the basis of disproportionate impact "in time of public emergency."⁵⁶⁴ As a threshold matter, these understandings would operate as reservations under the ICCPR in the face of contrary, authoritative interpretations. In this instance, they would nonetheless not preclude application of the ICCPR's prohibition against gender discrimination. First, it would be hard to envision how the Mexico City Policy's effective discrimination against women would survive even a U.S.-style rational relationship test. Beyond that, the rejection of disparate impact analysis in the extreme instance of public emergency by negative inference leaves open resort to such an approach in other contexts, such as aid restrictions on women during times of relative national calm.

Unfortunately, the real hurdle to application of the ICCPR comes from the language of the Covenant itself. Unlike its sibling, Article 2 of the ICCPR expressly states that each State Party "undertakes to respect and to ensure *to all individuals within its territory and subject to its jurisdiction* the rights recognized."⁵⁶⁵ As indicated, the Covenant's language extends its applicability beyond a State Party's territory to its jurisdiction in the sense of effective control.⁵⁶⁶ This extension notwithstanding, under no plausible reading can it be said that Kenya is or has ever been

563. Curiously, with regard to race and gender, this level of scrutiny falls below U.S. constitutional standards. See generally *Rust v. Sullivan*, 500 U.S. 173 (1991).

564. ICCPR Reservations, *supra* note 562, no. II(1).

565. ICCPR, *supra* note 22, art. 2 (emphasis added).

566. See *supra* note 170 and accompanying text. In the domestic setting, the U.S. Supreme Court recently concluded that effective and exclusive U.S. control of Guanta-

subject to U.S. jurisdiction in the sense meant in Article 2. That said, U.S. violations of ICCPR provisions, such as Article 19's protection of freedom of expression, may nonetheless furnish a basis for finding U.S. responsibility for the resulting effects within Kenya on a theory of derivative responsibility.

3. Convention on the Elimination of All Forms of Discrimination Against Women

CEDAW, finally, also fails to provide a promising basis for direct U.S. accountability for the consequences of the Mexico City Policy abroad. The reasons in part echo the problems with the other principal human rights treaties just considered.

As with the ICESCR, President Clinton signed CEDAW, but the Senate has yet to give its consent. To this extent, the United States has assumed the customary law obligation "to refrain from acts which would defeat the object and purpose" of the Covenant.⁵⁶⁷ This duty of course falls short of full assumption of CEDAW's provisions, even with reservations, as is the case with the ICCPR. Yet even the more attenuated duty not to defeat the object and purpose could prohibit policies that produce such radically disparate treatment as is the case with the Mexico City Policy.

Similar to the ICCPR's express text and the ICESCR's implicit understanding, the direct CEDAW approach ultimately fails because the standards it imposes upon a ratifying State do not run beyond its territory and jurisdiction. In this regard, CEDAW's text falls between that of the two Covenants. The Convention lacks the express limiting language contained in the ICCPR. It nonetheless makes clear that its obligations are essentially domestic, and in this sense, speaks more forcefully than the ICESCR. Article 2, for example, enjoins State Parties specifically to undertake to embody "the principle of equality of women in their national constitutions or other appropriate legislation,"⁵⁶⁸ to "adopt appropriate legislation,"⁵⁶⁹ to ensure effective protection of women against discrimination through "national tribu-

namo Bay, Cuba, expanded its jurisdiction beyond the territorial sovereignty of the United States. *See Rasul v. Bush*, 124 S.Ct. 2686, 2690-91 (2004).

567. Vienna Convention, *supra* note 38, art. 18.

568. CEDAW, *supra* note 30, art. 2(a).

569. *Id.* art. 2(b).

nals and other public institutions;”⁵⁷⁰ and to “repeal all national penal provisions”⁵⁷¹ that discriminate against women. Other articles likewise clearly contemplate domestic actions, such as eliminating discrimination through the banning of prostitution, the provision of equal voting rights, and the granting of non-discriminatory rules with regard to securing nationality. Conversely, no provision expressly sets forth extraterritorial obligations. For these reasons, one scans commentary on CEDAW in vain for interpretations that impose responsibility on State Parties for discrimination that occurs outside their territory and control.

Yet once again, the failure of the treaty itself to establish human rights obligations outside the State Party’s own jurisdiction is not necessarily the end of the story. Given that Kenya bears responsibility under CEDAW to promote gender equality and — more to the point for present purposes — prevent discrimination by any party, it would in the first instance face responsibility at least for any systemic discriminatory impact the Mexico City Policy yields on its watch. Nonetheless, the United States as author of the Policy may still have to shoulder indirect responsibility to the extent that international law imposes obligations on third-party States for facilitating human rights violations formally committed by others.

B. *U.S. Responsibility in Connection with the Acts of Kenya*

A second and more promising approach to holding the United States responsible for the effects of the Mexico City Policy centers upon concepts of State responsibility for acts of another State. The international community has set out these concepts most comprehensively in the Draft Articles on State Responsibility (“Draft Articles”), as well as their associated Commentaries, each adopted by the International Law Commission (“ILC”) in 2001.⁵⁷² Though neither a treaty nor otherwise directly binding law, the Articles represent a culmination of the ILC’s five-decade long effort to codify and develop international rules concerning the scope of State obligations generally applicable in international law.⁵⁷³ As such, they reflect a consensus of

570. *Id.* art. 2(c).

571. *Id.* art. 2(d).

572. See ILC 2001 Report—Draft Articles, *supra* note 542.

573. James Crawford has noted that the Draft Articles and Commentaries:

the world's leading jurists, are designed to provide the basis for a global, multilateral treaty,⁵⁷⁴ and furnish evidence of developing customary international law.⁵⁷⁵

Ordinarily a State is responsible only for human rights violations that it commits against persons within its jurisdiction or under its effective control.⁵⁷⁶ Article 2 of the Draft Articles sets forth the general analytic framework, stating that “[t]here is an internationally wrongful act of a State when conduct consisting of an action or omission: (a) [i]s attributable to the State under international law; and (b) [c]onstitutes a breach of an international obligation of the State.”⁵⁷⁷ In the conventional situation, a State does not bear responsibility for the human rights violations of another State on the ground of both legal attribution and international obligation. First, international law does not ordinarily attribute the actions of one State to an outside State out of a presumption that the primary State exercises sovereign power within its territory or jurisdiction. Second, treaties — including human rights treaties — generally obligate the primary State to undertakings only within its territory or control. The ICCPR, for example, expressly limits State Party obligations to individuals “within its territory and subject to its jurisdiction.”⁵⁷⁸

[A]re the product of nearly forty years of work by the I.L.C., guided by a series of Special Rapporteurs. . . . They are a contribution to the codification and progressive development of a fundamental chapter of international law. In this respect, potentially at least, they rank alongside the Draft Articles of the Vienna Law of Treaties of 1966, which became, with limited changes, the Vienna Convention on the Law of Treaties.

