A SURVEY OF ABORTION LAWS IN COMMONWEALTH COUNTRIES

prepared by

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for

THE COMMONWEALTH SECRETARIAT

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I. SUMMARY

Legal provisions have not kept pace with medical advances in the field of prevention of unwanted pregnancy. Accordingly, the Fourth Commonwealth Medical Conference (1974) recommended that the Commonwealth Secretariat collect information on laws on Medical Termination of Pregnancy (MTP). The Commonwealth Secretariat circulated a questionnaire to the 36 Commonwealth Member countries and to all associated states and dependencies to indentify their laws and intentions concerning MTP. This paper analyses the state of the law, those evaluations of it and those proposals for its change in the Commonwealth nations, associated states and dependencies given in the total response to the Commonwealth Secretariat questionnaire received from the Commonwealth Ministries of Health and Justice by 1 July 1977. The companion papers by M.P. Embrey and V. Tunkel deal with medical developments and legal initiatives respectively.

The Commonwealth responses show that most of the 53 Commonwealth jurisdictions surveyed inherited their abortion laws from the English Offences Against the Person Act 1861 (applicable to England and Northern Ireland, U.K.) and English Common law tradition. The English imprint has not been exclusive, however, since countries such as Malaysia have been influenced by Islamic law and Lesotho and Swaziland fit into the Roman-Dutch Common law tradition. A number of countries also retain, of course, the influence and jurisdiction of their indigenous Customary law.

Founded on this embracing Common law heritage, Commonwealth countries have laws ranging from apparent total prohibition to abortion on request. Table I outlines the grounds on which MTP is legally permitted and cites the relevant law. Table II outlines the provisions for implementation of MTP services. Table III provides the best available information on national assessments, and proposals by governments or professional associations for the application, interpretation and/or change of the law, including proposals both for legislation and for administrative clarification of the law.

It is hoped that by indicating what the law is in Commonwealth Member countries, associated states and dependencies, a useful step will be taken towards the better employment of abortion law to achieve acceptable abortion practice in the prevention of unwanted pregnancy.

II. LEGAL INDICATIONS

A. Generally

Abortion laws in Commonwealth countries are shown to be distinguishable by reference to four stages of progression. The national details are shown in Table 1. (See page 64).

Common law: All countries read their enacted law against the background of their historic Common law.

Basic law: The English Offences Against the Person Act 1861, in sections 58 and 59, furnishes basic prohibitory law that has been widely applied and retained throughout the Commonwealth. The substance of these sections was somewhat differently phrased in Sir James Fitzjames Stephen's draft penal codes, which were never implemented in England but which served as a mobile vehicle to transport the spirit of English abortion law. Its essence appears in specific abortion laws, in Offences Against the Person or Offences Against Morality legislation or in comprehensive criminal or penal codes.

Developed law: Sections 58 and 59 of the 1861 Act have been clarified in judicial decisions, notably that in the case of R v. Bourne, and by reference to, for instance, the Infant Life (Preservation) Act 1929 (applicable to England, U.K.). Many countries have developed the inherent meaning of the basic law by recourse to such legal authorities, and others that retain the expression of basic law have developed extra-legal administrative authority to the same effect (see Table I).

Advanced law: A number of countries have enacted detailed legislation positively to permit legal grounds for termination of pregnancy. The Abortion Act 1967 (applicable to England, Scotland and Wales) establishes specific indications and locations for the procedure, and a routine method of medical approval. Similarly, 1969 amendments to section 251 of the Canadian Criminal Code allow approval procedures by properly composed therapeutic abortion committees. Singapore's Abortion Act, 1974 relates gestational periods to medical specialty as an element of legitimate procedure, but has abortion on request during the first 24 weeks of pregnancy. A number of such advanced laws contain "conscience clauses" permitting medical personnel to be excused from legal liability for non-participation in many procedures medically indicated.

In the same way that the English 1861 Act is widely followed throughout the Commonwealth, and its interpretation in the Bourne case has been accepted, so laws that have advanced it, for example, the British Abortion Act 1967, the Indian Medical Termination of Pregnancy Act, 1971 and the Singapore Abortion Act, 1974, are being considered as models in a number of Commonwealth jurisdictions. The 1975 Report of the National Committee on the law of abortion in Barbados, however, recommended adoption of the position declared in 1973 in the United States Supreme Court in Roe v. Wade and Doe v. Bolton, removing all legal prohibitions from first trimester abortions.

Note: A division of jurisdictions with basic, developed and advanced laws appears in Appendix I (see page 86) to this Report. Appendix II (see page 87) reproduces the British, Indian and Singapore enactments and Regulations. Appendix III (see page 124) provides a sample bill, combining a number of innovative aspects of all the laws.

B. Common Law

Before legislation affected British abortion law in 1803, termination of pregnancy was punishable as a Common law misdemeanour. It was capable of commission by a pregnant woman on herself and by other persons on her, but in either case only if the stage in pregnancy of "quickening" had been reached. This reflected the influential Canon law where distinctions between the quickened and unquickened fetus were preserved until 1869. Accordingly, it may appear that in countries influenced by the historic Common law standard, abortion performed before quickening, normally taken to occur at about the fourteenth week of gestation, would not be illegal, unless violating other laws on, for instance, the unqualified practice of medicine. Common law offences may be neutralised by Common law defences to liability, notably the defence of necessity. (See F iv below, page 14).

C. Basic Law

Section 58 of the English Offences Against The Person Act 1861 states that:

> "Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent and whosoever, with intent to procure the miscarriage of any woman whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of a felony."

Section 59 provides that:

> "Whosoever shall unlawfully suppy or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanour."

The essence of these prohibitory provisions appears to provide the basis of Commonwealth abortion law. Many jurisdictions express the language of these sections almost verbatim as their own law. Several, however, adopt variations which are of special significance, for instance in rendering a woman liable for attempting to procure her own miscarriage even when she is not "with child"; section 192 of the Criminal Code of Bermuda has this provision. On the other hand, section 303 of the Penal Code of Sri Lanka renders another person liable only when the woman is "with child", and section 235 of the Penal Code of Mauritius renders such

person liable only when the woman is "quick with child."

Despite the prohibitory tenor of the language employed in basic laws, a feature of its expression is repeated use of the qualification "unlawfully" to describe administration, supply or procurement of poison and use of an instrument to procure a miscarriage. The implication that "lawful" administration and use is possible received early recognition in the 1909 Canadian case of R v. McCready, where Lamont, J. of the Saskatchewan Supreme Court said of a woman's abortion that "from the evidence before me I cannot say that the operation ... might not have been necessary to preserve her life, in which case it is not unlawful." Positive expression in law that the necessity to preserve the pregnant female's life renders her abortion lawful brings the law to a more developed level.

D. Developed Law

Most significant recognition of the legality of abortion under basic law came in the celebrated 1938 case of R v. Bourne, that has since been cited and approved in senior courts of the Commonwealth; no record appears, indeed, that the decision has ever been disapproved in a verdict. The case shows the legality of abortion to preserve not just the female's life, but also her health, and in particular her mental health. Dr. Bourne was ruled entitled to acquittal upon terminating the pregnancy of a female on the ground that if her pregnancy continued, she would become "a mental wreck."

Stating the meaning of the law in the Bourne case, Macnaghten, J. referred to the Infant Life (Preservation) Act 1929. Unlawfully killing a fetus in utero may be criminal abortion, and unlawfully killing a born person may be homicide, but during the process of birth itself a child is neither a fetus nor a born person, and the 1929 Act filled this legal gap by creating the crime of child destruction. Section 1(1) of the Act renders killing a child during its birth criminal,

> "provided that no person shall be found guilty ... unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother."

The Bourne case ruled this explicit 1929 proviso always to have been implicit in section 58 of the 1861 Act, on the reasoning that if preservation of the mother's life justifies sacrificing the child's life at the moment of birth, it also justifies such sacrifice at any earlier stage in pregnancy. The case went further however, in ruling that earlier in a pregnancy termination is lawful to preserve not only the fact of the mother's life but also the quality of her life. The quality of life is described as health, and includes both physical and mental aspects.

Expression of the law in a combination of statutes and judicial decisions causes lawyers no difficulty, but the law must be understandable to more than lawyers. For ease of understanding by physicians and others, the law is best expressed in adequate statutes, and a developed

abortion law is therefore most usefully contained within the limits of a single enactment. Few Commonwealth abortion laws offer this clarity.

An approach to developing a basic law by legislation appears in Ghana, whose basic law expressed in sections 58 and 59 of the Criminal Code is subject to section 67(2), which provides that:

> "Any act which is done, in good faith and without negligence, for the purpose of medical or surgical treatment of a pregnant woman is justifiable, although it causes or is intended to cause abortion or miscarriage or premature delivery, or the death of the child."

In 1973 the Law Reform Commission of Ghana still considered the law inadequately clear, however, and drafted three alternative versions of a proposed new enactment.

Section 122(2) of the Laws of Belize is identically worded, except in reversing the order of "abortion or miscarriage." Nevertheless, in responding to the Commonwealth Secretariat's questionnaire, Belize considered its law to permit abortion only in the event of risk of maternal life. (See Table I).

Comparable in its provisions is section 232 of the Penal Code of the Northern Nigerian States, which says that:

> "Whoever voluntarily causes a woman with child to miscarry shall, if such a miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished ..."

These provisions are close to the more general "Good Samaritan" law found in many codified systems of Commonwealth criminal law. Representative of these is section 240 of the Penal Code of Kenya, which states that:

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

Such a provision may be regarded as accommodating a necessity justification for abortion, compatible with the Bourne decision. Its presence may therefore elevate an expression of basic abortion law to the level of developed law. In Papua New Guinea, moreover, the only law on abortion is contained in section 285 of the Criminal Code, which is worded identically to section 240 of the Kenya Penal Code.

If the law is at the higher level of advanced law, however, in which specific grounds are detailed where abortion is permitted, the "Good Samaritan" defence may be excluded. The Supreme Court of Canada in Morgentaler v R (1975), for instance, ruled that section 45 of the

Criminal Code, which is almost identically worded to section 240 of the Kenya Code but without reference to an unborn child, is not applicable to a charge brought under the specifically permissive abortion law expressed in section 251 of the Criminal Code. It was held, nevertheless, that the Common law defence of necessity is applicable.

E. Advanced Law

Developed law prohibits abortion in general but gives express recognition to the necessity to preserve the female's life or health. Advanced law positively provides that abortion is lawful when sought by the female and when specified indications are satisfied. Such justifications for abortion are not identically contained in advanced laws, but different Commonwealth countries have selected their particular details from among the following indications (1 below). Further, provisions for implementation such as conditions concerning physicians and approved facilities (2 below), are often made cumulative with these indications affecting the female's circumstances.

1. Indications for Medical Termination of Pregnancy

a. Risk to the female's life or physical or mental health from continuation of pregnancy, meaning risk beyond that normally associated with pregnancy (the therapeutic indication).

b. Pregnancy by rape or incest (the juridical indication).

c. Likely physical or mental abnormality of a child if born (the eugenic indication).

d. The effect of childbirth upon the health and welfare of the female's existing children and family (the social or socio-economic indication).

e. Failure of a routinely employed contraceptive means.

f. On request.

2. Provisions for Implementation

a. The medical qualifications and specialties of those permitted to perform, authorise or advise on the need for abortion services.

b. The status of hospitals, clinics or other facilities in which abortions may be performed.

c. Stage of advancement of pregnancy as a. and/or b. above and/or d. below.

d. Medical concurrence, for instance, by a second opinion or an abortion committee.

The British Abortion Act 1967 in section 1(2) permits account to be taken of "the pregnant woman's actual or reasonably foreseeable environment", but this expression of a social indication (1d. above) is read elsewhere to cover socio-economic and/or socio-medical indications. A distinctive indication appears under section 169(A)(b) of the Criminal Code of Cyprus, which allows abortion if pregnancy "would seriously jeopardise the social position of the pregnant woman or that of her family.'

Further provisions may specifically take into account the female's age, citizenship, residence, or marital status. Others may give certain immunities from legal liability to persons owing duties to female patients but who have conscientious objections to participation in abortion procedures, except where risk exists of death or of grave injury to physical or mental health. Some statutes penalise those who may coerce or otherwise induce a female to undergo an abortion against her will.

No provisions exist making a husband's or biological father's consent a precondition for lawful abortion. Facilities undertaking procedures may, however, add to publicly legislated conditions for abortion such a more private precondition of their own. This may be under the authority of hospital regulations or otherwise, as the Canadian 1977 Report of the Committee on the Operation of the Abortion Law (Badgley Report) has shown. Where the abortion law does not expressly require parental consent regarding a young girl, hospital laws, regulations or by-laws may contain a general requirement of parental consent for medical procedures (or just for surgery) performed on minors.

Instances of advanced laws and of regulations made under their authority are given in Appendix II below, citing the laws of Britain, India and Singapore.

F. Special Issues

It is a canon of statutory interpretation that an enactment is to be read as a whole, to achieve consistency and find the sense of the legislature's intention. Similarly, the general legal background from which a statute emerges, and the effect of a statute's impact upon the general law, require an approach that integrates the enactment into its related setting rather than an approach that isolates separate components. Accordingly, consideration of special issues regarding Commonwealth abortion laws must be seen as an attempt to achieve a balanced understanding of their meaning, and not to focus disproportionately upon any single aspect.

(i) The Status of the Fetus

The 1861 Act was passed six years before John Lister published his discoveries in antiseptic surgery, at a time when abortion was so hazardous that it was an offence against the person even when self-induced. The historic Common law prohibited maiming under provisions to which the victim's consent was no defence because of public policy that forbade disabling mutilation, including self-mutilation. Morality laws such as governed sexual relations similarly regarded the partner's collaboration as no defence and often, indeed, as an offence in itself. The abortion law fitted easily into this setting.

Its post-feudal inspiration, however, lay in Canon law, and focused upon the spiritual status of the unborn, and the spiritual need for live birth to receive the sacrament of baptism and be spared the eternal consequence of unbaptised death. Such

inspiration remains worthy of the highest respect, and when a live fetus results from induced termination of pregnancy, all appropriate efforts should be made for its survival, notwithstanding the woman's expectation and intention not to become a mother; the rights of the child prevail over her preference.

At earlier stages, however, the interests of the unborn do not have this weight. The Common law recognises legal rights of persons only from the moment of their birth. Property dispositions may take into account the child en ventre sa mere, but for the purpose of determining present and future interests of existing people, rather than in recognition of the unborn's interest in birth. The law has not been an historic vehicle for carrying spiritual interests, as its easy recourse, until this century, to the death penalty may confirm. The different legal status of the guilty and the innocent is, of course, obvious, but the plane of spiritual concern is not necessarily congruent, since the unborn, tainted by original sin, is not "innocent". The difference between legal and spiritual concerns is further shown in that the 1861 Act governed pregnancy at all stages, whereas Canon law gave protection to the unquickened fetus only after 1869. The Penal Code of Mauritius, indeed, continues to confine sanctions to procedures undertaken on or by "any woman quick with child". (section 235). The law cannot easily be employed to serve spiritual interests, and the status of the fetus is accordingly not raised in abortion laws in Commonwealth jurisdictions.

(ii) "Unlawfully"

The word "unlawfully" permeates legislation prohibiting seeking, performing and facilitating abortion. Commonwealth courts have regularly held (see iii below) that the word is not superfluous or meaningless, but recognises a potential for lawful abortion. Accordingly, assertions that some authorities have advanced in jurisdictions following the basic law that abortion is always unlawful, appear to misrepresent the position. This recognition compels the question of when an abortion is legal, and the answer, except in countries with advanced law, lies in the area of necessity. Some countries with developed laws reinforce the necessity concept with their "Good Samaritan" provisions, which in different degrees apply to abortion undertaken by surgical means. Evidence shows that abortion is safer when undertaken at a stage before surgery is required, however, and good policy may therefore favour a concept of necessity going beyond the "Good Samaritan" licence, such as was detailed in the Bourne case.

(iii) The Bourne Case

There is a pedantic sense in which the Bourne judgment is of low authority, since it arose in a trial only at first instance (that is, it was not considered in the more rarified atmosphere of an appeal court), and the case was determined by a jury not required to give reasons for its decision. The strength of a case authority depends not simply upon its origin in the hierarchy of the courts, however, but upon the respect subsequent courts and legal literature pay it. A case not binding as precedent, for

instance because of its origination in another individual jurisdiction, may guide and persuade by accumulated authority.

The language used by Macnaghten, J. in directing the Bourne jury has received the highest approval. It occupies a distinguished place in legal literature not simply on abortion, but on the general law concept and defence of necessity. To cast doubt on the authority of the Bourne decision is not just to favour a different opinion on the legal propriety of abortion, but to question the foundations of modern Common law thought on recognition of the necessity concept. The strength of the Bourne ruling is confirmed in the British Abortion Act 1967, section 1(4) of which embodies and declares its spirit in providing that a registered medical practitioner shall not be bound by the Act's technical conditions for approval of lawful abortion:

> "in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman."

Apart from the high status of the decision in British law, it has received wide citation and approval in courts of other Commonwealth countries. For instance:

a) The highest Canadian court, the federal Supreme Court, while rejecting the "Good Samaritan" defence to abortion in the Morgentaler case, approved the necessity defence as articulated in the Bourne decision. Relying exclusively upon this defence, the defendant then gained acquittal both on a second charge of illegal abortion (upheld on appeal), and on retrial of the original charge.

b) The West African Court of Appeal in R v. Edgal (1938), hearing an appeal case from Southern Nigeria, cited the Bourne case in identifying the legality of abortion when necessary to save the pregnant female's life.

c) In Australia, the Supreme Court of Victoria in R v. Davidson (1969) adopted the Bourne case reasoning in ruling in favour of acquittal on four counts of illegal abortion.

d) In Queensland, Australia, the Bourne interpretation of the basic abortion law was accepted in R v. Ross and McCarthy (1955).

e) The New Zealand Supreme Court in R v. Anderson (1951) accepted the Bourne ruling as authoritative. Further, in R v. Woolnough (1976) the New Zealand Court of Appeal adopted the Bourne principle regarding preservation of the female's physical and mental health, since section 182(2) of the Crimes Act 1961 excused abortion only for the purpose of preserving life.

f) Sections 165 to 167 of the Penal Code of Fiji are closely reliant upon the prohibitive language of the basic law, but in R v. Emberson and Emberson (1976) the Supreme Court of Fiji ruled that:

"A qualified doctor is fully entitled to carry out what has been referred to in this trial as therapeutic abortion - that is to say to terminate a pregnancy which in his medical opinion constitutes a threat to the patient's physical or mental health."

This is the Bourne development of the basic law.

Beyond decided cases and statutes expressing the Bourne principle, answers specifically citing the Bourne judgment and adopting its spirit were given to the Commonwealth Secretariat's questionnaire by, for instance, Ghana, Kenya and Sierre Leone in Africa, by Barbados, Bermuda, British Virgin Islands, Guyana, St. Kitts/Nevis Anguilla, Trinidad and Tobago in the Caribbean, and by Malaysia.

(iv) Necessity

The Bourne case introduces into prohibitive basic abortion law the legality of an abortion procedure compelled by the necessity to preserve the pregnant female's life or her physical and mental health. Provided that some evidence of such necessity is adduced by a defendant accused of illegal abortion, its assessment by a jury leading to his acquittal will be beyond an appeal court's power to nullify. (See R v. Morgentaler (1976) Quebec Court of Appeal).

The necessity concept goes to the heart of the abortion issue, since the threat to the life or health of the pregnant female comes from the fetus she bears. This concept therefore orders priorities between the competing interests of the woman and fetus, favouring the woman. A number of Commonwealth statutes expressly accept priority of the women's actual life over the potential independent life of the fetus in specifically allowing life-preserving interventions in her pregnancy; in this, they adopt the principle of the proviso to section 1(1) of the Infant Life (Preservation) Act 1929.

Sacrificing the fetus to save the woman's health may seem more difficult to accept, however, especially when the danger to health, while exceeding that normally attendant upon pregnancy and childbirth, is transient. Indeed, while in the Bourne case Macnaghten, J. approved the purpose "of preserving the yet more precious life of the mother" in the 1938 All England Report, he omitted this reference from the official 1939 Kings Bench law report, suggesting that it was not critical. Nevertheless, since his direction to the jury was conditioned by evidence of the female becoming "a mental wreck", it seems clear that grave danger not only to life but to long-term physical or mental health constitutes a necessity that legalises abortion.

A juridical or social indication for sacrifice of the fetus may be objectionable, even to philosophies not founded in religious doctrine. Eugenic indications for abortion, moreover, concerned with the likely grave disability of the child to be born, may not justify abortion within the maternal health-saving view of necessity. Necessity to preserve health may nevertheless be

properly invoked if a female's apprehensions regarding the social or other circumstances of her pregnancy or, for instance, her knowledge of fetal congenital abnormality, is likely to endanger her physical or mental health. Justifications for abortion that are purely juridical, social or eugenic are expressed in advanced laws, since they are not contained within the concept of necessity that develops basic law.

Since necessity justifies abortion, it must be asked whether it compels abortion; that is, whether a physician faced with such a necessity can decline to perform abortion on grounds of his own religious or other convictions. Clearly, his failure to take appropriate measures to save his patient, the female, renders him liable to civil proceedings, for instance for negligence or breach of contract, and possibly even to liability for criminal negligence, especially if it resulted in the woman's death.

It is notable that "conscience clauses" in advanced laws protect medical personnel from liability, but only where the necessity that may justify abortion is not of an order that threatens life or to cause grave permanent injury to physical or mental health. This indicates that "necessity" need not be confined to these circumstances, which raises the issue of what is meant by "health" which legal abortion is necessary to preserve.

(v) Health

References in abortion statutes and case judgments to "health" are frequently made and rarely defined. Most Commonwealth countries subscribe to the World Health Organisation (WHO) definition that:

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

In the absence of other definition, some physicians in a number of Canadian provinces have been shown to apply the abortion law upon this understanding, while others reject it and apply more limited dictionary or personal tests. (See page 20 of the Badgley Report). The WHO definition is more of an admistrative programme than a working definition of indications for legal abortion. There are few conditions or causes of less than "complete physical, mental and social well-being" that would seem to be omitted. It is clear that insofar as the occurrence of pregnancy by rape or, for instance, by adultery or while unwed, may gravely affect a female's physical and/or mental health, these factors are accommodated under a narrow definition of "health".

Resisting a broadening of the concept of health by legislation may be difficult, since conscientious physicians may in their patients' interests apply a narrow definition in accommodating ways, recognising the effects of social circumstances upon medical health. Statutory language prohibiting or constricting a health indication may remain subject to Bourne-based judicial development, and in any event, may appear oppressive of the claims of women in the

community to enjoy good health. The only way effectively to limit the health concept may be to accommodate the purposes it is broadened to serve by providing alternative indications within an advanced abortion statute. It may be noted, moreover, that physicians are required to assess indications for abortion "in good faith", and the possibility that different assessments of the same situation may be made does not impair their conscientious and therefore lawful status.

(vi) Medical Practitioners

Necessity to act to preserve life or health is not confined to registered medical practitioners; "Good Samaritan" laws refer generally to "A (or every) person". Such laws also refer, of course, to "all the circumstances of the case", and where medically qualified personnel are available and prepared to undertake legal abortions, the initiative of a layperson (however well qualified and experienced) may be impossible to justify. Conversely, however, where those medically qualified are not available, or where, perhaps through fear of uncertain law, they refuse to act, the trained health professional's response to danger to a woman's life or physical or mental health may be legitimate. A nurse, midwife, or other appropriately trained or experienced health professional may have more ground for intervention than one utterly lacking in skill, but want of certification itself does not render an abortion attempt illegal, provided that a standard of care and skill is demonstrated that is reasonable in the circumstances. Simplification of early abortion procedures, for instance by suction or (promised) suppository techniques, will reduce the need for medically qualified execution as opposed to supervision. Similarly, necessity may justify a woman performing or attempting an abortion procedure on herself, or at least having recourse to drug and other non-invasive methods.

It may appear grave criticism of a medical profession in sufficient supply, and of legislative and governmental agencies, that they so fail adequately to allocate their resources that women must in necessity have recourse to the under-skilled who act in good faith.

Laws permitting only "qualified medical practitioner" to perform abortions are of little effect, however, where such practitioners are not adequately available within the country or any of its regions, or are not willing to perform the operation, or to allow others to perform it. Such laws may become an obstacle to health care, furthermore, where too many qualified practitioners are required for the consent procedure than can feasibly, conveniently, speedily or economically be gathered.

(vii) Good Faith

The requirement of a physician's good faith in making a medical assessment of a woman's needs or qualification for abortion imports an obligation to apply proper professional criteria of health care, and not be motivated by ulterior or non-professional purposes. The primary urge to earn a fee, for instance, may be ulterior in

this sense (see the Emberson case (Fiji 1976)), but so equally may be the pursuit of a social or other philosophy.

Where a developed law is acknowledged, the assessment of danger to life or physical or mental health must relate to medical (including psychiatric or psychological) matters. If the source of the danger to health is the adulterous, or, for instance, incestuous origin of pregnancy, this origin must be found to create a permissible medical indication in order for termination of the pregnancy to be lawful. Similarly, if it is proven medically that financial, social or other circumstances endanger life or health, abortion may be authorised; but the decision must be based on reasons of real danger to life and health, and not on financial and social factors as such.

The underlying reasoning is that a physician's opinion not formed upon the basis of his special skill and trained insight is not a medical opinion. A physician advising or performing an abortion in the belief that any woman asking for abortion should be entitled to it would not be exercising medical judgment, or would not be making his medical assessment in good faith. In countries with advanced laws, however, non-medical indications may be allowed, and here non-medical information may be relevant.

Where, for instance, a doctor is proposing to take into account "the pregnant woman's actual or reasonably foreseeable environment" (under, for example, section 1(2) of the British Abortion Act 1967), he may be concerned about the likelihood of her marriage disintegrating. Since his medical skill would not aid his perception, recourse to a social welfare or marriage counsellor's assessment may be more appropriate in determining social indications. Similarly, under section 169(A)(b) of the Criminal Code of Cyprus, for instance, medical termination of pregnancy is lawful:

> "following a certification by the competent police authority, confirmed by medical certification where this is possible, that the pregnancy has been brought about by rape or under such circumstances that, if it were not terminated, it would seriously jeopardise the social position of the pregnant woman or that of her family ..."

