## IV. The Legal Foreground: Emerging Issues

### A. The Contraception-Abortion Distinction

Some laws as a matter of policy encourage directly or indirectly contraception over abortion by, for example, making it more difficult to obtain abortion. Other laws discourage both contraception and abortion by prohibiting either, for example, to adolescents. Hong Kong, however is a forerunner in establishing an adolescent indication in its new abortion law (see III A ii above). No Commonwealth abortion law contains a provision similar to a Finnish provision requiring abortions be done at the earliest possible stage of pregnancy. Further no Commonwealth abortion law contains contraceptive provisions, similar to that of Iceland, requiring that contraceptive services and counselling be given to the woman and her partner in the post abortion phase. India, however, does recognise the contraceptive and abortion interaction by establishing an indication for abortion upon a showing of contraceptive failure (see II B iii above).

The point at which contraception becomes abortion is not clearly delineated in Commonwealth abortion laws and it varies according to jurisdiction. Further, while some might consider a procedure to be abortion in fact, it is not necessity so in law. Before criminal liability can exist for abortion in some Commonwealth countries certain stages such as implantation, proof of pregnancy or quickening have to have been proven beyond a reasonable doubt to have occurred. These stages vary according to Commonwealth law and to whether someone is acting on a woman or a woman is acting on herself.

A distinction of major significnace to both abortion law and fertility control by contraception was drawn late in 1981 by the U.K. Minister of Health, Dr. Gerard Vaughan. The Minister had been called upon to consider the status of administration post-coital ("morning after") contraceptive pills, and in particular whether administration was required to conform to the Abortion Act 1967 in order to preclude penalties under the Offences Against the Person Act, 1861 for unlawful abortion. The reasoning supporting conformity to the abortion law was that such administration was intended to procure miscarriage, by preventing a fertilized ovum from biological development into a fetus, and that the pill was a poison or noxious thing employed after intercourse for the purpose of obstructing its natural consequence of pregnancy and childbirth.

Underlying the argument was the view that legally protected life begins at conception, and that deliberate interference with the products of conception is legally justifiable only in accordance with abortion law. The possibilities that the pill acted to prevent conception, and that, were it not admitted, no conception would have occurred in any event, perhaps due to sterlity, were seen as no barrier to the argument. The English 1861 Act condemns the administration of "any poison or other noxious thing" done "with intent to procure the miscarriage of any woman whether she be or not with child"; that is, the Act condemns unlawful interference with women whether or not they have conceived.

The Minister, a personal supporter of more strict legal controls upon abortion, observed that administration of a pill within 72 hours after intercourse did not constitute abortion, and did not therefore have to conform to the law on abortion. It was legitimate contraception, and bound only by laws pertinent to the practice of contraception. Post-coital administration was

comparable to pre-coital administration of a drug or device taking effect after intercourse to prevent either fertilization of an ovum or its implantation and development.

The basis of the Minister's view, which was developed and expressed as an official Departmental opinion formulated by ministerial legal and other advisors, as opposed to an individual or purely personal view, is that fertilization of an ovum and a woman's conception are different processes. A woman cannot be said to have conceived simply because one or more of her ova have been fertilized. For the woman to have conceived and to have become pregnant, a fertilized ovum must have become implanted in her womb. Abortion is interference with pregnancy, not merely interference with a fertilized ovum, such as by preventing its implantation into the womb.

The Minister relied upon the recent experience of in vitro, (test-tube) fertilization to explain the distinction. Dr. Vaughan observed that when an ovum is fertilized in the laboratory, and remains in the test-tube before implantation, no woman can be said to have conceived and to have become pregnant. Similarly, destroying the ovum while it is in the test-tube, perhaps because of its abnormal development, cannot be described in law as abortion, although that may offend other laws, whether criminal or civil. It is only when the fertilized ovum becomes implanted in a woman's womb that her conception has occurred in the sense to which the abortion law applies. The Minister's conclusion was that prevention of conception in this sense constitutes contraception, and not abortion. If administration of a pill prevents or is intended to prevent conception, even by operating upon a fertilized ovum, the procedure is not required to conform to the abortion law.

Two issues of special significance are raised by the position taken by the Minister of Health. The first concerns the means used to prevent conception, since menstrual regulation or menstrual therapy (see IV. B. below) may be undertaken with the like effect, and even for the sole purpose of preventing conception. The impact of the Minister's reasoning upon menstrual therapy may be scarcely less important than its impact upon recourse to "morning after" contraception. The second concerns the length of time after intercourse during which means may be employed, whether chemical or, for instance mechanical, to prevent implantation of a fertilized ovum. It appears from Dr. Vaughan's statement, that such means undertaken or operative within a period of time before natural implantation occurs, would fall outside the scope of the abortion law. This offers the clarification that abortion consists in acting upon a woman with intent to prevent development of an implanted fertilized ovum, whereas contraception consists in acting with intent to prevent implantation.

This clarification may have a dynamic effect regarding test tube fertilization, which has appeared in the Commonwealth not only in the United Kingdom, but also in Australia and Canada (where birth occurred, the actual implantation having been undertaken in England), and, it is claimed in India. Test-tube fertilization is still in the stage of research and development. The technique remains associated with a sizeable proportion of cases resulting in wastage of the products of conception. This parallels to a significant degree spontaneous abortion naturally occuring in women of defectively developing zygotes. Classification of the loss resulting from test-tube fertilization as abortion would inhibit this aspect of test-tube fertilization directed towards the promotion of childbearing among woman incapable of conceiving children. It also opens up the possibility, however, of maintaining a fertilized ovum in the laboratory through several stages of

cell division and differentiation, for purposes not of implantation, but of pure research. The point at which cellular research becomes human research is not clearly marked, but such experimentation may compel some resolution of the intractable issue of when human life commences.

While means to distinguish between contraception and abortion have been clarified by Dr. Vaughan's 1981 observation, it must be recalled that in 1977 New Zealand amended its Crimes Act 1961 provision on procurement of miscarriage by entacting that:

> "the term 'miscarriage' means -
>
> (a) The destruction or death of an embryo or fetus after implantation; or,
>
> (b) The premature explusion or removal of an embryo or fetus after implantation, otherwise than for the purpose of inducing birth of a fetus belived to be viable or removing a fetus that has died."

The 1976 West German abortion law and the 1978 Liberian abortion law also define abortion as a post implantation procedure.

In limiting unlawful abortion to post-implantation procedures, the New Zealand law anticipated the need to separate contraception from abortion. It may not, however, have anticipated test-tube fertilization, and the capacity to preserve a fertilized ovum in vitro before undertaking implantation. While the legislation helpfully eased the legal path to contraception, and also to pre-implantation menstrual therapy (see IV B below), it may remain in need of continuing review in light of developments in the biotechnology of both fertility control and reproduction.

The effect of perceiving abortion to be possible only after implantation, whether the perception arises from legislation or from ministerial or administrative clarification, is that abortion laws which require proof of pregnancy as a condition of criminal liability are rendered subordinate to contraceptive practices which occur before implantation, and which are designed to prevent implantation. Laws requiring proof of pregnancy are widespread with the Commonwealth. Regarding persons who act upon other women, many laws follow the model of the Indian Penal Code in imposing liability for abortion only where the woman can be shown to have been "with child" (see II A iii). Scottish Common law still applies, with the precondition to abortion liability that the woman be "with child". The laws of Sierra Leone, Lesotho, and Swaziland appear to require a woman to be "quick with child" before liability for abortion could exist. This position is congruent with this provision of English Common law dating from before the abortion law was reduced to a legislated form in England in 1803.

Even in England, under section 58 of the 1861 Act, to which the Abortion Act 1967 applies only exceptions from criminal liability, a woman who acts upon herself with the intent to terminate her pregnancy is liable only when she can be proven to have been "with child". This provision, which is widely although not invariably applicable in Commonwealth jurisdictions influenced by the 1861 Act, may come to be of great significance. Safe and reliable means of self-applied menstrual therapies are imminent, and may come to be as available as routine chemical or mechanical contraception. Prostaglandin

suppositories, for instance, may induce menstration close to the time of implantation. Thus, the time span for contraception, in the sense of pre-pregnancy means of fertility control, may expand, and the beginning point of legal abortion liability may accordingly recede. The fact that this may occur under the legislation of 1861 existing in England and elsewhere without invoking or violating provisions of the Abortion Act 1967 or other such similar advance laws is an emerging perception of the contraception-abortion interaction which may prove to be of major significance to women's health.

