Issues in Reproductive Health Law in the Commonwealth

Commonwealth Secretariat

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by

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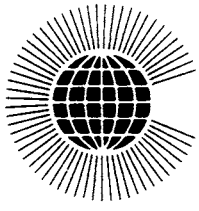

Commonwealth Secretariat

Printed and published by
The Commonwealth Secretariat

May be purchased from
Commonwealth Secretariat Publications
Marlborough House
London SW1Y 5HX

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

We are deeply indebted to many people whose efforts have made preparation of this Report possible. Mr. Jeremy Pope, Director of the Legal Division of the Commonwealth Secretariat and Editor of the invaluable Commonwealth Law Bulletin, Dr. K. Thairu, Medical Adviser to the Commonwealth Secretariat, and Ms. Dorienne Wilson-Smillie, Director, Women and Development Programme of the Commonwealth Secretariat were initial sponors of the project, and actively supported its research through circulation of requests for necessary information to appropriate departments of government of Commonwealth Member States. Mr. Richard Nzerem, of the Legal Division was an efficient and imaginative co-ordinator of liaison between responding government departments and ourselves, Mr. Neroni Slade of the same Division also gave valued assistance in identifying Commonwealth laws, and Ms. Jane Cole of the Secretariat's Medical Division assisted us greatly. Many officers in many government departments throughout the Commonwealth made considerable efforts to respond to our enquiries as helpfully as they could. To the named and unnamed persons who did so much to facilitate this Report, we express our admiration and gratitude.

Strongly supporting our work were Mr. Sev Fluss, Chief, Health Legislation, World Health Organization, Geneva, who is Editor of the comprehensive W.H.O. publication International Digest of Health Legislation, and Dr. Jan Stepan, Vice-Director and Chief Librarian of the Swiss Institute of Comparative Law, Lausanne. Their concern for progress of the Report, and the information they so kindly furnished, were of immeasurable aid, as was their enduring good will. To them too we express our profound respect and gratitude.

Our own institutions did much to facilitate our endeavours. The Development Law and Policy Program of the Center for Population and Family Health, Columbia University, New York, its Director, Mr. Stephen Isaacs, resources of the Carnegie Corporation of New York, as well as the Faculty of Law, University of Toronto, Toronto strongly supported the project, and made it possible. We express our indebtedness to the many persons who accommodated our work in our home centres. We give special thanks to Ms. Julia Hall of the Faculty of Law, University of Toronto, who typed the Report with her customary speed, efficiency, tolerance of unreasonable requests and good humour.

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MAY 1986

INTRODUCTION

Since 1977 the Commonwealth Secretariat has provided the meetings of Commonwealth Health Ministers and Commonwealth Law Ministers with surveys of Commonwealth experience regarding reproductive health law. The 1977 meetings received the Report, Three Studies of Abortion Laws in the Commonwealth and the 1983 meetings received an analysis of Emerging Issues in Commonwealth Abortion Laws, 1982. The latter report expanded upon the initial theme of abortion to address contraception, menstrual therapies, health personnel and relevant issues in constitutional and international human rights law. These reports were also made available to Ministers Responsible for Women's Affairs.

The present Report, designed for the 1986 Meetings of Commonwealth Ministers addresses general issues in Commonwealth reproductive health law. An initial overview of reproductive health services includes consideration of maternal and child mortality and their impact on family life. Succeeding chapters address a variety of legal aspects of contraception, sterilization and abortion. Having considered legal aspects of fertility control, the Report continues by addressing legal aspects of responses to infertility. The concluding chapter discusses some consequences of the Convention on the Elimination of All Forms of Discrimination Against Women.

Prominent issues in contraception include the House of Lords' decision on adolescent access to contraceptive services in the widely discussed English Gillick case, and legal aspects of newer forms of contraception, incuding "contragestives". Sterilization issues include discussion of the growing Commonwealth case law on legal consequences of sterilization failure, in "wrongful conception" and "wrongful birth" claims. Abortion issues include new legislation in Barbados, Bermuda, Ghana and Montserrat and litigation in, for instance, Canada and Australia.

Infertility is a growing problem in all parts of the Commonwealth. Causes of infertility are discussed, followed by consideration of legislation and proposals for legislation on human artificial reproduction. This concerns the techniques of artificial insemination, in vitro ("test tube") fertilization and employment of these or other procedures in surrogate motherhood transactions. Comparisons and contrasts are drawn between reports of such groups as the Warnock Committee (UK), the Waller Committee (Victoria, Australia), and the Ontario, Law Reform Commission (Canada).

The Convention on the Elimination of All Forms of Discrimination Against Women is considered to warrant special attention by the audiences addressed in this Report. Discussion draws attention to the Commonwealth Secretariat's accession kit developed to facilitate membership in this Convention by Commonwealth

countries which have yet to make a legal commitment to its principles and reporting mechanisms. The legal call for equal access to health including family planning services must be heard by Law Ministers and Health Ministers alike, and its importance to Ministers responsible for Women's Affairs is self-evident.

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 live births (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 moraltiy 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 marreid 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).

Adolesence 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 Commonwelath, 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 fith 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 poulated 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 Assitance: 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 adress 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 countris. 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 or 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

II. CONTRACEPTION

A. Introduction

There is little contention in the modern Commonwealth about the right of individuals in principle to acquire knowledge of means of contraception. Although in some jurisdictions less than two decades have passed since communication of contraceptive knowledge to the unmarried was classified as a crime against morality, family planning services and knowledge of means to avoid unwanted pregnancy are now promoted with few legal limits. Constraints of taste may control means of advertisement of contraceptive services and methods, and explicit commercial advertising for instance on television is rarely found, but restrained public service advertising is being developed to carefully targeted populations.

Contraception may not be presented as such, because of negative and moral connotations. It is often more positively expressed as family planning and birth-spacing. Since the unmarried may plan not to build families until after marriage, "family planning" is not euphemistic, but relates to individuals' perceived needs. Further, it appeals to responsible males as well as to responsible females, although the burden of contraceptive protection continues to fall disproportionately upon women. Birth-spacing education is appropriate in many Commonwealth cultures where the costs of close births, in high levels of maternal death and sickness and reduced levels of infant survival and health, are known. Most of those who practice contraception intend to postpone but not to avoid future conception. In many countries, avoidance of conception is achieved by voluntary sterilization (see Chapter III below), which in worldwide terms has become the most widely practical means of birth-control.

The legal issues in contraception concern adolescents' rights of access to confidential services, permission of a power of spousal veto, definitional distinctions between contraception and abortion, with special regard to the newly perceived "contragestive" drugs and therapies, and consequences of contraceptive failure. Contraception fails not only when conception occurs, but also when infertility results, for instance due to pelvic inflammatory disease. Additional issues concern health personnel legally entitled to offer family planning services, for instance by prescription or invasive procedures, and information drug manufacturers must give ultimate users of their products, through package inserts. Courts have distinguished contraceptive products from therapeutic products, in that the latter are taken by sick people seeking control of disease, or by healthy people seeking to prevent disease, whereas contraceptives are used primarily by healthy people seeking to avoid the natural consequences of healthy

conduct. Accordingly, their informational needs and their options are different from those seeking to resist or prevent sickness.

B. Adolescent Contraception - The Gillick Case

Few cases regarding reproduction and reproductive health can have aroused as much commentary, both in England where it originated and in many other Commonwealth jurisdictions, as Gillick v. West Norfolk and Wisbech Area Health Authority, [1985] 3 All E.R. 402 (House of Lords). The case began in mid-1982, when Mrs. Gillick sued for a declaration that advice issued in late 1980 by the Department of Health and Social Security (the DHSS) was unlawful. The advice, which was a revised version of earlier guidance, stated or implied that, at least in certain cases which were described as "exceptional", a doctor could lawfully prescribe contraception for a girl aged under 16 years old without her parents' consent, respecting the minor's confidentiality. Mrs. Gillick wrote to her local health authority forbidding contraceptive or abortion advice or treatment to any of her four (later five) daughters while aged under 16 years without her consent. When the health authority replied, in accordance with the DHSS guidance, that such treatment is a matter for a doctor's clinical judgment, taking into account all the factors of the case, Mrs Gillick sued the health authority and the DHSS for declarations that the health authority and DHSS guidance were wrong in law.

Trial: The Mature Minor Doctrine

On trial in the Queen's Bench Division of the High Court, Woolf J. refused the declarations; see [1984] 1 All E.R. 365. There was no binding jurisprudence resolving the conflict between parental rights to control their children's medical care and adolescents' medical autonomy and confidentiality, but the trial judge found guidance in the judgment of Addy J. of the Ontario High Court in Johnston v. Wellesley Hospital (1970), 17 D.L.R. (3d) 139. This reflected the so-called "mature minor" rule, expressed in the celebrated language of Lord Nathan's text Medical Negligence (1957) at p. 176:

> "It is suggested that the most satifactory solution of the problem is to rule that an infant who is capable of appreciating fully the nature and consequences of a particular operation or of particular treatment can give an effective consent thereto, and in such cases the consent of the guardian is unnecessary."

Woolf J. observed that a doctor who was so ill-advised as to give contraceptive advice or treatment to a girl aged under 16 years, in order to facilitate her having sexual intercourse, which might constitute an offence by her partner against

England's Sexual Offences Act 1956, would be at risk of legal liability. It was expected, however, that responsible doctors would give contraceptive advice and treatment only when satisfied that the treatment is medically indicated by a girl's actual or imminently prospective sexual activity, and that she will take the risks of contraceptively unprotected intercourse rather than have parental involvement in the medical care decision.

Appeal: Reversal

The Court of Appeal, by unanimous decision of its three judges, reversed the trial decision, and granted Mrs. Gillick the declaration she sought; see [1985] 1 All E.R. 533. Dominating the appeal judges' reasoning was an absolutist view of parental control of minor children's lives, and concern that, in the Sexual Offences Act 1956, Parliament had determined a policy of sexual abstinence by girls under 16 years of age which was incompatible with legal tolerance of contraceptive advice and treatment which would equip them to undertake with impunity the very conduct for which their partners could be imprisoned. Since sexual intercourse with girls under 16 years old is so proscribed, the judges found no licence in parents to consent to it, nor by implication to contraceptive advice and treatment which they considered to facilitate such conduct. They recognized an emergency exception, however, in which contraceptive services could lawfully be rendered to a girl below age, perhaps when she was abandoned by her parents, or wayward, beyond parental control and already determined to be or likely to become sexually active. The Court of Appeal's reasoning was reinforced by nineteenth-century precedents on rights of children's legal guardians to take decisions on their behalf, and to exercise control over their life styles.

In response to the Court of Appeal's decision, the DHSS withdrew its advice on adolescent contraception, pending appeal to the House of Lords. An interesting response in Commonwealth legal literature was publication of articles from a number of jurisdictions, including Scotland, New Zealand and Canada, explaining why the reasoning the English Court of Appeal found persuasive was inapplicable to circumstances in those jurisdiction. The literature drew attention to different legal provisions on the minimum age of female consent to sexual intercourse, and acceptance of the mature minor rule, or the emancipated minor rule, permitting legally effective consent to medical care by minors of sufficient capacity to understand its implications, or who had been left by their parents to make their own decisions.

Final Decision: Medical Discretion and the Mature Minor Doctrine Upheld

In October 1985, the House of Lords reversed the Court of Appeal, by a majority of three judgments to two, and reinstated the decision of the trial judge to refuse the declarations sought. The decision is of considerable importance, not only on the issues of contraception and abortion treatment for girls aged under 16 years, but also on the governing principles of minors' consent to medical treatment, for instance regarding psychiatric care and treatment for addiction to alcohol and other substances, and minors' rights to enjoy confidentiality in their dealings with health professionals. The dissenting two judges invoked the reasoning which had prevailed in the Court of Appeal, Lord Brandon of Oakbrook finding as a fact that (at p. 429):

> "... to give such a girl [aged under 16 years] advice about contraception, to examine her with a view to her using one or more forms of protection and finally to prescribe contraceptive treatment for her, necessarily involves promoting, encouraging or facilitating the having of sexual intercourse, contrary to public policy, by that girl with a man."

Lord Templeman's dissenting judgment was less committed to the views that contraception causes sexual activity and that the criminal character of such activity renders any accommodation to it unlawful. He found, however, that (at pp. 434-5):

> "The decision to authorise and accept medical examination and treatment for contraception is a decision which a girl under 16 is not competent to make. In my opinion a doctor may not lawfully provide a girl under 16 with contraceptive facilities without the approval of the parent responsible for the girl save pursuant to a court order, or in the case of emergency or in exceptional cases where the parent has abandoned or forfeited by abuse the right to be consulted."

The judicial majority in the House of Lords saw contraception as protection against pregnancy and premature motherhood or abortion, and considered that parental rights should be viewed pragmatically on the circumstances of each case, rather than as prevailing as a matter of legal doctrine due to the axiomatic incompetence of under 16 year-olds to make medical decisions. Lord Fraser of Tullybelton found that a doctor is legally entitled to advise a girl and to give her contraceptive treatment without her parent's consent or even knowledge provided that the doctor is satisfied on the following matters (p. 413):

(1) that the girl (although under 16 years of age) will understand the advice;

(2) that the doctor cannot persuade her to inform her parents or to allow the doctor to inform the parents that she is seeking contraceptive advice;

(3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;

(4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;

(5) that her best interests require the doctor to give her contraceptive advice, treatment or both without the parental consent.

Lord Fraser immediately added that the result ought not to be regarded as a licence for doctors to disregard parental wishes whenever they find it convenient to do so. He found, however, that (p. 413):

> "The medical profession have in modern times come to be entrusted with very wide discretionary powers going beyond the strict limits of clinical judgment and, in my opinion, there is nothing strange about entrusting them with this further responsibility which they alone are in a position to discharge satisfactorily."

The judge considered principles derived from the Sexual Offences Act 1956 to be irrelevant to the question of parental rights and doctors' capacity to treat minors confidentially with contraceptive protection.

Lord Scarman based his decision not only on the grounds of Lord Fraser's judgment, with which he expressly agreed, but also upon the mature minor doctrine. He found that (at p. 414):

> "The case is the beginning, not the conclusion, of a legal development in a field glimpsed by one or two judges in recent times ... but not yet fully explored .... The contraceptive pill has introduced a new independence, and offers new options, for women; but has it in the process undermined parental right and duty? In my judgment, the answer is No, even though parental right may not be as extensive or as long lasting as [Mrs. Gillick] believes it to be."

