ACCESS TO INFORMATION ON SAFE ABORTION: A HARM REDUCTION AND HUMAN RIGHTS APPROACH

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INTRODUCTION

The long-standing distinction between safe and unsafe abortion is proving unworkable. Not all clandestine abortions in restrictive legal environments are equally unsafe. Decreases in the numbers of severe complications and maternal deaths related to unsafe abortion are attributed to, among other

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factors, the use of medicines to terminate a pregnancy: a method of safer "unsafe" abortion.[1]

Not all risk, however, is eliminated. Women who self-administer medicines often lack information on their safe and effective use. The challenge is how to reach women with safer-use information. This Article examines one model of access to information, *Health Initiatives Against Unsafe Abortion* (*Iniciativas Sanitarias contra el Aborto Provocado en Condiciones de Riesgo*).[2] In clinical consultation, physicians provide women who are ineligible for a lawful abortion with evidence-based information on safer clandestine methods of pregnancy termination. No information is provided on where or how to obtain the drug, nor is it prescribed. This innovative model, developed by Iniciativas Sanitárias, a health professional organization in Uruguay, is referred to throughout the Article as the Uruguay Model.[3]

The Uruguay Model is expressly characterized as a harm reduction initiative to reduce abortion-related mortality and morbidity.[4] Harm reduction is not, however, the exclusive discourse around the model. It is also promoted as a means to realize reproductive rights.[5] Women's health advocates have seized upon the Uruguay Model and its expansion to countries across Latin America as "an important opportunity . . . to position reproductive rights as an essential part of the body of internationally recognized human rights, and to concretely apply these rights in a service provision setting."[6]

The conceptual links between harm reduction and human rights—both as approaches to and discourses on social action—are a subject of growing

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[1] Iqbal Shah & Elisabeth Ahman, *Unsafe Abortion in 2008: Global and Regional Levels and Trends*, 18 REPROD. HEALTH MATTERS 90, 91 (2010).

[2] Information on the initiative is gathered from published literature, authored primarily by members of Iniciativas Sanitárias. *See generally* Leonel Briozzo & Anibal Faúndes, *The Medical Profession and the Defense and Promotion of Sexual and Reproductive Rights*, 100 INT'L J. GYNECOLOGY & OBSTETRICS 291 (2008); Leonel Briozzo, Ana Labandera, Mónica Gorgoroso & José Enrique Pons, *Iniciativas Sanitarias: Una Nueva Estrategia en el Abordaje del Aborto de Riesgo*, *in* INICIATIVAS SANITARIAS CONTRA EL ABORTO PROVOCADO EN CONDICIONES DE RIESGO 21 (Leonel Briozzo ed., 2007) [hereinafter Briozzo et al., *Iniciatavas Sanitarias*]; L. Briozzo, F. Rodríguez, I. León, G. Vidiella, G. Ferreiro & J.E. Pons, *Unsafe Abortion in Uruguay*, 85 INT'L J. GYNECOLOGY & OBSTETRICS 70 (2004) [hereinafter Briozzo et al., *Unsafe Abortion*]; L. Briozzo, G. Vidiella, F. Rodríguez, M. Gorgoroso, A. Faúndes & J.E. Pons, *A Risk Reduction Strategy to Prevent Maternal Deaths Associated with Unsafe Abortion*, 95 INT'L J. GYNECOLOGY & OBSTETRICS 221 (2006) [hereinafter Briozzo et al., *Risk Reduction Strategy*]; Giselle Carino, Jennifer Friedman, Marrcela Rueda Gomez, Carrie Tatum & Leonel Briozzo, *A Rights-Based Model: Perspectives from Health Service Providers*, *in* 39 IDS BULLETIN 77 (Andrea Lynch et al. eds., 2008); Anibal Faúndes, Kamini Rao & Leonel Briozzo, *Right to Protection from Unsafe Abortion and Postabortion Care*, 106 INT'L J. GYNECOLOGY & OBSTETRICS 164 (2009).

[3] *See infra* notes 41–44 and accompanying text (describing the Uruguay Model in detail).

[4] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 222.

[5] Briozzo et al., *Iniciatavas Sanitarias*, *supra* note 2, at 35; Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 223 (describing women as "citizens, with rights, who should be provided with information").

[6] Carino et al., *supra* note 2, at 79.

interest and engagement. In the late 1990s, human rights and harm reduction were rarely mentioned in the same literature,[7] although it is argued that a commitment to human rights has marked the thinking and advocacy of the harm reduction movement from its outset.[8] There is now broad agreement that harm reduction and human rights enjoy a close kinship or share common cause, each reflecting core principles of the other.[9] Their convergence can be explained as follows. Harm reduction provides the neutral and pragmatic evidence-base to support principled legal argument. Harm reduction, in other words, offers evidence of the effectiveness of rights-based approaches to health.[10] Human rights, in turn, provide normative validation for harm reduction, namely the legal obligation to act on the evidence of effective interventions to reduce harm.[11] "Whether it is easier to establish a basic human right . . . and then push for public health than to establish public health and then push for human rights, depends upon the constellation of political circumstances in a given society at a given moment in history."[12]

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[7] *But see* Norbert Gilmore, *Drug Use and Human Rights: Privacy, Vulnerability, Disability, and Human Rights Infringements*, 12 J. CONTEMP. HEALTH L. & POL'Y 355 (1996) (analyzing the human rights of drug users with reference to the relationship between public health or harm reduction and human rights); Alex Wodak, *Health, HIV Infection, Human Rights, and Injecting Drug Use*, 2 HEALTH & HUM. RTS. 24 (1998) (discussing harm reduction and human rights related to injecting drug users).

[8] Richard Elliott, Joanne Csete, Evan Wood & Thomas Kerr, *Harm Reduction, HIV/AIDS, and the Human Rights Challenge to Global Drug Control Policy*, 8 HEALTH & HUM. RTS. 105, 106 (2005).

[9] There is growing literature on the relationship between harm reduction and human rights. *See generally* Jonathan Cohen & Joanne Csete, *As Strong as the Weakest Pillar: Harm Reduction, Law Enforcement and Human Rights*, 17 INT'L J. DRUG POL'Y 101 (2006) (advocating a human rights approach to injection drug use to achieve public health objectives); Jonathan Cohen & Daniel Wolfe, Commentary, *Harm Reduction and Human Rights: Finding Common Cause*, 22 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME S93 (2008) [hereinafter Cohen & Wolfe, Commentary] (describing how harm reduction and human rights movements can find affirmation of their core principles in the other); Elliott et al., *supra* note 8 (joining human rights law with public health evidence to advocate for change in the global drug control regime); Ralf Jürgens, Joanne Csete, Joseph J. Amon, Stefan Baral & Chris Beyrer, *People Who Use Drugs, HIV, and Human Rights*, 376 LANCET 475 (2010) (seeking to improve understanding of the health and human rights implications of approaches to drug use and HIV, and demonstrating that human rights protection is an essential precondition to improving the health of people who use drugs); Ian Malkin, Richard Elliott & Rowan McRae, *Supervised Injection Facilities and International Law*, 33 J. DRUG ISSUES 538 (2003) (arguing that pursuant to their international human rights obligations, states should implement trials of supervised injection facilities, a harm reduction intervention); Daniel Wolfe & Jonathan Cohen, *Human Rights and HIV Prevention, Treatment, and Care for People Who Inject Drugs: Key Principles and Research Needs*, 55 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME S56 (2010) [hereinafter Wolfe & Cohen, *Human Rights and HIV Prevention*] (describing the convergence or common cause between health and human rights advocacy in the injection drug use context).

[10] Sofia Gruskin, *Rights-Based Approaches to Health: Something for Everyone*, 9 HEALTH & HUM. RTS. 5, 6 (2006).

[11] Elliot et al., *supra* note 8, at 106; *see also* Cohen & Wolfe, Commentary, *supra* note 9, at S94.

[12] Craig Reinarman, *Public Health and Human Rights: The Virtues of Ambiguity*, 15 INT'L J. DRUG POL'Y 239, 240 (2004); *see also* Elliot et al., *supra* note 8, at 106 (describ-

Yet many are unwilling to see the relationship in a purely instrumental manner, and in this respect, harm reduction and human rights may not form a perfect union.[13] The divergence between the two approaches is attributed to their different underlying "moral warrants."[14] Human rights are set against the normative neutrality of harm reduction, which is characterized by a pragmatic (not principled) approach to health outcomes (not social justice). Some argue this was not always a feature of harm reduction,[15] but reflects a recent turn toward a "professional, medical management of social problems" with a "focus on individual consequences and societal costs rather than their social causes."[16] A normative anchor in human rights is seen as a means to resuscitate harm reduction as a platform for broad social change.[17]

With convergence-divergence as an organizing theme, this Article explores harm reduction and human rights as conceptual approaches to and discourses about unsafe abortion. The vehicle for this exploration is access to safer-use information as exemplified by the Uruguay Model.

On convergence, this Article seeks to test the claim that international human rights law "has evolved to the point where it now imposes . . . obligations on governments to provide, and to refrain from interfering with the communication of, information that is necessary for the protection and promotion of reproductive health and choice."[18] Access to information is protected in international law through a constellation of human rights. These rights are articulated in broad terms, but given content and meaning through interpretation by courts, committees, Special Rapporteurs, and commissions established to monitor and enforce international human rights law.[19] By ref-

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ing strategic reasons to focus on public health or human rights in argument for a specific reform).

[13] *See, e.g.*, Neil Hunt, *Public Health or Human Rights: What Comes First?*, 15 INT'L J. DRUG POL'Y 231, 231 (2004); Reinarman, *supra* note 12, at 240.

[14] Andrew D. Hathaway & Patricia G. Erickson, *Drug Reform Principles and Policy Debates: Harm Reduction Prospects for Cannabis in Canada*, 33 J. DRUG ISSUES 465, 484 (2003); *see also* Andrew D. Hathaway, *Shortcomings of Harm Reduction: Toward a Morally Invested Drug Reform Strategy*, 12 INT'L J. DRUG POL'Y 125, 135 (2001) [hereinafter Hathaway, *Shortcomings of Harm Reduction*].

[15] *See generally* Samuel R. Friedman, Matthew Southwell, Regina Bueno, Denise Paone, Jude Byrne & Nick Crofts, Commentary, *Harm Reduction: A Historical View from the Left*, 12 INT'L J. DRUG POL'Y 3 (2001) (describing the past and present political climates that shape and limit the perspectives, strategies, and tactics of harm reduction); Richard Velleman & Janet Rigby, *Harm Minimization: Old Wine in New Bottles?*, 1 INT'L J. DRUG POL'Y 24 (1990) (discussing the controversy around harm reduction concepts).

[16] Gordon Roe, *Harm Reduction as Paradigm: Is Better than Bad Good Enough? The Origins of Harm Reduction*, 15 CRITICAL PUB. HEALTH 243, 244–45 (2005).

[17] *See* Hathaway, *Shortcomings of Harm Reduction*, *supra* note 14, at 135; *see also* Elliott et al., *supra* note 8, at 121 (describing human rights as providing a "normative counterweight").

[18] Sandra Coliver, *The Right to Information Necessary for Reproductive Health and Choice Under International Law*, *in* THE RIGHT TO KNOW: HUMAN RIGHTS AND ACCESS TO REPRODUCTIVE HEALTH INFORMATION 38, 39 (Sandra Coliver ed., 1995).

[19] This Article relies on (1) the jurisprudence of the European Court of Human Rights and the Inter-American Court of Human Rights in the regional human rights systems; (2)

erence to this collective jurisprudence, normative validation for harm reduction in unsafe abortion, and specifically access to safer-use information, is constructed from the human rights to life,[20] health,[21] non-discrimination,[22] and information,[23] among others.

On divergence, this Article seeks to make explicit the different moral warrants underlying harm reduction and human rights in unsafe abortion. The human rights shortcomings of access to safer-use information via physician-patient consultation, the Uruguay Model, are contrasted against a model, the Safe Abortion Hotline, driven by an alternative ideology. The limitations of the pragmatic-neutrality of harm reduction in criminal law reform are set against a human rights approach, which envisions legal reform in service of broad social change.

I. Health Initiatives Against Unsafe Abortion: The Uruguay Model

The use of medicines to terminate a pregnancy, or medication abortion, has made unsafe abortion safer.[24] Unsafe abortion is defined as "a procedure for terminating an unintended pregnancy that is carried out either by a person lacking the necessary skills or in an environment that does not conform to the minimal medical standards, or both."[25] Despite strict criminal abortion laws throughout Latin America and the Caribbean, an estimated

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the work of treaty bodies and committees of independent experts in the UN human rights system, including Concluding Observations (recommendations based on review of State compliance), General Comments or Recommendations (interpretations on the content of human rights provisions, thematic issues, or methods of work), and Decisions (issued in a quasi-judicial capacity on the merits of petitions received from individuals); and (3) the reports of Special Rapporteurs and human rights commissions (independent expert bodies appointed to investigate, monitor, and report on thematic human rights issues).

[20] *See* Organization of American States, American Convention on Human Rights art. 4, Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123 (entered into force July 18, 1978); International Covenant on Civil and Political Rights art. 6, *adopted* Dec. 19, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976); European Convention for the Protection of Human Rights and Fundamental Freedoms art. 2, Nov. 4, 1950, 213 U.N.T.S. 222 (entered into force Sept. 3, 1953).

[21] *See* International Covenant on Economic, Social and Cultural Rights art. 12, *adopted* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976); European Convention for the Protection of Human Rights and Fundamental Freedoms art. 8, *supra* note 20, at 230 (the right to respect for private life, encompassing physical and mental health).

[22] *See* Convention on the Elimination of All Forms of Discrimination Against Women art. 12, *adopted* Dec. 18, 1979, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981).

[23] *See* Organization of American States, American Convention on Human Rights art. 13, *supra* note 20, at 148; European Convention for the Protection of Human Rights and Fundamental Freedoms art. 10, *supra* note 20, at 230.

[24] Shah & Ahman, *supra* note 1, at 91.

[25] *Id.* at 90 (noting that the definition of unsafe abortion was developed in the late 1980s when most abortions were surgical and/or invasive); *see also* World Health Organization ("WHO"), Division of Family Health, The Prevention and Management of Unsafe Abortion, at 3, WHO Doc. WHO/MSM/92.5 (Apr. 12–15, 1992) (describing and defining unsafe abortion).

four million abortions are performed in the region every year, the vast majority of them clandestine and by the formal definition unsafe.[26] Not all clandestine abortion methods, however, are equally unsafe.

A method in widespread use is women's self-administration of the drug misoprostol.[27] Misoprostol is a prostaglandin E1 analogue marketed for the prevention and treatment of gastric ulcers.[28] The drug also causes uterine contractions and cervical ripening, effective in pregnancy termination.[29] In contrast to other clandestine methods, misoprostol use is associated with reduced severity of complications and abortion-related deaths.[30] Misoprostol

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[26] Shah & Ahman, *supra* note 1, at 94.

[27] *See* María Mercedes Lafaurie, Daniel Grossman, Erika Troncoso, Deborah L. Billings & Susana Chávez, *Women's Perspectives on Medical Abortion in Mexico, Colombia, Ecuador and Peru: A Qualitative Study*, 13 REPROD. HEALTH MATTERS 75, 76 (2005) ("Studies . . . illustrate that women obtain misoprostol either from pharmacies without a prescription or from physicians, who prescribe or dispense it directly."); J. Sherris, A. Bingham, M.A. Burns, S. Girvin, E. Westley & P.I. Gomez, *Misoprostol Use in Developing Countries: Results from a Multicountry Study*, 88 INT'L J. GYNECOLOGY & OBSTETRICS 76, 77 (2005). The practice has been widely documented in Brazil. *See generally* S. Clark, J. Blum, K. Blanchard, L. Galvão, H. Fletcher & B. Winikoff, *Misoprostol Use in Obstetrics and Gynecology in Brazil, Jamaica, and the United States*, 76 INT'L J. GYNECOLOGY & OBSTETRICS 65; Helena Lutéscia Luna Coêlho, Ana Cláudia Teixeira, Maria de Fátima Cruz, Sandra Luzia Gonzaga, Paulo Sérgio Arrais, Laura Luchini, Carlo La Vecchia & Gianni Tognoni, *Misoprostol: The Experience of Women in Forteleza, Brazil*, 49 CONTRACEPTION 101 (1994); Helena Lutéscia Luna Coêlho, Ana Cláudia Teixeira, Ana Paula Santos, Eliane Barros Forte, Silvana Macedo Morais, Carlo La Vecchia, Gianni Tognoni & Andrew Herxheimer, *Misoprostol and Illegal Abortion in Fortaleza, Brazil*, 341 LANCET 1261 (1993); Sarah H. Costa & Martin P. Vessey, *Misoprostol and Illegal Abortion in Rio de Janeiro, Brazil*, 341 LANCET 1258 (1993); John M. Paxman, Alberto Rizo, Laura Brown & Janie Benson, *The Clandestine Epidemic: The Practice of Unsafe Abortion in Latin America*, 24 STUD. IN FAM. PLAN. 205.

[28] O.S. Tang, K. Gemzell-Danielsson & P.C. Ho, *Misoprostol: Pharmokinetic Profiles, Effects on the Uterus and Side-Effects*, 99 INT'L J. GYNECOLOGY & OBSTETRICS S160, S160 (2007).

[29] *Id.* at S163–65.

