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Advocacy in Whispers: The Impact of the Unsaid Global Gag Rule Upon Free Speech and Free Association in the Context of Abortion Law Reform in Three East African Countries

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ADVOCACY IN WHISPERS: THE IMPACT OF THE USAID GLOBAL GAG RULE UPON FREE SPEECH AND FREE ASSOCIATION IN THE CONTEXT OF ABORTION LAW REFORM IN THREE EAST AFRICAN COUNTRIES

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INTRODUCTION

In 2001, President George W. Bush restricted the participation in democratic processes for non-governmental organizations (NGOs) abroad by reinstating a policy restricting family planning funding granted by the United States Agency for International Development (USAID). The restriction sharply curtailed the ability to speak and to associate freely for organizations working to preserve women's health and lives. For this reason, I refer to the restriction as the Global Gag Rule (GGR).

Organizations in Uganda, Ethiopia, and Kenya had begun to identify the problems associated with their countries' restrictive abortion laws. In these three countries, as elsewhere in the world, illegal abortions are unsafe and a major cause of the high rates of maternal mortality and morbidity. By 2001, efforts toward abortion law reform were underway.

In 2002, with the institutional support of the Center for Reproductive Rights, I traveled to east Africa to study the effect of the GGR upon the free speech and free association of advocates of access to safe abortion.[1] Uganda, Ethiopia, and Kenya were selected because, in all three countries, stakeholders in the reproductive health of women were working to bring information to lawmakers about the detrimental impact of a restrictive abortion law. Additionally, prior to my departure, I had access to information about stakeholders in these countries.

In Uganda, Ethiopia, and Kenya, the ability of stakeholders to communicate with lawmakers is restricted by the GGR.[2]

I. THE GLOBAL GAG RULE: BACKGROUND

Under the GGR, in order to receive USAID funding for family planning, foreign NGOs are prohibited from using their own funds to provide abortion services, provide counseling or referrals regarding abortion, or to lobby their own governments for abortion law reform.[3] The restriction took effect on March 28, 2001, when President Bush issued a memorandum to the administrator of USAID, reinstating a policy that requires "foreign nongovernmental organizations to agree as a condition of their receipt of federal funds for family planning activities that such organizations would neither perform nor actively promote abortion as a method of family planning in other nations."[4]

The Global Gag Rule is a reinstatement of the Mexico City Policy (MCP) announced by President Reagan at the United Nations conference on population held in Mexico City in August of 1984.[5] Both the GGR and the original MCP place restrictions on promoting "abortion as a method of family planning," which, according to the Reagan

1. *See* CTR. FOR REPRODUCTIVE RIGHTS, Breaking the Silence: The Global Gag Rule's Impact on Unsafe Abortion (2003).
2. The names of all people interviewed, as well as all identifying information relating to their organizations, have been redacted to protect them from possible retaliation by the U.S. government. Wherever specific names are used, they have been obtained from sources in the public domain.
3. Restoration of the Mexico City Policy, 66 Fed. Reg. 17,303, 17,304–07 (March 29, 2001); *see also* CTR. FOR REPRODUCTIVE RIGHTS, THE BUSH GLOBAL GAG RULE: A VIOLATION OF INTERNATIONAL HUMAN RIGHTS AND THE U.S. CONSTITUTION (2001) [hereinafter THE BUSH GLOBAL GAG RULE].
4. Restoration of the Mexico City Policy, 66 Fed. Reg. at 17,303; *see also* THE BUSH GLOBAL GAG RULE, *supra* note 3.
5. Restoration of the Mexico City Policy, 66 Fed. Reg. at 17,303; Ctr. for Reprod. Law & Policy v. Bush, No. 01 Civ. 4986 (LAP) 2001 U.S. Dist. LEXIS 10903 at *4 (S.D.N.Y. July 31, 2001).

administration's interpretation, included "all abortions, except when performed in cases of rape, incest, or when the life (but not health) of the woman would be endangered if the fetus was carried to term."[6] The MCP/GGR affects only the NGOs' use of non-USAID funds; the 1973 Helms amendment prohibits USAID funds from being used to "to pay for the performance of abortions as a method of family planning."[7] In 1974, USAID added a prohibition on funding for "information, education, training, or communication programs that seek to promote abortion as a method of family planning."[8]

President Bill Clinton rescinded the GGR in 1993.[9] The restriction was reinstated for federal fiscal year 2000 when the U.S. Congress for the first time made the GGR statutory law, but was dropped from the fiscal year 2001 appropriations bill enacted in late 2000.[10] In 2001, by executive order, President Bush re-imposed the GGR as an administrative policy. Under the current President, the GGR's inception is more restrictive for organizations wishing to improve access to safe abortion than the 2000 congressional act; it prohibits funding for foreign NGOs that lobby "a foreign government to legalize or make available abortion as a method of family planning or . . . to continue the legality of abortion as a method of family planning."[11] The 2000 congressional GGR restricted USAID family planning funds to both organizations that lobby for and "*against* abortion."[12]

The Global Gag Rule would be unconstitutional if applied to U.S. organizations. The restrictions that make up the order apply only to foreign NGOs—which do not have U.S. constitutional protection over free speech and free association. Federal courts have prohibited restrictions placed on U.S. NGOs similar to those of the GGR. The Constitution does not permit Congress to enact legislation that restricts a U.S.-based organization's constitutional rights by dictating how a

6. CTR. FOR REPRODUCTIVE RIGHTS, THE BUSH GLOBAL GAG RULE: ENDANGERING WOMEN'S HEALTH, FREE SPEECH, AND DEMOCRACY (2003), *available at* http://www.crlp.org/pub_fac_ggrbush.html.

7. Foreign Assistance Act of 1961, 22 U.S.C. 5, 2151b(f)(1) (2002); *see also* THE BUSH GLOBAL GAG RULE, *supra* note 3.

8. Family Planning and Population Assistance Activities, 48 C.F.R. § 752.7016(b) (1996); *see also* THE BUSH GLOBAL GAG RULE, *supra* note 3.

9. *Ctr. for Reprod. Law & Policy*, 2001 U.S. Dist. LEXIS 10903 at *14.

10. Admiral James W. Nance and Meg Donovan Foreign Relations Authorization Act, Fiscal Years 2000 and 2001, Pub. L. No. 106-113, 113 Stat. 1501a-405 (1999).

11. Restoration of the Mexico City Policy, *supra* note 5, at 17,306; *see also* THE BUSH GLOBAL GAG RULE, *supra* note 3.

12. Admiral James W. Nance and Meg Donovan Foreign Relations Authorization Act, *supra* note 10 (emphasis added); *see also* THE BUSH GLOBAL GAG RULE, *supra* note 3.

grantee spends funds not provided by U.S. government sources.[13] The U.S. government may not use funding restrictions to impinge upon a U.S.-based NGO's ability to exercise its rights to free speech or to lobby using its own private funds.[14] U.S. courts have additionally held that although states can require that public monies not be used for constitutionally protected rights, they cannot restrict the funds to impinge upon the exercise of such rights with private funds.[15]

Such protections do not apply to foreign organizations. In 1989, the Court of Appeals for the District of Columbia upheld the Mexico City Policy in *DKT Memorial Fund v. Agency for International Development.* In a two-to-one majority, the court stated that as an "alien beyond the bounds of the U.S." a foreign NGO did not have standing to "assert a constitutional claim."[16]

II. By Hindering Free Speech and Free Association, the Global Gag Rule Prevents Effective Communication Between Lawmakers and Their Constituents

The Global Gag Rule infringes upon the free speech and free association of reproductive health advocates in Uganda, Ethiopia, and Kenya by inhibiting the flow of information from citizens invested in women's reproductive health and lives to the public and to lawmakers.

In the following section, I will first explain that, specifically with regard to abortion, a myriad of barriers create an information gap such that lawmakers are ignorant of the consequences of a restrictive abortion law as known by stakeholders. Consequently, impracticable abortion laws remain in effect in Uganda, Ethiopia and Kenya. These barriers include a lack of compiled accurate information on the impact of unsafe abortion and the risk of actually increasing the number of unsafe abortions by drawing attention to the need to liberalize.