Lord Scarman traced legal principles to show that [at p. 420] "The principle of the law ... is that parental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child." It follows that when a minor has personal capacity for self-protection, measured by factual criteria of intellectual and emotional growth and not by a mechanical test of age, parental rights decline. The judge endorsed the modern law governing parental rights and a child's capacity to make his or her own decisions, expressed in the House of Lords' 1984 decision in R. v. D., [1984] 2 All E.R. 449, noting that (at p. 423):

> "The House must, in my view, be understood as having in that case accepted that, save where statute otherwise provides, a minor's capacity to make his or her own decision depends on the minor having sufficient understanding and intelligence to make the decision and is not to be determined by reference to any judicially fixed age limit."

Lord Scarman went on to conclude that (at p. 423):

> "In the light of the foregoing I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law."

He added that a girl aged under 16 years considering contraceptive advice and treatment has much to understand, including questions of relationships with parents, long-term problems associated with the emotional inpact of pregnancy and its termination, and risks to health from sexual intercourse which contraception may diminish but cannot eliminate. Like Woolf J. below, Lord Scarman was helped by the Ontario decision in Johnston v. Wellesley Hospital.

Lord Bridge of Harwich primarily addressed procedural aspects of the case, but he expressly agreed with the judgments of Lords Fraser and Scarman, and approved the terms in which the trial judge, Woolf J. had disposed of the claim of a doctor's criminal complicity in giving contraceptive advice and treatment to a girl aged under 16 years, adding that (at p. 428):

> "On the issue of public policy, it seems to me that the policy consideration underlying the criminal sanction imposed by statute on men who have intercourse

> with girls under 16 is the protection of young girls from the untoward consequences of intercourse. Foremost among these must surely be the risk of pregnancy leading either to abortion or the birth of a child to an immature and irresponsible mother. In circumstances where it is apparent that the criminal sanction will not, or is unlikely to, afford the necessary protection it cannot, in my opinion, be contrary to public policy to prescribe contraception as the only effective means of avoiding a wholly undesirable pregnancy."

Commonwealth Implications

The judgment of the House of Lords has many implications, by no means confined to the areas of contraception and abortion in which Mrs. Gillick sought her declarations. Its implications within Commonwealth jurisdictions are also profound, since it addresses the doctrinal underpinnings of the Common law and indicates relationships between criminal prohibition of intercourse with girls under given ages and medical advice and treatment designed to protect girls against pregnancy. It reinforces the literature through which authors distinguished their national laws from the position reached by the Court of Appeal, and illuminates the way in which many jurisdictions may interpret the provisions of their own systems regarding medical care of adolescents (for information on which to base worldwide comparisons, see J.M. Paxman and R.J. Zuckerman Adolescent Health and the Law (1986, in press, W.H.O. Geneva), chs. 4-7.)

Most significantly, the Gillick case shows that, in the absence of unambiguous legislation, there is no "age of consent" for medical treatment. Legislation or subordinate legislation may express ages lower than majority when minors may give legally effective consent to medical including diagnostic and surgical care, but such provisions alone do not show that minors lack competence to give such consent below the specified ages. They may be competent in individual cases, if they are found to have sufficient understanding of the implications of having medical treatment, and of foregoing it. In case of doubt as to an individual minor's competence, a doctor may obtain another reliable professional opinion. There is accordingly not an age of consent in most jurisdictions, but a condition of consent, namely competence or maturity to make an adequately informed decision on accepting or rejecting medical care which appears objectively to be in the minor's best interests.

In view of the disadvantages pregnant unmarried adolescents face in Commonwealth countries, a decision which will be likely to reduce the incidence of unmarried adolescent pregnancy is to be welcomed. Those who share Mrs. Gillick's conviction that access to contraceptive services increases adolescent sexual

intercourse may doubt, of course, that the House of Lords' decision will have that effect. Nevertheless, evidence shows that in 1978, twenty percent of England's adolescents had had sexual experience by the age of 16 (J. Senderowitz and J.M. Paxman, Population Bulletin - Adolescent Fertility: Worldwide Concerns, Population Reference Bureau Vol. 40, No. 2, April 1985, at p. 8) and that 40 to 50 percent of girls had had intercourse by the age of 17 ("Youth in the 1980s: Social and Health Concerns", Population Reports, Population Information Program, The Johns Hopkins University, Series M No. 9 Nov.-Dec. 1985, p. M-357).

Apart from the health risks of adolescent pregnancy, childbirth and abortion, in some countries pregnant schoolchildren may be required to leave school, and may be unable to continue their education even when they are not actually expelled from school. It has been noted, for instance, that:

> "In the Caribbean islands, about 58 percent of first babies are born to mothers aged under 19, and half of those are aged 17 or less. This means a substantial number of schoolgirls become pregnant and, in accordance with prevailing custom, leave school with no chance of readmission" (J. McKay (ed.), Adolescent Fertility: Report of an International Consultation (1983), Int'l Planned Parenthood Fed., 8).

More grave than this is the relatively high incidence of maternal mortality among young mothers. In Jamaica and Nigeria, for instance, it has been found that women younger than 15 years old are four to eight times more likely to die during pregnancy and childbirth than women aged from 15 to 19 (Population Reports, ibid., p. M-365). Prenatal care for young mothers is unavailable to many in developing countries, but it may be essential to save life. In rural Bangladesh the mortality rate for women aged twenty to twenty-four was 4 deaths per 100,000 live births, but a study of 22,000 Nigerian women showed a death rate among those aged 14 or younger of 500 per 100,000 live births where prenatal care was good, and 4,300 per 100,000 for mothers in the same age range who had not received care (Ibid.). In the face of such figures, a judgment which removes barriers to adolescent contraceptive care, where it is available, appears particularly humane.

C. Spousal Veto

Some jurisdictions retain laws or maintain practices by which a spouse may veto a partner's decision to have recourse to for instance a chemical or mechanical means of contraception. Such laws or practices may apply to both husbands and wives, but the fact that there are so many more means of contraceptive intervention in the reproductive processes of females than of males that are dependent upon third-party provision of services (as opposed to male contraception dependent upon simple acquisition of a condom), means that discrimination is found primarily against wives' access to contraception. In Papua New Guinea, for instance, legislation prohibits distribution of contraceptives to wives without their husbands' consent (Annual Review of Population Law 1979, U.N. Fund for Population Activities, 20). As clinic practice, furthermore, the Gambia Family Planning Association requires women aged under 21 to have parents' consent if single, or husbands' consent if married, before services are given, although the government's own Department of Medicine and Health imposes no age condition for autonomous consent to services (Letter from the Women's Bureau to the Commonwealth Secretariat Women & Development Programme).

Laws of this controlling purpose or effect may reflect the values of an indigenous culture, but it is questionable whether such international provisions as the Convention on the Elimination of All Forms of Discrimination Against Women are to be interpreted in accordance with principles of cultural relativism, which may recognize the legitimacy of discriminatory legal provisions in one jurisdiction when they are offensive in others. In any event, it may be observed that spouses commonly bear legal responsibilities to provide each other with necessaries of life, which include medical care. The proven danger that repeated pregnancy and short birth-spacing present to women's lives and health (see Chapter I, B above) may show that husbands have legal duties to make medical means of fertility control and birth spacing available to their wives, if other means of preserving their lives and health are not practised. Further, husbands may have no power to obstruct women from obtaining for themselves the necessaries of life husbands are bound to provide. It may be presumed that husbands intend to observe rather than to violate their legal responsibilities to protect their wives against reproductive hazards presented by pregnancies the wives do not want.

Husbands' consent to contraceptive care, even when required by legal form, may be expressed through the wives who attend for contraceptive advice and treatment, rather than be given by husbands in person. This is so not only because of the legal presumption that men intend to respect rather than to violate their legal duties, but also because of the respect

paid to them by their wives. In a brief prepared for this Report by the Fiji Medical Association, it is observed that:

> "It is relevant that only a very small minority of women will express an opinion contrary to one their husband has already stated; or agree to an operation or procedure, or go and seek medical attention, if their husband has expressed himself opposed to it."

Husbands who do not wish the presumption of their consent to prevail may be expected to take initiatives expressly to veto contraceptive care their wives seek.

In contrast to jurisdictions that legislate a spousal veto, others make clear that one spouse's best reproductive health care, determined in consultation with an appropriate professional, is not to be subjected to the veto of the other. The written permission of a husband for medical care of his wife may do violence to customary law, where a woman's family retains an interest in her well-being after marriage, and a husband does not have control in this area of her life. Rejection of spousal veto power can be justified on other grounds too. In Swaziland, for instance, both Common law (see Palmer v. Palmer, 1955 (3) S.A. 55) and customary law exclude the capacity of a spouse to control the other's health (see A.K. Armstrong and R.T. Nhlapo Law and the Other Sex: The Legal Position of Women in Swaziland (1985) at pp. 106-108). Reinforcing the point is a Ministry of Health memorandum of 23rd November 1978, however, which informs particularly staff of public health agencies that:

> "The objective of family planning is to improve the health of the mother and child and to protect the unwed mother from accidental pregnancy. During the health worker - client interviews, the health worker is professionally trained to assess the needs of each client in accordance with the above named objectives. To then ask the client to produce a signed consent form from either the parent or his/her relative is contrary to the professonalism of the health worker" (at p. 110).

In jurisdictions where spousal consent is sought in practice though not legally required, a similar ministerial directive could serve the interests of both spousal autonomy and spousal health.

D. Post-coital Contraception and "Contragestion"

An issue identified in an earlier Report, Emerging Issues in Commonwealth Abortion Laws, 1982, concerns the distinction drawn in law between contraception and abortion. It was noted

that, since legal analysis shows that abortion occurs only after implantation of an embryo in the uterine wall, means intended to prevent such implanation will not fall under prohibitions of abortion laws. Whether the means are applied in anticipation of intercourse or post-coitally, they will fall on the contraception side of the contraception/abortion distinction. How long after intercourse they may be used is a matter of judgment made in good faith influenced by biological or medical knowledge. In the United Kingdom, the Minister of Health observed in 1981 (see Emerging Issues, p. 41) that use within 72 hours from unprotected intercourse constituted legitimate contraception. A respected legal commentator, Professor Ian Kennedy, has claimed that, since abortion is dependent upon successful implanation, post-coital contraception is legitimate as contraception during "that time period which the consensus of informed medical scientific opinion states is the maximum time after intercourse before implantation takes place. This may be 7 days or 8 or 9 or 10" ("The legal and ethical implications of postcoital birth control" in H. Grahame (ed.) Postcoital Contraception: Methods, services and prospects (1983) 62 at p. 66).

With development of antiprogestin drugs, which neutralize the reproductive function that renders a woman's uterus hospitable to embryonic implantation, the expression "contragestion" has emerged as a refinement of contraception. In its origin, "contraception" applied to prevention of conception, rather than to prevention of post-conceptive reproductive developments; prevention not of conception but of subsequent gestation may appropriately be described as "contragestion". This expression may not be confined to use of antiprogestin drugs, since other drugs, devices and procedures, such as prostaglandin drugs and menstrual aspiration, may also be employed contragestively, that is for the purpose of preventing post-conception gestation.

As an example, the antiprogestin drug RU486 has a wide range of potential applications, which are at present being explored through research, including clinical trials, in a number of Commonwealth jurisdictions. The drug may operate theoretically as a traditional contraceptive, as a contragestive affecting implantation, or as a method to correct menses delay. The drug promises a number of other uses, such as aiding safe childbirth. Its capacity to effect abortion must be tested and applied compatibly with a jurisdiction's abortion law, of course, but its contraceptive and contragestive capacities may not be subject to this limitation. For purposes of both legal analysis and medical assessment, the journalistic description of the drug as an "abortion pill" is therefore incorrect.

Removal of an embryo created in vivo for purposes of transplantation to the uterus of a second woman will be addressed in Chapter V below. It may be observed here, however, that for the legal reason explained above, such removal is not governed

by abortion law, since it is intended to occur before the process of implanation is completed.

E. Contraceptive Failure

Since all contraceptive (including contragestive) means bear an irreducible minimum risk of failure, it does not follow that contraceptive failure is necessarily legally actionable as negligence. If legally determined requirements of informing patients about contraceptive options and for instance risk/benefit implications of options are not met (see Chapter IIIB, below), legal action may succeed, but this is not because of the contraceptive failure per se. It may be the case, however, that contraceptive care was in fact negligently undertaken, for instance by prescription of a clinically contraindicated contraceptive drug, negligent fitting or instruction for fitting of a contraceptive device, or negligent conduct or checking of vasectomy.

Although contraceptive failure is usually indicated by conception and pregnancy followed by childbirth, still birth or spontaneous or induced abortion, it may also be indicated by consequent infertility. Where contraception is deliberately selected over voluntary sterilization for purposes of fertility control because a woman wants to have a child at a later time, a contraceptive means that causes infertility will be particularly injurious. Pelvic inflammatory disease associated for instance with improper design of or advice upon use or subsequent checking of an intrauterine device (I.U.D.) may be a cause of legal liability.

The basis of legal compensation for contraceptive failure is generally the same as that for sterilization failure, involving the central issues of whether and how conception and birth of a child is compensable as a species of legal injury. The issue is better addressed in the context of sterilization failure, (see Chapter IIIE, below) because the bulk of Commonwealth case-law has arisen in this area. Where negligent contraception results in infertility or in impairment of health not related to reproduction, such as development of blood clots due to an unsuitable contraceptive drug negligently prescribed or negligently compounded or delivered by a pharmacist, legal liability will follow the governing local principles of negligence law, reinforced perhaps by principles of liability for breach of contract. The type of disclosure which should be made to a women for whom a contraceptive drug has been prescribed has been distinguished, however, from information which should legally accompany prescription of a routine therapeutic drug.

F. Contraceptive Drug Information

In the case of Buchan v. Orth Pharmaceutical (Canada) Ltd. ((1986), 35 Can. C.L. Torts 1) the Ontario Court of Appeal upheld the decision of the High Court ((1984), 46 O.R. (2d) 113) that the scope of a drug manufacturer's duty to warn of dangers inherent in the use of oral contraceptives exceeds that applicable to regular therapeutic, diagnostic and curative prescription drugs. The case may prove to be of special Commonwealth significance because the Court found no decisions dealing specifically with oral contraceptives in Canada, England or other relevant Commonwealth jurisdictions, and therefore referred to and was influenced by United States' jurisprudence on products liability. This has been built upon the basis of liability established in the British Common law tradition by the House of Lords in Donoghue v. Stevenson, [1932] A.C. 562 (H.L.), especially through Lord Atkin's classic statement (at p. 599) that:

> "... a manufacturer of products, which he sells in such a form as to show that he intends them to reach the ultimate consumer in the form in which they left him with no reasonable possibility of intermediate examination, and with the knowledge that the absence of reasonable care in the preparation or putting up of the products will result in an injury to the consumer's life or property, owes a duty to the consumer to take that reasonable care."