[30] The major complication associated with misoprostol use in pregnancy termination is uterine bleeding, which is easier to treat than uterine perforation and pelvic infections associated with other clandestine methods. Margareth Arilha & Regina M. Barbosa, *Cytotec in Brazil: "At Least it Doesn't Kill"*, 1 REPROD. HEALTH MATTERS 41, 43 (1993); Regina M. Barbosa & Margareth Arilha, *The Brazilian Experience with Cytotec*, 24 STUD. IN FAM. PLAN. 236, 237 (1993) [hereinafter Barbosa & Arilha, *The Brazilian Experience with Cytotec*]; A. Faúndes, L.C. Santos, M. Carvalho & C. Gras, *Post-Abortion Complications After Interruption of Pregnancy with Misoprostol*, 12 ADVANCES IN CONTRACEPTION 1, 2 (1996); Suellen Miller, Tara Lehman, Martha Campbell, Anke Hemmerling, Sonia Brito Anderson, Hector Rodriguez, Wilme Vargas Gonzalez, Milton Cordero & Victor Calderon, *Misoprostol and Declining Abortion-Related Morbidity in Santo Domingo, Dominican Republic: A Temporal Association*, 112 BJOG: INT'L J. OBSTETRICS & GYNAECOLOGY 1291, 1292 (2005); Enrique D. Siña, *Reducción de la Mortalidad Maternal en Chile de 1990 a 2000*, 15 REVISTA PANAMERICANA DE SALUD PUBLICA 326, 329 (2004); Susheela Singh, *Hospital Admissions Resulting from Unsafe Abortion: Estimates from 13 Developing Countries*, 368 LANCET 1887, 1890 (2006). Increased post-abortion hospital admissions have been reported in some cases. Women may, however, report to hospitals as part of the "normal" process. They are instructed to or arrive at the emergency room once bleeding and contractions begin for treatment of spontaneous miscarriage as a means to complete the termination. The use of misoprostol has thus been described as a "passport" for obtaining abortion completion services.

abortion regimens have been studied in developing regions, and there is much information and instruction available on their safe and effective use in controlled settings.[31] Women, however, lack access to this information.[32] Misoprostol use in the clandestine practice of abortion has largely developed on a trial and error basis.[33] Studies reveal that women self-administer the drug with little knowledge about the mechanism of action, dosage and routes of administration, the process and its completion, and side effects.[34] To realize the full potential of misoprostol to reduce abortion-related death and dis-

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Clark et al., *supra* note 27, at 73; Henry Espinoza, Katrina Abuabara & Charlotte Ellerston, *Physicians' Knowledge and Opinions About Medication Abortion in Four Latin American and Caribbean Region Countries*, 70 CONTRACEPTION 127, 130 (2004); C.C. Harper, K. Blanchard, D. Grossman, J.T. Henderson & P.D. Darney, *Reducing Maternal Mortality Due to Elective Abortion: Potential Impact of Misoprostol in Low-Resource Settings*, 98 INT'L J. GYNECOLOGY & OBSTETRICS 66, 68 (2007) (providing estimates of mortality reductions if misoprostol were to replace riskier techniques).

[31] Deborah L. Billings, *Misoprostol Alone for Early Medical Abortion in a Latin American Clinic Setting*, 12 REPROD. HEALTH MATTERS S57, S60 (2004). A consensus regimen has been published for abortion through nine weeks gestation, consisting of 800 mcg vaginal misoprostol, repeated after twenty-four hours. GYNUITY HEALTH PROJECTS & REPROD. HEALTH TECHS. PROJECT, CONSENSUS STATEMENT: INSTRUCTIONS FOR USE—ABORTION INDUCTION WITH MISOPROSTOL IN PREGNANCIES UP TO 9 WEEKS LMP, at 2 (July 28, 2003), *available at* http://www.rhtp.org/news/publications/documents/Miso%20for%20Pregnancy%20Termination.IFU.English.pdf.

[32] Sherris et al., *supra* note 27, at 78–79; *see also* Espinoza, Abuabara & Ellerston, *supra* note 30, at 132 ("Information was the only characteristic of medication abortion that was seen solely as a disadvantage. . . . [M]any respondents noted a paucity of information for both physicians and women."). Moreover, little research has been conducted on the safety and effectiveness of misoprostol use in less controlled settings. Harper et al., *supra* note 30, at 68; *see also* Clark et al., *supra* note 27, at 66.

[33] *See generally* Kelly Blanchard, Beverly Winikoff & Charlotte Ellertson, *Misoprostol Used Alone for the Termination of Early Pregnancy: A Review of the Evidence*, 59 CONTRACEPTION 209 (1999) (reviewing available studies on the use of misoprostol for early pregnancy termination).

[34] Sherris et al., *supra* note 27, at 78–79:

> Many women were aware of the availability of a "pill" that causes abortion, but they often were unable to recall the name and were confused about the distinction between misoprostol, emergency contraceptive pills, mifepristone, and oral contraceptives. . . .
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> Women who had terminated a pregnancy described the process as one in which they lacked . . . information. . . . Although the women generally recognized that earlier abortions were safer and less difficult, their efforts often were delayed by seeking information and trying various options.
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> Most women reported that they had received little information about misoprostol and widely varying instructions for use and would have appreciated having better information. Although pharmacy staff provided some information about symptoms that might occur after taking the tablets (such as bleeding and severe cramps), many women had been unable to determine whether their symptoms were abnormal or whether a complete abortion had occurred. . . .
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> It is important to note that these results reflect information from a small group of women who sought postabortion care and does not include the experiences of other women who used misoprostol but did not seek medical attention.

See also Tang, Gemzell-Danielsson & Ho, *supra* note 28, at S165 (describing that many of the experienced effects of misoprostol are related to the abortion itself and include abdominal pain, cramping, and bleeding, while other common side effects include nau-

ability—to make unsafe abortion safer—the challenge is how to reach women with safer-use information in restrictive legal environments.[35]

In answer to this challenge, a study undertaken in an undisclosed Latin American country revealed a strong consensus that "physicians were the most appropriate channel for providing women with instructions on misoprostol use."[36] The study further identified verbal communication through physician-patient consultation as the best method to convey information.[37] This Article examines one model of access to safer-use information through patient-physician consultation: Health Initiatives Against Unsafe Abortion ("the Uruguay Model").

Similar to most countries in Latin America, the Penal Code in Uruguay prohibits abortion as a crime but allows for the lessening or exemption of punishment in mitigating circumstances: family honor, rape, severe economic hardship, and risk to maternal health or life.[38] These circumstances are referred to as the legal indications for abortion. They are strictly interpreted and rarely applied, with few abortions performed lawfully in the country.[39] Abortion nevertheless remains widespread, with clandestine abortion a leading cause of maternal death and disability.[40]

The objective of the Uruguay Model is to reduce the risk and harms of unsafe abortion through the provision of health information and services. The model consists of two interventions: a pre- and post-consultation, corresponding to the before and after of pregnancy termination.[41]

In the pre-consultation (the "before visit"), a woman who presents with an unwanted pregnancy is offered the following information and services:

- A medical examination to confirm pregnancy and gestational age and, more generally, to inform the woman about her health status (i.e., maternal or embryonic pathologies).
- Information on the Penal Code and whether she is lawfully entitled to a pregnancy termination under its provisions. If so, abortion services

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sea, vomiting, diarrhea, fever, chills, headache, and dizziness and appear to be dose-related and more frequent with oral regimens).

[35] Sherris et al., *supra* note 27, at 80:

> An important question that emerged from the data was how to inform and counsel women about the use of misoprostol for pregnancy termination. Physicians and pharmacists stated they were hesitant to provide such information because of the restricted status of abortion in their countries and the controversy surrounding misoprostol use, yet women expressed a desire for better information about misoprostol as an option for pregnancy termination.

[36] Jessica Cohen, Olivia Ortiz, Silvia Elena Llaguno, Lorelei Goodyear, Deborah Billings & Imelda Martinez, *Reaching Women with Instructions on Misoprostol Use in a Latin American Country*, 13 REPROD. HEALTH MATTERS 84, 86 (2005).

[37] *Id.* at 88.

[38] CÓDIGO PENAL [CÓD. PEN.] [CRIMINAL CODE] Ley 9.763, art. 1 (Uru.).

[39] Carino et al., *supra* note 2, at 78.

[40] Briozzo et al., *Unsafe Abortion*, *supra* note 2, at 71.

[41] This summary description of the initiative is based on the literature cited *supra* note 2.

can be provided upon her request. If not, abortion services are not provided.

- Evidence-based information on the risks of different methods of clandestine abortion, including *safer* self-induced methods, such as misoprostol use. This information includes the legal status of the drug, as well as dose, routes, symptoms, side effects, mechanism of action, effectiveness, and problems of use at later gestational ages. No information is provided on where or how to obtain misoprostol, nor is the drug prescribed by the attending physician.
- Non-directive counseling to discuss decision-making about continuing or terminating the pregnancy. Information is provided about available social support should the woman continue the pregnancy or adoption as an alternative. The purpose of this information is to inform rather than influence decision-making.

If the woman decides to terminate her pregnancy, she is encouraged to return for follow-up care. In the post-consultation, she receives the following information and services:

- A medical examination to confirm complete termination and follow-up care for complications or incomplete abortion as required.
- Information about contraceptive options to avoid future unwanted pregnancy, and contraceptive services as requested.

Patient-provider confidentiality is protected and assured to women in both consultations.

The Uruguay Model was first implemented as a pilot project in the Pereira Rossell Hospital, Montevideo, the main public maternity hospital in the country.[42] In 2004, the Health Ministry enacted a regulation to implement the model in all public sector facilities and to establish guidelines for pre- and post-consultation.[43] The ministerial regulation was subsequently affirmed in law.[44] The Uruguay Model does not merely provide safer-use information. The information is provided lawfully with full sanction of the state.

In this Article, the Uruguay Model is used as an analytical tool to explore harm reduction and human rights as conceptual approaches to and discourses about unsafe abortion. The model is not considered synonymous with a harm reduction or human rights approach. It is not treated as an ideal model, but rather an actualized model or prototype of access to information through physician-patient consultation in a restrictive legal environment.

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[42] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 222.

[43] On August 6, 2004, the Ministry of Public Health of the Republic of Uruguay issued Ordinance 369/04. Included in the appendix of the Ordinance are guidelines for the Uruguay Model, entitled "Health Care Rules: Protective Measures for Mothers Faced with Abortion Induced in Risky Conditions." *See also Round Up: Law and Policy*, 15 Reprod. Health Matters 208, 211 (2007).

[44] Código Civil [Cód. Civ.] [Civil Code] Ley 18.426, Capítulo I, art. 4(b)(2) (Uru.).

While the model and the Uruguayan legal context provide concreteness, the analysis is intended to extend beyond them. The model is also not studied as a practice. The description of the initiative does not account for what happens in any clinical setting. Rather, the description is limited to the objectives and design of the model as detailed in published literature. The extent to which these reflect or deviate from the concepts of harm reduction and human rights is used analytically to explore the relationship between them.

II. Harm Reduction and Human Rights: As Conceptual Frameworks and Discourses

Most of the literature on harm reduction and human rights is written in the drug use context.[45] More than ten years ago, a warning was issued on the ground lost and the opportunities missed by failing to see the intersections between drug use and abortion.[46] This Article pays heed.

The Uruguay Model is an opportune case study for thinking about harm reduction and human rights in the context of unsafe abortion. The model is expressly characterized as a harm reduction initiative, and was inspired by the experience of HIV/AIDS prevention programs in the drug use context.[47] Harm reduction is a rich but vague concept with no authoritative definition of the term.[48] There is nonetheless broad agreement as to its core content.[49]

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[45] Harm reduction as a concept and discourse came into development in the 1960s and 70s to describe interventions in illicit drug use other than criminal prohibition to prevent infection and overdose. In the mid-1980s, these alternatives became more widespread in response to the HIV/AIDS epidemic and were collectively referred to as "harm reduction." Access to safer-use information is an important harm reduction intervention in the drug use context (e.g., information on the use of sterile injecting equipment). *See* Alex Wodak & Annie Cooney, World Health Org., Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users 17 (2004).

[46] Lynn Paltrow, *The War on Drugs and the War on Abortion: Some Initial Thoughts on the Connections, Intersections and the Effects*, 28 S.U. L. Rev. 201, 202 (2001).

[47] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 222.

[48] Many efforts to define harm reduction can be found in the literature. *See* Simon Lenton & Eric Single, *The Definition of Harm Reduction*, 17 Drug & Alcohol Rev. 213, 213–19 (1998); R. Newcombe, *The Reduction of Drug Related-Harm: A Conceptual Framework for Theory, Practice and Research*, *in* The Reduction of Drug-Related Harm 1 (P.A. O'Hare, R. Newcombe, A. Matthews, E.C. Buning & E. Drucker eds., 1992); Diane Riley, Ed Sawka, Peter Conley, David Hewitt, Wayne Mitic, Christiane Poulin, Robin Room, Eric Single & John Topp, *Harm Reduction: Concept and Practice—A Policy Discussion Paper*, 34 Substance Use & Misuse 9, 10–11 (1999); *see also Harm Reduction Defined*, UK Harm Reduction Alliance, http://www.ukhra.org/harm_reduction_definition.html (last visited Apr. 12, 2011). For a discussion on the challenge of defining harm reduction, see Alex Wodak, Editorial, *What is this Thing Called Harm Reduction?*, 10 Int'l J. Drug Pol'y 169, 169 (1999).

[49] *See* Diane Riley & Pat O'Hare, *Harm Reduction: History, Definition, and Practice*, *in* Harm Reduction: National and International Perspectives 1, 6 (James A. Inciardi & Lana D. Harrison eds., 2000); *see generally* Tuukka Tammi & Toivo Hurme, Commentary, *How the Harm Reduction Movement Contrasts Itself Against Punitive Prohibition*, 18 Int'l J. Drug Pol'y 84 (2007) (deriving four theses of harm reduction based on the founding texts of the movement).

Harm reduction captures policies, programs, and practices that seek to reduce harms associated with an activity without requiring prohibition of the activity itself. Three core principles can be further elaborated: neutrality, humanism, and pragmatism.

The neutrality principle refers to non-judgment of the underlying activity. Harm reduction concerns only the risks and health-related harms of an activity, not whether the activity is normatively right or wrong. To say that harm reduction is value-neutral is not to say that it is value-free. The humanistic principle extends neutrality and the reservation of judgment beyond the activity to the individuals who engage in it. Regardless of imputed moral status or deviance from legal norms, all individuals are treated with respect and deserving of concern for their health and lives. The pragmatic principle has two dimensions. First, harm reduction is pragmatic in its acceptance that individuals will engage in the activity despite its legal prohibition; eradication is considered unrealistic if not impossible. Second, harm reduction is pragmatic in its assessment of interventions, favoring consequentialist evidenced-based assessment (i.e., cost-benefit efficiency or means-ends effectiveness).

Harm reduction is not the exclusive discourse around the Uruguay Model. Literature promoting the initiative describes the model as a rights-based initiative or human rights approach to unsafe abortion.[50] With a diverse range of actors increasingly linking human rights to health-related work, the term has ceased to have any one clear definition.[51] A human rights approach has come to characterize a range of approaches.

This Article uses the term human rights in two distinct ways. First, the term human rights is used to describe a mode of legal argument for government responsibility both to alter the conditions that create or exacerbate risk of health-related harm and to provide information and services necessary to promote health.[52] Second, the term is used to describe the application of human rights principles and norms, such as participation and acceptability, in assessment of the objectives and design of public health interventions.[53] Consideration of human rights in the latter sense is intended to ensure that "attention is given not only to the outcomes of health interventions, but also to the ways they are implemented."[54]

With convergence-divergence as an organizing theme and using the Uruguay Model as an analytical tool, this Article seeks to explore the rela-

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[50] Briozzo et al., *Iniciativas Sanitarias*, *supra* note 2, at 35; Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 223; Carino et al., *supra* note 2, at 79.

[51] Gruskin, *supra* note 10, at 6; Sophia Gruskin, Edward J. Mills & Daniel Tarantola, *History, Principles and Practice of Health and Human Rights*, 370 LANCET 449, 452 (2007).

[52] Gruskin, *supra* note 10, at 7–8; Gruskin, Mills & Tarantola, *supra* note 51, at 450–51.

[53] Gruskin, *supra* note 10, at 9; Gruskin, Mills & Tarantola, *supra* note 51, at 452.

[54] Gruskin, Mills & Tarantola, *supra* note 51, at 453.

tionship between harm reduction and human rights as conceptual approaches to and discourses about unsafe abortion. Given that the approaches reflect core principles of one another, this Article is structured in three parts, corresponding to the principles of neutrality, humanism, and pragmatism.

III. The Neutrality Principle

The neutrality principle refers to non-judgment of the underlying activity. Harm reduction concerns the risks and harms of an activity, not whether the activity is normatively right or wrong. Abortion itself is thus not the problem to be solved. The Uruguay Model seeks to reduce the risk of death and disability related to abortion, regardless of its moral or legal status.[55] Unsafe abortion is identified not as a criminal offense but as a contributor to maternal death. A retrospective study in Uruguay revealed that unsafe abortion was the leading single contributor to maternal death in the country from 1997 to 2001, especially for women among the lowest socioeconomic strata.[56]

It is perhaps unsurprising that a health professional organization would think of abortion in health-related terms and initiate a harm reduction program. Other than the women involved, health professionals encounter the harms of unsafe abortion most directly. The legal status of the abortion is medically irrelevant to survival from uterine perforation, hemorrhage, and sepsis. In post-abortion care, from the perspective of the health professional, only the fact of death matters.

The Uruguay Model follows a strong international trend in this regard. It draws support from the terms of the 1994 UN International Conference on Population and Development and its Programme of Action, which calls on governments "to deal with the health impact of unsafe abortion as a major public health concern . . . ."[57] The Programme further states that "[w]omen who have unwanted pregnancies should have ready access to reliable information and compassionate counseling."[58] The Uruguay Model is offered as a means for government to act on these commitments.[59] It is also a means to act on unsafe abortion without engaging the law on abortion. The Uruguay

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[55] *See generally* Briozzo et al., *Risk Reduction Strategy*, *supra* note 2 (describing the Uruguay Model's objectives and its approach to abortion); Briozzo et al., *Iniciativas Sanitarias*, *supra* note 2 (explaining the philosophy of the Uruguay model).

[56] Briozzo et al., *Unsafe Abortion*, *supra* note 2, at 70.

[57] International Conference on Population and Development ("ICPD"), Cairo, Egypt, Sept. 5–13, 1994, *United Nations Programme of Action of the International Conference on Population and Development*, ¶ 8.25, U.N. Doc. A/Conf.171/13 (Oct. 18, 1994). Unsafe abortion as a major public health concern was recognized long before the ICPD addressed it: both by the World Health Assembly in 1967 and at the Safe Motherhood Conference in 1987. World Health Assembly Res. WHA20.41 (May 1967); Susan A. Cohen, *The Safe Motherhood Conference*, 13 Int'l Fam. Plan. Persp. 68, 68 (1987).

[58] ICPD, *supra* note 57, ¶ 8.25.

[59] Faúndes et al., *supra* note 2, at 165–66.