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13. *See* Rust v. Sullivan, 500 U.S. 173, 190–98 (1991); *see also* The Bush Global Gag Rule, *supra* note 3.
14. *See generally* FCC v. League of Women Voters, 104 S. Ct. 3106 (1984); *see also* The Bush Global Gag Rule, *supra* note 3.
15. *See* Planned Parenthood Ass'n of Chicago Area v. Kempiners, 568 F. Supp. 1490 (N.D. Ill. 1983); *see also* Planned Parenthood Ass'n of Cent. and N. Ariz. v. Arizona, 789 F.2d, 1348, 1350 (9th Cir. 1986); *see also* The Bush Global Gag Rule, *supra* note 3.
16. DKT Mem'l Fund v. Agency for Int'l Dev., 887 F.2d 275, 285 (D.C. Cir. 1989); *see also* The Bush Global Gag Rule, *supra* note 3.

Secondly, I will describe the processes by which reproductive health providers are able to surmount the barriers creating the information gap through the free exercise of speech and association in Uganda, Ethiopia, and Kenya. I will show that reproductive health professionals are the very stakeholders trying to expose the effects of the restrictive law. Through a case study of activists' work in Kenya, I will explain that free association is vital in combination with free speech so that stakeholders' experiences of coping with the restrictive law can reach lawmakers. Through case studies of stakeholders' work in Uganda and Ethiopia, I will show that, without the exercise of association, they cannot garner sufficient authority to educate the public and lawmakers on unsafe abortion.

Finally, in this section, I will explain that by restricting free speech and free association, the GGR prevents stakeholders from bringing information on unsafe abortion to lawmakers. USAID has tremendous influence such that organizations cannot freely choose whether to certify.[17] For both those who are forced to certify and for those who did not, the GGR hinders a range of speech on unsafe abortion—both speech that is technically restricted and speech that is not. The Global Gag Rule's impact on free speech prevents stakeholders from gaining enough authority to inform lawmakers about unsafe abortion through three different processes. The restriction reduces the number of stakeholders involved in efforts to inform on the issue of unsafe abortion; it prevents reproductive health providers from conveying a unified message with respect to liberalization; and, through isolating them, the GGR diminishes the authority of organizations that connect unsafe abortion to the restrictive law.

A. Barriers Create a Gap in Information Between Lawmakers and the People Governed, Resulting in the Neglect of Unsuitable Laws

The abortion laws of Uganda, Ethiopia, and Kenya have a detrimental affect on the lives of women subject to them. Clear information on the laws' impact does not adequately reach lawmakers. Consequently, the laws remain in effect.

17. NGOs must sign a certificate of compliance with the Global Gag Rule ("certifying") or be denyied USAID funding. *See infra* Part II.C.1.

1. Laws that Prohibit Abortion Remain Impracticable in Uganda, Ethiopia, and Kenya

The laws and regulations that apply to abortion in Uganda, Ethiopia, and Kenya have not received the attention of informed lawmakers and thus remain impracticable as written and as applied.

Due to neglect, contradictory legal provisions allowing for a range of interpretation govern the provision of abortion in Kenya and Uganda. The two countries share colonial-era penal codes imposing penalties, including imprisonment, upon any woman who intends to "procure her own miscarriage" and to any person who intends to "procure the miscarriage of a woman."[18] Another provision deems surgical abortions lawful when the procedure is performed "for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case."[19] Courts in Kenya and Uganda have also followed the holding of a 1938 English case that allows legal abortion on the grounds of preserving the pregnant woman's physical and mental health.[20]

Application of these abortion laws remains inconsistent. Though Kenya and Uganda share abortion restrictions, the laws are enforced in vastly dissimilar manners. In Uganda, abortion providers are prosecuted, sentenced, and have had their ability to provide services suspended.[21] In

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18. LAWS OF KENYA, Ch. 63, §§ 158–60; The Penal Code Act of Uganda, ch. 106, §§ 136–38.

19. LAWS OF KENYA, Ch. 63, § 240; The Penal Code Act of Uganda, Ch. 106 § 217.

20. UNITED NATIONS DEP'T OF ECONOMIC AND SOCIAL AFFAIRS POPULATION DIV., ABORTION POLICIES: A GLOBAL REVIEW 87, 149 (2001). *See* UNITED NATIONS DEP'T OF ECONOMIC & SOCIAL AFFAIRS, ABORTION POLICIES: A GLOBAL REVIEW, vol. 11 Gabon to Nor. At 87, U.N. Doc. ST/ESA/SER. A/91, U.N. Sales No. E.01.XIII.18 (2002); UNITED NATIONS DEP'T OF ECONOMIC & SOCIAL AFFAIRS, ABORTION POLICIES: A GLOBAL REVIEW, Vol. III Oman to Zimb. At 149, U.N. Doc. ST/ESA/SER.A/196, U.N. Sales No. E.02.XIII.5 (2002).

21. On April 30, 1999, the Uganda Medical and Dental Practitioners' Council suspended Marie Stopes Uganda for allegedly administering abortions. *Marie Stopes Closed*, NEW VISION (Kampala) (May 6, 1999), *available at* http://allafrica.com/stories/printable/199905060077.html (last visited Apr. 8, 2004)). Later that year, a newspaper editorial relayed the sentencing of a doctor to four years in prison for carrying out an illegal abortion. *Illegal Abortions Bad*, NEW VISION (Kampala) (Oct. 8, 1999), *available at* http://allafrica.com/stories/printable/199910080134.html. In 1999, Dr. Dan Musisi was charged with carrying out abortion. *Doctor Admits to Performing 300 Abortions*, NEW VISION (Kampala) (Aug. 6, 1999), *available at* http://allafrica.com/stories/printable/199908060150.html. In October 2001, Alice Mutuwa was held by police in Sironko for "attempting to procure an abortion" of another woman. David Mafabi, *Women Arrested Over Abortion*, THE MONITOR

contrast, abortion is provided in Kenya largely unhindered by law enforcement authorities or medical boards.[22] Because the legality of an abortion depends upon the circumstances for which it is performed, and because in many cases the law is not enforced at all, some providers in Kenya find the legality of the procedure ambiguous, but see the law itself as coercive.[23] As the law in some cases remains unenforced, the reproductive health community is able to construe it broadly. Providers in Kenya understand the law to allow an HIV-positive woman to obtain an abortion.[24] Menstrual regulation[25] is also understood to be legal by Kenyan providers.[26] In Uganda, however, reproductive health providers understand the law—which is technically identical to the law of Kenya—to disallow most instances of abortion as well as menstrual

(Kampala) (Oct. 15, 2001), *available at* http://allafrica.com/stories/printable/200110150161.html. Mutuwa had "been masquerading as a nurse who would use herbs to help pregnant women abort." *Id.* In December of the same year, the Ugandan High Court annulled a ruling in which the Uganda Medical and Dental Practitioners' Council suspended Dr. Espilidon Tumukurate Kamugisha of Lyantonde for carrying out an abortion at his Kamugisha Nursing Home in Lyantonde. Edith Kimuli, *High Court Reverses Medical Council Ruling*, NEW VISION (Kampala) (Dec. 15, 2001), *available at* http://allafrica.com/stories/printable/200112160060.html. Police in Kasese, Uganda, arrested a couple in January 2002 on allegations that they helped their daughter have an abortion. *Kasese Couple Held Over Girl's Abortion*, NEW VISION (Kampala), (Jan. 18, 2002), *available at* http://allafrica.com/stories/printable/200201180469.html.