Since not only fully qualified physicians may perform abortion under a justification of necessity, a health professional's good faith may come under similar scrutiny. Relevant evidence of good faith may be, for instance, the unavailability of medically qualified services, the absence of financial motivation and the ability to use adequate skill, related perhaps to the stage of pregnancy and the jeopardy to life and health. Good faith is literally critical in any criminal prosecution, since abortion is a traditional crime in that it requires proof beyond reasonable doubt of the accused's guilty or improper intention. As the trial judge instructed the jury in the 1948 English case of R v. Bergmann and Ferguson:

"You are not concerned with the question as to whether Dr. Ferguson arrived at the right conclusion ... You will have to consider whether ... the /doctor/ gave a dishonest opinion, did not act in good faith, and was therefore advising something that was unlawful."

Evidence of good faith may consist in obtaining an independent concurring medical opinion even when it is not statutorily required, or making an adequate examination of the woman's medical history.

Evidence of good faith may also exist in the physician's intention to undertake a legitimate procedure not directed to pregnancy termination as such. Where, for instance, life or health is endangered by an ectopic pregnancy, surgery to safeguard the mother will remove the products of conception, but this will not need prior approval under abortion legislation. Similarly, the Lane Committee, reporting on the British Abortion Act 1967, acknowledged that techniques of menstrual regulation could achieve legitimate abortion outside the terms of current abortion legislation. (See Chapter IV.D. page 45). Menstrual extraction may also be undertaken before pregnancy is establishable without raising liability to conviction for unlawful abortion, provided that the physician having recourse to such means acts in good faith to serve the woman's health needs, for instance for diagnosis of irregular menstruation.

(viii) Jury Trial

The issue of good faith, and therefore of criminal guilt or innocence, is in most Commonwealth countries determined by a jury; that is, identification of, for instance, medical necessity to act, and of sincere belief in its existence, are matters of fact for jury determination. Personal convictions regarding the propriety of abortion have at times conflicted with convictions regarding the sanctity of trial by jury, since modern Commonwealth juries have shown a tendency to favour physician-defendants. They have thereby shown tolerance of accommodating abortion laws, or intolerance of restrictively expressed enactments such as the basic law. Where doctors have challenged the meaning of the law, either by provoking confrontation or by establishing clinics that undertake abortion, and have been prosecuted, juries have acquitted. Apart from the Bourne case, juries acquitted doctors, often on multiple charges, in the cases of, for instance, Bergmann and Ferguson (1948), Morgentaler (1973, 1975, 1976), Davidson (1969), Woolnough (1975), and Wald (1971). This fact poses a problem for routine no less than for crusading prosecutors, and, especially where a jury is respresentatively drawn from the community, may be indicative to legislators of popular sentiment.

(ix) Punishment

The survey of substantive Commonwealth abortion laws shows high consistency in language, reflecting origins in the English 1861 Act and in subsequent codifications of the criminal law not actually

implemented in the U.K. but applied or retained in other Commonwealth countries. Penalties for illegal abortion, however, differ very considerably. The Canadian Criminal Code, for instance, in section 251(1), renders one found guilty "liable to imprisonment for life." Such a formula allows for judicial discretion, of course, and quite short sentences and non-custodial sentences may be imposed; maximum punishment in Fiji is 14 years imprisonment, for instance, but the Embersons were simply fined. In contrast, the Criminal Code of Bermuda in section 192 has maximum punishment of "a term not exceeding three years", applicable not only to one procuring another's abortion but also a woman aborting herself. In Canada, where section 251(1) of the Criminal Code provides the fierce maximum of life imprisonment for one procuring another's abortion, section 251(2) provides that maximum punishment for a woman aborting herself unlawfully is only two years' imprisonment.

Abortion laws replete with punishment of women, abortionists, and suppliers of means of abortion, leave unsanctioned the biological fathers at whose urging abortion procedures are often triggered. General criminal provisions on conspirators and accessories may, of course, be applicable to them, but such provisions are equally applicable to all of the other parties, since they too collaborate in each other's offence. The Singapore Abortion Act, 1974 in section 5 punishes:

> "Any person who, by means of coercion or intimidation, compels or induces a pregnant woman against her will to undergo treatment to terminate pregnancy ..."

This offence could apply not only to the father seeking to avoid child maintenance responsibilities but also to a parent concerned to protect the family name. The offence arises, however, only when the woman is forced into the operation.

Commonwealth statutes reveal not simply inconsistent penal details, but fundamentally different philosophies of gravity of the offences both of terminating one's own pregnancy and that of another. A dilemma is that if potential punishment is too severe, juries may acquit for fear of excessive punishment, and judges may demand very strict proof, while if it is minor, the reason for rendering abortion illegal fades, and the offence is relegated to a technical or administrative infraction. This latter point is now emphasised by growing recognition of the territorial limitations of criminal law and the possibility of a woman leaving the jurisdiction for a lawful abortion elsewhere upon grounds not permitted in the country of her residence.

(x) Territorial Jurisdiction

The historical basis of Common law jurisdiction is territorial, reflecting its feudal origins. Accordingly, a female resident of a Commonwealth country with prohibitive law commits no offence against that law by having a lawful abortion in a country with more liberal provisions, on a ground not permitted where she resides. This is confirmed in the response to the Commonwealth Secretariat's

questionnaire from Bermuda, whose law is expressed in basic terms. This observed that some women travel to clinics in New York for abortions prohibited by the Criminal Code of Bermuda.

The same point, and much the same location, was indentified in the Badgley Report. This showed that 1 in 6 Canadian women having abortions (this sixth totalling about 10,000 a year) went to facilities in the U.S.A. Further, many women whose applications to Canadian therapeutic abortion committees had been rejected went to the U.S.A. for lawful (often second trimester) abortions. Canadian provincial health insurance schemes contribute to the expenses of a number of these abortions, though they might be unlawful if performed in Canada.

Clinics in the U.S.A., especially when privately maintained on a profit-making basis, may seek to attract clients, but publicly provided services may want neither heavy use from residents of their catchment area nor to attract females from outside. Accordingly, they may provide a comprehensive family planning and fertility control service, but impose residential qualifications upon those whom they will abort. Singapore's Abortion Act, 1974, for instance, in section 3(3), reserves treatment to citizens and wives of citizens and to residents of at least four months, except where treatment is necessary to save life.

The ability to be free of prohibitive local laws by going elsewhere discriminates, of course, between those having the money and domestic freedom to travel, and those without. Only the former can obtain legal, and therefore usually safer, medical procedures.

(xi) Commencement of Pregnancy

Commonwealth abortion laws speak of abortion, miscarriage and termination of pregnancy, but none considers the point of commencement of pregnancy. The Singapore Abortion Act, 1974 (section 4(2)), is the only Commonwealth enactment that provides a means of estimating the duration of pregnancy; it "shall be calculated from the first day of the last normal menstruation of the pregnant woman ... or the duration of pregnancy may be ascertained by clinical examination." Such a legal test, however, is clearly distinguishable from the biological and ethical question of commencement of pregnancy.

Laws based on section 59 of the British 1861 Act (see C above) prohibit supply of means to procure a miscarriage, but the same legal systems usually permit aid and instruction in contraception. They do not distinguish preventing conception from terminating pregnancy. (See generally the companion papers by M.P. Embrey and V. Tunkel).

This point has acquired a more acute cutting edge with development of post-coital ("morning after") contraceptives and simple means of clearing the uterus and restoring menstrual regularity by vacuum extraction techniques. A body of medical opinion exists that believes that some contraceptives might have

an abortifacient effect by operating to prevent embedding of a fertilised ovum, in the lining of the uterus. Those regarding fertilisation of the ovum as the point of conception or ensoulment may therefore regard what some legitimately use as contraception as achieving abortion in obstructing implantation and therefore growth of the fertilised ovum.

The practice of menstrual extraction and the use of post-coitally taken or operating contraceptives are likely to spread, and a harmful tension may develop between safe implementation of medical advances and the provision and enforcement of the law. The public interest may seem to render the conflict between permissible contraception and the law on abortion worthy of definitive resolution.

G. Judicial Proceedings

Courts clearly serve a major function in clarification and definition of the law, but they have no power to initiate litigation. The law's need for judicial clarification cannot be met, therefore, by the courts acting alone. They must be moved into action by litigants, whether private persons or organisations, or public officers such as Attorneys-General or other public prosecutors. Litigants are influenced by a variety of motives, but public prosecutors, on whom the main burden of law-enforcement almost invariably falls, may be reluctant to invoke the criminal process where the law is uncertain; uncertainty itself furnishes an obstacle to achieving certainty through judicial organs of state.

This point is reinforced in the experience of abortion proceedings where it has been noted that doctors are not often convicted, and those acting in public hospitals are rarely prosecuted; doctors such as Dr. Morgentaler, Dr. Woolnough, Dr. Davidson and Dr. Emberson ran private or specialised clinics. The female clients who sought their services seem not to have been prosecuted at all, possibly because prosecutors are critically dependent upon their evidence against abortion practitioners, and trade immunity for their testimony.

Public prosecutors may be expected to respond to administrative directives, rulings or even opinions expressed by their Attorneys-General on the meaning of the law, so that a basic law de jure is rendered developed law de facto (see III below), and an advanced law in in principle may become very restrictively construed. The existence of legal defences that may succeed in court may on practice also influence the decision to prosecute. Defences such as necessity (and evidence of good faith) must therefore be understood in the light of their capacity to lead not to acquittal, but to non-prosecution.

A number of Commonwealth jurisdictions accommodate a right of private prosecution, permitting anti-abortion activist groups in theory to initiate proceedings to test the law, and challenge administrative guidelines they disfavour. In practice, however, they have not done this, and lack a number of procedural means open to public prosecuting authorities. In particular, they cannot gain compulsory access to evidence, nor can they offer aborted females immunity from prosecution

for their own criminal acts in return for testimony against abortionists.

Defences must be seen in the context of the prosecution's duty to prove guilt beyond reasonable doubt. It must be shown not only that the defendant acted contrary to the prohibition of the law, but also that he had a criminal intention or did not act in good faith. Evidence of such intention or lack of good faith may exist in secrecy (as opposed to privacy) of the operation, failure to enquire into the woman's circumstances to establish legal indications, and charging of high fees. On the other hand, a physician's intention in good faith to save life or preserve health will in principle entitle him to exoneration, as may his intention to undertake legitimate protection against future pregnancy by means which might act after fertilisation. Similarly, a physician honestly undertaking menstrual extraction of a patient complaining of menstrual disorder and disclosing no recent history of unprotected intercourse, would commit no offence even in the absence of conducting a pregnancy test (since at an early stage of pregnancy this would be inconclusive).

The intention to save life or to preserve physical or mental health would protect a physician even under a basic law not expressing such indications for legal abortion. Developed abortion law is inherent in basic law, and a court following the Bourne decision, which it is highly likely to do, would lead its legal system from the latter to the former.

Once a prosecutor has shown prohibited conduct to terminate pregnancy, and supporting evidence of guilty intent or lack of good faith, a defendant must satisfy the court on a balance of probability of any defence he raises. A denial that the conduct to terminate pregnancy occurred or that he was involved in it, must turn upon factual evidence. If the defendant admits the conduct, however, but alleges good faith, he must call evidence from which such good faith can be inferred. If he alleges necessity to preserve life, he must show his genuine belief that life was at risk. The test is subjective, aimed at what the defendant himself actually believed, but if the evidence he calls is highly idiosyncratic it may lack credibility.

The defendant's argument must be admitted in court that pregnancy endangered not life but long-term physical or mental health, even when the prevailing basic law shows no such indication for legal abortion, since the argument goes not to legality of the procedure in itself, but to the specific defendant's alleged lack of proper intention. A legal system denying the existence of these defences would be awarding fetal life priority over maternal long-term health. No legal system in the Commonwealth claims this ordering of priorities, and no judge is on record as having instructed a jury in such terms.

In conclusion, it may be emphasised that, while the legislative focus of abortion provisions tends to concern indications displayed by a pregnant woman, the judicial focus concerns an accused defendant's good faith in acting to terminate her pregnancy. The court's capacity to clarify the law is contained within the confines of the prosecution's specific case and the defendant's particular defence. If a committee or other mechanism is established for authorising lawful abortion, a

defendant may successfully explain his failure to use it. Dr. Morgentaler, for instance, showed therapeutic abortion committees to be too unavailable and dilatory. If legislation is silent as to permissive means but simply expresses prohibition, courts may carve out of the residual Common law interpretations favouring an adequately well-motivated defendant. Moreover, however unfavourable to a defendant may be the judge's instructions to members of a jury (where, as is usual, trial is by jury), they retain the right to acquit where they consider in the circumstances that conviction would be unjust.

III. PROVISIONS FOR IMPLEMENTATION

Table II (see page 71) presents information on provisions for implementation of Medical Termination of Pregnancy (MTP) services given in responses received to the Commonwealth Secretariat questionnaire. Advanced laws disclose certain frequent features regulating the supply of and access to such services. These features include:

A. Performance by specified professionals

B. Performance at specified institutions

C. Stage of pregnancy

D. Approval procedures

E. Cost of abortion services

In addition, responses raised matters concerning residency, conscientious objection, and consent requirements as well as reporting procedures. These are not tabulated below, but appear to merit consideration, since they are detailed in a number of advanced laws. A number of responses indicate local practice of uncertain legal status, particularly in countries with basic and developed laws.

Patterns of formulation of local provisions vary among Commonwealth legal systems. The advantages and disadvantages of different approaches are discussed in this chapter.

A. Specified Professionals

Commonwealth abortion laws range from not specifically stating that termination procedures be undertaken by specifically qualified persons to requiring that they be performed only by registered medical practitioners, and even to requiring that the practitioners should have additional specialty qualifications. The 1861 statute does not direct that to be legal, abortion must be restricted to registered medical practitioners, although interpretation of the implied recognition of "lawful" abortion may suggest this. In jurisdictions where basic law applies, therefore, the law neither specifically requires that a procedure be confined to a doctor nor gives a doctor who performs a procedure any special protection. Abortion is just as serious a risk for the registered medical practitioner acting in good faith to preserve his patient's life or health, as it is for the untrained opportunist acting for money. It is well understood, however, that in many countries with only the basic law, many conscientious physicians terminate pregnancies upon grounds they, their colleagues and their communities consider justified. Prosecuting practice confirms this, in that enforcement of the law is considered only against untrained practitioners, and usually then only upon the incident of causing death. Some Commonwealth authorities, aware of ambiguities in their basic law or developed law, have evolved adminstrative practices to safeguard the position of physicians who undertake MTP for specified indications by reducing (to the practical point of eliminating) the possibility of their prosecution. (See, for instance, the Kenya Health Minister's 1976 statement, Table III, page 79).

The Bourne case presented the first occasion in the history of Commonwealth abortion law to consider that, as an element of its legality, an abortion procedure be undertaken by a physician. This judicial interpretation of basic law provides much greater protection against prosecution for doctors performing MTP upon physical and mental health indications. In countries where the Bourne case is persuasive, therefore, it is apparent that the law affords protection to doctors who act in good faith.

The Singapore Abortion Act, 1974, not only expresses the nature of this criminal immunity but advances it into the area of civil law. It provides in section 9 that:

> "No registered practitioner shall be liable civilly or criminally for carrying out treatment to terminate a pregnancy so long as the pregnant woman consents to such treatment and so long as such treatment is not carried out in a negligent manner."

The exception from protection in the event of negligence may be contrasted with section 8 of India's Medical Termination of Pregnancy Act, 1971, which simply states that:

> "No suit or other legal proceeding shall lie against any registered medical practitioner for any damage caused or likely to be caused by anything which is in good faith done or intended to be done under this Act."

Advanced laws invariably provide that the procedures they govern shall be performed only be registered medical practitioners. Other jurisdictions may approach this result directly through their provisions against the unqualified practice of medicine.

Singapore, India and the Northern Territory of Australia are the three Commonwealth jurisdictions that require, by statute, regulation or rule, that registered medical practitioners have specified qualifications beyond those of general practitioners. The Singapore statute states that a registered medical practitioner must have "such medical qualifications as may be prescribed;"(section 2(1)(a)). The Singapore Abortion Regulations, 1974 prescribe qualifications needed for doctors to do early abortions and those for late abortions. A medical practitioner in private practice doing abortions up to the 16th week requires at least six months experience in an obstetrics and gynaecology unit of a Singapore Government Hospital or a hospital recognised by the Minister of Health and Home Affairs. For doctors in private practice doing MTPs up to the 24th week, the 1974 Regulations (section 3(2)) require any of the following qualifications:

> "(a) Master of Medicine (Obstetrics and Gynaecology) of the University of Singapore;
> (b) Fellow of a Royal College of Surgeons; or
> (c) Member or Fellow of a Royal College of Obstetricians and Gynaecologists."

A doctor "employed by the Government and who holds, or has held, an appointment in a surgical or obstetric unit of any Government hospital

for a period of not less than six months shall be regarded as having acquired the requisite skill for carrying out treatment to terminate pregnancy" between the 16th and the 24th weeks (Reg. 3(3)).

The Singapore law waives the prescribed qualifications for a registered medical practitioner doing an MTP, section 11 providing that:

> "where the treatment to terminate pregnancy consists solely of the use of drugs prescribed by a registered medical practitioner and does not, therefore, include any surgical operation or procedure it shall not be necessary --
> (a) for the registered medical practitioner to hold the prescribed qualifications or to have acquired skill in such treatment over such period as may be prescribed ..."

The Indian Medical Termination of Pregnancy Act, 1971 (section 2(d)) provides that a registered medical practitioner have "such experience or training in gynaecology and obstetrics as may be prescribed by rules made under this Act." Rules made in 1975, changed in order to simplify rules of 1972, allow for a registered medical practitioner to qualify through on the spot training:

> "if he has assisted a registered medical practitioner in the performance of 25 cases of medical termination of pregnancy in a hospital established or maintained, or a training institute approved for this purpose by the Government." (Rule 3(b)iii)

or if he has one or more of the following qualifications:

1. Six months of house surgery in obstetrics and gynaecology.
2. A postgraduate degree or diploma in obstetrics and gynaecology.
3. Three years of practice in obstetrics and gynaecology for those doctors registered before the 1971 Act was passed.
4. One year of practice in obstetrics and gynaecology for those doctors registered on or after the date of commencement of the Act.

The purpose of these revised Rules is to enable a doctor who fulfills one or more of these qualifications, experience or training in obstetrics and gynaecology, to perform abortion, without obtaining any further certificate from any authority. The onus has thus been laid on the doctor himself to ensure that he fulfills the qualification prescribed under the Rules before undertaking abortions, or face the consequences of not possessing the requisite certification, by being penalised under the Indian Penal Code for conducting an illegal abortion. This has been done because such Certifying Boards seldom functioned and also because legal abortions are only permissible either in a hospital owned or maintained by Government or a "place" approved for this purpose by Government. (See III B below).

From observations on confining procedures to medical practitioners, and to those of them having special qualifications, a number of contending arguments emerge. It may at first seem difficult to oppose concentrating

abortion procedures exclusively in the hands of qualified physicians. Protection of the health of women is an interest of the highest individual and social priority. Emergency wards, and cemetries bear dismal testimony to the work of the unqualified. Equally, it is obvious that late abortion by surgery does more violence to delicate physiology and pysche than a procedure assisting routine menstruation, and compels the attendance of the most relevantly skilled physicians and advanced appliances. The argument finds support in the practice of conscientious physicians referring late and potentially complicated cases to appropriately equipped facilties.

The argument in favour of ensuring high standards is compelling, especially since adverse reactions to routine procedures may in principle arise from any individual case. Nevertheless, the argument can be overstated and its emphasis upon excellence may both condemn the merely good and disregard reality. If medical procedures require performance by only the most highly skilled, many fewer could be undertaken than in fact are, and skills would be more difficult if not impossible to develop. Leading physicians delegate many procedures, for which they remain medically responsible, to their staffs. They advise, supervise, and are at hand, for instance, in the event of an emergency.

In both developed and developing regions of the Commonwealth, properly trained midwives, public health nurses and comparable health and auxiliary personnel can conduct procedures early in pregnancy under adequate supervision. An advantage of their involvement may be their ability to provide a higher quality of pre- and post-abortion care and counselling than a busy physician, thereby securing better and more confidential overall patient management. They already play an important role in fertility control, including menstrual regulation to which the earliest abortion is analogous. Further, as research produces non-surgical abortifacients with controllable side-effects, a physician's proximity to their employment can be reduced, and effective management can be projected along more extended lines of delegation. Legally restricting medical services to the most scarce and costly personnel may prejudice community services.

In countries where qualified physicians are in inadequate supply, or are unevenly distributed, moreover, many procedures have to be undertaken by health and auxiliary personnel. The alternative is the unavilability of such procedures to those unable to acquire privileged treatment, and in particular by purchase. To set artifically high standards for delivery of overall health care seems unrealistic and indefensible in creating a service genuinely intended to relieve hazardous or oppressive pregnancy a given society has decided may be terminated. The allocation of health care resources to achieve optimal social benefit and justice is a continual concern of governments and national health professional organisations, and there may seem no case to distort the balances naturally devised by statutory directives or prohibitions centred upon pregnancy termination as opposed to other medical procedures. In particular, deployment of scarce medical specialists must be governed by overall strategies of hospital and other facility administrators to accommodate unscheduled priorities, and the rigidity of legislative prescriptions may have no place here. No other

laws specifically direct responses to medical needs, since medical personnel are trusted to balance performance of procedures and resources. Abortion services seem on medical grounds not to warrant such legislative intervention.

B. Specified Institutions

For the same reason that most Commonwealth abortion laws do not specify professional qualifications for MTP, being only basic or developed laws, so equally they do not specify where procedures may be conducted. There may be the same merit in non-specification moreover, namely that reliance must be placed in health administrators to accommodate their services to their institutional resources. Rigid statutory formulae may not improve their distribution of services but may obstruct appropriate response to health needs.

Advanced laws, such as exist in, for instance, Singapore and India, tend to accommodate MTP in defined government hospitals, and in other facilties specifically given health ministry approval. While all advanced laws thus accommodate both public and private sector facilties, however, the latter may be restricted in practice by requiring standards difficult for them to satisfy, or by not stating what the standards are. Canadian law, for instance, permits therapeutic abortion committees to approve procedures "in an accredited or approved hospital" (Criminal Code, section 251(4)(a)), as defined by central and provincial authorities for accredited and approved hospitals respectively, but the Badgley Report found as a matter of experience that:

> "Hospitals which would be permitted to establish a therapeutic abortion committee in some provinces would not be allowed to do so in other provinces. The requirements did not specify the services and facilities required for the abortion procedure when this operation was done on an out-patient or in-hospital basis or by the length of a patient's pregnancy." (p. 106)

Differences between standards required of facilities undertaking out-patient and in-patient services will become important as technology advances and barriers to early abortion are removed. Advanced laws seem not adequately to deal the with difference, however, relegating the function of specification to subordinate regulations or rules. These appear to be based upon consultations between legal and health personnel, and embody the detailed accommodation of needs to resources that comprises the discipline of hospital administration. The exercise is of inherent interest, and no doubt offers esoteric satisfactions, but it may also appear to degenerate into the drafting and promulgation of words that either support a weighty enforcement bureaucracy, or will be ignored. Insofar as they embody current practice, their expression does not control it, and insofar as they vary from practice, they either restrict hospital and other services which physicians are prepared to undertake, or create areas of shadowy legality.

Experience discloses that the complex authorising mechanisms with which countries such as India and Singapore initiated advanced laws, have been progressively simplified. India's first Rules implementing the Medical Termination of Pregnancy Act, 1971 were changed within five

years to ease the accommodation of places providing MTP services. Under new Rules (Rule 4(6)), MTP clinics can obtain a licence issued by Government simply upon a recommendation from the district Chief Medical Officer rather than prove conformity to 1971 requirements of specially devised and rarely constituted certifying boards. An exception to the locational requirement is given in section 5(1) of the Medical Termination of Pregnancy Act, 1971 "that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman." Singapore has excluded MTP by use of drugs alone from its specific approval mechanism. The British Department of Health and Social Security in 1975 authorised termination of pregnancies of under 12 weeks' duration in private day-care abortion centres, and immediately licensed two private charity organisations to operate.

The argument in favour of detailed supervision is that it promotes a high quality of care, and reduces or accommodates emergencies. Similarly, it may be required in late, surgical abortion when a viable fetus may be produced. The contending arguments are that closely drafted regulations over-intensify adminstrative and penal concerns irrationally; early abortion is shown to be safer than normal childbirth, management of which is not hedged around with such provisions. Medical procedures other than for MTP are not so governed, and it may be appropriate to trust the clinical judgment and resource-allocation of the medical profession in conducting such procedures no less than in conducting others.

C. Stage of Pregnancy

It is uniformly recognised that earliest abortion is safest abortion, and that the later in pregnancy a procedure is undertaken, the more demanding it is of trained skills and scarce resources. This explains the implementing provisions of advanced laws noted above directing later abortions to more highly trained specialists and better equipped facilities. In addition, some enactments excluded the availability of, for instance, social or socio-economic indications for later abortion, leaving only justifications of preservation of life or health. Further, the Indian Medical Termination of Pregnancy Act, 1971 requires the approval of two registered medical practitioners between 12 and 20 weeks of pregnancy, but requires only the opinion of the performing doctor during the first 12 weeks. These provisions expose a rational progression of permitting earliest abortion on the broadest indications, through permitting later abortions on restricted grounds to permitting child destruction "for the purpose only of preserving the life of the mother." (English Infant Life (Preservation) Act 1929, section 1(1)).

A number of advanced laws establishing provisions on employment of specified professionals and/or specified institutions exclude their application where there is risk to the woman's life or of grave injury to her health. The development is expressed in the Criminal Law Consolidation Ordinance (No. 2) 1973 of the Northern Territory of Australia. This permits a gynaecologist or obstetrician acting in a hospital to terminate a pregnancy not exceeding 14 weeks' duration upon general therapeutic and eugenic grounds, confirmed by a second opinion. It allows any medical practitioner to act alone where a woman's pregnancy is of not more than 23 weeks' duration if immediately necessary

to prevent grave injury to her physical or mental health, and to act at any later time for the purpose only of preserving her life.

