

ON DISPOSABLE PEOPLE AND HUMAN WELL-BEING: HEALTH,  
MONEY AND POWER

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But does not the poor man have a *right* to better himself? Yet what does it matter if he lacks the *power*? What good is the *right* to be cured to the invalid whom no one cures?<sup>1</sup>

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I. INTRODUCTION

The foundational premise of this essay is that health and well-being are human rights issues. My focus on this theme, specifically within the human rights<sup>2</sup> paradigm, is new, passionate, and personal. On December 15, 2005,

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<sup>1</sup> Louis Blanc, *Rights, Liberty and Social Reform* (1847), in HUMAN RIGHTS IN WESTERN CIVILIZATION 1600–PRESENT (J. Maxwell & J. Friedberg eds., 2d ed., 1994).

<sup>2</sup> This work uses the language of rights. However, this author is conscious of and in agreement with much of the literature on the critique of rights. See, e.g., DUNCAN KENNEDY, A CRITIQUE OF ADJUDICATION (1997); Fran Olsen, *Statutory Rapes: A Feminist Critique of Rights Analysis*, 63 TEX. L. REV. 387 (1984); Cass Sunstein, *Rights and Their Critics*, 70 NOTRE DAME L. REV. 727 (1995). A key component of the critique is the injustice of the existing system particularly in its protection and perpetuation of the status quo of the existing distributions and practices which are themselves bound by inequality. As such, any goal of equality and justice in the human “rights” field has to acknowledge the financial biases

just three months before the conference that prompted the writing of this essay, I lost my partner of over 20 years. She fought a valiant, strong, and dignified fight against cancer—a journey I traveled with her. During that time I learned much about health systems and health care. Most saliently, notwithstanding the reality of the extraordinarily good care she ultimately received, I realized there is a great need for reform in the way we think about, and act upon, patients' health care needs in order to promote and protect their dignity as well as their mental and physical health.

Significantly, this work suggests a paradigmatic shift in the way governments, health care and related institutions, and civil society evaluate, offer, and deliver health care services. It urges that, rather than continue with the current econometric service-delivery version that treats statistically fragile (health-wise) patients as disposable people, we embrace a worldwide model of health delivery that pursues a human rights vision by centering human dignity and well-being concerns. The paper utilizes the examples of the Global Gag Rule and HIV/AIDS to promote the concept that health care is a critical component in the protection of humanity and human flourishing.

Part II presents historical writings which show that, even before the advent of the discipline we call human rights, health was viewed as a fundamental right of "mankind." It then maps some key legal documents that designate and protect health as a human right. These documents provide the blueprint for claiming a right to human well-being to which a right to health (as well as other human rights) is central.

Next, Part III specifically focuses on the Global Gag Rule, a draconian policy deployed by the United States during President Reagan's administration in furtherance of its ideological support of strategies that lend a blind protection to unborn life. Such protection becomes the singular goal regardless of any other costs the policy may engender, including the physical or mental endangerment to women of unwanted pregnancy, and thus rendering them and their needs disposable. These disposable people are principally pregnant women, but also include members of their families and of their communities.

The Reagan policy—formally known as the Mexico City Policy—prohibits financial assistance through the U.S. Agency for International Development (USAID) to any groups or entities that perform, promote, or even provide counseling on abortion. United States' court decisions have upheld the constitutionality of the gag rule on speech and association

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inherent in any articulation of rights, which ultimately is intertwined with the power to articulate such rights and consequently reflects the interests of those engaged in the articulations. These are not novel thoughts, but they are significant ones if one is suggesting any type of paradigmatic shift.

grounds.<sup>3</sup> However, the courts' analytical framework seems at worst misplaced and at best incomplete as it focuses on protecting narrow "rights" but ignores broader critical concerns, including the physical and mental health of the pregnant woman. These concerns should include the consequences of the pregnancy on the individual woman, her family, and her community—all those who are involved in a realistic and holistic analysis of the medical decision. The policy fails to consider the human element involved in making such a difficult, complex decision as the termination of a pregnancy as well as the disruptions it causes. Rather than pursue a health and well-being goal, the policy simply deploys the political and financial—indeed imperial—power of a rich and powerful government to promote its anti-abortion stance.

Part IV focuses on HIV/AIDS. First, the article sets forth the circumstances surrounding the HIV/AIDS pandemic. Second, it shows the unfortunate and unintended consequences of the gag rule on HIV/AIDS services and treatments. Due to its ideological underpinnings, the policy causes disruptions beyond denying funding for the policy's expressly targeted activities.

These two realities provide the groundwork to pursue a paradigmatic shift in health care delivery at a broader level. The reality of the HIV/AIDS epidemic and the success of modern treatments serve to break down the prevailing curative/palliative dichotomy. Instead, they suggest that a continuum—from preventive to curative—exists with regard to treatment of illnesses. Health care needs occur within such a continuum and persons, in pursuit of human well-being, regardless of their location on the health

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<sup>3</sup> See *DKT Memorial Fund, Ltd. v. Agency for Int'l Dev.*, 691 F. Supp. 394 (D.D.C. 1988) (in ruling on the parties' cross-motions for summary judgment, court held that defendant's implementation of the policy was not inconsistent with or in excess of the Foreign Assistance Act of 1961, but implementation of the policy was an unconstitutional violation of the domestic nongovernmental organization's (NGO) right to freedom of speech and association. However, contrary to its holding regarding domestic NGOs, the court found that the foreign NGOs were not entitled to First Amendment protections.); see also *DKT Memorial Fund, Ltd. v. Agency for Int'l Dev.*, 887 F.2d 275 (D.C. Cir. 1989) (higher court held plaintiff's claim for unconstitutional interference with its right to associate with unnamed foreign nongovernmental organizations was not ripe for adjudication); *Pathfinder Fund v. Agency for Int'l Dev.*, 746 F. Supp. 192 (D.D.C. 1990) (court ruled in favor of defendant, holding that the right of expressive association was not absolute, particularly when the right of Americans to associate with foreigners was at issue. The court also reasoned that the fact that a domestic organization, in lieu of government policy, may experience difficulties when associating with foreign organizations does not substantiate a First Amendment violation.); *Ctr. for Reprod. Law v. Bush*, 304 F.3d 183 (2d Cir. 2002) (freedom of speech and association claims dismissed on the grounds that a federal court can designate a cause of action as jurisdictional, and can decide that question before resolving a dispute concerning the existence of an Article III case or controversy).

continuum or of their economic ability to access health care services, should be entitled to health care protections and solutions. This work, by centering human well-being, provides a framework to critique the prevailing discourse of economic ability to access health care that not only distorts but also undermines the human dimensions of health care policies.

The essay concludes by looking forward and suggesting that the content of such a right to human well-being should include a broad range of health care services—a broader range than even South Africa, one of the most progressive states in this regard, has recognized. The proposed paradigmatic shift utilizes feminist, third world, racial, and queer<sup>4</sup> interrogations to re-frame the debate and shift the focus from money—a focus that unveils the injustice of an economic power-based cost analysis—to human dignitary interests. Such understanding permits the crafting of a well-being/human thriving-based approach to health. It embraces an idea for the delivery of health care services that promotes human flourishing and centers people, not money or politics, in the provision of care.

## II. THE HUMAN RIGHTS IDEA<sup>5</sup>

International human rights are those rights vital to individuals' existence—they are fundamental, inviolable, interdependent, indivisible, and inalienable rights predicate to life as human beings.<sup>6</sup> Human rights are moral, social, religious, legal, and political prerogatives that concern the respect and dignity associated with personhood, with a human being's identity.<sup>7</sup> Human rights' origins are traced to religion, "natural law [and] contemporary moral values."<sup>8</sup> The concept of human rights is a relatively

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<sup>4</sup> Critical race, third world, and queer theories, respectively, challenge the law as white, male, and hetero-normative. See generally, FEMINIST LEGAL THEORY FOUNDATIONS (Kelley D. Weisberg ed., 1993); A QUEER WORLD: THE CENTER FOR LESBIAN AND GAY STUDIES READER (Martin Duberman ed., 1997); CRITICAL RACE THEORY: THE CUTTING EDGE (Richard Delgado ed., 1995).

<sup>5</sup> Portions of this section are taken from Berta E. Hernández-Truyol, *Human Rights Through a Gendered Lens: Emergence, Evolution, Revolution*, in WOMEN'S INTERNATIONAL HUMAN RIGHTS: A REFERENCE GUIDE (Kelly Askin & Dorean Koenig eds., 1999) [hereinafter Hernández-Truyol, *Gendered Lens*].

<sup>6</sup> See generally Hernández-Truyol, *Gendered Lens*, *supra* note 5; see also International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171, *entered into force* March 23, 1976 [hereinafter ICCPR] (noting that these rights derive from the inherent dignity of the human person); REBECCA M. WALLACE, INTERNATIONAL LAW 175 (1986) ("Human Rights . . . are regarded as those fundamental and inalienable rights which are essential for life as a human being.").

<sup>7</sup> See generally Hernández-Truyol, *Gendered Lens*, *supra* note 5; WALLACE, *supra* note 6.