22. Interview with anonymous NGO staff in Kampala, Uganda (June 6, 2002) [hereinafter Uganda: Interview One]; Interview with anonymous health care provider in Kampala, Uganda (June 6, 2002); Interview with anonymous NGO staff in Nairobi, Kenya (July 11, 2002) [hereinafter Kenya: Interview One]; Interview with anonymous health care provider in Nairobi, Kenya (July 18, 2002) [hereinafter Kenya: Interview Two].
23. Kenya: Interview One, *supra* note 22; Interview with anonymous NGO staff in Nairobi, Kenya (July 23, 2002) [hereinafter Kenya: Interview Three]; Interview with anonymous medical provider in Nairobi, Kenya (Aug. 1, 2002) [hereinafter Kenya: Interview Four]. According to a source inside the Ministry of Health in Kenya, however, the Kenyan abortion law is "very clear on what is illegal and what is legal." Interview with anonymous government official in Nairobi, Kenya (July 16, 2002) [hereinafter Kenya: Interview Five].
24. Kenya: Interview Four, *supra* note 23.
25. Menstrual regulation is defined by the World Health Organization as "early uterine evacuation without laboratory or ultrasound confirmation of pregnancy for women who report delayed menses." WORLD HEALTH ORG., SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 22 (2003).
26. Interview with anonymous NGO staff in Nairobi, Kenya (July 12, 2002); Interview with anonymous NGO staff in Nairobi, Kenya (July 18, 2002) [hereinafter "Kenya: Interview Six"]; Interview with anonymous government official in Nairobi, Kenya (July 26, 2002) [hereinafter "Kenya: Interview Seven"].

regulation.[27] No interviewee in Uganda was aware of any case of legal abortion.[28]

The requirements necessary to obtain a legal abortion in Uganda, Ethiopia, and Kenya are impossible to fulfill for the vast majority of the population—people who live with few resources. In Kenya, legal abortion is available in major hospitals only to the few women who can afford to meet the expensive requirements put forth by the registering board for medical and dental practitioners.[29] These state that a woman who undergoes an abortion must first obtain the signatures of two doctors that agree on the need for the procedure to preserve her life.[30] Signatures are typically provided by one obstetrician/gynecologist and one psychiatrist,[31] the cost of which is prohibitive to the majority of Kenyan women. The Ugandan abortion law is understood to permit abortion if the fetus has a severe deformity and if two doctors of "good repute" approve the procedure.[32] However, most Ugandans live in rural areas, where there exists no method to detect fetal deformities and, in many circumstances, no doctor.[33]

Abortion is also illegal in Ethiopia, except under infeasible circumstances. The procedure is legal on "medical grounds" requiring formalities including a written diagnosis by a medical practitioner certified by a second doctor, with the consent of the woman, her next of kin or legal representative.[34] The findings must be kept in duplicate and transmitted to an appropriate government official.[35] If the formalities are not completed and the pregnancy was not terminated upon the grounds of a medical emergency, the abortion is deemed illegal.[36]

27. Interview with anonymous intergovernmental staff in Kampala, Uganda (May 30, 2002) [hereinafter Uganda: Interview Two]; Interview with anonymous medical provider in Kampala, Uganda (May 31, 2002) [hereinafter Uganda: Interview Three].
28. Uganda: Interview Three, *supra* note 27.
29. Kenya: Interview Two, *supra* note 22.
30. *Id.*; *see also* Interview with annymous health care provider in Nairobi, Kenya (July 23, 2002) [hereinafter Kenya: Interview Eight].
31. Kenya Interview Two, *supra* note 22; Kenya: Interview Eight, *supra* note 30.
32. Interview with anonymous NGO staff in Kampala, Uganda (May 30, 2002) [hereinafter Uganda: Interview Four].
33. *Id.*
34. Pen. Code Art. 534 (Eth.).
35. *Id.*
36. *Id.* at Art. 536.

a. Restrictive Abortion Law Increases Rates of Maternal Mortality and Morbidity

A restrictive abortion law is detrimental to the health and lives of women.[37] The majority of deaths from unsafe abortion occur in countries where the procedure is restricted by law.[38] The World Health Organization draws a connection between restrictive abortion laws and high rates of unsafe abortion.[39]

Information on maternal mortality and morbidity due to unsafe abortion is scarce.[40] However, a growing body of evidence in Uganda, Ethiopia, and Kenya is beginning to show that unsafe abortion is a neglected health issue in need of attention.

The correlation between maternal death and injury and lack of access to safe abortion was stark when a regional health bureau closed a major provider of safe abortion in Ethiopia. Consequently, the number of cases of women needing care for complications from unsafe abortion reportedly rose at the public hospital.[41] According to the Prime Minister's Office in Ethiopia, fifty-three percent of the major health problems for women are obstetrical in nature, including those arising from abor-

37. This paper focuses on the public health arguments for liberalizing abortion laws. The need for abortion law reform is conceptualized most recently in terms of rights as expressed by national constitutions and international conventions. *See* Rebecca J. Cook & Bernard M. Dickens, *Human Rights Dynamics of Abortion Law Reform*, 25 HUM. RTS. Q. 1, 21–52 (2003). However, in Uganda, Ethiopia and Kenya, due to their histories of authoritarian governments, a culture of rights is less well-developed. Interview with anonymous NGO staff in Addis Ababa, Ethiopia (June 28, 2002) [herinafter Ethiopia: Interview One]; Interview with anonymous health care provider in Nairobi, Kenya (July 14, 2002) [hereinafter Kenya: Interview Nine]. In consequence, advocates for liberalization in these countries are primarily concerned with the detrimental impact of restrictive laws upon women's health and the endangerment of their lives.

38. THE ALAN GUTTMACHER INST., SHARING RESPONSIBILITY: WOMEN, SOCIETY AND ABORTION WORLDWIDE (1999).

39. In Romania, the number of abortion-related deaths increased sharply as the government tightened a liberal abortion law in 1966. When abortion was legalized again at the end of 1989, maternal deaths from unsafe abortion dropped dramatically by the end of the following year. WORLD HEALTH ORG., *Unsafe Abortion, Global and Regional Estimates of Incidence of and Mortality due to Unsafe Abortion with a Listing of Available Country Data* 1 (3d. ed., 1998). In South Africa, legalization of abortion immediately decreased maternal morbidity. Heather Brown et al., *Prevalence of Morbidity Associated with Abortion before and After Legalisation in South Africa*, 324 BRIT. MED. J. 1252 (2002).

40. *See infra* Part II.A.2

41. Interview with anonymous health care provider in Addis Ababa, Ethiopia (June 25, 2002) [hereinafter Ethiopia: Interview Two].

tion.[42] Studies show that between twenty-two and fifty-four percent of all maternal deaths are due to unsafe abortion[43] and that fifty-two per cent of Ethiopia's hospital beds are occupied by women that were suffering from complications related to unsafe abortions.[44]

In Uganda, illegal unsafe abortions are common; induced abortion has been ranked the second leading cause of maternal mortality.[45] In a 1986 study, thirty-five percent of maternal deaths in Uganda were linked to unsafe abortion.[46] Illegal abortion is more prevalent among young women: a 1988 survey found that twenty-three percent of women between the ages fifteen and twenty-four that had been pregnant have had at least one abortion.[47]

Ward Six at Kenyatta National Hospital in Kenya gained notoriety due to its staggering numbers of patients needing treatment for complications due to unsafe abortion.[48] Such complications have been found to account for sixty percent of all acute gynecological admissions to hospitals nationwide,[49] between twenty-nine and fifty percent of all

42. WOMEN'S AFFAIRS OFFICE IN THE PRIME MINISTER'S OFFICE, FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA (FDRE), NATIONAL REPORT ON IMPLEMENTATION OF THE BEIJING PLATFORM FOR ACTION 15 (2000).

43. "A community-based study conducted in Addis Ababa revealed that abortion accounted for 54% of the direct causes of maternal deaths (Kwast BE, Rochal RW, Widad Kidan Mariam. Maternal mortality in Addis Ababa, Ethiopia. Studies in Family Planning, 1986, 17 (6): 288–301). A hospital-based study in Addis Ababa reported that abortion accounted for 22.2% of all maternal deaths (Yoseph S. and Kifle G. A six-year review of maternal mortality in teaching hospital in Addis Ababa. Ethiop. Med. J. 1988; 26: 115–120). Another study on illegal abortion conducted in five hospitals in Addis Ababa showed that abortion-related maternal deaths contributed to 52.2% of all maternal deaths (Yoseph S et al.; A Survey of Illegal Abortion in Addis Ababa. December 1993)." ETHIOPIAN SOC'Y OF OBSTETRICIANS AND GYNECOLOGISTS (ESOG), REPORT ON SURVEY OF UNSAFE ABORTION IN HEALTH FACILITIES IN ETHIOPIA 8 (May 2002) (unpublished manuscript on file with Michigan Journal of Gender & Law).