B. Menstrual Therapies

Menstrual therapies is a generic term describing medical and surgical procedures performed on the uterus for diagnostic and therapeutic purposes. The term includes menstrual aspiration, also known as menstrual regulation, the use of drugs, and the more traditional dilation and curettage. A number of these medical means may also be used after conception for the purpose of termination of pregnancy, but they may be used for many other legitimate purposes. Diagnostic biopsy of the uterine lining may be indicated upon such clinical grounds such as apparent infertility, dysfunctional bleeding and suspected uterine cancer. Uterine evacuation may be indicated by heavy bleeding, amenorrhea and other menstrual irregularities. Menstrual aspiration, for instance, may be used to remove products of conception in incomplete, inevitable or septic abortion, whether such abortion may have been of spontaneous or induced origin.

Treatment of incomplete abortion, for instance, is a common medical procedure, involving the qualified operator in no liability under abortion laws, since such operator does not initiate the miscarriage, or participate in any criminal scheme or conspiracy. The practitioner simply responds to the clinical situation in a clinically appropriate way, according to the norms and standards of routine and reputable medical practice. Strategies may exist to preserve a pregnancy, depending upon the health status of the patient, but a doctor determining in good faith that such strategies would have a low probability of success, or that they would be too dangerous to the patient's life or health, may employ uterine evacuation without violation of laws on abortion. Abortion laws are designed to limit the deliberate initiation of abortion, but not to affect conscientious treatment of endangered women. This is invariably made explicit in developed and advanced abortion legislation, and is implicit in laws expressed in only negative, basic terms. Further, such laws affect the intention to procure miscarriage, per se, as opposed to the intention to preserve life and health upon the danger of incomplete or threatened abortion, when the actor has not deliberately caused or contributed to the existence of such danger.

Where uterine evacuation is initiated for purposes of abortion in a woman known to be pregnant, this must be done in conformity with the local law governing abortion. Many such procedures may be undertaken, however, before conception and pregnancy can be diagnosed by routinely available methods. In many Commonwealth jursdictions, pregnancy is not capable of medical confirmation until at least six weeks' gestation. Suspicion of pregnancy before that time, based perhaps upon the personal history of the woman, cannot be confirmed beyond reasonable doubt.

This point relates to a major distinction between two models of historic Commonwealth abortion laws, which has become of great significance upon development of medically reliable and safe means of undertaking menstrual

therapies. The effect of the distinction may have been reduced, however, by the statement of the U.K. Minister of Health, Dr. Gerard Vaughan, regarding definition of contraception as a pre-implantation procedure, and of abortion as a post-implantation procedure (see IV. A. above). Similarly legislation modelled on New Zealand 1977 Act would remove menstrual therapies performed before provable implantation from the scope of the Abortion law (see ibid).

It has been seen that basic law, expressed in Section 58 of the English Offences Against the Person Act, 1861, provides for punishment of:

> "whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully [act in defined ways]" (emphasis added).

Accordingly, a prosecutor pursuing a criminal charge is so relieved of the burden of having to show the woman's actual pregnancy. This is of considerable advantage, since in classical criminal proceedings the prosecution has to prove beyond reasonable doubt both elements which together consititute the crime charged, namely the defendant's specified wrongful intention, and the defendant's commission of the specified wrongful act in furtherance of such intention.

In contrast to the position under the many Commonwealth abortion laws which follow the English 1861 model is the position under the Indian Penal Code 1860. The abortion provision of the 1837 Draft Code was not materially altered in the 1860 Penal Code.

The 1860 Penal Code provides in Section 312 that:

> "whoever voluntarily causes a woman with child to miscarry shall .... be punished ...." (emphasis added).

The Indian Medical Termination of Pregnancy Act, 1971 and Singapore's Abortion Act 1974 express conditions for lawful abortion, but the significance of the language of the Penal Code is not its effect upon availability of abortion services, but its effect upon availability of menstrual therapies. Regardless of intent, the wrongful act of the crime of abortion under the Penal Code is acting upon a woman who has conceived and become pregnant; that is, a woman who can be proven to be "with child". Where menstrual therapy is conscientiously undertaken within six or so weeks of last menstruation, reasonable doubt about conception may be hard to rebut, so that the behaviour constituting unlawful abortion under the 1860 Code may be almost impossible to demonstrate. When the woman is acted upon, moreover, for a purpose of diagnosis or treatment outlined above, the mental or intentional element of unlawful abortion may be beyond clear demonstration.

The result is that, in jurisdictions under the Penal Code, the law regarding abortion can less easily be invoked against menstrual therapies than it can in jurisdictions conforming to the English model of law expressed in terms of the 1861 Act. It may be observed, however, that this observation is based upon comparison of the different behaviour constituting the crimes as defined, turning upon the need to prove whether the woman acted upon was pregnant. Analysis comparing mental intentions for commission of the crimes reveals less distinction, since in jurisdictions under both the 1861 and 1860 models, an innocent intention in performing the prohibited behaviour will be exonerating. This was shown in 1938 in the Bourne case, where procuring

miscarriage for the purpose of saving the woman's life or health was held not to be an offence against the 1861 Act. Further the recent statement of Dr. Gerard Vaughan, the U.K. Minister of Health, that acting with intent to prevent implantation of a fertilized ovum is part of contraception, and not abortion.

Since practitioners' intentions are directed towards diagnosis and therapies other than abortion, and in particular are concerned with avoidance of implantation of fertilized ova, and since women receiving services cannot be shown to have been "with child", Bangladesh is able to provide menstrual therapies to a sizeable number of women without violating its Penal Code provisions on abortion, and without passing new law to liberalize or amend those provisions. Neither the behavioural nor the mental components of the crime of abortion are present. In jurisidictions under the English model law of 1861, the behavioural component of the crime is not affected by whether a woman can be shown to have conceived, but the mental element of the crime may nevertheless be absent, for the reasons seen above at III B iv.

Where the mental element of the crime of abortion is absent, because the prevailing intention is for instance to perform one of the legitimate menstrual therapies, it is of no consequence that derived uterine contents may upon being filtered disclose a fertilized ovum, or even indeed an implanted ovum. Where the intention at the time of acting is innocent of intent to undertake abortion, the act does not retrospectively become unlawful when the true circumstances appear. Apart from having an innocent intent, a practitioner would also be protected by a defence based upon mistake fact.

If the menstrual therapy is concerned not simply with restoration of menstruation but also with a pathological conditon, examination of the uterine contents may be more likely. This may increase the chance of a fertilized ovum being found, but since the examination is consistent with and (except for a forensic examination) compelled by a therapeutic purpose, and is conducted in the routine course of a patient diagnosis and treatment, the presence of such an ovum can have no incriminating effect. There is a clear analogy with fitting an I.U.D., following which a woman may discharge a fertilized ovum which the device prevented from achieving implantation. There is no duty to seek out such an ovum, and no criminal consequences could result.

Accordingly, menstrual therapies are not confined by laws defining and prohibiting abortion. Whether they may be affected by laws on such offences as attempting or conspiring to commit abortion is matter to be analysed separately (see III B iv). The main point remains that the conscientious pursuit of menstrual therapies, like the similar pursuit of contraception by methods intended to operate before implantation of a fertilized ovum, have become distinguished in law from the practice of abortion.

This result proceeds from a priori reasoning, but it is reinforced by pragmatic and humane considerations. In jurisdictions following the English 1861 model, where absence of proof of pregnancy does not bar conviction for abortion, women in fact not pregnant are in medical need of the diagnostic and other services called menstrual therapies. Menstrual therapies can be undertaken with the intention to achieve abortion, of course, when it has been seen that they must conform to the local abortion law, but not all menstrual therapy is abortifacient in purpose or effect. If it is claimed

that all menstrual therapy must conform to the abortion law and, for instance, the regulations made to implement advanced laws, patients from young girls to the elderly, from apparently infertile women yearning for their own children to for instance celibate women in holy orders will be able to take advantage of these medical techniques to maintain their health only as abortion applicants and recipients. They will have to submit applications to hospitals and other bodies, with copies perhaps retained by governmental agencies, and their subsequent medical records will disclose their receipt of abortions. Such barriers to their receipt of legitimate medical care through doctors acting in good faith may appear both oppressive and unjustifiable.