Model "may be implemented in any country irrespective of current legislation . . . . Its application in many other contexts is a question of political will."[60]

This shift from crime to health in the definition of abortion reflects the sociological process of medicalization. The term—literally, to "make medical"—refers to the process by which social problems come to be defined and thus addressed as medical or more broadly health problems.[61] This definitional process happens at both conceptual and institutional levels.[62] At a conceptual level, the problem itself is characterized in health-related terms and concepts; for example, abortion is a major public health concern defined by mortality and morbidity statistics. At an institutional level, the solution to the problem is found in public health interventions—information and counseling rather than prohibition and penalty—and the responsibility for these interventions falls to health professionals, institutions, and authorities. In the Uruguay Model, health professionals are described as having both the capacity and the responsibility to reduce the harm of unsafe abortion.[63] State action, including law and regulation, is advocated to protect these actors and to implement the model system-wide.[64]

Sophisticated commentary on medicalization admits to its complicated mix of advantage and disadvantage.[65] One advantage is the value-neutrality of a health discourse. Rather than deprived of values, the discourse is experienced as neutral because the values it "expresses and promotes . . . are so widely accepted that they are not subject to debate. Instead they tend to be regarded as objective 'goods', for example, the protection and promotion of public health . . . ."[66] Harm reduction for this reason is regarded as a "pow-

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[60] *Id.* at 166.

[61] Peter Conrad, *Medicalization and Social Control*, 18 ANN. REV. SOC. 209, 210 (1992); *see generally* IRVING KENNETH ZOLA, SOCIO-MEDICAL INQUIRIES: RECOLLECTIONS, REFLECTIONS, AND RECONSIDERATIONS (1983) (discussing socio-medical research and the sociological process of medicalization).

[62] Conrad, *supra* note 61, at 211; *see generally* Peter Conrad & Joseph W. Schneider, *Looking at Levels of Medicalization: A Comment on Strong's Critique of the Thesis of Medical Imperialism*, 14 SOC. SCI. & MED. 75 (1980) (disagreeing with a narrow view of medicalization, and arguing that medicalization occurs not only on the level of doctor-patient interactions, but also on conceptual and institutional levels).

[63] Carino et al., *supra* note 2, at 79.

[64] *Id.* at 80–81.

[65] *See, e.g.*, Kathryn Pauly Morgan, *Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization*, *in* THE POLITICS OF WOMEN'S HEALTH: EXPLORING AGENCY AND AUTONOMY 83, 97–98 (Susan Sherwin ed., 1998); *see generally* PETER CONRAD & JOSEPH W. SCHNEIDER, DEVIANCE AND MEDICALIZATION: FROM BADNESS TO SICKNESS (1980) (investigating the origins and contemporary consequences of the medicalization of deviance); KAREN B. LEVY, THE POLITICS OF WOMEN'S HEALTH CARE: MEDICALIZATION AS A FORM OF SOCIAL CONTROL (1992) (discussing the process of medicalization in women's reproductive health); *see infra* notes 183–208 and accompanying text (describing further advantages and the disadvantages of medicalization).

[66] Helen Keane, *Critiques of Harm Reduction, Morality and the Promise of Human Rights*, 14 INT'L J. DRUG POL'Y 227, 228 (2003).

erful rhetorical intervention in . . . highly moralised landscape[s]."[67] Consensus can be found amidst the ideological conflict of abortion, allowing for progressive action to protect life and health. Medicalization, particularly the shift from crime to health, thus accounts for the strength of harm reduction as a public discourse. With its focus on public health harms and its rational claims to a normatively neutral, pragmatic approach, harm reduction can bring together disparate political and other actors, maximize the appeal of an intervention, and afford political legitimacy to action on an otherwise controversial issue.[68] Asked in a founding text of the harm reduction movement: "[w]ho, in their right mind, could oppose the notion of reducing harm?"[69]

The shift from crime to health also proves an advantage in constructing a normative validation for harm reduction in international human rights law. The value-neutrality of the discourse does not mean that harm reduction is value-free. Taking a non-judgmental stance on the need to reduce abortion-related mortality and morbidity, whatever the state of the law, is a value-based position.[70] Medicalization or an emphasis on health-related harms is a crucial step in the redefinition of unsafe abortion as a human rights issue. A human rights approach shifts the understanding of unsafe abortion from a mere misfortune to an injustice that states can and are obligated to remedy.[71]

A. State Responsibility for the Harms of Unsafe Abortion

The move from harm to state responsibility proceeds by very different rationales under human rights and harm reduction approaches. In simple but apt terms: one can "bite the hand of government that promotes a policy of harm maximization" or shake the benign hand of government that "proffers . . . resources for harm reduction services."[72] Under the doctrine of state responsibility in international law, states are held accountable if a causal connection can be drawn between the harm and a state act or omission that

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[67] *Id.* at 227.

[68] Reinarman, *supra* note 12, at 239; Hunt, *supra* note 13, at 233.

[69] Ethan A. Nadelmann, *Progressive Legalizers, Progressive Prohibitionists and the Reduction of Drug-Related Harm*, *in* Psychoactive Drugs and Harm Reduction: From Faith to Science 34, 37 (Nick Heather et al. eds., 1993).

[70] Keane, *supra* note 66, at 228; *see generally* Craig L. Fry, Kaveh Khoshnood, Robert Power & Mukta Sharma, Editorial, *Harm Reduction Ethics: Acknowledging the Values and Beliefs Behind Our Actions*, 19 INT'L J. DRUG POL'Y 1 (2008) (reviewing several papers on harm reduction ethics); Bernadette Pauly, *Harm Reduction Through a Social Justice Lens*, 19 INT'L J. DRUG POL'Y 4 (2008) (analyzing the underlying values of harm reduction as a basis for social action).

[71] Rebecca J. Cook, *Advancing Safe Motherhood Through Human Rights*, *in* GIVING MEANING TO ECONOMIC, SOCIAL, AND CULTURAL RIGHTS 109, 110 (Isfahan Merali & Valerie Oosterveld eds., 2001).

[72] Danny Kushlick & Steve Rolles, Response, *Human Rights Versus Political Capital*, 15 INT'L J. DRUG POL'Y 245, 245 (2004).

constitutes a breach of an international obligation.[73] This breach entails legal consequences, including new remedial obligations of prevention. Responsibility is thus always tied to causation in a human rights analysis. The same is not true in harm reduction. Reflecting the neutrality principle, a general avoidance of judgment or blame, there is a dislocation of responsibility. In harm reduction, the risk and harm of unsafe abortion can be conceptualized as having a simple, objective, factual existence. The focus is the harm not its cause. Responsibility on the state thus derives largely from a capacity to act to remedy the harm rather than an obligation to act as the cause of it. Responsibility in international human rights law, in contrast, carries the latter meaning. A rights-based approach may prove crucial in cases where risk and harm fall disproportionately on stigmatized communities, whose health-related needs even when identified are marginalized or neglected. Human rights can respond to those for whom public health evidence alone provides no incentive to act.[74]

While state obligations to reduce the harms of unsafe abortion can be a powerful public discourse, analytical effort is required to trigger these remedial obligations: a causal connection must be drawn between the harm and state action, and the state action must be demonstrated to breach international obligations.

A public health perspective has proven instrumental in the drawing of a causal connection between the harms of unsafe abortion and the state.[75] State responsibility is invoked not with respect to any one incident of unsafe abortion, but from its contribution to death and disability in population terms.[76] The international human rights jurisprudence reveals a preoccupa-

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[73] Rebecca J. Cook, *State Responsibility for Violations of Women's Human Rights*, 7 HARV. HUM. RTS. J. 125, 127 (1994) (citing SHABTAI ROSENNE, INTERNATIONAL LAW COMMISSION'S DRAFT ARTICLES ON STATE RESPONSIBILITY (1991)).

[74] *See, e.g.*, Jürgens et al., *supra* note 9, at 482:

> Some experts advocate for discussion of drug use mainly in the language and data of public health as an alternative to criminal prohibition. Some gains have been achieved through such a strategy; however, the pursuit of human rights along with public health is crucial. Without a fundamental challenge to the barriers blocking humane, rational drug policy, short-term public health advances will not be sustainable in the long term.

See also Cohen & Wolfe, Commentary, *supra* note 9, at S94 ("Although demonstrated to be effective, harm reduction measures face extensive legal and administrative restrictions . . . .").

[75] *See* REBECCA J. COOK, BERNARD M. DICKENS & MAHMOUD F. FATHALLA, REPRODUCTIVE HEALTH AND HUMAN RIGHTS: INTEGRATING MEDICINE, ETHICS, AND LAW 222–24 (2003) (internal citations omitted):

> Documentation of alleged violations of legal and human rights is a necessary step in holding governments and other institutions and officers accountable. . . .
> . . . .
> Evidence of high rates of abortion, for example, can be used to require governments and other institutional or private agencies to explain why they are not effectively providing contraceptive services, including emergency contraception.

[76] *Id.* at 223–24.

tion with abortion as a major cause of death.[77] Ministries of Health are called upon to undertake thorough investigations of the impact of unsafe abortion on women's health and lives.[78] There are advantages and disadvantages to event- or standard-based data in human rights analysis.[79] A disadvantage of statistical presentation is that it can too easily become a depersonalizing and alienating perspective, disguising the human side of unsafe abortion and losing sight of the women themselves.[80] Then again, women are too often the sole focus of abortion under a prohibitionist approach. Pregnancy termination is treated as an individual pathology—personal inadequacy or indulgence is described as the cause of clandestine abortion, moral weakness or failure the cause of the harm suffered. Unsafe abortion is then defined as an individual rather than collective problem.

The advantage of abstracting from the individual is to complicate and contextualize causation—to understand why women come to be exposed to risk or protective factors in unsafe abortion, what circumstances shape women's exposure to the harms of unsafe abortion.[81] The analytical task is to source the harms of unsafe abortion in a variety of causes, preventable by different actors. "Causes may be identified by reference to different time frames, ranging from the immediate precipitating cause of an injury . . . to long-standing socio-cultural practices . . . ."[82] Causes may also be attributed to different actors, from the individual to the state. Regardless of contextualization method, the cause of the harm is located beyond the practice of unsafe abortion by an individual woman. She is no longer the sole actor involved, and thus responsibility to avoid harm no longer resides solely with her. The burden of responsibility is shifted away from the individual woman

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[77] *See* Comm. on Econ., Soc. and Cultural Rights ("CESCR"), Concluding Observations of the Committee on Economic, Social and Cultural Rights: Brazil, ¶ 29, U.N. Doc. E/C.12/BRA/CO/2 (June 12, 2009) [hereinafter CESCR Concluding Observation: Brazil]; Human Rights Comm. ("HRC"), Concluding Observations of the Human Rights Committee: Chile, ¶ 8, U.N. Doc. CCPR/C/CHL/CO/5 (May 18, 2007) [hereinafter HRC Concluding Observations: Chile]; HRC, Concluding Observations of the Human Rights Committee: Madagascar, ¶ 14, U.N. Doc. CCPR/C/MDG/CO/3 (May 11, 2007); HRC, Concluding Observations of the Human Rights Committee: Honduras, ¶ 8, U.N. Doc. CCPR/C/HND/CO/1 (Dec. 13, 2006); HRC, Concluding Observations of the Human Rights Committee: Paraguay, ¶ 10, U.N. Doc. CCPR/C/PRY/CO/2 (Apr. 24, 2006).

[78] Comm. on the Elimination of Discrimination Against Women ("CEDAW"), Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Panama, ¶ 43, UN Doc. CEDAW/C/PAN/CO/7 (Feb. 5, 2010); *see also* CEDAW, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Tuvalu, ¶ 44, UN Doc. CEDAW/C/TUV/CO/2 (Aug. 7, 2010).

[79] Lynn P. Freedman, *Censorship and Manipulation of Reproductive Health Information: An Issue of Human Rights and Women's Health, in* THE RIGHT TO KNOW: HUMAN RIGHTS AND ACCESS TO REPRODUCTIVE HEALTH INFORMATION, *supra* note 18, at 1–2.

[80] Peter G. Miller, *A Critical Review of the Harm Minimization Ideology in Australia*, 11 CRITICAL PUB. HEALTH 167, 173 (2001).

[81] Freedman, *supra* note 79, at 2; *see infra* notes 253–65 and accompanying text (describing the relationship between vulnerability reduction and human rights).

[82] COOK, DICKENS & FATHALLA, *supra* note 75, at 222.

toward other members of society with the capacity, if not the obligation, to act.[83]

Studies that reveal high maternal mortality and morbidity rates, for example, are interpreted as "provid[ing] an important indication for States parties of possible breaches of their duties to ensure women's access to health care."[84] Why do high maternal mortality and morbidity rates indicate possible breaches of state obligations? What is the causal link between unsafe abortion and the state? It is the omission or failure to act that constitutes the breach.[85] A state is legally bound to do more than nothing in the face of known and avoidable suffering and death. "This obligation inheres in the term 'right.'"[86]

> "[R]ights talk" . . . asserts that concern for the welfare of those who are excluded and marginalized is not simply a matter of charitable humanitarianism. Rather, it establishes . . . rights-bearers, whose rights are disrespected through the deliberate application of policies known to produce avoidable suffering and death, and who have a moral and legal claim to the means of promoting and protecting their health.[87]

Human rights provide an entitlement to avoid premature death and preventable suffering, and to the means necessary to protect and promote life and health. This entitlement entails correlative obligations on the state, such that mere omission constitutes a breach. For this reason, the failure to reduce maternal mortality rates—without further qualification—is interpreted as a breach of state obligations.[88] The same is true with respect to abortion-re-

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[83] *See generally* Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80 (1995) (discussing the shifting burden of responsibility in a "social determinants of health" approach); Lynn P. Freedman, *Human Rights and the Politics of Risk and Blame: Lessons from the International Reproductive Health Movement*, 54 J. AM. MED. WOMEN'S ASS'N 165 (1997) (arguing that new understandings of the effect of socioeconomic conditions on poor health will only generate change when they are reframed into political claims).

[84] CEDAW, General Recommendation 24: Women and Health, (Article 12) 20th Sess., Jan. 19–Feb. 5, 1999, ¶ 17, U.N. Doc. A/54/38/Rev.1; GAOR, 54th Sess., Supp No. 38 (1999) [hereinafter CEDAW General Recommendation No. 24]; *see also* Cook, *supra* note 73, at 150 (describing the use of standards and statistics as evidence of breaches of state obligations).

[85] Comm. on Econ., Soc. and Cultural Rights ("CESCR"), General Comment 14: The Right to the Highest Attainable Standard of Health (Article 12), ¶¶ 49, 51, UN Doc. HRI/GEN/Rev.9 (Vol. I) (2000) [hereinafter CESCR General Comment No. 14]; *see also* Cook, *supra* note 73, at 149 (describing the concept of state responsibility as extending to the passive failure to meet positive obligations).

[86] Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 34 (1994).

[87] Elliot et al., *supra* note 8, at 124.

[88] *See* CESCR General Comment No. 14, *supra* note 85, ¶ 52; CEDAW General Recommendation No. 24, *supra* note 84, ¶ 17; *see also* UN High Commissioner for Human Rights, *Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights*, ¶¶ 8, 61, U.N. Doc. A/HRC/14/39 (Apr. 16, 2010) (characterizing preventable maternal mortality and

lated death and disability. The status quo of unsafe abortion and its harms constitute a legally cognizable wrong, triggering state responsibility and requiring remedial action.

State responsibility based on the failure to act is explicit in the interpretation of unsafe abortion as a form of violence against women and as a human rights violation on this basis.[89] This interpretation is more common in Latin America than other regions, likely due to the strong articulation and application of violence against women as a human rights concept in the Inter-American system.[90] Violence against women is defined as acts or conduct based on gender, that is, directed against a woman because she is a woman or that affect women disproportionately, and which cause death or physical, psychological, or sexual harm or suffering.[91] The fact that only women engage in unsafe abortion and are thus uniquely subject to its risks and harms formally qualifies the practice as violence against women under this definition. In the case *González et al. ("Cotton Field") v. Mexico*, the Inter-American Court of Human Rights held that state failure to investigate and prevent violence against women violates the rights to life, humane treatment, and personal liberty.[92] State accountability arises where violence "has occurred with the support or the acquiescence of the government, or [where] the State has allowed the act to take place without taking measures to prevent it."[93]

Unsafe abortion can thus be interpreted as a human rights violation where the state is aware of the pattern of unsafe abortion and its health-related harms, but fails to adopt measures for its prevention. Authoritative interpretations in international human rights law reflect this reasoning. Violations of the right to health can occur through omission to take measures arising from legal obligations, such as the failure to discourage or otherwise protect against practices harmful to health.[94] The state is obligated to under-

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morbidity as a human rights violation, citing to the work of UN treaty monitoring bodies among other authorities).

[89] Special Rapporteur on Violence Against Women, Its Causes and Consequences, *Report Addendum: Policies and Practices that Impact Women's Reproductive Rights and Contribute to, Cause or Constitute Violence Against Women*, Comm'n on Human Rights, ¶ 45, UN Doc. E/CN.4/1999/68/Add.4 (Jan. 21, 1999) (by Radhika Coomaraswamy).

[90] The Inter-American System has a dedicated regional treaty on the subject. Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ("Convention of Belem do Para"), June 9, 1994, 33 I.L.M. 1534 (entered into force Mar. 5, 1995) [hereinafter Convention of Belem do Para]; *see also* Anibal Faúndes, Maria José de Oliveira Araújo, Jorge Andalaft Neto, Maria de Fátima & Oliveira Ferreira, *Final Report: IX Fórum Interprofessional: Unsafe Abortion as a Form of Violence Against Women*, 32 FEMINA 877 (2004) (discussing how women's sexual and reproductive rights can be advanced in Brazil).

[91] Convention of Belem do Para, *supra* note 90, at 1535; CEDAW, General Recommendation 19: Violence Against Women, 11th Sess., ¶ 6, U.N. Doc. A/47/38; GAOR, 47th Sess., Supp. No. 38 (1993) [hereinafter CEDAW General Recommendation No. 19].

[92] González et al. ("Cotton Field") v. Mexico, Preliminary Objection, Merits, Reparations, and Costs, Inter-Am. Ct. H.R. (ser. C.) No. 205, ¶¶ 249–86 (Nov. 16, 2009).

[93] Id. ¶ 236.