44. Danachew Teklu, *Abortion Kills 1,000 Ethiopian Women Every Year*, THE DAILY MONITOR (ADDIS ABABA), Mar. 13, 2001, *available at* http://allafrica.com/stories/printable/200103210325.html.

45. UNITED NATIONS DEP'T. OF ECON. AND SOC. AFFAIRS POPULATION DIV., ABORTION POLICIES: A GLOBAL REVIEW 149 (2001).

46. *Id.*

47. *Id.*

48. Kenya: Interview Six, *supra* note 26; Interview with anonymous NGO staff in Nairobi, Kenya (July 25, 2002) [hereinafter Kenya: Interview Ten].

49. Kenya: Interview Nine, *supra* note 37; Dorothy Otieno & Kenneth Kwama, *Role of FLE in Curbing Teenage Pregnancies*, THE EAST AFRICAN STANDARD (Nairobi), Feb. 16, 2002, *available at* http://allafrica.com/stories/printable/200202160054.html.

gynecological ward admissions,[50] and over twenty per cent of all maternal deaths.[51]

b. Some Government Officials Support Access to Safe Abortion

Many government officials responsible for protecting and promoting the health of their citizens are aware that the standing abortion laws contravene their mandates. However, without the vocal support of an organized NGO community or of the public, many such officials lack the political strength to publicly advocate legal change.

Despite Ethiopia's law, some members of the Ethiopian government privately support access to safe abortion.[52] In 1999, the Ministry of Health deemed the number of youth dying from unsafe abortion a "national epidemic."[53] Interviewees indicated that Ministry of Health officials and the Prime Minister realize that hospital caseloads increase when safe abortion providers are unable to offer services.[54] Some government officials are therefore tolerant of providers who (without any support from USAID) interpret exceptions under the abortion law broadly.[55] As permitted by law, government hospitals in Ethiopia will provide abortion to a woman whose life is in danger due to the pregnancy.[56]

Numerous officials within the governments of Kenya and Uganda privately support access to safe abortion. Several NGOs in Kenya that are not subject to the GGR provide safe abortions with the unspoken consent of some government officials.[57] The Ugandan Ministry of Health does not have an official position with regard to the legality of

50. Julie Soko et al., *Creating Linkages Between Incomplete Abortion Treatment and Family Planning Services in Kenya*, 30 STUD. IN FAMILY PLANNING 17 (1999); FLORENCE MIREMBE ET AL., PUPULATION REFERENECE BUREAU, REPRODUCTIVE HEALTH IN POLICY AND PRACTICE: UGANDA 8 (1998), *available at* http://www.prb.org/pdf/RHPPUganda.pdf.).

51. Mirembe, *supra* note 50.

52. Interview with anonymous NGO staff in Addis Ababa, Ethiopia (June 18, 2002) [hereinafter Ethiopia: Interview Three]; Interview with anonymous government official in Addis Ababa, Ethiopia (June 24, 2002) [herinafter Ethiopia: Interview Four].

53. MINISTRY OF HEALTH ET AL., AN ASSESSMENT OF REPRODUCTIVE HEALTH NEEDS IN ETHIOPIA 30 (1999).

54. Interview with anonymous NGO staff in Addis Ababa, Ethiopia (June 26, 2002) [hereinafter Ethiopia: Interview Five].

55. *Id.*

56. Ethiopia: Interview Three, *supra* note 52.

57. Kenya: Interview Six, *supra* note 26.

abortion.[58] However, in 2000 the Assistant Commissioner for Reproductive Health called for the help of legislators in order to address unsafe abortion.[59]

2. Accurate Information on the Impact of Unsafe Abortion is Unavailable

Lack of information on unsafe abortion has hampered efforts to address it.[60] Studies on unsafe abortion are unavailable, and abortion rights advocates therefore have few statistics with which to inform the public and lawmakers.[61]

The need to generate evidence-based data on unsafe abortion is apparent to reproductive health providers, as advocates identified at a major reproductive health conference in Ethiopia.[62] A coalition of professionals working to liberalize the law in Kenya discerned that their first step in advocacy needed to be the collection of information, as studies on unsafe abortion had not been conducted.[63]

Data on unsafe abortion is scarce and unreliable because of ethical controversy, cultural beliefs and the illegality of the procedure.[64] Underreporting and misreporting is common.[65] Providers are reluctant to reveal their involvement,[66] and women in particular are reluctant to express their opinions. In Uganda, for example, during a debate on liberalization broadcast through the media, several men but not a single woman offered their opinions.[67] According to a Ugandan Ministry of Health official, "the problem is that people here do not want to talk about abortion."[68]

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58. Interview with anonymous health care provider in Kampala, Uganda (June 10, 2002) [hereinafter Uganda: Interview Five].
59. John Eremu, *Legalise Abortion, EU Advises Uganda*, NEW VISION, Jan. 16, 2000, *available at* http://www.allafrica.com/stories/200001160026.html
60. ETHIOPIAN SOC'Y OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 43, at 8.
61. Interview with anonymous medical provider in Kampala, Uganda (June 12, 2002).
62. ETHIOPIAN SOC'Y OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 43, at 1.
63. Kenya: Interview Four, *supra* note 23.
64. REBECCA J. COOK ET AL., REPRODUCTIVE HEALTH AND HUMAN RIGHTS 26 (2003); ETHIOPIAN SOC'Y OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 43, at 9; WORLD HEALTH ORG., UNSAFE ABORTION; GLOBAL AND REGIONAL ESTIMATES OF INCIDENCE OF A MORTALITY DUE TO UNSAFE ABORTION WITH A LISTING OF AVAILABLE COUNTRY DATA 12 (1998).
65. WORLD HEALTH ORG., *supra* note 64, at 12.
66. ETHIOPIAN SOC'Y OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 43, at 9.
67. *See* Interview with anonymous government official in Kampala, Uganda (June 7, 2002) [hereinafter Uganda: Interview Six]; Uganda: Interview Five, *supra* note 58.
68. Eremu, *supra* note 59.

3. Drawing Attention to the Need to Liberalize the Restrictive Law Can Lead to Decreased Access to Safe Abortions and Increased Maternal Mortality

In some regions, persons aware of the need to increase access to safe abortion may be reluctant to speak as doing so can lead to crackdowns on access. Speech on unsafe abortion before the reinstatement of the GGR was hindered by organizations' self-censorship—a situation that is severely exacerbated with the restriction. Whether the laws are enforced or unenforced, some advocates of safe abortion fear that their efforts will be frustrated if attention is brought to their work. Government officials have the power to enforce the law, and churches have the power to counter law reform efforts. These risks may create a barrier to bringing information on unsafe abortion to the attention of lawmakers and their constituents.

Where abortion laws are unenforced, advocates of access to safe abortion fear that by generating public information on the need to liberalize, opponents would be encouraged to work to tighten what may be seen as loopholes in the laws.[69] This is particularly true in Kenya—where some reproductive health professionals believe that people working to improve access to safe abortion will find more success if they do not draw attention to their effort.[70] They feel that when professionals quietly provide safe abortion services, more short-term gains may be made in the prevention of abortion-related death and injury.[71] Such gains are evident in Kenya, where a quiet advocate has been successful in increasing access, unsanctioned by lawmakers. His NGO works by training medical professionals and educating communities.[72]

Where abortion laws are enforced, providers who speak on the need to liberalize risk closure of their reproductive health facilities, as is the case in Uganda where reproductive health providers are unwilling to speak about the issue.[73] Though supportive of access to safe abortion,

69. Kenya: Interview One, *supra* note 22; Kenya: Interview Six, *supra* note 26; Interview with anonymous health care provider in Nairobi, Kenya (July 26, 2002) [hereinafter Kenya: Interview Eleven]; Interview with anonymous health care provider in Nairobi, Kenya (July 26, 2002) [herinafter Kenya: Interview Twelve].

70. Kenya: Interview One, *supra* note 22; Kenya: Interview Six, *supra* note 26.

71. Kenya: Interview One, *supra* note 22.

72. *See* Marc Lacey, *Despite a Ban, Teaching Safe Abortions in Kenya*, N.Y. TIMES, Feb. 17, 2002, at A3; *see also* Katini Nzau-Ombaka, *Alternative Access to Abortion Services Under Restrictive Law, in* ADVOCATING FOR ABORTION ACCESS ELEVEN COUNTRY STUDIES 173 (Barbara Klugman & Debbie Budlender eds., 2001).