The reasoning outlined above has been expressed in the article entitled "Menstrual Therapies in Commonwealth Asian Law", by Dr. Pouru P. Bhiwandiwala et al., published in International Journal of Gynaecology and Obstetrics (1982). The text of this article was sent to Commonwealth legal departments where the Penal Code is applied, and their responses were requested. These gave kind consideration to the thrust of the reasoning, and approved it. The Attorney General of Malaysia, for instance, felt "able to confirm that there can be no liability for abortion or causing miscarriage under the Penal Code of Malaysia where menstrual therapy is administered to a woman who is not proven to be "with child". Similarly, it was observed that "it appears that Menstrual Therapies can be performed in Sri Lanka without violating abortion law where a woman is not proven to be "with child."

These responses were consistent with that from Bangladesh, which observed that there was no specific law regarding menstrual therapies, and that they would not be questionable in courts unless they were to be used within the mischief of the abortion prohibition as defined by sections 312-316 of the Penal Code. This mischief, it must be remembered, consists in acting with intent to procure the miscarriage of a woman who is "with child." Where another intent animates a person, or where the woman cannot be proven to be "with child," such as where menstrual therapy is undertaken soon after menstrual delay, the mischief of the abortion provisions is not found. The Bangladesh response to the questionnaire underscores the 25 January 1980 Memorandum "Guidelines for Menstrual Regulation (MR)" of the Government of Bangladesh explaining the legality of MR. That memorandum includes an extract from a legal interpretation of the Institute of Law found in their Report on Legal Aspects of Population Planning in Bangladesh made to dispel any prevailing doubts about the legality of MR.

> "... many Family Planning Clinics are carrying out the post-conceptive method of "Menstrual Regulation" as a means of birth control which does not come under section 312 of the Penal Code. Under the statutory scheme, pregnancy is an essential element of the crime of abortion, but the use of menstrual regulation makes it virtually impossible for the prosecutor to meet the required proof."

The Malaysian response was less willing to accept the inapplicability of Penal Code provisions on liability for attempted abortion where a woman was not provable to have been "with child", because of the Malaysian Court of Appeal decision in the 1958 case of Munah bt. Ali v. Public Prosecutor, discussed above regarding Preparatory and Inchoate Offences (see III B iv). Although the jurisprudential underpinning of this decision has been severely corroded by the 1975 House of Lords decision in the English case of Haughton v. Smith (discussed at III B iv), it remains to be seen whether Malaysian

Courts will follow the reasoning of their own Court of Appeal, or review that 1958 decision in view of the 1975 reasoning of the House of Lords. The High Court of Malaysia applied Haughton v. Smith in Public Prosecutor v. Kee Ah Bah, (1979) paying attention to the principles decided by the House of Lords. The principles were applied to reverse an acquittal, however, rather than to exonerate a defendent, so their full effect has still to be determined.

## C. Health and Allied Health Personnel

### 1. Generally

Consistent with recommendations of the Sixth Commonwealth Health Ministers meeting in 1980 this Report examines what Commonwealth governments have done to enable the delivery of abortion services by adequately qualified health and allied health personnel. Statutory, judicial and administrative recognition of the propriety of the delivery of health care by health and allied health personnel is increasing throughout the Commonwealth. Some Commonwealth constitutions contain policies toward ensuring, as it is expressed in the constitution of the Federal Republic of Nigeria that:

> "there are adequate medical and health facilities for all persons" (17d)

Commonwealth governments are realising that they will not be able to fulfil these kinds of mandates unless they make more effective use of health manpower resources by using the most highly qualified for the more specialised kinds of care, while leaving the routine procedures and health education to those who are appropriately experienced and trained, but not over-trained for the tasks they are called upon to perform. Commonwealth governments have acknowledged the failure of traditional Western medical models to provide adequate health care for all. This is particularly the case in countries where large portions of the population have limited or no access to health care. Further, governments realise that it is more cost effective to improve skills of existing indigenous health care providers than to establish a completely new system of health care delivery.

Commonwealth governments are moving to provide legal recognition of health and allied health personnel whether they be trained by teaching or by experience and apprenticeship. They are doing this in a variety of ways and in a variety of circumstances. The choice of terms that encompass the broad spectrum of health personnel is difficult. Accordingly it was thought best to use the inclusive term, 'health and allied health personnel' used by the World Health Organisation. This term includes both those health care providers that receive formal training and usually are liscensed and those health care providers that learn their skills empirically perhaps by experience or apprenticeship with respected elders in their craft, but lack formal training and qualifications. The attitude of governments towards them range generally from exclusion to encouragement. Legal recognition of health and allied health personnel is achieved in several ways by Commonwealth governments. Among them are:

* Statutes or administrative decrees regulating indigenous health care providers or traditional birth attendants by excluding them, tolerating them, including them or integrating them;

* Native custom recognition acts;

* Statutes or administrative decrees registering trained health and allied personnel generally;

* Statutes or administrative decrees permitting the use of trained health and allied health personnel to do specific acts; and

* Judicial interpretation of statutes or subordinate regulations.

The 1981 decision of the U.K. House of Lords in the Royal College of Nursing case, recognised the legality under the Abortion Act 1967 of nurses administering drugs through a doctor-inserted catheter for the purpose of inducing abortion in the form of premature labour, and of nurses then managing the premature delivery while a doctor was available on call in emergency. This precludes any exercise of independent judgement to instigate abortion procedures, since doctors reach individual decisions specific to each patient affected. It may lead to the question, however, of whether doctors might set conditions upon which nurses may themselves determine and instigate appropriate medical procedures, upon the outcome of prescribed tests which nurses themselves conduct. Where medically qualified personnel are scarce, this may be appropriate, as indeed the position regarding performance of some menstrual therapies in Bangladesh may indicate.

ii. Indigenous Health Care Providers/Traditional Birth Attendants (TBAs)

The importance of the care provided by traditional birth attendants (TBAs) can't be overlooked as has been the case in the past. The definition developed by Verderese and Turnbull and used in a 1979 World Health Organization publication is:

> "A person (usually a woman) who asists the mother at childbirth and who initially acquired her skills delivering babies by herself or working with other TBAs. She is more commonly found in rural areas."

In view of recent trends to train TBA for other tasks, the definition of TBAs' activities could be broadened according to a definition developed by P.C.Y. Chen:

> "Care of a woman throughout the normal maternity cycle, care of the normal newborn baby, participation in family planning counselling and contraceptive distribution; nutrition; hygiene; health education; immunization and other such tasks as she may be trained and authorized to perform by the Ministry of Health of other health authority."

Indeed, recent report Traditional Midwives and Family Planning by Mayling Simpson-Herbert, Phyllis T. Piotrow, Linda J. Christie and Janelle Streich explains that between 60 and 80 percent of babies born in the developing world are delivered by TBAs. It continues by explaining that TBAs also perform abortion, which is usually less hazardous than deliveries, regardless of the legal status of abortion and sometimes even derive a major part of their income from abortion.

The nature of the care that is provided by TBAs is perhaps in many ways more responsive to women's needs and more sensitive to local cultural values than care provided by trained doctors, gynaecologists and obstetricians. As a result some governments are moving to train TBA's not only to attend birth but to provide maternal and child health care and family planning services. Indigenous health care providers in many situations know more about how to meet the health needs of a community, and as a result are more sought after and trusted. This can be particularly true of TBAs who do abortions, for example, by use of traditional means such as massage abortion, emmanagogues etc. This trust and confidence they enjoy could in part be due to the fact that TBAs are women and the fact that they are more accessible than doctors, particularly in rural areas.

Women-to-women services have accompanying benefits, such as health care recipients feeling more comfortable given, for example, the protection of modesty and preservation of cultural practices of communication of female biological problems which such a service can provide. Women are more forthcoming in explaining their female problems to other women who have experienced some or all of the same problems, accompanying fears, reservations and embarrassments. On the other hand it can't be overlooked that there is room for improvement of the quality of care that is provided by TBAs. Studies by R.W. Rochat and M.J. Rosenberg on abortion complications in Bangladesh showed that more than half of the complications and deaths occurred after abortions that were performed by TBAs.

Governments have various approaches to the regulation and improvement of the standard of care of indigenous health care providers generally and TBAs specifically. J. Stepan in his chapter on "Patterns of legislation concerning traditional medicine" explains that legislative approaches range from a monopolistic system where only the practice of modern scientific medicine is recognized as lawful with the exclusion of and sanctions against all other forms of healing to an integrated system in which there is official promotion of the integration of 2 or more systems under a single recognized service. J. Stepan explains that in between these 2 extremes are the tolerant system where only the system based on scientific medicine is recognized, although, the practice of various forms of traditional medicine is tolerated by law and the inclusive system in which medicines other than scientific medicine are recognized as legal.