The argument in favour of increasingly narrow permission of MTP is that duration of pregnancy increases risks of its termination. This argument presupposes, however, that early abortion is available and accessible, but approval procedures and similar non-medical requirements may cause delays in the timing of procedures that bring them into later periods when they are proscribed by increasingly restrictive laws. Similarly, such laws may negative a eugenic indication for therapeutic abortion, since certain congenital disorders affecting a fetus may occur, be caused or be detectable only later in pregnancy. Amniocentesis to monitor genetic defects, for instance, is impossible to perform until pregnancy is 14 to 16 weeks advanced, and requires four to six weeks to culture results. Limits may, of course, be prudent, but their application may be better left in the hands of physicians aware of all the circumstances of each case at the time of occurrence rather than be predetermined by legislators. Limits may be provided in flexible guidelines laid down specifically for a particular facility or region based on local and up to date knowledge.

Responses to the Commonwealth Secretariat's questionnaire indicated that in practice such guidelines often exist. Ghana's interpreted developed law, for instance, is confidently applied by medical practitioners up to a 16 week period, while the Bahamas' similar law is comparably applied up to 20 weeks, but others, such as Belize, run up to 28 weeks. Still others, such as Tasmania, indicate a limit of viability, leaving it up to the discretion of the doctor to determine such a state. The fact that these practices parallel express provisions in advanced laws suggests that they offer the same benefits of conscientious protection of patient's health, but also offer a level of adaption to evolving local circumstances legislation may obstruct.

D. Approval Procedures

Since most laws are at the basic or developed stage, they have no implementing provisions governing approval of MTP. They require, however, that a physician act in good faith, and the traditional method in practice of demonstrating good faith is to obtain and document a second medical opinion. This shows the procedure not to be clandestine, and may dilute or obscure responsibility for its choice and, more therapeutically, bring more information and critical judgment to bear on the circumstances. Advanced laws have institutionalised this by incorporating requirements of documented concurring opinions or of committee majority approval.

These laws are illustrated by the requirements of the British Abortion Act 1967 that "two registered medical practitioners are of the opinion, formed in good faith" (section 1(1)) that an indication for abortion specified in the Act is satisfied; regulations under the Act (see Appendix II, page 92) govern certification of these two opinions, but they are not required to agree as to the indication justifying the approved abortion. The Indian Medical Termination of Pregnancy Act, 1971 requires for pregnancies between 12 and 20 weeks the opinions of "not less than two registered medical practitioners" (section 3(2)(b)), although it does not state when more than two opinions must be sought nor

indicate the effect of the two being a minority of five or more opinions.

More specific and demanding is the Zambian Termination of Pregnancy Act, 1972, section 3(1), which permits a registered medical practitioner to perform an abortion:

> "if he and two other registered medical practitioners, one of whom has specialised in the branch of medicine in which the patient is specifically required to be examined before a conclusion could be reached that the abortion should be recommended, are of the opinion, formed in good faith..."

that physical or mental health, or eugenic indications are satisfied.

The most bureaucratic approval procedure exists under the Canadian Criminal Code, section 251(6) allows an accredited or provincially approved hospital (see B above) to constitute a therapeutic abortion committee "of not less than three members each of whom is a qualified medical practitioner," a majority of whose members may then authorise abortion to be performed by " a qualified medical practitioner, other than a member of a therapeutic abortion committee for any hospital,"(section 251(4)(a)). Complex though approval procedures may be, however, most provide exceptions for cases of emergency when life or health are at grave risk, and in any event the Common law justification of necessity would apply to such emergency, as the Morgentaler case showed in Canada.

The case for an approval procedure is to authenticate that abortion is performed only on a legal indication; the fact that the indication approved is not required to be common to the two or more opinions, suggests that the procedure is not really aimed at improving health care. It may be argued against such a legal requirement, however, that insofar as it embodies medical practice it is superfluous, and that in establishing form, it may fail to protect substance; that is, the second opinion may be given as a matter of routine, and the woman's condition not really be independently assessed. As in the case of other implementing provisions, moreover, the requirement distinguishing abortion from other comparable and more drastic medical procedures.

Further problems arise with a committee system, the abolition of which in Singapore after five years' experience may be instructive. Committee references increase delay (see IV C, page 42), reduce privacy, and can be unduly humiliating and degrading in a field where many women are routinely shy, not just because of embarassing origins of their pregnancy. Committee approval, in common with other second opinion provisions, may also increase the costs of MTP; few laws govern the fees that may be charged for that opinion. The incentive to earn fees may be medically counter-productive, it may be noted, in that a doctor requested to offer a second opinion may have an incentive to favour abortion to induce the referring doctor to seek subsequent opinions from him in other cases. Finally, it may be noteworthy that no Commonwealth laws provide for a formal appeal procedure against the opinion of doctors or hospital committees.

F. Costs of Abortion Services

The costs of abortion services are absorbed and distributed according to a variety of patterns in Commonwealth countries and jurisdictions, and the law implements the patterns that are favoured and pursued. They range from the national health and insurance scheme of the welfare state such as operates in the United Kingdom to unorganised recourse to individual self-reliance, in which the consumer of a service bears full economic cost.

Legislation regulating national health services makes no special reference to abortion, and governmental health insurance schemes operating within less comprehensive welfare programmes similarly absorb abortion costs along with other costs. The expenses can be broken down quite comprehensively to include, for instance, the costs of running referral services, pre-abortion testing and counselling, obtaining two or more medical opinions, providing the procedure itself, follow-up care and lost income to the woman for the time taken for the treatment. These costs clearly are greater the later the abortion is undertaken, but they must be set against less immediately calculable but more weighty costs. These include, for instance, the wasted investment in instruction of an unmarried girl whose education and career are ended by having to support an unwanted child, the economic loss of a trained woman leaving the labour market, or the public costs of maintaining a severely deformed child whose birth eugenic abortion could have prevented. The economic cost must also consider the expense of not having a safe legal abortion service, namely the cost of having unsafe illegal abortion. Items include maternal mortality and morbidity, involving hospital resources tied up in treating septic abortion and the aftermath of female internal mutilation.

Few responses to the Commonwealth Secretariat's questionnaire were informative on costs, and those touching the issue gave only limited information. Most governments replying provide free services in public hospitals, or a subsidised service depending on the patient's means or those of her family. Table II below shows some costs detailed, those from Australia most clearly distinguishing costs to government from those borne by the woman. The fear that desperate abortion applicants are easily exploitable by mercenary physicians is faced by statute, however, only in Singapore's Abortion Act, 1974. Subject to a power of Ministerial variation, section 10 provides that:

> "(1) Where treatment to terminate a pregnancy is carried out in a government hospital the fee payable for such treatment shall be five dollars.
> (2) Any additional hospital costs that may be incurred in the Government hospital where such treatment is carried out shall be borne by the pregnant woman."

This means, of course, that she is responsible for meeting such costs, not that it is improper for another to pay them for her.

Remuneration of physicians may be by the state on a salaried basis or on a fee-for-services basis. Limiting fees payable for salaried services raises no issues specific to abortion, but limiting fees in the private sector may make services less available to women with the means

to pay without making them more available to women without such means. No abortion laws in Commonwealth countries address the issue of the supply and social equity of abortion services through regulation of the cost mechanism.

F. Additional Provisions

(i) Citizenship or Residency Requirements

Countries that have enacted advanced laws may have feared that these might attract women from other countries within their regions. Accordingly, two Commonwealth jurisdictions (Singapore and South Australia) implement such laws subject to the condition that women having recourse to them must have a proper link with the country, usually citizenship or residency of defined duration. Countries with established national health programmes may be less attractive to this issue, however, since they have usually worked out general policies for supply of health services to non-nationals.

The United Kingdom in particular is accustomed to visitors coming specifically for the specialised health services offered in the prestigious centres of private-sector medicine.

Singapore, for instance, may have intended to discourage the chanelling of abortion services to women from nearby countries with restrictive laws. Section 3(3) of its Abortion Act, 1974 provides that:

> "No treatment to terminate pregnancy shall be carried out ... unless the pregnant woman is a citizen of Singapore, or is the wife of a citizen of Singapore or unless she has been resident in Singapore for a period of at least four months immediately preceding the date on which such treatment is to be carried out,"

the terms conclude, however, that:

> "the provisions of this subsection shall not apply in any case where such treatment is immediately necessary to save the life of the pregnant woman."

Although the selection of the four-month period may not have been done with this intention, its effect may be to provide for the termination of non-citizens' pregnancies commenced in Singapore. The amended Criminal Law Consolidation Act, 1935-1969 of South Australia, however, requires only two month's residence. Some physicians apply this provision as not necessarily requiring the residence test to be satisfied immediately prior to the operation.

South Australia may be concerned with inter-state services within Australia rather than with the more international concerns felt by Singapore, but the Badgley Committee in Canada showed how parochial individual hospitals can be in evolving practice patterns. Anxious to confine their abortion services to the population of of their general catchment area, hospital committees simply decline

applications from women whose given home address lies elsewhere. Such residential grounds of exclusion from services are not included in the Criminal Code, however, but exist in such documents as hospital by-laws to which the general public does not have easy access.

(ii) Conscientious Objection Clauses

Basic and developed laws, being only negatively phrased, do not positively accommodate the conscientious beliefs of medical, health and auxiliary personnel. Several advanced laws allow those with religious or other conscientious objection to induced abortion per se, as opposed to objection based on the features of an individual case, to be exempted from participation. In contrast to the Canadian and Indian laws, which have no such provision, the British Abortion Act 1967 expresses its conscience clause widely. Section 4(1), provides that:

> " ... no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection:
>
> Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it."

Conscience clauses cover all persons participating in an abortion procedure, including surgeons, general physicians and nurses, but do not explain the extent of participation; it is unclear if it includes, for instance, serving meals, administering general or local anaesthetic, and giving post-operative care. It may be made clear, however, that no-one may invoke his own conscience in an emergency, since section 4(2) of the British enactment declares that:

> "Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman."

The presence of a conscience clause does not compel those prepared to participate in abortion to serve in any particular case when conditions of the law are satisfied, but they cannot invoke the conscience clause to be exempted from a particular case. Equally, a physician could not invoke the clause to avoid operations as part of his public hospital duties while undertaking them in his private practice.

Requiring that one claiming this exemption shall discharge the burden of proving his conscientious conviction on the general issue of induced abortion simply requires him to show the conviction he has, and not his adversary in litigation to prove the beliefs he does not have. This in compatible with his burden under standard litigation. The British Abortion Act 1967 includes an evidentiary aid in Scottish proceedings that Zambia applies universally.

Section 4(3) of the Zambia Termination of Pregnancy Act, 1972, provides that:

> "In any proceedings before a court, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof /that he holds such objection/."

It may be noted that in jurisdictions incorporating conscience clauses, medical professional associations usually insist as an ethical requirement that exempted physicians refer applicants for abortion to another physician.

(iii) Consent Requirements

Few abortion laws mention consent, although one or two state in terms what is evident without expression, that the woman involved must consent to performance of the procedure upon her. The Indian Medical Termination of Pregnancy Act, 1971, is somewhat distinctive in saying in section 3(4)(a) that "No pregnancy of a woman, who has not attained the age of eighteen years ... shall be terminated except with the consent in writing of her guardian." Most legal systems contain age consent requirements, of course, but these are to be found under general laws on age of majority and, if different, age of consent to medical procedures or just to surgery. Where age consent requirements exist, ages vary from the traditional age of majority of 21, down to the age of independent consent to surgery in the Canadian province of Quebec of 14; this is the same age as in the Australian state of New South Wales. Many legal systems also take into account of concurrent Common law doctrines of the "mature minor" and "emancipated minor", to recognise autonomy in those under age who in fact take decisions affecting their own circumstances, for instance, when they live alone, are self-supporting or married.

The question of parental consent or other proxy, substituted or surrogate consent is also governed under general medical laws. It raises special difficulties regarding abortion, however, since such laws permit a parent or other lawful guardian of a child to veto performance of medical therapy. Legal issues arising for example when a Jehovah's Witness parent refuses blood-transfusion for his child show the nature of the problem. Child welfare laws requiring guardians to provide their charges with advised medical care do not seem to resolve the dilemma completely. The problem may be compounded when the woman's husband is himself a minor. The usual solution for married minors is to require the husband's consent for treatment to which his wife is too young to consent alone (although as an emancipated minor she may be authorised); but since age of marriage provisions are usually not always integrated with medical consent laws, he may give decisive consent to surgery on his wife when he is strictly unable to give consent to surgery upon himself.

While a husband's consent may be required on grounds of his wife's minority, no Commonwealth law requires his consent as a

party interested in the continuation of the pregnancy; similarly, no abortion laws consider the continuing interest of the biological partner in the pregnancy he created. The only recognition of his intervention is found under section 5 of Singapore's Abortion Act, 1974 providing punishment for anyone coercing, intimidating, compelling or inducing a woman to undergo abortion against her will. (See II, F, ix, page 18).

(iv) Reporting Requirements

The special regard in which the abortion procedure is held is shown in the frequent, complex and individualistic provisions for reporting to government departments on procedures performed and patients' characteristics. These spawn related provisions governing protection of confidentiality and the nature and duration of storage of data. Appendix II below gives illustrations of reporting provisions under the laws of Britain and of Singapore.

Compatibly with the variety of provisions, for instance, on pre-termination or post-termination reporting, they disclose no uniform purpose. They may be designed to guard against operations being performed in breach of the law, or to show that only lawful procedures are conducted in public facilities, or in private facilties. Some furnish data for analysis by health care researchers, or demographic or epidemiological evidence, but these purposes may be inconsistent with provisions limiting access to reports to preserve the patient's confidentiality. Similarly, scientific use of reports is constricted in that they tend to be confined to abortions performed, as opposed to procedures sought.

The Canadian Criminal Code, for instance, provides in section 251 (5) that the Minister of Health of a province may by order require that he be furnished with a certificate of medical opinion authorising abortion, "together with such other information relating to the circumstances surrounding the issue of that certificate as he may require;" he may also require the operating physician to give similar information. There is no comparable power to obtain reasons for refusal of an operation, even though refusals were shown in the Badgley Report often to be based on a health facility's inability to cope with demand for abortion services because the provincial health ministry has failed to make adequate resources available.

IV. NATIONAL ASSESSMENTS AND PROPOSALS FOR CHANGE

A. Generally

Table III below presents the information received in response to the Commonwealth Secretariat's questionnaire on evaluation of present laws in Commonwealth jurisdictions, and changes proposed by governments and professional associations. Specially appointed governmental commissions have recently reported on the operation and effects of advanced laws (for listing of governmental Reports see page 129) and other such commissions and, for instance, medical associations in jurisdictions with basic and developed laws, have made observations and proposals for change. These documents and commentaries vary in scope, purpose and depth, but together they provide streams of evaluation that feed into a pool of common experience of how abortion laws operate. Beyond these more traditional sources of information and criticism of legal availability of abortion services, a number of government-sponsored and independent groups concerned with the social, legal and economic status of women have expressed views, most of which favour refinement of existing legal prohibitions. From these more and less systematically undertaken investigations, proposals have arisen for such legal changes that reflect upon the unsatisfactory situations jurisdictions experience. A commentary on these assessments and proposals for change follows.

Opposition to changes broadening the scope of legal abortion has been expressed, of course, from predictable and also less predictable sources. Such opposition infrequently recommends alternatives to the status quo, except at times in favour of better family planning, better sex education, and restraint of the sexual appetite. Equally, however, opponents of legal change rarely find the situation within their jurisdictions satisfactory, and their contribution to change is negative in the sense of challenging proposals for change and ensuring that public debate on the issue is rounded. They add valuable dimensions to that debate, and give credibility to the processes that, by recorded observation, have prevailed against them to achieve legal reform.

Continuing opposition to passage of Britain's Abortion Act 1967 expressed itself as criticism of how the Act was being applied, and in June 1971 a committee was established to review its operation. The committee headed by the Honorable Mrs. Justice Lane, of the English High Court, with the exceptional if not unique feature that its fifteen person membership included ten women, issued its three volume report in April 1974. In accordance with the committee's unanimous conclusions, the text and effect of the Act were not changed, although subsequent thinking has brought about very minor changes in the implementing Regulations. (See Appendix II, page 100).

A comparably thorough statistical study was undertaken in Canada from late September 1975 under the auspices of the three-person (two female) Committee on the Operation of the Abortion Law, chaired by Professor Robin Badgley and presenting its 474 page report in January 1977. Unlike the Lane Committee, the Badgley Report was expressly excluded from making recommendations for change of the law, but the data it presented furnish material for criticism of Canadian abortion law,

and point to paths it might beneficially follow. The New Zealand Royal Commission on Contraception, Sterilization and Abortion was established in June 1975 under the Honorable Mr. Justice McMullin with a six-person (three female) membership. Its 454 page report, published in March 1977, was more philosophical than that of the Badgley Committee and less statistical than either the Lane or Badgley Reports, perhaps because its terms of reference were to consider legal,social and moral issues. It was enabled to consider legal change, however, and appears to have modelled its approach to the issue of abortion on that of the Lane Committee. The New Zealand Government has undertaken to introduce a Bill to implement recommendations made by the McMullin Committee for legal reform.

There is currently pending in Australia, a report which may prove comparable to those described above in size and scope, but dealing less specifically with abortion. The Report of the Royal Commission on Human Relations chaired by the Honorable Mrs. Justice Evatt, may, however, consider the location of abortion provisions in the interaction of state and federal laws.

There already exist in Australia annual reports of the standing Committee Appointed to Examine and Report on Abortions Notified in South Australia. This was established by the Government of South Australia to monitor the operation of its amended law, with authority to interview those who might be abusing its provisions. The value of annual or other periodic reports is in their ability to identify evolving attitudes to the practice and law of abortion. The sixth annual report (for 1975) of the South Australian Committee was able to observe, for instance, that "it is evident that much of the heat in debate over this Legislation is cooling" (p.3), and that evidence existed that "may indicate a more general acceptance of the 'on demand' principle."(p.5).

Not more trivial in substance but more simple in form are reports such as those of the Senate Select Committee on Population Trends in Fiji, whose Second Report (1976) included a Review and Recommended Revisions of Abortion Laws of Fiji. This relatively brief (16 pages) report is wide ranging and perceptive, looking out from a confined base to a world-wide horizon. Noting the evolving status of women, for instance, the Committee recorded that "countries which have adopted most liberal abortion laws are those which, with the exception of Japan, have most fully recognized and implemented an equal status for women." (para. 27). The Committee concluded its review by recommending adoption in principle of the British legislation of 1967, but interestingly rejected the need for a second medical opinion, urging that "the decision to perform an abortion be with the patient and her physician."(para. 137 (4)). It had already observed the claim that "the procedure under which abortion petitions are reviewed by hospital committees is but a thinly disguised attempt to perpetuate men's control over women in view of the all-male or nearly all-male composition of such committees."(para. 28).

A number of medical reports favour introduction of indications for abortion drawn from the British Abortion Act 1967, but add a further indication found in an explanation of the Indian Medical Termination of Pregnancy Act, 1971. Explanation II of section 3(2)(i) is that:

"Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman."

There is no reason in principle, of course, to presume that an unmarried, separated or widowed woman's anguish of mind would be any less.

The Report of the National Committee on the Law of Abortion of Barbados, published in March 1975, and, for instance, the St. Vincent Medical Association in its independently developed report of May 1977, considered the most useful role of abortion is not to replace or rival contraception, but to provide back-up or fail-safe insurance. It seems proper that a woman taking the step to seek contraceptive guidance, should be offered protection against pregnancy while means available continue to have an irreducible minimum risk of failure.

Replies to the Commonwealth Secretariat questionnaire show mechanisms for legal reform to be well in place in many countries, although many intend to broach the subject at the level of public debate with caution. The Law Reform Commission in Ghana put forward three alternative draft proposals in 1973, and the National Population Council of Nigeria has recommended abortion on request following the Nigerian Medical Association's support of law based on the 1967 British enactment. Similarly, Bar Associations in several countries have recommended broader grounds for abortion. A Bill directed to formulating an advanced law received consideration in 1973 by a Select Committee of the Legislature of Bermuda, and Nauru is considering a comparable Bill in line with reform of its criminal code. Other jursidictions facing issues of legal control of abortion need not be cited since they are shown in Table III (see page 79) to demonstrate the wave of concern in the matter sweeping through influential agencies in Commonwealth jurisdictions.

Distinguished by their inactivity are the courts. Canada, Australia, New Zealand and Fiji have recently experienced proceedings that have gone far to clarify and develop their laws, but these proceedings are exceptional even in the jurisdictions in which they occurred. The dearth of prosecutions for offences against abortion laws shown them to be almost completely unenforced. The overwhelming majority of jurisdictions have no recorded instance in their recent or longer-term history, or indeed ever, of a prosecution of an illegal abortionists or of a woman employing his services, or performing a procedure upon herself. In view of the significant rate of illegal abortion, its known burden upon the publicly funded emergency services of general hospitals, and, most tragically, the number of dying declarations of victims of illegal procedures naming the abortionists, it appears that prosecuting authorities have no intention of using the law's penal provisions to eliminate or at least reduce the rate of illegal abortions. There is little short of perfect uniformity within Commonwealth jurisdictions in law-enforcement authorities giving abortion law execution very low priority. This in itself gives cause to assess the expression and effect of these frequently violated, rarely enforced laws, and compels ideas of bringing

the terms of the law into accord with the experience and potential of their enforcement.

A not uncommon inspiration for reform of the law arises from its unsuccessful use in litigation, and the two major abortion law reports published in 1977, Canada's Badgley Report and New Zealand's McMullin Report, were closely associated with prosecutions of physicians who terminated pregnancies in specialised clinics. In the Morgentaler and Woolnough cases, furthermore, the juries acquitted the physicians in the face of knowledge not only of the nature of the incidents charged, but of the nature of the procedures the physicians were in the business of undertaking.

The main findings and, where they were made, proposals for change recommended by the Lane, Badgley and McMullin Reports are commented on below.

B. Report of the Committee on the Abortion Act (The Lane Report: Britain,1974)

For the purpose of evaluating the effects and workability of an advanced law, perhaps the most important recommendation of the Lane Report is for ...

> "the wording of the /Abortion/ Act laying down the criteria for abortion to be left unamended."(page 71).

The Committee's confirmation of the 1967 Act's indications for abortion, after its members undertook a considerable depth of study and received representations based both upon experience and principle, places the burden of proving his case upon anyone arguing against introduction of such a law, or against its introduction in this form. The Report contains evidence from which such a case may be built upon particular issues, but on a clear balance the Committee reports unanimously "that the gains facilitated by the Act have much outweighed any disadvantages for which it has been criticised."(para. 605). It was concluded that "By facilitating a greatly increased number of abortions the Act has relieved a vast amount of individual suffering."(para. 600). This leaves open the question, of course, of how it might be improved to relieve more.

The Report identified needs that may have appeared obvious, such as for better preventive action, education in sexual life and its responsibilities, the wide-spread provision of contraceptive advice and facilities, and for abortion facilities in public hospitals. The lack of the last in particular resulted in "marked inequalities over the country in the provision of services."(para. 601). The Lane Committee commented on abuse of the Act by a small number of richly-rewarded physicians, but desired equality in providing that the speed and confidentiality of service they offered should be available as well in the public sector, without women having to pay exorbitant fees. The solution to abuse was considered better sought by provision through administrative and professional action than by legislation.

The Lane Committee recognised the problem of the ethical claims of the fetus, and the conflict with those of the mother and her existing

family, but declined to take a position as a Committee, because of the individual quality of the decision required to be made. More incisively, however, the claims of a conscientious objector to participation in abortion procedures were identified, and evaluated at a lower level than the claims of women to therapeutic services as legally defined. With "great reluctance and hope that the occasions for such a decision will be rare", the Committee stated the view that "the needs of the many must take priority and that inevitably some who refuse this work may not obtain a particular appointment" (para. 607).

At a wider level, the Committee realised that its "generally tolerant attitude may disappoint those who see the Act and its workings as evidence of a serious and progresssive decline in the standards of morality in sexual behaviour" (para. 608), but was no less concerned with "the woman, who, after anxiety, heart-searching and doubt, decides to seek an abortion" when in "a situation which would often be tragic for her" (para. 609). The view was expressed that "we do not think that the Abortion Act can be interpreted, or should be used, in a punitive way in an attempt to improve this society's morals and to diminish sexual misbehaviour."(ibid.) Noting the rapid changes in attitude and opinion since the Act was passed, the Committee observed that "Progress in the emancipation of women, advances in medical research and the pressures of a population explosion ... will ensure that further changes will occur."(para. 610). This observation is compatible with the Committee's recognition that:

> "An unascertainable number of abortions performed in purported compliance with the Act are, strictly speaking, illegal because of disregard of the criteria of the Act."(para. 509).

In its more detailed recommendations, the Lane Report favoured an upper time-limit for abortion of 24 weeks' gestation, after which artifical termination of pregnancy should be by inducing labour and attempting to preserve the life of the child so born; this would restrict, for instance, the use of saline injection. In particular, however, it was very strongly urged that abortions be performed before the twelfth week of pregnancy and that delays to such an early procedure be avoided and minimized by, for instance, greater and more equitable provision of procedures through the National Health Service. Counselling and after-care services were recommended with special attention paid to girls aged under sixteen, higher parity or older women, and those seeking repeat abortion.

Regarding delivery of abortion services and information, the upgrading of gynaecological services in general was favoured over the establishment of special abortion units in hospitals. In the private sector, where referral agencies operate to direct women to private practitioners, it was recommended that fee-charging agencies be licenced to exclude from operation those not providing medical consultation. Beyond that, however, the private sector was to be allowed to function, without control on fees, special qualification requirements of practitioners, or restrictions on supply of services to foreign residents.

Regarding girls aged under sixteen receiving contraceptive instruction without parental consent or knowledge, differing views

existed within the Committee; it was reported, however, that:

> "A majority of members believe that in exceptional cases doctors should make contraception available without the knowledge or consent of the parents where the girl has refused to consent to their being told, on the ground that in such cases this may be a lesser evil than allowing the girl to run the risk of pregnancy."(para. 245).

C. Report of the Committee on the Operation of the Abortion Law (The Badgley Report: Canada, 1977)

The Badgley Committe was established after successive juries found it had been necessary for Dr. Morgentaler to perform abortions outside the permissive terms of the law because in Montreal, a city well served with hospitals, abortion services were not available within those terms The Committee was required "to conduct a study to determine whether the procedure provided in the /Canadian/ Criminal Code for obtaining therapeutic abortions is operating equitably across Canada." The Committee found, compatibly with the Morgentaler juries, that it was not, and the data accumulated provide material for instruction and warning to jurisdictions about to institute an advanced abortion law. The Report details the facts and dynamics of inequality, while remaining faithful to the imposed constraint of not criticising the policy of the law.

