

## **I. REPRODUCTIVE HEALTH RISKS**

### **A. Introduction**

There is an historical sense in which human reproduction can be said to have affected the values of men and the bodies of women. Women's health in itself was not a high priority in the value system of traditional cultures and the laws they created. The duty of women was principally to bear men's children, particularly sons, and to serve as the foundation of families. The cost of this duty to women's health, and the effects of women's ill health upon their families, went unrecognized. Ill health, influenced perhaps by early and excessive childbearing, and women's premature deaths in labour or from weakness or exhaustion consequent on childbearing, were explained through fate, destiny and divine will. They were not considered amenable to human control through reproductive health programmes and education.

Today, epidemiological and related data show how health care can reduce both maternal and infant and child mortality, and that health programmes can contribute significantly to the creation and survival of healthy family life. Data also show how the absence of maternal, infant and child health services leave mothers, infants, children and families at risk of sickness and death. Reproductive safety, both of men and women but particularly of women, raises sensitive issues in the Common law tradition, however, because it relates to human sexuality and affects the moral order. The moral belief under the law was that, if humans can indulge in "easy" sexual relations, without constant liability to pregnancy and the maintenance of children, sexual morality and family security will be in jeopardy. This traditional morality was expressed as recently as 1954 in the celebrated and unduly influential dissenting observation of Denning L.J. (as he then was), expressly disapproved by the majority of the English Court of Appeal, regarding vasectomy. He said:

Take a case where a sterilisation operation is done so as to enable a man to have the pleasure of sexual intercourse without shouldering the responsibilities attaching to it. The operation then is plainly injurious to the public interest. It is degrading to the man himself. It is injurious to his wife and to any woman whom he may marry, to say nothing of the way it opens to licentiousness." (Bravery v. Bravery, [1954] 3 All E.R. 59 at pp. 67-68).

Little concession was made to vasectomy inspired by the medical desirability of sparing a wife the hazards of future pregnancy. Lord Denning M.R. showed the same inclination to favour a vision of the public interest over the health of women

in his 1980 decision in The Royal College of Nursing case. He considered Britain's Abortion Act 1967 not legally to protect later-developed safer techniques of performing abortion that depended on nursing services, finding, since nurses could not act, that: "the doctor will have to use the surgical method with its extra hazards" ([1981] 1 All E.R. 545 at p. 556) or that the abortion will not be performed. The House of Lords subsequently reversed the Court of Appeal's decision, and upheld the Act's applicability to modern abortion methods, which reduce hazards to women's health (see [1981] 1 All E.R. 545 at p. 563).

In many Commonwealth countries, the law presents obstacles to medical and other pursuit of reproductive health. At risk in several areas is not simply health, but life itself. Data are reviewed below of how pregnancy and childbirth are causatively related to deaths of women and their children. Legal accommodation of birth spacing and other family planning practices could prevent many of such deaths. The status of national legislation and case-law which obstruct voluntary family planning is reviewed below in the context of the United Nations' Convention on the Elimination of All Forms of Discrimination Against Women. Since at least 25 out of 49 Commonwealth countries had signed, ratified or acceded to this Convention by May 1986, and others are considering accession, its relevance to reduction of health hazards to women due to pregnancy is apparent.

## **B. Maternal Mortality**

In developed regions of the Commonwealth, reported maternal mortality (meaning deaths among women who are or have been pregnant during the previous 42 days) may be close to an irreducible minimum at about 10 per 100,000 live births. In North America, the World Health Organization has estimated a maternal mortality rate varying from 7 to 15 per 100,000 live births (W.H.O. Maternal and Child Health Programme The Health Situation of Mothers and Children: A Brief Overview, Nov. 1983). Not all regions of developed countries are necessarily developed, of course; health standards among the northern populations of Canadian provinces, for instance, are lower than in the south. In the developing world, maternal mortality rates are up to 200 times higher than in the industrialized world (Prevention of Maternal Mortality, Report of a World Health Organization Interregional Meeting, 11-15 November 1985 (1985, W.H.O. Geneva) at p. 2). In Africa, for instance, maternal mortality rates range from 160 to 1,100 deaths per 100,000 livebirths (A. Rosenfield and D. Maine, "Maternal Mortality - A Neglected Tragedy", 8446:ii The Lancet (1985) 83). The extent of the death rate is masked by under-reporting. In Jamaica, for instance, where the official maternal mortality rate was 48 per 100,000 live births, a national study uncovered a rate of 102 (W.H.O. Maternal Mortality Report, at p. 4). Hospital data are reliable in

themselves, but, of course, exclude maternal deaths outside hospitals. In Nigeria, for example, the hospital maternal mortality rate was reported in 1985 at 1,050 (Ibid.).