<sup>8</sup> RESTATEMENT (THIRD) OF THE FOREIGN RELATIONS LAW OF THE UNITED STATES §

recent idea that some suggest is universally applicable, at least in principle.<sup>9</sup>

Even before the formal birth of the human rights discipline, early writers recognized the importance of individuals to the Law of Nations. Because it is natural persons who comprise “the personal basis of every State,”<sup>10</sup> international law needs to “provide certain rules regarding individuals.”<sup>11</sup> However, in the early days of the discipline individuals were deemed to be objects, but not subjects, of the Law of Nations.<sup>12</sup> Thus, international laws, while applicable to individuals, could not be enforced by or against individuals who were considered to lack standing to enforce infractions.

Oppenheim, an early philosopher of international law, identified certain “rights of mankind” that should be guaranteed to all individuals regardless of nationality, pursuant to the Law of Nations. Specifically he identified the “right of existence, the right to protection of honor, life, health, liberty, and property, the right of practicing any religion one likes, the right of emigration and the like” as “rights of mankind.”<sup>13</sup> It is significant that contemporary human rights documents recognize each and every right Oppenheim listed.

Of particular importance to this essay’s thesis is the reality that, even before human rights had evolved as a discipline, early writers of international law recognized health as a “right of mankind.” Thus, since the birth of the discipline, the literature acknowledged the centrality of health to human well-being.

While recognizing that individuals could not be subjects of international law because it is limited to relations between states, Oppenheim philosophized about and acknowledged the ostensibly supra-sovereign nature of what he called “rights of mankind” that today we describe as “human rights”:

[T]here is no doubt that, should a State venture to treat its own subjects or a part thereof with such cruelty as would stagger humanity, public opinion of the rest of the world would call

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701 cmt. b (1987).

<sup>9</sup> See Berta E. Hernández-Truyol, *Women’s Rights as Human Rights—Rules, Realities and the Role of Culture: A Formula for Reform*, 21 *BROOK. J. INT’L L.* 605 (1996) [hereinafter Hernández-Truyol, *Women’s Rights as Human Rights*]. For a discussion of the universality versus relativity debate, see *id.*, at nn.168–73 and accompanying text.

<sup>10</sup> I.L. OPPENHEIM, *INTERNATIONAL LAW: TREATISE* 362–69, § 288 (2d ed., 1912) reprinted in LOUIS B. SOHN & THOMAS BUERGENTHAL, *INTERNATIONAL PROTECTION OF HUMAN RIGHTS* 1 (1973).

<sup>11</sup> *Id.*

<sup>12</sup> *Id.* at § 290, reprinted in SOHN & BUERGENTHAL, *supra* note 10, at 3.

<sup>13</sup> *Id.* at § 292, reprinted in SOHN & BUERGENTHAL, *supra* note 10, at 4.

upon the Powers to exercise intervention for the purpose of compelling such State to establish a legal order of things within its boundaries sufficient to guarantee to its citizens an existence more adequate to the ideas of modern civilization.<sup>14</sup>

Suggesting that Oppenheim was correct in evaluating the importance of health to human existence, when the human rights field became structured, formal instruments guaranteed all persons “the highest attainable standard of physical and mental health.”<sup>15</sup> Article 25 of the Universal Declaration on Human Rights first articulated this right:

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.<sup>16</sup>

Article 25 realistically contextualizes the right to health within an amalgam of rights, all of which are necessary for healthy human thriving. Article 25’s holistic approach reflects the indivisibility paradigm.<sup>17</sup> While focusing on health, it includes a range of social, economic, and cultural rights such as work, housing, nutrition, and medical care as well as civil and political rights including equality and nondiscrimination. This approach recognizes the complexity of human health and suggests the myriad interlocked locations that must be protected in order to attain human

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<sup>14</sup> *Id.* The evolution of the role of the individual in international law can clearly be seen in Lauterpacht’s revision of Oppenheim’s work. See I.L. OPPENHEIM, INTERNATIONAL LAW: A TREATISE 632–42 (8th ed. 1955) reprinted in SOHN & BUERGENTHAL, *supra* note 10. For example, in revising § 289, Lauterpacht concluded that “[s]tates may, and occasionally do, confer upon individuals . . . international rights *stricto sensu*, i.e., rights which they acquire without the intervention of municipal legislation and which they can enforce in their own name before international tribunals.” *Id.* at § 289, reprinted in SOHN & BUERGENTHAL, *supra* note 10, at 5.

<sup>15</sup> International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3, entered into force Jan. 3, 1976, Art. 12(1) [hereinafter ICESCR].

<sup>16</sup> Universal Declaration of Human Rights, U.N.G.A. Res. 217 (III 1948), adopted Dec. 10, 1948, art. 25.

<sup>17</sup> ICCPR, *supra* note 6, Preamble (recognizing that “the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved if conditions are created where everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights”).

thriving.

Other human rights documents substantially protect the specific fundamental right to health as well as other rights that are indivisible from and interdependent with that right. Among the international human rights treaties, the Convention on the Elimination of All Forms of Discrimination against Women<sup>18</sup> (Women's Convention or CEDAW) holds a significant place in the body of human rights law as it makes the female half of humanity the focus of human rights concerns.<sup>19</sup> The Women's Convention creates an important and broad legal norm prohibiting sex-based discrimination with the central aim of promoting women's equality. The comprehensive definition of prohibited discrimination includes:

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 a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.<sup>20</sup>

The Convention emphasizes that such discrimination "violates the principles of equality of rights and respect for human dignity."<sup>21</sup> Significant for this work, the Convention includes "express and comprehensive" provisions on women's health, including specifically reproductive health and health care services, as a means to attainment of equality.<sup>22</sup>

The plain language of Article 1—which protects fundamental freedoms ranging from political to economic, from civil to cultural—shows that the Women's Convention, like the Universal Declaration, embraces the indivisibility of rights paradigm. The Convention's objective is to effect equality between women and men; it achieves this goal by establishing normative standards that ensure women's equal access to, and equal opportunities in, political and public life—including the right to vote and to

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<sup>18</sup> Convention on the Elimination of All Forms of Discrimination against Women, U.N.G.A. Res. 280, 19 I.L.M. 33 (1980), *adopted* by U.N.G.A. Dec. 18, 1979, *entered into force* Sept. 3, 1981 [hereinafter Women's Convention].

<sup>19</sup> *See id.*, Preamble (noting that notwithstanding nondiscrimination mandates in international conventions, discrimination against women persists forming the impetus behind the Women's Convention to eradicate discrimination against women in all its forms and locations ranging from government to family, from traditional roles to economic locations).

<sup>20</sup> *Id.*, art. 1.

<sup>21</sup> *Id.*, Preamble.

<sup>22</sup> *Id.*, art. 12(1) ("States Parties shall take all appropriate measures to eliminate discrimination against women 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.").

stand for election as well as rights to education, health, and employment.

Specifically with respect to health, the Women's Convention is the only human rights treaty that affirms and protects the reproductive rights of women. Indeed, recognizing the universality/relativism discourse,<sup>23</sup> and that culture is often used as a pretext to subordinate women, the Convention targets culture and tradition as influential forces shaping gender roles and family relations, and seeks to eliminate oppressive gender roles and problematic gender stereotyping. Article 12 directly addresses health beyond the broad prohibition against sex discrimination in health care brought about by Paragraph 1. Paragraph 2 provides that:

States Parties shall ensure to women 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.<sup>24</sup>

Thus, the Women's Convention is concerned with the myriad dimensions of health and human reproduction as well as with the impact of cultural factors on gender relations—critically important matters with regards to the gag rule.

Another significant convention, with respect to the right to human well-being, is the Convention on the Rights of the Child<sup>25</sup> (CRC). Like Article 12 of the Women's Convention, Article 24 of the CRC provides for comprehensive health protections.<sup>26</sup> Beyond a mandate that there be broad

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<sup>23</sup> Hernández-Truyol, *Women's Rights as Human Rights*, *supra* note 9.

<sup>24</sup> Women's Convention, *supra* note 18, art. 12(2).

<sup>25</sup> Convention on the Rights of the Child, 28 I.L.M. 1448 (1989), *entered into force* Sept. 2, 1990 [hereinafter CRC]. The United States has not ratified the convention.

<sup>26</sup> Article 24 of the CRC provides, in full, as follows:

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious

access to health care, the provision requires states to implement practices that will reduce infant and child mortality. Much like the Women's Convention, the CRC seeks to abolish "traditional practices prejudicial to the health of children."<sup>27</sup> Lastly, consistent with the desire to eradicate harmful cultural practices, the CRC includes a right to non-discrimination on the bases of the child's, the parent's, or the legal guardian's "race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status."<sup>28</sup>

Finally, the Convention on the Elimination of All Forms of Racial Discrimination<sup>29</sup> also provides for "[t]he right to public health, medical care, social security and social services."<sup>30</sup> In summary, existing human rights law specifically protects the right to health and health care, includes reproductive health and autonomy in the existing mix of rights, and maps health and health care in the broad geography of human thriving.

Although the right to health, including both physical and mental health, is expressly protected, precisely what such a right encompasses is less settled. To be sure, family planning, maternal and infant health, and prevention of maternal mortality and morbidity are explicitly included as protected health concerns. Beyond that, however, not much guidance exists as to what protections the human right to health affords individuals.

In light of the extensive paper protections of the right to health, a right acknowledged quite early in the consideration of "rights of [hu]mankind" as

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foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

CRC, *supra* note 25, art. 24.