JAMES CRAWFORD, *THE INTERNATIONAL LAW COMMISSION'S ARTICLES ON STATE RESPONSIBILITY: INTRODUCTION, TEXT, AND COMMENTARIES* ix (2002) [hereinafter *TEXT AND COMMENTARIES*].

574. *Id.*

575. Cf. Martin Flaherty, *Human Rights Violations Against Defense Lawyers: The Case of Northern Ireland*, 7 *HARVARD HUM. RTS. L. J.* 87, 91-92 (1994) (discussing how the U.N. Declaration on the Role of Lawyers and similar declarations furnish evidence of customary international law).

576. As an initial matter, the Articles make clear that the actions of USAID are directly attributable to the United States on the ground that:

[T]he conduct of any State organ shall be considered an act of that State under international law, whether the organ exercises legislative, executive, judicial or any functions, whatever position it holds in the organization of the State, and whatever its character as an organ of the central government or territorial unit of the State.

ILC 2001 Report — Draft Articles, *supra* note 543, art. 4(1).

577. *Id.* art. 2.

578. ICCPR, *supra* note 22, art. 2(1); *see also* Convention for the Protection of

By contrast, express or even implicit obligations concerning the rights of persons outside a country's authority — such as those analyzed in the previous part — are the exception rather than the rule.

The Articles nonetheless recognize that in certain situations the actual inequality among States belies the presumption of sovereign equality that normally insulates one country from the effects of its policies within another. Chapter IV of the Articles specifies three situations in which one State may be responsible for the act of another State in the commission of an internationally wrongful act: (1) when the outside State provides aid and assistance for the primary State's breach; (2) when it directs or controls commission of the primary State's wrongful act; or (3) when it coerces the primary State's violation.⁵⁷⁹ In each of these contexts, the Articles extend what counts as an act or omission attributable to the external State beyond its immediate actions. As further explained in the Commentaries, each instance describes a case of "derived responsibility."⁵⁸⁰ With regard to coercion, the Articles also expand the scope of the external State's obligations to include those undertaken by the primary State.⁵⁸¹ For the purposes of the Mexico City Policy, the two most promising approaches involve firstly, aid and assistance, and secondly, coercion.

1. Derived Responsibility Through Aid and Assistance

Article 16 "deals with the situation where one State provides aid or assistance to another with a view to facilitating the commission of an internationally wrongful act by the latter."⁵⁸² In essence it sets out three elements for the outside State to be held responsible. First, the State must "aid . . . or assist . . . another

Human Rights and Fundamental Freedoms art. 1, Europ. T.S. No. 5, 213 U.N.T.S. 221 (entered into force Sept. 3, 1953) (stating "[t]he High Contracting Parties shall secure to everyone in their jurisdiction the rights and freedoms defined in Section I of this Convention."); American Convention on Human Rights art. 1(1), Nov. 22, 1969, OAS Treaty Ser. No. 36, 1144 U.N.T.S. 123 (1978) (stating that the State Parties to the Convention undertake to ensure to all persons within their jurisdiction the free and full exercise of the rights recognized in the Convention).

579. See TEXT AND COMMENTARIES, *supra* note 573, at 148, 151, 156.

580. *Id.*

581. See *id.* at 64, 145-59.

582. *Id.* at 148.

State in the commission” of the internationally wrongful act.⁵⁸³ Second, the State must do so “with the knowledge of the circumstances” of the wrongful act.⁵⁸⁴ Finally, the wrongful act in question must be “internationally wrongful if committed by that State.”⁵⁸⁵

Several, though not all, features of this standard either expressly or implicitly limit the responsibility that may be attributed to the assisting State. As a threshold matter, the Commentaries make clear that the “assisting State will only be responsible to the extent that its own conduct has caused or contributed to the internationally wrongful act.”⁵⁸⁶ Conversely, the aid or assistance need not itself necessarily be unlawful.⁵⁸⁷ Nonetheless, Article 16 expressly requires that the aiding State must act with express knowledge of the internationally unlawful act.⁵⁸⁸ While the aid or assistance itself need not necessarily be unlawful, the aid or assistance must at least be given “with a view to facilitating the commission of the wrongful act,” a requirement that limits responsibility to “cases where the aid or assistance is clearly linked to the subsequent wrongful conduct.”⁵⁸⁹ Finally and most importantly, the final condition limits the assisting State’s culpability to the breach of obligations by which it is itself bound. This limitation reflects the standard principle in the Vienna Convention on the Law of Treaties⁵⁹⁰ that “a State is not bound by the obligation of another State vis-à-vis third States.”⁵⁹¹ Given the comparative U.S. reluctance to sign and ratify human rights instruments — and especially to do so without reservations⁵⁹² — this limitation has potentially far-reaching consequences for assigning responsibility based upon aid and assistance that contribute to human rights violations in another country.

These limitations place substantial hurdles before any effort to hold the United States accountable for the effects of the Mexico City Policy in Kenya. That said, some requirements are less

583. *Id.* at 64.

584. *Id.*

585. *Id.*

586. *Id.* at 148.

587. *Id.* at 150-51.

588. *Id.* at 64.

589. *Id.* at 149.

590. *See id.*; *see also* Vienna Convention, *supra* note 38, arts. 34-35.

591. TEXT AND COMMENTARIES, *supra* note 573, at 149.

592. *See* Spiro, *supra* note 561, at 567.

problematic than others. As noted, a colorable case can be made that the restrictions placed upon USAID health care funding, while lawful by themselves, bear a direct causal connection to retrogression in health care, a disparately onerous impact on women, and a chilling effect on medical counseling. Moreover, a case can also be made that U.S. and USAID authorities would have been fully aware of these consequences as the likely result of the Mexico City restrictions, especially since previous unrestricted USAID funding had helped establish and sustain the NGO health care structure that the restrictions would threaten. Translated into the language of the Commentaries, the Mexico City limitations are "clearly linked" to Kenya's failure to sustain progressive realization of its health care obligations or to meet its core minimum obligations, among other wrongful acts.⁵⁹³