Canadian abortion law provides for specially composed therapeutic abortion committees to consider abortion applications in the light of indications of developed law; that is, to consider whether "the continuation of the pregnancy ... would or would be likely to endanger /the woman's/ life or health,"(section 251(4)(c), Criminal Code). The Badgley Committee found that many physicians and nurses, to say nothing of patients, did not know the terms of the abortion law, and on being questioned, revealed significant misapprehensions as to what it allowed. Many health professionals, for instance, approved the law's tolerance of indications for abortion such as rape and congenital fetal defect, which in fact Canadian law does not recognise. It was observed that "lack of knowledge or inaccurate knowledge about the law poses a major dilemma in how its procedures operated in practice."(page 66).

The main problem the Badgley Committee found was one upon which the members were required not to comment, namely that abortion has been singled out from the whole range of medical treatments for special attention. Only special hospitals are eligible to undertake abortion procedures, by reference to a number of tests of equipment and staff not uniformly applied; only eligible hospitals can apply for permission to establish a therapeutic abortion committee, but no such hospital need apply. A therapeutic abortion committee, once established, can see its role as fastidiously to screen applicants on medical, pyschiatric and legal grounds, to safeguard the hospital, its medical and auxiliary staff, and themselves, from the risk of liability to up to life imprisonment for participating in an illegal abortion. As against this, other committees may rarely meet together, but by telephone and correspondence approve applications as a matter of course, subject only to keeping within their facility's periodic quota of surgical time and hospital beds that can be devoted to the procedure.

Of all civilian hospitals in Canada, only 20 per cent had established a therapeutic abortion committee. Committees often imposed internal rules restricting their service where it might be offered within the law. Many declined applications, for instance, from women living outside their regular catchment area by setting undisclosed residency tests. The Committee found that:

> "the combined effects of the distribution of eligible hospitals, the location of hospitals with therapeutic abortion committees, the use of residency and patient quota requirements, the provincial distribution of obstetrician-gynaecologists, and the fact that the abortion procedure was done primarily by this medical specialty resulted in sharp regional disparities in the accessibility of the abortion procedure."(page 28).

Unlike the Lane Committee, however, which favoured upgrading gynaecological units in general facilities, the Badgley Committee was persuaded that specialised abortion units or clinics concentrating upon fertility regulation and female health were of advantage, since concentration of skill and experience increased proficiency. It was found that "hospitals performing the largest number of abortions had the lowest complication rate in spite of performing a larger number of abortions in the later stages of gestation."(page 29). Specialised centres could also attract staff, such as nurses, not averse to the procedure.

Safety in abortion is obviously associated with the woman's stage of gestation, and the Committee favoured making abortion available at the earliest stage possible. It was found, however, that on average, women took two point eight weeks after first suspecting pregnancy (not just after actually becoming pregnant) to visit a physician, and that after this the average interval was eight weeks until the abortion was induced. The eight week average is ominous in light of some committee's "rubber stamp" approach. The delay resulted from the manner in which physicians, hospitals and therapeutic abortion committees often interact among themselves to evaluate their increasingly desperate and frustrated applicants. The Badgley Committee found that:

> "many patients get the medical 'merry-go-round' treatment. This sequence of events is costly to the public purse, heightens the level of stress among patients, and extends the length of their pregnancies for many women."(page 19).

For the women legally entitled to abortion, the Badgley Committee exposed the Canadian delivery system as a health hazard.

Physicians appeared unaware of this situation, a number believing that Canada had, de facto, an abortion-on-request system. When asked in a national survey undertaken by the Badgley Committee how long was the delay between consultation with a physician and induction of abortion, only one in two hundred recognised it was eight weeks.

The Badgley Committee was unable to comment upon an aspect of the functioning of abortion committees the lawyer would find the most disturbing, namely the complete absence of any entitlement of applicants to due process. Provision exists in the Criminal Code for a provincial

Health Minister to receive a copy of a certificate authorising an abortion, together with such other information relating to its issue and the procedure conducted under it as he may require, although no Minister appears ever to have taken this initiative. This is no provision, however, for a Minister, an applicant, her physician or any other person to receive grounds of refusal of an application. The need for means to question decisions (other than by application to another committee) may appear from evidence of committee requirements. The formula of the Criminal Code must be observed, of course, but many committees impose additional and at times idiosyncratic demands. For example, a number had residence tests, quotas and gestational limits, but beyond that many had a series of further requirements. Two-thirds (68.4 per cent) of committes required consent of the woman's spouse if she was married and one out of five (18.4 per cent) required this even if the couple were separated or divorced. Some committees required consent of the male responsible for conception even if the woman had never been married.

Related to provincial laws on the age of majority, it was found that "there was a diversity of consent requirements relating to the age of the woman and to /consent of/ the father."(page 238). The age of consent to medical treatment appears to range from 14 in Quebec, to 19 in some Maritime provinces, even though the general provincial age of majority may be higher; in Quebec, for instance, it is 18. This leaves open the way to uncertainty, since some committees observe the age of consent to medical treatment (16 in Ontario, for instance) while others in the same province observe the general age of majority (18 in Ontario). Below the age of majority or medical consent, which may be above the age of marriage, the position is even less certain since the girl's parents may disagree as to therapeutic abortion, and a spouse or other male causing the pregnancy may himself be a minor.

Reasons upon which abortion committees have allowed abortions are not more satisfactory. The Criminal Code accommodates no eugenic indication for abortion such as gross abnormality of the fetus, not a juridical indication of rape or incest. Nevertheless, in 87.7 per cent of hospitals the possibility of deformity or congenital malformation of the fetus was considered in review of a pregnant woman's medical history, and "pregnancy resulting from rape or incest was a consideration given high priority by therapeutic abortion committees, most of which (80.6 per cent) considered their occurrence as valid reasons for the approval of a therapeutic abortion."(page 265). Many committees considered in addition the effect of continuance of a woman's pregnancy on the health of her family, the economic implications of pregnancy, its extramarital origin and her age if below 18 or over 40. A majority, however, (68.5 per cent) was not prepared to support an application solely on the grounds of preventing an out-of-wedlock pregnancy.

About 10,000 Canadian women a year (about one in six having abortions) have recourse to facilities in the United States and commercial and other referral agencies are available to ease arrangements. It was detailed that some commercial agencies misrepresented both Canadian law and actual costs involved in proceedings in Canada. The Committee found reasonable doubt about the propriety of their work, but that "they existed because there was a demand for their services which was not otherwise being met." (page 386).

D. Report of the Royal Commission on Inquiry (The McMullin Report: New Zealand, 1977)

The McMullin Comission's terms of reference required the Commissioners to probe legal, social and moral issues of abortion, and to report on changes that should be made to the law. The Commission's focus differed from that of the Badgley Committee, therefore, in many regards, and this gives added significance to its assessment of evidence of the working of New Zealand's abortion law, since it closely parallels the Badgley findings in Canada. It was found, for instance, that:

> "It is apparent from this evidence that widely differing interpretations of the law have been adopted throughout New Zealand. Whether a woman or girl has been able to obtain an abortion has, to some extent, depended on the particular geographical location in which she has lived and the view of the law held by the medical practitioners in the area."(page 147).

Similarly, a survey of doctors found that "medical practitioners assumed a knowledge as to the existing law on abortion, which, in the view of those conducting the research, was not correct", and that the concept of "health" was often understood in the terms proposed by the World Health Organisation (pages 147-8). An additional comparison with Canada, from where many women go to the U.S.A. for lawful procedures, lies in proof of the ability of wealthier women from New Zealand to obtain lawful abortion in Australia.

Particularly instructive, and legally significant, is the way the Commission came to define its terms, since its awareness of legal doctrine and procedures required it to pursue the same reasoning processes as a court. In separating "legal" from "illegal" abortion, therefore, the Commission was compelled to reason that:

> "While ... medical practitioners have performed illegal abortions within hospitals under the guise, sometimes of dilation and curettage, sometimes of hysterotomy, it is difficult to prove that they were not acting in good faith. Because of our inability to determine whether an operation performed by a medical practitioner in a hospital or surgery is legal or otherwise, we propose to confine our definition of an "illegal" abortion to one which is performed by a non-medical person outside a hospital."(page 153).

The necessary recognition that hospital-based physician-induced terminations of pregnancy are difficult, if not impossible, to prove unlawful accords with the widespread presumption of law-enforcement officers and others, and suggests the wisdom of removing theoretical legal reservations from their regulation. The vision of abortion as a back-up family planning measure emerges from the Commission's findings on women seeking abortion. It was found that "for older women, age alone may be the greatest motivating force" while "single women use abortion to delay their anticipated child-bearing."(page 179).

The Report was indeterminative on the issue of rights of the

"unborn child" and the pregnant woman. It assumed these rights to exist within the same system of ordering, but found no convincing evidence in criminal law for protection of the fetus outside the abortion law itself, and recognised in civil law that such rights as exist are contingent upon live birth. The right to life was considered not to be absolute, but to have to yield to "compelling competing interests."(page 192). Similarly, treatment of "The Morality of Abortion" ran to only one page and a half of the 455 page Report although the Commission concluded this somewhat brief consideration by offering three principles and a six-point moral code, giving particular emphasis to the morality of the eugenic indication for abortion. Empirically, the Commission found that "of all abortions induced in New Zealand in the period between 1 October 1975 and 30 September 1976, 96 per cent were performed on psychiatric grounds." (page 202).

Although in obedience to its terms of reference the Commission gave regard to abstract moral philosophy, more indeed than may have been warranted by the nature and scale of its enquiry, it recognised the need for grass-root support, or at least tolerance, of a legal regime aiming to regulate human behaviour. Pursuit of moral precepts that condemn, upon esoteric criteria, conduct widely followed or tolerated in society was seen to be of no value; there is a need for balance, since "laws should not be so rigorous that only a minority of citizens willingly obey them in their entirety, nor should they be geared to the level of conduct of those whose moral standards leave much to be desired." (page 268).

The Commission's statements of social principles might appear "traditional" and not "progressive", but conclusions on individual interests controlling the abortion decision are in fact advanced. It was considered, for instance, that while proper counselling requires knowledge of the father's views, he should have no power to veto an abortion for which a legal indication exists. Equally, it was considered that in the same circumstances the opinion of a girl under the legal age of consent to medical or surgical procedure should be decisive. It was noted that:

> "the girl's wishes should prevail if proper grounds for her abortion have been established ... It seems to us that, if it can be shown than an abortion is legally permissible on one of the grounds which we have recommended, it would be harsh as well as illogical to deny it to her because of her age."(page 278).

Her interests should be subject, however, to a "conscience clause" in favour of individual medical, nursing and paramedical personnel (page 315).

A curious twist of principle appears, however, concerning the practice of menstrual extraction. The Commission favoured discouragement of use of this technique not principally upon grounds of medical safety but because the law and its enforcement would leave unclear whether or not it achieves abortion. It was observed that:

> "If in fact the process of menstrual regulation is carried out on a woman or girl with intent to procure her miscarriage, the act would plainly be within the existing abortion law ... If it cannot be proved that

that was its purpose, then it would not. Unless, however, some curbs are placed on the use of this technique, it could become a means of circumventing the operation of the law."(page 282).

It may appear short-sighted to curb employment of a medical procedure offering such early and therefore safe termination of pregnancy on the ground that the law is not adequately capable of labelling its use lawful or unlawful. The Lane Committee's response to the dilemma had the virtue of recognising the need to change the law to accommodate the medical reality, although its solution of bringing menstrual regulation within an expanded abortion law is not necessarily the only solution.

The McMullin Commission was working comtemporaneously with the Canadian Badgley Committee and obviously had no access to its findings on the delays, health hazards or injustices caused by operation of therapeutic abortion committees. This evidence must cast considerable doubt, however, upon the McMullin recommendation of setting up 12 to 14 referral panels to consider abortion applications, and require women to be interviewed as a normal precondition of abortion. The humane sensitivities that the Commission envisaged as surrounding the procedure may be difficult, if not impossible, to ensure. Implementing a legal facility by this means may simply obstruct access to the service ostensibly made available, with risking higher maternal mortality and morbidity rates and the continuing profit to the illegal or fringe practitioner. The plan to attach counselling services to abortion services may be welcomed in principle, but the recommendation that "in order to ensure the uniform, impartial, and efficient working of the abortion laws, panels be established ... to decide, after considering all relevant information, whether abortion sought is justified within the law" (page 296) may appear ironic in light of the Badgley Committee findings, and the earlier reasoned rejection of such a proposal by the Lane Committee.

V. COMMENTARY

A. Generally

This commentary attempts to explain the implications of Commonwealth abortion laws in a social and pragmatic light. It evaluates particular legal provisions in terms of their benefits, effects and risks for maternal and family health disclosed in practice. The perspective that has developed in the course of reviewing the detail and particularly the operation of Commonwealth abortion laws differs from the perspective in which such laws were enacted. They emerged from a medical background where surgery of any kind was considerably more dangerous than it has since become. Modern evidence proves legal abortion to be significantly safer than its frequent social alternative, notably illegal (including self-induced) abortion. Experience shows that a prohibitive approach may be dysfunctional, since it neither instructs nor prevents, but simply channels abortion into the worst of circumstances, to the prejudice of physical and mental health. These conclusions are based upon a socio-legal perspective that considers abortion a legitimate health service.

B. Conditions for Abortion

i. Health

The very earliest derogation from the absolute prohibition of abortion was to preserve the life of the mother, and this remains an obvious and ubiquitous ground for legal abortion. Fortunately, its incidence is very low, and is identified by criteria upon which medical personnel can reach a high degree of consensus. The indication of preservation of maternal health, physical and mental, is also widely adopted, expressed in developed and advanced laws.

The central concept of "health" remains elusive, however, as confirmed in the fact that the only uniformly recognised definition, that proposed by the World Health Organization, is the most accommodating, least restrictive formulation. Some physicians, and others troubled by the broad licence of abortion, prefer a more pedantic, dictionary meaning and point out that pregnancy and child-birth naturally impair optimal health on an objective scale; subjectively, however, different levels of health exist within the evolving stages of pregnancy. A particular challenge to broad medical indications lies in the contention that physicians can consider only physical and mental criteria, and that social evaluation and prognosis lie outside their competence and accordingly outside the area within which they can express a professional opinion as to the suitability of abortion. Objection focuses upon such provisions of advanced law as exists in section 1(2) of the British Abortion Act 1967, stating that in estimating risk to health, "account may be taken of the pregnant woman's actual or reasonably foreseeable environment."

Physicians are concerned not just with symptoms and indications, but with people, and with their health not just as biological units, but as social beings. A physician's estimate of health must consider social environment, and in this sense he takes acount of socio-

economic or socio-medical factors. The words of section 1(2) of the 1967 Act may accordingly appear properly to direct the physician to employ the wider concept of health, compatibly with the World Health Organisation definition.

Support for consideration of this factor in assessing health is muted by only one concern, namely that if a physician seeks assistance from, for instance, welfare workers in collecting data and opinions upon which to base his foresight of the patient's environment, delay may follow that renders eventual abortion unnecessarily hazardous. It may be hoped, therefore, that a physician persuaded that conscientious discharge of his prognostic role requires such account to be taken will also see the need for a speedy decision both to achieve earlier and speedier procedures, and, if his assessment is adverse to the woman's request, to leave her time to exercise her legal and ethical right to seek a second medical opinion.

ii. Contraceptive Failure

Progress in techniques of early pregnancy termination make it increasingly safe as a medical procedure, but traditional conviction remains sound in stating that abortion is the worst means of family planning. It is not doubted that abortion is not and should not be an alternative to contraception. Encouragement of contraceptive practice on one hand and regulation of abortion on the other may seem to operate in different legal areas, but they may usefully be related through the provision of contraceptive failure as an indication for lawful abortion. (See sample bill in Appendix III, page 124).

Abortion then serves as a back-up or fail-safe insurance for contraception. The idea needs some refinement, of course, since notoriously unreliable contraceptive techniques, such as the rhythm method, may be reinforced to the disadvantage of more trustworthy techniques. Similarly, some evidence may have to be offered by the applicant under this indication of conscientious pursuit, by herself or her partner, of a contraceptive method. A further, policy-directed factor is that a family planning agency able to offer this insurance might lose incentive to improve upon its services and technology, to the prejudice of the practice the indication may be introduced to encourage.

Nevertheless, the indication may appear prudent in principle and feasible in effect. It makes a clear statement of priority, and ensure, as contraceptive methods aim to do, that the woman diligent about her or her partner's contraceptive protection will not have to experience unplanned unwanted childbirth.

iii. Rape and Incest

Many unprepared to approve abortion to relieve the effects of sexual irresponsbility concede that pregnancy imposed by rape is exceptional on the grounds that no woman should have to nuture within her body a seed planted in callous violence. Compassion would seem to demand her speedy relief.

While this humane response may be lauded, it considers rape as an "indication" for legal abortion, whereas it has to operate in law as a "legal indication" for abortion; that is, the rape must be legally established in time for the pregnancy to be safely terminated. Medical procedures are not easily undertaken upon legal (or juridical) indications. Legal tests may reduce apparent rape to, for instance, indecent assault, such as where the assailant is below the age at which he is deemed to have sexual potency, or where he is the woman's husband. Further, the very application of legal tests, such as identifying the suspect, and finding evidence and corroboration that the complainant did not consent to intercourse, may cause delay that defeats her abortion request.

The essence of the indication is not the condition or status of the asssailant, but the fact that the woman genuinely believes she has been outraged and made pregnant in an act in which she was in no way a willing participant. The belief affects her disposition, physical tolerance of her condition and mental composition. Accordingly, it can be accommodated under a traditional physical or mental health indication.

Incest differs from rape in that it is voluntary, except perhaps in the sense of being conditioned by social or psychological predisposing factors. The degenerate effects of incest upon offspring are not clearly established in medical science, although widely accepted in popular culture. A eugenic indication may not really cover incest, in the absence of a specific genetic prognosis. Incestuous pregnancy may, of course, be terminable under the socio-medical aspects of a health indication, but introduction or tolerance in legislation of an incest indication as such may represent anticipatory social discrimination against a type of person because of his social origins. Nevertheless, the consent that separates incest from rape may be less than freely given, and, for instance, the McMullin Committee accepted incest as an indication for abortion.

iv. Specific Indications Generally

Jurisdictions with no "on request" law have reputable physicians who employ specific health indications to achieve "on request" effects; their practice is by no means confined, furthermore, to the private sector. Once a ground for abortion exists, a physician so disposed, perhaps from the most worthy of motives, may approve abortions upon that ground which no court or professional colleague could clearly show irregular, unless accompanied by some vitiating factor such as advantage to the authorising practitioner. The Lane, Badgley and McMullin Reports demonstrated the futility of structuring words, at times agonizingly retrieved from a reluctant legislature, to contain medical assessments, since procedures were routinely undertaken under the aegis of a lawful indication that could be characterised as neither legal nor illegal.

A strong case exists, upon this empirical evidence, to legislate not by indications but by personnel and institutions. Many advanced laws have achieved this de facto, in that medical practitioners in

approved facilities are able to practice conscientious medicine free from the aura of criminality, and are at legal risk only when their conduct is so unconscionable as to offend medical ethics as well as abortion prohibitions. Specific indications have encouraged legally unchallengeable "on-request" abortion by euphemism.

v. Residency and Foreign Abortions

Fear of becoming the "abortion capital" of their region, and of dissipating scarce public health resources on foreigners, may persuade countries with advanced laws to confine services to nationals or residents. In fact, only Singapore and the state of South Australia have such provisions, and do not find them easily enforceable. Countries such as Britain and other Australian states, and outside the Commonwealth the United States, however, receive abortion patients from residing elsewhere, usually for private sector services. Seeming to close the doors to public and/or private abortion procedures for aliens may be practically necessary for the introduction of advanced and perhaps controversial legislation. This may divert the wealthy elsewhere, direct the less wealthy to illegal practitioners closer to their homes, and feed domestic xenophobia. These prices may need at times to be paid, however, to placate opposition to advanced laws.

A woman's acquisition of legal abortion outside her own country of residence is not an offence against that jurisdiction's laws in any Commonwealth country, and no move has been observed to make it so.

vi. Biological Criteria

Abortion has to be recognised in law as an area of human decision-taking. Whether by specific indications or by personnel and institutional approval, legislation must order priorities according to a human and social scale. Absolutist doctrine opposing abortion as such, once based on theology and now given expression in terms of biology, locates the rights of the unborn on the same plane of legal protection as the rights of the living persons. In practice, however, the interests of the unborn are not accorded equal respect so that, for instance, a fetus (as opposed to a stillbirth) is not usually buried in consecrated ground, nor is premature, spontaneous or induced expulsion from the mother regarded in society as a death.

Attempts through demonstration of the biological human individuality of the fetus to pre-empt human debate and human determination of fetal destiny confuse legality and spirituality. Legislation may properly permit humans to reach decisions regarding the fetus, and may positively express legitimate methods of deciding upon abortion.

C. The Control of Choice

i. The Right to Choose

The individuality and human integrity of the woman give her a strong claim to control her fertility and regulate her future; she need not be committed by her sexuality to a pre-determined social role. Recognition if her claim to access to termination of pregnancy

in lawful and medically safe circumstances compels legislation giving effect to this claim not to deny by method what it purports to allow in principle.

Surrounding advanced legislation with institutional requirements unlikely to be met, because of limitations upon and uneven distribution of resources or personnel, may be ethically objectionable and socially futile. If the right of choice is admitted by legislation, an obligation is imposed upon administrative agencies to make that choice effective by provision of means for its exercise. When resources are not available, the legislation is nullified, illegal practice continues and legitimate choice is frustrated.

The matter has both positive and negative aspects. Clearly, where resources for legal abortion are not available a woman cannot choose to use them, but equally where they are inadequately available she may be denied the choice not to use them. If a woman uncertain about continuing her pregnancy gains an opportunity of lawful termination that may not recur, she may be denied the chance to take counselling better to understand her situation, and to plan for childbirth. The more scarce the opportunity of having a lawful procedure, the more tenaciously she may retain any opportunity she gains. Restricting availability of abortion therefore denies a woman the chance to try to continue her pregnancy confident that, should her circumstances render it impossible, she can have recourse to a procedure a little later.

ii. Parental Consent

Few Commonwealth abortion laws require parental consent for procedures of girls below majority, but hospital or medical laws may contain such a requirement. This barrier to lawful termination of pregnancy following a medical finding of justification of the procedure may afford the parents disposal not only of their child's health, but of her educational and social future. This is the more oppressive in jurisdictions where the age of majority is relatively high, such as 21. The McMullin Committee's carefully reasoned rejection of parental powers of veto over medically approved and lawful abortion appears irrestible.

iii. Spousal/Paternal Consent

No Commonwealth abortion law requires the biological father's consent to an operation, and since such laws generally permit abortion only to save the life or health, his veto clearly has no place. As more accommodating laws evolve, however, a fashion may develop to recognise the interests of the biological father in the abortion decision. It may appear on analysis, however, that this is not justifiable, and may be destructive.

If a wife and husband agree on abortion, the wife can express that agreement. If they do not agree, the husband cannot compel abortion the wife resists. If she is entitled to abortion on health grounds, the husband should have no veto. If the grounds are wider, for instance, if they are socio-economic, again the husband should not be given the means by veto to prevail in the disagreement. The

wife may be driven, for instance, to deny his fatherhood of her pregnancy. If in fact he is not the father, of course his interest expires, since otherwise he would compel birth of a child he would have no obligation to support.

The unmarried father's veto of abortion may appear to balance his support obligation, but his willingness to maintain a future child is of reduced value when, for instance, he is in school, in casual employment, or financially committed. In any event, the right to veto abortion in return for paying for support distinguishes between unmarried fathers on the basis of their financial means and prospects. If the girl is under age, furthermore, the father will have committed an offence, and may stand equally with, for instance, the rapist, who cannot from his gaol cell command the continued pregnancy of his victim. The recognition of paternal consent and veto rights appears better omitted from the decision on abortion.

iv. Second (and other) Medical Opinions

The tradition of a physician seeking a second opinion is honourably established in medical practice, but its use in the legality of an abortion decision has become perverted. It serves not to advance the health needs or treatment of the patient, but simply as a token of the initial physician's good faith in evidencing that he is acting in a non-clandestine manner. The British Abortion Act 1967, for instance, incorporated medical practice of the second opinion, but the two medical opinions need not agree as to the indication for abortion, and the method to be employed does not have to be discussed. Further, if a second physician feels a procedure medically unjustified or legally not indicated, the first physician is free to look elsewhere for a concurring opinion, although more free in the private sector than in the public. In practice, it has been observed that concurring and dissenting physicians become known, and the former will tend to be more approached. The concurring opinion requirement increases expense, delay and therefore risk. It also increases injustice where a woman's means confine her to public sector facilities, where she is more at the disposal of physicians she cannot select or reject.

The second opinion requirement is also oppressive in areas where physicians are scarce. The requirement in Zambia's Termination of Pregnancy Act, 1972, for instance, that three medical practitioners, including at least one specialist, concur in a decision, suggests an abundance of physicians in Zambia not supported by the rate of one for each 8,110 of population (1971 WHO statistics); the rate in England is one per 770. In Canada there is one physician for every 600 persons, and the Badgley Committee revealed the capriciousness of the three-person therapeutic abortion committee system, and how it delays services by on average two months, and defeats their equitable availability. An appeal system, which may contribute to objective justice in committee operation, would also contribute to delay.

An uncertain public may be comforted by the monitoring of physician by physician, and the medical profession finds it

unobjectionable. It may have something for everyone, indeed, except the woman seeking abortion. An alternative system of trusting registered medical practitioners, perhaps when acting in approved facilities, to behave responsibly, and trusting the self-regulating medical profession to police its own members, should not be casually dismissed.

D. Medical Practice

i. Good Faith

A physician who acts in good faith cannot be convicted of illegal abortion. Good faith is established by evidence, traditionally found in seeking the concurring opinion of another practitioner. Additional and, in principle, alternative evidence lies in the thorough examination of the applicant to establish medical satisfaction of legal indications. Despite the uniqueness of each case, a fairly uniform checklist could be developed by, for instance, the Ministry of Health, of questions a physician should ask, in areas of physical health, mental health, existing children's health or, for instance, congenital transmission. Adequate answers could confirm the objective validity of a decision for MTP, even in the absence of a concurring opinion where not statutorily mandated. If a completed checklist, containing suitable detail, was registered for each procedure, the second opinion might be obviated.