<sup>27</sup> *Id.*, art. 24(3). A child is defined as someone under the age of 18. *Id.*, art. 1.

<sup>28</sup> *Id.*, art. 2.

<sup>29</sup> Convention on the Elimination of All Forms of Racial Discrimination, 5 I.L.M. 352 (1966), *entered into force* Jan. 4, 1969.

<sup>30</sup> *Id.*, art. 5.

articulated by Oppenheim, the lack of health care worldwide that persists in the 21st century should be deemed to constitute, in Oppenheim's words, a "cruelty that staggers humanity."<sup>31</sup> Some facts bring the deplorable and inequitable health and health-related conditions of people around the world into stark relief. To Hindus, the Ganges River is a representation of purification; they bathe in and drink its waters in search of salvation. Yet cities, towns, and villages together daily deposit in excess of 345 million gallons of raw sewage into the river.<sup>32</sup> In addition, factories deposit industrial waste and farmers deposit chemical fertilizers and pesticides.<sup>33</sup> Of the over 4 billion population of developing states, "nearly three-fifths lack access to safe sewers, a third have no access to clean water, a quarter do not have adequate housing, and a fifth have no access to modern health services of any kind."<sup>34</sup> Interestingly, people in Europe "spend \$11 billion a year [on] ice cream—\$2 billion more than the estimated annual total needed to provide clean water and safe sewers for the world's population."<sup>35</sup>

Two statistics are particularly poignant because they suggest, in vivid contexts, how easy it would be to better the human condition. One, people from Europe and the United States combined spend a total of \$17 billion annually on pet food, a figure that is \$4 billion greater than the estimated additional funds necessary "to provide basic health and nutrition for everyone in the world."<sup>36</sup> Two, \$40 billion a year is estimated as the "additional cost of achieving and maintaining universal access to basic education for all, basic health care for all, reproductive health care for all women, adequate food for all and clean water and safe sewers for all."<sup>37</sup> Such a figure represents "less than 4 percent of the combined wealth of the 225 richest people in the world."<sup>38</sup> For its part, the global community should show the appropriate outrage at these conditions. The Global Gag Rule, discussed in the section that follows, is a proper location in which to direct its rage.

As the next section details, the approach to health that the gag rule presents engages two protections that are expressly included in the international instruments. Moreover as Section IV further shows, the impact of the gag rule on health care delivery services goes beyond its intended ideological target; it spills over to other health concerns.

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<sup>31</sup> See *supra* note 14 and accompanying text.

<sup>32</sup> Barbara Crossette, *Kofi Annan's Astonishing Facts*, N.Y. TIMES, Sept. 27, 1998.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

## III. THE GLOBAL GAG RULE

In 1984 President Reagan announced the implementation of the Mexico City Policy,<sup>39</sup> commonly referred to as the Global Gag Rule. The policy, in effect until it was rescinded in 1993 by President Clinton,<sup>40</sup> required nongovernmental organizations (NGOs) to agree, as a condition of their receipt of U.S. federal funds, neither to perform nor actively to promote abortion as a method of family planning in other nations.<sup>41</sup> President George W. Bush reinstated the policy by memorandum dated January 22, 2001<sup>42</sup>—interestingly the anniversary of the 1973 *Roe v. Wade*<sup>43</sup> decision.

For a full understanding of the Mexico City Policy, it is helpful to briefly present some background information. In September 1961, Congress passed the Foreign Assistance Act<sup>44</sup> (FAA) which ordered the creation of an agency to administer economic assistance programs.<sup>45</sup> Following this Congressional mandate, in November 1961 President John F. Kennedy created the USAID.<sup>46</sup> This agency “became the first U.S. foreign assistance organization whose primary emphasis was on long-range economic and social development assistance efforts.”<sup>47</sup> This organization provided a new focus on the needs of a changing world; its goal was to provide fundamental assistance to other countries with the aim of having such states maintain their independence while at the same time becoming self-supporting.<sup>48</sup>

After the passage of the FAA, Congress authorized research on family planning issues.<sup>49</sup> In 1963, when President Kennedy addressed the World Food Congress,<sup>50</sup> he recognized that rapid population growth in

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<sup>39</sup> Policy Statement of the United States to the United Nations International Conference on Population, 2d Session, Mexico City, Aug. 13–16, 1984, *available at* <http://www.populationaction.org/resources/documents/MexicoCityPolicy1984.pdf> [hereinafter U.S. Policy Statement].

<sup>40</sup> Memorandum for Secretary of Health and Human Services (on the Title X Gag Rule) (Jan. 22, 1993), *available at* <http://www.clintonfoundation.org/legacy/012293-presidential-memo-on-the-title-x-gag-rule.htm>.

<sup>41</sup> U.S. Policy Statement, *supra* note 39.

<sup>42</sup> George W. Bush, *Memorandum on Restoration of Mexico City Policy* (Jan. 22, 2001), in JOHN WOOLLEY & GERHARD PETERS, *THE AMERICAN PRESIDENCY PROJECT*, <http://www.presidency.ucsb.edu/ws/index.php?pid=29766>.

<sup>43</sup> *Roe v. Wade*, 410 U.S. 113 (1973).

<sup>44</sup> Foreign Assistance Act of 1961, as Amended, Pub. L. No. 87-195, 75 Stat. 424.

<sup>45</sup> U.S. Agency for International Development (USAID), *USAID History*, [http://www.usaid.gov/about\\_usaid/usaidhist.html](http://www.usaid.gov/about_usaid/usaidhist.html).

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> John F. Kennedy, 217—*Remarks at the Opening Session of the World Food Congress*

underdeveloped countries was a serious concern. Poignantly he observed that explosive population growth is “too often the highest where hunger is already the most prevalent.”<sup>51</sup>

The USAID began its family planning program in 1965. The United States instituted programs such as the War on Hunger<sup>52</sup> and family planning programs, through which it sought to reduce the birth rates in developing countries.<sup>53</sup> In 1968, Congress amended the Food for Peace Act<sup>54</sup> to authorize the USAID to use funds to manufacture and distribute medical supplies, including contraceptives.<sup>55</sup> By the end of the 1960s, the USAID had taken a leadership role in providing condoms and contraceptives to developing countries,<sup>56</sup> thus furthering the goals of controlling population growth in order to pursue better health conditions, reduce hunger, and promote independence.

In 1973, however, the political climate started to shift ostensibly with the U.S. Supreme Court’s handing down of the *Roe v. Wade*<sup>57</sup> decision. That year Congress enacted the Helms Amendment<sup>58</sup> which prohibited the use of foreign assistance funds to pay for, among other things, the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions.<sup>59</sup> Significantly, the Helms Amendment applied only to U.S. government funds. Thus, even after the Helms Amendment went into effect, foreign NGOs receiving economic

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(Jun. 4, 1963), in JOHN WOOLLEY & GERHARD PETERS, THE AMERICAN PRESIDENCY PROJECT, <http://www.presidency.ucsb.edu/ws/index.php?pid=9249>.

<sup>51</sup> *Id.*

<sup>52</sup> See USAID, *Family Planning Timeline*, [http://www.usaid.gov/our\\_work/global\\_health/pop/timeline\\_b.pdf](http://www.usaid.gov/our_work/global_health/pop/timeline_b.pdf) (noting that in 1965 “[t]he United States government adopt[ed] a plan to reduce birth rates in developing countries through its War on Hunger and investments in family planning programs”). See also Lyndon B. Johnson, 33—*Special Message to the Congress on Food for India and on Other Steps to Be Taken in an International War on Hunger* (Feb. 2, 1967), in JOHN WOOLLEY & GERHARD PETERS, THE AMERICAN PRESIDENCY PROJECT, <http://www.presidency.ucsb.edu/ws/index.php?pid=28372> (reporting “progress in organizing the war against hunger” and noting that “[t]he first obligation of the community of man is to provide food for all of its members. . . . In pursuing the War on Hunger, the world must face up to stark new facts about food in our times . . . [including the reality that] food is scarce. . . .”).

<sup>53</sup> See USAID, *USAID History*, *supra* note 45.

<sup>54</sup> Agricultural Trade Development and Assistance Act of 1954 (Food for Peace Act), Pub. L. No. 83-480.

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> 410 U.S. 113 (1973) (holding that the constitutional right of privacy protects a woman’s liberty to choose to terminate a pregnancy).

<sup>58</sup> Helms Amendment to the 1961 Foreign Assistance Act, 22 U.S.C. § 2370a.

<sup>59</sup> USAID, *Family Planning Timeline*, *supra* note 52; H.R. 2673 Omnibus Appropriations Bill, Division D, FY 2004.

assistance from the United States could promote or perform abortions without violating the terms of the statute if they did so with separate, non-U.S. government funds.<sup>60</sup> While the Mexico City Policy remained intact only until 1993 when President Clinton rescinded it, the Helms Amendment restrictions keeping U.S. funds separate remain in place.<sup>61</sup>

A little over a decade after the *Roe* decision and enactment of the Helms Amendment, the United States took a strong anti-abortion policy stance. In 1984, the United Nations held a conference in Mexico City at which President Reagan and the U.S. delegation presented a policy statement outlining the types of abortion-related restrictions that the United States would institute as prerequisites to offering foreign aid.<sup>62</sup> This “Mexico City Policy” statement has become infamously known as the Global Gag Rule.