Many Commonwealth laws exclude TBAs from attending births thus establishing a monopoly for doctors or licensed midwives. The degree to which such laws are enforced varies not only from country to country but within countries. Other Commonwealth laws are tolerant in that they neither prohibit practice by TBAs nor provide any legal protection. For example, in Nigeria TBAs have no legal status or protection but they can practice in their respective communities.

Another example is the Malaysian Medical Act of 1971 which contains a broad general exemption:

> 34.(1) "Subject to the provision of subsection (2) and regulations made under this Act, nothing in this Act shall be deemed to affect the right of any person, not being a person taking or using any name, title, addition or description calculated to induce any person to believe that is he is qualified to practise medicine or surgery according to modern scientific

methods, to practise systems of therapeutics or surgery according to purely Malay, Chinese, Indian or other native methods, and to demand and recover reasonable charges in respect of such practice".

Several such exemptions exist in Commonwealth Medical Practice statutes. If such exemptions do exist the question then becomes whether the TBA's practice is considered to be a practice of "systems of therapeutics or surgery according to purely Malay, Chinese, Indian or other native methods", and whether TBAs can "demand and recover reasonable charges in respect of such practice." Where such exemptions do exist the TBAs practice is monitored by a regulation of the Health Ministry usually by a register. TBAs are recognized but not accorded any legal status. Another tolerant approach, taken for instance in Belize, is to allow TBAs to work but only in areas where physicians or licensed nurse midwives are not available.

The inclusive System recognises and supports traditional medicine as part of the state-regulated structure of health care. Such systems are particularly prevalent in India, Sri Lanka and Bangladesh where medical traditions, such as ayurvedic medicine, have long histories of development, literature or teaching. The traditional ayurvedic physicians in Sri Lanka are controlled by the Ayurvedic Medical Council. The scope of their practice includes treatment in "ailments or diseases associated with pregnancy and childbirth." (Ayruvedic Medical Council Notice of 5 October 1970).

The full scope of this authorisation is not apparent, but it may be argued that, undertaking a diagnostic or other menstrual therapies may be authorized. For avoidance of doubt clarification by Ministries of Justice or Health or Indigenous Medicine would be helpful particularly in areas where ayurvedic practice might overlap with liscensed nurses, midwives or modern medical practice. Such an overlap might exist in the area of prescription of therapeutic drugs. In India, for example, provisions regulating Ayurvedic and Unani drugs and homoeopathic medicine were introduced by the Drugs and Cosmetics Act, 1940, as amended in 1966, and the Drugs and Cosmetics Rules, 1945, as amended in 1964 and 1970. "Ayurvedic and Unani drugs" are defined as "medicines intended for internal or external use for or in the diagnosis, treatment, mitigation or prevention of disease in human beings, mentioned in, and processed and manufactured exclusively in accordance with the formulae described in the authoritative books of the Ayurvedic and Unani systems of medicine, as specified in further texts". Clarification perhaps by a Ministry of Indigenous Medicine as to whether vaginal suppositories that might eventually be used for menstrual therapies come within this definition or other similar definition in other Commonwealth countries with a Ayurvedic or Unani system might be helpful to these professions who have a mandate to treat ailment or diseases associated with pregnancy. Inclusive systems might also specify duties of responsibilities of TBAs through, for example, training courses. Successful completion of a training course might earn a TBA a certificate but not legally protected license. A TBA is thus included through her training but not necessarily by law.

Very few Commonwealth countries have actual integrated systems. Some achieve an integrated system by what happens in fact. For example, several Commonwealth countries including India make considerable efforts to train and register TBA's and to integrate them into the health care system particularly in the rural areas. The scope of their practice depends in part on their apprenticeship and the kind of formal training however minimal they might

receive. Application of sanctions against TBA's acting outside the scope of their practice is very infrequent given the lack of legal infrastructure in rural areas. If they are applied they are only in the most extreme cases of negligence usually causing the woman's death.

In the years ahead Commonwealth countries will have to decide whether to leave the situation as is, determine whether they want to prohibit or promote the practice of TBAs. If they want to promote the practice of TBAs they will have to establish whether acts legalizing indigenous medical practice includes the practice of TBAs, or whether TBAs need a separate act to, for example, establish their scope of practice. Will the scope of practice include de jure menstrual therapies and perhaps early abortion as it now does de facto, the prescription of certain drugs necessary for the specified practice as it now does with registered midwives? Commonwealth countries will also have to determine whether any kind of training is legally required apart from apprenticeship and experience. Further, they will have to decide whether a registration or liscensing system would improve the standard of care and what kind of sanctions if any are appropriate for TBAs acting outside the scope of their practice and for their malpractice.

Beyond tolerating or including health services administered by TBAs, some legal systems show willingness to take into account practitioners' intentions in Western criminal proceedings. For instance, custom may be invoked in Papua New Guinea under the Native Customs (Recognition) act, 1963 in common law courts of criminal jurisdiction to ascertain the existence of a state of mind, to decide the reasonableness of behaviour and the reasonableness of an excuse. It may give TBA's greater immunity from oppressive legal limitations on their work done according to their custom. Similarly, customary belief held in good faith may be found a justification in an individual case for not proceeding with a criminal case. When applied locally it may require wider recognition of rights of communities and potential receipients of services to the practice of TBAs.

iii. Trained Health and Allied Health Personnel

It is notable that the 1979 study by John M. Paxman, Francis M. Shattock and N.R.E. Fendall, entitled The Use of Para-Medicals for Primary Health Care in the Commonwealth: A survey of medical-legal issues and alternatives, which drew upon responses of 28 Commonwealth Member States covering many more legal jurisdictions, and which devoted many pages to illustrating the laws developed in a number of countries, gave no evidence of para-medical personnel being granted authorisation to perform abortions. Personnel such as licensed midwives were in some instances allowed to conduct childbirth by Caesarian Section in emergency, a procedure far more dangerous than abortion particularly early abortion. They were also allowed to conduct routine internal examinations upon women, but abortion services appeared not to be included in details, lists and schedules of the medical treatments they might be permitted by law to perform in an independent capacity.

The study did note, however, that in Bangladesh certain menstrual therapies are undertaken by para-medical personnel, such as Lady Family Planning Visitors who use procedures which are comparable to early inducement of abortion. This is compatible, of course, with the performance of post-coital contraception by mechanical (as opposed to pharmacological) means, and congruent with the widespread permission many suitably qualified paramedicals are reported by Paxman, Shattock and Fendall to possess to perform

vaginal douching, fit intrautering devices and use appliances, internally for obtaining specimens of the uterine contents.

The legal authority of such personnel administering those methods before pregnancy can be definitively established will emerge in years to come particularly as those methods M.P. Embrey discusses in his article in Appendix C, become available. Those methods used before pregnancy can be established in many Commonwealth countries can be legally administered by licensed health and allied health personnel. Few Commonwealth countries have taken advantage of this legal opportunity. Bangladesh, however, has trained family welfare visitors to administer those procedures before pregnancy can be proven. Mauritius, in contrast, where pregnancy must be established as an element of the crime, has not moved to train health and allied health personnel to administer menstrual therapies or pre-implantation methods often called hinsight methods. It is often asked whether appropriately trained health or allied health personnel can perform menstrual regualation (MR) or abortion safely. A study by S. Bhatia, A.S.G. Faruque and J. Chakraborty on "Assessing Menstrual Regulation Performed by Paramedics in Rural Bangladesh" showed that the complication rate of MR performed at less than seven weeks of the last missed period was minimal and compared favourably with complications rates of menstrual therapies performed by doctors. The study concludes:

> "The preceding account of the results of 212 MRs preformed by Bangladeshi lady family planning visitors indicates that LFPVs or other categories of paramedical staff can perform menstrual regulation if they are properly trained and are provided with appropriate medical supervision and back-up".

Important questions concern not simply the techniques which para-medical personnel may be permitted to employ, but the length of the lines of communication by means of which they receive supervision. The drafters of the Barbadian bill, 1979 - 10:31, allowed for delegation when they allowed for the termination of pregnancy of not more than 12 weeks to "be administered by or under the supervision of an authorised medical practitioner ..." The words "under supervision" may be taken to mean standing orders to those acting under doctor supervision so as to allow them to act independently in certain specified situations and to require them to refer higher risks cases to the more specialized skill of a doctor.