More difficult to overcome is the barrier requiring that the United States accept the same international obligations as Kenya before State responsibility can attach. Consider first the right to health. As noted, the United States has yet to ratify the ICESCR. Yet, as also noted, the United States as a signatory to that instrument must nonetheless refrain from acts which would defeat the object and the purpose of the Covenant.⁵⁹⁴ The strongest argument for U.S. responsibility would be that the ICESCR obligates a State Party to promote the rights set forth not just within its own territory or jurisdiction, but generally among all State Parties. According to this interpretation, Draft Article 16 would merely reinforce the U.S.'s direct obligation not to undermine Covenant rights in the territory or jurisdiction of other State Parties, as discussed in the previous section. An intermediate interpretation would hold that, even if the ICESCR does not impose a direct obligation on a State Party to promote rights beyond its borders, signing the Covenant nonetheless satisfies Article 16's requirement that the assisting State be bound at home by the obligations it helped violate abroad. On this view, to the extent that the United States is under a duty not to frustrate the object and purpose of an obligation within its own borders, it could be held responsible for undermining the same obligation in Kenya. In this way, Article 16 would deliver the "derived responsibility"

593. See *supra* notes 579-89 and accompanying text.

594. See *supra* notes 579-89 and accompanying text.

that this Chapter of the Draft Articles address.⁵⁹⁵ Finally, the most mechanical reading of the provision would be that United States bears no responsibility even under Article 16 on the ground that any obligation it has to promote health care runs solely within its borders, that it would not be wrongful for the United States to violate health care rights within Kenya, and therefore that its assistance in Kenya's own violations creates no "derived responsibility."

Of these possibilities, the most sensible is to read Article 16 as requiring only that an assisting State be bound by the same human rights undertakings within its own territory or jurisdiction rather than by human rights undertakings that bear directly on the assisted State. On one hand, mandating that an assisting State affirmatively sign on to parallel obligations goes some distance in addressing the classic concern that nations should not be held responsible for international commitments they themselves have in no way accepted.⁵⁹⁶ This interpretation reinforces the importance of not reading too broadly a State's human rights commitments. On the other hand, the intermediate interpretation of Article 16 addresses Chapter IV's basic concern that States be held responsible for international wrongs to the extent they have helped bring about their commission.⁵⁹⁷ More specifically, this reading helps prevent a situation in which an individual whose human rights have been violated can complain only to their own State rather than to an outside State whose actions may have had as much, or more, to do with bringing about the violation. That said, it is clear that the Commentaries do not deal with this type of situation.⁵⁹⁸ To this extent, both Article 16 and its supplementary materials require further clarification along the lines proposed.

A similar analysis applies with even greater force to freedom of expression under the ICCPR. As discussed, in this instance the United States has both signed and ratified the Covenant, albeit with reservations.⁵⁹⁹ Conversely, the ICCPR's express limitation that a State Party ensure the recognized rights to all individ-

595. See TEXT AND COMMENTARIES, *supra* note 573, at 147.

596. See *supra* notes 579-89 and accompanying text.

597. See *id.*

598. By contrast, Article 18, which deals with coercion, expressly discusses this problem. See TEXT AND COMMENTARIES, *supra* note 573, at 157.

599. See *supra* notes 579-89 and accompanying text.

uals “within its territory and subject to its jurisdiction” precludes direct U.S. responsibility with regard to such rights as expression.⁶⁰⁰ Nonetheless, derivative responsibility under Article 16 may be asserted. First, the Mexico City Policy aids and assists the violation of the right to free expression, as the epithet “Global Gag Rule” implies.⁶⁰¹ Second, U.S. officials adopted the policy with an even greater knowledge and awareness that it would lead to such violations given that prohibiting speech was the centerpiece of the new rules.⁶⁰² Finally, U.S. ratification of the ICCPR fulfills the requirement that an assisting State may be held responsible for an international wrong so long as it has assumed the same obligations within its borders that the principal State has within its territory.⁶⁰³

For these reasons, derived responsibility through aid and assistance also applies to the prohibition against gender discrimination contained not just in CEDAW, but in the general anti-discrimination provisions of the Covenants themselves. Once again, the Mexico City Policy closely aided and assisted the violation of the relevant rights, here through the disproportionately adverse effects on Kenyan women.⁶⁰⁴ Likewise, it would have been difficult for U.S. officials not to know that the proposed funding restrictions would have anything other than the type of disparate impact that this Report has identified.⁶⁰⁵ And lastly, U.S. signature of CEDAW, as with the ICESCR, carries the basic obligation not to frustrate the object and purpose of the Convention. Again, on a reading of Article 16 that requires States to

600. ICCPR, *supra* note 22, art. 1.

601. *See supra* notes 579-89 and accompanying text.

602. *See supra* notes 579-89 and accompanying text.

603. Nor, in this instance, do U.S. reservations to the ICCPR alter this analysis. The United States has made no reservation to Article 19, which protects freedom of expression. By contrast, it has ratified Article 20, which prohibits war propaganda and hate speech, with the proviso that nothing in that article shall “authorize or require legislation or other action by the United States that would *restrict* the right of free speech and association protected by the Constitution of the United States.” ICCPR Reservations, *supra* note 562, no. I(1) (emphasis added). More broadly, the United States has also attached what amounts at least to a declaration stating that nothing in the ICCPR requires any action “*prohibited*” by the Constitution “as interpreted by the United States.” *Id.* at no. IV (emphasis added). None of these restrictions apply, among other reasons, because application of Article 19 to the Mexico City Policy expands the right beyond what the United States protects rather than reduces it to something less than current constitutional protection. *See generally* *Rust v. Sullivan*, 500 U.S. 173 (1991).

604. *See supra* notes 579-89 and accompanying text.

605. *See supra* notes 579-89 and accompanying text.

be bound by the same obligation within its territory or jurisdiction, it follows that it bears responsibility for having undermined these instruments' central objects through the close and knowing discrimination against women abroad that the Mexico City Policy has effectively caused.⁶⁰⁶

2. Derived Responsibility Through Coercion

Whereas Article 16 identifies State responsibility in the case of aid and assistance, Article 18 attributes responsibility in circumstances of outright coercion. Accordingly, it sets out only two elements. First, the act at issue "would, but for the coercion, be an internationally wrongful act of the coerced State."⁶⁰⁷ Second, as before, the outside State must cause the international wrong "with the knowledge of the circumstances of the act."⁶⁰⁸ By contrast, there is no requirement that the coercing State be bound by the same obligations as the primary State. The Commentaries explain this omission in part because the injured party would potentially have no redress since the primary State could defend itself from responsibility on the ground that the outside coercion constituted *force majeure* and so precluded the principal State from responsibility.⁶⁰⁹ Despite one less element, application of Article 18 to the Mexico City Policy entails greater difficulties. For the reasons already discussed, the United States had every reason to have "knowledge of the circumstances of the act" of placing informational restrictions on its aid, including the likely effect on individuals within the countries dependent on