The draconian efforts to deploy economic power to pursue the ideological opprobrium against abortion continued. The year after the articulation of the Mexico City Policy, Congress passed the 1985 Kemp-Kasten Amendment, which further limited access to funds for certain procedures.<sup>63</sup> Specifically, the Amendment provided that

[n]one of the funds made available in this Act nor any unobligated balances from prior appropriations may be available to any organization or program which, as determined by the President of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization.<sup>64</sup>

Congress purposely enacted this amendment in response to the U.N. Population Fund’s (UNFPA) extensive involvement in China’s coercive abortion program implementing the one child

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<sup>60</sup> 22 U.S.C.S. 2151b(f)(1).

<sup>61</sup> USAID, *USAID Family Planning Timeline: 1990s–2003*, [http://www.usaid.gov/our\\_work/global\\_health/pop/timeline.html](http://www.usaid.gov/our_work/global_health/pop/timeline.html); Population Action International (PAI), *The Global Gag Rule: History and Resource Library* (Sept. 15, 2006), <http://www.populationaction.org/resources/publications/globalgagrule/GagRuleTimeline.htm> [hereinafter PAI, *The Global Gag Rule*].

<sup>62</sup> U.S. Policy Statement, *supra* note 39; USAID, *Family Planning Timeline*, *supra* note 52.

<sup>63</sup> Supplemental Appropriations Act of 1985 (H.R. 2577), *signed into law* Aug. 15, 1985, Pub. L. No. 99-88 (what in time came to be called the Kemp-Kasten Amendment). *See also* National Committee for a Human Life Amendment (NCHLA), *Kemp-Kasten Amendment: Legislative History* (Jun. 2003), <http://www.nchla.org/datasource/iddocuments/KempK8503.pdf>.

<sup>64</sup> H.R. 2673 Omnibus Appropriations Bill, Division D, FY 2004.

rule.<sup>65</sup>

In 1999, Congress enacted the Tiahrt Voluntary Family Planning Amendment<sup>66</sup> which implemented additional requirements for voluntary family planning projects. One requirement is that “service providers or referral agents” in family planning programs neither implement nor set quotas or numerical targets with respect to total number of births for acceptors, i.e., the individual clients receiving services. Similarly, target number of acceptors of particular methods of family planning could not be set. Another requirement prohibits family planning projects from offering rewards to persons for becoming family planning acceptors or to program personnel for achieving numerical targets or quotas of births or number of acceptors. A third provision plainly states that a person’s decision not to participate in family planning is not to have an impact on the right to participate in other programs on general welfare or health. Last, the Amendment provides that the programs must give acceptors comprehensive information on “health benefits and risks” of the chosen method. Persons who are involved must be properly informed about and provide consent to all matters.<sup>67</sup> The USAID incorporates all of these provisions into all agreements with organizations that are involved in family planning services delivery.

It is plain that certain restrictions flowed from the implementation of the Mexico City Policy. All USAID population planning grants and cooperative agreements must contain a clause, called the “Standard Provision to be used in Grants and Cooperative Agreements with U.S. NGOs” (the Standard Clause) which effectuates the Mexico City Policy through specific eligibility provisions.<sup>68</sup> The basic requirement imposed on U.S. NGOs is that they are responsible for enforcing the policy on their

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<sup>65</sup> U.S. Dep’t of State, Bureau of Population, Refugees, & Migration, Press Release: July 18, 2002 (Jul. 24, 2002), <http://www.state.gov/g/prm/rls/12128.htm>; NCHLA, *infra* note 79.

<sup>66</sup> Foreign Operations Appropriations Act of 1999 (in part enacting the Tiahrt Amendment); H.R. 4328 Omnibus Appropriations for FY 1999. “The requirements of the Tiahrt [A]mendment [were] implemented through a standard clause/provision, entitled ‘Requirements for Voluntary Family Planning Projects’ (the Tiahrt clause), . . . added to existing clauses/provisions in USAID contracts, grants, and cooperative agreements that provide population assistance under the Development Assistance account.” UNAIDS, *Guidance for Implementing the “Tiahrt” Requirements for Voluntary Family Planning Projects* (Apr. 1999), [http://www.usaid.gov/our\\_work/global\\_health/pop/tiahtqa.pdf](http://www.usaid.gov/our_work/global_health/pop/tiahtqa.pdf).

<sup>67</sup> USAID, *Tiahrt Voluntary Family Planning Requirements*, [http://www.usaid.gov/our\\_work/global\\_health/pop/tiahtpolicy.html](http://www.usaid.gov/our_work/global_health/pop/tiahtpolicy.html).

<sup>68</sup> Larry Nowels, *International Family Planning: The “Mexico City” Policy*, CRS Report for Congress (Apr. 2, 2001), [http://www.policyalmanac.org/culture/archive/abortion\\_Mexico\\_City.pdf](http://www.policyalmanac.org/culture/archive/abortion_Mexico_City.pdf). The standard provisions require foreign NGOs to certify they do not “perform or actively promote abortion as a method of family planning.” *Id.*, at CRS-4.

foreign NGO partners. However, the foreign NGOs are hugely affected by the policy.<sup>69</sup> A foreign NGO that receives USAID assistance for family planning under a grant or cooperative agreement must sign the agreement and abide by the restrictions as a precondition to funding.<sup>70</sup> The definition of assistance for family planning by the USAID is broad and goes beyond receipt of money. It includes “the provision of technical assistance, customized training, and commodities, including contraceptive supplies.”<sup>71</sup> The restrictions do not apply to non-family planning assistance from the agency, such as aid pertaining to HIV/AIDS, child survival, or health assistance,<sup>72</sup> even if the organization would not be eligible for family planning assistance because of the restrictions.

To be sure, the policy does not create a blanket prohibition on abortion or abortion counseling. For example, “abortion in cases where ‘the life of the mother would be endangered if the fetus were carried to term’ or ‘following rape or incest’” does not violate the restrictions.<sup>73</sup> Foreign NGOs that perform abortions for any other reason or under any other circumstance are forbidden from using U.S. funding for those ends. For example, simply possessing equipment for vacuum aspirations for dilation and curettage or possessing drugs intended to induce menstruation to be used in cases of threat to life, rape, or incest do not preclude an organization from being eligible to receive USAID support; “[h]owever, no [such] family planning funds may be used to produce or distribute equipment for the purpose of inducing abortions....”<sup>74</sup>

As noted above, the gag rule still permits counseling and referral for abortion in cases of threat to the life of the woman, rape, or incest.<sup>75</sup> In countries where abortion is legal for broader reasons, the rule permits counseling and referral only if four conditions are met—a situation that effectively limits actions or procedures within a state even if such actions or procedures are legal within the country. The conditions that must be met include:

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<sup>69</sup> PAI, *The Global Gag Rule*, *supra* note 61.

<sup>70</sup> USAID, *Mandatory Standard Provisions for Non-U.S., Nongovernmental Recipients: A Mandatory Reference for ADS Chapter 303* at 19 (June 14, 2006), <http://www.usaid.gov/policy/ads/300/303mab.pdf> (outlining prohibitions on abortion-related activities).

<sup>71</sup> PAI, *What You Need to Know About the Mexico City Policy Restrictions on U.S. Family Planning Assistance: An Unofficial Guide* at 2 (Apr. 2006), [http://www.populationaction.org/resources/publications/globalgagrule/Mexico\\_City\\_Policy.pdf](http://www.populationaction.org/resources/publications/globalgagrule/Mexico_City_Policy.pdf) [hereinafter PAI, *What You Need to Know*].

<sup>72</sup> *Id.*, at 2-3.

<sup>73</sup> *Id.*, at 5.

<sup>74</sup> *Id.*, at 5-6.

<sup>75</sup> *Id.*, at 6.

[t]he woman is already pregnant; [t]he woman “clearly states that she has already decided” to have an abortion; [t]he woman “specifically asks” where a safe, legal abortion may be obtained; and [t]he family planning counselor has reason to believe that the country’s medical ethics require him or her to provide a referral for a safe, legal abortion.<sup>76</sup>

Beyond the interference with access to a range of medical options effected by the policy itself, these four conditions further limit the open communication between women and their health care providers.

The Mexico City Policy exempts health care and family planning services provided pursuant to the support of foreign governments. Such exempted services include government-run universities and hospitals that provide abortion services as part of health care delivery. The policy also exempts particularized abortion research as well as government-related population or family planning entities. In addition, multilateral organizations are exempt from the policy’s limitations.<sup>77</sup>

On January 22, 2001, the 28th anniversary of the U.S. Supreme Court’s 1973 *Roe v. Wade* decision, President George W. Bush reinstated the Mexico City Policy.<sup>78</sup> In March of 2001 “President Bush formally issued restrictions virtually identical to those that had been included in all NGO grants and cooperative agreements between 1985 and 1993 with one important clarification concerning post-abortion care.”<sup>79</sup> President Bush’s memorandum makes it clear that the restrictions do not preclude funded organizations from treating “injuries and illnesses” caused by abortions be they legal or not.<sup>80</sup> Moreover, USAID funds may be used by health care providers in delivering non-abortion care. On August 29, 2003, President Bush extended the Mexico City Policy to all population-planning funds, whether furnished by the USAID or by other components of the U.S. State Department.<sup>81</sup>

The World Health Organization (WHO) estimates that almost 20 million unsafe abortions occur annually worldwide, almost all in developing

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<sup>76</sup> *Id.*

<sup>77</sup> *Id.*, at 4.