Evidence of defective motivation could counteract other evidence of good faith. Personal involvement with the patient may do this, and in particular so may receipt of a sizeable fee. Codes of medical ethics often require reasonable restraint in fee-setting, suggesting that the physician who sets a high fee is acknowledging that, in undertaking the abortion procedure, he is running a legal risk. The presence of another vitiating element in the integrity of the medical judgment involved is not remedied, however, by setting a moderate fee. (See Commentary in Appendix III, page 125).

ii. Conscience Clause

Advanced laws, perhaps permitting abortion on other than health grounds, not uncommonly provide for medical personnel to excuse themselves on grounds of conscientious objection from participation in abortion procedures, except in emergency, health-threatening situations. This may embody a fair balance between the competing interests of patient and physician, nurse and other health personnel, provided that the patient is not denied routine services available in hospital, such as delivery of food and post-operative care, and respect.

Conscience must be general, not confined, for instance, to public sector procedures. Further, as the Lane Committee recognised in principle and the Badgley Committee found in fact, a physician or other health provider who cannot, for whatever reason, discharge the range of functions a hospital has undertaken to provide, cannot expect absolute equality of appointment, promotion and responsibility with those who can. (See Appendix III).

iii. Authorisation

While approval of only certain physicians, perhaps with specialised skills, to undertake abortion may be regular, especially later in pregnancy, the scarcity of routine skills prejudices delivery of abortion services. This is more so where private practice thrives. A means to spread a physician's services between public and private sectors may be to permit only those specially authorised to undertake them, to permit every registered medical practitioner automatically to be deemed so authorised, but to withdraw abortion privileges in both sectors from a physician not discharging a specified number of term of procedures in public hospitals. This "selecting out" rather than "selecting in" mechanism may help to overcome the problem of qualified personnel choosing not to apply for authorisation. (See Commentary in Appendix III).

iv. Delegation

Medical involvement in each abortion is essential, but newer techniques can be managed by health personnel working under medical supervision. In time, supervision may be through quite extended lines of control, but even now appropriately trained health personnel may be permitted to exercise a defined range of skills, under supervision of a physician delegating function to such personnel. (See Commentary in Appendix III).

v. Fees

Medical fees are always, as the Badgley Committee observed, a sensitive and divisive matter which, coupled to the abortion issue, assumes emotive proportions. Advanced laws have on occassion attempted to define fee levels, but it may be doubted that this is justified or necessary. A physician willing to do the procedure will not set a fee so high as to price himself out of the private market, and his contribution to public service can be ensured by means other than regulating fees, such as by authorisation systems for entitlement to undertake or supervise the services. (See iii. above).

vi. Reporting Procedures

The British Abortion Act 1967 has authorised regulations governing reporting of abortion. (See Appendix II). In that many medical procedures require reporting, abortion cannot be exempted, but equally it should not be distinguished by special reporting requirements. The Canadian provision that a provincial Health Minister may demand copies of certificates issued for abortion, and related information, was shown by the Badgley Committee not to have been employed. The case for treating abortion just as any other medical procedure appears convincing.

vii. The Trimester Approach

Early abortion laws distinguished between the woman quick with child and not quick with child. This has been proven to display a certain pragmatic wisdom, since early abortion, up to the end of the 13th or 14th week, which with modern measurements of pregnancy duration approached the stage of quickening, can be performed very

safely. Decriminalisation of first trimester abortion undertaken under medical supervision would remove many of the burdens of abortion management, and encourage early abortion with its attendant diminution of health risks. A public hesitant of later termination of pregnancy might feel more relaxed, moreover, regarding procedures precipitating little more than delayed menstruation. Accordingly, it may be proposed that no limits other than medical supervision be attached to first trimester abortions.

Particular instruction may be gained from Singapore, whose advanced Abortion Act, 1969 was indication-based. Experience gained from operation of this system, however, persuaded the legislature to abolish it by repeal of the 1969 Act and to replace it with the present Abortion Act, 1974. This provides for an appropriately qualified registered medical practitioner to undertake abortion on request up to the end of 16 weeks of pregnancy. Thereafter up to 24 weeks, an "on request" abortion may be performed only by further specially qualified practitioners; after 24 weeks, abortion is lawful only to save the life or prevent grave permanent injury to physical or mental health. Since pregnancy may be measured under the 1974 Act from the first day of the last normal menstruation, or by clinical examination (section 4(2)), the 16 week period may be approximately coterminous with the first trimester.

Under an indication-based system allowing early procedures upon liberal grounds, later abortions would require satisfaction of increasingly demanding (that is, increasingly restrictive) indications, focusing upon preservation of health and progressively refining the effect of more socio-economic considerations. At the end of normal pregnancy, sacrifice of the fetus would be permissible only when necessary to save the woman's life, which is the position reached now in jurisdictions with a child destruction law expressed in, for instance, the English Infant Life (Preservation) Act 1929.

E. Legislation

i. The Role of Legislation

There is much that nationally reformed legislation can achieve in relieving the toll upon maternal life and health exacted by illegal abortion. Writing of Canada's new legislation of 1969, for instance, the Badgley Committee noted that:

> "The number of deaths of women in Canada resulting from attempted self-induced or criminal abortions, which averaged 12.3 each year between 1958 and 1969, dropped to 1.8 deaths annually from 1970 to 1974." (page 66).

The law can facilitate access to legal services delivered by conscientious, adequately qualified practitioners, by declaring the legality of the procedure and, where necessary, by easing restrictions in parallel laws or practices, for instance, on parental consent.

Declaration of the legality of abortion, whether upon indications or on a trimester or gestational basis, does not, however, direct

resources. In a number of jurisdictions where legal barriers to abortion have been lowered, the rate and the toll upon life and health of illegal abortion have not significantly declined, because the services made legal in theory have not been made available in practice. Legitimation of termination of pregnancy does not in itself compel administrative authorities controlling health resources to meet the existing demand for abortion, nor ensure availability of services at the earliest possible stage of pregnancy. It need scarcely be stated that unless such authorities back up new law with adequate resources, the only visible change in the national scene will be confined to the statute book. Without a commitment by government to meet the demand for abortion being channelled into the legal branch of practice, the illegal branch will retain the numbers of its clientele and safe abortion will continue to be within the means only of the wealthy.

Legislation inspired by the quest for social justice, aiming to afford the poor equal rights to health care, including safe medical procedures to terminate pregnancy, may be part of a programme extending beyond the mere enactment of legislation; indeed, legislation may be not the end of the programme, but the beginning. Abortion need not be the central focus of legislation, furthermore, but a residual part of a fertility control programme giving priority to family life education and instructing in contraceptive means. Legislation can encourage such a programme by protecting participants through constituting contraceptive failure a ground for lawful abortion. Social spread of services can also be reinforced by, for example, making specified service in public facilities a condition of authorisation of physicians to practise in the better rewarded private sector.

While legislation cannot itself guarantee the supply of resources, it could be designed to facilitate and encourage more equitably available services, and to serve female health by favouring speedy abortion decisions so that procedures to be undertaken can be performed at the earliest possible time.

ii. The Role of Sanctions

It does not necessarily follow that disfavoured conduct of individuals must be governed by criminal prohibitions, nor does it follow that the formal existence of such prohibitions actually controls individual conduct. Criminal prohibitions of, for instance, adultery, did not reduce its incidence and removal of legal sanctions did not approve or condone it; legal change simply withdrew liability to sanctions, that in any event were not enforced, from conduct society regretted but tolerated. Comparable legal change has occurred in the areas of divorce, suicide, contraception, homosexual relations and deviant sexual practices; these remain condemned by religious doctrine, but not by secular law. Law must respond to shifts in the limits of public tolerance, as demonstrated not only in the rhetoric of those occupying positions of social leadership but also in the conduct of ordinary people living private lives. Law advertises its impotence and risks irrelevance in continuing to condemn in doctrine, while failing to prosecute, what the bulk of society no longer condemns in practice.

Legislation attaching sanctions to abortion does not prevent abortion in society, although it may deter safe medical procedures and deny to the poor the publicly provided services that are their only means of access to qualified practitioners. Reliance upon controlling the abortion rate by criminal law does disservice to women seeking abortions and doctrinal opponents of abortion alike. The force of the criminal law, even when it is effective, is a poor substitute for the creation of conditions in which deplored conduct can be averted and deterred. In resisting changes in formal law, those opposing the abortion alternative may misapply their resources which are better devoted to encouraging continuation of pregnancy by offering not threats but help and assistance to pregnant girls and women. Counselling, support and example can show how unwanted pregnancy can be borne, but this enlightened calibre of counselling cannot be conducted against a coercive background. Prohibitive services and criminal sanctions may prevent identification of, and approaches to, those liable to profit from such counselling. The abortion problem in modern societies concerns issues of individual welfare, and these are not successfully managed under concepts of crime and punishment.

iii. The Psychology of Legislation

Not only basic and developed but also many advanced laws are expressed in exclusively negative terms. The former usually state that whoever performs defined acts unlawfully shall be guilty of an offence and punishable. Advanced laws are grafted onto such basic or developed laws by providing that such laws do not apply under conditions then specified. In creating detractions from prohibitions, legislation psychologically shies away from expressing in terms that abortion is lawful, and retains guilt-laden language of an earlier time of social development.

In logic and law the application of a negative to a negative produces a positive, but if law is to communicate its provisions to those it governs, it requires clear positive expression. This is true of all law, but especially that on abortion since its provisions concern not just lawyers' law but the basis upon which a physcian may properly treat his patient. Termination of pregnancy is the only medical procedure in which the criminal law claims so to direct physicians, and this makes it more desirable that it is expressed in language they can understand and apply by reading a single enactment. Legislation introducing a developed or advanced law is better expressed to include such a statement as that "it shall be lawful to terminate a woman's pregnancy when ...". Present negative expressions seem to offer physicians only a defence upon prosecution, but a positive statement would show legality of procedures undertaken in conformity with the enactment. (See Commentary in Appendix III).

Further evidence of the unsatisfactory expression of present laws and of their esoteric conceptual base lies in their tendency to develop an internal dynamic of their own that generates a barrage of detail and regulations. These appear fearful to the non-lawyer, and intimate numerous pitfalls for the unwary physician who through inadvertence may infringe the complex system of law and fall liable

to severe penal and professional sanctions for illegal abortion. It is bad policy, and unethical if deliberate, for legislation permitting a physician to treat a patient in accordance with their common wish so to conceal or confuse its effect as to leave a lack of clarity about the legal status of the procedure.

iv. The Dynamics of Law Reform: Women's Rights

Traditional institutions most resistant to liberalisation of abortion laws tend overwhelmingly to be resistant to the elevation of women in their own ranks. Commonwealth countries are progressively finding, however, that their public and political institutions must recognise and be sensitive to the wishes of women as a special group unified by common interests. Operation of abortion laws frequently shows those interests not to be served. It may be projected upon the lines of current developments that the claims of women will lead to new thinking and laws with subsequent impact upon their status within society. The equalisation of the grounds for divorce and inheritance, education and employment opportunities as well as salary, show this trend.

It may be predicted that women, increasingly educated and articulate, will no longer tolerate having to fear the processes of their own bodies. Equally, they will oppose the development of national population policies at the cost of the quality of their individual lives. In the same way that they reject involuntary sterilisation, they will reject involuntary motherhood when forced upon them to serve political purposes.

Experience of the operation of abortion laws shows the despair and panic with which a woman may learn of her unwanted pregnancy, and the desperation with which she seeks its termination. Under even an advanced abortion law, she may have to submit to examination of her personal circumstances, including the origin of her pregnancy, for physiological, psychiatric or sociological means to satisfy an indication for lawful abortion. She may suffer humiliation at having to disclose to strangers intimate details of her personal, family and social life, and may feel degradation and loss of autonomy at finding her personal destiny placed at the disposal of others. Her vulnerability to their decision is little short of total. They may pursue their philosophies and preferences at her cost while she may lack even the right to address them directly, and they may determine her case upon bureaucratic grounds such as unavilability of resources to perform the procedure she meets the legal indications to receive.

It is clear that women who can escape this process do. One in six Canadian women having an abortion goes to the United States for a confidential on-request service. Many woman from Bermuda follow the same path, and New Zealand women with the means go to Australia. The urge for confidentiality may send women, economically compelled to stay within their own region, to a hospital outside their area for abortion services, although their application may then be denied solely upon the ground of their lack of residence in the hospital's catchment area.

Groups representing women's interests increasingly express their dissatisfaction and outrage at what women must endure to maintain their physical integrity and to control their personal and social destinies. Women with economic means can escape the humiliations of domestic abortion procedures by obtaining confidential and safe services, abroad or at home, in the private sector of health care. When women's rights, as a major division of human rights, are further politicised, restrictive abortion laws will pass into history along with other discarded laws comparably repressive of individual self-determination.

v. Experience of Advanced Laws

It has been seen that advanced laws may reduce the death rate from illegal abortion dramatically (see i above), but methods of implementing advanced laws also show that their benefits to the health of women may be forfeited by over-cautiousness. The Badgley Committee evidence that recourse to therapeutic abortion committees causes on average an eight week delay in the performance of abortion procedures in Canada, confirms how legal requirements may prejudice early and therefore safer and less costly abortion. The argument that these delays are compelled by the need to screen out cases not entitled to legal abortion disregards the finding of the Lane Committee that:

> "evidence indicates that a woman determined to obtain abortion is not easily deflected for her purpose, particularly if she is unmarried. Some who have failed to obtain it lawfully endeavour to abort themselves, with or without success, others resort to illegal abortionists (both these unlawful means may have disastrous physical consequences); a few attempt or commit suicide." (para. 162).

The benefit obtained in delaying lawful abortion to those women entitled to it, in order to disqualify others who will probably have recourse to other means, has never been established.

Concurring medical opinions are similarly not directed to protection of women's health, and at best show only that a particular procedure is justifiable according to the language of legally expressed indications. The British Abortion Act 1967 is representative in not requiring the second medical opinion to be based on the same ground as the first, with which it may actually disagree, and not requiring agreement on the means of abortion proposed, although the choice of means may be of some significance to the woman and to the outcome.

Requirements to submit reports of abortion practice place physicians under legal threat for theoretical impropriety, but, complex though reporting duties are, they are confined to abortions done and omit reporting on abortion refused. The Badgley Committee showed that Canadian provincial Health Ministers had never used their investigational powers regarding abortions performed, and the Lane Committee disclosed a similar lack of knowledge about negative abortion practice, notwithstanding the detailed statutory Abortion

Regulations. (See Appendix II).

The Lane Report found that:

> "It is not possible to determine accurately how many women there are during whose pregnancy the question of abortion is raised but who are advised that there are insufficient grounds for termination ... At least 30 per cent of those at first refused may eventually obtain an abortion, and a substantial proportion (perhaps about one fifth) of these do so within the National Health Service." (para. 160).

It continues:

> "The outcome in cases where therapeutic abortion is not performed may be spontaneous abortion, illegal abortion or bearing the child. There are no national statistics to show the proportion of babies born after the mother has been refused an abortion ... results indicate that under two-thirds of those refused abortion accept the refusal ... The remaining third eventually obtain abortion." (para. 161).

The Badgley Report showed that many applications for abortion are refused not upon grounds of the women's condition but because the facilities of the hospital are overburdened by demands made upon its services. Since refusals are not notifiable, however, the provincial Health Minister responsible for allocating public health resources gains no information of this under abortion reporting provisions. This confirms that their function is to monitor not the quality of health service but simply the legality of the procedures undertaken. It may be doubted that the complex mechanisms established for this purpose are warranted, not least because illegalities are in any event ignored.

Criticism of regulations made under the authority of advanced laws does not imply, of course, that they have no useful function to serve. Where the law provides, for instance, that abortion may be performed in approved facilities, and/or by authorised practitioners, the terms of approval and/or authorisation are better contained in regulations than in the substantive enactments. As national circumstances evolve, regulations can more easily be changed to reflect them than can statutes. The accommodation of resources to demand may take the form, for instance, of constituting family planning clinics "approved facilities" to undertake menstrual extraction very early in suspected pregnancy, or of withdrawing approval from a named facility whose trained personnel have departed. Similarly, where public facilities are adequately served by qualified personnel, the tests of authorisation of practitioners may be less demanding of their time for public services, leaving them more free for private practice. These adjustments are better undertaken by ministerially-produced regulations than by reference to the full national legislature, which is not equipped for the periodic fine tuning that regulations can achieve.

vi. Legal Evolution

It is evident to legal analysts that developed law is implicit in a jurisdiction's basic law, but the medical and associated professions would be aided in this understanding by an enactment clearly expressing what the law allows, changing not its essence but simply its expression to give the law a developed form. Alternatively, without trespassing upon the legislature's function, a minister, such as the Attorney-General or Justice Minister, or perhaps more suitably the Health Minister acting upon legal advice, could issue an authoritative declaration of the law's meaning, which would be subject to any subsequent judicial correction.

A developed or advanced law could also resolve theoretical conflicts between abortion law and the practice of legitimate contraception, for instance, by post-coital or "morning after" methods, either extending the abortion law to cover certain of them, or making clear that lawful contraception as defined prevails over provisions of the abortion law.

The law and management of abortion in Commonwealth jurisdictions contain the seeds of a development that may in time, perhaps a short time, flower into the new reality of abortion law. Medical advances and social attitudes have rendered abortion safe and more widely acceptable, so that the atmosphere of crime has largely been removed de facto. Egregious cases may still be prosecuted, but the widespread pattern within the Commonwealth is that legal proceedings are very infrequent, and quite unknown in many jurisdictions where abortion practitioners are easily identifiable, if not affordable. Sanctions continue to impress the cautious physician, of course, but even their psychological effect is in decline. Abortion control is passing out of the realm of criminal law and into the realm of welfare law, which includes fertility control and female health. In response to the Badgley Report, for instance, the Canadian Minister of Health and Welfare envisaged clinics dealing not only with pregnancy termination but also, and particularly, with family planning, fertility counselling, cancer screening including breast self-examination, and general maternal health.

Since unqualified medical practice is already prohibited, it is quite feasible, under most systems of criminal law, to repeal abortion laws as such and regulate the practice under health and welfare laws. Control of improper practice by physicians in this field as in any other may be entrusted to the vigilance of the medical profession, reinforced indirectly, perhaps, by civil law on negligence and breach of contract.

Few, if indeed, any Commonwealth countries are yet ready to recognise de jure the decriminalisation of medically conducted abortion that has occurred de facto. The Lane, Badgley and McMullin Reports noted the legal ambivalence of many conscientiously conducted procedures departing from strict conformity to advanced laws, however, and regarded the matter as of little consequence. A society giving priority to the preservation of women's health and to equal opportunities for women of all socio-economic classes to control

their fertility will be prepared to see abortion within a wider health-care setting, permitting its availability to be regulated in the same manner and under the same law as other medical procedures.

The evolution of abortion law may thus be seen to follow a course moving from prohibitive basic law to developed law, by means of a Bourne type of ruling or an administrative declaration to the same effect, and on to an advanced law stating grounds and conditions of lawful abortion. Once the scope of permitted abortion is defined, the justification for a separate abortion law may weaken, and it may be superceded by health or welfare legislation concerned not with crime and punishment but with the allocation and distribution of health resources to health requirements. At its furthest stage of progression, therefore, abortion law may not be separately identifiable. It may not be too early to work towards the objective of assimilating abortion law into the general law affecting women's health needs.

F. Conclusion

This Report aims to present a synthesis of Commonwealth abortion laws, and a synopsis of lines of development. It gives emphasis to common characteristics and patterns of evolution, acknowledging not only the common legal heritage but also the fact of Commonwealth diversity. In the same way that each jurisdiction may place its law within the basic, developed and advanced framework, so equally each jurisdiction may determine for itself its pace and direction of change.

The Report identifies factors that those planning change may need to consider, indicates how individual jurisdictions have responded to particular issues and shows how certain laws have been found to operate. It is hoped that this may enable the Report to inform and to serve, but it does not aim to instruct or direct. Each Commonwealth country and each jurisdiction faces a variety of needs and pressures too individual to be considered in an overall report of this nature. Differences in resources, in cultural traditions and in, for instance, social dynamics and popular expectation, will fashion indigenous responses to the issue of abortion and its legal regulation. Each governmental administration has its own philosophy to resolve the theoretical conflict between serving the people and leading the people, in the field of abortion law and in all other fields. The ordering of national priorities is a function of government, which best discharges its duties by being sensitive to the spiritual and pragmatic aspirations of those it serves by leading.

It is hoped that the data, analysis and commentary presented in this Report will contribute to the fund of information, the pool of experience and the range of ideas available to those charged with the responsibility of managing or of advancing abortion laws in the individual Commonwealth country.

TABLE I - LEGAL INDICATIONS*

ABORTION LAWS IN COMMONWEALTH COUNTRIES

Commonwealth countries by Region	LEGAL INDICATIONS FOR GRANTING AN ABORTION							Statutes and Cases in Force
	Risk to Life	Physical Health	Mental Health	Eugenic (Fetal impediment)	Juridical (Rape, incest)	Socio-Economic	On request	
AFRICA								
Botswana	x							Penal Code, (Cap.8:01), ss. 160-3.
The Gambia	x							Criminal Code, (Cap. 37), ss. 198, 199.
Ghana	x	x	x					Criminal Code, 1960 (Act No. 29 of 1960), ss. 58, 59, 67(2); R v. Bourne applied.
Kenya	x	x	x					Penal Code Cap. "Offences Against Morality" ss. 158-160, 228, 240; Mehar Singh Bansel v. R /1959/ E.A.L.R. 813; R v. Bourne and R v. Newton and Stungo applied.
Lesotho	x							Common law governed de jure by the 'defence of necessity'.
Malawi	x							Penal Code, (Cap. 7:01), ss. 149-151.
Mauritius	x							Penal Code Ordinance (Cap. 195), s. 235.
Nigeria Southern States	x	x	x					Criminal Code, Laws of the Federation of Nigeria, Laws R.E. 1958 Vol II (Cap. 42), ss. 228-230, 297; R v. Edgal, 4 W.A.C.A. 133 (1938); R v. Bourne applied.

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AFRICA (cont'd)								
Nigeria Northern States	x							Northern Penal Code, Laws of Northern Nigeria, Laws R.E. 1963 (Cap. 89), ss. 232-6.
Seychelles	Prohibited altogether							Penal Code, (Cap.75), ss. 147-8, 226.
Sierra Leone	x	x	x					English Offences Against The Person Act of 1861, ss.58-59; Common law governed de jure by the 'defence of necessity'; R v. Bourne applied.
Swaziland	x	x	x					Common law governed de jure by the 'defence of necessity'
Tanzania	x							Penal Code, (Cap. 16), ss. 150-2, 219.
Uganda	x	x	x					Penal Code, (Cap. 106), ss. 136-8, 190, 205, 217.
Zambia	x	x	x	x		x		Penal Code, (Cap. 146), ss. 151-3, Act No. 26 of 1972.
ASIA & OCEANIA								
Australia South Australia	x	x	x	x		x		Criminal Law Consolidation Act 1935-66, Sec. 82, Criminal Law Consolidation Amendment Act. No. 109 of 1969, s. 82A.

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ASIA & OCEANIA (cont'd)								
Australia								
Victoria	x	x	x	Where it may be interpreted as a risk to the health				Crimes Act 1958, ss. 10, 65-6; R v. Davidson [1969] V.R. 667.
New South Wales	x	x	x	Where it may be interpreted as a risk to the health				Crimes Act 1900, sections 82-84, R v. Davidson (1969) V.R. 667; R v. Wald (1971) 3 D.C.R. (N.S.W.)25.
Queensland	x	x	x					Criminal Code 1828-1962, ss. 224-6, 282; R v. Ross and McCarthy [1955] Q.S.R. 48.
Western Australia	x							Criminal Code Act No. 28 of 1913, ss. 5, 199-201.
Tasmania	x							Criminal Code Act of 1924, ss. 134, 135, 165.
Northern Territory	x	x	x	x				Criminal Law Consolidation Act and Ordinance 1876-1969, ss. 78-79 as amended by ss. 3, 4 of the Criminal Law Consolidation Ordinance (No. 2), 1973.
Capital Territory	x	x	x	Where it may be interpreted as a risk to the health				Crimes Act 1900, ss. 82-84; R v. Davidson (1969) V.R. 667, R v. Wald (1971) 3 D.C.R. (N.S.W.) 25.
Bangladesh	x	x	x					Penal Code (XLV of 1860) ss. 312-314.

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	Risk to Life	Physical Health	Mental Health	Eugenic (fetal impediment)	Juridical (Rape, incest)	Socio-Economic	On request	
ASIA & OCEANIA (cont'd) Fiji	x	x	x	Where it may be interpreted as a risk to the health				Penal Code, (Cap. 11), ss. 165-167, s. 265; R v. Emberson and Emberson Criminal Case No. 16 of 1976.
Hong Kong	x	x	x			x		Offences Against The Person (Amendment) Ordinance 1976, (Cap. 212), ss. 46, 47, 47A.
India	x	x	x	x	x	x		Penal Code s. 45 of 1860, Medical Termination of Pregnancy Act 1971, (No. 34 of 1971) and Rules and Regulations of 1975.
Jammu and Kashmir	x	x	x	x	x	x		State Act XXIII of 1974.
Malaysia Peninsular	x	x	x	x	x			Penal Code, (Cap. 75), ss. 312-6.
Sarawak	x	x	x	x	x			Penal Code Laws of Sarawak 1958, (Cap. 57), ss. 321-6.
Sabah	x	x	x	x	x			Penal Code, no. 3 of 1959, ss. 312-6.
Nauru	x							First Schedule of Criminal Code Act 1899, s. 224-6 of Queensland Australia applicable as adopted law.