73. Uganda: Interview Two, *supra* note 27.

providers are reluctant to support liberalization as legal safe abortion is available in certain circumstances such as when the life of the mother is in danger or the fetus is malformed, but these procedures can only be utilized, if facilities are able to remain open.[74] Further, providers are reluctant to speak against government policy;[75] one interviewee stated that her organization "can't do campaigns [to liberalize the law] because abortion is illegal."[76]

Reproductive health advocates are aware that churches can counter their efforts when information about their activities is made public.[77] In 2002, the Ugandan government immediately complied with a request by the Cardinal of Uganda to stop its efforts to promote emergency contraception and to deem emergency contraception an abortifacient.[78] Reproductive health professionals in multiple sectors were involved in the promotion, and upon becoming aware of their efforts, the Cardinal contacted the Ugandan government.[79] The Solicitor General in turn issued an interpretation in which it declared emergency contraception illegal under the laws restricting abortion.[80] One NGO subsequently curtailed its publicizing of a successful post-abortion care program, as it did not want to attract the attention of the religious community for fear of a reprisal similar to that of the promotion of emergency contraception.[81]

B. Through the Free Exercise of Speech and Association, Reproductive Health Professionals Are Able to Generate the Requisite Authority to Overcome Barriers and Inform Lawmakers of the Effect of the Laws

Among the people aware of the impact of the abortion laws, only those who acquire power and authority are able to bring this information to the attention of lawmakers and their constituents.

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74. *Id.*
75. *Id.*
76. Interview with anonymous NGO staff in Kampala, Uganda (May 29, 2002).
77. Uganda: Interview Five, *supra* note 58.
78. Uganda: Interview Six, *supra* note 63.
79. *Id.*
80. *Id.*; Memorandum from P.K. Asiimwe, Director General of Health Services, Ministry of Health of the Republic of Uganda, Re: Legal Opinion on the Definition of Abortion in Uganda (May 7, 2002) (on file with author).
81. Uganda: Interview One, *supra* note 22.

1. The Actors Working to Change the Restrictive Law Are Reproductive Health Professionals

Reproductive health professionals, working where the law restricts abortion, experience the impact first-hand as they treat injury and are faced with death that results from a lack of access to safe abortion. In Ethiopia, nearly seventy percent of reproductive health workers surveyed had encountered incomplete abortion patients frequently or sometimes, and 90 percent had at least one such encounter.[82]

Because of their status as professionals and the authority which accompanies their position, reproductive health care providers can overcome the barriers to addressing a restrictive law.[83] In Kenya, Uganda, and Ethiopia, reproductive health professionals have spoken publicly on the need to address unsafe abortion. They have determined that the need to save women's lives through legal reform outweighs the risks associated with speaking out. Only those professionals not subject to the GGR have been able to continue such speech since the reinstatement.

a. Reproductive Health Professionals Have Spoken Publicly on the Need to Address the Issue of Unsafe Abortion in Kenya

Kenya's most outspoken advocates are leading medical professionals who both have treated women with abortion complications and are established professionals somewhat able to weather personal and professional risks. After several years of providing reproductive health care as a medical doctor, one Kenyan advocate of access to safe abortion understands that, once a woman decides to terminate a pregnancy, she will do anything to make it happen.[84] Both an activist in Kenya's liberalization movement and a high-ranking government official who has spoken out treated women for abortion complications on the well-known Ward Six of Kenyatta National Hospital.[85]

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82. ETHIOPIAN SOC'Y OF OBSTETRICIANS AND GYNECOLOGISTS (ESOG), *KAP Study on Abortion Among Ethiopian Health Workers* 2 (2002).
83. Interview with anonymous NGO staff in Kampala, Uganda (June 4, 2002).
84. Kenya: Interview Twelve, *supra* note 69.
85. Interview with anonymous NGO staff in Nairobi, Kenya (July 25, 2002) [hereinafter Kenya: Interview Thirteen]; Kenya: Interview Six, *supra* note 26; Kenya: Interview Four, *supra* note 23.

b. Reproductive Health Professionals Have Spoken Publicly on the Need to Address the Issue of Unsafe Abortion in Uganda

Leaders of the medical community in Uganda have voiced their recommendations that the abortion law be reviewed at conferences, workshops, and meetings.[86] During a workshop in Kampala one such leader urged the World Health Organization to recommend legalization among adolescents.[87] Another leader and vocal supporter of liberalization has publicly stated, "all medical doctors should come out publicly and voice their concern about abortion."[88]

c. Reproductive Health Professionals Have Spoken Publicly on the Need to Address the Issue of Unsafe Abortion in Ethiopia

Leading medical professionals in Ethiopia have publicly discussed the high rates of maternal mortality and morbidity due to unsafe abortion.[89] As a result of a study on attitudes on abortion among health workers, one medical organization recommended that the "abortion law needs to be liberalized to accommodate termination of pregnancy in certain circumstances like rape, contraceptive method failure, maternal indication and others."[90] Additionally, medical professionals organized a conference about the hazards of unsafe abortion[91] during which they

86. Uganda: Interview Four, *supra* note 32; Interview with anonymous NGO staff in Kampala, Uganda (June 6, 2002).

87. *Ugandan Doctor Wants Abortion Legalised*, NEW VISION (Kampala), Aug. 6, 1999, *available at* http://allafrica.com/stories/199908060150.html.

88. *Uganda: Doctors Want Abortion Declared Legal*, NEW VISION (Kampala), Mar. 27, 2000, *available at* http://allafrica.com/stories/200003270118.html.

89. *Unsafe Abortion Identified As Second Major Killer Of Pregnant Women*, ADDIS TRIBUNE, Mar. 16, 2001, *available at* http://allafrica.com/stories/200103160283.html (quoting Dr. Yirgu Gebrehiwot, honorary secretary of the Ethiopian Society of Obstetrics and Gynecology, as saying that "unsafe abortion accounted for about 54 percent of the mortality among pregnant women.") *Abortion Kills 1,000 Ethiopian Women Every Year*, THE DAILY MONITOR (Addis Ababa), Mar. 13, 2001, *available at* http://allafrica.com/stories/printable/200103210325.html. (quoting Dr. Lukman Yosef, a medical consultant at Addis Ababa University, as saying that "25 per cent of the world's population are living in countries where abortion is forbidden" and that "52 per cent of [Ethiopia's] hospital beds are occupied by women that were suffering from complications related to unsafe abortions.").

90. ETHIOPIAN SOC'Y OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 82.

91. *See* CTR. FOR REPRODUCTIVE RIGHTS, WOMEN OF THE WORLD: ANGLOPHONE AFRICA 22 (2001) citing email from Helen Seifu, Ethiopian Women Lawyers' Association, to the Center for Reproductive Law and Policy (Dec. 19, 2000).

prioritized research on issues regarding abortion.[92] Medical professionals have also helped to arrange a panel discussion on "the impact of unsafe abortion and its solution."[93]

2. The Requisite Authority to Generate Effective Speech on the Need to Change the Abortion Law Is Created by the Exercise of Association in Kenya

The ability to organize and form associations is crucial to bringing the issue of unsafe abortion to the attention of lawmakers and their constituents. Stakeholders who come together can generate the requisite authority to overcome barriers and endure the associated political and professional risks. When reproductive health professionals have not organized themselves, the requisite authority to bring information on unsafe abortion to lawmakers is lacking.

Without enough support from associations aware of the issue of unsafe abortion, two successive Permanent Secretaries of Health in Kenya were unable to overcome barriers inhibiting speech on the need to liberalize. Both Permanent Secretaries made statements in support of liberalization shortly after their appointments, and both had neither the political capital nor sufficient support from organizations needed to fortify their positions. Consequently, calls for legalization were retracted. In 1999, with the support of other top health officials, then Permanent Secretary Julius Meme called for the legalization of abortion at a regional workshop for journalists on law and reproductive rights.[94] However, the Permanent Secretary met strong opposition from political leaders, the President, the public, and the church.[95] As the backlash against the Permanent Secretary's comments ensued, no one came forward to voice their support for liberalization.[96] He was forced to weaken

92. ETHIOPIAN SOC'Y OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 82, at 1.

93. *Unsafe Abortion Identified As Second Major Killer Of Pregnant Women*, *supra* note 89.