<sup>78</sup> See *supra* note 42; see also PAI, *What You Need to Know*, *supra* note 71, at 1.

<sup>79</sup> Memorandum on Restoration of the Mexico City Policy, 66 FED. REG. 17,303 (Mar. 28, 2001), construed in PAI, *What You Need to Know*, *supra* note 71.

<sup>80</sup> *Id.*

<sup>81</sup> Memorandum for the Secretary of State: Assistance for Voluntary Population Planning (Aug. 29, 2003), available at [http://a257.g.akamaitech.net/7/257/2422/20apr20040800/edocket.access.gpo.gov/cfr\\_2004/janqr/pdf/3CFRAug29.pdf](http://a257.g.akamaitech.net/7/257/2422/20apr20040800/edocket.access.gpo.gov/cfr_2004/janqr/pdf/3CFRAug29.pdf); see also NCHLA, *Mexico City Policy*, <http://www.nchla.org/issues.asp?ID=2>.

countries.<sup>82</sup> Yet no evidence shows that from 1984 to 1992, when the Mexico City Policy was first in place, it had any impact in reducing the number of abortions performed.<sup>83</sup> These abortion figures exist in the context of daunting and depressing statistics with respect to maternal and infant mortality and morbidity as well as maternal, infant, and children's health.

Beyond the general right to health, any discussion of the gag rule from a health-as-a-human-right perspective requires a specific analysis of reproductive health and also implicates myriad other protected human rights including the right to life, family, culture, and religion, and non-discrimination/equality on the basis of sex, race, ethnicity, and social status among others. The gag rule, and particularly its consequences, effects an assault on many of these health and health-related fundamental rights.

For example, protecting a woman's right to reproductive health requires access to a full range of services and processes. These necessities include having contraceptive choices. However, they also include having access to other reproductive health services, including safe abortion services, information on family planning, and sexual and reproductive health care.

Women's ability to survive pregnancy and childbirth depends upon various complex and interrelated facts including access to high-quality reproductive health care; freedom from social, cultural, economic, and legal discrimination; and autonomy over decisions relating to their reproductive lives. When women lack the means to control their fertility, they are more likely to experience unwanted or unintended pregnancies. In turn they may give birth at shorter intervals. These consequences—unwanted or unintended pregnancies and giving birth at shorter intervals—increase both maternal and infant mortality rates.

Data on maternal health, mortality, and morbidity serve to underscore the link between health and economic power. In low-income countries, maternal mortality accounts for the greatest proportion of deaths among women of reproductive age.<sup>84</sup> The sad truth is that the vast majority of these deaths are preventable<sup>85</sup> by simply providing access to high quality reproductive health services. Services such as pre- and post-natal care, trained attendants at birth, emergency obstetric care, and family planning

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<sup>82</sup> Global Gag Rule Impact Project, *The Global Gag Rule & Maternal Deaths Due to Unsafe Abortion*, [http://www.globalgagrule.org/pdfs/issue\\_factsheets/GGR\\_fact\\_maternaldeath.pdf](http://www.globalgagrule.org/pdfs/issue_factsheets/GGR_fact_maternaldeath.pdf).

<sup>83</sup> *Id.*

<sup>84</sup> Ghada Hafez, WHO Regional Office for the Eastern Mediterranean, *Maternal Mortality: A Neglected and Socially Unjustifiable Tragedy*, 4(1) EASTERN MEDITERRANEAN HEALTH J. 7 (1998).

<sup>85</sup> WHO ET AL., REDUCTION OF MATERNAL MORTALITY: A JOINT WHO/UNFPA/UNICEF/WORLD BANK STATEMENT I (1999).

would contribute to a reduction in the maternal mortality rates. Yet at least 35 percent of women in low-income countries receive no pre-natal care during pregnancy, almost 50 percent give birth without a skilled attendant, and 70 percent receive no postpartum care in the six weeks following delivery.<sup>86</sup> Every minute another woman in Africa or Asia dies in childbirth,<sup>87</sup> with more than a half million women lost each year from treatable causes: severe bleeding, infections, hypertensive disorders, and obstructed labor.<sup>88</sup>

Regarding the money and health linkages, even where services and facilities exist, the cost of services makes them inaccessible to many women. It would not take huge amounts of resources to overcome this lack of access to maternal health services. According to the World Bank, governments need only to commit \$2 US per person per year to ensure basic and acceptable maternal health services.<sup>89</sup>

To be sure, other infrastructure factors also affect access to health care services. For reproduction-related matters, for example, location of facilities is an important factor in determining access. Many existing facilities are concentrated around urban areas. Yet, most rural women live more than five kilometers from the nearest hospital with the distance presenting a barrier to access.<sup>90</sup> The lack of transportation and other physical barriers exacerbate the situation for rural women. However even in urban centers, these same conditions—both physical and economic accessibility—prevent women from obtaining the high quality care they need.<sup>91</sup>

Other factors also play a role with regard to women's real access to reproductive health services. One is, sadly, the poor quality of many health care services. The deficiencies may include poorly-trained medical staff, disrespectful and uncaring attitudes, lack of privacy, deteriorating facilities, inconvenient operating hours, and restrictions on who may stay with a woman at a health-care facility. Such conditions dissuade many women from utilizing maternal health services even where they are available and accessible.<sup>92</sup>

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<sup>86</sup> Safe Motherhood Inter-Agency Group, *Good Quality Maternal Health Services* (1998), [http://www.safemotherhood.org/facts\\_and\\_figures/maternal\\_health.htm](http://www.safemotherhood.org/facts_and_figures/maternal_health.htm) (citing WHO, COVERAGE OF MATERNITY CARE: A LISTING OF AVAILABLE INFORMATION (4th ed., 1997)).

<sup>87</sup> United Nations Development Fund (UNFPA), *Preventing Fistula Saves Mothers' Lives*, [http://www.endfistula.org/safer\\_motherhood.htm](http://www.endfistula.org/safer_motherhood.htm).

<sup>88</sup> *Id.*

<sup>89</sup> PANOS, BIRTH RIGHTS: NEW APPROACHES TO SAFE MOTHERHOOD 26 (2001).

<sup>90</sup> May Post, *Preventing Maternal Mortality through Emergency Obstetric Care*, Support for Analysis and Research in Africa (SARA) Issues Paper (1997).

<sup>91</sup> *Id.*

<sup>92</sup> GLORIA COSPIN & ROSA XIQUITA, ASSOCIACION GUATEMALTECA DE EDUCACION SEXUAL (AGES) & RICARDO VERNON, INOPAL III/POPULATION COUNCIL, ACCESS TO

Many of the modern health concerns revolve around young women. Teenage pregnancies are risky, and the younger the girl, the higher the risk.<sup>93</sup> Girls under 15 are five times more likely to die in childbirth than women in their twenties.<sup>94</sup> In developing countries, 82 million girls marry before they turn 18, and about half of all teenage girls will have their first child by the time they turn 18.<sup>95</sup> These young women are not well served by any policy that results in the lack of services that could alleviate health concerns.

Organizations that have been refused funding because of the Mexico City Policy have found that they are unable to continue programs that were working to reduce maternal mortality, infant mortality, and ill consequences of complicated pregnancies. These realities, not surprisingly, cause great consternation in the health care delivery community. Much frustration exists concerning the pressures—largely political, hugely ideological, and frequently imperialistic—caused by the policy. There is tension between the desire to provide adequate and necessary health care, on the one hand, and the policy’s evisceration of the full range of services that health care professionals can offer, on the other. Dr. Nirmal Bista, Director General of Family Planning Association of Nepal (FPAN), who testified before the U.S. Senate Foreign Relations Committee at a hearing on the impact of the Mexico City Policy in 2001, effectively articulated the hardship the policy imposes on health care: “This is the challenge: Do I listen to my own government that has asked FPAN to help save women’s lives, or do I listen to the U.S. government?”<sup>96</sup>

There are many consequences to NGOs refusing to abide by the Mexico City Policy. As discussed above, one is the real contraction of available services. Another consequence, discussed below, is less patent and concerns perhaps unintended consequences of the Global Gag Rule.

#### IV. HIV/AIDS

HIV/AIDS is a major epidemic around the world. The virus attacks the immune system and thus destroys the human body’s ability to fight disease.<sup>97</sup> While the virus is spread mostly by having unprotected sex, other risky behavior such as sharing drug needles can also be a source of transmission. In addition, HIV can be spread by having contact with

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REPRODUCTIVE HEALTH SERVICES AND EDUCATION IN INDIGENOUS COMMUNITIES (1998).

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

<sup>96</sup> Global Gag Rule Impact Project, *Impacts on Impacted Countries: Nepal*, [http://www.globalgagrule.org/caseStudy\\_nepal.htm](http://www.globalgagrule.org/caseStudy_nepal.htm).