[94] CESCR General Comment No. 14, *supra* note 85, ¶¶ 49, 51.

take "legislative and other measures . . . to protect women from the effects of clandestine and unsafe abortions and to ensure that women do not resort to such harmful procedures."[95] Under the right to life, the state is similarly asked to report on "any measures [undertaken] . . . to ensure [women] do not have to undergo life-threatening clandestine abortions."[96] Where unsafe abortion disproportionately impacts the lives and health of women from socially disadvantaged or vulnerable groups or communities, failure to reduce abortion-related harm may constitute a separate breach of the legal obligation of non-discrimination.[97]

B. State Obligations to Reduce the Harms of Unsafe Abortion

State accountability for human rights violations entails legal consequences; in particular, new remedial obligations of prevention arise. The human rights to life, health, and non-discrimination obligate the state to act—to adopt measures to protect women from the risks of unsafe abortion and to ensure women need not resort to harmful procedures.

The State enjoys discretion in determining the measures by which it will comply with its international obligations, given that the most appropriate measure may vary from one state to another.[98] This discretion, however,

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[95] CESCR Concluding Observation: Brazil, *supra* note 77, ¶ 29. In a series of Concluding Observations, the CESCR identified maternal mortality due to unsafe abortion as requiring government action. *See, e.g.*, CESCR, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Cambodia, ¶ 32, U.N. Doc. E/C.12/KHM/CO/1 (June 12, 2009); CESCR, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Philippines, ¶ 31, U.N. Doc. E/C.12/PHL/CO/4 (Dec. 1, 2008); CESCR, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Bolivia, ¶¶ 14(f), 27(f), U.N. Doc. E/C.12/BOL/CO/2 (Aug. 8, 2008); CESCR, Concluding Observations of the Committee on Economic, Social and Cultural Rights: El Salvador, ¶¶ 25, 44, U.N. Doc. E/C.12/SLV/CO/2 (June 27, 2007); CESCR, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Mexico, ¶ 25, U.N. Doc. E/C.12/MEX/CO/4 (June 6, 2006).

[96] HRC, General Comment No. 28: Equality of Rights Between Men and Women (Article 3), ¶ 10, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000) [hereinafter HRC General Comment No. 28].

[97] CEDAW General Recommendation No. 24, *supra* note 84, ¶ 26; *see also* CEDAW, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Malawi, ¶¶ 36–37, U.N. Doc. CEDAW/C/MWI/CO/6 (Feb. 5, 2010); CEDAW, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Timor-Leste, ¶¶ 37–38, U.N. Doc. CEDAW/C/TLS/CO/1 (Aug. 7, 2009); CEDAW, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Cameroon, ¶¶ 40–41, U.N. Doc. CEDAW/C/CMR/CO/3 (Feb. 10, 2009); CEDAW, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Ecuador, ¶¶ 38–39, U.N. Doc. CEDAW/C/ECU/CO/7 (Nov. 7, 2008); CEDAW, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Nigeria, ¶¶ 336–37, U.N. Doc. CEDAW/C/NGA/CO/6 (July 8, 2008); CEDAW, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Bolivia, ¶¶ 42–43, U.N. Doc. CEDAW/C/BOL/CO/4 (Apr. 8, 2008).

[98] CESCR, General Comment 3: The Nature of States' Parties Obligations, ¶ 4, U.N. Doc. E/1991/23 (1990) [hereinafter CESCR General Comment No. 3]; *see also* CEDAW

is not absolute. "Each State party must be able to justify the appropriateness of the particular means it has chosen and to demonstrate whether it will achieve the intended effect and result."[99]

Harm reduction interventions can serve an important function in this justificatory exercise. The Uruguay Model is an evidenced-based intervention to reduce abortion-related mortality and morbidity. The provision of safer-use information through physician-patient consultation has proven effective: "[it] clearly prevented the use of dangerous means to induce abortion, such as the introduction of sharp, unsterile [sic] objects into the pregnant uterus, toxic infusions, etc."[100] All of the women who returned for the "after visit" carried out their abortion with misoprostol.[101] "The fact that the rate of complications was minimal among the women participating in the program and that not a single death after abortion has occurred since the program started is suggestive, but not conclusive [that the strategy is working]."[102]

The effectiveness of harm reduction to protect life and health is a background fact against which the state must justify the appropriateness of its measures to reduce abortion-related harm.[103] This will prove a difficult task to the extent the state impedes or otherwise neglects harm reduction. While human rights law does not explicitly require the state to adopt harm reduction interventions in unsafe abortion, this may be the *de facto* result of an assessment of appropriate measures. The direct and immediate link between

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General Recommendation No. 28 on the Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination Against Women, ¶ 23, U.N. Doc. C/2010/47/GC.2 (2010) [hereinafter CEDAW General Recommendation No. 28].

[99] CEDAW, General Recommendation No. 28, *supra* note 98, ¶ 23; *see also* CESCR, General Comment No. 3, *supra* note 98, ¶ 4.

[100] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 225.

[101] *Id.*

[102] *Id.* at 226.

[103] Comparative data may be relevant in the justificatory exercise. The appropriateness of state action, for example, may be assessed against harm reduction measures introduced in similarly situated jurisdictions that have endeavored to tackle the health-related harms associated with drug use. *See* Malkin, Elliott & McRae, *supra* note 9, at 544 ("The establishment of SIFs [supervised injection facilities] in several jurisdictions shows that it is possible to take this step toward realizing the right to health. . . . [C]ountries such as Canada and the United States, with pronounced and escalating drug crises, should be measured against similarly situated, relatively wealthy jurisdictions . . . which have endeavored to tackle the problems associated with drug use by means of introducing novel harm minimization measures . . . ."). Research in the drug use context has also moved beyond demonstrating the effectiveness of existing measures. Mathematical modeling can estimate the future trajectory of the HIV epidemic and thus the reduction of harm if measures, such as opioid substitution and needle exchange, are implemented. *See generally* Steffanie A. Strathdee, Timothy B. Hallett, Natalia Bobrova, Tim Rhodes, Robert Booth, Reychad Abdool & Catherine A. Hankins, *HIV and Risk Environment for Injecting Drug Users: The Past, Present and Future*, 376 LANCET 268 (2010) (modeling changes in risk environments in regions with severe HIV epidemics associated with injecting drug use, and estimating significant reductions in these regions upon the implementation of programs for opioid substitution, needle exchange, and antiretroviral therapy).

harm reduction and the prevention of death and disability leads to state obligations specific to harm reduction as a remedial intervention.

The obligation to respect requires that the state refrain from interfering with harm reduction measures,[104] supporting the permissiveness of interventions such as the Uruguay Model. The right to health includes the right to seek, receive, and impart information.[105] Restraint by the state must therefore be exercised against both the recipient and provider of information. The right to seek and receive information obligates the state to "refrain from limiting access to . . . [the] means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information."[106] The state must exercise restraint from "obstructing action taken by women in pursuit of their health goals."[107]

Neither may the state obstruct the provision of health-related information. The right to impart information was affirmed by the European Court of Human Rights in *Open Door and Dublin Well Woman v. Ireland*.[108] The case concerned an injunction that prohibited counselors from providing information to women in Ireland about lawful abortion services in the U.K.[109] The injunction was held in violation of the freedom to receive and impart information.[110] The injunction could not be justified in the public interest, the Court reasoned, because of its adverse effects on women's health and well-being, namely delay leading to later-term abortion and denied access to post-abortion care.[111]

The right to health is interpreted similarly in international law to protect against restrictions on access to information that are "likely to result in bodily harm, unnecessary morbidity, and preventable mortality."[112] This includes restricted access as a consequence of *de facto* discrimination. In *Open Door*, the European Court noted the discriminatory effects of the injunction on "women who were not sufficiently resourceful or had not the necessary level of education to have access to alternative sources of informa-

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[104] CESCR General Comment No. 14, *supra* note 85, ¶¶ 34, 50; *see also* CEDAW General Recommendation No. 24, *supra* note 84, ¶ 14.

[105] CESCR General Comment No. 14, *supra* note 85, ¶ 12(b).

[106] *Id.* ¶ 34; CEDAW, General Recommendation No. 24, *supra* note 84, ¶ 50.

[107] CEDAW, General Recommendation No. 24, *supra* note 84, ¶ 14.

[108] Open Door Counselling and Dublin Well Woman v. Ireland, App. Nos. 14234/88 & 14235/88, 15 Eur. H.R. Rep. 244 (1992).

[109] *Id.* at 259–60.

[110] *Id.* at 261. It is unclear whether Article 10 of the European Convention implicitly includes a right to access information. Peter Noorlander, *The Right to Information on Reproductive Health Under International Law*, *in* TIME FOR CHANGE: PROMOTING AND PROTECTING ACCESS TO INFORMATION AND REPRODUCTIVE AND SEXUAL HEALTH RIGHTS IN PERU 22, 32 n.56 (Bethan Grillo & Louise Finer, ed., 2006) ("[T]he European Court has held that the freedom of expression provision in the ECHR does not guarantee access to information: *Sirbu v. Moldova*, 15 June 2004 (admissibility), Application no. 73562/01.").

[111] Open Door Counselling and Dublin Well Woman, 15 Eur. H.R. Rep. at 266–67.

[112] CESCR General Comment No. 14, *supra* note 85, ¶ 50.

tion."[113] The right to health specifically requires that information be accessible to all, especially the most vulnerable or marginalized.[114] The implementation of the Uruguay Model in public health facilities is designed to achieve this equalizing effect. Advocates of the model note that "[i]n many countries, women with resources and education often access information about safer abortion methods . . . through the internet, an advantage that poorer and more marginalised women are denied."[115] The Uruguay Model allows all women regardless of social status to access life-saving information.[116]

An important difference between *Open Door* and the Uruguay Model must be noted. In the former case, information is provided on lawful abortion services as emphasized by the Court.[117] In the latter, safer-use information is provided to women who do not qualify for a lawful abortion—the abortions are not merely clandestine but unlawful. The literature on the Uruguay Model respects this distinction between lawful and unlawful abortion: "see[ing] a patient before or after the abortion does not mean I am inducing or collaborating with a crime, but that I am acting as my professional duty obliges me to."[118] The reference to "professional duty" seeks refuge in the medicalized discourse of harm reduction. Information is provided to reduce risk and promote health, not to induce or counsel criminal activity.[119] To further distinguish between lawful and unlawful action, the act of informing is set apart from prescribing or promoting.[120] "Women were only provided with the evidence-based information on misoprostol efficacy, risks, side effects, dosage and route of administration, the same way as it is done with all other alternatives for abortion induction."[121] This statement seeks to render information provision indistinguishable from the everyday activities of health professionals. The information and counseling are also explicitly referred to as "neutral."[122] Pre-consultation is intended not to influence decision-making, but to provide full and non-directive information on all alternatives.[123]

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[113] Open Door Counselling and Dublin Well Woman, 15 Eur. H.R. Rep. at 267.
[114] CESCR General Comment No. 14, *supra* note 85, ¶ 12(b).
[115] Carino et al., *supra* note 2, at 79.
[116] *Id.* at 77.
[117] Open Door Counselling and Dublin Well Woman, 15 Eur. H.R. Rep. at 266 ("The injunction limited the freedom to receive and impart information with respect to services which are lawful . . . and may be crucial to a woman's health and well-being.").
[118] Briozzo et al., *Iniciativas Sanitarias*, *supra* note 2, at 24.
[119] SEE Lawrence O. Gostin & Zita Lazzarini, *Prevention of HIV/AIDS Among Injection Drug Users: The Theory and Science of Public Health and Criminal Justice Approaches to Disease Prevention*, 46 EMORY L.J. 587, 686–89 (1997) (describing the "necessity" defense in harm reduction in which physicians' actions are justified as lawful based on the "necessity" to avert greater public health harm).
[120] Carino et al., *supra* note 2, at 81; Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 226.
[121] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 226.
[122] *Id.*
[123] *Id.* at 222–23.

European case law suggests the distinction between information provision and other activities may be crucial to the permissibility of harm reduction in the abortion context. Ministry of Health guidelines on abortion were held potentially unlawful by a court in Northern Ireland based on provisions related to non-directive counseling.[124] The guidelines described the purpose of counseling "as offer[ing] support in a non-judgmental and non-directive way to enable [women] to make an informed choice about termination or its alternatives."[125] The guidelines did not, however, restrict counseling to lawful abortion. Rather, the Court held that the provision could be interpreted as allowing counseling before a woman was advised her termination was lawful, raising a number of legal questions: To what extent can a doctor "advise a patient about the availability of abortion services . . . when under [the] law an abortion could not be provided? Could the giving of such advice constitute an offence of counseling or procuring an abortion . . . ? Is the giving of such advice (in a neutral and non-directive way) lawful provided abortion is not being advocated or promoted?"[126]

These questions seek a clear distinction between information on and promotion of abortion. This same distinction was emphasized in *Open Door*. The European Court noted that the information provided was non-directive: "counselors neither advocated nor encouraged abortion, but confined themselves to an explanation of the available options" and that provision of such information would not inevitably result in pregnancy termination.[127] The literature on the Uruguay Model stresses the same finding. Some women decide not to seek an abortion after receiving information and counseling.[128] Evidence that information-provision does not necessarily lead to abortion in an individual case, and has not or would not have a substantial impact on the numbers of abortions, seems crucial to distinguishing the activity and establishing its permissiveness.[129] Current interpretations of international human rights law likely protect information provision when the abortion is unlawful, but not counseling to undergo or provide an unlawful abortion.[130]

An obligation to respect human rights—the mere permissiveness of harm reduction—suffers a further limitation. This limitation can be explained by reference to a U.S. case on abortion-related information, *Rust v. Sullivan*.[131] The U.S. Supreme Court held that conditions on state funding, effectively prohibiting provision of all-abortion related information, did not

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[124] Society for the Protection of Unborn Children, Re Judicial Review, [2009] N.I. 92 (Q.B.), ¶ 33–38.

[125] *Id.* ¶ 33.

[126] *Id.* ¶ 37.

[127] Open Door Counselling and Dublin Well Woman v. Ireland, App. Nos. 14234/88 & 14235/88, 15 Eur. H.R. Rep. 244, 266 (1992).

[128] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 225.

[129] Coliver, *supra* note 18, at 65.

[130] *Id.* at 40.

[131] 500 U.S. 173 (1991).

violate any information-related right.[132] "The Government can . . . selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternate program which seeks to deal with the problem in another way."[133] Restriction by state subsidy was thus treated differently from restriction by direct regulation, such as an injunction. The consequence, however, was the same. Women dependent on public facilities for health services were denied access to information.

Such an impoverished interpretation of state accountability is countered in international human rights law by a positive obligation to ensure effective enjoyment of human rights. The obligation to fulfill requires the state to take positive measures to promote life and health protection.[134] Based on the significant body of evidence regarding the effectiveness of harm reduction interventions, the right to health has been interpreted as requiring the state to implement these interventions.[135] The implementation of harm reduction measures is considered, in other words, necessary for the realization of the right to health.[136] The measures adopted by the state cannot be justified as appropriate without harm reduction. A harm-reduction initiative is by definition a right-to-health initiative.[137]

The same holds true in the abortion context. The right to health can be interpreted to require the enactment of precisely the kind of legal and regulatory measures supporting the Uruguay Model. The right to health guarantees "access to appropriate health care services that will . . . enable women to go safely through pregnancy."[138] Information is a health care service,[139] and the Uruguay Model demonstrates that safer-use information on clandestine abortion methods allows women to survive an unwanted pregnancy. The obliga-

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[132] *Id.* at 192–200.

[133] *Id.* at 193.

[134] CESCR General Comment No. 14, *supra* note 85, ¶ 37; Human Rights Comm., General Comment 6 (article 6), Annex V, ¶ 5, U.N. Doc. A/37/40 (Sept. 22, 1982).

[135] Special Rapporteur on the Right to Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Human Rights Council, ¶ 55, U.N. Doc. A/65/255 (Aug. 6, 2010) (by Anand Grover); *see also* CESCR, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Ukraine, ¶ 51, U.N. Doc. E/C.12/UKR/CO/5 (Jan. 4, 2008); CESCR, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Tajikistan, ¶ 70, U.N. Doc. E/C.12/TJK/CO/1 (Nov. 24, 2006); Special Rapporteur on the Right to Health, *Rep. of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health, Paul Hunt, on his Mission to Romania,* Comm'n on Human Rights, ¶ 50, U.N. Doc. E/CN.4/2005/51/Add.4 (Feb. 21, 2005) (by Paul Hunt).

[136] Special Rapporteur on the Right to Health, *Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health, Paul Hunt, on his Mission to Sweden,* Human Rights Council, ¶ 60–62, U.N. Doc. A/HRC/4/28/Add.2 (Feb. 28, 2007) (by Paul Hunt).

[137] Jürgens et al., *supra* note 9, at 480.

[138] CESCR General Comment No. 14, *supra* note 85, n.12; *see also* Convention on the Elimination of All Forms of Discrimination Against Women art. 12(2), *supra* note 22; CEDAW General Recommendation No. 24, *supra* note 84, ¶ 27.

[139] CESCR General Comment No. 14, *supra* note 85, ¶¶ 11, 36.

tion to fulfill the right to health requires the state not simply to permit, but to disseminate appropriate health-information on the main health problems in the community and methods for their prevention.[140] By definition this includes death and disability from unsafe abortion, and information as a method to prevent these adverse consequences. Harm reduction is not merely consistent with but required by international law. The objective "is not to keep the state out of health programmes . . . [but to] encourage states and other relevant actors to provide . . . reproductive health information in a way that vindicates rights, health and the well-being of women and society."[141]

Before concluding this section, it is important to note that safer-use information initiatives, such as the Uruguay Model, rely on availability of the means for safer abortion, namely misoprostol. The initiative only works if women can access the drug, and yet whether and how women obtain the drug is at best a secondary consideration in the literature.[142] This is most likely a deliberate effort to distance lawful information provision from unlawful drug procurement. The registration and distribution of drugs, however, is also subject to state action. Misoprostol is not registered in Uruguay for obstetric-gynecologic indications and, given high legal market prices, access is believed to be largely restricted to the black market.[143] In the early 1990s, the Ministry of Health in Brazil enacted regulations restricting sales of misoprostol to curb its use for clandestine abortion.[144] Similar restrictions were enacted in Thailand, limiting the availability of the drug to prescription in hospitals.[145] While misoprostol will likely remain accessible in Uruguay through the black market, state action restricting availability and impacting quality and cost may violate international human rights law for reasons of health-related harms. Harm reduction and human rights approaches may thus support access to medicines in addition to information for safer abortion.