606. Chapter IV sets out a third case of derived responsibility that falls between aid and assistance, see *supra* notes 579-89 and accompanying text, and coercion, see *supra* note 579-89. Under Article 17, an outside State may be responsible for an international wrong "when it directs and controls another State." TEXT AND COMMENTARIES, *supra* note 573, at 64. As with Article 16, derived responsibility further depends on whether the directing State acts with knowledge of the circumstances of the wrongful act and whether the act would be internationally wrongful if committed by that State. *Id.*

607. TEXT AND COMMENTARIES, *supra* note 573, at 64.

608. *Id.*

609. See *id.* at 1567. This explanation for the omission of the requirement for Article 18 reinforces an "intermediate" reading of Article 16 to require no more than that a State have bound itself to an international human rights norm within its jurisdiction. The Article 18 commentary indicates an overriding concern for an injured party having recourse with some State. The intermediate interpretation of Article 16 balances this concern, to the extent a wrongful act was caused by an outside State, with the opposing concern that such a State not be bound by international standards it did not undertake.

such funding.⁶¹⁰ Conversely, whether the aid restrictions at issue amounted to coercion is another matter. According to the Commentaries, “coercion for the purpose of Article 18 is narrowly defined,” and “has the same essential character as *force majeure*.”⁶¹¹ They elaborate that, “[n]othing less than conduct that forces the will of the coerced State will suffice, giving it no effective choice but to comply with the wishes of the coercing State.”⁶¹² To force a State’s will, moreover, establishes a demanding test: “It is not sufficient that compliance with the obligation is made more difficult or onerous.”⁶¹³ Nor is it “enough that the consequences of the coerced act merely make it more difficult for the coerced State to comply with the obligation.”⁶¹⁴

Given this narrow definition of coercion, attributing responsibility to the United States would be hard to sustain. As this Report has shown, U.S. imposition of onerous restrictions to essential health care aid — especially upon which Kenya had become reliant — presented the Kenyan NGOs, who had assumed a significant portion of reproductive and general care, with the difficult choice of accepting these limitations and undermining their core mission or rejecting them at the cost of seeing essential services dramatically decline.⁶¹⁵ However much U.S. policy-makers sought to pressure Kenyan NGO’s to choose funding over their freedom to operate, this attempt at coercion failed.

As a legal matter, however, the key question relates not to U.S. attempts to pressure non-governmental providers, but to pressure the government of Kenya. To the extent it presided over a diminution in health and information, the Kenyan government violated the relevant human rights obligations that it had assumed. Under Article 18, the inquiry comes down to whether Kenya had any choice but to accept this situation. However difficult, Kenya could have obtained support from other donor nations to make up the shortfall, reallocated admittedly scarce resources to increase the public health care sector, increased taxes, and further taken these or other steps in anticipation of the real possibility that the Mexico City Policy would re-

610. TEXT AND COMMENTARIES, *supra* note 573, at 64.

611. *Id.* at 156.

612. *Id.*

613. *Id.*

614. *Id.*

615. *See supra* notes 579-89 and accompanying text.

cur. In each instance, one would have to show that these or other options were not available before the United States could be deemed to have engaged in outright coercion. Certainly as a practical matter the Kenyan government was left with very few realistic alternatives once the United States reinstated the Mexico City restrictions. As a matter of international law, however, the alternatives would have to be so limited that the United States effectively gave Kenya no choice but to violate its international obligations.

For similar reasons, Article 18 also precludes Kenya from asserting the defense that it has been coerced. To mount such a defense, it would have to show that its actions resulted from *force majeure*: “[T]he occurrence of an irresistible force or of an unforeseen event, beyond the control of the State, making it materially impossible in the circumstances to perform the obligation.”⁶¹⁶ The Commentaries make clear that for the purpose of derived responsibility, coercion “has the same essential character as *force majeure*” for the purpose of a defense.⁶¹⁷ It follows “that in most cases . . . the responsibility of the coerced State will be precluded vis-à-vis the injured third State [or, under human rights instruments, injured persons].”⁶¹⁸ Equating the two concepts, however, reinforces their narrowness. Aside from demonstrating an irresistible force or unforeseen event, the Draft Articles further make clear that a State can assert *force majeure* only if it did not result in whole or part from the State’s own conduct,⁶¹⁹ or if the State has assumed the risk of the situation occurring.⁶²⁰ As applied, it would therefore be no less difficult for Kenya to assert a defense than it would be to maintain U.S. coercion. The return of the Mexico City Policy could not be said to be unforeseen. Nor could it be said that Kenya’s own policies had nothing to do with the effects of the restrictions once the

616. TEXT AND COMMENTARIES, *supra* note 573, at 65.

617. *Id.* at 156-57.

618. *Id.* at 157. As noted, the Commentaries explain that one reason for not requiring that coercing States be obligated to the same international commitments as the coerced States is the equivalence of coercion and *force majeure*. Given that a coerced State can preclude responsibility for an internationally wrongful act as a matter of *force majeure*, to allow the coercing State to preclude responsibility on the ground that it did not share the same obligations as the coerced State would mean that an injured party would not have any State to hold accountable for the international wrong suffered. *Id.*

619. *See id.* at 65

620. *See id.*

United States reinstated them. As a practical matter, the Bush Administration gave countries such as Kenya few alternatives other than to oversee the violations of the fundamental rights at issue. But as a legal matter, even such a powerful application of economic pressure does not suffice to make the United States accountable for the consequences it has effectively wrought.

3. Need for Clarification and Reform

The Mexico City Policy highlights both the promise and limitations that the Draft Articles present. The culmination of a decades-long international process, they consolidate State responsibility doctrine and extend it well beyond its classical origins. As such, the Draft Articles merit conversion into a multilateral treaty on the model of the Vienna Convention. Yet they should not be deemed the last word on the subject. At the most general level, neither the Draft Articles nor the Commentaries focus State responsibility on the special context of multilateral human rights obligations. Still less are they clear or comprehensive with regard to affirmative rights in circumstances involving rich and powerful States effectively exerting pressure on weaker counterparts that results in violations of the more vulnerable States human rights commitments.

The case of Kenya highlights both the strengths and weaknesses of the approach of the Draft Articles. Article 16's treatment of aid and assistance provides the basis for an argument that would hold nations such as the United States accountable for those violations of Kenya's formal human rights obligations to the extent these foreseeably resulted from aid restrictions along the lines of the Mexico City Policy. It would do so, however, only on an interpretation that held that the actions of the United States would have been unlawful had they violated parallel obligations that applied within its own borders. By contrast, Article 18's handling of coercion works to foreclose U.S. responsibility by dropping altogether the requirement that an act be a violation of its own commitments. In the end, however, it sets so high a bar in defining coercion that neither the Mexico City Policy, nor in all likelihood any aid restrictions, however onerous, would plausibly qualify.