94. Kenya: Interview Nine, *supra* note 37; Interview with anonymous NGO staff in Nairobi, Kenya (July 23, 2002) [hereinafter Kenya: Interview Fourteen]; Kenya: Interview Thirteen, *supra* note 85; *Kenya: Officials Call For Legalization Of Abortion*, U.N. WIRE, Aug. 3, 1999, *available at* http://www.unfoundation.org/unwire/utlil/display_stories.asp?objid=4123.

95. Kenya: Interview Five, *supra* note 23; Kenya: Interview Seven, *supra* note 26; Kenya: Interview Four, *supra* note 23; Kenya: Interview One, *supra* note 22; Kenya: Interview Ten, *supra* note 48; *see Calls to Legalise Abortion Censured*, THE DAILY NATION (Nairobi), Aug. 13, 1999, *available at* http://allafrica.com/stories/199908130074.html.

96. Kenya: Interview Four, *supra* note 23.

his position, stating that abortion is appropriate only in circumstances where the doctor finds the health of the mother in danger,[97] as is consistent with prevailing interpretations of the current law. On March 5, 2003, the Current Permanent Secretary of Health, Charity Ngilu stated publicly that "it was a gross violation of human rights to continue denying women access to safe motherhood and abortion services."[98] Churches immediately denounced Ngilu's statement and, by the next day, March 6, during a parliamentary session the Health Minister denied her support for legalization of abortion.[99]

The need to form associations is particularly salient for NGOs, which do not have authority equal to government officials'. Alliances have formed in Kenya to acquire the requisite power and resources to bring the issue of unsafe abortion to the attention of the public and of lawmakers. In the wake of Secretary Meme's pro-liberalization statement,[100] a coalition of concerned NGOs that are not subject to the GGR formed to formally advocate for liberalization.[101] Composed of respected professionals from the legal and medical fields, the coalition has been able to overcome some barriers and disseminate information on the effects of the restrictive law.

a. The Coalition Is Generating Speech on the Issue of Abortion

To address the unavailability of information on the impact of unsafe abortion, the Kenyan coalition set out to systematically collect this information. From October through December 2002, the coalition undertook a multi-faceted nation-wide study on unsafe abortion.[102] It collected data on patients with abortion complications in fifty public hospitals and studied the cost of treating unsafe abortion.[103] At a large hospital, the coalition planned to conduct interviews with women who, according to their illness type, likely underwent induced abortion and to

97. Silas Nthiga, *Abortion Stays Illegal*, THE DAILY NATION (Nairobi), Aug. 14, 1999, *available at* http://allafrica.com/stories/printable/199908140037.html.

98. *Ngilu Retreats from Legal Abortion Talk*, THE EAST AFRICAN STANDARD (Nairobi), Mar. 6, 2003, *available at* http://www.eastandard.net/articles/March/thur06032003/headlines/news060320030018.htm.

99. *Id.*

100. Kenya: Interview Four, *supra* note 23.

101. *Id.*

102. *Id.*

103. *Id.*

use these interviews to discern the women's perception of the procedure.[104]

The coalition also facilitated the creation of public speech on abortion. It held a series of public discussions in each province in Kenya during which a panel composed of a medical provider, a legal expert, and a religious representative made presentations on different aspects of unsafe abortion.[105] A moderator facilitated a discussion among attendees, which included reproductive health professionals and members of the general public, who were invited through posters and newspaper advertisements.[106]

The coalition also works to disseminate existing information on unsafe abortion. During public discussions, the coalition distributes a fact sheet on unsafe abortion,[107] and they have undertaken a media campaign that includes television, radio and newspapers.[108]

b. The Coalition Is Working to Increase Its Authority Through Association

The coalition has been strategizing to build upon its authority through the exercise of association. It has formed a stakeholders group within one of its organizations to educate the remainder of the association on the need to liberalize.[109] The coalition is also working with its members to sensitize them on the effects of the restrictive law.[110] Additionally, it is working to widen its network and plans to cultivate relationships with other organizations serving the reproductive health needs of Kenya.[111]

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104. *Id.*
105. *Id.*
106. Interview with anonymous NGO staff in Nairobi, Kenya (July 22, 2002) [hereinafter Kenya: Interview Fifteen]; Kenya: Interview Four, *supra* note 23.
107. Kenya: Interview Six, *supra* note 26; Kenya: Interview Four, *supra* note 23.
108. Kenya: Interview Four, *supra* note 23; *Project Calls for Debate on Reproductive Health*, THE DAILY NATION (Nairobi), July 18, 2002, *available at* http://www.nationmedia.com/dailynation/oldarchives.asp?archive=true.
109. Kenya: Interview Twelve, *supra* note 69.
110. Kenya: Interview Fifteen, *supra* note 106; Kenya: Interview Four, *supra* note 23.
111. Kenya: Interview Fifteen, *supra* note 106.

c. The Requisite Authority Is Created by Association

Because of its ability to form associations, the coalition was able to gain the authority to develop relationships with key members of parliament, which allowed it to work with them in bringing light to the issue of unsafe abortion.[112]

The coalition met with the Parliamentary Committee on Social Welfare, Health, and Housing to bring information to the attention of other parliamentarians.[113] The Committee was interested in addressing unsafe abortion in order to curb maternal mortality and morbidity and, additionally, wanted to see research conducted on the issue.[114] The Committee planned to educate parliament as a whole on the magnitude of the problem and the need to take steps to address it.[115]

3. Where Association Is Not Being Exercised, Authority Is Too Weak to Bring the Issue of Unsafe Abortion to the Attention of Lawmakers

Without the formation of adequately strong associations, advocates lack the authority to bring the issue of unsafe abortion to the attention of lawmakers.

a. In Uganda

In Uganda, association with regard to unsafe abortion has yet to be exercised such that information on the issue can reach lawmakers. Organized advocacy efforts are still developing. Associations are beginning to form to discuss liberalization in cases of rape, but strategies toward liberalization do not yet exist.[116] Without the strength of solid networks, advocates of access to safe abortion are hindered by the barriers to bringing information to the attention of lawmakers. Though advocates are likely to discuss the issue of unsafe abortion among themselves, they remain hesitant to speak on solving the problem by changing the

112. *Id.*
113. *Id.*; Kenya: Interview Four, *supra* note 23.
114. Kenya: Interview Four, *supra* note 23; Kenya: Interview Twelve, *supra* note 69.
115. Kenya: Interview Eleven, *supra* note 69; Kenya: Interview Four, *supra* note 23.
116. Uganda: Interview Three, *supra* note 27.

restrictive laws.[117] Organizations may support liberalization, yet only a few do so openly.[118]

b. In Ethiopia

The creation of associations to influence law and policy is at the early stages of development in Ethiopia.[119] Consequently, civil society is not reaching lawmakers with information on unsafe abortion. Few formal relationships between groups exist.[120] Stakeholders recognize, however, that building associations is needed in order to safeguard their interests,[121] and like-minded NGOs are beginning to initiate the creation of networks.[122]

C. By Restricting the Free Speech and Free Association of Reproductive Health Providers, the Global Gag Rule Prevents Stakeholders from Narrowing the Information Gap Between Policy Makers and Those Affected by Policy

The Global Gag Rule curtails the ability of the reproductive health community to bring information on the effect of the restrictive law to lawmakers. The restriction hinders the free speech and free association of stakeholders that is vital to informing lawmakers.