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[140] *Id.* ¶¶ 16, 37, 44(d).

[141] Freedman, *supra* note 79, at 23.

[142] *See, e.g.*, Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 226 (noting only that "women adopted several different strategies" to obtain the drug).

[143] Maria M. Fernandez, Francine Coeytaux, Rodolfo Gomez Ponce de León & Denise L. Harrison, *Assessing the Global Availability of Misoprostol*, 105 INT'L J. GYNECOLOGY & OBSTETRICS 180, 185 (2009).

[144] S.H. Costa, *Commercial Availability of Misoprostol and Induced Abortion in Brazil*, 63 INT'L J. GYNECOLOGY & OBSTETRICS S131, S133 (1998). The pharmaceutical distributor supported these restrictions, entering into an agreement with the Ministry of Health to reduce production. Barbosa & Arilha, *The Brazilian Experience with Cytotec*, *supra* note 30, at 237.

[145] Andrea Whittaker, *The Struggle for Abortion Law Reform in Thailand*, 10 REPROD. HEALTH MATTERS 45, 46 (2002).

IV. The Humanistic Principle

The neutrality of harm reduction extends beyond the activity of abortion to the women who engage it. Judgment is reserved. Regardless of imputed moral status or deviance from legal norms, all individuals are treated as deserving of concern for their health and lives. This is the humanistic principle of harm reduction, an "acceptance of the simple humanity of the drug user, her connection to the rest of us."[146] Harm reduction is thus once again not a value-free discourse. The Uruguay Model and other harm reduction interventions seek to counter stigmatization of the individual, a process enacted in both the criminal justice and health systems. Health systems "are not only producers of health or health care but . . . purveyors of a wider set of societal values and norms."[147] More than technical interventions of health information or services, harm reduction seeks to imbue the health system with values of respect, worth, and dignity.[148] Harm reduction and human rights strongly converge on this principle. The humanism of harm reduction corresponds to respect for the human rights of the individual.

A. Entitlement to Receive and Provide Health Information

In the Uruguay Model, women receive safer-use information when they do not qualify for a lawful abortion.[149] This feature may simply reflect the focus on harm irrespective of legality. From a humanistic perspective, however, the irrelevance of legality reflects something more. A woman does not forfeit her right to information by engaging in illegal activities.[150] All women are treated as "citizens, with rights, who should be provided with information."[151]

Human rights are not revocable based on conduct. They inhere in the individual and not in status or action. The right to life is explicitly interpreted to require state protection for the "life of *all* persons, including women whose pregnancies are terminated."[152] The right to health is violated

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[146] Scott Burris, Response, *Harm Reduction's First Principle: "The Opposite of Hatred,"* 15 Int'l J. Drug Pol'y 243, 243 (2004); *see also* Elliot et al., *supra* note 8, at 115–16; Fry et al., *supra* note 70, at 2.

[147] Lucy Gilson, *Trust and the Development of Health Care as a Social Institution*, 56 Soc. Sci. & Med. 1453, 1461 (2003).

[148] Cohen & Wolfe, Commentary, *supra* note 9, at S94.

[149] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 226.

[150] Cohen & Wolfe, Commentary, *supra* note 9, at S94 (noting that "harm reduction recognizes that engaging in illegal activities does not mean forfeiting claims to healthcare or other basic protections").

[151] Briozzo et al., *Risk Reduction Strategy, supra* note 2, at 223; *see also* Briozzo, *Iniciativas Sanitárias*, *supra* note 2, at 34–35.

[152] HRC, Concluding Observations of the Human Rights Committee: Chile, ¶ 15, U.N. Doc. CCPR/C/79/Add.104 (Mar. 30, 1999) (emphasis added); *see also* HRC, Concluding Observations of the Human Rights Committee: Guatemala, ¶ 19, U.N. Doc. CCPR/CO/72/GTM (Aug. 27, 2001).

when care is denied to "prisoners . . . minorities, asylum seekers and illegal immigrants."[153] Health status is independent of legal status. The latter cannot be a reason to neglect the former.

A case from the Inter-American Court of Human Rights, *De La Cruz Florez v. Peru*, affirms this principle.[154] The case concerned the criminal prosecution of a physician for provision of health care to suspected terrorists.[155] In his separate opinion, Judge Sergio García Ramírez, President of the Inter-American Court of Human Rights, reasoned that the prosecution violated "the right to life and health of the individual, both directly and by intimidation or restrictions imposed on those who, due to their profession, are regularly obliged to intervene in the protection of those rights."[156] Reflecting the principle of non-discrimination, the state cannot "criminally penalize . . . a doctor who provides care designed to protect the health and life of other individuals, notwithstanding their *characteristics*, *activities* and *beliefs*, and the *origin* of their injuries or illnesses."[157] Health has its "own meaning, totally independent of the political, religious or philosophical ideas of the doctor and his patient."[158] The value-neutrality of a health discourse is explicitly used in support of the humanistic principle.

A state cannot, Judge Ramírez reasoned, require physicians to deny health care in service of a state objective.[159] It is a basic contravention of human rights to use individuals and their health as instruments of state policy.[160] The European Court of Human Rights applied this principle in *Odièvre v. France*, a case concerned with unsafe reproductive health practices.[161] The European Court upheld an adoption law protecting the privacy of the birth mother even against disclosure requests by her child.[162] The law was considered necessary to prevent health-related harm, namely that without privacy protection, women may forgo medical care and engage in clandestine unsafe births.[163] The right to life was thus interpreted to protect against denial of care for "medically irrelevant" reasons.[164] Health care is

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[153] CESCR General Comment No. 14, *supra* note 85, ¶ 34.

[154] De La Cruz Florez v. Peru, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 115 (Nov. 18, 2004).

[155] *Id.* ¶ 3.

[156] *Id.* ¶ 7 (Ramirez, J.).

[157] *Id.* ¶ 13 (emphasis added).

[158] *See Id.* ¶ 7.

[159] *Id.* ¶ 7–8; *see also* Odièvre v. France, 2003-III Eur. Ct. H.R. 51, 92 (2003) (Greve, J., concurring) ("[T]he medical profession is called upon to heal, to alleviate suffering and to comfort the medically distressed. It is not a means to be used to ensure compliance with conditions that sound counselling is unable to bring about.").

[160] Freedman, *supra* note 79, at 5 (defining human rights as encompassing "a right not to have one's reproductive and sexual capacity used as an instrument to serve the interests of other individuals, collectivities or states"). The reasoning in *Rust v. Sullivan*, 500 U.S. 173 (1991), is objectionable under international human rights law on this basis.

[161] Odièvre, 2003-III Eur. Ct. H.R. 51.

[162] *Id.* at 78–83.

[163] *Id.* at 79–80.

[164] *Id.* at 92 (Greve, J., concurring).

"itself a human right not to be revoked by society to achieve some unrelated other social goal."[165]

Regardless of whether the objectives underlying criminal abortion laws are legitimate, depriving women of health information is an inhumane means to achieve them. Whatever objectives underlie prohibitionist laws, the state cannot require the sacrifice of health or life to achieve them. Such a requirement is cruel, inhuman, and degrading—freedom from which is expressly protected as a human right in international law.[166] In the communication, *K.L. v. Peru*, the Human Rights Committee determined that state denial of lawful reproductive health services (specifically, a therapeutic abortion) violated this right.[167] This determination offers support for harm reduction insofar as the violation turns on denial of access to health services that causes immediate or foreseeable suffering.[168]

B. Treatment Within Health Settings

The humanistic principle of harm reduction applies not only to the entitlement to information, but also to the manner in which it is provided: how individuals are treated within the health setting. In international human rights law, health services are required to be "acceptable." Acceptable services are respectful, ensure free and informed decision-making, guarantee confidentiality, and are informed by the needs and perspectives of the individual.[169]

Mistreatment in public health care facilities of women who terminate their pregnancies is widespread.[170] These women tend to be of lower socioeconomic status,[171] thereby exacerbating power inequalities between provider and patient. They "may be left to receive care after other patients have been seen, they may be victims of psychological aggression, or may be punished by being forced to undergo curettage without anesthesia."[172] The Uruguay Model literature acknowledges the status quo: "many health providers seem to believe that they have the right to accuse, judge and condemn wo-

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[165] *Id.*

[166] International Covenant on Civil and Political Rights art. 7, *supra* note 20; *see also* Organization of American States, American Convention on Human Rights art. 5, *supra* note 20; European Convention art. 7, *supra* note 20.

[167] HRC, Views of the Human Rights Committee Under Article 5, Paragraph 4 of the Optional Protocol to the International Covenant on Civil and Political Rights, Human Rights Comm., ¶ 6.3, U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 22, 2005).

[168] *Id.*

[169] CESCR General Comment No. 14, *supra* note 85, ¶ 12(b); CEDAW General Recommendation No. 24, *supra* note 84, ¶ 22.

[170] *See, e.g.*, Cynthia Steele & Susana Chiarotti, *With Everything Exposed: Cruelty in Post-Abortion Care in Rosario, Argentina*, 12 Reprod. Health Matters 39, 42–44 (2004).

[171] *See id.* at 40–42; Briozzo et al., *Risk Reduction*, *supra* note 2, at 222.

[172] Faúndes et al., *supra* note 2, at 166.

men" who are seeking abortion-related care.[173] Mistreatment is a barrier to care, deterring women from seeking care, and is a wrong in itself.[174]

The value-neutrality of harm reduction breaks the rationale for mistreatment. Physicians divorce themselves from the normative implications of a woman's decision to terminate her pregnancy. The moral or legal status of her action is no longer reason to degrade, humiliate, or otherwise mistreat her. In the Uruguay Model, women are treated not as criminals deserving of punishment, but as patients entitled and, more importantly, encouraged to seek safer-use information.[175]

Privacy protection is one means by which this is accomplished. The Uruguay Model literature emphasizes that a trust relationship is essential to overcoming the deterrent effects of secrecy and fear related to clandestine abortion.[176] "Women are often deterred from seeking health care when they know that governmental officers, including police officers, could gain access to their health care information."[177] The pre-consultation is designed to create a friendly environment in which patients are assured they will not be reported to authorities, while confidentiality is the main condition of post-consultation.[178] Respect for privacy is a strongly protected human right in the medical context, imposing duties of confidentiality on state providers and institutions.[179] Confidentiality in women's health is especially emphasized. Interpretation of the right to non-discrimination in health care acknowledges that "lack of respect for the confidentiality of patients . . . may deter women from seeking advice and treatment and thereby adversely affect their health and well-being."[180] Specific attention is drawn to the deterrent

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[173] *Id.*

[174] *See* Cohen et al., *supra* note 36, at 87:

> [Women] mentioned some physicians' poor treatment of women. One woman from an urban region said that her experience of physicians was that they 'insult, assault, offend, lecture and scold people.' She said that physicians must treat women with dignity and respect if they are to be effective channels for misoprostol information.

[175] *See* Gerry V. Stimson, *Harm Reduction in Action: Putting Theory into Practice*, 9 Int'l J. Drug Pol'y 401, 402 (1998) ("Harm reduction has been typified by innovative methods for 'contacting' populations."). The Uruguay Model is coupled with a community engagement strategy involving non-governmental organizations and local community groups, which inform women about the initiative and their right to access pre- and post-abortion care. *Addressing the Needs of Women in Uruguay: A Harm-Reduction Strategy for Pregnancy Termination*, Ipas, http://www.ipas.org/Topics/ma/Addressing_the_needs_of_women_in_Uruguay.aspx (last visited Mar. 5, 2011).

[176] Briozzo et al., *Iniciativas Sanitárias*, *supra* note 2, at 28.

[177] Cook, Dickens & Fathalla, *supra* note 75, at 177.

[178] Briozzo et al., *Risk Reduction*, *supra* note 2, at 223; Faúndes et al., *supra* note 2, at 165.

[179] *See, e.g.*, Z. v. Finland, App. No. 9/1996/627/811, 25 Eur. H. R. Rep. 371 (1997) (finding a violation of the right to privacy contained in Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms where the Helsinki Court of Appeals disclosed the applicant's identity and HIV-positive status in its published opinion).

[180] CEDAW General Recommendation No. 24, *supra* note 84, ¶ 12(d).

effect of disclosure in the abortion context.[181] Legal requirements that health providers denounce women are interpreted as violations of the right to be free from cruel, inhuman, and degrading treatment.[182]

A trust relationship, however, extends beyond privacy protection. Women report that they value consultation with a physician not only for "the technical aspects of misprostol use . . . [but] the importance of being taken care of, feeling cared for . . . ."[183] Regardless of the impact of the Uruguay Model on public health outcomes, the literature reports: "[w]hat is perfectly clear . . . is that women . . . felt better cared for and safer, after participating in the program."[184] Their inclusion in the "health system generates feelings of calmness and safety . . . ."[185] These are the individual advantages of medicalization. A woman may value access to information through physician consultation not only pragmatically, a means to protect against risk and harm, but as a legitimating encounter, a break from the marginality she may otherwise experience. Deriving from the authority and social standing of the health professional, a positive physician-patient experience may comfort, if not restore worth to the patient as a member of the community whose health and life matter. "[D]octor-patient interactions can, even in situations of power inequality, function as micro-sites of healing, as relations that are significant in restoring integrity, as providing liberating growth from abusive, repressive, or limiting constraints—in short, can function as relationships that empower the patient."[186]

Harm reduction—especially information-based intervention—seeks to empower the individual, respected as an active rather than passive entity, capable of making free and informed decisions. The relationship between information and decision-making is similarly emphasized in the human right to health.[187] Individuals "have the right to be fully informed, by properly trained personnel, of their options . . . including likely benefits and potential adverse effects of proposed procedures and available alternatives."[188] The phrase "available alternatives" is not limited to services within the formal health system.

The relationship between information and decision-making anchors the Uruguay Model: providing women with information "guarantees that *they* will be in a better position to take [sic] the best decisions [about *their* preg-

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[181] *Id.*

[182] HRC General Comment No. 28, *supra* note 96, ¶ *20.*

[183] Cohen et al., *supra* note 36, at 87; Lafaurie et al., *supra* note 27, at 81 ("[W]omen had not received the counselling and support, both emotional and clinical, that we found here [with clinical supervision].").

[184] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 226.

[185] *Id.* at 223.

[186] Morgan, *supra* note 65, at 92.

[187] CESCR General Comment No. 14, *supra* note 85, ¶ 37.

[188] CEDAW General Recommendation No. 24, *supra* note 84, ¶ 20.

nancy], according to *their* own situations, environment and values."[189] The woman is the primary decision-maker. Her needs are not subordinated to the interests of another, provider or state.[190] She is entrusted to make decisions about her reproductive health and to take action to protect against the risks and harms of unsafe abortion. She is entitled to access safer-use information without providing the physician any objectively valid reason for her decision. Her free and informed decision is reason enough. The role of the physician is facilitative: to help her, not judge her.[191] The Uruguay Model is thus characterized as a move away from traditional paternalism toward empowerment.[192]

C. Participation and Empowerment

It cannot be ignored, however, that the Uruguay Model remains a health professional initiative. Sexual and reproductive rights are "approached from the perspective of bioethics, professional commitment and scientific evidence."[193] The model is described as a means to "empower health professionals to actively defend their patients' rights and act as agents of social and legal change by giving them a public voice in the debate over unsafe abortion."[194] These are the often-criticized consequences or the disadvantage of medicalization: domination if not monopolization of a social problem by professionalized medical experts.[195]

The strongest critique is medicalization as a form of social control, whereby surveillance and discipline are transferred from state to health authorities.[196] Social control can be repressive and constitutive.[197] The latter is

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[189] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 223 (emphasis added); Carino et al., *supra* note 2, at 79 ("The harm reduction approach enables clients to access the information they need to make educated decisions and adequately care for their own health.").

[190] *See* Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 223 (discussing the "before" visit of the Uruguay Model during which pregnant women are given advice about their options and "[t]here is no pressure to adopt any of the alternatives, which are presented as neutrally as possible.").

[191] Briozzo et al., *Iniciativas Sanitarias*, *supra* note 2, at 22; Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 223; Carino et al., *supra* note 2, at 81.

[192] Briozzo et al., *Iniciativas Sanitarias*, *supra* note 2, at 24; Carino et al., *supra* note 2, at 78.

[193] Briozzo & Faúndes, *supra* note 2, at 294.

[194] Carino et al., *supra* note 2, at 79.

[195] Conrad, *supra* note 61, at 223–24. For a critique of the medicalization of harm reduction interventions specifically, see Roe, *supra* note 16, at 244–45.

[196] Conrad, *supra* note 61, at 215–18; *see generally* Levy, *supra* note 65 (discussing the consequences of medicalization in the area of women's reproductive health); Irving K. Zola, *Medicine as an Institution of Social Control*, 20 Soc. Rev. 487 (1972) (analyzing the consequences of medicalization). For a critique of harm reduction as extending the mechanisms of social control and medical dominance, see Miller, *supra* note 80.

[197] The concept of constitutive social control is developed in Michel Foucault's writing on governmentality. *See generally* Michel Foucault, Discipline and Punish (Alan Sheridan trans., Vintage Books 2d ed. 1995) (1977); Michel Foucault, *Governmentality*,

most dangerous to individual freedom because it can be camouflaged as benevolent if not empowering. Precisely because of the strong trust relationship created, and the view of physicians as either benevolent holders of expert information or liberators from marginality and restorers of integrity, physician-patient interactions can function as powerful sites of social control.[198]

Consider, for example, that counseling is a model of abortion regulation adopted to protect not women's rights but prenatal life, an underlying objective of most prohibitionist regimes.[199] Counseling anchors the legislative abortion framework in Germany and many other countries.[200] In the German model, counseling may include information on abortion, but its goal is to strengthen a woman's responsibility to continue the pregnancy and through support to enable her to do so. Counseling is preferred over criminal sanction because it is regarded as more effective in inducing women to decide against abortion. Women are integrated into the normative order by reminding them of and persuading them to act on their responsibilities within it. Women must reflect on their behavior against these standards. The counseling model is thus described as "soft surveillance"—a means of social control by constitution of the discourse, notions of what is permissible and impermissible, and the exercise of evaluation and judgment.[201]

Physician-patient consultation in the Uruguay Model can be understood as a form of social control in similar terms. The information provided to women is not restricted to safer abortion methods. The woman is also informed of the Penal Code and whether she is lawfully entitled to an abortion under its provisions.[202] Women are informed that the health team is there to help them, but only within the law.[203] By placement of women in one of two groups—those entitled to an abortion within the health system and those who must resort to clandestine measures—the physician acts as a gatekeeper and agent of the state, policing the boundaries of the law and communicating state-sanctioned norms and values. This classification also delineates cate-

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in THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY 87 (Gordon Burchell, Colin Gordon & Peter Miller eds., 1991).