<sup>97</sup> National Institute of Allergy and Infectious Diseases (NIAID), *HIV Infection and AIDS: An Overview* (March 2005), <http://www.niaid.nih.gov/factsheets/hivinf.htm>.

infected blood which can occur in transfusions (although this is less likely given the advent of careful screening of blood donors as well as the development of techniques to treat blood that destroy the virus) or by sharing needles contaminated by blood. Moreover, women can transmit the virus during pregnancy or birth or through breast milk, although treatment of mothers while pregnant drastically reduces the incidence of transmission.<sup>98</sup>

AIDS is unique in human history in its rapid spread, the extent of infection, and the depth of its impact. Since the diagnosis of the first AIDS case in 1981, the world has struggled to reconcile the devastation the disease has caused. At present, more than 20 years after the first diagnosed case, the disease has claimed over 20 million lives. Astoundingly, the estimate is that 37.8 million people worldwide are living with HIV.<sup>99</sup> The disease continues to spread at an alarming rate. Beyond claiming lives, it seriously threatens the fabric of some societies.<sup>100</sup>

Notwithstanding the seriousness of the epidemic, over the years it has become evident that comprehensive action, including comprehensive approaches to prevention, yield positive results in its containment.<sup>101</sup> The now 20-year-old battle against AIDS has resulted in important successes and has taught significant lessons about which approaches work best. Although a cure remains elusive, the palliative care available is effectively curative because the prolongation of life it produces can be indefinite.<sup>102</sup>

In instances where national leadership has focused on the disease and there exist efforts to create widespread public awareness and to engage in intensive prevention efforts, entire nations have succeeded in reducing HIV transmission. For example, “[with]in Africa, Uganda remains the pre-eminent example of sustained success. In Asia, it is estimated that comprehensive action in Thailand averted some five million HIV infections during the 1990s. Cambodia, too, has managed to curb rapid growth of its epidemic.”<sup>103</sup> On every continent it is possible to show examples of where concerted efforts have managed to curb spread of the disease.

Currently “antiretroviral medicines can prolong life and reduce the

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<sup>98</sup> *Id.* See also Centers for Disease Control and Prevention (CDC), *HIV and Its Transmission* (July 1999), <http://www.cdc.gov/hiv/resources/factsheets/transmission.htm>.

<sup>99</sup> UNAIDS, 2004 REPORT ON THE GLOBAL AIDS EPIDEMIC 2004, UNAIDS/04.16E (July 2004), [http://www.unaids.org/bangkok2004/GAR2004\\_html/GAR2004\\_00\\_en.htm](http://www.unaids.org/bangkok2004/GAR2004_html/GAR2004_00_en.htm) [hereinafter UNAIDS, 2004 REPORT] (the range of the number of persons living with HIV is placed at 34.6–42.3 million).

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

physical effects of HIV infection.”<sup>104</sup> The advances in treatment have slowed the progression of HIV infection to AIDS and has hugely decreased the incidence of death from AIDS, although the number of diagnoses has risen.<sup>105</sup> In addition, the existence and development of effective treatments also has resulted in a larger number of persons who are living with AIDS.<sup>106</sup>

People on the antiretroviral drugs may still need treatment for opportunistic infections from time to time and treatment for pain that may be a side effect of the drugs themselves.<sup>107</sup> Moreover, many persons with HIV/AIDS will need access to psychosocial support and treatment to cope with an illness that has serious familial and societal implications with respect to behavior and lifestyle. Finally, patients on antiretroviral drugs will have ongoing needs for sexual and reproductive health services.<sup>108</sup>

One problem attendant to antiretroviral treatments is the frequent need to change the medication. As learned in countries where antiretroviral therapy has been widely used for many years, the “first-line” of antiretroviral therapy at some point ceases to work for many patients. This failure of the treatment then requires that the patients switch onto a “second-line” regime.<sup>109</sup> This creates a new layer of economic concerns because second-line drugs are far more expensive than first-line drugs. For example, in Kenya, Doctors Without Borders pays \$1400 per patient/per year for a second-line regimen, compared to only \$200 for the first-line drugs.<sup>110</sup>

Nation states and international bodies have bonded together to place

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<sup>104</sup> *Id.*; see also AVERT, *AIDS Treatment: Target & Results* (Sept. 20, 2006), <http://www.avert.org/aidstarget.htm> (“Someone who is infected with HIV is likely to ultimately become sick with AIDS, but if treated with antiretroviral (ARV) medication their life can be prolonged, often for many years. ARV treatment has already dramatically cut the rate of AIDS diagnoses and deaths in Western countries where it has been provided since the mid 1990s. . . . Treatment for HIV/AIDS has been shown to be effective and feasible in even the poorest parts of the world.”).

<sup>105</sup> CDC, *A Glance at the HIV/AIDS Epidemic* (Apr. 2006), <http://www.cdc.gov/hiv/resources/factsheets/At-A-Glance.htm> (“Although the decrease in the estimated number of AIDS deaths continues (8% decrease from 2000 through 2004), the number of AIDS diagnoses increased 8% during that period.”)(citation omitted).

<sup>106</sup> *Id.* (“From 2000 through 2004, the estimated number of persons in the United States living with AIDS increased from 320,177 to 415,193—an increase of 30%.”)(citation omitted).

<sup>107</sup> UNAIDS, 2004 REPORT, *supra* note 99; see also NIAID, *supra* note 97 (“People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by microbes such as viruses or bacteria that usually do not make healthy people sick.”).

<sup>108</sup> UNAIDS, 2004 REPORT, *supra* note 99.

<sup>109</sup> Doctors Without Borders, *The Second Wave of the Access Crisis: Unaffordable AIDS Drug Prices . . . Again*, Briefing Note (Dec. 10, 2005), [http://www.doctorswithoutborders.org/news/hiv-aids/briefing\\_doc\\_12-10-2005.cfm](http://www.doctorswithoutborders.org/news/hiv-aids/briefing_doc_12-10-2005.cfm).

<sup>110</sup> *Id.*

recently-developed, effective medications within economic reach of individuals and countries alike. The price of once untouchably expensive medication has been greatly reduced to allow access to necessary medications to low- and middle-income countries. There exist ongoing efforts to make these medications available to people living with HIV across the world who desperately need antiretroviral therapy but lack the economic means to afford treatment.<sup>111</sup>

It is significant that the secrecy about, and stigma associated with, AIDS that has hugely interfered with efforts to respond to the epidemic is either disappearing or softening in many countries and within society as a whole.<sup>112</sup> Leaders of governments, businesses, and religious and cultural institutions are increasingly joining forces to take action against AIDS.<sup>113</sup> In addition, the social/political movements of people living with HIV have been global forces in the vanguard of social change in demanding that states and international entities alike respond to the epidemic.

Notwithstanding concerted efforts, including comprehensive prevention programs in which local governments, international entities, and social networks participate to battle the HIV/AIDS epidemic, it continues to grow. Sadly, the growth mirrors deprivation of economic, social, and cultural power.<sup>114</sup> Increasingly, there is global recognition of the impact of AIDS on development prospects in the worst-affected regions. Thus, this recognition motivates the action necessary to make fundamental shifts in development practice.<sup>115</sup> In this regard, the demographics of AIDS are telling. Of the 40.3 million people infected with AIDS in 2005, 17.5 of them were women and 2.3 were children under the age of 15.<sup>116</sup> Out of the 4.9 million people newly infected with HIV in 2005, 700,000 were children and 3.2 million of the new infections occurred in sub-Saharan Africa.<sup>117</sup> That year, a total of 3.1 million people died of HIV/AIDS-related causes.<sup>118</sup>

The North/South and East/West populations experience markedly different conditions with respect to contraction and spread of HIV/AIDS. In sub-Saharan Africa, 25.8 million persons are living with HIV/AIDS while

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<sup>111</sup> *Id.*

<sup>112</sup> UNAIDS, 2004 REPORT, *supra* note 99. However “[a]ccording to UNAIDS and WHO, stigma and discrimination, whether actual or feared, remain perhaps the most difficult obstacles to prevention of HIV.” Global Health Council, *HIV/AIDS*, [http://www.globalhealth.org/view\\_top.php?id=227](http://www.globalhealth.org/view_top.php?id=227).

<sup>113</sup> UNAIDS, 2004 REPORT, *supra* note 99.

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> Global Health Council, *supra* note 112.

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

3.2 million people became infected with the disease and 2.4 million people died from it in the past year.<sup>119</sup> In contrast, in Western and Central Europe, 1.9 million persons have HIV/AIDS—a figure less than 10 percent of the sub-Saharan Africa numbers—while 65,000 people became infected this past year and 58,000 died of AIDS-related causes.<sup>120</sup>

As discussed above, widespread effort to create public awareness about the disease remains a significant component in the containment and eradication of AIDS. A comprehensive approach is necessary to deliver preventive treatments. In this regard, the rights to seek, receive and impart information<sup>121</sup>—fundamental human rights—become a *sine qua non* condition for ensuring effective HIV prevention and AIDS care.<sup>122</sup> This suggests that public dissemination of information is a necessary component of a program for HIV/AIDS prevention and containment. Therefore, people should have a right of access to the necessary information on how to protect themselves from being infected with HIV. This suggests the existence of a corollary right to know one's HIV status—a right that can also be located in the rights to life<sup>123</sup> and health.<sup>124</sup> Moreover, infected persons should have the right to know how to obtain treatment, care, and support. The Global Gag Rule is affecting these rights although the impediment of transfer of such information is not the intent of the policy.