The plaintiff in Buchan claimed damages because she suffered a stroke as a result of taking contraceptive pills manufactured and distributed by the defendant company. She alleged that the defendant knew of the drug's potential to cause blood clotting that could result in a stroke, and had failed to give her an adequate warning, by label or package insert. the trial judge found as a fact that the use of the contraceptive probably caused or at least materially contributed to the plaintiff's stroke, and the Court of Appeal, finding no evidence that there was transcending procedural error at trial or that the trial judge was plainly wrong, considered the law in light of that finding. The focus of the decision was on the duty of the manufacturer and distributor of the drug owed directly to the ultimate consumer, and not upon the duty of any intervening prescribing doctor.

In general prescription drug liability cases, it has been held that what in the United States is called the "learned intermediary" rule prevails. This holds that since a prescribing physician can and must take into account the propensities of a drug and the susceptibilities of the patient, and is primarily relied upon by the patient to exercise judgment, there is no direct responsibility upon the drug manufacturer to inform the

patient of the drug's characteristics; indeed, drug manufacturers may be legally constrained from advertising prescription drugs to the general public. In contrast, non-prescription ("over-the-counter") drugs can be advertised to the public, and are selected by consumers usually without a doctor's recommendation or intervention. The defendant invoked this principle of prescription drug law to show that no legal duty existed to inform the plaintiff directly of the drug's known tendency to cause blood clotting, and that legal liability was discharged by giving of appropriate information to prescribing physicians.

The Court distinguished contraceptive drugs from others by observing that, unlike therapeutic, diagnostic and curative drugs, which are taken by those who are sick or suspected to be sick, contraceptive drugs are taken by healthy persons who wish to prevent the natural consequences of sexual intercourse. Contraceptive drugs are potent products voluntarily sought by healthy women. They go to doctors for the purpose of obtaining prescriptions which will entitle them to repeated supplies of drugs for protracted times without any new medical examinations. The decision to take the drug involves an individual woman's active exercise of choice; it is unlike other decisions in that it is primarily directed by the patient's choice of life style rather than the doctor's clinical or medical judgment. Accordingly, the Court found a different principle of manufacturer liability to disclose known risks of taking the drug. The Court concluded that a legal duty was owed directly to the consumer, and that there should have been a label or package insert specifically warning consumers of known adverse effects of the product upon general health. The Court was influenced by the fact that the drug was marketed in the United States by the same parent drug company with the warning which the plaintiff alleged would, if given with the Canadian product, have deterred her from taking the drug and thereby becoming liable to the stroke she suffered.

G. Administrative Issues

A number of Commonwealth jurisdictions have legal provisions on the power of nurses and other personnel to prescribe contraceptive drugs and, for instance, fit intrauterine devices. In Malaysia, for instance, ayurvedic practitioners may prescribe various herbal contraceptives when suitable to patients' conditions and health, although this may be an analogy with individual rights of self-medication by means of non-prescription substances (see 1 Mal. J. Repro. Health (1984), Supplement at pp. S.97-98). More actively involved in delivery of contraceptive services in, for instance, Dominica, are health visitors, district nurse/midwives and family nurse practitioners. They are entitled, in the absence of identified contraindications, not only to conduct physical examinations of women for contraceptive devices, but

also to insert intrauterine devices, and remove them when appropriate.

In Barbados, the Barbados Family Planning Association Act authorizes the Association to determine its own objectives, but services themselves are not controlled by legislation. A physician staff-member is available for consultation, advice and instruction, but qualified nurses counsel and advise those seeking services. Para-medical personnel provide the basic and practical family planning services (see N. Forde and J. Dyrud, A Report on the [Barbados] Law Relating to Fertility and Population Growth, for U.N. Fund for Population Activities (1983) 37). An issue of legal interest is whether personnel who are not physicians are deemed to act under the staff-member who is medically qualified, along extended lines of authorization, or whether they are acting independently and engaging in the practice of medicine. Nurses are governed by the laws and regulations relating to their own profession, and are liable to its discipline. Where non-physicians' professional relations to physicians are not regulated, however, a legal issue concerns whether they are engaged in the practice of medicine.

Two Commonwealth traditions exist, one not limiting the practice of medicine by law but controlling unqualified personnel who hold themselves out or permit themselves to be supposed to be physicians, the other rendering it a punishable offence to engage in the practice of medicine when not qualified and locally registered. If giving contraceptive services is the practice of medicine, para-medical personnel cannot engage in this in jurisdictions following the latter tradition, unless authorized by specific legislation. Some Commonwealth countries have legislated a medical monopoly on rendering of health services, and so limit the supply of contraceptive care by para-medical personnel to populations with no access to doctors, although a number of these have legal concessions in favour of nurses. See also Chapter I, D above, on approaches to traditional birth attendants.

III. STERILIZATION

A. Introduction

Voluntary sterilization is an increasingly applied method of fertility control in the Commonwealth, as in the world at large, and may protect more women against pregnancy than any other method of contraception (see below). Despite a history of restrictive laws and, for instance, medical and religious attitudes, voluntary sterilization figures very prominently in many Commonwealth countries' practice of reproduction control, although in many others recourse to permanent surgical contraception is treated with caution by the population of reproductive age, the medical profession and the law.

An historical and socio-medical curiosity is the continuing disproprotionate respect paid to the observation made in a dissenting opinion in 1954 by Dennning L.J. (as he then was) on the propriety of purely contraceptive sterilization. The statement was expressly disapproved by the two other Court of Appeal judges in 1954, and it has not grown in legal significance in the last three decades, but it persists in lay perceptions of the law. In Bravery v. Bravery, [1954] 3 All E.R. 59 the issue was whether sterilization without spousal agreement constituted matrimonial cruelty. The Court held that on the facts of the case it did not, but Denning L.J. invoked perceived principles of criminal law, reflecting feudal objections to the maim of castration, to conclude that vasectomy, even when voluntary, was unlawful. Objection was taken to sterilization that would enable a man to be sexually active without risking financial and other responsibility for offspring. This was considered to open the way to licenciousness, personal degradation and injury to the public interest (see the quotation at Chapter I, A). The disagreement of the Court of Appeal's majority in 1954 should have shown that the case was legal authority for the reverse proposition to that addressed by Denning L.J., namely that purely contraceptive sterilization is lawful. Jurisdictions applying English Common law differently are anachronistic and fallacious. In Queensland, Australia, for instance, it has not been made clear that vasectomy is lawful by Common law principles.

Distinguishable from contraceptive sterilization is that performed for therapeutic reasons. When a woman's life or permanent health would be endangered by future pregnancy and delivery, for instance, sterilization is thereapeutic. Women may also be affected by diseases for which treatment is indicated such as hysterectomy which renders them incapable of childbearing. The latter treatment is only indirectly described as sterilization, however, since its primary purpose is to remove or prevent pathological conditions. Its effect of ending reproductive potential is secondary. It is similarly the case when a man

affected for instance with testicular cancer is operated upon. Removal of testicles renders him sterile, but that is an effect of the treatment, not its purpose. Because of its concern with reproduction law, this Report gives attention to sterilization effected for purposes of reproductive control, rather than as a secondary result of treatment directed to another purpose. More ambivalent is sterilization performed for the eugenic purpose of preventing transmission of harmful genetic characteristics to offspring. That will be considered here as primarily contraceptive, although courts may be willing to see it as analogous to therapeutic sterilization.

Rates of recourse to voluntary sterilization vary in the Commonwealth. It has been estimated (see J.A. Ross, S. Hong and D.H. Huber, Voluntary Sterilization: An International Fact Book, 1985, Table 2.1 at pp. 10-11) that, by 1982, 20.6 percent of couples used sterilization, amounting to over 24 million voluntarily sterilized people, predominantly women. This rate is comparable to that in other Commonwealth countries, such as Hong Kong, with a 1981 rate of 17.7 percent, Singapore with 22 percent by 1977, and Sri Lanka with 20.7 percent by 1982. In the United Kingdom the rate by 1976 was 13 percent, suggesting that by present time it would be more comparable to India's rate, as might Australia's rate, which by 1979 stood at 22.2 percent. Highest in the Commonwealth was Canada's rate by 1984 of 43.5 percent. In contrast, the rate by 1981 in Bangladesh was 4.8 percent, and in Malaysia was 5 percent. The Commonwealth Caribbean countries appeared to occupy an intermediate position, the 1979 rate in Jamaica being 9.8 percent and the rate in Barbados by 1981 being 14.7 percent. As non-surgical means of sterilization develop, and microsurgical means evolve, recourse to procedures may increase (see M. Klitsch, "Sterilization Without Surgery" 8 In't'l. Fam. Planning Perspectives 101).

Key legal issues of Commonwealth concern include how doctors are required to inform potential patients for sterilization of its risks and side-effects, whether involuntary sterilization can be undertaken upon mentally impaired persons for therapeutic, contraceptive or eugenic reasons, and whether legal minors are amenable to sterilization procedures upon the sole consent of their parents. A number of cases, particularly in England, have tackled the question of whether, following negligently conducted or explained sterilization resulting in pregnancy and childbirth, damages can successfully be claimed, and, if they can, what items of expense such damages may cover. The Commonwealth may in time generate a body of case law comparable in directiveness, although not necessarily in bulk or outcome, to that of the United States. A further area of concern is the role of spousal veto, where the position may be comparable to that prevailing regarding contraception in that, whatever legislation provides, husbands have veto power over their wives' choices when the reverse is not the case.

Chapter V below, which addresses responses to infertility, is affected by sterilization. If a woman's illness necessitates surgical removal of her uterus, her ovaries may remain functional. She may accordingly be able to avail herself of recovery of ova, their in vitro fertilization through her husband's sperm, and implantation of the resultant embryo in the uterus of a woman, such as a relative, willing to act as a surrogate mother. This scenario may be remote in many Commonwealth countries, due both to technological and legal barriers; it must be recognized, however, that when the barriers are the latter and not the former, they obstruct the woman's only opportunity to receive and rear the child of her family. If treatment of disease renders a woman infertile due to surgical or drug-related damage to her fallopian tubes, in vitro fertilization may be available to assist conception through her ovum and her husband's sperm, and implantation in her uterus of the resultant embryo for subsequent gestation and birth. In vitro fertilization will thus offer an artificial fallopian tube to relieve inferility, and permit the couple to have their own gestation and delivery as would a couple not suffering infertility.

B. The Law on Informed Consent to Sterilization

Commonwealth law on informed consent to medical care, relevant to the decision to accept a sterilization procedure and the choice of which means of sterilization to have, has recently shown a division of jurisprudential approach. The English House of Lords in Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital, [1985] 1 A.C. 871 declined to follow the lead given by the Supreme Court of Canada in Reibl v. Hughes (1980), 114 D.L.R. (3d) 1, which adopted a body of modern United States' case-law exemplified particularly in the cases of Canterbury v. Spence (1972), 464 F. 2d 772 and Cobbs v. Grant (1972), 104 Cal. Rptr. 505. The Canadian Court rejected existing precedents in favour of the modern United States' approach, but the House of Lords' retention of its earlier doctrines, expressed in particular in Bolam v. Friern Hospital Management Committeee, [1957] 2 All E.R. 118 (H.L.), now discloses a division between English and modern North American judicial approaches to the issue of informed consent to medical care.

Emphasis upon consent to medical care arises from the legal need to remove a defendant's liability for surgical or other medical battery or assault by showing that the patient gave consent, since consent negates battery and assault. To show that the plaintiff patient's compliance with medical care was not adequately voluntary, the practice evolved, principally in the United States, of arguing that to be of legal effect, consent has to be adequately informed. Hence, the doctrine of "informed consent" arose. In modern times, however, the doctor's duty to give information to a patient about prospective

treatment is considered to relate not to the law of assault and battery, but to negligence law. If treatment is given that has not been discussed with the patient, or which differs from or exceeds that to which consent was given, battery law is applicable. If the only treatment given is that to which the patient consented, but without having been given adequate information, the case for the plaintiff/patient will be considered to fall only under the law of negligence.

Although the expression "informed consent" can be anticipated to take root in Commonwealth legal literature, it may be hoped and urged that the concept be expressed instead as "informed decision-making" or "informed choice" (see Laskin, C.J.C. in Reibl v. Hughes at p.11). The expression "informed consent" incorrectly suggests that:

(1) the purpose of informing is to induce consent;

(2) that if consent is not given it is because the patient is not adequately informed; and

(3) that a refusal of consent does not have to be as well informed as a decision to accept treatment.

The purpose of informing is to serve a patient's self-determination and medical choice. Patients determine the goals of treatment, but frequently leave the means of achieving those goals to medical judgment. To know what goals are reasonably achievable, patients must be given information. Reciprocally, doctors must learn from patients what the patients consider to be important in their lives, including what physical, mental and, for instance, reproductive capacities they most value and wish to preserve if possible, and what capacities patients are willing to sacrifice in pursuit of goals of general health. Doctors need this information of patients' priorities in life in order to judge what medical options may be presented to patients as likely to serve their goals. Patients' reproductive intentions are clearly of major significance to their medical care.

Patients may decline treatment options of which they have been appropriately informed on rational grounds, but as competent, autonomous beings, patients are entitled to decline treatment options upon irrational, sentimental, emotional, religous, philosophical or other grounds. It does not follow that refusal of an advised medical option is due to lack of information, and doctors should not add to or emphasize adequate information already presented, or exaggerate benefits of treatment or risks of declining treatment, lest they may appear to be pressuring, unduly inducing or coercing a particular decision. The duty to inform appropriately applies, however, to decisions not only to have treatment, but also to delcine it; the counterpart of

"informed consent" is "informed dissent". When legal analysis centred upon battery and assault law, a decision not to touch the patient did not need consent, whereas a decision to touch clearly did. Now that analysis is based upon negligence law, however, a doctor may be liable whose negligent informing of a patient caused the patient to forego probably beneficial care, including sterilization where indicated.

Analysis discloses three levels at which information may be pitched, namely:

(i) the professional standard;
(ii) the subjective patient standard; and
(iii) the objective patient standard.