A number of research studies have shown that the risks of morbidity and mortality associated with pregnancy are greater for the mothers, and for their children, in the cases of women in the following categories:

- (i) women less than 18 years old;
- (ii) women 35 years and older;
- (iii) women whose last birth occurred less than 24 months ago; and
- (iv) women with four or more births

("Healthier Mothers and Children Through Family Planning" Population Reports, The Johns Hopkins University Population Information Program, 1984 Series J. No. 27).

- (v) An additional factor is that rural women suffer higher rates of maternal morbidity and mortality, due perhaps to reduced access to health services.

**(i) Adolescent maternity.** Early age of marriage and childbearing, and repeated pregnancy in youth, are associated with above-average maternal mortality. In Nigeria, for instance, one quarter of all women are married by the age of 14, one half by the age of 16, and three quarters by age 18 (see "Digest" 11(3) Int'l Family Planning Perspectives (1985) 98, summarizing National Population Bureau, The Nigeria Fertility Survey, 1981/1982, Principal Report, 1984). Regarding young age of first pregnancy, it has been found that in Jamaica and Nigeria, for instance, women younger than 15 are four to eight times more likely to die during pregnancy and childbirth than women aged 15-19 ("Youth in the 1980s: Social and Health Concerns" Population Reports ibid., 1985 Series M No. 9, at p. M.365). In the developed world, the maternal death rate for mothers under age 15 has been found to be 2.5 times higher than the rate among mothers aged 20 to 24 (ibid.). It has been found that in rural Bangladesh, for instance, among women aged 15 to 19, almost 6 in 10 of all deaths are related to pregnancy and childbirth (L.C. Chen, M.C. Gesche et al. "Maternal Mortality in Rural Bangladesh" 5(11) Studies in Fam. Planning (1974) 334). In fact, adolescent pregnancy is quite common in the Commonwealth. In developed countries, contraception may limit the incidence, but in, for instance, Botswana, among women who have ever been pregnant, 28 percent had first been pregnant when aged under 18 years old. (W.G. Manyeneng, P. Khulumani, M.K. Larson and A.A. Way, Botswana Family Health Survey 1984 (1985) at p. 111).

Adolescence aggravates other factors which obstruct women's access to reproductive health services. Where parental and

spousal consent requirements are made by family planning agencies, younger women whose parents or spouses oppose contraceptive services are less likely to persuade them to give consent than are older persons. Less experienced women are also at a disadvantage in gaining access to available services which do not observe such requirements. Indeed, where knowledge of human reproduction is not available to youths through education in their families, schools or communities, young girls may have no means to become aware of any method to counter conception, including sexual abstinence.

**(ii) Advanced Maternal Age.** Studies including data from Bangladesh and Jamaica have shown that, when compared to women aged 20-24, those aged 35-39 were from 85 percent to 461 percent more likely to die from a given pregnancy (W.H.O. Maternal Mortality Report at p. 7). In England and Wales, women aged 40 or older had at least five times the risk of death in childbirth than women aged 20-24 (D. Maine, Family Planning: Its Impact on the Health of Women and Children (1981) at p. 30). Aggravating pregnancy relatively late in reproductive life are high parity (see (iv) below) and the natural consequences of advancing years. The risk of hemorrhage rises sharply with age, the toxemias become more frequent among older mothers, and the risk of sepsis increases. Constitutional disorders resulting from aging, such as cardiovascular disease, make older women more susceptible to pregnancy complications. Further, especially in more developed countries, longer periods of taking contraceptive drugs may more significantly predispose women to risks in pregnancy. This may be related to the greater likelihood of women and their husbands seeking contraceptive sterilization (see chapter III below). Where abortion is unlawful and unsafe, or lawful but unavailable so that unlawful practice and self-induced abortion are used, a woman of advanced age and perhaps a higher number of pregnancies may be at higher risk from unskilled abortion.