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ASIA & OCEANIA (cont'd) New Zealand	x	x	x					Crimes Act, ss. 182-187 (1961); Hospitals Amendment Act 1975 (To amend Hospitals Act 1957); R v. Woolnough Court of Appeal, July 22, 1976 (CA 14/76).
Papua New Guinea	x	x	x					Criminal Code, (Cap. XXVI), s. 285.
Singapore							x	Penal Code, (Cap. 103), ss. 312-315; Abortion Act 1974 (Act No. 24 of 1974); Abortion Regulations 1974.
Sri Lanka	x							Penal Code, (Cap. 19), ss. 303-307.
Tonga	Prohibited altogether							Criminal Offences Act, ss. 94, 95, 96.
Western Samoa	x							Crimes Ordinance 1961, ss. 40, 73, 73A, 73B, 73C, 73D.
EUROPE Cyprus	x	x	x	x	x	x		Criminal Code, (Cap. 154), ss. 167-169, 169A, (Amended by Law No. 59 of 1974).
Malta	Prohibited altogether							Criminal Code, (Cap. 12), ss. 255-257.
United Kingdom Britain	x	x	x	x		x		Offences Against The Person Act 1861 (24 & 25 Vict., Cap. 100), ss. 58, 59, Abortion Act 1967 (Cap. 87), Abortion Regulations 1968, Abortion (Amendment) Regulations 1976.
Northern Ireland	x	x	x					Offences Against The Person Act 1861 (24 & 24 Vict., Cap. 100), 55, 58, 59; R v. Bourne applicable.

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WESTERN HEMISPHERE Antigua	x							Offences Against The Person Act, (Cap. 58) Part IX, ss. 53 and 54; Infant Life (Preservation) of 1937, (Cap. 38), ss. 1-3.
Barbados	x	x	x					Offences Against The Person Act, 1868 (Cap. 141), ss. 61, 62; R v. Bourne applied.
The Bahamas	x	x	x	Where it may be interpreted as a risk to the health				Penal Code of 1965, (Cap. 48) s. 357.
Belize	x							Criminal Code, (Cap. 21) Title IX, ss. 106, 119, 122.
Bermuda	x	x	x					Criminal Code Title 8: Item 31, ss. 192-194; R v. Bourne applied.
British Virgin Islands	x	x	x					Offences Against The Person Act, (Cap. 54), ss. 53 and 54; R v. Bourne applied.
Canada	x	x	x					Criminal Code, R.S.C. 1970, c. C-34, s. 251; Morgentaler v. R /1975/ 53 D.L.R. (3d) 161 (S.C.C.); R v. Morgentaler /1976/ 64 D.L.R. (3d) 718 (Quebec C.A., leave to appeal to S.C.C. refused).

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WESTERN HEMISPHERE (cont'd)								
Dominica	x							Offences Against The Person Act (Cap. 44), ss. 56 & 77.
Grenada	x							Criminal Code 1958, (Cap. 76). ss 238 & 251.
Guyana	x	x	x					Criminal Law (Offences) Act, (Cap. 8:01), ss. 78-80 & 99; R v. Bourne and R v. Newton and Stungo applied.
Jamaica	x	x	x					Offences Against The Person Act, 1864, (Revised edition 1973) ss. 72, 73; R v. Bourne applied; Min. of Health Paper No. 1, 1975 (M.P. No. H.H. 490/01).
Monserrat	x							Offences Against The Person Act, (Cap. 56), ss. 53 & 54.
St. Kitts/Nevis Anguilla	x	x	x					Offences Against The Person Act, (Cap. 56), ss. 53 & 54; Infant Life (Preservation) Act (Cap. 35), ss. 1-3; R v. Bourne applied.
St. Lucia	x							Criminal Code, (Cap. 250), ss. 117-119.
St. Vincent	x	x	x					Administration of Justice Ordinance 1912: An Ordinance to Consolidate and Amend the Laws Relating to Indictable Offences, (Cap. 24), ss. 98 & 100; R v. Bourne applied.
Trinidad and Tobago	x	x	x					Offences Against The Person Ordinance, (Cap. 4), No. 9, ss. 57 & 58; R v. Bourne applied.

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TABLE II - PROVISIONS FOR IMPLEMENTATION (IN LAW AND PRACTICE)*

ABORTION IN COMMONWEALTH COUNTRIES

Commonwealth Country by Region	Specified Professionals	Specified Institutions	Stage of Pregnancy	Approval Procedures	Cost** to government	Cost** to client
AFRICA						
Botswana						
The Gambia						
Ghana	Registered medical practitioner	Government hospital or other approved institution	Practice suggests up to 16 weeks		-	Patient pays
Kenya	Registered medical practitioner	No firm instructions but hospitals advised		Practice suggests 2nd medical opinion but not mandatory	Depends on status of patient	
Lesotho						
Malawi						
Mauritius						
Nigeria				Practice suggests 2nd medical opinion	For all medical services patients are charged rates lower than the cost of care to the institution	
Sierre Leone						
Swaziland	Registered medical practitioner	Government hospitals, private clinic and/or approved institutions	Practice suggests up to 20 weeks	Practice suggests Chief Medical Officer	Mainly at government expense or minimal contribution by patient based on means test	Free

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AFRICA (cont'd)						
Tanzania						
Uganda	Registered medical practitioner			Practice suggests 2nd medical opinion	in taxation	
Zambia	Registered medical practitioner	Government hospital or other approved institution		3 registered medical practitioners "one of whom has specialised in the branch of medicine in which the patient is specifically required to be examined" except if it is "immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the woman"		
ASIA & OCEANIA						
Australia	Legally qualified medical practitioner	Prescribed hospital	28 weeks	Law requires 2nd medical opinion except in emergency cases	Common fee approx. $65(Australian) (approx. UK£42.48)	
South Australia					$60 £39.21	$5 £3.26
Victoria	Doctor		28 weeks		Common fee $65(Aus) (UK£42.48)	
					$60 £39.21	$5 £3.26

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ABORTION IN COMMONWEALTH COUNTRIES

Commonwealth Country by Region	Specified Professionals	Specified Institutions	Stage of Pregnancy	Approval Procedures	Cost** to government	Cost** to client
ASIA & OCEANIA (cont'd) Australia						
New South Wales	Medical practitioner				Common fee $65(Aus) (UK£42.48)	
					$60 £39.21	$5 £3.26
Queensland	Medical practitioner				Common fee $65(Aus) (UK£42.48)	
					$60 £39.21	$5 £3.26
Western Australia			Viability		Common fee $65(Aus) (UK£42.48)	
					$60 £39.21	$5 £3.26
Tasmania			Viability		Common fee $65(Aus) (UK£42.48)	
					$60 £39.21	$5 £3.26
Northern Territory	Gynaecologist obstetrician	Hospital	14 weeks for broad indications. 23 weeks for physical and mental indications			
Capital Territory	Medical practitioner					

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ABORTION IN COMMONWEALTH COUNTRIES

Commonwealth Country by Region	Specified Professionals	Specified Institutions	Stage of Pregnancy	Approval Procedures	Cost** to government	Cost** to client
ASIA & OCEANIA (cont'd) Bangladesh	1. Registered medical practitioner 2. Appropriately trained health personnel	1. Hospital 2. Out-patient abortions done during first six weeks		Practice suggests 2nd medical opinion	Free of cost at govt. hospital or medical centre	
Fiji						
Hong Kong	Registered medical practitioner	Government hospital of a hospital or clinic approved by notice in the Gazette by the Director of Medical and Health Services		Law requires 2nd medical opinion except in emergency cases		
India	Registered medical practitioner with prescribed training or experience in obs. and gyns. as provided in MTP Rules, 1975	Government hospital or government approved institution as provided in MTP Rules, 1975	20 weeks unless 'immediately necessary to save the life of the pregnant woman '	Law requires 2nd medical opinion between 12 and 20 weeks except in emergency cases	Free of cost in government hospital	In non-govt institution at client's expense

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ABORTION IN COMMONWEALTH COUNTRIES

Commonwealth Country by Region	Specified Professionals	Specified Institutions	Stage of Pregnancy	Approval Procedures	Cost** to government	Cost** to client
ASIA & OCEANIA (cont'd) Malaysia	Registered medical practitioner	Government, university and other hospitals		Practice suggests 2nd medical opinion		In govt. hospitals free. Other hospitals between $300 and $500 (Malaysian) (UK70.42 -£117.37
Nauru						
New Zealand	Registered medical practitioner	Approved institution		Practice suggests 2nd medical opinion	Free if performed in public hospital	Private hospital $NZ90.00 (UK£51.13)
Papua New Guinea	Registered medical practitioner	A government health institution	Practice suggests up to 12 weeks		K.40.00 (approx. UK£29.00)	Public client K2.00 (approx. £2.00). Intermediate client K.40.00

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ASIA & OCEANIA (cont'd) Singapore	Registered medical practitioners with specified qualifications in obstetrics and gynaecology up to 16th week and further specified qualifications between 16 and 24 weeks	The abortion may be done in any clinic or doctor's office where drugs are used but it has to be done in a hospital or a government approved institution where surgical procedures are used	24 weeks			Limited by statute $5.00 (Singapore) (UK£1.18)
Sri Lanka						
Tonga						
Western Samoa						
EUROPE Cyprus	Registered medical practitioner	Hospital or approved clinic		Law requires 2nd medical opinion and competent police authority where the pregnancy is a result of rape	Free medical treatment in government hospitals	
Malta						

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Commonwealth Country by Region	Specified Professionals	Specified Institutions	Stage of Pregnancy	Approval Procedures	Cost** to government	Cost** to client
EUROPE (cont'd)						
United Kingdom	Registered medical practitioner	Government hospital or institution approved by the Secretary of State	1. Up to 20 weeks in an approved institution 2. Up to 28 weeks in a government hospital or approved institution specially authorised to do so	Law requires 2nd medical opinion except in emergency cases	Not assessed separately - part of total cost of all hospital gyn. services	1. No charge if operation performed under National Health Service 2. Hospital in-patient: £80. Clinic out-patient: £25
WESTERN HEMISPHERE						
Antigua						
Barbados						
The Bahamas	Registered medical practitioner	Hospital, not necessarily government	Practice suggests 20 weeks (Majority under 12 weeks)		For non-paying patients in govt. hospital	For private paying patients in govt. hospital
Belize			28 weeks			

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Commonwealth Country by Region	Specified Professionals	Specified Institutions	Stage of Pregnancy	Approval Procedures	Cost** to government	Cost** to client
WESTERN HEMISPHERE (cont'd) Bermuda						
British Virgin Islands						
Canada	Registered medical practitioner	Accredited or approved hospital		Hospital therapeutic abortion committee (not less than 3 physicians)	Provincial government hospital and medical insurance plans, where applicable	
Dominica						
Grenada						
Guyana						
Jamaica						
St. Kitts/Nevis Anguilla			28 weeks			
St. Lucia						
St. Vincent						
Trinidad & Tobago						

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TABLE III - NATIONAL ASSESSMENT AND PROPOSED CHANGES*

ABORTION LAWS IN COMMONWEALTH COUNTRIES

COMMONWEALTH COUNTRIES BY REGION	GOVERNMENTAL	NON-GOVERNMENTAL
AFRICA		
Botswana	Commission on Family Planning laws (1975).	
The Gambia		
Ghana	1. Ghanaian Law Reform Commission drafted 3 Bills for comment (1973). 2. Reportedly on June 25, 1969, the crime was reduced from a first degree felony with a minimum 10-year prison sentence to a second degree felony subject to an indeterminable sentence not to exceed ten years or a fine.	
Kenya	Statement of ethics issued through Min. of Health, outlining the permitted conditions for MTP (1976).	
Lesotho		
Malawi		
Mauritius		
Nigeria	National Population Council of Nigeria has recommended that women should have access to abortion on request for health and welfare reasons (1976).	Nigeria Medical Association recommended clarification of law along British 1967 Act (1974). The Society of Gynaecologists and Obstetricians of Nigeria called for liberalisation of abortion law in 1975 and re-affirmed its stand in 1976.
Sierre Leone		Medical practitioners recommend extending grounds for abortion (1975).

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TABLE III - NATIONAL ASSESSMENT AND PROPOSED CHANGES*

ABORTION LAWS IN COMMONWEALTH COUNTRIES

COMMONWEALTH COUNTRIES BY REGION	GOVERNMENTAL	NON-GOVERNMENTAL
AFRICA (cont'd)		
Swaziland	Consideration is presently being given to passing a statute to control abortions and extend the indications for it (1976).	
Tanzania		
Uganda		
Zambia		
ASIA & OCEANIA		
Australia	Royal Commission on Human Relations (1977).	Australian Council of Obstetricians and Gynaecologists recommend extension of grounds for abortion (1976).
South Australia	1. Committee appointed to examine and report annually on abortions notified in South South Australia. 2. Proposed change of law to allow out-patient day care abortion (1976).	
Victoria		
New South Wales	State investigation (1977). Bill restricting the availability of MTP failed in the NSW Legislative Assembly (1976).	
Queensland		
Western Australia	Attorney General says no prosecution will be brought provided certain conditions are met (1976).	
Tasmania		
Northern Territory		

* Based on data received by 1 July 1977; amendments and corrections must be notified immediately to the Legal or Medical Division of the Commonwealth Secretariat.

TABLE III - NATIONAL ASSESSMENT AND PROPOSED CHANGES*

ABORTION LAWS IN COMMONWEALTH COUNTRIES

COMMONWEALTH COUNTRIES BY REGION	GOVERNMENTAL	NON-GOVERNMENTAL
ASIA & OCEANIA (cont'd)		
Capital Territory	1. Report of the Working Party on Territorial Criminal Law with amended provisions with respect to abortion (1975). 2. Legislative Inquiry into the feasability of establishing a clinic (1977).	
Bangladesh	Draft bill pending (1977).	
Fiji	Second Report of the Select Committee on Population Trends in Fiji: A Review and Recommendations of Abortion Law in Fiji (1976).	Fiji Medical and Dental Board suspended Dr. Emberson's licence for 9 months. Right to Appeal to Supreme Court against suspension not exercised (1976).
Hong Kong		
India		
Malaysia		Subcommittee on Abortion of the Malaysian Medical Association did opinion survey of doctors showing 85% of respondents favoured liberalisation(1975).
Nauru	Draft bill pending in conjunction with the Revision of the Penal Code (1977).	
New Zealand	McMullin Report (1977).	
Papua New Guinea		
Singapore		

* Based on data received by 1 July 1977; amendments and corrections must be notified immediately to the Legal or Medical Division of the Commonwealth Secretariat.

TABLE III - NATIONAL ASSESSMENT AND PROPOSED CHANGES*

ABORTION LAWS IN COMMONWEALTH COUNTRIES

COMMONWEALTH COUNTRIES BY REGION	GOVERNMENTAL	NON-GOVERNMENTAL
ASIA & OCEANIA (cont'd)		
Sri Lanka		National Seminar on Law and Population in 1974 and sub-committee on Abortion of Medical Association of Sri Lanka recommended in 1975 clarification of law so as not to make it a criminal offence for doctor to do abortion for reasons of physical and mental health of the woman. "The Seminar on the Role of the Medical Profession in Relation to Population Law in Sri Lanka organised by the Law and Population Committee of the Family Planning Association of Sri Lanka, in collaboration with the Department of Forensic Medicine of the University of Sri Lanka and the Law and Population Project of Sri Lanka, held in November 1976, endorsed this recommendation, and further recommended that the law be amended also to encompass situations where termination is requested on the grounds of (a) failure of contraceptives; and (b) social and humanitarian considerations."
Tonga		
Western Samoa		

* Based on data received by 1 July 1977; amendments and corrections must be notified immediately to the Legal or Medical Division of the Commonwealth Secretariat.

TABLE III - NATIONAL ASSESSMENT AND PROPOSED CHANGES*

ABORTION LAWS IN COMMONWEALTH COUNTRIES

COMMONWEALTH COUNTRIES BY REGION	GOVERNMENTAL	NON-GOVERNMENTAL
EUROPE		
Cyprus		Cyprus Medical Association supports the changes effected by the 1974 Amendment (1976).
Malta		
United Kingdom	1. Lane Report (1974). 2. Parliamentary Select Committee on abortion (1976). 3. Abortion (Amendment) Bill (House of Commons) (1977). 4. House of Commons Expenditure Committee recommended out-patient day care abortion units (1977).	1. British Royal Society of Obstetrics and Gynaecology continually recommends maintaining the 1967 Act. 2. Doctors for Women's Choice on Abortion established in 1976 to change present British law to enable the woman to decide herself about continuation of her pregnancy.
WESTERN HEMISPHERE		
Antigua	Government reviewing the law (1977).	
Barbados	1. Governmental Committee recommended an extended law (1975). 2. Discussion on Draft Bill (1977).	National survey of doctors, nurses and social workers on liberalisation of the Barbados Abortion Law (1976).
The Bahamas	Minister of Health says need for clarification (1976).	
Belize		
Bermuda	An extended Bill was prepared and examined by a Select Committee of the Legislature (1973).	
British Virgin Islands		

* Based on data received by 1 July 1977; amendments and corrections must be notified immediately to the Legal or Medical Division of the Commonwealth Secretariat.

TABLE III - NATIONAL ASSESSMENT AND PROPOSED CHANGES*

ABORTION LAWS IN COMMONWEALTH COUNTRIES

COMMONWEALTH COUNTRIES BY REGION	GOVERNMENTAL	NON-GOVERNMENTAL
WESTERN HEMISPHERE (cont'd)		
Canada	Badgley Report (1977)	Canadian Medical Association recommended decriminalisation of abortion. Canadian Bar Assn. recommended postponement of abortion trials until law be reconsidered
Dominica		
Grenada		
Guyana	Special Select Committee of the National Assembly appointed to consider abortion law, among other issues (1971).	
Jamaica	Plans to codify common law (1976).	Ghobham Society (professional organisation of obstetricians and gynaecologists) recommended extending the law for physical, mental health and socio-economic reasons (1971). National survey of physicians, nurses and midwives (1973).
Monserrat		
St. Kitts/Nevis Anguilla		
St. Lucia		
St. Vincent	Committee created by Minister of Health to consider the matter (1977).	St. Vincent Medical Association recommends a change in the law for allow for MTP on broad indications (1977).

* Based on data received by 1 July 1977; amendments and corrections must be notified immediately to the Legal or Medical Division of the Commonwealth Secretariat.

TABLE III - NATIONAL ASSESSMENT AND PROPOSED CHANGES*

ABORTION IN COMMONWEALTH COUNTRIES

COMMONWEALTH COUNTRIES BY REGION	GOVERNMENTAL	NON-GOVERNMENTAL
WESTERN HEMISPHERE (cont'd)		
Trinidad and Tobago	Nat. Commission on the Status of Women recommended that the medical profession be presented with clearer guidelines for abortion (1975).	Medical Association Select Committee created 1977 to make recommendations by 1978 on abortion laws. 3 opinion surveys undertaken - by the University of West Indies of doctors' attitudes; Housewives Assn. of womens' attitudes; and Professional Business Womens Assn. of business womens' attitudes on changing abortion law (1977).

* Based on data received by 1 July 1977; amendments and corrections must be notified immediately to the Legal or Medical Division of the Commonwealth Secretariat.

APPENDIX I

Division of Jurisdictions with Basic, Developed and Advanced Laws*

(following table sequence)

BASIC	DEVELOPED	ADVANCED
Africa	**Africa**	**Africa**
Botswana	Ghana	Zambia
Gambia	Kenya	
Malawi	Southern States (Nigeria)	
Mauritius	Sierre Leone	
Northern States (Nigeria)	Uganda	
Asia and Oceania	**Asia and Oceania**	**Asia and Oceania**
Queensland (Australia)	Victoria (Australia)	South Australia (Australia)
Western Australia	New South Wales (Australia)	Northern Territory (Australia)
Nauru	Capital Territory (Australia)	Hong Kong
Sri Lanka	Bangladesh	India
Tonga	Fiji	Kashmir (India)
Western Samoa	Peninsular Malaysia	Singapore
	Sabah (Malaysia)	
	Sarawak (Malaysia)	
	New Zealand	
	Papua New Guinea	
Europe	**Europe**	**Europe**
Malta	Northern Ireland (U.K.)	Cyprus
		Britain (U.K.)
Western Hemisphere	**Western Hemisphere**	**Western Hemisphere**
Antigua	Barbados	Canada
Belize	Bahamas	
Dominica	Bermuda	
Grenada	British Virgin Islands	
Monserrat	Guyana	
St. Lucia	Jamaica	
	St. Kitts/Nevis Anguilla	
	St. Vincent	
	Trinidad & Tobago	

* Excluding Lesotho and Swaziland, which are governed by Roman-Dutch Common law.

APPENDIX II

THREE COMMONWEALTH STATUTES AND INSTRUMENTS

The British Abortion Act 1967
The Abortion Regulations 1968
The Abortion (Amendment) Regulations 1976

The Indian Medical Termination of Pregnancy Act, 1971
The Medical Termination of Pregnancy Rules, 1975
The Medical Termination of Pregnancy Regulations, 1975

The Singapore Abortion Act, 1974
The Abortion Regulations, 1974

ELIZABETH II

1967 CHAPTER 87

An Act to amend and clarify the law relating to termination of pregnancy by registered medical practitioners. [27th October 1967]

BE IT ENACTED by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

Medical termination of pregnancy

1.—(1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—

(*a*) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

(*b*) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (*a*) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the said Minister or the Secretary of State.

(4) Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Notification

2.—(1) The Minister of Health in respect of England and Wales, and the Secretary of State in respect of Scotland, shall by statutory instrument make regulations to provide—

(*a*) for requiring any such opinion as is referred to in section 1 of this Act to be certified by the practitioners or practitioner concerned in such form and at such time as may be prescribed by the regulations, and for requiring the preservation and disposal of certificates made for the purposes of the regulations;

(*b*) for requiring any registered medical practitioner who terminates a pregnancy to give notice of the termination and such other information relating to the termination as may be so prescribed;

(*c*) for prohibiting the disclosure, except to such persons or for such purposes as may be so prescribed, of notices given or information furnished pursuant to the regulations.

(2) The information furnished in pursuance of regulations made by virtue of paragraph (*b*) of subsection (1) of this section shall be notified solely to the Chief Medical Officers of the Ministry of Health and the Scottish Home and Health Department respectively.

(3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of regulations under subsection (1) of this section shall be liable on summary conviction to a fine not exceeding one hundred pounds.

(4) Any statutory instrument made by virtue of this section shall be subject to annulment in pursuance of a resolution of either House of Parliament.

Application of Act to visiting forces etc.

3.—(1) In relation to the termination of a pregnancy in a case where the following conditions are satisfied, that is to say—

(*a*) the treatment for termination of the pregnancy was carried out in a hospital controlled by the proper authorities of a body to which this section applies; and

(*b*) the pregnant woman had at the time of the treatment a relevant association with that body; and

(*c*) the treatment was carried out by a registered medical practitioner or a person who at the time of the treatment was a member of that body appointed as a medical practitioner for that body by the proper authorities of that body,

this Act shall have effect as if any reference in section 1 to a registered medical practitioner and to a hospital vested in a Minister under the National Health Service Acts included respectively a reference to such a person as is mentioned in paragraph (*c*) of this subsection and to a hospital controlled as aforesaid, and as if section 2 were omitted.

(2) The bodies to which this section applies are any force which is a visiting force within the meaning of any of the provisions of Part I of the Visiting Forces Act 1952 and any headquarters within the meaning of the Schedule to the International Headquarters and Defence Organisations Act 1964; and for the purposes of this section—

(*a*) a woman shall be treated as having a relevant association at any time with a body to which this section applies if at that time—

(i) in the case of such a force as aforesaid, she had a relevant association within the meaning of the said Part I with the force; and

(ii) in the case of such a headquarters as aforesaid, she was a member of the headquarters or a dependant within the meaning of the Schedule aforesaid of such a member; and

(*b*) any reference to a member of a body to which this section applies shall be construed—

(i) in the case of such a force as aforesaid, as a reference to a member of or of a civilian component of that force within the meaning of the said Part I; and

(ii) in the case of such a headquarters as aforesaid, as a reference to a member of that headquarters within the meaning of the Schedule aforesaid.

Conscientious objection to participation in treatment

4.—(1) Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection:

Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

(2) Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

(3) In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section.

Supplementary provisions

5.—(1) Nothing in this Act shall affect the provisions of the Infant Life (Preservation) Act 1929 (protecting the life of the viable foetus).

(2) For the purposes of the law relating to abortion, anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorised by section 1 of this Act.

Interpretation

6. In this Act, the following expressions have meanings hereby assigned to them:-

" the law relating to abortion " means sections 58 and 59 of the Offences against the Person Act 1861, and any rule of law relating to the procurement of abortion;

" the National Health Service Acts " means the National Health Service Acts 1946 to 1966 or the National Health Service (Scotland) Acts 1947 to 1966.

Short title, commencement and extent

7.—(1) This Act may be cited as the Abortion Act 1967.

(2) This Act shall come into force on the expiration of the period of six months beginning with the date on which it is passed.

(3) This Act does not extend to Northern Ireland.

1968 No. 390

MEDICAL PROFESSION

The Abortion Regulations 1968

Made - - - -	*15th March* 1968
Laid before Parliament	*1st April* 1968
Coming into Operation	*27th April* 1968

The Minister of Health, in exercise of the powers conferred on him by section 2 of the Abortion Act 1967(a) and of all other powers enabling him in that behalf, hereby makes the following regulations:—

Citation and commencement

1. These regulations may be cited as the Abortion Regulations 1968, and shall come into operation on 27th April 1968.

Interpretation

2.—(1) In these regulations "the Act" means the Abortion Act 1967 and "practitioner" means a registered medical practitioner.

(2) The Interpretation Act 1889(b) shall apply to the interpretation of these regulations as it applies to the interpretation of an Act of Parliament.

Certificate of opinion

3.—(1) Any opinion to which section 1 of the Act refers shall be certified in the appropriate form set out in Schedule 1 to these regulations.

(2) Any certificate of an opinion referred to in section 1(1) of the Act shall be given before the commencement of the treatment for the termination of the pregnancy to which it relates.

(3) Any certificate of an opinion referred to in section 1(4) of the Act shall be given before the commencement of the treatment for the termination of the pregnancy to which it relates or, if that is not reasonably practicable, not later than 24 hours after such termination.

(4) Any such certificate as is referred to in paragraphs (2) and (3) of this regulation shall be preserved by the practitioner who terminated the pregnancy to which it relates for a period of three years beginning with the date of such termination and may then be destroyed.

Notice of termination of pregnancy and information relating thereto

4.—(1) Any practitioner who terminates a pregnancy shall within 7 days of the termination give to the Chief Medical Officer of the Ministry of Health notice thereof and the other information relating to the termination in the form set out in Schedule 2 to these regulations.