The Bolam approach representing the professional standard, which prevailed in Ontario and Canada generally before Reibl v. Hughes, requires the doctor in principle to give such information as would be given by an ordinary skilled doctor of the speciality or style of practice of the doctor in question, acting in accordance with the practice accepted at the time as proper by a responsible body of medical opinion. In Sidaway, the House of Lords applied the Bolam test, adding some fine tuning to the effect that the proposed treatment might involve substantial risk of grave consequences in which it might be found that, without regard to contrary medical opinion, a patient's right to decline is so obvious that no prudent doctor could fail to warn of the risk, except in emergency or other exceptional circumstance.

In Reibl v. Hughes, the Supreme Court of Canada, approving in principle the decision of the Ontario Court of Appeal, rejected the professionally-oriented approach, reasoning that when doctors have to decide what to say to patients, they should direct their attention not inwards to representative doctors, but outwards to representative plaintiffs. In adopting a patient-oriented approach, however, the Court rejected the subjective patient standard, because of the realities of litigation. The patients who sue are disappointed, often injured and perhaps embittered. They must show that the defendant doctors' failure to make disclosure caused them to accept the treatments they claim injured them. The Court considered that defendants should not be at the mercy of the "bitter hindsight" of patients, and that their defences should not be vulnerable to patients' answers to the question "Had you known then what you know now (namely, that the treatment will cause injury), would you have agreed to the treatment?" The Court favoured the so-called objective patient standard of disclosure, not only by elimination of alternative standards but also because of its positive merits.

The subjective patient standard is pitched at the prudent person in the patient's circumstances, and requires disclosure of such information as such a patient would consider material to the choice to accept or reject a proposed treatment. This would include the normal risks of relatively mild effects, and also low risks of exceptional or unusual effects of a serious nature. Since the patient is deemed to be reasonably intelligent, however, information of a general nature that ordinary people know is not required to disclosed, such as that no medical treatment is completely safe and that, for instance, a blood transfusion bears an irreducible minimum risk of causing injury, such as hepatitis, which no amount of care can prevent. A plaintiff who alleges that failure to give information caused the plaintiff to accept a treatment that caused injury, including injury that no amount of care could have prevented, must show not only that he or she would not have accepted the treatment if informed of the risk, but also that a prudent person in his or her circumstances would have refused the treatment.

In the context of sterilization, the Bolam test of disclosure requires doctors to identify and observe what their peers would do, whereas the Reibl v. Hughes test requires doctors to consider the position in life and preferred life styles of their patients, and to adjust this information to what they actually know or should know of the individual patients concerned. It has been held, for instance, that when a patient is conscientiously troubled by the proposal to have contraceptive sterilization because of her Roman Catholic faith, its risks of adverse effects must be explained with care since they may persuade her to decline the procedure; see the discussion in Videto v. Kennedy (1981), 125 D.L.R. (3d) 127 (Ont. C.A.).

C. Sterilization and Retardation

It has been seen that the purpose of informing patients is to serve their right of self-determination. Not all persons have the capacity, however, to be legally autonomous. Legal minors may not (see below), although the Gillick case (see Chapter II, B, above) shows that minority age in itself does not bar legal capacity to give effective consent to confidential medical treatment. Similarly, mental retardation in itself is not a bar to autonomy. If mental age can be determined by some reliable, objectively verifiable or replicable measure, retarded persons may be considered by reference to their mental age rather than to their chronological age. So assessed, many may be found to be capable of autonomy. Since autonomy is the right to make decisions, it includes the choice to exercise judgment unwisely, and to have to bear the consequences. Young children should not be allowed to hurt themselves through inexperienced exercise of choice, because they lack foresight, hindsight and insight; they are accordingly protected by paternalism of their parents or other guardians. Adults should

not be treated paternalistically, however, and nor should mature minors. When retarded persons have the capacity of mature minors, they should be treated equally and be recognized to have some capacity for autonomy, with all of its positive and negative consequences.

Retarded persons are often divided into the four categories of the mildly, moderately, severely and profoundly retarded (see B.M. Dickens, "Retardation and Sterilization" (1982), 5 Int'l J. Law & Psychiatry 295). Mildly retarded persons may be comparable to legal minors, and, at the other end of the spectrum, profoundly retarded persons may be so incapacitated that they require assistance to cope with the regular discharge of their bladders and bowels. Accordingly, periodic menstruation is a difficulty for those responsible for their care rather than for them themselves. Sterilization by hysterectomy to obviate menstruation of this population, in order to ease caretakers' duties, would in itself be unlawful. Mentally incompetent persons are not liable to be subjected to major, highly invasive, irreversible non-therapeutic surgery solely for the advantage of others.

A distinction must be drawn in principle, although its clinical application requires particular clarity of diagnosis, between therapeutic and non-therapeutic (particularly contraceptive) sterilization. Therapeutic sterilization may be considered where pregnancy would be life-endangering or a serious risk to enduring health. This cannot affect males, and is not too common among females. Concerning retarded females, sterilization procedures may be proposed because they would be psychologically devastated by pregnancy, but procedures are more often proposed not to preclude pregnancy per se, but to end liability to menstruation among those unable to cope with it although they can otherwise care for themselves. They may be acutely distressed by blood (see Re K and Public Trustee (1985), 19 D.L.R. (4th) 255 (B.C.C.A.)) or be severely disoriented, at hygienic risk, and incapable of being trained to deal with each new month's experience. Hysterectomy may accordingly be proposed in order to end their liability to unmanageable severe distress. Its effect of rendering them sterile is secondary.

Eugenic sterilization is a middle ground between therapy which has a side-effect of causing sterility, and purely contraceptive sterilization. It is usual to find guarded legal tolerance of eugenic sterilization (see the Bravery case, A above) although its underlying presumption that the retarded peson's retardation is of genetic origin and likely to be transmitted had to be tested in each case. When retardation is due to a congenital but non-genetic condition, or to a birth trauma such as hypoxia or a post-natal incident, the presumption is false, and provides no legal basis for intervention on eugenic grounds.

Purely contraceptive sterilizations cannot in principle be authorized for retarded persons where these treatments would pre-empt reproductive decisions such persons have, or could develop or be trained to have, capacity to exercise for themselves. Where a mildly retarded person has or could reach capacity to marry, for instance, the decision on reproduction should legally be made within the marriage, although it may be subject to non-directive advice from outside persons.

Where capacity to exercise choice appears chronically lacking, a decision on the legality of consent to contraceptive sterilization by a third party depends on the prevailing view of sterilization. If it is seen as a procedure done primarily to the individual, it may appear unjustly paternalistic and oppressive. In the context of minors, such a view of sterilization has condemned it in forthright terms as a violation of human rights (see Heilbron J. in Re D. (a minor), [1976] 1 All E.R. 326 at p. 332, discussed below). It may be seen, however, as a procedure done primarily for the individual. It may be observed that contraceptive sterilization is widely practised among mentally competent persons for their perceived benefit, and that, as a matter of human rights to the equal benefit and protection of the law, it should not be unavailable to retarded persons. If they cannot avail themselves of it due to incompetence, others should be able to seek and approve it on their behalves.

This view should be treated with great caution. Courts have expressed strong reservations about the legality of competent adolescents consenting to non-therapeutic, irreversible surgical contraception, meaning sterilization (see Woolf J. in the Gillick case, [1984] 1 All E.R. 365 at p. 374). Further, the population of competent adults having recourse to contraceptive sterilization is often quite differently situated from retarded persons whose guardians seek their sterilization, in that they are older and have completed the building of families according to their preferred design. The claim to exercise rights on behalf of an unmarried adolescent with no children on analogy with those a competent woman aged, for instance, over thirty years with three or four children will exercise for herself may be specious, and require stronger libertarian justification than the principled claim itself provides.

The issue of the conditions under which retarded adults may be sterilized upon third parties' consent is pending decision in the Supreme Court of Canada, in the case In Re Eve. On appeal in Prince Edward Island, the court held by majority that the retarded woman could be sterilized on the decision of her parent (see (1981), 115 D.L.R. (3d) 283), but the dissenting judgment of McDonald J. conformed to an approach United States' courts have taken. This favours neither a simple prohibition upon contraceptive sterilization, nor simple

permission of a conclusive decision of a guardian, but addresses the range of questions the medical answers to which will determine the issue. The questions concern such matters as the retarded person's present and prospective capacity for autonomy including marriage, the likelihood and imminence of sexual intercourse, the availability of less invasive contraceptive alternatives, the effect upon the person's emotional health and morale of later learning of inability to have children and, for instance, the person's capacity to rear a child, with and without assistance. Further, the approach requires independent legal representation of the retarded person before an impartial decision-maker, and assurance that a guardian's proposal for sterilization is not affected by self-interest, but is addressed solely to the benefit of the retarded person. Within this limit, it may be determined that it is a benefit that the person will, if sterilized, be afforded a more liberated style of living, including, for instance, company of and private time with members of the other sex, as befits persons of similar age and disposition. Nevertheless, it is clearly oppresive that retarded persons can escape unduly circumscribed social environments, whether in their own homes or in institutions only by being submitted to non-therapeutic sterilizations. An independent decision-maker must be careful to ensure that a retarded person is not manipulated through a contrived and unfair "bargain".

D. Sterilization of Minors

As in the case of adults, care must be taken to distinguish sterilization per se from therapeutic treatment which may have the side-effect of rendering the subject incapable of procreation but which in itself is primarily directed to a health-preserving end. Further, the category of legal minors includes those who are retarded while under the age of majority or the age which legislation or statutory instruments make sufficient in itself to give autonomous medical decisions legal effect. The future procreative rights of minors must be no less protected than those of retarded adults, and the procreative capacity of minors is no more at the free disposal of their parents than is that of retarded persons at the free disposal of their guardians. Equally, however, the therapeutic needs of minors must be met according to objective data dependent upon medical predictions, and parents are bound to provide their children with necessaries of life, which include health care. Health options may be expected to be exercised so as to maximize retention of procreative capacity, but it must be sacrificed when essential as an unavoidable side-effect of other, urgently compelled treatment.

It is unlikely that a non-therapeutic sterilization would be proposed for a mentally normal adolescent, but the sub-division of contraceptive sterilization dealing with risks of genetic transmission of severely handicapping traits may be presented

as a legitimate eugenic claim to sterilization of a minor. It should be resisted in principle, however, because adults possess the right to risk dysgenic reproduction, and a minor's future right of adult choice should not be denied by a pre-emptive exercise of parental power. Even mentally impaired minors may grow to capacity to exercise choice, and any doubt regarding the development of such capacity must be resolved in their favour. A decision to sterilize for contraceptive or eugenic reasons should not be taken prematurely, lest it may foreclose basic human rights the individual will become capable of exercising in adulthood (see In Re D. (a minor), [1976] 1 All E.R. 326).

The mature minor doctrine, approved in the Gillick case, raises the question whether minors can give legally satisfactory sole consent to contraceptive sterilization. Judges have expressly denied this (see Woolf J. in Gillick, Chapter II, B, above) and it may be accepted, not necessarily axiomatically but with considerable ease, that the tests proposed in Gillick by Lord Fraser (Chapter II, B, above) are not satisfied by a legal minor requesting or otherwise purporting to consent to purely contraceptive sterilization.

E. Sterilization Failure

Since all techniques of sterilization (and contraception) of the sexually active have an irreducible minimum risk of failure, it does not follow that subsequent pregnancy is necessarily proof of negligence. It must be remembered, however, that failing to give appropriate information to a patient regarding risks of failure associated with different types of sterilization procedures may in itself constitute actionable negligence. Similarly, failing to conduct a proper post-vasectomy test or to warn the patient of the time after the procedure during which he may still release sperm in intercourse may give rise to a successful claim if pregnancy occurs. A particular difficulty is that, while sterilization should be approached as if it were irreversible, patient selection of means may be influenced by the possibility of reversibility. Reversibility is more achievable, perhaps by microsurgery, where intrusiveness of the procedure is less. Merely severing the fallopian tubes is less intrusive, for instance, than removal of a relatively lengthy section. The difficulty is that the greater the chance of reversibility, the greater the chance of spontaneous recanalization or other effect which restores the patient's fertility. The patient's interests in reversibility and in finality of the procedures conflict, and a patient may require sound counselling to set these interests at the balance of risk to benefit preferred by the patient.

(i) Contract Law

Although post-sterilization procedure conception may not be due to negligence, it will be successfully actionable if the surgeon involved gave an undertaking of a "safe" or sterile outcome. The plaintiff may sue not for inherent negligence in the selection, conduct or post-operative monitoring of the procedure, but for breach of contract. While negligence law centres upon reasonable person tests, contract law does not. Persons may contractually bind themselves to achieve impossible or unreasonably expectable results, and be contractually liable when they fail. This occurred at trial in the English vasectomy case of Thake v. Maurice, [1984] 1 All E.R. 513 (Q.B.D.), although on appeal the Court of Appeal found liability not in contract law per se but for negligent informing of the patient about the vasectomy operation in question ([1986] 1 All E.R. 497).

At Common law, a medical practitioner is not deemed to guarantee the effectiveness of any procedure or treatment undertaken, but, by express words or conduct, a doctor may warrant that a certain outcome will be achieved, such as sterility. Such a warranty forms part of any contract made with the doctor. Under a national health service in which a doctor is paid a fixed sum by the service per capita of the patients empanelled, no contract may exist between doctor and patient for services rendered. Under a public health insurance plan where doctors receive payments on a fee-for-service basis, a contract between doctor and patient does exist even though a third party, the health insurance plan, pays the contract price, usually agreed between representatives of doctors and a govenment officer such as a health minister. In either case, services may be sought by patients outside the health insurance scheme, such as by private insurance or personal payment. Whether a contract exists with the patient in such a case will be legally determined by reference to the doctor's basis of payment.

In Thake v. Maurice, the trial judge found that the doctor had warranted the success of the sterilization treatment. There is a difference between undertaking "to render the patient sterile", which imports a guarantee of effectiveness, and undertaking "to perform a vasectomy", which is understood to bear an unavoidable risk of failure. The doctor in the case was found at trial to have undertaken the former, and was according held liable for failure to render the patient sterile. On appeal, the Court of Appeal reversed this finding, on the ground that a reasonable person would not have taken the doctor to give a guarantee of absolute sterility, but upheld a second basis of liability for negligence in the doctor's failure to warn the patient that he might post-operatively remain or become fertile. In the absence of such warning, the patient's wife did not suspect her pregnancy early enough to be able to

terminate it safely, and accordingly gave birth to an unplanned sixth child.