**(iii) Short Birth Spacing.** This factors appears more related to infant and child mortality than to maternal mortality. Nevertheless, especially among women with poor nutrition, pregnancy following soon after childbirth creates greater risks than to those whose physical status had recovered from earlier childbearing. Infant and child deaths associated with close birth spacing themselves impose health risks on mothers due to higher parity (see (iv) below), since family incentives are created to conceive a replacement child. Further, a mother with a young dependent child may be impaired in obtaining prenatal care during a subsequent pregnancy. The short spacing of births may also be associated with the risks of young childbearing. By the age of 17, for instance, 16 percent of Bangladeshi wives have more than one child (A. Petros-Barvazian, "Family Planning: a preventive health measure" 57 J. Christian Med. Ass. of India (1984) 475). When unsafe abortion is used to

end pregnancy arising too soon after childbirth, it introduces all of the risks of the procedure to a woman of reduced physical capacity to endure and recover from them.

**(iv) Parity (Number of Previous Births).** Since pregnancy and childbirth in themselves present high health risks to women in many parts of the Commonwealth, it follows that frequent pregnancy increases risks. Health may progressively deteriorate under the impact of repeated pregnancy, childbearing and childrearing, however, so that parity is a cumulative factor in reproductive health. It has been observed, for instance, that:

"At the Princess Christian Maternity Hospital in Sierra Leone, it is not unusual to see women who have brought 11 to 22 pregnancies to term. These women are usually very anemic, and are exposed to such serious complications of pregnancy as postpartum hemorrhage, cord prolapse, and other hazards. Many reach the hospital with obstructed labor, infection, and maternal exhaustion" (see Meeting the Needs of the 80's, Report of the 5th Int'l Conference on Voluntary Surgical Contraception, World Fed. of Health Agencies for the Advancement of V.S.C., at p. 5).

Parity naturally tends to rise with age. In Botswana, for instance, women in the 45-49 year age bracket have on average had 6 children, with 5 surviving, in an urban area, and 7, with 6 surviving, in a rural area (W.G. Manyeneng et al. above, at p. 95). In Nigeria, grandmultiparity (5 or more births) accounts for 17-21 percent of all deliveries; women in West Africa have an average of 6.8 children (see Conference on Reproductive Health Management in Sub-Saharan Africa, November 1984. Abstract of paper by A.E. Omu, no. 28). In Jamaica, compared to women having their second child, those having their fifth to ninth births are 43 percent more likely to die (W.H.O. Maternal Mortality Report, at p. 7). Similarly, evidence from rural Bangladesh shows that among women having their fourth or fifth birth, the risk of death was almost double that of women having their second or third birth. (See L.C. Chen et al. "Maternal Mortality in Rural Bangladesh", above).

A startling feature of multiparity is that, while women want families, many women clearly destined to have future pregnancies reply, when asked about their future childbearing preferences, that they want no more children. The World Fertility Survey country reports show that the proportion of married women in Ghana who say that they want no more children is 12 percent, while in Sri Lanka it is 61 percent (see D. Maine, "Mothers in peril: the heavy toll of needless deaths" 12 People (I.P.P.F.) (1985) 6). Disfavour of future pregnancy is relevant not only to the socioeconomic implications of larger families,

but to women's survival of pregnancy and childbirth. In Sri Lanka, about 40 percent of maternal deaths would be averted if women who want no more children and are not using efficient contraception were to have no more children, and in Ghana, the same would avert 14 percent of maternal death (Ibid. at p. 8). Nevertheless in Ghana over 80 percent of women who say they want no more children are not using an efficient method of contraception, and in Sri Lanka the rate is close to 70 percent (Ibid. at p. 7). Obstacles to access to contraceptive means may be cultural, but there are also obstacles related to age, spousal consent, and the simple unavailability of services.

**(v) Rural Residence.** Statistics of maternal mortality, both in themselves and in relation to adolescence, advanced age and parity, often distinguish urban from rural populations, and show the latter to be at disadvantage. Populations of many Commonwealth countries are predominantly rural. The rural setting renders health services more difficult to deliver, since more widely distributed communities require more time and expense to reach. Further, medical equipment may be difficult to transport, and health centres equipped with adequate resources may be difficult for outlying peoples to reach, especially in emergency. Health services, not only to save life endangered by advanced pregnancy and delivery but also to provide routine contraceptive care, may be simply inaccessible to rural residents of many countries.