1. Foreign Non-Governmental Organizations Are Forced to Certify

Foreign NGOs that are eligible for USAID funding do not have free choice in deciding wheather to comply with the Global Gag Rule or to relinquish USAID funding. USAID is an influential actor in the provision of reproductive health care by NGOs throughout the developing world. The agency is the largest single donor of international population

117. Uganda: Interview Two, *supra* note 27.
118. Uganda: Interview Three, *supra* note 27.
119. Interview with anonymous NGO staff in Addis Ababa, Ethiopia (June 19, 2002).
120. Ethiopia: Interview One, *supra* note 37; Interview with anonymous NGO staff in Addis Ababa, Ethiopia (July 4, 2002).
121. Ethiopia: Interview One, *supra* note 37; Interview with anonymous NGO staff in Addis Ababa, Ethiopia (June 19, 2002) [hereinafter Ethiopia: Interview Six].
122. Ethiopia: Interview Six, *supra* note 121.

assistance[123] and contributes forty-three percent of the developed world's bilateral aid for family planning.[124] Organizations providing reproductive health care are dependant on the agency. The choice faced by NGOs deciding whether to sign a certificate of compliance ("certifying") in order to receive USAID funding is often between survival and working for legal change to improve the health and save the lives of their clients. Because funding for NGOs is limited, few organizations have the ability to limit themselves further by advocating for liberalization.[125]

The decision whether to certify compliance with the GGR depends on NGOs' ability to survive without USAID funding. Large NGOs are able to remain in operation without USAID; they have broad funding bases and can decline certification and reduce their programming to continue with a diminished budget. To cope, they have closed clinics and laid off staff that had provided a range of reproductive health care to underserved populations.[126] For many clients, such NGOs provided their only source of health care, which included contraceptives, pap smears, STI management, baby care and immunization.[127] The GGR has left these poor clients without vital life-saving services.[128]

Smaller NGOs, however, are more reliant on USAID and unable to refuse the restriction.[129] The decision to certify is not an ideological choice for USAID recipients. The director of an affiliate of a large NGO in Ethiopia supports the refusal of his headquarters office to certify despite the accompanying loss of USAID funding.[130] He would, however, advise the consortium of NGOs of which he is a member to certify given their dependence on the agency.[131] The "choice" turns solely upon whether the organization can survive without USAID.

The organizations that serve clients who are victims of the restrictive abortion laws are especially vulnerable to the GGR. Worldwide,

123. DKT Mem'l Fund Ltd. v. Agency for Int'l Dev., 887 F.2d. 275, 302 (D.C. Cir. 1989) (Ginsburg, J., concurring and dissenting).

124. UNITED NATIONS POPULATION FUND, FINANCIAL RESOURCE FLOWS FOR POPULATION ACTIVITIES IN 2001 15 (2003), *available at* http://www.unfpa.org/upload/lib_pub_file/226_filename_GPAR2001.pdf.

125. Kenya: Interview Eleven, *supra* note 69.

126. Ethiopia: Interview Five, *supra* note 54; Interview with anonymous government official in Addis Ababa, Ethiopia (June 30, 2002); Interview with anonymous NGO staff in Nairobi, Kenya (July 12, 2002) [hereinafter Kenya: Interview Sixteen].

127. Interview with anonymous NGO staff in Nairobi, Kenya (July 18, 2002).

128. Interview with anonymous NGO staff in Addis Ababa, Ethiopia (June 30, 2002); Ethiopia: Interview Five, *supra* note 54.

129. Interview with anonymous NGO staff in Addis Ababa, Ethiopia (July 1, 2002).

130. Ethiopia: Interview Five, *supra* note 54.

131. *Id.*

USAID is likely the largest single donor of post-abortion care,[132] and many organizations that treat and prevent complications from unsafe abortion are therefore beholden to USAID.

2. By Violating Freedom of Speech, USAID Prevents the Dissemination of Information on Unsafe Abortion

Since the reinstatement of the Global Gag Rule, speech on unsafe abortion has been reduced. The Global Gag Rule silences speech that is subject to the restriction as well as that which is not. According to an Ethiopian government official, conversation on liberalization will take place in whispers.[133]

a. The Global Gag Rule Hinders SpeechThat Is Subject to the Restriction

The Global Gag Rule restriction is technically limited to preventing non-US based organizations that receive USAID funding from speaking about unsafe abortion in the context of liberalization. Under the GGR, foreign NGOs working to decrease maternal mortality and morbidity may not address the role that the law plays upon the high rates of death and injury.

USAID-funded foreign NGOs follow the restriction in practice. Since the reinstatement, they have not used their own non-U.S. funds to speak on unsafe abortion in connection with liberalization,[134] despite their support of abortion law reform.[135] According to the staff of a USAID-funded NGO in Kenya, "[one would] be able to follow the money trail" from those silent in the liberalization debate back to USAID.[136] Prior to the reinstatement, USAID-funded organizations would discuss the restrictive law in connection with unsafe abortion.[137] Subsequent to the restriction, such a connection cannot be made. The

132. LAUREL COBB, ET AL., GLOBAL EVALUATION OF USAID'S POSTABORTION CARE PROGRAM 5 (2001).

133. Ethiopia: Interview Four, *supra* note 52.

134. Such NGOs have not used USAID funds for abortion-related speech since the 1973 Helms amendment under which such use of USAID funding is prohibited. Interview with anonymous NGO staff in Ethiopia (June 26, 2002) [hereinafter Ethiopia: Interview Seven].

135. Ethiopia: Interview Four, *supra* note 52.

136. Kenya: Interview Thirteen, *supra* note 85.

137. Kenya: Interview Four, *supra* note 23.

change was stark in a meeting in which USAID staff came to Kenya from the U.S. to evaluate reproductive health programs in the country.[138] The discussion turned to liberalization in order to reduce the need for post-abortion care.[139] The USAID representative stated that the agency was not able to discuss the abortion law.[140] A discussion of liberalization continued; USAID-funded NGOs remained silent.[141]

In Kenya, the GGR diminishes the speech generated through coalition-organized public discussions. USAID-funded NGOs are noticeably absent although specifically invited to attend.[142] At the public discussion in Nairobi, where many NGOs that work in Kenya are based, the only reproductive health NGO to attend was non-certifying.[143]

USAID-funded NGOs in Ethiopia likewise cannot use their own, non-U.S. resources to participate in discussions of abortion law reform.[144] When a non-certified NGO in Ethiopia asked USAID-funded NGOs for their involvement in abortion law reform, they refused due, in part, to the GGR.[145] A staff member from a USAID-funded NGO stated that she fears the withdrawal of USAID funds and therefore will not participate in liberalization advocacy.[146]

b. The Global Gag Rule Hinders Speech that Is Not Subject to the Restriction

Speech of the types allowed under the provisions of the GGR has been hindered because of the reinstatement of the rule. The GGR's requirements do not restrict the speech of U.S.-based organizations as they enjoy the protection of the U.S. Constitution. Speech on unsafe abortion not used in the context of liberalization is permitted. Nevertheless, these types of speech have been stifled.

Because of the GGR, providers and advocates avoid discussing abortion. NGOs are afraid to associate themselves with the issue.[147] NGOs that receive USAID funding consider the agency to be "wincing

138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.*
142. *Id.*
143. *Id.*
144. Ethiopia: Interview Three, *supra* note 52.
145. *Id.*
146. Interview with anonymous NGO staff in Addis Ababa, Ethiopia (June 30, 2002).
147. Interview with anonymous NGO staff in Addis Ababa, Ethiopia (June 21, 2002) [hereinafter Ethiopia: Interview Eight].

at the A-word"[148] and the USAID mission to be to harbor "discomfort" with regard to abortion.[149] A professional medical association is able to work only with the few non-USAID funded NGOs in generating information on unsafe abortion.[150] NGOs aware of the loss of USAID funding to one of Ethiopia's major reproductive health providers will not speak about abortion due to fear of their own funding loss.[151]

Speech on unsafe abortion outside the context of law reform by a U.S.-based NGO—exempt from the restriction on two grounds—is hindered by the GGR. Because of the GGR and former USAID abortion-related restrictions, NGO staff members constantly avoid using the word *abortion*, even in the context of post-abortion care.[152] With the reinstatement, the NGO decided not to publish information about its successful post-abortion care program.[153]

Other U.S.-based NGOs, in Uganda,[154] Ethiopia,[155] and Kenya,[156] though aware that they are not subject to the restriction, would not speak on the need to liberalize for fear of losing funding. The GGR prevents U.S.-based NGOs from taking a position on the issue of abortion and HIV-positive women. The issue is currently being debated in Ethiopia, yet one staff member of a U.S.-based NGO stated his organization is unable to take a position due to the restriction.[157] Another U.S.-based NGO working on the issue of HIV/AIDS will not discuss exceptions to the abortion law for HIV-positive women.[158] A staff member of a U.S.-based NGO stated he and his colleagues would attend workshops on unsafe abortion as silent observers and refrain from speaking.[159]

U.S.-based Cooperating Agencies (CAs), through which USAID channels its funds to local organizations, do not speak about liberalization due to the GGR.[160] Such organizations in Uganda[161] and

148. Kenya: Interview Thirteen, *supra* note 85.
149. *Id.*
150. Ethiopia: Interview Two, *supra* note 41.
151. Ethiopia: Interview Four, *supra* note 52.
152. Uganda: Interview One, *supra* note 22.
153. *Id.*
154. *Id.*
155. Ethiopia: Interview Five, *supra* note 54.
156. Kenya: Interview Thirteen, *supra* note 85; Kenya: Interview Three, *supra* note 23.
157. Ethiopia: Interview Seven, *supra* note 134.
158. Ethiopia: Interview Two, *supra* note 41.
159. Interview with anonymous NGO staff in Addis Ababa, Ethiopia (June 25, 2002).
160. Kenya: Interview Fourteen, *supra* note 96.
161. Interview with anonymous NGO staff in Kampala, Uganda (May 28, 2002).