(ii) Tort Law

Failure to warn a patient of the risks of failure of a sterilization procedure due not to negligence in its performance but to its irreducible uncetainty of outcome can constitute professional negligence, or negligence in fact. Whether this is also negligence in law, however, as found by the Court of Appeal in Thake v. Maurice, depends upon legal doctrine. Classically, there are four elements to legal negligence:

(i) A duty of care;

(ii) Breach of the duty of care;

(iii) Damage; and

(iv) Causation, that is that the damage is not merely subsequent to but actually caused by the breach of duty care.

In sterilization cases, item (i) is rarely contested, since it is normally clear that the attending doctor owes the patient a duty of care. This is both to perform the procedure according to the professional standard of care, and to give the patient appropriate information relevant to choice of means and uncertainty of outcome. A duty of care may be less clear, however, when a mentally incompetent person is treated (see C, above); a duty exists to treat the patient carefully, but the informing duty may be owed, contractually or otherwise, to others.

Whether there is breach of duty is measured, with regard to performance of the procedure, by standards of a competent doctor or specialist, as the case of the defendant may be, in the circumstances. The duty of disclosure is measured, however, according to prevailing legal doctrine on informed consent (see B above). A duty may exist to disclose not only uncertainty of the method of sterilization proposed and accepted, but also of alternative methods available. In the South Australia case of F. v. R. (1983), 33 SASR 189 the patient claimed that, had she been informed of the risk of recanalization in tubal ligation, she would have insisted upon a more radical treatment which would have considerably reduced the risk of post-operative fertility. The patient failed on her claim of wrongful nondisclosure because the Supreme Court of South Australia found that a more radical sterilization procedure (for instance bilateral salpingectomy) was not good medical practice (at p. 195). Applying the professional standard of disclosure of information embodied in Bolam and later confirmed in the House of Lords in Sidaway (see B above), the Court ruled that the doctor was not

in breach of the duty of disclosure, since a competent doctor would not have informed her of such an alternative.

Where disclosure must relate not to the conduct of other doctors but to needs of patients, as in Canada undeer the principle in Reibl v. Hughes (see B above), a different result may follow. In the British Columbia case of Dendaas v. Yackel (1980), 109 D.L.R. (3d) 455, a doctor was held liable for not disclosing an alternative means of sterilization which the patient might have selected; the case may be consistent with F. v. R., however, because the more successful alternative procedure was professionally acceptable. The Canadian approach is nevertheless likely to follow United States' jurisprudence in holding that choice of treatment must be governed by the patient's priorities and risk-to-benefit assessment, and not merely by the doctor's preferred choice of options. Failure to inform according to the patient's informational needs will constitute breach of the duty of care.

The issue of damages is addressed below, but a significant point of principle is whether birth of a child can in law be a species of compensable injury. It may be considered instinctively or aesthetically offensive to regard a human being's birth as a legal damage, and courts have expressed distaste at the concept (see e.g. Doiron v. Orr (1978), 86 D.L.R. (3d) 719 (Ont. S.C.)). Nevertheless, it may be equally distasteful and contrary to good policy to hold that medical or other negligence in fact is legally protected or cured provided that it results in birth of a child. A distinction may be considered between birth of a healthy child and birth of a handicapped child, but this may be objectionable in stereotyping handicapped children as a damage to their parents, and in opening the way to discrimination against them. It may be claimed, however, that the child itself is not the damage, but that birth is a damaging event. The Quebec Superior Court awarded damages on birth of a healthy child following negligently conducted sterilization in Cataford v. Moreau (1978), 114 D.L.R. (3d) 585, and the English Court of Appeal in Emeh v. Kensington and Chelsea and Westminister Area Health Authority, [1984] 3 All E.R. 1044 held that there was no inconsistency with public policy to award damages for birth of a healthy child.

The causation issue concerns whether sterilization failure was due to the doctor's improper conduct of the procedure itself, or due to its inherent risk of spontaneous failure, which is resolved by medical evidence and the legal burden of proof. Alternatively, causation may depend on whether the doctor's misinformation of the patient as to options caused the patient to select a method which failed due to either negligent or spontaneous causes. This involves the legally required standard of disclosure (see B above) and whether the patient can show that, if more information would have been

given, a different choice would have been made which would have prevented the injury that resulted. Inadequate information as to risk of failure of the procedure may also deny an opportunity to seek abortion on pregnancy. The plaintiff must then show that abortion could and would have been obtained. This concerns causation not just of the injury but of the extent of damage.

(iii) Damages

Accepting that birth of a child through negligence in sterilization is actionable, an initial issue is the duty to mitigate the damage. On the principle that wrongdoers take their victims as they find them, they cannot complain if victims prove to be people to whom abortion or adoption is unacceptable; defendants cannot require injured plaintiffs to mitigate damages by abortion of fetuses or adoption of children resulting from their negligence (see Emeh, at p. 1053). In Thake v. Maurice (see above) the abortion issues was treated as one on which the plaintiff bore the onus of proof; here, as in Emeh, the Court of Appeal accepted the plaintiff's contention that, due to the pregnancy being disclosed at a relatively advanced stage, it was not reasonable to expect abortion to mitigate damage, even though there was no conscientious objection to abortion per se. If the issue is whether the refusal of abortion breaks the chain of causation which links the defendant's breach of duty of care to the plaintiff's damage, the plaintiff understandably bears the burden of proof on the issues. If the matter is treated, however, only as an unreasonable failure to mitigate damage, the defendant must address this when liability is established and the court considers the level of compensation. In Selvanayagam v. University of West Indies, [1983] 1 All E.R. 824, the Privy Council stated otherwise, but this seems inconsistent with the overwhelming weight of authority (see W.V. Horton Rogers, "Legal implications of ineffective sterilization" (1985), 5 Legal Studies 296 at p. 300, n. 26).

Parents' actions for sterilization or contraceptive failure are often described as wrongful conception or wrongful birth actions (contrast the child's action for wrongful life, below). Most courts accepting the action in principle are willing to award damages for inconvenience and pain and suffering in pregnancy, confinement and delivery and for lost income, costs of maternity clothes, preparing a nursery and similar out-of-pocket expenses. They also may allow recovery of medical costs of the negligent sterilization or contraceptive advice and/or treatment. More contentious is whether they will award damages for the prospective costs of rearing the child until termination of parents' legal responsibility provide children with necessaries of life.

In Cataford v. Moreau (above), the Quebec Superior Court awarded a sum to cover such expenses, although calculated at a

very modest level (see R.P. Kouri, case comment at (1979), 57 Can. Bar Rev. 89); in contrast, the contemporaneous Ontario case of Doiron v. Orr (above) observed, obiter, that such an award would be highly offensive to principle and dysfunctional in practice, because of harm to a child from knowing that it was unwanted and was being supported from outside its family. The South Australian Supreme Court in R. v. F. (above) similarly rejected a claim for care of the child born of failed sterilization, while awarding damages for pain and suffering in wrongful pregnancy. This shows how courts may balance the costs of pregnancy against the benefit (often call the "blessing") of having a child; the benefit of a healthy child may exceed that of a sickly or handicapped child whose health is a source of anxiety (see Emeh, above).

A balancing approach was applied to damages in Udale v. Bloomsbury Area Health Authority, [1982] 2 All E.R. 522, where liability for failed sterilization was admitted. The High Court judge weighed heavily the mother's love for and joy in the child, and found it to at least balance the inconvenience and financial disadvantage she had suffered. The Court also expressed the opinion, however, that damages should not be awardable as a matter of principle lest unloving parents may receive damage awards when loving parents would not. This appears to be an unnecessary formulation of a normative rule when it is more appropriate to address each case upon its merits, in a pragmatic fashion. The judge similarly observed that it is a long-standing cultural assumption that birth of a child is a blessing and an occasion for rejoicing (see at p. 531). Again, this is a matter better addressed pragmatically. A number of Commonwealth Courts have implemented the observation of a 1971 Michigan judgment on contraceptive error resulting in birth, equally applicable to sterilization error, that:

> "Contraceptives are used to prevent the birth of healthy children. To say that for reasons of public policy contraceptive failure can result in no damage as a matter of law ignores the fact that tens of millions of persons use contraceptives daily to avoid the very result which the defendant would have us say is always a benefit, never a detriment. Those tens of millions of persons, by their conduct, express the sense of the community." (Troppi v. Scarf (1971), 187 N.W. 2d 511 (Mich. C.A.))

On their understanding of their community, based on the empirical data of sterilization and contraceptive practice, courts may assess damages for injuries caused by childbirth. In the later Emeh case, the English Court of Appeal saw the matter of damages differently from the court in Udale. The child in Emeh had abnormalities, which may distinguish the case from Udale, but the Court of Appeal appeared to disapprove the Udale

expression of public policy opposed to awards of damages for wrongful birth following negligent failure of contraception or sterilization.

(iv) Wrongful Life

The difficulty Commonwealth courts have found before accepting the contention that birth of a child, for instance through negligent sterilization, can be a species of legal damage to the parents offers some guidance to how they might respond in principle to the claim that the child itself is also legally injured by such birth. A claim of this nature is increasingly called a "wrongful life" claim, but the name arose less by way of explanation than as a parody of the wrongful death action, which Common law courts also rejected. When statutes of the mid-nineteenth century afforded a deceased person's estate the means to sue for the injury causing death, the "wrongful death" action was created. This was invoked to deride the subsequent claim that a plaintiff's very life could be a source of legal injury.

Modern commentators go further, to distinguish the wrongful life action from the "dissatisfied life" action, in which a child seeks damages not simply for having been born but for having been born illegitimate or otherwise socially (as opposed to physically or mentally) disadvantaged. In the United States, the first case to allow a claim for wrongful life was a Californian case of 1980 (Curlender v. Bio-Science Laboratories (1980), 165 Cal. Rptr. 477). The arguments that the wrong of wrongful life is not the life itself but the predictable pain and suffering a child with a foreseeable handicap suffers, and that the blessing of the experience of life can be weighed against the burden of such pain to assess compensation, if any, has not greatly promoted success of the action. It is clearly accepted in less than a full handful of United States' jurisdictions.

When the claim first arose in the Commonwealth, in the English case of McKay v. Essex Area Health Authority, [1982] 2 All E.R. 771, it was emphatically rejected. This was compatible with the English Law Commission's 1974 Report on Injuries to Unborn Children (No. 60, HMSO 1974 Cmnd. 5709), which was followed by enactment of the Congenital Disabilities (Civil Liability) Act 1976. In McKay, it was alleged that the defendant's laboratory negligently tested prenatal blood samples, thereby failing to inform a mother of rubella infection and denying her the opportunity to have an abortion. A severely handicapped child was born, who was plaintiff in the case, alleging negligence resulting in birth against the Area Health Authority, and against the attending doctor for negligent treatment of the mother, and negligent management of the child before birth resulting in aggravation of its injuries experienced upon birth. The High Court and Court of Appeal (above) dismissed the

claim, the latter presenting reasons of an absence of a duty of care owed to a child before birth, an absence of damages, since live birth is a benefit outweighing any disadvantage, and principles of public policy which preclude allowing wrongful life claims. These reasons may be faulted both in substance and in the way they were presented (see e.g. C.J. O'Neil, "Damages and the Unwanted Child" (1985), 5 Auckland Univ. L.R. 180, at pp. 186-189, and H. Teff, "The Action for 'Wrongful Life' in England and the United States" (1985), 34 Int'l and Comp. L.Q. 423, at pp. 438-441), but for the time being at least they seem likely to prevail in Commonwealth jurisprudence.

F. Spousal Veto

It has been seen (see Chapater I, E, above) that a state's enactment or tolerance of laws permitting husbands to veto their wives' sterilizations, whether therapeutic, eugenic or purely contraceptive, could be inconsistent with the United Nations' Convention on the Elimination of All Forms of Discrimination Against Women, and a violation by Commonwealth countries that are States Parties to the Convention. The same would be true of laws giving only wives veto power over husbands, although no Commonwealth provisions to this effect are apparent. More difficult to assess are laws providing for mutual veto power which are applied in fact to place one sex under the control of spouses. The same is true of formal and informal practices lacking a legislative foundation which discriminate against one sex. Since the experience of laws and practices in the Commonwealth is that discrimination in form or effect is directed against women, they may be assessed according to the provisions and values of the Convention. It must be observed in addition that, even in countries which have not ratified or acceded to the Convention, spousal veto of a woman's therapeutic sterilization will violate laws obliging a husband or parent to provide a wife or dependent with necessaries of life, which include therapeutic care.

The differential opportunity for spousal veto under laws or practices which appear applicable mutually to husbands and wives is evidenced in, for instance, the 1983 Annual Report of the National Family Planning Programme of Trinidad and Tobago. This shows (at p. 9) that, while 1,313 tubal ligations were performed on women, 52 vasectomies were performed on men. Practices at clinics where sterilizations are offered not uncommonly differentiate between women and men patients. The 1985 paper Status of Family Planning Practices and Policies in Dominica observes on voluntary sterilizations, of which 3,257 have been done since 1967, that (at p. 6) "Where clients are married the husbands' written consent must be obtained prior to sterilization." On vasectomy, the paper observes only that "Few of these were done in the past." Since vasectomy is considerably safer than women's treatments, some agencies have

promoted it in effective campaigns. The 1984-85 Annual Report of The Family Planning Association of Hong Kong, for instance, shows that, while 451 female sterilizations were done in 1984, a Male Responsibility Campaign raised the annual vasectomy total to 632.

IV. ABORTION

A. Introduction

This Chapter of the Report includes reviews of new Commonwealth abortion legislation, and key litigation in the general area. It also discusses new executive observations on relevance of the leading English ruling in the 1938 Bourne case to Commonwealth legislation. In addition, it considers how cases have addressed issues of spousal consent and parental consent, which has tended to be in favour of freeing women's decisions from the control of others.

Although the thrust of legislation and litigation has been towards liberalization and decriminalization, opposition to such a thrust has remained active. In a number of jurisdictions, legislation has been proposed which would limit the legality of or access to abortion services. In mid-October 1983 in the New Zealand Parliament, for instance, a Private Member's Bill, the Status of Unborn Children Bill, was defeated. The Bill was aimed at abortion rather than either contraception or contragestion (see Chapter II, D, above), defining "unborn child" as a human embryo or fetus "at any time after implantation" (section 3). Its provision in section 5(2) that "There shall be a presumption that every unborn child will in the natural course of events be born alive" raises interesting conflicts of legislative presumption and scientific fact, since mounting scientific evidence indicates a very high rate of spontaneous embryonic loss. Section 5(3) provides that the presumption may be rebutted by evidence on a balance of probabilities. Professor David Baird, of Edinburgh University's Centre for Reproductive Biology has observed that "only about one fertilized egg in four results in a viable offspring" (Introduction, Abortion: Medical Progress and Social Implications, Ciba Foundation Symposium 115 (1985)). Whether the bulk of loss occurs before or after implantation is a scientific matter that would have been relevant to operation of the proposed presumptions.