(a) 1967 c. 87. (b) 1889 c. 63.

[M.H. 795]

(2) Any such notice and information shall be sent in a sealed envelope to the Chief Medical Officer, Ministry of Health, Alexander Fleming House, Elephant and Castle, London, S.E.1.

Restriction on disclosure of information

5. A notice given or any information furnished to the Chief Medical Officer in pursuance of these regulations shall not be disclosed except that disclosure may be made—

(*a*) for the purposes of carrying out their duties,

(i) to an officer of the Ministry of Health authorised by the Chief Medical Officer of that Ministry, or

(ii) to the Registrar General or a member of his staff authorised by him; or

(*b*) for the purposes of carrying out his duties in relation to offences against the Act or the law relating to abortion, to the Director of Public Prosecutions or a member of his staff authorised by him; or

(*c*) for the purposes of investigating whether an offence has been committed against the Act or the law relating to abortion, to a police officer not below the rank of superintendent or a person authorised by him; or

(*d*) for the purposes of criminal proceedings which have begun; or

(*e*) for the purposes of bona fide scientific research; or

(*f*) to the practitioner who terminated the pregnancy; or

(*g*) to a practitioner, with the consent in writing of the woman whose pregnancy was terminated.

SCHEDULE 1

IN CONFIDENCE **Certificate A**

Not to be destroyed within three years of the date of operation

ABORTION ACT 1967

CERTIFICATE TO BE COMPLETED BEFORE AN ABORTION IS PERFORMED UNDER SECTION 1(1) OF THE ACT

I, ...
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

and I, ...
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

hereby certify that we are of the opinion, formed in good faith, that in the case

of .....
(Full name of pregnant woman in block capitals)

of .....

.....
(Usual place of residence of pregnant woman in block capitals)

(Ring appropriate number(s))

1. the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;

2. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;

3. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greater than if the pregnancy were terminated;

4. there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers.

Signed .....

Date.....

Signed .....

Date.....

SCHEDULE 1

IN CONFIDENCE **Certificate B**

Not to be destroyed within three years of the date of operation

ABORTION ACT 1967

CERTIFICATE TO BE COMPLETED IN RELATION TO ABORTION PERFORMED IN EMERGENCY UNDER SECTION 1(4) OF THE ACT

I, ...
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

hereby certify that I *am/was of the opinion formed in good faith that it *is/was necessary immediately to terminate the pregnancy of

.....
(Full name of pregnant woman in block capitals)

of .....

.....
(Usual place of residence of pregnant woman in block capitals)

(Ring appropriate number) in order 1. to save the life of the pregnant woman; or

2. to prevent grave permanent injury to the physical or mental health of the pregnant woman.

This certificate of opinion is given—

(Ring appropriate letter) A. before the commencement of the treatment for the termination of the pregnancy to which it relates; or,
if that is not reasonably practicable, then

B. not later than 24 hours after such termination.

Signed .....

Date.....

*Delete as appropriate

SCHEDULE 2

IN CONFIDENCE

ABORTION ACT 1967

NOTIFICATION TO THE CHIEF MEDICAL OFFICER OF AN ABORTION PERFORMED UNDER SECTION 1 OF THE ACT

I, ...

(Name and qualifications of practitioner in block capitals)

of .....

.....

(Full address of practitioner)

hereby give notice that I terminated the pregnancy of

.....

(Full name of pregnant woman in block capitals)

of .....

.....

(Usual place of residence of pregnant woman in block capitals)

The grounds for terminating the pregnancy were certified as:—

(Ring appropriate numbers)

1. the continuance of the pregnancy would have involved risk to the life of the pregnant woman greater than if the pregnancy were terminated;
2. the continuance of the pregnancy would have involved risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;
3. the continuance of the pregnancy would have involved risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greater than if the pregnancy were terminated;
4. there was a substantial risk that if the child had been born it would have suffered from such physical or mental abnormalities as to be seriously handicapped;

In case of emergency

The grounds for terminating the pregnancy were:—

5. it was necessary to save the life of the pregnant woman; *or*
6. it was necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Place of termination

The pregnancy was terminated at:

1. N.H.S. hospital
2. Approved place
3. Other place.

(Ring appropriate number)

(address) .....

.....

(on date) .....

Signature of practitioner who terminated pregnancy

.....

In all non-emergency cases, particulars of the practitioner(s) who joined in giving the certificate required for the purposes of section 1 should be shown below in the appropriate space(s):—

If the operating practitioner joined in giving certificate, insert at A. particulars of the other certifying practitioner.

A. Name .....
Address .....
.....
Qualifications .....

If the operating practitioner did not join in giving certificate, insert at A. & B. particulars of the two certifying practitioners.

B. Name .....
Address .....
.....
Qualifications .....

Other information relating to the termination (Items 1 to 8 to be completed to the best of the knowledge and belief of the operating practitioner):	For official use only
1. N.H.S. Number of woman	.....
2. Maiden name of woman	.....
3. Date of birth of woman	.....
4. Marital status of woman: 1. Single 2. Married 3. Widowed 4. Divorced or separated 5. Not known (Ring appropriate number)	.....
5. Occupation ..... NOTE: (a) If woman is married, specify husband's occupation (b) If woman is unmarried, specify her own occupation	.....
6. Date of woman's last menstrual period	.....
7. Previous pregnancies of woman: Number of live-births	.....
stillbirths	.....
abortions	.....
If applicable, date of last termination of pregnancy under the above-mentioned Act	.....
8. Number of woman's existing children*	.....
9. Date of admission to place of termination of pregnancy	.....
10 Date of discharge from place of termination of pregnancy	.....
11. Grounds for termination of pregnancy	.....
(a) Medical condition of woman: Obstetric disease (specify)	.....
Non-obstetric disease (specify)	.....
(b) Suspected medical condition of foetus (specify)	.....
(c) Non-medical grounds for termination of pregnancy (specify)	.....

*children mean a woman's natural children and any adopted, foster or step-children up to the age of 16 years living with her.

For official use only

12. Type of termination of pregnancy:

    1. Dilation and evacuation
    2. Hysterotomy—abdominal
    3. Hysterotomy—vaginal
    4. Hysterectomy
    5. Vacuum aspiration
    6. Other (specify) .....

    (Ring appropriate number)

13. Was sterilization performed? .....

14. Complications or death prior to notification:

    1. None
    2. Sepsis
    3. Haemorrhage
    4. Death
    5. Other (specify) .....

    (Ring appropriate number)

15. In the case of death, specify cause .....

.....

.....

NOTE: This form is to be completed by the operating practitioner and sent in a sealed envelope within seven days of the termination of the pregnancy to the Chief Medical Officer, Ministry of Health, Alexander Fleming House, Elephant and Castle, London, S.E.1.

Given under the official seal of the Minister of Health on 15th March 1968.

(L.S.) *Kenneth Robinson,*

Minister of Health.

EXPLANATORY NOTE

(*This Note is not part of the Regulations.*)

These Regulations, made under the Abortion Act 1967,

(*a*) prescribe forms for the purpose of certifying opinions under section 1 of the Act and the time for such certification (regulation 3(1), (2) and (3) and Schedule 1);

(*b*) provide for the preservation and disposal of such certificates (regulation 3(4));

(*c*) require the notification of the abortion and prescribe the information relevant thereto to be given to the Chief Medical Officer (regulation 4 and Schedule 2); and

(*d*) restrict the disclosure of such notices and information (regulation 5).

STATUTORY INSTRUMENTS

1976 No. 15

MEDICAL PROFESSION

The Abortion (Amendment) Regulations 1976

Made - - - -	*7th January* 1976
Laid before Parliament	*15th January* 1976
Coming into Operation	*1st March* 1976

The Secretary of State for Social Services, as respects England, and the Secretary of State for Wales, as respects Wales, in exercise of the powers conferred by section 2 of the Abortion Act 1967(**a**), as amended by the Transfer of Functions (Wales) Order 1969(**b**), and now vested in them(**c**), and of all other powers enabling them in that behalf, hereby make the following regulations:—

Citation and commencement

1. These regulations may be cited as the Abortion (Amendment) Regulations 1976, and shall come into operation on 1st March 1976.

Interpretation

2.—(1) In these regulations "the Act" means the Abortion Act 1967, as amended, and "the principal regulations" means the Abortion Regulations 1968(**d**), as amended(**e**).

(2) The rules for the construction of Acts of Parliament contained in the Interpretation Act 1889(**f**) shall apply for the purposes of the interpretation of these regulations as they apply for the purposes of the interpretation of an Act of Parliament.

Amendment of regulation 5 of the principal regulations

3. In regulation 5 of the principal regulations (restriction on disclosure of information) there shall be added after paragraph (*g*) the following paragraph:—

> "or (*h*) when requested by the President of the General Medical Council for the purpose of investigating whether there has been serious professional misconduct by a registered medical practitioner, to the President of the General Medical Council or a member of his staff authorised by him.".

Amendment of Schedule 1 to the principal regulations

4. In Schedule 1 to the principal regulations (certificates to be completed before an abortion is performed under section 1 of the Act) for Certificate A there shall be substituted the certificate set out in the Schedule to these regulations.

(a) 1967 c. 87. (b) S.I. 1969/388 (1969 I, p. 1070).
(c) *See* Secretary of State for Social Services Order 1968 (S.I. 1968/1699; 1968 III, p. 4585).
(d) S.I. 1968/390 (1968 I, p. 1060). (e) S.I. 1969/636 (1969 II, p. 1756).
(f) 1889 c. 63.

[H.490]

Amendment of Schedule 2 to the principal regulations

5. In Schedule 2 to the principal regulations (form of notification to be given to the Chief Medical Officer of an abortion performed under section 1 of the Act) immediately before the part of the Schedule headed "*Other information relating to the termination*" there shall be inserted the following:—

"If the operating practitioner joined in giving the certificate did he see/and examine† the pregnant woman before doing so?.....

Has the practitioner named at A certified that he saw/and examined the pregnant woman before giving the certificate?.....

Has the practitioner named at B (if any) certified that he saw/and examined† the pregnant woman before giving the certificate?.....

†Delete as appropriate".

Barbara Castle,

Secretary of State for Social Services.

2nd January 1976.

John Morris,

Secretary of State for Wales.

7th January 1976.

SCHEDULE

Regulation 4
Certificate A

IN CONFIDENCE

Not to be destroyed within three years of the date of operation

ABORTION ACT 1967

CERTIFICATE TO BE COMPLETED BEFORE AN ABORTION IS PERFORMED UNDER SECTION 1(1) OF THE ACT

I, ...

(Name and qualifications of practitioner in block capitals)

of .....

.....

(Full address of practitioner)

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at .....

.....

(Full address of place at which patient was seen or examined)

on .....

and I, ...

.....

(Name and qualifications of practitioner in block capitals)

of .....

.....

(Full address of practitioner)

Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at .....

.....

(Full address of place at which patient was seen or examined)

on .....

We hereby certify that we are of the opinion, formed in good faith, that in the case of .....

(Full name of pregnant woman in block capitals)

of .....

.....

(Usual place of residence of pregnant woman in block capitals)

(*Ring appropriate number(s)*)

1. the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;
2. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;
3. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greater than if the pregnancy were terminated;
4. there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers and relates to the circumstances of the pregnant woman's individual case.

Signed .....

Date.....

Signed .....

Date.....

*Delete as appropriate.

EXPLANATORY NOTE

(This Note is not part of the Regulations.)

These Regulations, made under the Abortion Act 1967, further amend the Abortion Regulations 1968 to allow information furnished to the Chief Medical Officers under those regulations to be disclosed to the President of the General Medical Council, or any authorised member of his staff, for the purpose of investigating whether there has been serious professional misconduct by a doctor. Provision is also made for a doctor when giving a certificate under section 1(1) of the Abortion Act 1967 to state therein whether he has or has not seen and examined the pregnant woman before doing so.

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LAW AND JUSTICE (MINISTRY OF.....)

THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971

No. 34 OF 1971

[10th *August*, 1971]

An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto.

BE it enacted by Parliament in the Twenty-second Year of the Republic of India as follows:—

Short title, extent and commencement

1. (1) This Act may be called the Medical Termination of Pregnancy Act, 1971.

(2) It extends to the whole of India except the State of Jammu and Kashmir.

(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

Definitions

2. In this Act, unless the context otherwise requires,—

(*a*) "guardian" means a person having the care of the person of a minor or a lunatic;

Price: *Re.* 0·20 *P. or* 4 *d.*

(*b*) "lunatic" has the meaning assigned to it in section 3 of the Indian Lunacy Act, 1912; 4 of 1912.

(*c*) "minor" means a person who, under the provisions of the Indian Majority Act, 1875, is to be deemed not to have attained his majority; 9 of 1875

(*d*) "registered medical practitioner" means a medical practitioner who possesses any recognised medical qualification as defined in clause (*h*) of section 2 of the Indian Medical Council Act, 1956, whose name has been entered in a State Medical Register and who has such experience or training in gynaecology and obstetrics as may be prescribed by rules made under this Act. 102 of 1956.

When pregnancies may be terminated by registered medical practitioners

3. (*1*) Notwithstanding anything contained in the Indian Penal Code, a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act. 45 of 1860.

(*2*) Subject to the provisions of sub-section (*4*), a pregnancy may be terminated by a registered medical practitioner,—

(*a*) where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or

(*b*) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are,

of opinion, formed in good faith, that—

(*i*) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(*ii*) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped

Explanation I.—Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation II.—Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(*3*) In determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in sub-section (*2*), account may be taken of the pregnant woman's actual or reasonably foreseeable environment

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman.

Place where pregnancy may be terminated.

4. No termination of pregnancy shall be made in accordance with this Act at any place other than—

(a) a hospital established or maintained by Government, or

(b) a place for the time being approved for the purpose of this Act by Government.

Sections 3 and 4 when not to apply.

5. (1) The provisions of section 4, and so much of the provisions of sub-section (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

45 of 1860.

(2) Notwithstanding anything contained in the Indian Penal Code, the termination of a pregnancy by a person who is not a registered medical practitioner shall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.

Explanation.—For the purposes of this section, so much of the provisions of clause (d) of section 2 as relate to the possession, by a registered medical practitioner, of experience or training in gynaecology and obstetrics shall not apply.

Power to make rules.

6. (1) The Central Government may, by notification in the Official Gazette, make rules to carry out the provisions of this Act.

(2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely:—

(a) the experience or training, or both, which a registered medical practitioner shall have if he intends to terminate any pregnancy under this Act; and

(b) such other matters as are required to be or may be, provided by rules made under this Act.

(3) Every rule made by the Central Government under this Act shall be laid, as soon as may be after it is made, before each House of Parliament while it is in session for a total period of thirty days which may be comprised in one session or in two successive sessions, and if, before the expiry of the session in which it is so laid or the session immediately following, both Houses agree in making any modification in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

Power to make regulations.

7. (*1*) The State Government may, by regulations,—

(*a*) require any such opinion as is referred to in sub-section (*2*) of section 3 to be certified by a registered medical practitioner or practitioners concerned, in such form and at such time as may be specified in such regulations, and the preservation or disposal of such certificates;

(*b*) require any registered medical practitioner, who terminates a pregnancy, to give intimation of such termination and such other information relating to the termination as may be specified in such regulations;

(*c*) prohibit the disclosure, except to such persons and for such purposes as may be specified in such regulations, of intimations given or information furnished in pursuance of such regulations.

(*2*) The intimation given and the information furnished in pursuance of regulations made by virtue of clause (*b*) of sub-section (*1*) shall be given or furnished, as the case may be, to the Chief Medical Officer of the State.

(*3*) Any person who wilfully contravenes or wilfully fails to comply with the requirements of any regulation made under sub-section (*1*) shall be liable to be punished with fine which may extend to one thousand rupees.

Protection of action taken in good faith.

8. No suit or other legal proceeding shall lie against any registered medical practitioner for any damage caused or likely to be caused by anything which is in good faith done or intended to be done under this Act

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GMGIPND—M—65 Law—2-3-72—7,000

MINISTRY OF HEALTH AND FAMILY PLANNING

(Department of Family Planning)

New Delhi, the 10th October, 1975

G.S.R. 2543.—In exercise of the powers conferred by section 6 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following rules, namely:—

1. Short title and commencement.—(1) These rules may be called the Medical Termination of Pregnancy Rules, 1975.

(2) They shall come into force on the date of their publication in the Official Gazette.

2. Definitions.—In these rules, unless the context otherwise requires,

(a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971);

(b) "Chief Medical Officer of the District" means the Chief Medical Officer of a District, by whatever name called;

(c) "Form" means a form appended to these rules;

(d) "Owner" in relation to a place, means any person who is the administrative head or otherwise responsible for the working or maintenance of such hospital or clinic, by whatever name called;

(e) "Place" means such building, tent, vehicle, or vessel, or part thereof, as is used for the establishment or maintenance therein of a hospital or clinic which is used, or intended to be used, for the termination of any pregnancy;

(f) "Section" means a section of the Act.

3. Experience or training etc.—For the purpose of clause (d) of section 2, a registered medical practitioner shall have one or more of the following experience or training in gynaecology and obstetrics, namely;

(a) In the case of a medical practitioner who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period of not less than three years;

(b) in the case of a medical practitioner who was registered in a State Medical Register on or after the date of the commencement of the Act,—

(i) if he has completed six months of house surgency in gynaecology and obstetrics; or

(ii) unless the following facilities are provided therein, if he had experience at any hospital for a period of not less than one year in the practice of obstetrics and gynaecology; or

(iii) if he has assisted a registered medical practitioner in the performance of twenty five cases of medical termination of pregnancy in a hospital established or maintained, or a training institute approved for this purpose, by the Government.

(c) in the case of a medical practitioner who has been registered in a State Medical Register and who holds a post-graduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.

4. Approval of a place.—

(1) No place shall be approved under clause (b) of section 4,—

(i) unless the Government is satisfied that termination of pregnancies may be done therein under safe and hygienic conditions; and

(ii) unless the following facilities are proyided therein, namely :—

(a) An operation table and instruments for performing abdominal or gynaecological surgery;

(b) anaesthetic equipment, resuscitation equipment and sterilisation equipment;

(c) drugs and parenteral fluids for emergency use.

(2) Every application for the approval of a place shall be in a form A and shall be addressed to the Chief Medical Officer of the District.

(3) On receipt of an application referred to in sub-rule (2), the Chief Medical Officer of the District shall verify or enquire any information contained in any such application or inspect any such place with a view to satisfying himself that the facilities referred to in sub-rule (1) are provided therein, and that termination of pregnancies may be made therein under safe and hygienic conditions.

(4) Every owner of the place which is inspected by the Chief Medical Officer of the District shall afford all reasonable facilities for the inspection of the place.

(5) The Chief Medical Officer of the District may, if he is satisfied after such verification, enquiry or inspection, as may be considered necessary, that termination of pregnancies may be done under safe and hygienic conditions, at the place, recommend the approval of such place to the Government.

(6) The Government may after considering the application and the recommendations of the Chief Medical Officer of the District approve such place and issue a certificate of approval in Form B.

(7) The certificate of approval issued by the Government shall be conspicuously displayed at the place to be easily visible to persons visiting the place.

5. Inspection of a place.(1) A place approved under rule 4 may be inspected by the Chief Medical Officer of the District, as often as may be necessary with a view to verify whether termination of pregnancies is being done therein under safe and hygienic conditions.

(2) If the Chief Medical Officer has reason to believe that there has been death of, or injury to, a pregnant woman at the place or that termination of pregnancies is not being done at the place under safe and hygienic conditions, he may call for any information or may seize any article, medicine, ampule, admission register or other document, maintained, kept or found at the place.

(3) The provisions of the Code of Criminal Procedure, 1973 (2 of 1974), relating to seizure shall, so far as may be, apply to seizure made under sub-rule (2).

6. Cancellation or suspension of certificate of approval.—

(1) If, after inspection of any place approved under rule 4, the Chief Medical Officer of the District is satisfied that the facilities specified in rule 4 are not being properly maintained therein and the termination of pregnancy at such place cannot be made under safe and hygienic conditions, he shall make a report of the fact to the Government giving the detail of the deficiencies or defects found at the place. On receipt of such report the Government may, after giving the owner of the place a reasonable opportunity of being heard, either cancel the certificate of approval or suspend the same for such period as it may think fit.

(2) Where a certificate issued under rule 4 is cancelled or suspended, the owner of the place may make such additions or improvements in the place as he may think fit and there after, he may make an application to the Government for the issue to him of a fresh certificate of approval under rule 4 or, as the case may be, for the revival of the certificate which was suspended under sub-rule (1).

(3) The provisions of rule 4 shall, as far as may, apply to an application for the issue of a fresh certificate of approval in relation to a place, or as the case may be, for the revival of a suspended certificate as they apply to an application for the issue of a certificate of approval under that rule.

(4) In the event of suspension of a certificate, of approval, the place shall not be deemed to be an approved place for the purposes of termination of pregnancy from the date of communication of the order of such suspension.

7. Review :

(1) The owner of a place who is aggrieved by an order made under rule 6, may make an application for review of the order to the Government within a period of sixty days from the date of such order.

(2) The Government may, after giving the owner an opportunity of being heard, confirm, modify or reverse the order.

8. Form of consent.—The consent referred to in sub-section (4) of section 3 shall be given in Form C.

9. Repeal and saving.—The Medical Termination of Pregnancy Rules, 1972, are hereby repealed except as respects things done or omitted to be done before such repeal.

FORM A

(See sub-rule (2) of rule 4)

Form of application for the approval of a place under clause (b) of section 4.

1. Name of the place (in capital letters)

2. Address in full.

3. Non-Governmental/Private/Nursing Home/Other Institutions*.

4. State, if the following facilities are available at the place.

(i) An operation table and instruments for performing abdominal or gynaecological surgery.

(ii) Drugs and parenteral fluid in sufficient supply for emergency cases.

(iii) Anaesthetic equipment, resuscitation equipment and sterilisation equipment.

Place :
Date

Signature of the owner
of the place

*Strike out whichever is not applicable.

FORM B

(See sub-rule (6) of rule 4)

Certificate of approval.

The place described below is hereby approved for the purpose of the Medical Termination of Pregnancy Act, 1971 (34 of 1971).

Name of the Place
Address and other
descriptions
Name of the owner
Place :
Date

to the Government of the————

FORM C

(See rule 8)

I ..... daughter/wife of .....
..... aged about..... years of
.. ..

(here state the permanent address)

at present residing at .....
do hereby give my consent to the termination of my pregnancy at ....

(State the name of place where the pregnancy is to be terminated)

Place :
Date :

Signature

(To be filled in by guardian where the woman is a lunatic or minor)

I ..... son/daughter/wife of
.....aged about .....years
of .....at present residing at.....

(Permanent address)

.....do hereby give my consent to to the termination of the pregnancy of my ward.....
.....who is a minor/lunatic
at.....

(place of termination of pregnancy)

Signature

Place :
Date :

[No. 4-6(i)/75-MTP&OP]
SERLA GREWAL, Jt. Secy.

New Delhi, the 10th October, 1975

G.S.R. 2544.—In exercise of the powers conferred by section 7 of the Medical Termination of Pregnancy Act, 1971 (34 of 1971), the Central Government hereby makes the following regulations, namely :—

1. Short title extent and commencement.—(1) These regulations may be called the Medical Termination of Pregnancy Regulations, 1975.

(2) They extend to all the Union territories.

(3) They shall come into force on the date of their publication in the Official Gazette.

2. Definitions.—In these regulations, unless the context otherwise requires,—

(a) "Act" means the Medical Termination of Pregnancy Act, 1971 (34 of 1971) ;

(b) "Admission Register" means the register maintained under regulation 5 ;

(c) "approved place" means a place approved under rule 4 of the Medical Termination of Pregnancy Rules, 1975 ;

(d) "Chief Medical Officer of the State" means the Chief Medical Officer of the State, by whatever name called ;

(e) "Form" means a form appended to these regulations ;

(f) "hospital" means a hospital established or maintained by the Central Government or the Government of Union territory ;

(g) "section" means a section of the Act.

3. Form of certifying opinion or opinions.—

(1) Where one registered medical practitioner forms or not less than two registered medical practitioners form such opinion as is referred to in sub-section (2) of section 3 or 5, he or they shall certify such opinion in Form I.

(2) Every registered medical practitioner who terminates any pregnancy shall, within three hours from the termination of the pregnancy certify such termination in Form I.

4. Custody of forms.—(1) The consent given by a pregnant woman for the terminatioin of her pregnancy, together with the certified opinion recorded under section 3 or section 5, as the case may be and the intimation of termination of pregnancy shall be placed in an envelope which shall be sealed by the registered medical practitioner or practitioners by whom such termination of pregnancy was performed and until that envelope is sent to the head of the hospital or owner of the approved place or the Chief Medical Officer

of the State, it shall be kept in the safe custody of the concerned registered medical practitioner or practitioners, as the case may be.

(2) On every envelope referred to in sub-regulation (1), pertaining to the termination of pregnancy under section 3, there shall be noted the serial number assigned to the pregnant woman in the Admission Register and the name of the registered medical practitioner or practitioners by whom the pregnancy was terminated and such envelope shall be marked "SECRET".

(3) Every envelope referred to in sub-regulation (2) shall be sent immediately after the termination of the pregnancy to the head of the hospital or owner of the approved place where the pregnancy was terminated.

(4) On receipt of the envelope referred to in sub-regulation (3), the head of the hospital or owner of the approved place shall arrange to keep the same in safe custody.

(5) Every head of the hospital or owner of the approved place shall send to the Chief Medical Officer of the State, a weekly statement of cases where medical termination of pregnancy has been done in Form II.

(6) On every envelope referred to in sub-regulation (1), pertaining to a termination of pregnancy under section 5, shall be noted the name and address of the registered medical practitioner by whom the pregnancy was terminated and the date on which the pregnancy was terminated and such envelopes shall be marked "SECRET".

Explanation.—The columns pertaining to the hospital or approved place and the serial number assigned to the pregnant woman in the Admission Register shall be left blank in Form I in the case of termination performed under section 5.

(7) Where the Pregnancy is not terminated in an approved place or hospital, every envelope referred to in sub-regulation (6) shall be sent by registered post to the Chief Medical Officer of the State on the same day on which the pregnancy was terminated or on the working day next following the day on which the pregnancy was terminated :

Provided that where the pregnancy is terminated in an approved place or hospital, the procedure provided in sub-regulations (1) to (6) shall be followed.