Rural life may also predispose women to early marriage and childbearing, and to multiparity. Urban life may offer inducements to postpone marriage and/or childbearing, through educational and employment opportunities, and make a single woman's social and economic independence possible and culturally acceptable. Thus, rural residence may deprive women both of reproductive care and of alternative life styles to early marriage and repeated pregnancy. This imposes a toll not only on the health and the very lives of the women themselves, but also on the lives of their children.

### **C. Infant and Child Mortality**

Child survival is jeopardized by a number of the factors that contribute to maternal mortality. A mother's death in childbirth may in itself prejudice the child, but apart from that children born, for instance, to very young mothers are more likely to die than those born to women aged 20 to 30. The World Fertility Survey relating to some countries in Asia shows that mothers aged under 16 are twice as likely to lose their babies than are those aged over 20 (A. Petros-Barvazian, above, at p. 475). In part, these infants' disadvantages may originate in utero, as shown in higher fetal death rates; they tend, for instance, to have lower birth weight (Ibid.) At the other end of the maternal age range, children born to older women run a

greater risk of birth defects than those born to younger mothers and, in addition, fetal and neonatal mortality rates increase with high maternal age (Ibid.).

Close birth spacing is also a risk to children born of mothers of any age. The older child may be affected by early or abrupt weaning from its mother's milk, which, apart from its nutritive value, can protect the infant from infection. Breastmilk substitutes and weaning foods, perhaps diluted with impure water, may introduce contamination and predispose children to malnutrition with effects that are felt even later in life. The World Health Organization's International Code of Marketing of Breastmilk Substitutes is intended to reduce these dangers. Recent data have shown that mortality rates for children aged between one and two years are up to four times higher if their birth was followed by another within 18 months (Ibid.) Younger children born after a short birth interval suffer higher perinatal and infant mortality rates if born fewer than two years after a previous birth. A World Health Organization study of rural India, for instance, showed mortality rates more than twice as high among infants born fewer than two years after end of an earlier pregnancy than among those born after an interval of more than four years. A Singapore study shows that poor school performance is also linked to close birth spacing (Ibid.)

Data on infant mortality are often unavoidably questionable, due in part to difficulties of gathering data in overcrowded urban settings and sparsely populated rural areas. The errors to which these features contribute are almost invariably of under-reporting. Governments themselves recognize the problem. The paper from the Maldives presented at the Joint National W.H.O./U.N.F.P.A. Workshop on Maternal Child Health and Family Spacing, held in New Delhi in November 1984, showed infant mortality at 77 per 1000 live births in 1983, but another study prepared by the United Nations Fund for Population Activities in 1982 (Maldives: Report of Mission on Needs Assessment for Population Assistance: Report No. 49) showed infant mortality to be 121 per 1000 live births (p. 7). Nevertheless, reliable relative data have been produced, comparing one country or one location within a country with others. The 1986 UNICEF publication The State of the World's Children, for instance, shows that the infant mortality rate per 1000 live births for Sierra Leone is 180 and Malawi 165, for Ghana 95 and Zambia 90, for Trinidad and Tobago 24, for Australia 10 and the same for the United Kingdom (pp. 84-85).

Death rates among infants born at the end of short (under 2 years) and long (over 2 years) birth intervals differ significantly. In Lesotho, for instance, the death rate for the former is about 155 per 1000 live births, and about 95 for the latter. For Malaysia, the former rate is about 60, the

latter about 40 (D. Maine and R. McNamara, Birth Spacing and Child Survival (1985) p. 9). The proportion of all children born within a short birth interval in Malaysia is 38 percent, 40 in Jamaica and, for instance, 35 in Kenya (Ibid. p. 15). This indicates that relatively high proportions of children are at disproportionate risk of mortality associated with mothers' reproductive histories. Estimated reduction in infant deaths if all children were born at least 2 years after mothers' last births is 12 percent in Malaysia, 26 in Jamaica and, for instance, 20 in Kenya (Ibid. p. 17). On average in the developing world, about one in 5 infant deaths could be averted by the spacing of births at intervals of 2 or more years (Ibid.). Accordingly, practical and legal barriers to birth spacing, such as legal obstacles to access to effective contraceptive methods, can be shown to cost lives of infants and children.