To this extent, a significant disconnect between law and reality persists when powerful countries coerce, assist, or otherwise

pressure weaker ones to commit international wrongful acts. The existing gaps and uncertainties may or may not be advisable with regard to international rules generally. The impact of the Mexico City Policy in Kenya, however, demonstrates that the divergence between law and reality needs to be closed when what is at issue are fundamental human rights.

C. *Duty to Cooperate*

A final possible source for U.S. accountability for the effects of the Mexico City Policy arises out of the duty to assist and cooperate with developing countries in a manner that respects fundamental human rights. As a principle of international law, mutual cooperation predates even sovereignty in reflecting the established practice of States. Some authorities have accordingly asserted that the duty to cooperate is grounded in customary international law, and cite evidence of the reiteration of a general principle of cooperation in numerous international agreements as evidence of the custom.⁶²¹ The U.N. Charter includes several references to cooperation, including Article 1 on the purposes of the United Nations, in which Members pledge to “achieve international cooperation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights.”⁶²² The Charter recognizes “general principles of cooperation”⁶²³ and empowers the General Assembly to promote international cooperation in politics and the development of international law⁶²⁴ as well as in “problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights.”⁶²⁵ Finally, the Charter pledges the U.N. Organization as well as individual members to cooperate in achieving

621. See 2 ENCYCLOPEDIA OF PUBLIC INTERNATIONAL LAW 1242 (1995) (defining international law of cooperation) [hereinafter EPIL]. The view that the duty of cooperation is part of customary law is supported by the reiteration of the duty in several international agreements, including the Charter of the League of Arab States, the Organization of American States and the African Unity. *Id.* at 1244; see also IAN BROWNLIE, BASIC DOCUMENTS ON HUMAN RIGHTS 119 (1981); General Comment Three, *supra* note 33, ¶ 14.

622. U.N. Charter art. 1, ¶ 3.

623. *Id.* art. 11.

624. *Id.* art. 13, ¶ 1.

625. *Id.* art. 13, ¶ 2.

the enumerated goals.⁶²⁶ International cooperation is commonly understood to mean the provision of technical and financial assistance to developing countries or to countries experiencing a humanitarian crisis. In recent decades, there have been efforts to define target levels for development aid measured by percentage of developed countries' GDP, but the substance of a duty of international cooperation has been largely undefined.⁶²⁷ As noted, the ICESCR also contains language reflecting a duty to cooperate.⁶²⁸

These treaties and other international instruments provide evidence of a duty to provide assistance as a matter of international custom whether or not they themselves establish the principle as binding treaty law. The Committee on Economic, Social and Cultural Rights takes just this position. Framing the duty to cooperate as a matter of customary international law renders the principle applicable to all State regardless of whether they were parties to the ICESCR or other specific instruments. Additionally, the customary duty brings corollary obligations respecting how assistance is provided, including the obligation to provide assistance in a manner that promotes the realization of human rights and respects the principle of sovereign equality.⁶²⁹ The Committee has further asserted that respect for and promotion of human rights underpins the obligation to provide assistance. The Limburg Principles, an interpretation of the Covenant by noted scholars and experts, emphasizes that "[i]nternational cooperation and assistance shall be based on the sovereign equality of States and be aimed at the realization of the rights contained in the Covenant."⁶³⁰ Under these inter-

626. The U.N. Organization is discussed in Article 55. *See* U.N. Charter, art. 55. Member States are addressed in Article 56. *See id.* art. 56.

627. EPIL, *supra* note 621, at 13. There have been efforts to establish a monetary level of aid. UNCTAD recommends countries dedicate one percent of their GDP to development aid while a U.N. General Assembly resolution and the Organization for Economic Cooperation and Development, a multilateral organization comprising the wealthy countries, recommend 0.7% for development aid. *Id.*

628. *See supra* notes 579-89 and accompanying text.

629. *See* BROWNLEE, *supra* note 621, at 249-50; *see also* EPIL, *supra* note 623, at 9; ECOSOC, CESCR, *International Technical Assistance Measures*, CESCR General Comment 2, U.N. Doc. E/1990/23 (1990); General Comment Three, *supra* note 33; General Comment Fourteen, *supra* note 34.

630. U.N. ESCOR, Comm'n on Hum. Rts, *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, at 33, U.N. Doc. E/CN.4/1987/17 (Dec. 1987) *reprinted in* 9 Hum. Rts. Q. 122 (1987).

pretations, the Mexico City Policy is inconsistent with international obligations both to the extent that it fails to respect human rights and constitutes interference with the recipient country's national health policies and political process.

Further evidence of an evolving customary duty to cooperate comes from non-binding instruments. At the most general level, the U.N. Declaration on Friendly Relations recognizes cooperation as a general principle of international law in the preamble, but the operative paragraphs frame the duty to cooperate "in accordance with the Charter."⁶³¹ The Declaration obligates States to cooperate in the promotion of human rights "in accordance with the principles of sovereign equality and non-intervention."⁶³² The pairing of the duty to cooperate and respect for sovereign equality and non-intervention is reiterated in several other General Assembly Declarations, all of which were adopted with large majorities.⁶³³ This tension reflects the dispute during negotiations during which Western and developing States clashed over whether the duty to cooperate is a customary or contractual duty. With regard to health care specifically, 1978 Alma-Ata Declaration reiterated the concern of the new international order that "gross inequality" between States in the foundation of the need for cooperation.⁶³⁴ The Declaration posited that inequality in access to primary health care as a matter of "common concern to all countries."⁶³⁵ The Declaration calls on countries to join together to eliminate gross inequality in access to primary health care.⁶³⁶

The U.N.'s various human rights bodies, as well as NGOs, sought further to define poverty a matter of international concern. These efforts culminated in the assertion of a right to de-

631. Declaration on Principles of International Law Concerning Friendly Relations and Co-Operation Among States in Accordance with the Charter of the United Nations, pmbl., U.N. Doc. A/8028 (XXV) (Oct. 24, 1970).

632. *Id.*

633. *See generally* Declaration on Permanent Sovereignty Over Natural Resources, G.A. Res. 1803, Supp. No. 17, U.N. GAOR, 17th Sess., U.N. Doc. A/5217 (Dec. 14, 1962), *reprinted in* 2 I.L.M. 223 (1963); Charter of Economic Rights and Duties of States, G.A. Res. 3281, Supp. No. 31, at 50, U.N. GAOR, 29th Sess., U.N. Doc. A/9631 (Dec. 12, 1974), *reprinted in* 14 I.L.M. 251, 260 (1975).