The increase of the availability of services early on in pregnancy or suspected pregnancy decreases the rate of procedures and associated complications done later in pregnancy. Thus, some Commonwealth countries, most notably Bangladesh, are achieving an increase in overall safety of and accessibility to more cost effective women's health services and a decrease in the monopoly and accompanying high costs on the delivery of a health service solely by a scarce medical profession and an increase in the more effective and efficient use of their time and expertise through supervision and delegation.

iv. The Role of Nurses and Comparable Professionals

The location of abortion regulation within the field of criminal law and jurisprudence fundamentally affects the delivery of abortion services. This was shown in an abortion-related English case decided in 1981 in the House of Lords, named Royal College of Nursing of the United Kingdom v. Department of Health and Social Security. The case arose with regard to Britain's Abortion

Act 1967, in force in England, Wales and Scotland and concerned whether nurses performing professional functions of management of abortion procedures are protected by the Act. In England and Wales abortion is taken to mean those procedures done from the time of nidation. In Scotland abortion is taken to mean those procedures done from the time pregnancy can be proven beyond a reasonable doubt by reasonably available methods, about 6-8 weeks (see IV A above). As a result those procedures, done in England and Wales before nidation and in Scotland before pregnancy can be proven, do not fall under the British Abortion Act 1967.

A conflict of criminal principles had to be resolved. One principle accepts the inherent illegality of abortion, as expressed in the basic law, the Offences Against the Person Act, 1861 Section 58 provides that:

> "... whosoever, with intent to procure the miscarriage of any woman ... 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 felony ..."

The celebrated 1938 case of R. v. Bourne, still applicable in Northern Ireland, recognised that abortion performed to preserve the woman's life or physical or mental health is not "unlawful", but the legislation, while subject to this interpretation, remained expressed in only negative terms. The underlying presumption is that, whether in defence of women's protection against improper interference, or in defence of unborn life against improper termination, this law serves the public interest. The 1967 Act introduces an exception that, in the language of section 1(i),

> "... a person shall not be guility of an offence ... when a pregnancy is terminated by a registered medical practitioner if ... "

stated conditions are observed. The initial principle prescribes that, since this language constitutes an exception from a law protecting the public interest, it must be construed strictly, or narrowly. That is, the exception must be afforded minimal scope, since it exposes the public interest to a limitation upon its protection. The 1967 Act relieves guilt only when "a pregnancy is terminated by a registered practitioner." If it is termination by another person, such as a nurse, the protection of the Act would not be available, upon a strict reading.

Other principles of reading the Act are also applicable. A general principle of criminal law is that liberty of individual action is presumed, and any body of legislation imposing criminal prohibitions and penalties must be strictly construed in favour of the accused, so as to maximise liberty and afford penalties minimum scope. While this principle may protect abortion procedures engaging nurses in significant acts, it may not afford the nursing profession an ethical and reputable basis for positive involvement, since it seems to require the profession to hide its practices behind legalistic and procedural technicalities, dependent for a finding of innocence upon only a reasonable doubt of guilt. This is inelegant and undignified for a self-respecting profession anxious to assert the positive legality of its services.

A more important principle is that an Act shall be construed functionally, in order to give effect to its purposes. By this reading, the

requirement that "a pregnancy is terminated by a registered medical practitioner" means not that such practitioners may alone be involved in termination, but that qualified doctors be in charge of procedures, and have them performed by routine and conventional medical means involving appropriate recourse to the skills of related professionals such as nurses, and auxiliary personnel. Part of the professional duty doctors owe patients is to collaborate with other health professionals, and to employ their applicable skills. That is, doctors are required to delegate to nurses those health care functions which nurses do routinely, and as a result are more experienced to do. Accordingly, doctors can make more effective use of their time in performing functions only they are qualified to do. Such an arrangement improves the quality and quantity of health care.

The case concluding in the House of Lords arose when the Royal College became concerned about nurses' status in abortions performed not by surgical means, which before 1972 had been the only means generally available and conducted principally by doctors, but the technique replacing surgery of using prostaglandin drugs. These are placed into the womb in a two-stage process. The first does not terminate pregnancy, but involves inserting a catheter into the womb, and is carried out by doctors. The second involves administering the drug into the womb through the catheter, by a pump or drip apparatus, and is carried out by nurses under doctors' instructions, usually in their absence while they are available on call. The drug induces premature labour, managed usually in the same way by nursing staff with doctors on call if needed.

The College sued for a declaration that nurses' involvement in these procedures was unlawful. This claim took a neutral and traditionally conservative approach, and constructively required the defendant Department to argue in favour of legality of nurses' involvement, compatibly with legal advice which had earlier been expressed on behalf of the Department. In the High Court (Queen's Bench Division), the judge interpreted the 1967 Act functionally, favoured the view expressed on behalf of the Department, and declared the legality of involvement in such abortions of qualified persons other than registered medical practitioners. For greater certainty, the College appealed to the Court of Appeal. Here, the trial judge was reversed in favour of a strict reading of the 1967 Act, confining its protection to procedures conducted by doctors alone. Lord Denning, MR considered that this reading might result in doctors using the older surgical method with its extra hazards, but felt that this was a matter for Parliamentary reform, rather than for judicial initiative. The Court of Appeal considered it appropriate to sacrifice the benefits improved techniques offered women, for the sake of reading the 1967 Act conservatively.

On the Department's appeal to the House of Lords, their Lordships by majority restored the decision of the trial judge, and ruled that the 1967 Act is to be given a functional interpretation. The Act was intended to amend and clarify the unsatisfactory and uncertain state of the previously existing law. The policy of the Act is to broaden the indications for lawful abortion recognised in the Bourne case, and to ensure that abortions are carried out with proper skill and care in ordinary hospitals as part of ordinary medical care and in accordance with normal hospital practice. By this, tasks forming part of treatment are entrusted as appropriate to nurses and other staff members under instructions of the doctor in charge of treatment. Accordingly, the judgement provided that a doctor prescribes the treatment, remains in charge and accepts responsibility throughout, and the treatment is

conducted in conformity with instructions given, the pregnancy is "terminated by a registered medical practitioner", and all persons associated with it are protected by the Act. The Department's legal advice, eventually upheld, applied to involvement in abortions not only of nurses, but also of qualified midwives.

Part of the problem leading to the case and addressed by the House of Lords was that the 1967 Act was passed against a background of experience unaware of the prostaglandin technique of abortion which evolved into general usage after 1972, on account of its greater safety to women. Questions raised by the House of Lords' decision include whether other developments in biotechnology may be similarly accommodated, and how closely in control of chains of command doctors must remain.

The former question may separate abortifacient means available only upon a doctor's instructions or prescription, from those to which women may make independent recourse. The former alone, may satisfy requirements of doctors prescribing treatment, being in charge and accepting responsibility. The latter question becomes more important with recognition that, while doctors may determine medical appropriateness of abortion and recommend a particular technique, and its critical elements may then be administered by others under the doctor's charge. Techniques of evacuating the uterus exist which can be performed in clinics upon an out-patient basis which rely upon diagnostic and medical support. Doctors may set guidelines for nurses' determinations in individual cases, without themselves considering such individual cases. They may be on call for second opinions and emergencies, but permit nurses to initiate and complete routine processes of uterine evacuation. This matter is further explored above regarding early termination of a possible pregnancy by inducement of menstruation (see IV. B). It may be, however, that, subject to the wording of particular legislation and the willingness of courts to interpret it compatibly with evolving technology, its safety and women's health needs, advanced legislation permitting lawful procedures through doctors may permit doctors to act to safe effect in the relativity of local conditions, through extended lines of communication. They may be permitted to guide other appropriately qualified persons rendering health care in general rather than individual, patient-specific terms.

The approach of the House of Lords' majority is of special significance to abortion law reform. Their Lordships' minority and the Court of Appeal considered that accommodation of the means of abortion that have arisen since 1967, and affording women the benefits to health and safety of those means, were the responsibility of Parliament. It was also recognised, however, that abortion legislation is contentious, socially divisive and, whatever the direction of proposed legislation, prone to failure. The House of Lords' majority was less willing to entrust the health and welfare of women and their access to improved medical techniques to this parliamentary process, where existing legislation could be read to accommodate the lawful availability of safe techniques in routine medical practice. Clearly, the House of Lords' decision is not binding outside the United Kingdom. Courts of other jurisdictions interpreting their own particular legislation and its particular language may usually reflect, however, upon the House of Lords' approach. They might consider the cost imposed upon women, their families and their communities by adopting a narrower approach unsympathetic to improved medical procedures. This may hold the end of abortion lawful, but only when pursued in circumstances of avoidable inconvenience, expense of scarce resources of personnel and surgical facilities, and individual hazard to women lawfully eligible for termination of pregnancy.