#### **D. Improving Maternal Health**

A number of proposals have been advanced aimed to decrease maternal mortality by improving reproductive health. Zimbabwe's National Family Planning Council Act 1985 and Malaysia's 1984 new description of its Family Planning Act 1966 as the Population and Family Development Act are hopeful moves in this direction. Medical causes of death can be classified in many ways, but a usual distinction is between direct and indirect obstetric deaths. The former result from complications of pregnancy, delivery or their management, the latter are the result of the aggravation of some existing condition, such as heart disease or hepatitis, by pregnancy or childbirth. In developing countries, most maternal deaths are direct obstetric deaths, the major causes of which are hemorrhage, infection and toxemia (sometimes called pregnancy-induced hypertension). In a number of countries, another leading cause of direct obstetric deaths is unskilled abortion and self-applied interference upon suspicion of pregnancy.

Medical causes of maternal death reveal, however, only a part of the explanation. A study has shown that 63-80 percent of direct obstetric deaths and 88-99 percent of all maternal deaths can probably be avoided with proper handling of the women's pregnancies and deliveries within the range of resources available in the women's countries at the time (see W.H.O. Maternal Mortality Report, p. 6). Avoidable factors that contribute to deaths include deficient medical treatment of complications, lack of essential supplies such as blood for transfusion, and absence of adequately trained personnel in medical facilities. Lack of access to maternity services is also a significant contributory cause of death, since travel may delay treatment too long or deny it altogether. Women who do not receive prenatal care are more likely to die than women who receive care.

Medical and health service factors affecting maternal mortality are aggravated by socioeconomic factors such as poverty and poor education, and by the reproductive factors noted above of low or advanced age, close birth-spacing and, for instance, high parity. There are clearly economic and cultural limits to what can be done to address these factors in the short term, but a number of strategies have been recommended to improve maternal health, provide prenatal and maternal health care, and afford women more control over commencement and duration of their childbearing phase and of frequency of pregnancy. Several of these depend upon legal provisions, which may obstruct means to protect reproductive health, or alternatively facilitate access to wanted services that are available. If Commonwealth countries were to make prevention of maternal death a high priority health issue, legal doctrinal barriers to appropriate care would be lifted, and legislation could facilitate availability of and access to appropriate health services. Governmental policy reviews could cover such issues as removing obstacles to family planning.

Responses to medical causes precipitating death, such as hemorrhage and infection, may be made primarily through availability and training of medical personnel, but reduction of pregnancies which the women do not want because they are too young, too old, or too recently pregnant, can be approached through contraception, voluntary sterilization (including vasectomy) and safe abortion services to which access may be eased by legal reforms. For instance, counselling of women who are being treated for complications of abortion, in order to assist them to avoid repeated unwanted pregnancies and abortions, is obstructed where the women are themselves legally classified as offenders and accomplices of criminals.

The law can also assist availability of appropriate health personnel. Suitably trained nurses can legally be afforded greater autonomy of action, to allow them independently to conduct physical examinations, make prognoses and prescribe treatments including certain drugs for the purposes both of protecting women and unborn children during pregnancy, and of spacing births. Perhaps more significant than the training of nurses to discharge wider duties in pregnancy and labour, however, is the training of traditional birth attendants (T.B.A.s). They are often the first, and frequently the only health care workers with whom pregnant women in poor countries have contact. It has been pointed out that, particularly because T.B.A.s are so active in Africa, Asia and Latin America, they probably deliver two-thirds of the neonates in the world (J. Stepan, "Traditional and Alternative Systems of Medicine: A Comparative Review of Legislation," 36(2) Int'l Digest of Health Legislation (1985) 283, at p. 314).

National legislative approaches to traditional medicine, which at times include the practices not only of T.B.A.s but also of midwives, have been divided into four broad categories of policies for regulation (see Stepan, at p. 287). These are:

- (a) Exclusive (monopolistic) systems, where only the practice of modern, scientific medicine by professionals and auxiliaries is recognized as lawful;
- (b) Tolerant systems, where only the system based on modern medicine is recognized, but to some extent, practitioners of various forms of traditional medicine are tolerated by law;
- (c) Inclusive systems, in which systems other than modern medicine are not merely tolerated, but are recognized as forming a special part of the structure of health care; and
- (d) Integrated systems, in which there is official promotion of the integration of two or more systems within a single recognized service; integrated training of health practitioners is the official policy.