[198] Conrad, *supra* note 61, at 216; Morgan, *supra* note 65, at 91–92.

[199] *See generally* Sjef Gevers, *Abortion Legislation and the Future of the "Counseling Model,"* 13 EUR. J. HEALTH L. 27 (2006) (exploring the counseling model of abortion legislation; that is, the so-called "conflict (or emergency) oriented discourse model").

[200] The German "counseling model" [Beratungslösung] and its objectives are described in Bundesverfassungsgerichts [BVerfG] [Federal Constitutional Court] May 28, 1993, 88 BVerfGE 203, 1993. For a description of the counseling model in Hungary, see Alkotmánybír óság (AB) [Constitutional Court], Decision of Nov. 18, 1998, 1998/105 MK.

[201] Nanette Funk, *Abortion Counselling and the 1995 German Abortion Law*, 12 CONN. J. INT'L L. 33, 62–63 (1997). Harm reduction generally has been criticized for its failure to engage dominant discursive practices. Miller, *supra* note 80, at 168.

[202] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 222–23.

[203] *Id.*

gories of identity and can be constituting of the individual.[204] By virtue of her consultation with the physician, the woman knows her action is unlawful and that she is by definition in breach of the normative order. The legal environment, in other words, interferes with the capacity to create a truly nonjudgmental encounter. The interaction reflects, constitutes, and reconstitutes the normative order, literally recreating itself over and over with each encounter reinforcing it.[205]

Non-directive options counseling can serve the same social control function as in the counseling models of prohibitionist regimes.[206] The purpose of counseling is to facilitate rather than influence decision-making, and yet it is widely reported that most women have reached a firm decision on whether to continue or terminate pregnancy before seeking health services.[207] Further exploration of the patient's decision-making, even if non-directive, is generally unnecessary and often unwanted—suggesting it serves interests other than those of the woman.[208]

These aspects of social control in the Uruguay Model and other physician-based safer-use models are most evident when set against an alternative. It is not an imagined alternative but a parallel harm reduction initiative: the Safe Abortion Hotline. This initiative was developed by a Dutch nonprofit organization, Women on Waves ("WOW").[209] Founded in 1999 by a physician-activist, WOW is dedicated to providing women living in restric-

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[204] Miller, *supra* note 80, at 174–75 ("Whilst the rhetoric of harm minimization states that it holds 'a value-neutral view of users', it fails to consider the fact that through the classification of individuals according to group characteristics, harm minimization adds to the discourses that create an oppositional mindset and perpetuates marginalization."). A critique of the physician-patient interaction as a site of social control should not neglect the capacity for agency and acts of resistance. Women may actively co-construct the meaning of their actions and their identity within and against the normative order.

[205] Susan A. Speer & Ceri Parsons, *Gatekeeping Gender: Some Features of the Use of Hypothetical Questions in the Psychiatric Assessment of Transsexual Patients*, 17 DISCOURSE & SOC'Y 785, 806 (2006).

[206] There is an important difference between options counseling and abortion counseling. Options counseling refers to counseling on the decision to continue or terminate a pregnancy. Abortion counseling refers to counseling once a woman has decided to terminate the pregnancy, and generally pertains to different methods of abortion; that is, the experience, efficacy and safety, symptoms, and side effects.

[207] *See, e.g.,* Usha Kumar, Paula Baraitser, Sheila Morton & Helen Massil, *Decision Making and Referral Prior to Abortion: A Qualitative Study of Women's Experiences*, 30 J. FAM. PLAN. & REPROD. HEALTH CARE 51, 52–53; Philippa Matthews & Sarah Ball, Letter, *Counselling, Psychological Morbidity and Termination of Pregnancy*, 29 J. FAM. PLAN. & REPROD. HEALTH 39, 39 (2003).

[208] The 2011 draft clinical guideline of the U.K. Royal College of Obstetricians and Gynaecologists on pre-abortion management recommends that "[w]omen who are certain of their decision to have an abortion should not be subjected to compulsory counselling." Royal College of Obstetricians and Gynaecologists, The Care of Women Requesting Induced Abortion: Evidence-Based Clinical Guideline Number 7, at 16 (Jan. 2011) (draft for peer review), *available at* http://www.ossyr.org.ar/pdf/TheCareOfWomenRequestingInducedAbortion_PeerReviewDraft_Jan2011.pdf. The recommendation is supported by evidence that the vast majority of women requesting an abortion define their pregnancy as unwanted. *Id.* at 51.

[209] WOMEN ON WAVES, http://www.womenonwaves.org (last updated Jan. 16, 2011).

tive legal environments with access to safe, non-surgical abortion. WOW is perhaps best known for its "Abortion Ship"—the provision of medication abortion in a mobile clinic aboard a commissioned ship in international waters.[210]

The following description of the objectives and design of the Safe Abortion Hotline is based on the WOW website.[211] Rather than as harm reduction, access to safer-use information is envisioned as a means to allow women to take their lives into their own hands irrespective of the law and without supervision of health professionals. WOW seeks to empower women to self-administer misoprostol for pregnancy termination by distributing information through the internet and by supporting safe abortion telephone hotlines run by women's organizations. Hotline numbers are posted in public spaces (bathrooms, restaurants, and trains), advertising "free information services for women with unwanted pregnancies." The launch of the hotlines is often accompanied by public campaigns and marches. When women call the hotline, they are informed about misoprostol, including the brand names under which it is available, where they can obtain it, instructions for safe and effective use, and descriptions of the process. Women are informed about the lawfulness of follow-up treatment for miscarriage and post-abortion care. Safe Abortion hotlines have been launched in Argentina, Chile, Ecuador, Pakistan, and Peru.[212] The trained hotline operators are members of local women's organizations, and the information they provide is based on research conducted or published by the World Health Organization and the Latin American Federation of Obstetric and Gynecological Societies.[213]

The Safe Abortion Hotline raises the question: Why must access to safer-use abortion information be mediated through health professionals within a clinical setting? This question applies beyond criminally restrictive

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[210] *See* Affaire Women on Waves et autres c. Portgual [Women on Waves and others v. Portugal], App. No. 31276/05, Eur. Ct. H.R. (2009), http://echr.coe.int/echr/en/hudoc/ (follow "HUDOC database" hyperlink; type case name into "title" field; then follow "search" hyperlink) (holding that the government of Portugal was in violation of the right to freedom of expression for banning and physically blocking a decriminalization campaign by WOW).

[211] *Safe Abortion Hotline Peru, May 2010*, WOMEN ON WAVES, http://www.womenonwaves.org/set-2212-en.html (last visited Apr. 13, 2011).

[212] The hotline in Argentina was launched in 2009. The hotlines in Chile and Ecuador, both launched in 2009, are supported by the Coordinadora Juvenil por la Equidad de Género and Women on Waves. The hotline in Peru, launched in 2010, is supported by the Collective for Free Information for Women. Launched in 2010, the hotline in Pakistan is supported by Asia Safe Abortion Partnership, Women on Waves, and Women on Web. Further information on these hotlines is available through the following blogs: http://www.informacionaborto.blogspot.com, http://www.abortoinformacionsegura.blogspot.com, http://www.lineabortoinfosegura.blogspot.com.

[213] The WOW website provides links to relevant research on safe misoprostol-use published in leading medical journals such as the LANCET, and to an independent website with an extensive bibliography of medical literature on misoprostol use in obstetrics and gynecology (http://www.misoprostol.org/). *How can I do an abortion with pills?*, WOMEN ON WAVES, http://www.womenonwaves.org/set-274-en.html (last visited Apr. 16, 2011).

environments to medication abortion generally as a woman-centered method.[214] Asked differently: Why are medical professionals privileged as the source of information?

Physician-consultation is valued for pragmatic reasons of safety and accurate information. Professional training, for example, is claimed to ensure clear or correct instruction.[215] Reports suggest that women also regard medical professionals as the only trustworthy source of health-related information.[216] As described, the expertise of physicians combined with their benevolent social role contributes to the legitimating if not empowering experience of the medical encounter: restoring integrity and worth to the woman by accepting her into the health system.[217] The trustworthiness of physicians extends into the policy realm. "[O]rganisational backing from respected institutions, such as medical schools, professional medical societies, and ministries of health adds legitimacy to the [Uruguay] initiative . . . ."[218]

The privileged status of physicians—their expertise and control—is challenged in harm reduction initiatives such as the Safe Abortion Hotline. Effective communication on the safer use of misoprostol outside the medical context undermines the claim to expertise, namely that physicians are uniquely qualified to provide information and ensure safer-use. Women's health movements have long sought to demystify medical expertise in reproductive health, to "challeng[e] the 'credentialed expert' monopoly" over health, and to translate it in empowering ways to large communities of women, to democratize it.[219] Women's preference for physician-controlled information, the comfort they derive from the experience, may itself be

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[214] *See generally* Wendy Simonds, Charlotte Ellertson, Beverly Winikoff & Kimberly Springer, *Providers, Pills, and Power: The US Mifepristone Abortion Trials and Caregivers' Interpretations of Clinical Power Dynamics*, 5 HEALTH 207 (2001) (describing the power dynamic between physician and patient with introduction of medicated abortion). Home-use of medication abortion under permissive legal frameworks is also a subject of increasing attention. *See generally* Christian Fiala, Beverly Winikoff, Lotti Helström, Margareta Hellborg & Kristina Gemzell-Danielsson, *Acceptability of Home-Use of Misoprostol in Medical Abortion*, 70 CONTRACEPTION 387 (2004) (describing research on the acceptance of home-use abortion); *see also* British Pregnancy Advisory Serv. v. Sec'y of State for Health, [2011] EWHC (Admin) 235 (Eng.) (holding that responsibility for determining the appropriate place of treatment resided with the British Secretary of State).

[215] *See* Open Door Counselling and Dublin Well Woman v. Ireland, App. Nos. 14234/88 & 14235/88, 15 Eur. H.R. Rep. 244, 267 (1992) (emphasizing the positive health effects of access to information through "qualified personnel" rather than public avenues such as magazines or phone directories); *see also* Sherris et al., *supra* note 27, at 79 ("All providers expressed concern about self-use and cited specific safety issues . . . . [and] most remained concerned about its use without medical supervision.").

[216] Cohen et al., *supra* note 36, at 89.

[217] *See supra* text accompanying notes 183–86.

[218] Carino et al., *supra* note 2, at 82.

[219] Morgan, *supra* note 65, at 113; *see also* C.E. Joffe, T.A. Weitz & C.L. Stacey, *Uneasy Alliances: Pro-Choice Physicians, Feminist Health Activists and the Struggle for Abortion Rights*, 26 SOC. HEALTH & ILLNESS 775, 785–76 (2004).

challenged as over-informed by this mystification. Recall that the physician-consultation can function as a powerful site of social control precisely because it is experienced as legitimating if not empowering. The claim of social control is not unmerited. Physician-controlled information is sometimes expressly justified as necessary to ensure that abortion is not made too easy, that women cannot use the method "too frequently" or "irresponsibly."[220] The objective of the Safe Abortion Hotline, in contrast, is to "empower women as knowledgeable health care subjects . . . capable of bypassing medical control."[221] The model operates on the assumption that "whoever controls access to contraception and abortion effectively owns the tools to control women's reproduction. And one key to controlling access . . . is to control information about them and their uses."[222]

The Safe Abortion Hotline as a harm reduction strategy is qualitatively different from patient-physician consultation. It is most appropriately and historically characterized as one of many safe abortion initiatives marked by a feminist ideology of "self-help" and lay provision of services.[223] Among the most renowned is the Abortion Counseling Service of the Chicago Women's Liberation Union, or "Jane," an underground collective in the United States that operated from 1969 to 1973 before the legal reform that accompanied *Roe v. Wade*.[224] Feminist activists with no formal medical training provided abortion counseling and referrals, but later performed abortions themselves with a safety record better than or comparable to that of licensed facilities.[225] Jane remains celebrated as a feminist model of care, for "its demonstration that abortions could be done by women for women—in short, abortion could be demedicalized."[226]

The Safe Abortion Hotline seeks not simply to provide access to information, but to empower women collectively to appropriate and share information on safer abortion, to "seize the means of reproduction."[227] Demystification and democratization are not value-neutral but normative acts. The Declaration on Public Information for Safer Abortion that accompanied the launch of the Argentina hotline speaks to its political dimen-

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[220] Espinoza et al., *supra* note 30, at 132.

[221] Morgan, *supra* note 65, at 113.

[222] Freedman, *supra* note 79, at 31.

[223] *See generally* Denise A. Copelton, *Menstrual Extraction, Abortion, and the Political Context of Feminist Self-Help*, 8 GENDER PERSP. ON REPROD. & SEXUALITY: ADVANCES IN GENDER RES. 129 (2004) (examining woman-centered approaches to abortion and reproductive health more generally).

[224] Roe v. Wade, 410 U.S. 113 (1973). For a detailed description of Jane, see LAURA KAPLAN, THE STORY OF JANE: THE LEGENDARY UNDERGROUND FEMINIST ABORTION SERVICE (1995); Katherine Pyne Addelson, *Moral Revolution*, 22 RADICAL AM. 36 (1988); Pauline B. Bart, *Seizing the Means of Reproduction: An Illegal Feminist Abortion Collective—How and Why it Worked*, 10 QUALITATIVE SOC. 339 (1987).

[225] Mary Kay Blakely, *Remembering Jane*, N.Y. TIMES MAGAZINE, Sept. 23, 1990, *available at* http://www.nytimes.com/1990/09/23/magazine/hers-remembering-jane.html.

[226] Joffe, Weitz & Stacey, *supra* note 219, at 787.

[227] *See* Bart, *supra* note 224.

sion.[228] The Declaration expressly defines knowledge (information) as an instrument of domination and control, and laments that its diffusion and utilization remains in the hands of a few, subject to their interests rather than the real needs and legitimate desires of women.[229] "We consider scientific and technological knowledge to be the common property of all humanity, and it should be accessible to everyone, in free circulation . . . . Every obstacle impeding its availability should be removed."[230]

The Declaration is drafted in the first person, eliding distinction between provider and recipient of information.[231] They only share the common identity of being women.[232] Provider and recipient are leveled moreover by the common 'legal ambiguity' of their actions: there is no obsessive distinguishing between information and promotion, no concern to avoid running afoul of the law.[233] The objective is to provide information truly irrespective of legality. This is further demonstrated in the refusal to separate women who call the hotline by the legal status of their abortion.[234] Women are again

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[228] *Declaration—Abortion: More Information, Less Risks (Declaración: Aborto: Más Información, Menos Riesgos)*, WOMEN ON WAVES, http://www.womenonwaves.org/article-2092-en.html (last visited Mar. 5, 2011) [hereinafter Abortion Declaration].

[229] *Id.*

[230] *Id.*

[231] *Id.*

[232] *See* Bart, *supra* note 224, at 351–52 (noting that members of Jane did not use the term "patient" because it implied a subject-object relation).

[233] Bart identifies "illegality" in the tradition of civil disobedience as the crux of Jane. "No time was spent in what they termed hassling with the licensing agencies or maintaining bureaucratic forms. . . . [W]e were all partners in the crime of demanding the freedom to control our own bodies and our own childbearing." *Id.* at 346, 352. *See also* Carole Joffe, *What Abortion Counselors Want From Their Clients*, 26 SOC. PROBS. 112, 113 (1978) (describing the feminist ideological underpinnings of abortion counseling); Barbara Katz Rothman & Melinda Detlefs, *Women Talking to Women: Abortion Counselors and Genetic Counselors*, *in* THE WORTH OF WOMEN'S WORK: A QUALITATIVE SYNTHESIS 151, 152 (Anne Statham, Eleanor M. Miller & Hans O. Mauksch eds., 1988) (characterizing abortion counseling as an activist illegal activity highly valued in a political counterculture).

[234] The press release that accompanied the launch of the Safe Abortion Hotline in Peru, for example, identified information-provision as a means by which women can prevent unsafe abortion, "irrespective of the availability or willingness of doctors or the legality of abortion in their country." *Press Release: Abortion Hotline Launched in Lima, Peru,* WOMEN ON WAVES, http://www.womenonwaves.org/article-2233-en.html (last visited Apr. 16, 2011). All women at risk of unsafe abortion, in other words, whether because of denied access or unavailability of lawful services or because of legal restrictions, are the intended beneficiaries of the service. The only distinction drawn between women is socio-economic: "[W]omen who are wealthy and/or very computer literate can either pay large amounts of money to get a safe abortion in a well-run clandestine clinic, or travel abroad, or at least access the reliable information on a number of websites . . . . However, most women are not able to pay for the Internet and/or do not know where to look for this information." *Peru Hotline, Day 1*, WOMEN ON WAVES, http://www.womenonwaves.org/article-2213-en.html (last visited Apr. 16, 2011). The Safe Abortion Hotline is intended to provide the latter group of women, that is most women, with access to safer-use information. The implementation of the Uruguay Model in public health facilities similarly seeks to ensure that all women regardless of social or economic status can access safer-use information. *See supra* notes 114–16 and accompanying text.

defined by a common status, that of having an unwanted pregnancy. The only standards that matter are the individual woman's beliefs, values, and personal ideals. These are not set against a state-sanctioned norm.

The Declaration is most striking in the primary grounding of its political claims in international human rights law.[235] Women are declared to have not only the capacity but also the right to use complete and current information in their decision-making.[236] The Declaration demands that the state respect women's autonomy and dignity and recognize their right to information on safer abortion.[237]

This political dimension of the Safe Abortion Hotline reveals its fundamental difference from the Uruguay Model. The danger of empowering health professionals as agents of change—as envisaged in the Uruguay Model—is that the right to access safer-use abortion information will come to be defined exclusively in the medicalized terms of the initiative: as the medical management of a health problem.[238] The right to access information means something very different to the women at the Safe Abortion Hotline. Information is instrumental to women's self-determination. "Reproductive information is a political resource . . . [that] enables women to take control of their lives and to join in transforming social institutions."[239] The Declaration reflects both dimensions of self-determination: women's autonomy to make decisions about their bodies according to their own beliefs, values, and ideals, and women's claims for decriminalization of abortion, the transformation of law as a social institution.[240] A feminist ideology underlies WOW and its movement for safer abortion.[241]

Harm reduction acknowledges the importance of participation within the health intervention. In the Uruguay Model, however, it is a depoliticized form: the right to free and informed decision-making within a health setting. A human rights approach requires more.[242] It requires participation as empowerment within a political space.[243] The right to health is interpreted to require "improvement and furtherance of participation of the

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[235] The Declaration cites to the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Universal Declaration of Bioethics and Human Rights, and to related jurisprudence under these treaties. Abortion Declaration, *supra* note 228.