A Private Member's proposal in the Saskatchewan provincial legislature of Canada to limit access to abortion services was held unconstitutional in December 1985 by the Saskatchewan Court of Appeal, on the ground that the Bill purported to affect criminal law, which is a federal responsibility. The comparable attempt by Mr. Joseph Borowski to limit availability of abortion through constitutional challenge before the Saskatchewan Court of Appeal awaits decision, as does the opposing constitutional challenge to restriction of abortion maintained by Dr. Henry Morgentaler. His challenge before the High Court and Court of Appeal of Ontario has failed (see D, below), and the appeal is pending presentation before the Supreme Court of Canada.

A theoretical expansion of abortion availability has occurred where several Commonwealth jurisdictions' abortion legislation recognizes rape as a ground. In the early history of the Common law, it was accepted that a husband could not be guilty of raping his wife. He might be convicted of assault, or of related violence, depending upon local law, but, as the classical texts observed, "... the husband cannot be guilty of rape committed by himself upon his lawful wife, for by their mutual matrimonial consent and contract the wife hath given up herself in this kind unto her husband, which she cannot retract" (M. Hale, The History of the Pleas of the Crown (Emlin ed. 1736) at p. 629). The proposition cited no authority, and has been questioned on the ground that in fact, it lacks legal authority. Further, some courts have distinguished cohabiting spouses from those living separate and apart, whether or not by judicial order of separation, and have considered rape convictable in the latter case. Increasingly, however, legislation is providing that in principle husbands are convictable of rape of their wives. Where legislation also provides a rape indication for abortion, a wife made pregnant in this way by her husband may avail herself of lawful abortion no less than any other woman.

It is a matter of speculation whether legal acknowledgement of spousal rape would increase recourse to abortion to any appreciable degree. Where pregnancy follows such an offence, abortion may be accommodated under a mental health indication. In New Zealand in 1984-85 for instance, the Report of the Abortion Supervisory Committee for the year ending 31st March 1985 shows that of 7275 abortions, 6965 were due to serious danger to mental health, and a further 174 involved serious danger to physical and mental health (Report at p. 10). Alleged rape was a factor in 78 cases of the 7275. The potential for a husband to be convicted of rape of his wife has been accepted, however, by Commonwealth judgments and proposed legislative changes that are explicit, or that are implicit in, for instance, replacement of rape by various other sexual offences of which husbands can be convicted when their victims are their wives.

Where rape laws are retained as such, a number of Commonwealth jurisdictions are moving to make them applicable between husband and wife. It has been held in Scottish law that a husband has no immunity in principle from rape liability against his wife (H.M. Advocate v. Duffy, [1983] S.L.T. 7 (H.C.)), and in another case where the couple were living apart in accordance with a judicial order, the Full Court of the Supreme Court of Victoria refused leave to appeal against a husband's conviction (R. v. McMinn, [1982] V.R. 53). The English Criminal Law Revision Committee in its Report Sexual Offences (H.M.S.O. Cmnd. 9216, 1984) divided on rape between co-habiting spouses, but recommended liability when the two do not live together. In Australia, however, it has been proposed in the Australian Capital Territory, New South Wales, South

Australia, Tasmania and Victoria that spousal immunity from rape liability be partially or totally abolished.

A particularly sensitive issue regarding abortion concerns that undertaken following prenatal genetic diagnosis disclosing the female gender of the fetus. The knowledge may be a by-product of genetic testing performed to diagnose genetic abnormality, or itself be the goal of prenatal testing such as amniocentesis or chorionic villus sampling. At the February 1985 World Congress on Law and Medicine held in New Delhi, India, evidence of sex-based abortion was presented which aroused considerable discussion. Abortion due solely to fetal sex was believed by some to be symptomatic of the devalued status of girls and women in the societies in which it is practised. To others, its condemnation reflected an attempt at "ethical imperialism", through which the values developed in one region of the world were being transmitted across geographical and political boundaries to regions whose value-systems were different but no less worthy of respect. The explanation was offered that sex-based abortion, which might be of male fetuses as well as of female, is a proper extension of family planning, and legitimately serves the wishes of parents with several children of one sex who want one of the other sex. It is observed to be not necessarily the case that parents prefer boys to girls, and that if that preference is present, it will not endure in society since a scarcity of children of one sex will soon result in their raised status.

Counter-arguments were presented that in countries pursuing policies aimed at one-child families, that child is likely to be preferred to be male, and that in any event in multi-child families preference might be to have a boy first and then a girl, perhaps balancing the birth rate of the sexes but producing a society whose women are accustomed from birth to the status of being second and to the role of being socially led by a male. This opposition to sex-based abortion was itself resisted by the claim that, if it is undesirable, the remedy lies not in mandating parents to suffer the socio-economic disadvantages of having a daughter, and mandating the daughter herself to endure a disadvantaged life, but in redressing the disadvantages. That is, it was claimed that if women were to have equal opportunities with men in the labour force, in career and professional opportunities, in inheritance rights, in the capacity to provide for their families and, for instance, to give their children their family names, the birth of a girl would not be considered a disadvantage to families in contrast to the birth of a boy.

States Parties to the Convention on the Elimination of All Forms of Discrimination Against Women are obliged to seek to reduce not only the stereotyping which may induce parents to prefer boys over girls, but also the economic, social and other

circumstances which may make such parental choice rational. Parental preference reflected in sex-based abortion may be a symptom rather than a cause of women's low status in many Commonwealth societies. It is often the case that abortion is conditioned by a variety of social inequities that attacks concentrated on abortion alone conceal, and thereby perpetuate.

There is reason to believe that liberalized abortion laws save women's lives, and protect the welfare of children and families that depend on women's well-being. A ten-year study of abortion-related deaths at Kenyatta National Hospital in Nairobi, Kenya, ending in 1983, concluded that

> "The study clearly shows that illegal abortion is an important cause of maternal death among admissions for abortion in Kenyatta National Hospital, accounting for 80 % of such deaths" (S. Wanjala, N. Murugu and J. Mati, "Mortality due to abortion at Kenyatta National Hospital, 1974-1983" in Abortion: Medical Progress and Social Implications (1985) Ciba Foundation Symposium 115, 41 at p. 47).

Septic abortion with its complications accounted for 97.4 percent of deaths from induced abortion (ibid.) The success of liberal abortion laws is shown in Singapore, of which it has been observed that

> "One of the most important objectives underlying the move to legalize abortion in Singapore was to discourage illegal abortion and thereby reduce the mortality and morbidity associated with abortions performed under unsafe conditions" (A.J. Chen, S. Emmanuel et al.," Legalized Abortion: The Singapore Experience" (1985), 16 Studies in Fam. Planning 170 at p. 177).

The law was first liberalized in 1969. Septic abortion cases admitted to government hospitals fell from 350 in 1964 to 28 in 1974 (see ibid.) and it has been found that "With the further liberalization of abortion laws in 1975, the number of septic abortions diminished to a negligible amount" (ibid.).

Even liberalized abortion laws may preserve pockets of inequity. Britain's Abortion Act 1967 remains inapplicable to Northern Ireland, where women unable to afford to travel to England, Wales, or Scotland are denied protection enjoyed by other women in the United Kingdom. An estimated 1,600 women each year from Northern Ireland have abortions in England (Sunday Telegraph, London, Oct. 31, 1982).

B. New Legislation

A number of Commonwealth jurisdictions have enacted laws liberalizing provisions on abortion since the publication of Emerging Issues in Commonwealth Abortion Laws, 1982. The new Acts have not endorsed legitimacy of the abortion option with enthusiasm, but have primarily represented exercises in damage control. They recognize the inescapable incidence of abortion and aim to channel it into safe, lawful hands rather than to keep it in unsafe hands of unqualified practitioners and of women acting on themselves. In contrast, a recommendation for decriminalization of abortion was made in the 1986 report A Feminist Review of Criminal Law commissioned by the federal agency Status of Women Canada, in order to afford women control over their reproduction and sexuality, and to end inequity in access to services. Rather than embrace such libertarian principles, the new Acts are limited pragmatic attempts to deal with countries' harmful abortion experiences.

Following several years of deliberation, including in some cases consideration of alternative models, Barbados, Bermuda, Ghana and Montserrat have recently enacted laws for the legitimate performance of abortions. Against a background of considerable abortion experience and almost no prosecutions (see P.K. Menon, "The Medical Termination of Pregnancy Act 1983 (Barbados)", 34 Int'l and Comp. L.Q. (1985) 630), Barbados decriminalized abortions by distinguishing between pregnancies of not more than 12 weeks' duration, those of 12 or more weeks' duration but not more than 20 weeks', and those of 20 weeks' duration or more. Where a pregnancy does not exceed 12 weeks' duration, it is lawfully terminable when an individual medical practitioner acting in good faith is of the opinion that continuance of the pregnancy would involve risk to the life or grave injury to the physical or mental health of the pregnant woman or that there is substantial risk that a child, if born, would suffer such physical or mental abnormalities as to be seriously handicapped. In determining risk to health, "the medical practitioner must take into account the pregnant woman's social and economic environment, whether actual or foreseeable" (Medical Termination of Pregnancy Act, 1983, s. 4(3)). Further, the woman's written statement of her reasonable belief that pregnancy was caused by rape or incest "is sufficient to constitute the element of grave injury to mental health" (s. 4(2)).

The same indications govern pregnancies of 12 or more weeks' duration but of under 20 weeks, but they must be found by two medical practitioners (s. 5). For pregnancies of 20 or more weeks' duration, 3 registered physicians must be of the opinion that termination is immediately necessary to save the woman's life or to prevent grave permanent injury to the physical or mental health of the woman or her unborn child (s. 6). Termination of any pregnancy exceeding 12 weeks'

duration must be conducted in an approved hospital (s. 9). Nevertheless, where abortion appears immediately necessary to save the life or prevent grave permanent injury to the physical or mental health of the woman, provisions relating to the number of medical opinions and place of performance of the procedure do not apply (s. 11).

Immediate necessity also renders inapplicable the Act's conscience clause (s. 10), and also its consent provision which in other cases requires that "a medical practitioner may require the written consent of the pregnant woman before administering treatment for the termination of pregnancy" (s. 8(1)). Since a practitioner in a routine case has a discretion but no duty to obtain consent in writing (the practitioner "may", but not "shall", require written consent), it may appear that in emergency the practitioner may dispense not only with writing, but also with consent itself; that is, on immediate danger to the woman's life or permanent health, abortion may be undertaken without her consent. This is reasonable where she cannot give consent, for instance when she is unconscious or sedated, but may raise difficulties when she is competent to decide to risk her life or health for her unborn child, and determines to do so. When she is responsible for the welfare of other dependent children, her choice may appear irresponsible, but when it is based on conscientious convictions, the choice may weigh heavily in the balance.

When the pregnant woman is aged under 16 years or is of unsound mind, her parent's or guardian's written consent is required (s. 8(2)), except in the above-described condition of immediate necessity. Outside such condition, however, the Act appears to supersede the position at Common law established in the Gillick case, recognizing autonomy of the "mature minor" (see Chapter II, B, above). It is not clear from the Act whether the necessary parental consent to asbortion of a person aged under 16 years is itself sufficient consent, or whether a young person of adequate understanding could refuse to submit to an abortion with legal effect. Her refusal might justify a medical practitioner's decision not to abort her even when parental consent has been given. Since adults' refusals of consent may not prevent emergency abortions to save their lives or permanent health, however, a person aged under 16 may be aborted without her agreement in comparable conditions of emergency.

Under authority of the Act, the Minister responsible for Health has made regulations which emphasize and implement physicians' duties to be familiar with counselling functions, and to give or ensure availability of appropriate counselling before terminating pregnancies. Counsellors must advise on alternatives to abortion, on the consequences both of having and of not having abortions, and on methods of contraception

and availability of family planning services. The Act also permits regulations to be made on residence requirements a woman must satisfy in order to be eligible for services under the Act, perhaps for the purpose of preventing Barbados from becoming a centre for abortions in its region. Existing regulations indicate that no need has been found for such control to be exercised.

Shortly after Barbados amended its law, Bermuda became another Commonwealth country in the region to amend its abortion law. The Criminal Code Amendment Act 1983 became operative in August 1983 immediately on enactment. Its effect is to add new sections 196A to 196D to the Criminal Code, exempting from liability to the conventional prohibitions of abortion both qualified medical practitioners and their assistants who act in good faith in designated hospitals to procure miscarriages, and the pregnant women who thereby permit themselves to be aborted. This is lawful, however, only when the hospital's therapeutic abortion committee has by majority certified its opinion that pregnancy resulted from incest or rape, that continuation of pregnancy, however arising, would or would be likely to endanger the woman's life or health, or that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

These latter indications reflect in general those provided by Britain's Abortion Act 1967, but the mechanism of therapeutic abortion committees constituted in designated hospitals reflects the regulatory system created in 1969 in Canada. It differs only in minor ways, such as in copying the committee structure of three doctors but expressly requiring that at least one of them be a qualified psychiatrist. The Act repeats Canadian practice of permitting but not compelling designated hospitals to establish committees. Whether committees will be established, and whether hospitals, physicians or prospective patients will press the Minister responsible for Health to designate sympathetic hospitals for purposes of the Act, remains to be seen. The Act names The King Edward VII Memorial Hospital as capable of having a committee, and the inference may be that this centre will be equipped to bear main responsibility for abortions. It will be interesting in years to come to see if experience in Bermuda repeats the inequity in provision of access to services found in Canada by the Badgley Committee in 1977 (see R.J. Cook and B.M. Dickens, "A Survey of Abortion Laws in Commonwealth Countries" in Three Studies of Abortion Laws in the Commonwealth, Commonwealth Secretariat (1977) at pp. 42-44).

In Ghana, the Criminal Code (Amendment) Law, 1985 substituted new provisions on abortion for those previously existing in the Criminal Code. Section 58(1) now contains the standard prohibition of acting to procure miscarriage by a woman herself, or by any other person on a woman whether she is pregnant or not, and

includes related offences of supplying things knowing that they are to be used for abortion. Section 58(2) provides an exemption, however, where continuance of pregnancy would involve risk to a pregnant woman's life or injury to her physical or mental health, or where pregnancy results from a sexual offence such as rape or incest, or where there is substantial risk that, if the child were born, it may suffer from or later develop a serious physical abnormality or disease. The procedure must be undertaken by a registered physician specializing in gynaecology, or by any other registered physician acting in a government hospital or in an approved private hospital, clinic or other place.