Throughout the developing world, the trend has been observed towards providing T.B.A.s with some formal training, to give more structure to their historic reliance upon learning through apprenticeship and experience (M. Simpson-Hebert, "Traditional Midwives and Family Planning", Population Reports, Population Information Program, 1980 Series J, No. 22). In some Commonwealth countries such as Belize, T.B.A.s may legally work only in areas where physicians or registered midwives are unavailable. In India and Malaysia, however, governmental efforts are being made to register and train T.B.A.s and to integrate them into maternal health care systems (see Stepan, p. 315). In addition to their primary tasks of taking care of deliveries, they may be employed as auxiliaries in teaching hygiene and in family planning. In Malaysia, for instance, the Midwives (Registration) Regulations, 1971 afford T.B.A.s a broad opportunity to legalize their practice, and to be eligible to practise as midwives (see generally M. Owen, "Laws and policies affecting the training and practice of traditional birth attendants", 34(3) Int'l Digest of Health Legislation (1983) 439).

The November 1985 W.H.O. Interregional Meeting on Prevention of Maternal Mortality recommended that a major role of T.B.A.s should be referral where, of course, there are maternal and related health care facilities to which women can be referred. Training of T.B.A.s should then be in recognition of risk factors such as age, parity and bleeding during pregnancy, and

in detection of anemia, infection, prolonged labour and excessive blood loss, and also when necessary in referral to a source of legal abortion (see Report, above, at p. 11). T.B.A.s should also be given the training and supplies to prevent or treat complications whenever possible, including use of antiseptic techniques in delivery and the administration of drugs to reduce anemia, and provision of contraceptives. Treatment skills could include first aid for treatment of hemorrhage and safe removal of retained placenta (Ibid.).

It was also recommended that accessible health centres be established to prevent maternal deaths through appropriately trained health personnel. Where objectively perfect standards are unattainable, resources and personnel may still be deployed and trained to higher levels of effectiveness. Personnel can be trained to recognize health and pregnancy abnormalities, to use antibiotics, intramuscular iron supplements, and appropriate drugs and to repair lacerations. In areas where physicians are not available to perform life-saving caesarean deliveries, the feasibility of teaching trained midwives to undertake this operation should be explored (Ibid.).

The role of midwives is being addressed in developed Commonwealth countries as well as in developing countries. The context of the discussion may be different, however, in that, unlike in most developing regions, midwives' practices may be legally controlled because adequate numbers of physicians are available. The advantages midwives offer are of economy in public health expenditures, and of freedom of maternal choice, for instance of home birth rather than hospital delivery. In Canada, for instance, the College of Physicians and Surgeons of the province of Alberta has observed that medical attendance at non-emergency home birth constitutes professional misconduct. In the province of Ontario, on the other hand, the government is proposing for the first time to recognize midwifery as a legitimate health profession. The scope of permitted practice has still to be established, however, since midwives may function either under doctors' supervision, as health auxiliaries, or independently of such supervision. Medical contentions that avoidable home births are not in the best interests of women or children, due, for instance, to the risk of unexpected events which require the care that only hospitals can provide, are countered by claims to maternal choice and control of the birth environment, mothers responsibility for welfare of their children and families, and by the risk of medically- or hospital-induced injuries to children, such as nosocomial infections (medically-originating diseases). The argument between doctors and the home birth movement may appear, from the perspective of developing countries, to be a dilemma primarily of luxury, however, rather than of accommodating limited resources to immense and urgent maternal health care needs.

### **E. The "Women's Convention"**

The conclusion of this Report (Chapter VI below) addresses the general significance for Commonwealth reproductive health law of the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention). Its relevance to reproductive health risks merits preliminary consideration, however, because of the obvious fact that women are the direct victims of mortality due to pregnancy and childbirth. It is a function of legal, philosophical and social analysis to decide whether maternal mortality primarily affects women as opposed to men, or pregnant persons as opposed to non-pregnant persons, many of the latter of whom, of course, are also women. To discriminate against the pregnant is nevertheless to discriminate against women, even though more than mothers have interests in the successful and safe outcome of pregnancy, and even though not all women are or will become pregnant.