634. WORLD HEALTH ORGANIZATION, Global Strategy for Health for All by the Year 2000, 71-77 (1981), *available at* <http://whqlibdoc.who.int/publications/9241800038.pdf>.

635. *Id.*

636. *See id.*

velopment, which asserts an individual and collective right to be free of poverty and to enjoy the benefits of development and links this to an international obligation to provide assistance.⁶³⁷ The right to development is theoretically grounded in the fundamental right of the self-determination of peoples and is conceived as belonging to both nations and individuals.⁶³⁸ The General Assembly gave substance to the right in its 1986 Declaration on the Right to Development.⁶³⁹ The Declaration reiterates the principle that international cooperation should be carried out in accordance with the principle of sovereign equality and respect for human rights.⁶⁴⁰ The 1993 World Conference on Human Rights strongly affirmed the right to development in its Declaration and Program of Action,⁶⁴¹ which was adopted by consensus by representatives of 171 States.⁶⁴² The human rights organs of the U.N. have continued to promote the idea, give it substance, and to mainstream it with other U.N. agencies responsible for development work.⁶⁴³ The right to development is not a binding norm and is not the subject of any treaties. It is significant, however, because it demonstrates the limitations of any evidence of consent to an international obligation to provide economic assistance. Commitments to providing assistance, as expressed in declarations and at international conferences, remain voluntary commitments couched in hortatory language and do not create binding obligations on donors. The right to development is significant to the analysis of the effects of the Mexico City Policy to the extent that it provides evidence of an international consensus when development assistance is provided. Development policy must be consistent with human

637. *See id.*

638. *See* 4 *ENCYCLOPEDIA OF PUBLIC INTERNATIONAL LAW* 368 (2000) (discussing self-determination). ICJ Judge Mohammed Bedjaoui states that “[t]he right to development flows from the right to self-determination and is of the same kind.” Mohammed Bedjaoui, *The Right to Development*, in HENRY J. STEINER & PHILIP ALSTON, *INT’L HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS* 1118 (1996).

639. *See* Declaration on the Right to Development, G.A. Res. 41/128/Annex, U.N. GAOR, 41 Sess., 97th plen. mtg., U.N. Doc. A/RES/41/128 (Dec. 4, 1986).

640. *See id.*

641. *See generally* Report of the World Conference on Human Rights, U.N., U.N. Doc. A/CONF.157/24 (1993).

642. *See id.*

643. For more information on the U.N. approach to the right to development, visit the website for the right to development of the Office of the High Commissioner for Human Rights, available at <http://www.unhchr.ch/development/right.html>.

rights norms and must respect the obligation not to intervene in a State's internal affairs without its consent.

In recent years, the idea of a transnational duty to cooperate has received renewed and substantial impetus from the movement culminating in the Millennium Development Goals ("MDGs"). These standards themselves result from the Millennium Declaration, which was adopted by the U.N. General Assembly at a special meeting held in 2000 and attended by 147 heads of government.⁶⁴⁴ Their purpose is to form a blueprint agreed to by all the world's countries and all the world's leading development institutions for mutual, transnational cooperation. Among the eight goals the MDGs set out, three bear directly on the conditions recounted in this Report: The third, to promote gender equality and empower women; the fourth, to reduce child mortality; and the fifth, to combat HIV/AIDS, malaria, and other diseases.⁶⁴⁵ As a practical matter, they have already had an enormous impact on international development planning.⁶⁴⁶ Their implications for international human rights law are only now being explored. At least one leading commentator, Philip Alston, suggests that the MDGs eventually will be viewed as evidence for emerging transnational obligations for development cooperation in customary international law.⁶⁴⁷ The establishment of such a norm may lie well into the future. The MDGs and the movement that they articulate may nonetheless offer the best promise for a firm duty for nations to cooperate in realizing certain basic economic and social rights beyond their borders.

The United States is one of the largest donors to development programs in Kenya, the leading donor to population programs, and provides extensive funding in other areas as well.⁶⁴⁸ Despite its failures to achieve monetary targets for providing aid, it is not likely that the United States could be considered to be in violation of the duty to cooperate contemplated in the U.N.

644. See United Nations Millennium Declaration, G.A. Res. 55/2, U.N. GAOR, 55th Sess., U.N. Doc. A/RES/55/2 (2000), available at <http://www.un.org/millennium/declaration/ares552e.htm>.

645. See *id.*

646. See Philip Alston, *Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals*, 27 HUM. RTS. Q. 755, 757 (2005).

647. See *id.* at 775-78.

648. See USAID/KENYA, ANNUAL REPORT FY 2004, at 4 (June 14, 2004), available at http://pdf.dec.org/pdf_docs/PDACA031.pdf.

Charter. Scholarly interpretations interpret the customary obligation to respect human rights as limited to those rights that are considered customary rights and *jus cogens*, such as systemic racial discrimination, genocide, or torture. According to this view, the U.S. actions do not violate the substance of the international obligation, despite their negative effects, because the assistance was not provided with the intention of violating a *jus cogens* norm.

The version of the duty to cooperate articulated in non-binding instruments provides a more expansive articulation of the duty to respect human rights and sovereign equality while providing development assistance. To the extent that the Mexico City Policy impairs the enjoyment of human rights in Kenya and undermines Kenya's national policies with regard to reproductive health, it is also inconsistent with the expansive view of the duty to cooperate. This view, however, has yet to achieve the requisite level of State practice and *opinio juris* to have achieved customary law. The persistent tensions between developed and developing countries regarding the nature of the duty to cooperate and the establishment of a new international order were never fully resolved, but in the changed international climate of the 1990s, the developed country language of contractual and non-binding duties to provide assistance came to dominate development agreements.

CONCLUSION

This Report ranges widely from specific instances of human deprivation to the theoretic limits of international law. Throughout its study of Kenya, the Crowley delegation found that the United States's Mexico City Policy significantly reduced the availability of reproductive and general health care in populations that need it the most. This pattern, moreover, was manifest in each of the regions that we visited. This situation simultaneously implicates a number of human rights standards, but also reveals important limitations of the traditional human rights framework. This Report sets out evidence of cognizable violations of the right to health care, the right to equal treatment on the basis of gender, and to the freedom of information. Yet, although these obligations bind Kenya, they do not run to the United States, the government whose policy in the first instance

caused the violations at issue. By focusing on the intersection between Kenyan and U.S. policy, this Report has endeavored to show both the reach and the limits of international human rights law in addressing the fundamental issues of health, discrimination, and information that it explores. Finally, and importantly, the limitations analyzed here are not confined to the right to health care or even the Mexico City Policy. International human rights law simply has little to say about transnational human rights obligations in general. By identifying these legal limits while also describing the actual human costs, the Crowley Program hopes to make more visible the challenges that the international legal community must face when wealthy, powerful nations export despair to those less fortunate.