D. Constitutional and International Human Rights Principles

1. Generally

Constitutional and international recognition of abortion rights has recently begun to emerge. National recognition has not necessarily focused on abortion rights per se but, for example on rights to equal protection which could affect women who are discriminated against on account of say, pregnancy or soio-economic status. Further many national constitutions include among their enumerated goals or directives economic and social guarantees relating to the satisfaction of basic human needs for example rights to health or education. In countries where womens' health is put in severe jeopardy because of restrictive abortion laws or where women particularly adolescent women are denied an education because of their pregnant status, these women's constitutional guarantees are denied or abridged. Still other Commonwealth constitutions contain express provisions protecting people's privacy, integrity or autonomy. The constitutional principle of privacy or integrity in some systems is derived from a due process right or a right to fundamental fairness found in most Commonwealth constitutions.

These specific constitutional guarantees have to be seen against the background of how the judiciary reviews constitutional infringements by individuals, governments and by conflicting legislation. Without a strong judicial system of constitutional review in courts such constitutional provisions state goals and not necessarily positive law that is enforced judicially. Some Commonwealth constitutions provide for negative rights. They state freedoms, governments may not deny or abridge. Other Commonwealth constitutional systems might also include positive rights essential for human existence such as health and education which governments in theory must provide.

Commonwealth constitutional systems differ in the degree to which their provisions are justiciable. Fundamental principles are justicable when they they are enforceable law and protected by the courts. Directive Principles of State policy, for example, guarantees of health and health care outlined in some Constitutions are not necessarily justiciable but they are essential in the governance of any country. In a sense it is the difference between prescriptive and descriptive sources of constitutional law. Some constitutional provisions are prescriptive outlining sources of law the courts have to apply; others are descriptive stating aspirational goals. With either presciptive or descriptive constitutional provisions people do not necessarily view their constitution as an instrument to enforce their rights or indeed in some places they don't have the means to go to courts to enforce their constitutional rights. Nevertheless the actual enumeration of constitutional ideals, even if not enforced by courts is a declaration of the way things should be. If governments act in a contrary way they are increasingly being called upon to explain their departures from declared constitutional principles and in some systems to provide remedies for constitutional infringements.

International and regional human rights instruments reinforce national constitutional principles of equal protection and due process or sometimes called general fairness. For example, Article 1 the Convention on the Elimination of All Forms of Discrimination Against Women has a very useful definition of what constitutes "discrimination against women". Further some human rights instruments have provisions on health and social guarantees and

on privacy. The degree to which these instruments are enforceable against ratifying or signatory states is a contentious issue but regional human rights commissions have recently considered challenges to national court decisions. While some of the court decisions that have been challenged are not court decisions of Commonwealth countries, the decisions of the various regional Human Rights Commissions have implications for Commonwealth governments by virtue of their membership in such commissions or by their signature or ratification or incorporation of regional human rights instruments.

ii. Guarantees of Health and Health Care

Some Commonwealth constitutions contain provisions promoting the health and well being of the individual:

> "The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties..."
> (Constitution of the People's Republic of Bangladesh, Article 18).

Other constitutions enunciate policies toward ensuring access:

> "To adequate medical and health facilities for all persons."
> (Constitution of the Federal Republic of Nigeria Section 17 3 (d)).

Health does not seem to be specifically defined in Commonwealth constitutions. It would probably be interpreted by courts to be very similar to or synomous with the definition of health in the preamble of the constitution of the World Health Organisation:

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

The courts of Commonwealth countries that subscribe to the World Health Organization principles, would most probably use this as the operative definition.

Statistics overwhelmingly show that restrictive abortion laws adversely effect women's health. The Report of the National Commission on the Status of Women in Barbados explains that incomplete or badly done abortions were the 2nd highest cause of hospital admission in Barbados in 1976. In Africa statistics reported in Malawi workshop, Medical-Legal Issues: Report of a Combined Medical-Legal workshop, show that in the main medical centre in Dar es Salaam, over 4,000 (two-thirds) of the total 6,000 gynaecological admissions in 1978 were diagnosed as abortion cases; of these, 85 per cent were classified as spontaneous abortions, in 5 per cent there had been clear illegal interference before admission and 10 per cent were of uncertain origin. The Ministry of Justice of Botswana has interpreted their law to allow abortion only to save the life of the woman and yet the African charter on Human and Peoples' Rights provides in Article 16.1 that:

> "Every individual shall have the right to enjoy the best attainable state of physical and mental health."

It would seem that this Article compel measures to implement at least a therapeutic indication. Indeed, the African Commonwealth countries that subscribe to the World Health Organization principles and therefore its definition of health would be obliged under Article 16.2 of the African charter to "take the necessary measures to protect the health of their people". The mandate "take the necessary measures" might require African Commonwealth countries to consider social and sociomedical indications for abortion.

The United Nations Convention on the Elimination of all Forms of Discrimination Against Women, adopted by the General Assembly in December 1979 and entered into force in September 1981 upon ratification by its twentieth signatory, has been ratified by some Commonwealth Member States e.g. Barbados, Canada, Dominica, Guyana, Sri Lanka, St. Vincent and the Grenadines. Its thrust is to afford women the protections enjoyed by men including the right to protect life and health, which may require adequate legislation to implement abortion upon therapeutic indications. Its Article 12(1) mandates that:

> "State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning."

And yet Lord Denning and his colleagues who joined him in his decision were quick to interpret the British Abortion Act 1967 so as to limit availability of health care services for women seeking abortions done by prostaglandin. Had the House of Lords not overturned Lord Denning's decision, an appeal to the European Commission on Human Rights might have been successful under Article 14, and for example, Article 8 of the European Convention.

In contrast to Lord Denning, the leader of the Mauritian delegation to the 24th Commonwealth Parliamentary Conference (1978) The Honorable K. Ramoly explained that with the health effects of illegal abortion were experienced by men, it is unlikely that abortion laws would remain as restrictive. Further, constitutional and international principles would be more readily used to eliminate laws that infringe on or deny women health and well being.

iii. Provisions on Elimination of Discrimination

Fundamental law, expressed and often entrenched in State Constitutions and Bills of Rights and in international and regional human rights conventions or charters operate against discrimination on grounds of sex, age, race, religion, socio economic status, and for instance, place of residence in the state. For example, the Ghanian Bill of Rights contains the following defintion of "discriminatory":

> "... the expression "discriminatory" means affording different treatment to different persons attributable only or mainly to their respective descriptions of race, place of origin, political opinions, colour, sex, occupation or creed whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description."

Article 1 of the Convention on Elimination of All Forms of Discrimination Against Women defines "discrimination against women" broadly:

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

Discrimination against Women

It may be argued, for instance, that men may medically protect their lives and health against danger without restraint, but that pregnant women may not do so where restrictive abortion laws exist. It would seem that restrictive abortion laws with their accompanying social and health effects "impair ... or (in some cases) nullify the ... enjoyment or exercise by women on a basis of equality of men and women of human rights and fundamental freedoms in (all) fields." Further advanced laws requiring that women submit to special procedures and public record before achieving health protection without requiring similar special procedures and public records for men undergoing medical treatment of a comparable complexity is discriminatory against women on account of their sex. It may be concluded that such restrictive laws discriminate between men and women. Against this it may be argued, however, that any discrimination is between pregnant and non pregnant people and is not based on sex as such. Nontheless it can't be denied that pregnancy is in the exclusive realm of the female sex and while denial of abortion services effects the pregnant it potentially effects non pregnant women because many of them could become pregnant.

Discrimination against the Poor

The argument that restrictive abortion laws discriminate unfairly against the poor might find legal support in Commonwealth Constitutions particularly those which call for the elimination of discrimination on account of socio-economic status or, for example caste as in the case of India. Wealthier women may obtain medical evidence of need more easily and may travel to other jurisdictions where lawful safe services are more easily accessible. Indeed, the Report of the proceedings of the 24th Commonwealth Parliamentary Association shows that its delegates were most concerned by the fact that restrictive abortion laws are laws against the poor. Under such laws women obtain abortions in the worst of circumstances and as a result often times end up in the hospital. It was put succinctly by Mrs. A.D. Laurie a delegate from the Northern Territory of Australia at the 24th Commonwealth Parliamentary Association Meeting:

> "... laws against abortion are simply laws against the poor. No abortion law has ever stopped any woman of affluence and influence from in obtaining a well-done abortion under medical supervision. They do, however, stop the less influential and the poor woman from obtaining treatment. It does not stop her getting an abortion, but she gets it under the poorest of circumstances and she usually has no one to blame but ecclesiastic laws..."