It is uncertain whether a woman attempting her own abortion must be shown to be pregnant before she can be convicted. Section 58(1)(a), dealing with this case, is silent on the issue, but section 58(1)(b), which concerns a person who acts on another is expressed to create an offence "whether or not that woman is pregnant." At historic Common law, a woman acting alone had to be proven pregnant in order to be convictable, and the exclusion of the pregnant-or-not provision found in clause (b) from clause (a) is consistent with this origin of the law. The fetal damage indication is restrictively expressed, covering substantial risk that the child would be affected by "serious physical abnormality or disease". The omission of serious mental or psychiatric abnormality may mark an interesting distinction between the visibly abnormal and the mentally or functionally abnormal. It is unclear whether neurological malfunction affecting, for instance, facial expression or gait, will be found to express itself in a physical abnormality.

By section 58(3), abortion and miscarriage are defined to mean "the premature expulsion or removal of conception from the uterus or womb before the period of gestation is completed". Removal <u>from</u> the uterus suggests that implantation is a precondition to abortion or miscarriage, so that an intent to remove a conceptus from the fallopian tube <u>through</u> the uterus would constitute contraception as opposed to abortion. This reading is consistent with evolving perceptions in Commonwealth laws distinguishing abortion from contraception and contragestion (see Chapter II, D, above).

Montserrat's Penal Code No. 12 of 1983 excludes from its customary prohibition of abortion terminations of pregnancies performed in hospitals or other places approved by the Chief Medical Officer if performed by doctors following agreement of two doctors on given indications. These are that there is risk to the pregnant woman's life, or risk of injury to her physical or mental health from continuation of pregnancy greater than if the pregnancy were terminated. A further indication is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped. Requirements of two doctors' opinions and of place of performance

do not apply where in good faith a doctor is of the opinion that the procedure is necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

C. The Applicability of R. v. Bourne

The two earlier Commonwealth Secretariat reports in this series, Three Studies of Abortion Laws in the Commonwealth (1977) and Emerging Issues in Commonwealth Abortion Laws, 1982 included tables indicating the grounds on which each Commonwealth jurisdiction permitted the performance of abortion through its legislation and case-law. The relevant table has been brought up to date, as of April 1986, and appears as the Appendix to this Chapter.

In many jurisdictions where no case-law has explained the abortion legislation, it is accepted that the 1938 English jury direction in R. v. Bourne, [1939] 1 K.B. 687, [1938] 3 All E.R. 615 is applicable. This leading case has invariably been accepted where it has been judicially considered in the Commonwealth, including at highest judicial levels, as being a correct explanation of the abortion law. Where legislation has not been judicially interpreted, legal commentators and Attorneys-General generally understand that the direction which interprets England's Offences Against the Person Act, 1861, section 58, also interprets local law derived from this origin. Where local legislation shares Common law roots with this provision but is immediately traceable to another codification, such as, for instance, the Indian Penal Code, 1860, the case is again considered an authoritative interpretation.

The Bourne principle provides that, even when legislation expresses only a prohibition of abortion, often described as "procurement of miscarriage", the procedure is nevertheless lawful when undertaken in good faith to save a woman's life or to save her physical or mental health. In the Bourne case itself, a doctor was acquitted of an offence for performing an abortion to save the patient from becoming "a mental wreck". The judge recognized the legal justification of abortion when performed to save not only life itself, but the condition of continuing life, namely health, and that health has both physical and mental aspects. Commonwealth legislation often now makes explicit the meaning the Bourne case found implicit in the English 1861 Act, and enacts the legality of abortion when intended for preservation of life and of physical and mental health. Few legislatures that have an explicit provision depart from this. Zimbabwe's Termination of Pregnancy Act, 1977 provides only a physical health indication, although it allows abortion for rape, which was the origin of pregnancy in the Bourne case.

The 1982 Emerging Issues report table of Legal Indications for Abortion showed that in a small number of Commonwealth jurisdictions where no case-law had interpreted their legislation, which was expressed only in terms of prohibiting abortion on the model of England's 1861 Act, it was uncertain whether the case of R. v. Bourne was considered applicable. In order to reduce this uncertainty, a questionnaire was sent to the offices of the Attorneys-General of those jurisdictions. It was designed to obtain opinions on whether abortion was justifiable or excusable when undertaken to save a woman's life, physical health or mental health. We are greatly indebted to officers in the various Attorneys-General's departments who took time to consider the questionnaire and to offer their researched opinions on the matter. Those opinions are reflected in the updated Appendix.

The strongly preponderant view is that the Bourne principle is applicable to legislation making no explicit statement of grounds upon which abortion may lawfully be performed. This may be through direct acceptance of the Bourne direction, or through recognition and sometimes enactment of a necessity defence to a criminal charge. The defendant in Bourne was a doctor, but the necessity defence was recognized as a Common law principle. Accordingly, it might be available to other than doctors; indeed, where a doctor declines to become involved in a case because of legal uncertainty about possible prosecution and loss of professional status, necessity for a non-doctor to act may appear more acute. Some jurisdictions observed, however, that an abortion initiative by a non-doctor is more likely to be prosecuted than action by a doctor.

Opinions on applicability of Bourne do not enjoy the status of legal precedent, of course, and clearly do not bind courts of their jurisdictions. As exercises in legal interpretation they are valuable, however, and reliable indicators of the principles by which the law may be enforced. Only two jurisdictions considered the Bourne principle excluded by their law. Accordingly, a woman whose continued pregnancy endangers not her life itself but poses, in the words of the questionnaire, "grave risk" to her physical health or continuing mental health could not have pregnancy terminated. Opinion in Kiribati is that only preservation of life itself is defensible, and that abortion to preserve only physical or mental health against grave risk would be an offence. Similarly, opinion in Antigua and Barbuda is that, if no medical treatment other than abortion will preserve a woman's physical or mental health, she must be left medically untreated. Nursing care may be rendered to her, of course, while continuation of her pregnancy is medically managed.

Opinions in Law Officers' departments in Northern Nigeria differ. Although they are all under the Penal Code of Northern Nigeria, no relevant case-law exists, and, while the view in

some states is that the Bourne principle applies, the view in others is that the Penal Code's permission of saving "life" is to be read more restrictively. It may be relevant to note, however, that, unlike Kiribati and Antigua and Barbuda, Nigeria is a State Party to the Convention on the Elimination of All Forms of Discrimination Against Women. It may be asked if this would influence judicial interpretation of the Penal Code in favour of preserving women's physical and mental health against grave risk.

An indication of Commonwealth standing of the Bourne principle came in January 1986 from Queensland, Australia. In R. v. Bayliss and Cullen, District Court Judge McGuire reviewed the historic and international foundations on which the relevant case-law of the abortion provision in Queensland's Criminal Code is built. In a comprehensive ruling (of 72 transcribed pages, including three appendices, unreported to date) he observed that:

> "Bourne has spawned offspring who have grown to adulthood. They cannot now - at least by Courts of first instance - easily be disowned or made to disappear. It is hard to turn the clock back." (Transcript at p. 122).

It may be speculated that the Bourne ruling has become a cohesive principle in Commonwealth jurisprudence. In the jurisdictions in which its application is uncertain, its significance is such that courts cannot ignore its effect, lest their decisions may be per incuriam (not precedents due to oversight of relevant law). A court rejecting Bourne will be expected to specify its reasons; that is, it must expressly find that under the legislation of its jurisdiction, women's health cannot be preserved against grave risk posed by pregnancy.

D. Litigation

While the overwhelming majority of Commonwealth jurisdictions have had no experience of abortion-related litigation in recent years, or indeed ever, the few that have been active have been very active. In Canada, cases have been brought in Federal courts and the provincial courts of British Columbia, Manitoba, Ontario, Quebec and Saskatchewan. In Australia, the Bayliss case in Queensland has become a local abortion cause celebre comparable to the Morgentaler saga in Canada. A number of cases are prosecutions for performing abortions, but most are peripheral to that issue. They involve procedural matters pertaining to prosecution and questions of control of access to abortion services. A series of related minor cases involves injunctions sought by and against abortion clinics, notably those opened by Dr. Morgentaler in Ontario and Manitoba, and

prosecutions of protesters involved in scuffles and forms of mischief to property.

The central litigation in Canada is Dr. Morgentaler's prosecution in Ontario. The case, now pending in the Supreme Court of Canada, is strictly not an abortion case, since the charge is that three doctors conspired to perform an illegal act, namely abortion. The conspiracy charge makes the criminal defence of necessity more difficult to employ. While it may be shown ex post facto that performing abortion on a particular woman was necessary, it is not so easily arguable that it is necessary to conspire with others, in advance of any individual woman presenting herself, to terminate a pregnancy. The defence was primarily concerned in fact with constitutional arguments that Canada's Criminal Code restriction on abortion violates the Canadian Charter of Rights and Freedoms. The constitutional challenge, mounted in an extensive hearing before a trial jury was empanelled, was wide ranging, and resisted principally by the Attorney-General of Canada, rather than that of Ontario, because the issue affects federal law. The constitutional challenge failed, and a regular criminal trial followed, at the end of which the jury acquitted the three defendant doctors (R. v. Morgentaler, Smoling and Scott (1984), 12 D.L.R. (3d) 502 (Ont. S.C.)). The prosecution exercised the right it enjoys in Canada to appeal against the acquittal, successfully, and the defendants cross-appealed unsuccessfully against rejection of their constitutional arguments. The Ontario Court of Appeal ordered a new trial ((1985), 52 O.R. (2d) 353), but the defendants have exercised their right to appeal further to the Supreme Court of Canada. This appeal is unlikely to be argued before the autumn of 1986.

Another abortion-related charge is pending against Dr. Morgentaler in Ontario but, although he has continued to operate his abortion clinic in the province, the provincial Attorney-General has undertaken not to consider proceeding until the Supreme Court of Canada's decision is known. Meanwhile, in Manitoba, pending charges involving Dr. Morgentaler's clinic in that province will also not be pursued until the Ontario case is resolved. The Manitoba charge was originally for conspiracy but, on the defendants' protest, it was amended to a direct prosecution for unlawful performance of abortion. Spin-off litigation in the province concerned Dr. Morgentaler's application to the College of Physicians and Surgeons of Manitoba for approval of his clinic. The College's refusal was subsequently held to have been improperly reached since the College did not afford the applicant proper means to present his case. The College will be required to resolve the application properly. The Attorneys-General of Ontario and Manitoba have decided not to seek injunctions against Dr. Morgentaler's clinics in their provinces, but in Quebec, where Dr. Morgentaler practises without provincial governmental intervention, a

private person is acting for an injunction to restrain Dr. Morgentaler's activities. It would be very remarkable were the application to succeed.

Mr. Joseph Borowski, a resident of Manitoba, holds views on abortion diametrically opposed to Dr. Morgentaler's. His constitutional objection to the Criminal Code is not that it prohibits abortions, but that it permits them. Acting in his lawyer's province of Saskatchewan, he sought to challenge the constitutionality of the law, but was faced with resistance on the procedural ground that, as a person with no special personal legal interest in the matter, he lacked standing to present his case. The Supreme Court of Canada eventually ruled on that issue, in favour of Mr. Borowski (Borowski v. Attorney-General of Canada (1981), 130 D.L.R. (3d) 588). In subsequent litigation on the merits of his claim he was unsuccessful ((1983), 4 D.L.R. (4th) 112 (Sask. Q.B.)) and judgment is now pending in his appeal to the Saskatchewan Court of Appeal.

The Federal Court of Appeal of Canada upheld a federal trial court's decision declining jurisdiction on an allegation that hospitals' therapeutic abortion committes were interpreting too liberally the Criminal Code's permission of their certification of abortion if they were to find danger to "health" (Carruthers v. Therapeutic Abortion Committees of Lions Gate Hospital et al. (1983), 6 D.L.R. (4th) 57). The basis of the decision is that, although the federal Criminal Code establishes the law, questions of health fall within provincial jurisdiction. The applicant subsequently failed in his provincial application before the British Columbia Supreme Court and Court of Appeal to have committees' practices reviewed and declared illegal (Carruthers v. Langley (1985), 23 D.L.R. (4th) 623). The Courts considered that as members of a hospital society, the plaintiffs lacked standing to seek civil review of conduct they considered criminal. The Ontario Supreme Court in the 1984 Medhurst case on spousal consent (see E, below) added that such committees' decisions are medical, and non-justiceable.

The flurry of court proceedings in Queensland, Australia, concerning the abortion clinics run by Dr. Bayliss is comparable to that seen in Canada. Events originated in May 1985 when, in a spectacular raid on an abortion clinic, 47,000 patients' files were seized. Dr. Bayliss was arrested and charged with conspiracy regarding the clinic's activities. At a bail application, the prosecution failed in its effort to have a bail condition imposed that the defendant not perform any more abortions. In the Supreme Court of Queensland a judge in chambers refused the Crown's appeal from that decision (Re Bayliss O.S. No. 326 of 1985, unreported), on the ground that the restriction sought was excessive. It was considered that abortion itself is not necessarily unlawful, and no need existed to restrain the defendant's performance of lawful procedures. The Full Court

of the state Supreme Court upheld this assessment. The Full Court also ruled, in response to a separate challenge by the defendant, that the search warrants under which the initial raid had been conducted were invalid.

It appeared that the original conspiracy charge was no longer sustainable, since evidence obtained in consequence of invalid warrants was not usable by the prosecution. Upon a former patient's complaint, however, proceedings were pursued against Drs. Bayliss and Cullen for unlawfully procuring a miscarriage. In preparation for the direction on law to the trial jury, District Court Judge McGuire prepared a comprehensive written ruling (see C, above), which was released following the jury's verdict on the facts of the case. The defence was that the offence charged against section 224 of the Queensland Criminal Code was defensible under section 282, which exempts from criminal liability one who in good faith reasonably performs surgery on an unborn child to preserve the mother's life. The trial judge explained the law consistently with the Bourne direction and the Australian case-law which had given effect to the principle. At the end of January 1986, both defendants were acquitted.