The Convention has now been signed, ratified or acceded to by over half of the countries of the Commonwealth (see Appendix), including the most heavily populated. Accordingly, the priority they give to allocating their resources to the prevention and relief of reproductive health risks affecting women is open to assessment in light of both the legal provisions and the moral values of the Convention. The Convention is legally binding only upon those countries that have ratified or acceded, known as States Parties. Their obligations are so to conduct their national including legislative affairs as to conform to the Convention, particularly but not only to achieve the elimination of "discrimination against women". This is defined in Article 1 of the Convention as:

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

The freedom to exercise reproductive choice without danger to one's life, which men usually enjoy without difficulty, appears fundamental to women, but often its enjoyment is dependent upon the maternal health care services and trained personnel reviewed above. Where States Parties with the means decline or fail to apply them appropriately to maternal health care, they may be in breach of the Women's Convention. Articles of the Convention require States Parties to issue initial and subsequent periodic reports of their compliance with the

Convention to the Committee on the Elimination of Discrimination Against Women (the CEDAW Committee - see Articles 17-22).

Of relevant concern to maternal health care through birth spacing and care in pregnancy is Article 12. This provides that:

- "1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connexion with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

Where national resources are limited, their due allocation to the needs of women's reproductive survival and welfare must be assured. It is not a phenomenon limited to the Commonwealth that, when defence of countries' populations is considered, the threat is conceived by governments more in military than health terms, and defence budgets are accordingly afforded priority over budgets for medical, welfare and related services. Deaths of women from pregnancy and childbirth are often a more imminent threat and a more frequent national experience, however, than women's deaths from hostile military action.

Militaristic, commercial and comparable values often prevail in countries' political priorities over values of women's reproductive health due to traditions and culture which leave the interests of all women, including the actually and potentially pregnant, served only indirectly. Women themselves are often non-participants in political and commercial life and, for instance, excluded from leadership in social and religious life. Male participants and leaders may accept responsibility for welfare of their wives, mothers and daughters. The paternalistic view may prevail that it is the function of men to protect women's interests, and not for women to take self-protective initiatives. Nevertheless, the Women's Convention provides in Article 5 that:

"States Parties shall take all appropriate measures:

- (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the

superiority of either of the sexes or on stereotyped roles for men and women...."

States Parties may have federal constitutions in which, for instance as in Canada, treaty-making power is vested in the federal government, but responsibility for health and welfare constitutionally resides in the provincial authorities. Each being sovereign within the scope of its constitutional competence, the federal government cannot legally compel a provincial authority to conform to the international legal commitment made through exercise of the treaty-making power. While this may create legislative, political and judicial challenges within a State Party, it is of no international legal consequence. It is a cardinal principle of international law, by which Commonwealth countries almost invariably claim to be bound, that a State Party cannot invoke the provisions of its own constitution to evade the treaty obligations it has accepted at international law. (On further aspects of the Women's Convention, including the scope of reservations, see Chapter VI below).

APPENDIX**COMMONWEALTH STATES THAT HAVE SIGNED, RATIFIED  
OR ACCEDED TO THE CONVENTION, AND STATUS OF REPORTS  
OF STATES PARTIES TO THE CONVENTION, AS OF MAY 1986**

Australia (3)  
 Bangladesh (2)  
 Barbados (3)  
 Canada (1)  
 Cyprus (3)  
 Dominica (3)  
 Gambia\*  
 Ghana (4)  
 Grenada\*  
 Guyana (3)  
 India\*  
 Jamaica (3)  
 Kenya (3)  
 Lesotho\*  
 Mauritius (3)  
 New Zealand (3)  
 Nigeria (4)  
 Saint Christopher and Nevis (4)  
 Saint Lucia (3)  
 Saint Vincent and Grenadines (3)  
 Sri Lanka (2)  
 Tanzania (4)  
 Trinidad and Tobago\*  
 Uganda (4)  
 United Kingdom of Great Britain and Northern Ireland (4)  
 Zambia (4)

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 \* States which have only signed  
 1-4 States which have ratified or acceded  
 1 Reports received and considered by the Committee  
 2 Reports received and to be considered by the Committee  
 March 1987  
 3 Reports due by May 1986  
 4 Reports due after May 1986