[236] *Id.*

[237] *Id.*

[238] *See, e.g.*, Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 222 ("[Unsafe abortion is] a cause of maternal death that can be relatively easily reduced with the right interventions.").

[239] Dorothy E. Roberts, Rust v. Sullivan *and the Control of Knowledge,* 61 GEO. WASH. L. REV. 587, 646 (1993).

[240] *See* Abortion Declaration, *supra* note 228.

[241] *See* Friedman et al., *supra* note 15, at 9 (describing harm reduction initiatives as movements rather than service agencies).

[242] *See, e.g.*, Hunt, *supra* note 13, at 231–32 (distinguishing between weak and strong human rights in harm reduction).

[243] *See generally* Pol De Vos, Wim de Caukelaire, Geraldine Malaise, Dennis Pérez, Pierre Lefèvre & Patrick Van der Stuyft, *Health Through People's Empowerment: A*

population in the provision of . . . health services . . . and, in particular, participation in political decisions relating to the right to health . . . ."[244] The latter part of the statement suggests the right to participation concerns how the boundaries are set in the first instance: why limit access to safer-use information on abortion to the patient-physician encounter? This preference comes from somewhere and that somewhere is a political space.[245] Empowerment in a human rights approach is defined precisely by the capacity of individuals and communities to participate "as 'makers and shapers' rather than as 'users and choosers' of . . . interventions."[246] Participation in governance reflects the use of information as a political resource for action, a means by which women can gain control over their health and lives by transforming social institutions, including the health care system and the law on abortion. Engagement with the right to access information on safer abortion as an issue of women's self-determination is exemplary of participation as empowerment. This political dimension of harm reduction is essential to ensure that an empowerment strategy does not thereby discharge the state of its responsibility to address unsafe abortion and the continuing needs of women within the formal health system.[247] The growth of civil society should neither require nor allow for the contraction of the state, and its human rights obligations to protect life and health.

V. The Pragmatic Principle

Harm reduction is largely adopted in criminal legal frameworks, but rather than engage with abstract policy goals of prohibition or legalization, it is pragmatic. One aspect of this pragmatic orientation is the acceptance that individuals will engage in the activity regardless of legal prohibition, that

Rights-Based Approach to Participation, 11 Health & Hum. Rts. 23 (2009) (analyzing the core aspects of participation and empowerment from a human rights perspective).

[244] CESCR General Comment No. 14, *supra* note 85, ¶ 17; *see also* Special Rapporteur on the Right to Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, Human Rights Council, ¶¶ 39–43, U.N. Doc. A/HRC/7/11 (Jan. 31, 2008) (by Paul Hunt); Special Rapporteur on the Right to Health, *Economic, Social and Cultural Rights: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, Comm'n on Human Rights, ¶ 48, U.N. Doc. E/CN.4/2004/49 (Feb. 16, 2004) (by Paul Hunt).

[245] *See* Helen Potts, Human Rights Ctr., Univ. of Essex, Participation and the Right to the Highest Attainable Standard of Health 25 (2008), *available at* http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Participation.pdf.

[246] Alicia Ely Yamin, *Suffering and Powerlessness: The Significance of Promoting Participation in Rights-Based Approaches to Health*, 11 Health & Hum. Rts. 5, 15 (2009) (citing John Gaventa, *Towards Participatory Governance: Assessing the Transformative Possibilities*, *in* Participation—From Tyranny to Transformation? Exploring New Approaches to Participation in Development 25, 29 (Samuel Hickey & Giles Mohan eds., 2004)).

[247] *See generally* Jane Aiken & Katherine Goldwasser, *The Perils of Empowerment*, 20 Cornell J.L. & Pub. Pol'y 139 (2010) (critiquing empowerment models as a means to address the problem of domestic violence).

eradication of the activity is unrealistic if not impossible. The objective is thus to reduce the harm associated with the activity. The Uruguay Model is designed to reduce the health-related harms of unsafe abortion within the existing legal framework. Unsafe abortion is treated as an enduring but nonetheless contingent feature of women's lives.

A. Harm, Risk and Vulnerability Reduction

The Uruguay Model literature describes harm reduction as an effort "to minimize the negative effect of certain social behaviors that are known to be dangerous, but are practiced by a group of people that are particularly vulnerable to engaging in such practices."[248] The terms 'risk' and 'vulnerability' refer to distinct concepts and carry unique meaning in harm reduction discourse.[249] Risk is defined as the likelihood of the harmful consequences or negative effects resulting from behaviors known to be dangerous, or risk behaviors.[250] Much of harm reduction is risk reduction insofar as it seeks to minimize the risk or likelihood of harm.[251] More specifically, harm reduction tends to focus on individual-level risk factors—that is, on persons who are particularly vulnerable—and to function through individual behavior modification or the altering of risk behavior.[252] The Uruguay Model, for example, seeks to minimize the harms of unsafe abortion through behavior modification, namely the safer use of medicines to terminate pregnancy and to thereby reduce the likelihood of complications.

In risk reduction, the risk and harm of unsafe abortion can be conceptualized as having a simple, objective, factual existence. Neglected are the factors that render an individual or group of individuals vulnerable to the risk behavior or that otherwise influence decision-making to engage in the

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[248] Briozzo et al., *Risk Reduction Strategies*, *supra* note 2, at 222.

[249] *See, e.g.*, Nadine Ezard, Commentary, *Public Health, Human Rights and the Harm Reduction Paradigm: From Risk Reduction to Vulnerability Reduction*, 12 INT'L J. DRUG POL'Y 207 (2001) (exploring the utility of expanding the harm reduction paradigm to incorporate vulnerability reduction); Tim Rhodes, Commentary, *The 'Risk Environment': A Framework for Understanding and Reducing Drug-Related Harm*, 13 INT'L J. DRUG POL'Y 85 (2002) (offering the concept of the 'risk environment' as a framework to overcome the limits of individualism in harm reduction) [hereinafter Rhodes, *Risk Environment*]; Tim Rhodes, *Risk Environments and Drug Harms: A Social Science for Harm Reduction Approach*, 20 INT'L J. DRUG POL'Y 193, 196 (2009) (considering different social science perspectives on drug-related harms as a product of the risk environments in which individuals act) [hereinafter Rhodes, *Social Science for Harm Reduction*]; Tim Rhodes, Merrill Singer, Philippe Bourgois, Samuel R. Friedman & Steffanie A. Strathdee, *The Social Structural Production of HIV Risk Among Injecting Drug Users*, 61 SOC. SCI. & MED. 1026 (2005) (describing the risk environment, the interplay of social, structural and political-economic factors, that shape HIV risk in injection drug use) [hereinafter Rhodes et al., *Social Structural Production*].

[250] Ezard, *supra* note 249, at 211.

[251] *Id.* at 211–12.

[252] *Id.* at 212; Rhodes, *Risk Environment*, *supra* note 249, at 86; Rhodes, *Social Science for Harm Reduction, supra* note 249, at 194.

behavior.[253] Vulnerability concerns "how risk and harm . . . [are] mediated by, or a product of, determinants that extend beyond proximate individual-level factors . . . ."[254] The space in which vulnerability factors—physical, geographic, social, economic, and political situations, processes, and structures—interact to influence risk is referred to as the risk environment.[255] Vulnerability thus focuses on the context that shapes the likelihood of the risk behavior itself. Harm reduction can be accomplished through vulnerability reduction. Interventions may reduce harm by reducing engagement in the activity itself, the behavior known to be dangerous. A lower incidence of unsafe abortion, for example, will reduce abortion-related mortality and morbidity.[256]

Harm reduction as vulnerability reduction, however, requires that the focus of intervention shift from the individual to their environment.[257] In a vulnerability paradigm, efforts to understand or change unsafe abortion practices are meaningless without consideration of the environments in which women live: the situations, processes, and structures that underlie and influence their behavior.[258] Unsafe abortion, in other words, cannot solely be attributed to the characteristics or behavior of individual women. The advantage of the vulnerability paradigm is that it seeks to complicate and contextualize the causes of risk and harm: "to separate more proximal notions or risk from more distal notions of vulnerability."[259] Shifting the causal analysis of harm from the individual to their environment shifts the responsibility for that harm from individuals alone to the social and political-economic institutions that have a role in harm production.[260] Responsibility for the harms of unsafe abortion is redirected to those who can and do shape the intermediate and structural factors that influence individual behavior. Attention is called to "other sorts of risk takers, namely policy makers."[261]

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[253] Ezard, *supra* note 249, at 213, 214, 217.

[254] Rhodes, *Social Science for Harm Reduction*, *supra* note 249, at 194.

[255] *Id.* at 193; Rhodes, *Risk Environment*, *supra* note 249, at 88; Rhodes et al., *Social Structural Production*, *supra* note 249, at 1027.

[256] For a clear articulation of the distinction between risk and vulnerability reduction, consider the relationship between family planning and safe motherhood. Family planning can reduce total numbers of maternal deaths and improve maternal mortality. Family planning does little, however, to reduce deaths among pregnant women; in other words, to reduce the risks of continuing pregnancy to term. Deborah Maine, Lynn Freedman, Farida Shaheed & Schuyler Frautschi, *Risk, Reproduction, and Rights: The Uses of Reproductive Health Data*, *in* POPULATION AND DEVELOPMENT: OLD DEBATES, NEW CONCLUSIONS 203, 212 (Robert Cassen ed., 1994). The same logic applies to family planning and safe abortion. Improved access to family planning may reduce numbers of unsafe abortion, but it does little to make abortion safer.

[257] Rhodes, *Risk Environment*, *supra* note 249, at 91.

[258] Rhodes, *Social Science for Harm Reduction*, *supra* note 249, at 196.

[259] Ezard, *supra* note 249, at 208; *see also* Rhodes, *Social Science for Harm Reduction*, *supra* note 249, at 198.

[260] Rhodes, *Social Science for Harm Reduction*, *supra* note 249, at 194.

[261] Alex Wodak, Response, *All Drug Politics is Local*, 17 INT'L J. DRUG POL'Y 83, 84 (2006).

Vulnerability reduction, for this reason, is convergent with a human rights approach.[262] The unit of interest, analysis, and change is the structure or system.[263] By making visible and acting on the structural dimensions of risk and harm, including the legal and policy environment, vulnerability reduction is a human rights approach to harm reduction.[264] In unsafe abortion, vulnerability reduction focuses on the factors that contribute to unwanted pregnancy and the clandestine nature of abortion as the causes of unsafe abortion. Human rights law holds the state accountable for these factors and requires remedial action.

The Uruguay Model incorporates not only the reduction of risk and harm, but also the reduction of vulnerability. It seeks to reduce the harm of unsafe abortion and to reduce the numbers of unsafe abortions.[265] In pursuit of the latter objective, the model addresses underlying factors that render women vulnerable to unsafe abortion: Why do women engage in unsafe abortion? What factors influence a woman's decision to terminate a pregnancy? Transcending simplistic accounts of individual decision-making, the model seeks to contextualize a woman's experience of unsafe abortion within a risk environment.

The vulnerability approach of the Uruguay Model is reflected in its focus on the unmet needs of women who resort to clandestine abortion. These include: access to contraception to prevent unwanted pregnancy, accurate pregnancy diagnosis to avoid unnecessary recourse to abortion, access to services within the formal health sector when entitled by law, and support for women who wish to carry pregnancies to term.[266] Sexual violence, abuse, and exploitation are also recognized as vulnerability factors.[267]

The Uruguay Model is designed to meet these needs and to thereby reduce women's vulnerability to unsafe abortion. In addition to safer-use information, the following services and information are provided: contraceptive options on request to avoid future unwanted pregnancy, medical examination to confirm pregnancy and gestational age, abortion services within the

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[262] *See supra* text accompanying notes 81–84. *Cf.* Ezard, *supra* note 249, at 209–10 (mapping measures to reduce harm, the risk of harm, and underlying vulnerabilities against human rights in which such measures can be grounded); Jürgens et al., *supra* note 9, at 482 (arguing that an understanding of harm reduction must include reduction of vulnerability); Wolfe & Cohen, *Human Rights and HIV Prevention*, *supra* note 9, at S57 (demonstrating how examining risk environments, which include factors increasing vulnerability, contextualizes intravenous drug use).

[263] Rhodes et al., *Social Structural Production*, *supra* note 249, at 1036.

[264] Ezard, *supra* note 249, at 215, 217; Rhodes, *Social Science for Harm Reduction*, *supra* note 249, at 194; Rhodes, *Risk Environment*, *supra* note 249, at 92.

[265] The Uruguay Model objectives are to protect the health of women, reduce the risks and harm associated with unsafe abortion, reduce the numbers of unsafe abortions, and lower the number of maternal deaths associated with this practice. *See* Briozzo et al., *Iniciativas Sanitarias*, *supra* note 2, at 21.

[266] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 225.

[267] Briozzo et al., *Iniciativas Sanitarias*, *supra* note 2, at 30.

health facility when entitled by law, and information about available support and adoption alternatives should a woman wish to continue her pregnancy.[268]

The Uruguay Model literature expressly identifies the history of state failure to protect women's sexual and reproductive rights as the cause of unwanted pregnancy leading to unsafe abortion: the failure to provide access to sexual health information and education, contraceptives, and other sexual health services.[269] The linking of women's vulnerability to state inaction reflects a human rights approach.

International human rights law recognizes state obligations to address vulnerability factors related to unsafe abortion. Unequal gender relations—which limit the capacity of women and adolescent girls to refuse sex or engage in contraceptive practices—are expressly named as social structural causes of unwanted pregnancy.[270] The conception of unsafe abortion as a form of violence against women, and a human rights violation on this basis, relies on a vulnerability approach. Reproductive health policies are identified as contributing to or causing unsafe abortion.[271] Women should not be forced to seek unsafe abortion, for example, because of unmet needs, such as lack of appropriate fertility control services.[272]

Prevention of unwanted pregnancy has received much attention in international human rights law. "[T]he large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care."[273] Racial and other social disparities in unwanted pregnancy and abortion rates are also interpreted as violations of the right to non-discrimination in health.[274] States are thus called upon to "[p]rioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance."[275] These services are to be provided free of charge where necessary.[276] Prenatal

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[268] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 223–24.

[269] Briozzo et al., *Iniciativas Sanitarias*, *supra* note 2, at 30–31.

[270] CEDAW General Recommendation No. 24, *supra* note 84, ¶ 18.

[271] Report of the Special Rapporteur on Violence Against Women, *supra* note 89, ¶ 45.

[272] CEDAW General Recommendation No. 19, *supra* note 91, ¶ 24(m).

[273] CEDAW General Recommendation No. 24, *supra* note 84, ¶ 17.

[274] Rep. of the Comm. on the Elimination of Racial Discrimination, 72nd–73rd Sess., Feb. 18–Mar. 7, July 28–Aug. 15, 2008, ¶ 504, U.N. Doc. A/63/18; GAOR, 63rd Sess., Supp. No. 18 (2008). The Committee on the Elimination of Racial Discrimination monitors and enforces the International Convention on the Elimination of All Forms of Racial Discrimination. Article 5(iv) requires the state to prohibit and eliminate racial discrimination and to guarantee the right of everyone to public health, medical care, social security, and social services without discrimination. *See* International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195 (entered into force Jan. 4, 1969).

[275] CEDAW General Recommendation No. 24, *supra* note 84, ¶ 31(c). *See also id.* ¶¶ 2, 17, 23, 28.

[276] *Id.* ¶ 27.

and childcare services reduce abortion-related maternal mortality by supporting women who wish to continue their pregnancies. Access to contraceptives and other reproductive health services is regarded as essential to "prevent women from resorting to unsafe abortion."[277]

International human rights law also addresses denied access to lawful abortion as a vulnerability factor. Many women resort to unsafe abortion because they cannot access services to which they are lawfully entitled.[278] Human rights have thus been interpreted to require state regulation and procedural safeguards to ensure women are not wrongfully denied lawful services.[279] In *Tysiac v. Poland*, the European Court of Human Rights articulated a positive state obligation to enact a legal framework to ensure lawful abortion services are accessible in practice.[280] In *Paulina del Carmen Ramírez Jacinto v. Mexico*, a friendly settlement before the Inter-American Commission on Human Rights resulted in a Ministry of Health circular calling on state institutions to ensure access to lawful abortion.[281] Consistent with this trend, guidelines have been developed on medico-legal indications for abortion in Uruguay to improve women's access to lawful services.[282]

B. Criminal Law Reform and Harm Reduction

A vulnerability approach to unsafe abortion inevitably leads to the criminal law. Women resort to unsafe abortion because they are not lawfully

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[277] CEDAW, Concluding Observations: Dominican Republic, ¶ 309, U.N. Doc. A/59/38 (Mar. 18, 2004).

[278] Lawful services are inaccessible for a range of reasons. Primary among them is misinformation on the legal indications for abortion. Human Rights Watch has documented information deficits and their effects on safe abortion in Argentina, Mexico, and Peru. *See generally* HUMAN RIGHTS WATCH, DECISIONS DENIED: WOMEN'S ACCESS TO CONTRACEPTIVES AND ABORTION IN ARGENTINA (2005); HUMAN RIGHTS WATCH, MY RIGHTS AND MY RIGHT TO KNOW: LACK OF ACCESS TO THERAPEUTIC ABORTION IN PERU (2008); HUMAN RIGHTS WATCH, THE SECOND ASSAULT: OBSTRUCTING ACCESS TO LEGAL ABORTION AFTER RAPE IN MEXICO (2006).