HIV/AIDS affects different populations, especially vulnerable populations, differently. In March 2003, the U.N. Committee on the Rights of the Child issued the General Comment on HIV/AIDS and the Rights of the Child.<sup>125</sup> It was the first General Comment on the AIDS epidemic to be issued by a treaty-monitoring mechanism.<sup>126</sup> The General Comment identifies good practices and specifically prohibits discrimination against children on the basis of real or perceived HIV status.<sup>127</sup> It calls for countries to report on measures they have implemented to protect children from

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<sup>119</sup> UNAIDS, *Uniting the World Against AIDS*, [http://www.unaids.org/en/Regions\\_Countries/default.asp](http://www.unaids.org/en/Regions_Countries/default.asp).

<sup>120</sup> *Id.*

<sup>121</sup> *See, e.g.*, ICCPR, *supra* note 6, art. 19 (recognizing “the right to freedom of expression, this right shall include freedom to seek, receive and impart information and ideas of all kinds[.]” Art. 19(2), but “subject to certain restrictions . . . as provided by law and are necessary . . . [f]or the protection of . . . public health or morals[.]” Art. 19(3)).

<sup>122</sup> UNAIDS, 2004 REPORT, *supra* note 99.

<sup>123</sup> ICCPR, *supra* note 6, art. 6(1).

<sup>124</sup> ICESCR, *supra* note 15, art. 12.

<sup>125</sup> U.N. Committee on the Rights of the Child, *General Comment No. 3 (2003): HIV/AIDS and the Rights of the Child*, U.N. Doc. CRC/GC/2003/3 (Mar. 17, 2003).

<sup>126</sup> UNAIDS, 2004 REPORT, *supra* note 99.

<sup>127</sup> *Id.*

HIV.<sup>128</sup>

Moreover, HIV affects men and women in dissimilar ways. It appears that women's immune systems may respond distinctively to the virus.<sup>129</sup> Women on antiretroviral treatment may experience stronger side effects.<sup>130</sup> Studies suggest female hormones may play a role, as may the fact that both sexes take the same size dose of drugs, even though the average woman is smaller and weighs less than a man.<sup>131</sup>

Despite these gender differences, when the sexes receive equal HIV/AIDS treatments, the differences between men's and women's survival rates disappear.<sup>132</sup> Unfortunately, in most parts of the world, the social and economic power imbalances between men and women<sup>133</sup> raise fears that women may not enjoy equitable and timely access to HIV/AIDS treatment options.

Notwithstanding the efficacy of antiretroviral treatment and other HIV-related disease care, access to these treatments and care are imbalanced around the world and it remains abysmally low especially in the South. Five to six million people in low- and middle-income countries need antiretroviral treatment immediately.<sup>134</sup> Yet, WHO has estimated that only 400,000 people at the end of 2003 had access to such necessary or available treatment and care.<sup>135</sup> These figures translate to the reality that nine out of ten people who urgently need HIV treatment are not receiving it.<sup>136</sup> Consequently an estimated five to six million people in low- and middle-income countries will die in the next two years if they do not receive antiretroviral treatment.<sup>137</sup>

While on average 80 percent of responding countries report having a policy in place to ensure or improve access to HIV-related drugs, in reality it is estimated that access to antiretroviral treatment is below 10 percent in every region except the Americas.<sup>138</sup> In South America and Eastern Europe, most patients receive at least the essential package of care services

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<sup>128</sup> *Id.*

<sup>129</sup> *Id.*

<sup>130</sup> *Id.*

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

<sup>133</sup> UNITED NATIONS, HUMAN DEVELOPMENT REPORT: UNITED NATIONS HUMAN DEVELOPMENT PROGRAM 1995 (1995).

<sup>134</sup> UNAIDS, 2004 REPORT, *supra* note 99.

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

recommended by WHO and UNAIDS.<sup>139</sup> In Africa and Asia, only one-third of people receive at least the essential package.<sup>140</sup> Specifically, several South American countries have universal coverage for antiretroviral therapy, including Argentina, Brazil, Chile, Cuba, Mexico, and Uruguay.<sup>141</sup> Several others cover about two-thirds of people in need, including Barbados, Colombia, Costa Rica, and Paraguay.<sup>142</sup> In sub-Saharan Africa, on the other hand, the figures contrast sharply. An estimated 4.3 million people need AIDS home-based care, but only about 12 percent receive it.<sup>143</sup> In South-East Asia, coverage drops to two percent.<sup>144</sup>

One example of an organization that has done impressive work regarding HIV/AIDS is Doctors Without Borders. Since the early 1990s, Doctors Without Borders has been caring for people living with HIV in low- and middle-income countries.<sup>145</sup> It began its first antiretroviral treatment programs in 2001.<sup>146</sup> By April 2004, approximately 13,000 people in 19 different countries in Africa, Asia, and Latin America were receiving treatment from projects run by Doctors Without Borders.<sup>147</sup> The organization's programs have been growing: in mid-2002 they were reaching approximately 1,500 people in 10 countries. Figures projected that Doctors Without Borders would reach 25,000 people in 25 countries by the end of 2004.<sup>148</sup> While running treatment centers, Doctors Without Borders also shares lessons learned through its diverse treatment experience that may be useful in expanding the range of treatments. These lessons include the following:

- “One pill twice a day” — the organization has found that following a treatment must be made as easy as possible; 80 percent of the organization's patients are on a WHO-recommended, triple fixed-dose combination.
- “Decentralize and adapt” — Doctors Without Borders operates

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<sup>139</sup> *Id.*

<sup>140</sup> *Id.*; see also UNAIDS/USAID/WHO/CDC AND THE POLICY PROJECT, PROGRESS REPORT ON THE GLOBAL RESPONSE TO THE HIV/AIDS EPIDEMIC, UNAIDS, 2003: COVERAGE OF SELECTED SERVICES FOR HIV/AIDS PREVENTION AND CARE IN LOW- AND MIDDLE-INCOME COUNTRIES IN 2003 (2004).

<sup>141</sup> UNAIDS, 2004 REPORT, *supra* note 99.

<sup>142</sup> *Id.*

<sup>143</sup> *Id.*

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

in areas with limited infrastructure and personnel. So, it uses mobile treatment clinics, delegates basic patient care to nurses and community health workers, and often begins treatment on the basis of a positive HIV test and clinical assessment by trained staff.

- “Available to the poorest” — cost should never be a barrier to treatment, and treatment will therefore have to be free for most people in the poorest countries.
- “Price matters” — the lower the price of medicines, the higher the number of patients who can be treated.
- “Involve the community” — community engagement helps to raise treatment and prevention adherence, and to break down the taboo surrounding HIV.<sup>149</sup>

The effect of antiretrovirals on individual lives is often near-miraculous. They are not a permanent cure, but by slowing the progression of the disease, they can extend the lives of people living with HIV by years. Indeed in some cases it appears that the extension of life is indefinite— hopefully until a cure for AIDS is found. Antiretrovirals interfere with the replication of the virus’ genetic material and therefore slows the spread of the virus within the body. Antiretroviral therapy must be part of an integrated package of interventions that includes prevention, care and support activities, all of which complement and reinforce each other.

There are clear and intricate linkages between existence and delivery of reproductive health services and disease, specifically HIV/AIDS. Nonetheless, although the policy does not apply to separate HIV/AIDS funds, the loss of funding due to the Global Gag Rule has affected not only the existence of locales for the delivery of reproductive health services and education, which include instruction on HIV transmission and its prevention, but also of supplies such as condoms which play a significant role in HIV transmission prevention. Thus, even if perhaps unintentionally, the gag rule has also put USAID-supported family planning NGOs in the difficult position of having to deny their clients the provision of contraceptive and disease prevention services to which they are legally entitled and that the rule, in theory and intent, is not meant to reach.<sup>150</sup>

From an international law perspective the rule also effects an imperialistic move that undercuts states’ sovereignty. Countries and their

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<sup>149</sup> *Id.*

<sup>150</sup> NIAID, *supra* note 97.

agents, that are dependent upon foreign funding assistance for the attainment of important domestic goals, may become unable to pursue them because of the gag rule's restrictions.

Organizations that refuse to sign the Standard Clause accepting the limitation on the use of funding are precluded from offering the support needed to train and equip providers of safe, legal abortion care. Moreover, they lose access to U.S. donated contraceptives, including condoms. Modern contraceptives enable women and men to prevent unwanted pregnancy, to protect themselves against HIV/AIDS, and to avoid unsafe abortions—a leading cause of maternal injury, illness, and death in the developing world.