ANNEX I: Crowley Mission Itinerary**Monday, May 17, 2004**

TIME INTERVIEW

- 0900 *Jane Onyango*, Head of Litigation, FIDA-Kenya
- 0900 *Karoki Elicide*, Taxi Driver, Client of MSI-Eastleigh
- 1100 Pathfinder International
Margaret W. Gatei, Project Manager, PMTCT
Gilbert Magiri, Senior Program Officer
Pamela S.A. Onduso, Associate for Adolescent and Sexual Health
Georgianna Platt, Program Manager
- 1500 USAID, *Sheryl Strumbus*, Director, Office of Democracy and Governance

Tuesday, May 18, 2004

- 1000 *Dr. Assumpta Muriithu*, National Program Officer for Reproductive Health, World Health Organization
- 1000 Family Planning Association of Kenya Briefing
Mr. Godwin Z. Mzenge, Executive Director
Dr. Linus Etyyang, Program Manager
- 1200 Ribeiro Clinic Interview, Staff
Sarah Imbadi, Registered Nurse
Dr. J.A. Osur Odour, Supervising Physician
- 1200 Interviews at Ribeiro Clinic, former FPAK Eastleigh Community Health Workers
Dorothy Akinyi
Charles Kanyi
Virginia Njue
Grace Adams
- 1200 Interviews at Ribeiro Clinic, former and present clients of FPAK Eastleigh
Beatrice
Lorna
Rose Mugure
Esther Mutui

Veronica Ngina
Elizabeth Njeri
Lucy Omondi
Josephine Wanjiru

- 1330 Visit to Nairobi Youth Center (escorted by *Ruth Wachira*, Program Officer for Service Delivery, FPAK)
Diana Moreka, Nairobi Youth Centre
Peter Nzioki, Nairobi Youth Centre

Field Visits

Team One: Eldoret/Kisii **Wednesday, May 19, 2004 (Eldoret)**

- 0700 Flight from Nairobi to Kisumu
- 1100 Anglican Church of Kenya-Eldoret HQ
Jackson Sambu, Director Christian Community Services
 Florence
Agnes Kosk Dutto, Project Supervisor
Helen Nyego, Project Supervisor
Joan Wege, Project Supervisor
Daniel Korir, Project Supervisor, Kesses
Senyo Gutho
- 1230 *Peter Kagwe*, Pathfinder, Area Manager, Eldoret
- 1300 *Dr. Gertrude Akolo*, Assistant Program Officer, Service Delivery Family Planning Association of Kenya, Eldoret
- 1500 Field Visit to Anglican Church of Kenya Community Based Distribution Project in Kesses, Presentation/Songs by 18 Community Health Workers

Thursday, May 20, 2004 (Kisii)

- 0930 *Heryne Ayiemba Dok*, formerly of FPAK-Kisii, now of FPAK-Eldoret
- 1015 *Alice Nyagaka*, former FPAK Community Health Volunteer
- 1045 FPAK Kisii, former clients
Colsolata Achieng
Marren Achieng

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Dorothy Akelo
Margaret
Angela Owino
Immaculate Waka
Asha Abdallah

1215 Gussi Youth Community Workers
Linet Osebe, Organizer for Osoro Township
Kennedy Nyankundi Nyandoro, Organizer for Mosoch
Ben Giseemba, Organizer for Suneka Division

1300 *Zipporah Kuamboka*, former FPAK Kisii client

1430 Site Visit to Aries Medical Clinic, location of former
FPAK Kisii Office

1500 Site Visit to Kisii District Hospital, Family Planning
Division

Friday, May 21, 2004 (Kisumu) RB/MH/EK

0930 *Christine Ochieng*, Program Officer—Litigation, FIDA-
Kisumu Branch
Return to Nairobi

Team Two: Embu

Wednesday, May 19, 2004 (Nairobi/Embu)

0900 Pathfinder, *Margaret W. Gatei*, Project Manager, PMTCT

1000 *Pamela S.A. Onduso*, Associate for Adolescent and
Sexual Health

1130 *David Adriance*, Engender Health, Regional Director

1430 *Dr. Richard O. Muga*, Director, National Council for
Population and Development, Ministry of Planning and
National Development
Government of Kenya

1900 *Dr. Methuselah M. Ocharo*, formerly of FPAK Embu

Thursday, May 20, 2004 (Embu)

0700 *Dr. Methuselah M. Ocharo*, formerly of FPAK Embu

- 0800 *Egla Njeru*, Registered Nurse at private clinic at former FPAK Embu Site and midwife)
- 0900 Former FPAK Embu Clients
Catherine Mjura Kinyua
Celina G. Marangu
Roseline Mwenda Mwai
Josephine Wantiku Mwangi
Petwnila Masimiyu Wanyama
- 1000 *Dr. Ngari M. Benson*, Medical Officer of Health
- 1100 *B.M. Mugo*, EmbuTown Clerk
- 1115 *Dan K. Kiara*, Fiscal Planning and Land Policy Administrator
- 1125 Former FPAK community health providers
Nancy W. Kamau
Muchoki Kithinji
Hussein Marjan
Mary W. Nyagah
Halima S. Shaban
- 1230 Site visit to proposed location of new FPAK clinic
- 1400 *Sister Florence Karanja*, Administrator/Nurse in Charge Embu General Hospital
- 1500 FPAK Embu Grassroots & Advocacy Volunteers
Sophia Juena, Secretary Treasurer
Dick Mukono, Assistant Secretary

Friday, May 21, 2004

Travel back to Nairobi

Team Three: Kisumu (Escorted by *Mr. Richard Olewe*, Marie Stopes, Regional Manager-Western Kenya)

Wednesday, May 19, 2004

- 0700 Flight from Nairobi to Kisumu
- 0830 Marie Stopes International—Kisumu
Michael Oyah, Regional Medical Advisor
Richard Olewe, Regional Director, Western Kenya

Elizabeth A. Bunei, client

- 1200 Nyanza General Hospital
Rose Amolo, Maternity Ward
Dr. Kouko
Margaret Odhidambo, Hospital Matron in Charge
Lilian Oketch, Medical Officer in Charge, Support Center
Veronica Ogonya, Prevention of Mother to Child Transmission Unit
Diana Rochine, Nurse Officer in Charge, Pediatric Unit
Dr. Wangata

- 1500 Women in Fishing Industries Project Trust
Charles Otieno, Materials Coordinator
Beth Allardice, Associate Consultant