5. Maintenance of Admission Register.—

(1) Every head of the hospital or owner of the approved place shall maintain a register in form III for recording therein the admissions of women for the termination of their pregnancies.

(2) The entires in the Admission Register shall be made serially and a fresh serial shall be started at the commencement of each calendar year and the serial number of the particular year shall be distinguished from the serial number of other years by mentioning the year against the serial number, for example, serial number 5 of 1972 and serial number 5 of 1973 shall be mentioned as 5/1972 and 5/1973.

(3) The Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person.

6. Admission Register not to be open to inspection.—The Admission Register shall be kept in the safe custody of the head of the hospital or owner of the approved place, or by any person authorised by such head or owner and save as otherwise provided in sub-regulation (5) of regulation 4 shall not be open to inspection by any person except under the authority of;—

(i) in the case of a departmental or other enquiry, the Chief Secretary to the Government of a Union territory ;

(ii) in the case of an investigation into an offence, a Magistrate of the First Class within the local limits or whose jurisdiction the hospital or approved place is situated ;

(iii) in the case of suit or other action for damages, the District Judge, within the local limits of whose jurisdiction the hospital or approved place is situated:

Provided that the registered medical practitioner shall, on the application of an employed woman whose pregnancy has been terminated, grant a certificate for the purpose of enabling her to obtain leave from her employer :

Provided further that any such employer shall not disclose this information to any other person.

7. Entries in registers maintined in hospital or approved place.—No entry shall be made in any case-sheet, operation theatre register, follow-up card or any other document or register (except the Admission Register) maintained at any hospital or approved place indicating therein the name of the pregnant woman and reference to the pregnant woman shall be made therein by the serial number assigned to such woman in the Admission Register.

8. Destruction of Admission Register and other Papers.—Save as otherwise directed by the Chief Secretary to the Union territory Administration or for in relation to any proceeding pending before him, as directed by a District Judge or a Magistrate of the First Class, every Admission Register shall be destroyed on the expiry of a period of five years from the date of the last entry in that Register and other papers on the expiry of a period of three years from the date of the termination of the pregnancy concerned.

SECRET

FORM I

(See Regulation 3)

.....

(Name and qualifications of the Registered Medical

.....

Practitioner in block letters)

.....

(Full address of the Registered Medical Practitioner)

I .....

(Name and qualifications of the Registered Medical

.....

Practitioner in block letters)

.....

(Full address of the Registered Medical Practitioner)

hereby certify that *I/We am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of.....

(Full name of pregnant woman in block letters)

resident of.....

(Full address of woman in block letters)

for the reasons given below**.

*I/we hereby give intimation that *I/We terminated the pregnancy of the woman referred to above who bears the serial No.————————in the Admission Register of the Hospital/approved place.

Signature of
Registered Medical Practitioner

Signatures of Registered
Medical Practitioners

Place :

Date :

*Strike out whichever is not applicable.

**of the reasons specified items (i) to (v) write the one which is appropriate :—

(i) In order to save the life of the pregnant woman.

(ii) In order to prevent grave injury to the physical or mental health of the pregnant woman.

(iii) In view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(iv) As the pregnancy is alleged by pregnant woman to have been caused by rape.

(v) As the pregnancy has occurred as a result of failure of any contraceptive device or methods used by married woman or her husband for the purpose of limiting the number of children.

Note.—Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in determining whether the continuance of a pregnancy would involve a grave injury to her physical or mental health.

Place :

Date :

Signature of the
Registered Medical Practitioner
Signatures of the
Registered Medical Practitioners

FORM II

[See Regulation 4(5)]

1. Name of the State.
2. Name of Hospital/approved place.
3. Duration of pregnancy (give total No. only)
   (a) Upto 12 weeks.
   (b) Between 12—20 weeks.
4. Religion of women.
   (a) Hindu
   (b) Muslim
   (c) Christian
   (d) others
   (e) Total
5. Termination with acceptance of contraception.
   (a) Sterilisation
   (b) I.U.D.
6. Reasons for termination : (give total number under each sub-head).
   (a) Danger to life of the pregnant woman.
   (b) Grave injury to the physical health of the pregnant woman.
   (c) Grave injury to the mental health of the pregnant woman.
   (d) Pregnancy caused by rape.
   (e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
   (f) Failure of any contraceptive device or method.

Signature of the Officer
Incharge with date

FORM III

(See Regulation 5)

ADMISSION REGISTER

(To be destroyed on the expiry of five years from the dated of the last entry in the Register)

S. No.	Date of Admission	Name of patient	Wife/Daughter of	Age	Religion	Address	Duration of Pregnancy
1	2	3	4	5	6	7	8

Reasons on which Pregnancy is terminated	Date of termination of Pregnancy	Date of discharge of Patient	Result and Remarks	Name of Registered Medical Practitioner (s) by whom the opinion is formed.	Name of Registered Medical Practitioner by whom Pregnancy is terminated.
9	10	11	12		14

[No. 4—6 (ii)/75—MTP&OP]

SERLA GREWAL, Jt. Secy.

MGIPRRND—3 M of H & FP/75—Sec. VII—24-11-75—10,000.

REPUBLIC OF SINGAPORE

GOVERNMENT GAZETTE

ACTS SUPPLEMENT

Published by Authority

NO. 39] FRIDAY, DECEMBER 27 [1974

No. A 39—The following Act passed by Parliament on 6th November, 1974, and assented to by the President on 2nd December, 1974, is hereby published for general information.

THE ABORTION ACT, 1974.

(No. 24 of 1974).

ARRANGEMENT OF SECTIONS.

Section.

REPUBLIC OF SINGAPORE

No. 24 of 1974.

I assent.

(LS)

B. H. SHEARES,
President.

2nd December, 1974.

Date of coming into operation: 27th December, 1974.

An Act to consolidate and amend the law relating to termination of pregnancy by registered medical practitioners, to repeal the Abortion Act (Chapter 150 of the Revised Edition) and for matters connected therewith.

Be it enacted by the President with the advice and consent of the Parliament of Singapore, as follows:—

Short title.

1. This Act may be cited as the Abortion Act, 1974.

Interpretation.

2.—(1) In this Act, unless the context otherwise requires —

"approved institution" means any institution, hospital, maternity home, clinic or other place for the time being approved by the Minister for the purposes of this Act;

"Government hospital" means any hospital, maternity home or clinic under the control of the Minister;

"law relating to abortion" means sections 312, 313, 314 and 315 of the Penal Code and any other written law relating to abortion; Cap. 103.

"registered medical practitioner" means any person registered under the Medical Registration Act, who — Cap. 218.

(*a*) is in possession of such medical qualifications as may be prescribed; or

(*b*) has acquired skill in the treatment to terminate pregnancy either in practice or by virtue of holding an appointment in a

Government hospital or in an approved institution over such period as may be prescribed.

(2) The word "abortion" in this Act shall have the same meaning as the word "miscarriage" has under sections 312, 313, 314 and 315 of the Penal Code. Cap. 103.

Medical termination of pregnancy.

3.—(1) Subject to the provisions of this Act, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner acting on the request of a pregnant woman and with her written consent.

(2) Subject to section 11, every treatment to terminate pregnancy shall be carried out by a registered medical practitioner in a Government hospital or in an approved institution.

(3) No treatment to terminate pregnancy shall be carried out by a registered medical practitioner unless the pregnant woman is a citizen of Singapore, or is the wife of a citizen of Singapore or unless she has been resident in Singapore for a period of at least four months immediately preceding the date on which such treatment is to be carried out but the provisions of this subsection shall not apply in any case where such treatment is immediately necessary to save the life of the pregnant woman.

(4) Any person who contravenes or fails to comply with the provisions of this section shall be guilty of an offence under this Act and shall be liable on conviction to imprisonment for a term not exceeding three years or to a fine not exceeding three thousand dollars or to both such imprisonment and fine.

Treatment to terminate pregnancy not to be carried out if pregnancy is of more than a certain duration unless in special circumstances.

4.—(1) No treatment for the termination of pregnancy shall be carried out —

(*a*) if the pregnancy is more than twenty-four weeks duration unless such treatment is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman; or

(*b*) if the pregnancy is of more than sixteen weeks duration but less than twenty-four weeks duration unless the treatment is carried out by a registered medical practitioner who —

(i) is in possession of such surgical or obstetric qualifications as may be prescribed: or

(ii) has acquired special skill in such treatment either in practice or by virtue of holding an appointment in a Government hospital or in an approved institution over such period as may be prescribed.

(2) For the purposes of subsection (1), the duration of the pregnancy shall be calculated from the first day of the last normal menstruation of the pregnant woman to the end of the twenty-fourth week or to the end of any week between the sixteenth and the twenty-fourth week, as the case may be, or the duration of the pregnancy may be ascertained by clinical examination.

Coercion or intimidation.

5. Any person who, by means of coercion or intimidation, compels or induces a pregnant woman against her will to undergo treatment to terminate pregnancy shall be guilty of an offence under this Act and shall be liable on conviction to imprisonment for a term not exceeding three years or to a fine not exceeding three thousand dollars or to both such imprisonment and fine.

Conscientious objection to participate in treatment to terminate pregnancy.

6.—(1) Subject to subsection (3), no person shall be under any duty whether by contract or by any statutory or legal requirement to participate in any treatment to terminate pregnancy authorised by this Act to which he has a conscientious objection.

(2) In any legal proceedings the burden of proof of conscientious objection referred to in subsection (1) shall rest on the person claiming to rely on it and that burden may be discharged by such person testifying on oath or affirmation that he has a conscientious objection to participating in any treatment to terminate pregnancy.

(3) Nothing in subsection (1) shall affect any duty to participate in such treatment which is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

Privilege against disclosure of matters relating to treatment for termination of pregnancy.

7.—(1) No person who —

(*a*) is concerned with the keeping of medical records in connection with treatment to terminate a pregnancy; or

(*b*) participates in any treatment to terminate a pregnancy,

shall, unless the pregnant woman expressly gives her consent thereto, disclose any facts or information relating to such treatment except to such persons and for such purposes as may be prescribed.

(2) Any person who contravenes the provisions of subsection (1) shall be guilty of an offence under this Act and shall be liable on conviction to imprisonment for a term not exceeding twelve months or to a fine not exceeding two thousand dollars or to both such imprisonment and fine.

Power to inspect approved institutions and examine records, etc

8. Any public officer, appointed by the Minister for the purpose, shall have power to enter any approved institution for the purpose of ensuring that the provisions of this Act, and any regulations made thereunder, are being complied with and may examine and make copies of or take extracts from any records or documents connected with any treatment to terminate pregnancy.

Immunity of registered medical practitioners.

9. No registered medical practitioner shall be liable civilly or criminally for carrying out treatment to terminate a pregnancy so long as the pregnant woman consents to such treatment and so long as such treatment is not carried out in a negligent manner.

Charges for treatment to terminate pregnancy.

10.—(1) Where treatment to terminate a pregnancy is carried out in a Government hospital the fee payable for such treatment shall be five dollars.

(2) Any additional hospital costs that may be incurred in the Government hospital where such treatment is carried out shall be borne by the pregnant woman.

(3) The Minister may from time to time by notification in the *Gazette* vary, either by way of increase or decrease, the fee payable for the treatment specified in subsection (1).

Relief from certain restrictions where treatment consists solely of drugs.

11. Notwithstanding anything contained in this Act, where the treatment to terminate pregnancy consists solely of the use of drugs prescribed by a registered medical practitioner and does not, therefore, include any surgical operation or procedure it shall not be necessary—

(*a*) for the registered medical practitioner to hold the prescribed qualifications or to have acquired skill in such treatment over such period as may be prescribed; and

(*b*) for the treatment to be carried out in a Government hospital or in an approved institution.

Regulations.

12.—(1) The Minister may make regulations for, or in respect of, every purpose which is deemed by him necessary for carrying out the provisions of this Act and for prescribing any matter which is authorised or required under this Act to be so prescribed.

(2) Without prejudice to the generality of subsection (1) the Minister may make regulations —

(*a*) requiring registered medical practitioners to keep records of termination of pregnancy and to forward such records to the Director of Medical Services together with such information relating to such termination as the Director may require;

(*b*) providing for the preservation and disposal of records in respect of treatment to terminate pregnancy and for the use of such records for statistical or research purposes so long as such use does not disclose the identities of the persons who have received such treatment under this Act;

(*c*) prescribing the qualifications of registered medical practitioners who may carry out treatment to terminate pregnancy or the period of time considered adequate to confer skill in such treatment upon registered medical practitioners who do not possess such prescribed qualifications; and

(*d*) prescribing the form of consent to be given by a pregnant woman undergoing treatment for termination of pregnancy.

Repeal. Cap. 150.

13. The Abortion Act is hereby repealed.

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No. S 377

THE ABORTION ACT, 1974.
(ACT 24 OF 1974).

THE ABORTION REGULATIONS, 1974.

In exercise of the powers conferred by section 12 of the Abortion Act, 1974, the Minister for Health and Home Affairs hereby makes the following Regulations:—

1. These Regulations may be cited as the Abortion Regulations, 1974.

2.—(1) An application to the Minister for the approval of any institution, hospital, maternity home, clinic or other place as an "approved institution" shall be in the Form I set out in the Schedule to these Regulations.

(2) The Minister may reject an application made under paragraph (1) without giving any reason therefor.

(3) The Minister may cancel the status of an approved institution granted under paragraph (1) without giving any reason therefor.

3.—(1) A registered medical practitioner in private practice who has had at least six months experience in an obstetrics and gynaecological unit of a Singapore Government hospital or a hospital recognised by the Minister, that is outside Singapore, shall be regarded as having the requisite skill to carry out treatment to terminate any pregnancy which is of not more than sixteen weeks duration.

(2) A registered medical practitioner in private practice or working in an approved institution who holds any of the following qualifications, that is to say —

(*a*) Master of Medicine (Obstetrics and Gynaecology) of the University of Singapore;

(*b*) Fellow of a Royal College of Surgeons; or

(*c*) Member or Fellow of a Royal College of Obstetricians and Gynaecologists,

shall be regarded as having the requisite surgical or obstetric qualifications for the purposes of paragraph (*b*) of subsection (1) of section 4 of the Act to carry out treatment to terminate any pregnancy which is of less than twenty-four weeks duration.

(3) A registered medical practitioner who is employed by the Government and who holds, or has held, an appointment in a surgical or obstetric unit of any Government hospital for a period of not less than six months shall be regarded as having acquired the requisite skill for carrying out treatment to terminate pregnancy for the purposes of sub-paragraph (ii) of paragraph (*b*) of subsection (1) of section 4 of the Act.

4. All registered medical practitioners who carry out treatment to terminate pregnancy shall keep records of the treatment in the Form II set out in the Schedule to these Regulations and shall forward these records to the Director of Medical Services within thirty days of such treatment.

5. Written consent for treatment to terminate pregnancy under subsection (1) of section 3 of the Act shall be in the Form III set out in the Schedule to these Regulations.

6.—(1) Facts and information relating to treatment to terminate a pregnancy may be disclosed by a person mentioned in paragraph (*a*) or (*b*) of subsection (1) of section 7 of the Act to the following persons and only for the purpose of —

(*a*) carrying out his duties — to an officer of the Ministry of Health or the Singapore Family Planning and Population Board, authorised by the Director of Medical Services;

(*b*) carrying out his duties in relation to offences against the Act or any law relating to abortion — to the Attorney-General or a member of his staff authorised by him;

(*c*) investigating whether an offence has been committed against the Act or any law relating to abortion — to a police officer not below the rank of superintendent or a person authorised by him;

(*d*) criminal proceedings which have begun; or

(*e*) bona fide research.

(2) Except as provided in paragraph (1) no facts or information relating to treatment to terminate a pregnancy shall be given to any person for any purpose unless the applicant has expressly consented to such disclosure.

7. The Abortion Regulations, 1970, are hereby revoked.- G.N. No. S 91/70.

THE SCHEDULE.

THE ABORTION ACT, 1974. *Form 1*

(ACT 24 OF 1974).

THE ABORTION REGULATIONS, 1974.

(Regulation 2 (1)).

APPLICATION FOR STATUS OF APPROVED INSTITUTION.

Application is hereby made by ..... of
(Insert name of person)
..... for the status of an
(Insert Address)
approved institution in respect of .....
(Name and address of institution, hospital,
.....
maternity home, clinic, etc.)

Information on relevant matters are supplied hereunder:—

1. The total number of registered medical practitioners employed is .....

2. The names of registered medical practitioners who possess the qualifications set out in paragraphs (1) and (2) of regulation 3 of the Abortion Regulations, 1974 are as follows:—

Name.	*Qualification.*

3. The names of qualified anaesthetists are as follows:—

4. Details of other Staff:

Type.	*Total Number Employed.*
(*a*) Qualified Nurses	
(*b*) Pharmacists	
(*c*) Dispensing Assistants	
(*d*) Qualified Laboratory Technicians	
(*e*) Qualified Radiographers	
(*f*) Cooks	
(*g*) Medical Attendants	

5. Details of other items:

Item.	*Total Number.*
(*a*) Beds	
(*b*) Major and Minor Operating Theatres	
(*c*) Operating tables	
(*d*) Operating lights (fixed and portable)	

6. Is there a Laboratory? *Yes/No
7. Is there a Blood Transfusion Service? *Yes/No
8. Is there an X-ray Department? *Yes/No
9. Are there facilities for sterilization of instruments and dressings? *Yes/No
10. Is there an alternate electricity supply besides Public Utilities Board service, e.g. generators? *Yes/No

I am prepared to give all facilities to any public officer of the Ministry of Health to enter and inspect the .....
(Insert name of institution, hospital, maternity
..... and to answer any questions that may be put to me pertaining home, clinic, etc.)
to this application.

Dated this day of 197

.....
Signature and designation of applicant.

* Delete as appropriate.

Form II

THE ABORTION ACT, 1974.
(ACT 24 OF 1974).

THE ABORTION REGULATIONS, 1974.
(*Regulation 4*).

IN CONFIDENCE

REPORT ON TREATMENT TO TERMINATE PREGNANCY.

1. PREGNANT WOMAN'S NAME

2. Date of Birth
Day Month Year

3. Ethnic Group
Chinese 1 ☐
Malay and Indonesian 2 ☐
Indian and Pakistani 3 ☐
Others 9 ☐

4. Citizenship
Singapore 1 ☐
Malaysian 2 ☐
Others 9 ☐

Singapore NRIC No. .....

5. Marital Status
Married 1 ☐
Unmarried 2 ☐
Divorced 3 ☐
Separated 4 ☐
Widow 5 ☐

6. Education
No formal education 1 ☐
Primary 2 ☐
Secondary 3 ☐
Tertiary 4 ☐
Others 9 ☐

7. Total No. of children born alive

8. RESULT OF OPERATION
Satisfactory 1 ☐
Anaesthetic complications 2 ☐
Haemorrhage/shock/perforation 3 ☐
Sepsis/Inflammation of Adnexa 4 ☐
Death 5 ☐
Other complications 9 ☐

9. Name and signature of Medical Practitioner

10. Remarks, if any

Date: .....

Note:—In completing items with checkboxes, mark 'X' in the checkbox corresponding to the answer applicable; only one checkbox is to be marked.
This Form must be duly completed and submitted to the Director of Medical Services within thirty days of the above treatment.

Form III

THE ABORTION ACT, 1974.
(ACT 24 OF 1974).

THE ABORTION REGULATIONS, 1974
(*Regulation 5*).

IN CONFIDENCE

CONSENT FOR THE TREATMENT TO TERMINATE PREGNANCY.

I hereby request and give my consent for treatment to terminate pregnancy to be performed on me by .....
(Name of registered medical practitioner)
of .....
(Hospital/Approved Institution)
at .....
(Address)

I also consent to such further alternative operative measures as may be found necessary during the course of the operation and to the administration of anaesthesia for this purpose.

Name of Pregnant Woman:	Name of Witness:
Address:	Address:
Citizenship:	Citizenship:
NRIC No.:	NRIC No.:
Signature/R.T.P.	Signature/R.T.P.
Date:	Date:

Made this 27th day of December, 1974.

HO GUAN LIM,
Permanent Secretary (Health),
Ministry of Health and Home Affairs,
Singapore.

[MH. Cf. 78 : 20 Vol. 4; AG./L./10/70]

APPENDIX III

SAMPLE MEDICAL TERMINATION OF PREGNANCY BILL

WITH COMMENTARY

Be it enacted etc ...

1. Notwithstanding (reference to existing statutory or other prohibitions on on abortion), termination of pregnancy shall be lawful when undertaken or supervised by an authorised registered medical practitioner, if he is of the opinion, formed in good faith -

   (1) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

   (2) that there is substantial risk that the child born would suffer from such physical or mental abnormality as to be seriously handicapped; or

   (3) that there is clear evidence of the use in good faith of a recognised contraceptive means by the pregnant woman or her partner.

2. In determining whether the continuance of a pregnancy would involve such a risk of injury to physical or mental health as is mentioned in subsection (1) of section 1 of this Act, account may be taken of the pregnant woman's present and future environment.

3. Any treatment for the termination of pregnancy shall be carried out in a public hospital or other place for the time being approved for the purpose of this section by the Minister for the time being responsible for health, unless the treatment to terminate pregnancy consists solely of the use of drugs prescribed by a registered medical practitioner and does not include any surgical operation or procedure:

   Provided that a pregnancy may be terminated in any place by an authorised registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life of or to prevent grave injury to the physical or mental health of the pregnant woman.

4. (1) Except where there is a duty to participate in treatment which is necessary to save the life of or to prevent grave injury to the physical or mental health of a pregnant woman, no person shall be under any duty to participate in the termination of a pregnancy made lawful by this Act to which he has a conscientious objection:

   (2) In any legal proceedings the burden of proving conscientious objection shall rest on the person relying on it.

5. No authorised registered medical practitioner or person supervised by him shall be in any way liable for the carrying out of or the supervision of treatment to terminate a pregnancy where the pregnant woman has consented to such treatment, unless such treatment is carried out in a negligent

manner.

6. In this Act, the following expression has the meaning hereby assigned:-

"authorised registered medical practitioner" means a registered medical practitioner authorised to undertake or to supervise medical termination of pregnancy under Regulations issued by the Minister for the time being responsible for health.

7. The Minister for the time being responsible for health may make Regulations:-

(1) Defining conditions of authorisation of authorised registered medical practitioners

(2) Defining places other than a public hospital where any treatment for the termination of pregnancy may be carried out under this Act.

8. Nothing in this Act shall affect the provisions of the law concerning child destruction.

Commentary on Sample Bill

The sample Bill draws upon many advantageous features of advanced Commonwealth abortion laws, but omits some features,(even though commonly found) that appear to serve no health interest of the pregnant woman.

The major principles and features of the sample Bill, and the basis of its wording,are discussed below in sequence.

Section 1

(a) This states in positive terms that, when undertaken in accordance with the enactment, "termination of pregnancy shall be lawful".

(b) "undertaken or supervised". Since new and developing techniques of early abortion, by drug and non-surgical means, may be safely managed by suitably qualified health personnel acting under a physician's supervision, this expression allows delegation of functions to such personnel.

(c) "formed in good faith". There is no requirement in the sample Bill that a physician's good faith be policed by means of a second medical opinion. Where a second opinion requirement exists, it is found to be directed not to health care but to criminal enforcement, and in any event is discarded in emergency, of which the individual physician is sole judge. Accordingly, this sample provision operates by requiring the physician to evidence his good faith by, for instance, the quality of his concern for the pregnant woman's health, and the moderation of his fee.

(d) Subsections 1 and 2 are drawn from the British Abortion Act 1967.

(e) Subsection 3, drawn from the Indian Medical Termination of Pregnancy Act, 1971, introduces the indication of contraceptive failure where the pregnant woman or her partner has used in good faith a recognised contraceptive.

Section 2

This is drawn from the British Abortion Act 1967, recognising the domestic environmental component of the concept of health.

Section 3

This section confines performance of procedures to public hospitals or appropriately equipped and staffed facilities, except in emergency. Non-physicians not supervised by an authorised registered medical practitioner responding to emergency are not protected by this sample enactment, but would be covered under the general law by Good Samaritan provisions and the necessity defence. Abortions by drug use need not be in specified facilities, but such use must be under supervision of physicians.

Section 4

This introduces a provision for conscientious objection, except in emergency, to participate in the abortion procedure as such. This exemption must be based on principle, not on the merits of a particular case. It is confined to participation in the procedure for termination of pregnancy and does not cover, for instance, post-operative care. It states the requirement of regular judicial proceedings, that a party claiming exemption from legal duty must show his entitlement to the exemption.

Section 5

This section, drawn from the Singapore Abortion Act, 1977, makes clear that for the termination procedure to be lawful, the woman must give her consent, meaning informed and free consent. Where such consent exists, persons supervising and performing a procedure have legal protection, except for negligence. In particular, they are not liable to a spouse, biological father or, for instance, parent, whose consent is not required for a procedure under this enactment.

Sections 6 and 7

The requirement that a registered medical practitioner be "authorised" in order to perform or supervise terminations of pregnancy can be under regulations providing that every registered medical practitioner is automatically deemed to be so authorised. He may be liable to de-authorisation, however, if he fails to meet specified conditions. These may concern, for instance, attendance at courses of training in new methods. In particular, however, to ensure availability of physicians to perform abortion procedures in public hospitals or other facilities, a condition of authorisation may be service in a public or other specified facility for a given time or with prescribed frequency. A physician refusing or failing to render public service under such conditions will forfeit his right to provide abortion services in the private sector. As in the British Abortion Act 1967, there is no requirement in the sample Bill that the authorisation procedure requires special qualifications for registered medical practitioners performing MTPs.

Public hospitals are automatically approved under its act for any treatment for the termination of pregnancy. The Minister for the time being responsible for health may make regulations defining the conditions which places other than public hospitals must comply with in order to carry out any treatment for the termination of pregnancy. The onus has thus been laid in such places to comply with the specified conditions, not on the Minister for the time being responsible for health to approve such places.

Section 8

For the avoidance of doubt, this section declares the time for termination of pregnancy not to extend to the time of the process of birth. The "law concerning the offence of child destruction" is expressed in the English Infant Life (Preservation) Act 1929 and in many Commonwealth laws expressing its spirit.

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