The USAID and UN Population Fund are the largest donors of contraceptives, including condoms, to the developing world.<sup>151</sup> The USAID, the most important single donor, between its procuring and delivering functions, accounts for more than one-third of all donated supplies. Such contributions translate to approximately \$75 million US per year.<sup>152</sup> In 2000, donors provided just over 950 million condoms. This amounts to less than one-eighth of the number necessary to attain the level of access required to significantly reduce both HIV infection and prevalence rates in developing countries and Eastern Europe.<sup>153</sup>

Most women in developing states exist at a level of poverty in which they lack the economic means to have reliable access to contraceptives. Some populations are especially vulnerable to the lack of access, including adolescents, refugees, victims of sexual coercion or violence, and those suffering from acute or chronic diseases such as HIV/AIDS.<sup>154</sup>

To be sure, although the gag rule does not technically apply to HIV/AIDS funds from the USAID, it nevertheless hampers HIV prevention efforts.<sup>155</sup> When family planning organizations refuse to accept the terms of the gag rule, the sexually transmitted infection prevention services (including HIV prevention services) as well as the condom supplies that those organizations would routinely provide are either undermined or no longer available.<sup>156</sup>

The realities of the HIV/AIDS epidemic, the progress in its containment made possible with treatment—treatments to which only those with personal wealth, cooperating governments, or with recourse to third party assistance

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<sup>151</sup> Global Gag Rule Impact Project, *The Global Gag Rule & Contraceptive Supplies*, [http://www.globalgagrul.org/pdfs/issue\\_factsheets/GGR\\_fact\\_contraceptive.pdf](http://www.globalgagrul.org/pdfs/issue_factsheets/GGR_fact_contraceptive.pdf).

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> Global Gag Rule Impact Project, *The Global Gag Rule & HIV/AIDS*, [http://www.globalgagrul.org/pdfs/issue\\_factsheets/GGR\\_fact\\_HIV.pdf](http://www.globalgagrul.org/pdfs/issue_factsheets/GGR_fact_HIV.pdf).

(such as Doctors Without Borders) have access—and the effect of the gag rule on HIV/AIDS programs provide fertile ground to suggest a paradigmatic shift in the delivery of health care services. The epidemic shows that some populations are particularly vulnerable and that governments and societies need to be mindful that these persons not be denied the opportunity to enjoy human well-being. The developments in treatment options unveil two significant realities in the health care delivery field. First, money matters with respect to access to treatment. Second, hitherto clear lines as to the effect of treatment—either palliative, i.e., that merely abates the violence of a disease, or curative—are blurred.

In the following section the essay utilizes a South African Constitutional Court decision to show the great difference operating under a palliative/curative dichotomy can make regarding access to treatment. It then concludes that both such categorization and an econometric approach to health care ought to be abandoned and instead a human well-being approach adopted.

#### V. LOOKING FORWARD

In *Soobramoney v. Minister of Health*, the South African Constitutional Court upheld a hospital administration's decision to provide dialysis only to those who were eligible for transplants, i.e., those patients who, in the judgment of the state, could be "cured."<sup>157</sup> Conversely, the state could deny dialysis treatments to patients ineligible for transplants, i.e., for whom it would simply be palliative care, notwithstanding whether the treatments would be beneficial to the patient's length or quality of life. The *Soobramoney* Court's reasoning, ostensibly a rational allocation of scarce resources case, might be palatable or necessary in non-health related contexts. It held that the state, which has limited means, can make the difficult decision on how best to utilize its available resources. However, in dealing with health matters, this framework has the state effectively deciding which life to value.

Each re-reading of *Soobramoney* increases my discomfort with the decision and the reasoning behind it. To be sure, no one can argue with the reality of a state's finite resources. But it seems inappropriate, if not alarming, to place the potentially life and death delivery of health care services decision-making power on a governmental body with its attendant and ubiquitous structural prejudices. The process unveils and underscores some reasons for concern. For example, until very recently in South Africa,

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<sup>157</sup> *Soobramoney v. Minister of Health*, Constitutional Court of South Africa, Case CCT 32/97, Judgment of Nov. 27, 1997, [http://www.chr.up.ac.za/ggp/coursematerial/socio\\_rights/soobram.pdf](http://www.chr.up.ac.za/ggp/coursematerial/socio_rights/soobram.pdf).

all classes of nonwhites were disposable people—second-class citizens who were denied well-being.

In addition, to make treatment delivery options contingent on the state's perception of the treatment being curative is inappropriate. Nobody has a preordained time-line. Anyone can be healthy and be involved in a tragic accident or suffer a catastrophic illness and be gone in an instant. Specifically with regard to the *Soobramoney* rationale, even with respect to those eligible for transplants, there are enormous risks and contingencies involved. For one, the transplant might not take. Similarly, an organ might not be available for transplant, or a person who undergoes a successful transplant may have an accidental death or suffer an unrelated, yet still terminal, illness.

Moreover, although a treatment may be palliative, one day a cure may be found for the disease. Alternatively, as in the HIV/AIDS case, the palliative treatment may effectively indefinitely prolong life although it does not effect a cure. The possibilities concerning efficacy of treatments are innumerable. Thus, having the state decide the guidelines for who gets treatment and who does not, effectively deciding who lives and who does not—reasonable as the guidelines may appear to be—seems to be a hugely dangerous proposition particularly in a world where not all lives are valued equally, in a world that is replete with disposable people.

In this regard, the ostensibly clear line drawn by the *Soobramoney* Court between palliative and curative care is deeply flawed. The palliative/curative distinction is not a bright, clear line; rather, it is part of a continuum. The HIV/AIDS pandemic exposes this reality. Medications that have been developed, while not curative, in fact have the effect of the indefinite prolongation of life. As such, the palliative function of the medications blurs the line to cure because they do more than reduce the violence of a disease. Thus, we should consider health care delivery to be a process that operates along a life/death continuum. The process ranges from prevention to cure. The delivery of health care services and treatment that takes place along this life/death continuum works to effect human dignity and well-being.

Human well-being is an international human right. This goal of human thriving involves the rights to health, health care, life, family, information, nondiscrimination, and conditions for an adequate standard of living. Yet as the figures for the gag rule and the HIV/AIDS statistics reveal, these rights are at best illusory for vulnerable populations. Disposable people—the poor, the ill, the disempowered and disenfranchised, women and children, populations from the South and the East—all disproportionately lack access to well-being.

The effects of the Global Gag Rule on health care and the realities of HIV/AIDS epidemic for disposable populations provide lessons to be

learned about human rights, economic power, and human well-being. Both show the connection of money and health.

An analysis of the gag rule reveals that it can be interpreted as an imperial power move that contributes to the deterioration of health. It deploys economic power to ignore sovereignty and subtract from human well-being. The policy purposely denies access to funds that enable the provision of health education, supplies, and services simply to implement political ideology. Ironically, while claiming a policy of preventing loss of life through prohibition of abortion, the gag rule policy actually costs more lives by not engaging in programs that can reduce maternal and infant mortality. Significantly, the policy also deleteriously results in more orphans (who are usually left in very vulnerable and unstable situations) and in the failure to provide certain services and supplies necessary for HIV/AIDS victims. This reveals a direct link between economic power (quantity of aid) and availability of service.

The HIV/AIDS example, on the other hand, unveils both direct and indirect connections between money and health. As suggested above, the gag rule affects delivery of some HIV/AIDS-related services although that is not the intent of the policy and, indeed, separate HIV/AIDS USAID funding would, in theory, be able to support the delivery of supplies and services.

Beyond the gag rule, it has become evident that states with greater access to economic resources can better protect their endangered ill citizens. However an important lesson, that is significant to any analysis of health as a fundamental human right, can be learned from the HIV/AIDS treatment options. The scientific progress in treating HIV/AIDS blurs the palliative/curative line and instead places health care delivery on a prevention to cure continuum. Lack of clear lines separating palliative treatment from curative treatment exacerbates the problem of economic access. The concern is that the most disempowered persons around the world, North and South, East and West alike—women and children, the aged, the poor, the ill, the infirm—may lack the economic power to enjoy the benefits of human well-being if delivery of health care services is based upon an econometric model that includes evaluating whether the treatment can effect a cure. This reality provides the foundation for starting a conversation about the reconstruction of the health paradigm along dignitary lines.

In this regard, the *Soobramoney* case from South Africa is instructive both to some perceived parameters of the right to health care and the need for a paradigmatic transition that centers human well-being in considering health matters. Even in South Africa with one of the most progressive constitutions in the world that expressly includes a right to health, the power of money is patent. The right to health—in this instance, access to state-provided health care—is dependent upon, as *Soobramoney* underscores, the

state's available resources. The decision is in accord with the international documents, which provide that access to protected services depends upon the economic limitations of the state.<sup>158</sup> This results in a situation in which those who can afford to pay for health care treatment can obtain it and have access to procedures and medication that can improve their condition. Yet those who cannot privately pay for medical care are limited to receiving only the treatment that the state has chosen to provide. That, in turn, subjects persons to the state's value judgment of what is important treatment and what are properly treatable illnesses. This judgment is linked to a state's decision about who is a disposable person rather than the health needs of the individual human being.

The human rights construct acknowledges that all human rights are indivisible. Since the earliest days the right to health has been viewed as a right central to humanity. A critical analysis reveals that vulnerable populations bear the cost of life by the deployment of money as the factor to determine access to health care services. The value of life ought not to depend upon uncritical economic models, relative value of life judgments by those on the economic power, or the whims of the state. All families, not just the rich, western, or northern ones, are important; all parents have the right to health for their children; all children deserve a chance at a long healthy life. To achieve these goals it is imperative to overcome the economic urge to ignore disposable people and instead to center human well-being in the health paradigm.

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<sup>158</sup> See, e.g., ICESCR, *supra* note 15, art. 2(1)("[e]ach State Party . . . undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights . . . by all appropriate means").