It is not only restrictive laws that discriminate against the poor but some advanced laws as well. Some advanced laws that require abortions particularly early abortions to be done by the most specialized doctors in hospitals discriminate against the poor by restricting the availability of services particularly in rural and slum areas where the specialist doctors and hospitals do not exist. In countries with such requirements poorer women still resort to the quacks. The Honorable Puan Rafidah Aziz, a delegate from Malaysia at the 24th Commonwealth Parliamentary Association meeting urged that:

> "... if you allow abortion on request, (one needs) to provide the necessary facilities for the under priviledged and the less priviledged to go to good doctors for a proper abortion, and not resort to quacks ..."

Discriminatory Effect

Discriminatory effect of restrictive laws or some provisions of advanced laws whether they discriminate against women as a sex or against poor women as a class are subject to challenge under Commonwealth constitutions with "in its effects" clauses in the provisions on elimination against discrimination. For example, the Kenya Bill of Rights, as does the Ghanian Bill of Rights, provides that no law shall be enacted which results in a provision "that is discriminating either of itself or in its effect" (Kenya Constitution Section 82). A law that says men can get health care services but woman can't is discriminatory "of itself" or on its face. A law that says no gynaecological services can be provided in hospitals is discriminatory "in its effect" because only women seek such services. Further laws, regulations or school policies that require schools to dismiss girls who become pregnant are discriminatory "in their effect", because only women and not men become pregnant. Such laws or policies have the effect of denying women who become pregnant their education and as a result usually their livelihood.

Negative and Positive Rights

Commonwealth constitutional provisions requiring the elimination of discriminatory laws do not necessarily compel public provision of services to promote equal protection of the laws. It is the difference between constitutional provisions requiring negative action, for example, the elimination of discrimination as opposed to requiring positive action, for example, the promotion of equal protection and equal opportunity involving the delivery of services. The former relies on due process or the Rule of Law to protect the individual from arbitrary government interference. The latter, however, relies on governmental provision of services and is difficult to enforce by traditional legal remedies. An example of a negative constitutional provision is:

> "The state shall not discriminate against any citizen on the grounds only of religion, race, caste, sex, place of birth or any of them."
> The Constitution of India Section 15 (1).

Similar provisions in other Commonwealth constitutions might well require the repeal of restrictive abortion laws in those respective countries.

In contrast to a negative provision requiring the elimination of discrimination are the positive provisions requring affirmative action to promote

equal protection. An example of such a provision is Section 15 of Canada's 1982 Charter of Rights and Freedoms which provides for "the right to equal protection and equal benefit of the law without discrimination." It is not obvious, however, that the Charter which comes into operation in 1985, will compel more equitable access to legal services even though it was found in 1977 by the government sponsored Badgley committee that legal abortion services are inequitably available. The enforcement of the Canadian equal protection provision is further complicated by the fact that provincial legislation may expressely override it (see section 33 (1)).

The Convention on the Elimination of All forms of Discrimination Against Women in its Article 3 encourages positive action by requiring states parties to to take "all appropriate measures, including legislation, to ensure full development and advancement of women, for the purpose of guaranteeing them the exercise and employment of human rights of fundamental freedoms on a basis of equality with men." Provisions requiring positive action are particularly important for challenges to inequitable services in those Commonwealth countries that have ratified the convention.

iv. Privacy Provisions

Commonwealth Constitutions vary with respect to whether they contain privacy, autonomy or integrity provisions in their constitutions and what those provisions actually mean. The right to privacy of one's home is usually given express protection. Illegal seizure and search are generally forbidden. At Common law the right of privacy was derived from the law of trespass. It has been developed in some legal systems to include privacy of correspondence and telephone conversations for example, Nigeria. The 1982 Canadian Charter on Rights and Freedoms makes no reference to a privacy right. In contrast to the Canadian Charter, the Constitution of Papua New Guinea in Section 49 says that:

> "Every person has the right to reasonable privacy in respect of his private and family life, his communications with other persons and his personal papers and effects..."

What is thought reasonable has to be viewed in the context of the whole constitution by a judge. As Papua New Guinea does not have a jury system, the judge would have to weigh the reasonableness of privacy against the constitution's section 35 on the right to life of any person. In doing so he would have to consider section 295 of the Criminal code which explains that a foetus does not become a person capable of being killed until it has completely proceeded in living state from the woman's body. A judge would be hard pressed to decide that the right to life as stated in section 35 would take precedence over a woman's privacy right under section 49 enabling her the privacy to decide whether or not to have an abortion particularly an early abortion.

An examination of international human rights agreements discloses no provision which explicitly protects fetal over maternal life. The Universal Declaration of Human Rights (1948) provides in Article 1 that "All human beings are born free and equal in dignity and rights", indicating that birth is the precondition to rights. Indeed, this is implicit in the reference to "human beings", since in Common law jurisprudence, a human in being is one born alive. International agreements must be construed by reference not only to their official languages of expression but also to the practices including

the legal traditions of the states which are parties to them. This is similarly the case where international provisions afford rights to "everyone", "all persons" and, for instance, "all people". It is of interest that the 1981 African Charter gives respect for life in Article 4 to "Every human being", and provides in Article 16.1 for the health of "Every individual", which does not clearly cover a child in utero.

A number of international assemblies in which Commonwealth States participate, including both judicial and quasi-legislative bodies, have addressed the issue of abortion in recent years. In Europe, for instance, the European Parliament has voted in recognition that a woman has the right to seek lawful and safe abortion "as a last resort." Further, the European Commission of Human Rights has upheld the decision of the English Court in Paton v. Trustees of British Pregnancy Advisory Service, that under the British Abortion Act 1967, a husband has no right of veto over his wife's decision to terminate pregnancy (Paton v. U.K. 1980)). The Commission found that the 1967 Act was compatible with the European Convention on Human Rights, although a challenge to West Germany's limited permission of abortion was dismissed in 1977 (Bruggeman and Scherten v. Federal Republic of Germany (1977).

An important feature of the 1977 West German case before the European Commission of Human Rights was the significance attached to the liberality of the Federal Republic's abortion legislation in the Commission upholding the restrictions it imposed. The Commission found pregnancy not to fall within a sphere of privacy because of the close connection between the life of the woman and that of the fetus, although in the subsequent Paton case, the Commission further defined the limited status given to the fetus under the European Convention. The Commission appeared to find absence of complete maternal privacy under the German legislation tolerable, however, because that law has liberal regulations which protect the woman's interests. Abortion is permitted thereunder for medical, eugenic and ethical reasons, and in the absence of any of these indications, the woman herself (as opposed to, for instance, a doctor) is exempt from punishment of abortion is medically performed within the first 22 weeks of pregancy and if she made use of medical and social counselling. Had the legislation not made such accommodation of abortion, the Commission suggested its disposition to create it under the privacy concept. The term of 22 weeks of pregnancy may run because of uncertainty as to commencement of pregnancy, close to 24 or 26 weeks of gestation. This approaches the point of fetal viability, which was critical to the protected privacy interest recognized by the U.S. Supreme Court in Roe v. Wade. Accordingly, the European Commission's conclusion may appear to be that, provided that legislation adequately respects privacy interests in early pregnancy,it may impose limits upon abortion thereafter consistently with human rights provisions.

The right of individuals to privacy is the subject of several international human rights agreements to which Commonwealth Member States subscribe. The Universal Declaration of Human Rights, for instance, provides in Article 12 for legal protection against arbitrary interference with an individual's privacy, family and home. The International Covenant on Civil and Political Rights similarly provides, in Article 17, for such legal protection, the Covenant having entered into force in March, 1976. The right to privacy is also found in regional human rights agreements such as the European Convention for the Protection of Human Rights and Fundamental Freedoms (see Article 8, addressing the right to respect for individual

private and family life), and the American Convention on Human Rights (see Article 11). Article 4 of the African Charter on Human and Peoples' Rights unanimously signed in 1981 and operative upon its twenty-sixty ratification entitles "Every human being ... to respect his life and integrity of his person."