- 1700 Plan International
Rasi Masuhi, Program Unit Manager

Thursday, May 20, 2004

- 0900 Kisumu Medical Education Trust (KMET)
Monica A. Oguttu, Executive Director
Ochieng Ochollah
Jacob Ochieng Ajwang
- 1100 FPAK Kisumu
Martha Achesi, Nurse in Charge
- 1230 God's Will Clinic
Sammy Kisaid
- 1600 Universities of Nairobi, Illinois and Manitoba (UNIM)
Project, Lumumba Health Centre
Dr. Kwango Agot, Project Coordinator
- 1700 Mildmay International
Grace V. Olang
Wilfred O. Owour

Friday, May 21, 2004

Center for Disease Control

Nairobi Interviews**Monday, May 24, 2004**

- 0900 *Owuor Olumgah, Ph.D.*, Research Fellow University of Nairobi, Institute of African Studies
- 0930 Maendeleo ya Wanawake Organisation
Rose Olende-Arungu, Executive Director
- 1130 Kenya Association for the Promotion of Adolescent Health (KPAH)
Mr. Joseph Karueru, Executive Director
- 1400 University of Nairobi, Faculty of Law
Dr. Patricia Kameri-Mbote, Senior Lecturer, Department of Private Law
Pauline Nyamweya, Deputy Secretary, Research, Drafting & Technical Support, Constitution of Kenya Review Commission
- 1430 *Dr. Peter O. Odongo*, Kenya Medical Association
- 1500 *Mr. Tom Chuma*, Family Planning Association of Kenya, Finance and Administration Officer
- 1600 Pathfinder, *Charles Thube*, Country Representative, Kenya

Tuesday, May 25, 2004

- 0830 *Nyabera Emmanuel*, Public Information Officer, UNHCR
- 0930 *Sam Mwamburi Mwale*, Economic Advisor
Government of Kenya
Ministry of Planning and National Development
- 1000 *Ms. Elizabeth Oyugi*, CARE-Kenya, Sector Advisor for Civil Society & HIV/AIDS
- 1100 Research Visit to FIDA-Kenya Resource Center
- 1300 *Dr. Henry van den Hamburg*, Coordinator of Health Programs, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)
- 1400 Transparency International-Kenya

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Gladwell Wathoni Otieno, Executive Director
Mwalimu Mati, Deputy Executive Director

1530 *Dr. F.M. Kimani*
Deputy Director of Medical Services
Government of Kenya, Ministry of Health

Wednesday, May 26, 2004

0830 Pumwani Hospital, *Sista Ambetsa*, Hospital Matron in Charge

1030 Video Documentation of Eastleigh Youth Center

1100 *Grace Otiemo*, Center Manager, Marie Stopes, Eastleigh

1100 *Julian Wambui*, Former Client, Marie Stopes, Eastleigh

1300 Kenya AIDS NGO Consortium
James Kimani

1300 Site Visit to Mathare Valley (site of former MSI clinic)
Rose Were, Nurse
Grace Achewa, Community Health Volunteer
Henrietta Asitsu, Community Health Volunteer
Mary Kiilu, client
Somali woman, client
Nancy Wanjiku, client
Jane Waniyiku, client

1400 *Dr. Solomon*, Deputy Director, Reproductive Health Services
Ministry of Health

Thursday, May 27, 2004

0830 Pumwani Hospital
Dr. Daniel M. Nguku, Medical Officer of Health
David Kiragu, OB/GYN, Hospital Superintendent

0900 Wholistic Caring and Counseling Center
Grace Gitaka, Founder and Executive Director
Amoso (Jane) Wanza, Nurse
Jane Owour, Social Worker

- 1000 *Dr. Sam Kalibala*, International AIDS Vaccine Initiative,
Regional Representative, Nairobi
- 1300 *Professor Wanjiku Kabira*, Commissioner
Nancy Baraza, Rapporteur for Bill of Rights Committee
- 1400 *Robert Schrembs*, GTZ
- 1500 *Mr. Cyprian Awiti*, Program Director, Marie Stopes
Kenya
- 1600 *Dr. Bernard Sinyana*, University of Nairobi, Law Faculty
- 1800 *Ann Gathumbi-Masheti*, Coalition on Violence Against
Women, Co-Ordinator

Friday, May 28, 2004

- 0800 *Professor Githu Mathai*, University of Nairobi
Joined by *Jean Kamal*, Femnet, former Director of
FIDA-Kenya
- 0900 *Dr. R. Koigi Kamau*, *Dr. Oyeba*
Kenyatta National Hospital, High Risk Clinic
- 0900 *Mr. Mbugua Kang'ethe*, AMKENI, Operations Manager,
Finance and Administration
- 0930 National Council of Churches of Kenya
Ms. Suzie Ibutu, Director of Advocacy
Bwibo Adieri, Director of Social Services Delivery
- 1000 *Mr. Tewodros Melesse*, Regional Director, International
Planned Parenthood Federation
- 1400 Former Clients of Marie Stopes-Mathare Valley
Wilfred Adhiambo
Dorothy Akimyi
Caroline Akoth
Josephine Atori
Oliver Khitieyi
Dorcas Sanya
Virginia Wambui
- 1430 *Tama Bein Aime*, Executive Director, Equality Now
- 1500 *Mr. Justice J.B. Ojwang*, High Court of Kenya

ANNEX II: Additional Interviews

**Mehlika Hoodbhoy Preliminary Trip to Nairobi,
Kenya, February 2-6, 2004**

Monday, February 2, 2004

Rob Burnet, Program Officer, Ford Foundation

*Florence Manguyu, Regional Policy Advisor, International AIDS
Vaccine Initiative*

Tuesday, February 3, 2004

Jane Kiragu, Executive Director, FIDA-Kenya

Cyprian Awiti, Program Director, Marie Stopes Kenya

Martha Mutunga, Manager, VSC Projects

Afternoon site visit to MSK Clinic in Eastleigh

Wednesday, February 4, 2004

David Adriance, Regional Director, Engender Health

Dr. Job Obwaka, Project Director, AMKENI

Mbugua Kang'ethe, Operations Manager, AMKENI

Michael Strong, USAID/Kenya

Thursday, February 5, 2004

*Hon. Prof. P. Anyang' Nyong'o, Minister of Planning and National
Development*

Dr. Linus Ettyang, FPAK, Program Manager

*Dr. Charles Weiyu, FPAK, Program Officer in Charge of Service
Delivery*

Tom Chuma, FPAK, Finance and Administration Manager

*Mr. Mwalumi Mati, Deputy Executive Director, Transparency
International-Kenya*

Ms. Mary Ann Burris, Trust for Indigenous Health and Culture

Friday, February 6, 2004

Site visit with Marie Stopes Kenya to Machakos-Kyawalia Clinic,
escorted by *Martha Mutunga, Manager, VSC Projects*