Kenya[162] believe that by speaking they risk losing funding and thereby would sacrifice their reproductive health programs. Staff of one CA stated that the agency has to be "really careful" with regard to speaking on the abortion law because of the GGR.[163] After the reinstatement, the director of a CA in Ethiopia stated that his organization will not participate in the debate on liberalization.[164] Prior to the reinstatement, however, the director had said that his organization would be involved in the public discussion on liberalization due to its interest in preventing unsafe abortion.[165]

3. By Violating Freedom of Association, USAID Prevents Stakeholders From Gaining Adequate Authority to Bring to Lawmakers Information on Unsafe Abortion

The Global Gag Rule prohibits associations between USAID-funded organizations and those working to liberalize the abortion law. The effect on the authority of stakeholders is threefold: the number of providers who pledge their support to liberalization is diminished; the unity of the reproductive health community is compromised; and organizations working toward liberalization are isolated from the remainder of the reproductive health community.

a. The Global Gag Rule Prevents the Sufficient Number of Stakeholders from Gaining the Authority to Inform Lawmakers on the Effect of the Restrictive Abortion Law

Speech on unsafe abortion is effective in influencing law reform when an adequate proportion of stakeholders participate by associating with others working toward abortion law reform. When some stakeholders are forced to remain uninvolved, pro-liberalization organizations are less able to acquire adequate authority to influence the opinions of lawmakers and the public.

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162. Kenya: Interview Fourteen, *supra* note 94; Interview with anonymous NGO staff in Nairobi, Kenya (July 23, 2002).

163. *Id.*

164. Ethiopia: Interview Seven, *supra* note 134.

165. *Id.*

The GGR prevents stakeholders in Kenya from participating in liberalization efforts.[166] As a result it hinders the ability of the coalition working for abortion law reform to secure the alliances of reproductive health professionals. Thus, the GGR limits the extent to which the coalition is able to gain the attention and support of lawmakers and undermines their strategy of broadening stakeholders.[167]

b. The Global Gag Rule Splinters the Work of Reproductive Health Providers, Creating a Division Within the Community

With the restriction, stakeholders are unable to unifiedly support liberalization. While the vast majority of stakeholders are concerned with the impact of the restrictive abortion law, the GGR will not permit the public and lawmakers to be aware of this concern. Some non-certifying members may advocate liberalization, but NGOs influenced by the restriction cannot support them.

Since the reinstatement, NGOs working to prevent maternal mortality and morbidity fall into two distinct groups. In the first are organizations whose work is limited by the GGR. They cannot work to change the law that sustains their high number of caseloads.[168] The second group consists of NGOs that publicly recognize the relationship between unsafe abortion and the restrictive law.[169] A prominent NGO that trains providers of post-abortion care in Kenya also works to prevent maternal death and injury through law reform. Prior to the reinstatement of the GGR, the NGO was part of a USAID project to train post-abortion care providers.[170] This NGO is now unable to participate in the project and its work is very separate from efforts funded by USAID.[171] A second non-certifying NGO was excluded from the project with the reinstatement[172] and now works exclusively with non-USAID funded organizations.

Partnerships between reproductive health NGOs have been destroyed by the GGR. A planned partnership between a CA in Kenya

166. Kenya: Interview Fifteen,, *supra* note 106; Interview with anonymous NGO staff in Nairobi, Kenya (July 22, 2002) [hereinafter Kenya: Interview Seventeen].
167. Interview with anonymous NGO staff in Nairobi, Kenya (July 12, 2002); Kenya: Interview Four, *supra* note 23.
168. COBB, *supra* note 132, at 12.
169. *Id.*
170. Kenya: Interview Seventeen, *supra* note 166.
171. *Id.*
172. Kenya: Interview Eight, *supra* note 29.

and a non-certifying NGO to provide contraception was cancelled because of the reinstatement.[173]

c. The Global Gag Rule Diminishes the Authority of Organizations that Draw a Connection Between Unsafe Abortion and the Restrictive Law

As certain NGOs are unable to procure resources from the largest funding source, their authority within the reproductive health community is diminished. Organizations working for access to safe abortion are isolated due to their inability to work with USAID-affiliated organizations. The few organizations that refused to certify in Kenya had been leaders in providing comprehensive reproductive health care, training post-abortion care providers, and providing menstrual regulation. Without access to USAID funds for family planning services and without the support of other providers, their position within the reproductive health community is in danger of decline.

The GGR's isolating effect was exacerbated in Kenya as USAID restructured its grant-making at nearly the same time the GGR was reinstated. Since the restructuring, the agency funds a consortium of NGOs instead of individual organizations.[174] A leading reproductive health provider in Kenya refused to certify and therefore cannot work with the other prominent reproductive health providers in the country who make up a consortium of USAID-funded NGOs.[175]

Where the leading reproductive health care provider is funded by USAID, pro-liberalization organizations lose the involvement of prominent NGOs. One NGO working toward liberalization in Ethiopia works with other NGOs by providing them with project support. Since the reinstatement, it is unable to work with USAID-funded organizations. Because this NGO's funding capacity is a fraction of USAID's, the majority of reproductive health providers choose to work with USAID-affiliated organizations. The GGR leaves the NGO that is advocating liberalization the ability to associate only with the small pool of non-USAID-funded NGOs.[176]

The authority of the non-certifying provider of menstrual regulation in Ethiopia has been compromised; its name has disappeared from the letterhead of correspondence within the reproductive health

173. Kenya: Interview Fourteen, *supra* note 94; Ethiopia: Interview Five, *supra* note 54.
174. Kenya: Interview Sixteen, *supra* note 126.
175. *Id.*
176. Ethiopia: Interview Eight, *supra* note 147.

community.[177] The executive director of this NGO serves as chairperson of a consortium of family planning organizations, and the NGO's letterhead had been used in conducting the consortium's activities prior to the GGR.[178] As the consortium receives USAID funding, correspondence is now written on the letterhead of the leading CA in Ethiopia.[179]

CONCLUSION

Free speech and free association are instrumental to informed lawmaking. Accordingly, these freedoms are retained against government infringement through constitutional protections. Such freedoms in the United States are enshrined within the First Amendment. However, these rights do not extend beyond our borders. The people of poorer nations find no protection against human rights violations by the global superpower.

The United States controls a great proportion of the resources available for reproductive health care, giving rise to an even greater need to fortify human rights in the face of its power. Developing world governments are unable to fulfill the health needs of their citizens, leaving women dependent on USAID and susceptible to the impact of the GGR. Under the Global Gag Rule, human rights protection depends on whether a citizen's own country can (and is willing to) fulfill her health needs. Without the protection of human rights against infringement by all governments, the most vulnerable members of humanity will suffer. In this case, it is the poorest women of developing nations whose health and lives are jeopardized by the United States Government. ⚘

177. Due to requirements of the Ethiopian Ministry of Justice, the consortium cannot have its own letterhead; previously, all correspondence was written on the letterhead of the NGO. Ethiopia: Interview Five.

178. *Id.*

179. *Id.*