The right to privacy in such agreements tends to be expressed in general terms, which may be construed in a restrictive manner or alternatively in a liberal manner. Conservative construction may regard privacy as little more than the right to limit bureaucratic acquisition and transfer of information about a person, and not to extend to the right to decide upon termination of pregnancy. The European Commission of Human Rights in the West German case of 1977 found "certain inherent limits to treating pregnancy and its termination as part of private life." Even though this restrictive reading of the right does not preclude state control of abortion, it may still affect the amount of information governments record, keep and perhaps transmit about abortion patients. The plethora of forms and records which advanced Commonwealth abortion legislation and particularly subordinate regulations require to be maintained may appear very questionable in light of this human rights interest, even when narrowly construed. For example the new Seychelles Act requiring three certified expressions of medical opinion and reports on abortions performed may violate a woman's integrity under Article 4 of the African charter.

The wish to confine rights of privacy was significantly demonstrated when, in August 1980, Australia ratified the International Covenant on Civil and Political Rights, which had entered into force in March 1976. Article 17 of the Covenant recognizes the right to freedom from interference with privacy and family, which might present a basis upon which a right to abortion might be founded. Australia made a reservation, however, which is unique among the 69 ratifying or acceeding States to the Covenant (as at January 1982). That reservation provides that Australian acceptance of Article 17 is "without prejudice to the right to enact and administer laws which, insofar as they authorise action which infringes on a person's privacy, family, home or correspondence, are necessary ... in the interests of ... the protection of public health or morals or the protection of the rights and freedoms of others." This reservation would permit restrictive laws on abortion, and may reflect the special problems faced in international treaty affairs by federal governments where treaties affect matters falling under domestic state or provincial jurisdiction. In Australia, of course, criminal abortion law is a state as opposed to a federal matter, and it is understandable that the federal authority would not want to employ its external responsibility so as to limit state authority and risk upsetting the internal constitutional balance of powers.

The Australian reservation to the International Covenant on Civil and Political Rights allows impingement on "a person's privacy" to protect the rights of "others", which is equally ambivalent. The European Convention on Human Rights was found in the Paton case to contain no indication of prenatal application of the right to life protected under Article 2 for "everyone". The Commissioners observed that "both the general usage of the term everyone in the Convention and the context in which it was employed in Article 2 tend to support the view that it does not include the unborn".

A similar conclusion was reached in 1981 by the Inter-American Commission on Human Rights. The case of Baby Boy (1981) arose from a challenge to the decision of the Supreme Judicial Court of Massachusetts,

U.S. in Commonwealth v. Edelin (1976), holding that a lawfully performed abortion was not punishable under the homicide law. The Inter-American Commission held that the U.S. Supreme Court decision of 1973 in Roe v. Wade (see below) did not violate the American Declaration of the Rights and Duties of Man. Thus, the privacy right was permitted to enjoy priority over the life of a pre-viable fetus. The American Declaration governs member states of the Organisation of American States, which include Barbados, Dominica, Grenada, Jamaica, St. Lucia and Trinidad and Tobago. (Canadian application for membership is currently under serious consideration.)

Human rights obligations arise through the Charter of the Organisation of American States, and a number of states, including Grenada and Jamaica (but not the United States), have ratified the American Covention on Human Rights. States not parties to that Convention are expected to observe rights contained in the Declaration under which the Baby Boy case was brought. The Convention uses language protecting human life in general from the moment of conception. It is not clear that such life is given priority over the life or health of the mother, or even that it supersedes her interests in privacy until for instance, fetal viability occurs. The Baby Boy decision, expressly rejected any interpretation of the Declaration which protected unborn life more stringently then it was protected under the principles applied by the U.S. Supreme Court in Roe v. Wade. This appears to confirm that the legally protected interest in privacy, which prevails over laws restricting rights to contraception and to abortion before fetal viablity is fully consistent with human rights obligations arising under the Charter of the Organisation of Amercian States, and the American Declaration of the Rights and Duties of Man.

The landmark decision of the United States Supreme Court in 1973 in the case of Roe v. Wade applied the right of privacy as developed in some of the former contraceptive cases to abortion. This privacy right was derived from the two following clauses of fourteenth Amendment to the United States Constitution:

its due process clause:

"... nor shall any state deprive any person of life, liberty or property without due process of law" and

its equal protection clause:

"... nor deny to any person within its jurisdiction the equal protection of the laws."

The basis of these decisions is that individual decisions on reproduction, including contraception and abortion, exist within a realm of privacy which the state acting through such agencies as police, courts and legislatures, can invade only when a legitimate state interest can be shown. Such a state interest was considered to exist only from the point of fetal viability although after the first trimester of pregnancy but before viability, the state may properly express a concern to assist a woman to achieve her personal reproductive choice in conditions of medical safety. After viability, furthermore, protection of a woman's life and health would supersede any state-sponsored interest on fetal survival. The key concept was that of privacy, which was elevated to the status of a fundamental constitutional right.

v. Remedies

Remedies for constitutional or human rights violations exist to some degree in constitutions and human rights instruments. They exist only for those rights or guarantees enumerated in constitutional or human rights instruments. Most of these documents contain rights to due process of law and equal protection under the law. Others vary with respect to whether they contain rights of privacy and the nature of the privacy right and whether they contain guarantees of health and health care. For example, Article 17 of the Sri Lanka constitution entitles every person to apply to the Supreme Court for "the infringement or imminent infringement of executive or administrative action ... of a fundamental right ..."

Regional human rights instruments differ with respect to the kind of remedy available for a denial or infringement of their enumerated rights. The European Convention for the Protection of Human Rights and Fundamental Freedoms provides in its Article 25 for the right of petition to the European Commission on Human Rights:

> "... from any person, non governmental organisation or group of individuals claiming to be the victim of a violation by one of the High Contracting Parties of rights set forth in this Convention..."

provided that "the only Party against which the complaint has been lodged has declared that it recognises the competence of the Commission to receive such petitions",(Article 25 (1)), and provided that all domestic remedies for such violations have been exhausted, (Article 26). If the State Parties do not reach a friendly settlement under Article 28, State Parties in violation of the convention are bound by the 2/3 majority decision of the Committee of Ministers to whom the report of facts and findings has been referred by the Commission (Article 32). For those state parties that do not recognize the competence of the Commission to receive petitions from its citizens, Article 24 enables one state party to refer to the Commission a complaint about an alleged breach of the Convention by another state party.

The African Charter on Human and Peoples' Rights provides in its Article 49 for procedures for investigations of transgressions by ratifying parties but does not provide for a right of petition as the European Convention does. The African Commission on Human and Peoples' Rights established upon ratification of 26 states (Article 64) will generally deal with requests from State Parties of violations of the African Charter provided that all local remedies have exhausted (Article 50). Requests by other than State Parties will be considered if a simple majority of the Commission members so decide, (Article 55). Once the Commission makes an investigation, under its Article 46, it reports the facts, findings and its recommendations to the State concerned and to the Assembly of African States (Article 52 and 53). A report can be published if the Assembly so decides (Article 59). Apart from publication of a Report on specific human rights violations and powers of friendly settlement for such violations under Article 47, no other remedies for violations are contemplated by the African Charter.

Few International Conventions provide for rights of individual petition except, for example, in optional protocols. Parties to the International Covenant on Civil and Political Rights, which has a useful equal protection provision in its Article 3 can submit reports to the Human Rights Committee

(Article 40). This convenant has an optional protocol whereby individuals can complain against their government if it has become a party to the protocol (Article 1). Atleast 5 Commonwealth countries, Barbados, Canada, India, Jamaica and Mauritius, have become parties to the optional protocol.

The implementation of the convention on the Elimination of All Forms of Discrimination Against Women is left primarily to its signatories and ratifying states. However a mechanism is established to monitor the implementation. Now that the convention has entered into force as a result of ratification by the twentieth state pursuant to its Article 17, a committee has been established. This committee pursuant to Article 18 must report to the UN Secretary General atleast every 4 years on measures that have been adopted to implement the Convention, and pursuant to Article 21 must report Annually to the General Assembly on its activities. Both types of reports could provide important vehicles for characterizing which kinds of sex discrimination are internationally prohibited.

The Committee itself has no investigatory powers to receive individual petitions. A State Party to the Convention under Article 29 could, if a dispute arose between 2 or more signatories "concerning the interpretation or application of the present Convention which is not settled by negotiation shall, at the request of one of them be submitted to arbitration." If the arbitration hasn't resolved the dispute within six months, one of those parties can refer the dispute to the International Court of Justice.