[279] Concerned about "the difficulties in obtaining a legal abortion . . . owing, *inter alia*, to the lack of implementing regulations for the laws in force and the tendency, as a result, for many women to seek illegal and unsafe abortions," CEDAW urged the state to adopt regulations implementing the law. CEDAW, Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Bolivia, ¶¶ 42–43, U.N. Doc. CEDAW/C/BOL/CO/4 (Apr. 8, 2008). "Concerned that, in practice, women may not have access to legal abortion services," CEDAW urged the state to adopt a regulatory framework and guidelines to ensure access to legal abortions services. CEDAW, Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Colombia, ¶¶ 22–23, U.N. Doc. CEDAW/C/COL/CO/6 (Feb. 2, 2007) [hereinafter CEDAW Concluding Comments: Columbia].

[280] Tysiac v. Poland, App. No. 5410/03, 45 Eur. H.R. Rep. 42, 970–74 (2007).

[281] Paulina del Carmen Ramírez Jacinto v. Mexico, Friendly Settlement, "Friendly Settlement Agreement," ¶ 16 (Inter-Am. Ct. H.R. Mar. 9, 2007), *available at* http://www.cidh.org/annualrep/2007eng/Mexico161.02eng.htm; Oficio-Circular No. 2192 [Official Circular No. 2192], Centro Nacional de Equidad de Genero Y Salud Reproductivia [National Center of Gender Equity and Reproductive Health], 4 de Abril de 2006 (Mex.).

[282] *Round Up: Law and Policy*, *supra* note 43, at 211.

entitled to access safe services. Prohibition is a cause of unsafe abortion. On another interpretation, of course, prohibition may itself be claimed a harm reduction strategy: it too seeks to prohibit engagement in and thus vulnerability to unsafe abortion.[283] If clandestine abortion can be effectively prohibited, its health-related harms will be correspondingly reduced if not eliminated.

Harm reduction, however, does not refer to any and all interventions intended to minimize risk. A second aspect of its pragmatic orientation is the favoring of a consequentialist evidence-based assessment (i.e., cost-benefit efficiency or means-ends effectiveness).[284] The Uruguay Model, for example, is assessed by its effectiveness in terms of behavior change ("all of the women who returned for the 'after visit' and who had had an abortion said it was carried out it [sic] with misoprostol") and health outcomes ("There were no maternal deaths or severe complications due to abortion registered among the women who participated in the program . . . .").[285] A means-ends effectiveness assessment is explicit: "It appears that our strategy is achieving its purpose of reducing maternal complications and deaths associated with unsafe abortion, through the several mechanisms described above."[286]

Law within a harm reduction approach is assessed in similar pragmatic terms, an intervention to change behavior and reduce harmful consequences. A prohibitionist abortion law must thus reduce more harm than it creates. If it does not, the law cannot be characterized as harm reduction. On the contrary, a harm reduction approach may properly require its reform.

Criminal abortion law, in other words, may be treated as a structural vulnerability factor if on balance it contributes to rather than reduces unsafe abortion. Evidence suggests that prohibition has not produced its purported benefits. It has been counter-productive. The criminal law, as described in the Uruguay Model literature, "directly contribute[s] to the circumstances that force women . . . to resort to unsafe and clandestine abortion practices."[287] Decriminalization is thus advocated as a harm reduction intervention: "[A]bortion must be legal for the procedure to be offered under safe conditions."[288]

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[283] Harm reduction rhetoric to support prohibitionist law and policy is criticized in the drug use context. Miller, *supra* note 80, at 169 ("The rationality . . . that ultimately abstinence reduces harm, appears somewhat dubious and illustrates not only an ignorance of the fundamental basis of harm minimization, but also a rhetorical and discursive strategy designed to taint the more progressive harm-reduction strategies.").

[284] *See* Gostin & Lazzarini, *supra* note 119, at 643–44 (describing consequentialist analysis).

[285] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 224.

[286] *Id.* at 226.

[287] Carino et al., *supra* note 2, at 77.

[288] Faúndes et al., *supra* note 2, at 165. The terms decriminalization and legalization are not strictly distinguished in the article given that abortion (at least during some stage of gestation) for safety reasons must remain a medical procedure and thus subject to a regulated system the same as all other medical procedures.

The legal status of abortion is well-documented as a co-determinant of the frequency and related mortality of unsafe abortion.[289] Abortion rates do not correlate to the legal status of abortion.[290] First, criminalization is ineffective in achieving its stated objective: preventing abortion. The millions of unsafe abortions performed every year in countries with restrictive criminal abortion laws testify to this fact. These countries also predictably have high rates of abortion-related death and disability.[291] Second, liberalization of abortion laws, including decriminalization throughout pregnancy or to a defined gestational limit, is associated with significantly decreased abortion-related harm.[292] This is because abortion rates in countries with liberal laws are lower than in countries with restrictive laws,[293] but more importantly, because safe abortion methods, such as those recommended by the World Health Organization, are among the safest clinical interventions with minimum morbidity and a negligible risk of death.[294] Liberalization allows for the training of practitioners, proper facilities and equipment, and greater accessibility to information and services.[295] The principal effect of liberalization is thus to shift "previously clandestine, unsafe procedures to legal and safe ones."[296]

The evidence is so overwhelming that criminal laws generate more health-related harm than they prevent, it is exceedingly difficult not to advo-

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[289] WORLD HEALTH ORG., WOMEN AND HEALTH: TODAY'S EVIDENCE, TOMORROW'S AGENDA 42–43 (2009); *see generally* Marge Berer, *National Laws and Unsafe Abortion: The Parameters of Change*, 12 REPROD. HEALTH MATTERS 1 (2004) (presenting data indicating that, where legislation allowed abortion, there is lower incidence of unsafe abortion and related mortality, as well as data showing that most abortions become safe when women's reasons for abortion and legal grounds coincide).

[290] Shah & Ahman, *supra* note 1, at 93.

[291] K. Singh & S.S. Ratnam, *The Influence of Abortion Legislation on Maternal Mortality*, 63 Suppl. 1 INT'L J. GYNECOLOGY & OBSTETRICS S123, S127–28 (1998).

[292] *Id.* at S126, S128 (describing the decrease in maternal mortality rates attributed to the liberalization of abortion legislation); *see also* Rachel Jewkes, Helen Rees, Kim Dickson, Heather Brown & Jonathan Levin, *The Impact of Age on the Epidemiology of Incomplete Abortions in South Africa After Legislative Change*, 112 BJOG: INT'L J. OBSTETRICS & GYNAECOLOGY 355 (2005) (describing the positive impact of legalization on abortion-related mortality and morbidity); Brooke R. Johnson, Mihai Horga & Peter Fajans, *A Strategic Assessment of Abortion and Contraception in Romania,* 12 REPROD. HEALTH MATTERS 184, 184 (2004) (describing the decrease in abortion-related mortality following liberalization); Frederick E. Nunes & Yvette M. Delph, *Making Abortion Law Reform Work: Steps and Slips in Guyana*, 9 REPROD. HEALTH MATTERS 66, 66, 71 (1997) (describing the decrease in hospital admissions for septic and incomplete abortion following liberalization).

[293] Shah & Ahman, *supra* note 1, at 93; Singh & Ratnam, *supra* note 291, at S127.

[294] Shah & Ahman, *supra* note 1, at 90; *see also* David A. Grimes, Janie Benson, Susheela Singh, Mariana Romero, Bela Ganatra, Friday E. Okonofua & Iqbal H. Shah, *Unsafe Abortion: The Preventable Pandemic*, 368 LANCET 1908, 1908 (2006).

[295] Singh & Ratnam, *supra* note 291, at S127. Liberalization alone is insufficient to guarantee safe abortion. In Cambodia, India, Ethiopia, Nepal, and South Africa, for example, women continue to resort to unsafe abortion, despite liberalization, where safe and lawful services are not available or accessible. Shah & Ahman, *supra* note 1, at 94, 96.

[296] Grimes et al., *supra* note 294, at 1913.

cate legal reform under a harm reduction rationale.[297] The Uruguay Model literature reflects this view: "decriminalization of abortion is the most effective means to reduce maternal deaths, on the condition that safe abortion services became available."[298]

International human rights law engages with criminal abortion law in the pragmatic terms of harm reduction. The approaches strongly converge in this respect. Punishment of abortion as an illegal act is identified as a cause of unsafe abortion and related death and disability.[299] Laws "likely to result in bodily harm, unnecessary morbidity, and preventable mortality" are expressly declared in violation of human rights.[300] The relationship between criminal law and unsafe abortion thus grounds violations of the human rights to life and health,[301] and state obligations for legal review and reform. "[L]aws that criminalize medical procedures only needed by women and that punish women who undergo these procedures" are declared inconsistent with the right to non-discrimination in health.[302] States are called upon to amend, "[w]hen possible, legislation criminalizing abortion . . . to withdraw punitive measures imposed on women who undergo abortion,"[303] to ensure that women need not resort to unsafe abortion.[304]

C. Criminal Law Reform and Human Rights

The neutrality and pragmatic principles of harm reduction are related. By assessing law in pragmatic terms, harm reduction need not engage with the normative commitments underlying prohibition or decriminalization.[305] As described in the Uruguay Model literature, harm reduction identifies a

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[297] Reinarman, *supra* note 12, at 240 (arguing for legal change regarding drugs due to the "human toll of punitive prohibition").

[298] Briozzo et al., *Risk Reduction Strategy*, *supra* note 2, at 225.

[299] CEDAW, Concluding Observations of the Committee for the Elimination of Discrimination against Women: Timor-Leste, ¶ 37, U.N. Doc. CEDAW/C/TLS/CO/1 (Aug. 7, 2009). In a 1999 report on Colombia, the Inter-American Commission on Human Rights identified criminalization, together with unsafe methods, as the reason abortion is the second leading cause of maternal death in the country. Third Report on the Situation of Human Rights in Colombia, Inter-Am. Comm'n H.R., OEA/Ser.L/V/II.102, doc. 9 rev. 1, Chapter XII ¶ 51 (Feb. 26, 1999), *available at* http://www.cidh.oas.org/countryrep/colom 99en/table%20of%20contents.htm.

[300] CESCR General Comment No. 14, *supra* note 85, ¶ 50.

[301] CEDAW Concluding Comments: Colombia, *supra* note 279, ¶ 393. *See also* CEDAW Concluding Observations: Tuvalu, *supra* note 78, ¶ 44; CESCR Concluding Observations: Brazil, *supra* note 77, ¶ 29; CEDAW Concluding Observations: Panama, *supra* note 78, ¶ 43; HRC Concluding Observations: Chile, *supra* note 77, ¶ 8.

[302] CEDAW General Recommendation No. 24, *supra* note 84, ¶ 14.

[303] *Id.* ¶ 31(c).

[304] HRC Concluding Observations: Chile, *supra* note 77, ¶ 8; HRC, Concluding Observations of the Human Rights Committee: El Salvador, ¶ 14, U.N. Doc. CCPR/CO/78/SLV (July 22, 2003); HRC, Concluding Observations of the Human Rights Committee: Madagascar, ¶ 14, U.N. Doc. CCPR/C/MDG/CO/3 (June 2, 2009); HRC, Concluding Observations of the Human Rights Committee: Poland, ¶ 8, U.N. Doc. CCPR/CO/82/POL (Dec. 2, 2004).

[305] Hathaway, *Shortcomings of Harm Reduction, supra* note 14, at 125.

space for action irrespective of the legal framework.[306] Recall this is the claimed advantage of value-neutrality.

Neutrality can also be a distinct disadvantage. By finding a space for interventions to reduce health-related harms, often through individual behavior change, any legal framework can be made to work—that is, to no longer contribute to morbidity and mortality. Harm reduction functions as a "band-aid" or "safety net."[307] If prohibition can be made to work, there is no reason on pragmatic grounds to reject it. Harm reduction interventions moreover—by reducing harm—may be the very means by which prohibition becomes an acceptable legal framework, including in a human rights approach where accountability is based on a harm reduction rationale.[308] The consequences are heavily critiqued: "by ameliorating their worst effects, harm reduction simply relieves the institutions of prohibition . . . of responsibility for those harms. It reduces their incentive to fundamentally change those damaging policies."[309]

No mere hypothetical, this was precisely the consequence in the most recent case on abortion from the European Court of Human Rights, *A. B. & C. v. Ireland*.[310] The criminal law in Ireland, which prohibits all abortion except when necessary to save the life of the woman, was held consistent with international human rights law.[311] The prohibition was acceptable primarily because of harm reduction measures that ensure women can access safe and lawful abortion abroad. The Court carefully detailed the legislative measures adopted to ensure provision of information and counseling (with reference to *Open Door*), and any necessary medical treatment before and after the abortion.[312] The Court further noted the important role of physicians in providing information on all options available, including abortion abroad.[313]

> [H]aving regard to the right to lawfully travel abroad for an abortion with access to appropriate information and medical care in Ireland, the Court does not consider that the prohibition . . . exceeds the margin of appreciation accorded in that respect to the Irish State. In such circumstances, the Court finds that the impugned prohibition in Ireland struck a fair balance . . . .[314]

Harm reduction is well suited to reveal the rational flaws in prohibition, but when the injustice of a prohibition does not derive from its ineffective-

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[306] Carino et al., *supra* note 2, at 77; Faúndes et al., *supra* note 2, at 166.
[307] Miller, *supra* note 80, at 177.
[308] Hathaway, *Shortcomings of Harm Reduction, supra* note 14, at 125–26.
[309] Roe, *supra* note 16, at 247.
[310] A. B. & C. v. Ireland, App. No. 25579/10, Eur. Ct. H.R. 2032 (2010), *available at* http://www.bailii.org/eu/cases/ECHR/2010/2032.html.
[311] *Id.* ¶ 241.
[312] *Id.* ¶ 239
[313] *Id.*
[314] *Id.* ¶ 241.

ness or dysfunction, the value-neutrality and pragmatic orientation of harm reduction are themselves harmful.[315] Harm reduction leaves the reasons behind the law unexamined and thus intact, passively supporting the status quo.[316] By allowing a criminal law that offends a normative commitment to stand—where prohibition is not simply irrational but immoral—harm reduction converges not with human rights but with their violation.[317]

Criminal abortion laws violate women's human rights for reasons more than their contribution to unsafe abortion and related death and disability. These laws often derive from a characterization of abortion as normatively wrong. A neutral and pragmatic harm reduction approach refuses to engage with abortion as a normative matter. It offers no counter understanding of abortion to contest prohibition. International human rights law is a stark contrast in this respect. Criminal abortion laws are interpreted to violate women's rights where they deny normative plurality on the meaning and significance of abortion. These laws fail to give due respect to abortion—a woman's decision to terminate her pregnancy—as an act of self-determination. The European Court of Human Rights in *Tysiac v. Poland* acknowledged that abortion touches on a woman's private life, protected as a human right.[318] Private life includes physical and mental health, but extends beyond. The right to private life "include[s] the right to personal autonomy, personal development and to establish and develop relationships with other human beings and the outside world."[319] The Inter-American Commission on Human Rights similarly emphasized that abortion "constitutes a very serious problem for . . . women, not only from a health perspective, but also considering their rights as women, which include the rights to personal integrity and to privacy."[320] Within a human rights discourse, harm is located in the law, not its health-related effects. The challenge to the law is epistemic: to introduce new forms of knowledge and thinking about the act of abortion, and to contest existing forms as means of oppression and domination.

Decriminalization, when it does occur, often results from a shift in normative judgment rather than a pragmatic, effects-based assessment.[321]

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[315] Hathaway, *Shortcomings of Harm Reduction, supra* note 14, at 135 (describing how the failure to establish and articulate the moral warrants behind harm reduction renders the approach strategically flawed to address prohibition).

[316] Miller, *supra* note 80, at 173.

[317] Hathaway, *Shortcomings of Harm Reduction, supra* note 14, at 135. Danny Kushlick and Steve Rolles similarly question whether harm reduction leads us to "collude with a policy that invariably degrades and sometimes destroys our clients and the communities in which they live." Kushlick & Rolles, *supra* note 72, at 245.

[318] Tysiac v. Poland, App. No. 5410/03, 45 Eur. H.R. Rep. 42, 969 (2007) (citing Bruggemann and Scheuten v. Federal Republic of Germany, 3 Eur. Comm'n H.R. 244 (1981)).

[319] *Id.*

[320] Third Report on the Situation of Human Rights in Colombia, *supra* note 299, Chapter XII ¶ 51.

[321] Hathaway & Erickson, *supra* note 14, at 483.

Human rights allows for criminal abortion laws to be challenged on grounds of power, equality, and freedom, not merely on health-related effects. Human rights provide a means to articulate the wrong of criminal abortion laws in normative, not simply rational terms, in the service of broad social change.

Conclusion

Whether access to safer-use information on abortion—or the Uruguay Model specifically—should or can be defended as a harm reduction or human rights approach is a question neither raised nor addressed in this Article. The conceptual and discursive dimensions of the two approaches do not admit to a single or easy prescription.

The objectives of the Article were more modest: the first, to provide normative validation for state action to permit and facilitate access to safer-use information on abortion as a harm reduction intervention; and second, to use international human rights law to guide action on unsafe abortion with a normative commitment.

While the comparison and contrast of harm reduction and human rights can be illuminating, "there is the danger of a kind of political romanticism in which the everyday, practical achievements of [harm reduction] programs . . . are minimised by being measured against a goal of perfect freedom [in human rights]."[322] The concrete achievements of harm reduction should not be set against the sweeping transformative aspirations of human rights.[323] There is nothing limiting about meeting the immediate needs of women to protect their lives and health in any legal environment. Such is the view adopted in the Uruguay Model: "[w]e should clearly differentiate what is desirable as a final objective from what is possible."[324] Yet the final objective should not be abandoned, and thus the preceding statement continues: "while at the same time . . . generating conditions for the advancement of a long term solution."[325] Harm reduction may generate these conditions, shifting the discourse on abortion from crime to health and making prohibition inappropriate on pragmatic grounds. "[H]arm reduction may well be a necessary step towards broader reform where more confrontational challenges to the dominant order are still too politically volatile."[326] Political volatility is not always to be avoided, however, in the same way that gradualist reform is not always inevitable.[327] The realization of women's human rights to safe abortion may simply necessitate confrontation with the dominant normative order.

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[322] Keane, *supra* note 66, at 229.
[323] *Id.* at 229.
[324] Briozzo et al., *Iniciativas Sanitarias*, *supra* note 2, at 21.
[325] *Id.*
[326] Hathaway, *Shortcomings of Harm Reduction, supra* note 14, at 132.
[327] *Id.* at 134–36 (summarizing the shortcomings of a harm reduction movement that avoids challenges to prohibition in ideological terms).