In contrast to the frenzy of litigation in the Canadian jurisdictions and Queensland, other Commonwealth jurisdictions appear to have been quiescent. The New Zealand Court of Appeal's judgment in Wall v. Livingston, [1982] 1 N.Z.L.R. 734 upheld the High Court's decision that an applicant for judicial review of approval given to a proposed abortion under the Contraception, Sterilisation and Abortion Act 1977 lacked standing to obtain review. He was a stranger to the decision he sought to challenge, and could not claim to represent an unborn child. In drawing upon relevant English and Canadian case-law, the Court demonstrated the highly interactive Commonwealth jurisprudence that has evolved in this area of law.

E. Spousal and Parental Consent

Case-law in Queensland, Ontario and other jurisdictions has recently been instructive in clarifying principles governing third parties' consent to and veto of a woman's abortion. In Attorney-General for Queensland; Ex rel. Kerr v. T. (1983), 46 A.L.R. 275, the High Court of Australia confirmed decisions of the Queensland state courts that an injunction could not be granted to an unmarried man to restrain the woman he had made pregnant from having an abortion. The Court reasoned that an injunction was inappropriate to restrain an anticipated offence triable by jury, that a fetus as such has no legal rights and none can be claimed on its behalf, and that a person claiming paternity of a woman's child has no control over her. This raises the issue of whether a man who is both father of a

woman's unborn child and also her lawful husband has a superior right.

It was held in Ontario that he has not. A husband's application for an injunction was rejected in Medhurst and Medhurst (1984), 46 O.R. (2d) 263 (Ont. S.C.), later affirmed in Re Medhurst and Medhurst (1984), 45 O.R. (2d) 575 (Ont. S.C.). In this latter case it was considered that if he had independent evidence of impropriety, a husband could ask a court to inspect records of proceedings of a hospital's statutorily constituted therapeutic abortion committee, in order to review whether it had acted according to the legal grounds for approving the procedure. As both husband and admitted father, however, he was held to lack standing to intervene in his wife's decision lawfully to seek abortion. Her unilateral act might constitute a matrimonial offence such as mental cruelty justifying divorce or other matrimonial relief. A divorce was granted on this ground in, for instance, Satya v. Siri Ram, A.I.R. 1983 Punjab & Haryana 252, by the Punjab High Court, India. When abortion is medically indicated for preservation of a wife's health, however, a husband's obstruction might also be cruelty on his part, and a violation of his legal obligations to provide his wife with necessaries of life. In Canada, this obligation exists under the Criminal Code.

The Gillick case in England (see Chapter II, B, above) involved issues not only of adolescent contraception, but also of adolescent abortion without parental consent or knowledge. Mrs. Gillick's claim expressly addressed abortion, and the terms in which the House of Lords rejected it clearly govern abortion. The majority judgments deal with legal principles of adolescent autonomy, taking contraception as an illustration of principle but not as an exclusive concern or focus. The dissenting judgments, being centred upon sexual offences, fail to address the abortion issue raised in the claim. Confirmation of the mature minor's capacity for independent decision-making is of double significance. It means that a minor of sufficient understanding may legally authorize an abortion procedure without her parents' consent or knowledge, but also that, if she is adequately aware of the health and other implications of continuing her pregnancy, she may resist abortion when her parents authorize the procedure. The younger she is, however, the more significance may be given to her parents' role in protection of her well-being.

A number of Commonwealth jurisdictions with laws approving abortion make express provision for minors which supersedes the Common law and excludes the issue from the general law on medical treatment of adolescents. In Barbados, for instance, the Medical Termination of Pregnancy Act, 1983 (see B, above) provides in section 8(23) that:

> "The treatment for the termination of the pregnancy of a female under the age of 16 years or of a person of unsound mind of any age shall not be administered except with the written consent of her parent or guardian."

Provisions of this nature do not leave minors' well-being to parents' arbitrary discretion, since, as the Gillick case established, parents enjoy powers in order that they may discharge their duties. An important duty of parents is to provide their children with medically indicated health care. A parent who refused to seek or to consent to abortion necessary to save a child's life or physical or mental health would bear legal responsibility under laws promoting child welfare and limiting child abuse. The responsibility binds anyone who act in loco parentis; in K. v. Minister for Youth and Community Services, [1982] N.S.W.L.R. 311, Helsham C.J. in Eq. authorized medically indicated abortion for a 15 year old ward of the Australian state of New South Wales over the refusal of consent of the Minister in charge, which he withheld on moral grounds. Further, the Common law defence of necessity to save human life would protect performance of abortion without parental consent where it was medically so indicated. Even when parental consent is a necessary condition of abortion, it may not alone be a sufficient condition. The minor's own consent may be required when she has capacity to give it, and to withhold it, unless continuation of pregnancy would be life-endangering.

Some Commonwealth legislation addresses abortion of minors through an indication for abortion of a criminal offence, such as rape, incest, or sexual intercourse with a girl under a given age. Since the purpose of such criminal offences and of their often heavy punishment is to protect younger girls against the physical, mental and reproductive hazards of pregnancy, a parental discretion to deny a victim's health-indicated abortion through exercise of a veto appears incompatible with the policy of the law. In a sense, tolerance of a veto would appear to give a parent a capacity an offender faces punishment for exercising. Tolerance would be even more incongruous when the parent himself is the offender. Adolescent abortion may also be eased through a provision such as appears in Hong Kong's Offences against the Person (Amendment) Ordinance 1981. This permits doctors to find risk of injury to health from continuation of pregnancy exceeding the risk of abortion, which is sufficient to justify abortion and presumably to require parents to consent to it under their legal duties of child protection, simply on the ground that the patient is aged under 16 years.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Legal indications for Granting an Abortion							Statutes and Cases in Force as of 1 March 1986
	Risk to Life	Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	
AFRICA								
Botswana	X	X	X					Penal Code (Cap.8:01), Secs. 160-162, 241
The Gambia	X	X	X					Criminal Code (Cap.37), Secs. 15, 140-142; R. v. Bourne applied.
Ghana	X	X	X	X	X			Criminal Code, 1960, Secs. 58-59, 67(2); R. v. Bourne applied.
Kenya	X	X	X					Penal Code (Cap.63), Secs. 158-160, 240; Mehar Singh Bansel v. R. [1959] E.A.L.R. 813; R. v. Bourne and R. v. Newton and Stungo applied.
Lesotho	X	X	X					Common law governed de jure by the "defence of necessity".
Malawi	X	X	X					Penal Code (Cap.7:01), Secs. 149-151. R. v. Bourne applied
Mauritius	X	X	X					Penal Code Ordinance (Cap.195), Sec. 235. Anath v. The Queen Supreme Court, 17 May 19?? Record No. 3103; R. v. Bourne applied.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Risk to Life	Legal indications for Granting an Abortion: Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	Statutes and Cases in Force as of 1 March 1986
AFRICA (cont'd)								
Nigeria								
Northern States	X	X	X					Laws of Northern Nigeria, Laws R.E. 1963, Penal Code (Cap.89), Secs. 232-235; R. v. Bourne applied.
Southern States	X	X	X					Criminal Code, Laws of the Federation of Nigeria, Laws R.E. 1958, Vol. II (Cap. 42), Secs. 228-230, 297; R. v. Edgal, 4 W.A.C.A. 133 (1938); R. v. Bourne applied.
Seychelles	X	X	X	X	X			Penal Code (Cap.93), Secs. 147-149, 226. Termination of Pregnancy Act, 1981 (Act 5 of 1981).
Sierra Leone	X	X	X					English Offences against the Person Act, 1861, Secs. 58-59; Common law governed de jure by the "defence of necessity"; R. v. Bourne applied.
Swaziland	X	X	X					Common law governed de jure by the "defence of necessity".
Tanzania	X	X	X					Penal Code (Cap.16), Secs. 150-151; R. v. Bourne applied.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Legal indications for Granting an Abortion							Statutes and Cases in Force as of 1 March 1986
	Risk to Life	Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	
AFRICA (cont'd)								
Uganda	X	X	X					Penal Code (Cap.106), Secs. 136-138, 217; R. v. Bourne applied.
Zambia	X	X	X	X		X		People v. Gulshan, Smith, Finlayson (1971), Zambia High Court [Criminal] H.P. 11/1971, Penal Code (Cap.146), Secs. 151-153. Termination of Pregnancy Act, 1972, (Cap.554), Secs. 1-6.
Zimbabwe	X	X		X	X			Termination of Pregnancy Act, 1977; S. v. Collop [1979 (4)] SA 381.
ASIA AND OCEANIA								
Australia Capital Territory	X	X	X	Where it may be interpreted as a risk to health.				Crimes Act, 1900, Secs. 82-84; R. v. Davidson [1969] V.R. 667; R. v. Wald [1971] 3 D.C.R. (N.S.W.) 25.
New South Wales	X	X	X	Where it may be interpreted as a risk to health.				Crimes Act, 1900, Secs. 82-84; R. v. Davidson [1969] V.R. 667; R. v. Wald [1971]3 D.C.R. (N.S.W.) 25.
Northern Territory	X	X	X	X				Criminal Law Consolidation Act and Ordinance 1876 to 1974, Sec. 78-79A.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Legal indications for Granting an Abortion							Statutes and Cases in Force as of 1 March 1980
	Risk to Life	Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	
Australia (con'd)								
Queensland	X	X	X					Criminal Code, Secs. 224-226, 282 R. v. Ross and McCarthy (1955) Q.S.R. 48; Queen v. Bayliss and Cullen (Jan. 1986)
South Australia	X	X	X			X		Criminal Law Consolidation Act, 1935-1966, Secs. 81-82. Criminal Law, Consolidation Amendment Act, 1969, Sec. 82a.
Tasmania	X	X	X					Criminal Code Act 1924, Secs. 51(1), 134-135, 165; R. v. Davidson (1969) V.R. 667.
Victoria	X	X	X	Where it may be interpreted as a risk to health.				Crimes Act 1958, Secs. 65-66; R. v. Davidson (1969) V.R. 667.
Western Australia	X	X	X					Criminal Code Act 1913, Secs. 199-201, 259; R. v. Bourne applied.
Bangladesh	X	X	X					Penal Code, 1860, Secs. 312-316, Memorandum Guidelines for Menstrual Regulation (MR) Memo No. 5-4/MCH-FP/ Trg./80 25 January 1980

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Legal indications for Granting an Abortion							Statutes and Cases in Force as of 1 March 1986
	Risk to Life	Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	
ASIA OCEANIA (con'd)								
Brunei Darussalam	X	X	X					Penal Code (Cap.22), Secs. 312-316, 81. R. v. Bourne applied.
Fiji	X	X	X	Where it may be interpreted as a risk to health.				Penal Code (Cap.11), Secs. 165-167, 265; R. v. Emberson and Emberson, Criminal case No. 16 of 1976.
Hong Kong	X	X	X	X	X	X		Offences against the Person (Amendment) Ordinance 1976 (Cap.212), Secs. 46-7, 47A. Termination of Pregnancy Regulations 1973. Offences against the Person (Amendment) Ordinance, No.13 of 1981, Termination of Pregnancy (Amendment) Regulations 1982.
India	X	X	X	X	X	X		Penal Code, 1860, Secs. 312-316. Medical Termination of Pregnancy Act, 1971, Medical Termination of Pregnancy Rules, 1975.
Jammu and Kashmir	X	X	X	X	X	X		Ranbir Penal Code, Samvat, 1989 (1932 A.D.), Secs. 312-316. Medical Termination of Pregnancy Act, 1974.
Kiribati	X							Penal Code (Cap.8), Secs. 150-152.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Legal indications for Granting an Abortion						Statutes and Cases in Force as of 1 March 1986
	Risk to Life	Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	
ASIA & OCEANIA (con'd)								
Malaysia	X	X	X	X	X			Penal Code (Cap.75), Secs. 312-316, The Penal Code (Amendment and Extension) Act 1976 extended the Penal Code (FMS Cap.45) throughout Malaysia and repealed the respective Penal Codes of Sabah and Sarawak.
Maldives	X							Islamic Shari-a law
Nauru	X	X	X					First Schedule Criminal Code Act 1899, of Secs. 224-226, 282, R. v. Ross and McCarthy [1955] Q.S.R. 48 of Queensland (Australia) applicable as adopted law, 1968.
New Zealand	X	X	X	X	X			Crimes Act 1961, Secs. 183-187, as amended 1977, No.113; 1978, No.6 Hospitals Amendment Act 1975 (to amend Hospitals Act 1957). R. v. Woolnough [1977] 2 N.Z.L.R. 508. Contraception, Sterilisation, and Abortion Act 1977 as amended 1978, Abortion Regulations 1978, Abortion Regulations 1978 and Amendment No.1.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Legal indications for Granting an Abortion						Statutes and Cases in Force as of 1 March 1986
	Risk to Life	Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	
ASIA & OCEANIA(con'd)								
Niue	X	X	X					Miscarriage Act 1966, Secs. 166-168
Papua New Guinea	X	X	X					Criminal Code (Cap.XXII), Secs. 228-230; (Cap.XXVI), Sec. 285, 319 Law Department/Legal Opinion, 13 Aug. 1974.
Singapore							X	Penal Code (Cap.119), Secs. 312-316, Abortion Act, 1974, Abortion Regulations 1974; Abortion (Amendment) Act 1980 (No. 32 of 1980).
Solomon Islands	X							Penal Code (Cap.5), Secs. 150-152, 227.
Sri Lanka	X	X	X					Penal Code (Cap.19), Secs. 303-305, R. v. Bourne applied.
Tonga	X							Criminal Offences Act (Cap.15), Secs. 94-96.
Tuvalu	X							Penal Code (Cap.8) Secs. 150-152.
Vanuatu	X	X	X					The Penal Code Act No. 17 of 1981, Sec. 117(3).
Western Samoa	X	X	X					Crimes Amendment Act 1969, Secs. 73A-73D. R. v. Bourne applied.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Risk to Life	Legal indications for Granting an Abortion: Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	Statutes and Cases in Force as of 1 March 1986
EUROPE								
Cyprus	X	X	X	X	X	X		Criminal Code (Cap.154), Secs. 167-169, 169A (amended by Law No.59 of 1974).
Gibraltar	X	X	X					Criminal Offences (Cap.37), Secs. 71-72. R. v. Bourne applied.
Malta	X							Criminal Code (Cap.12), Secs. 255-258.
United Kingdom England and Wales	X	X	X	X		X		Offences against the Person Act 1861, Secs. 58-59. Infant Life Preservation Act, 1929, R. v. Bourne [1939] 1 K.B. 687. Abortion Act 1967. Abortion Regulations 1968. Abortion (Amendment) Regulations 1976, Abortion Amendment Regulations 1980.
Northern Ireland	X	X	X					Offences against the Person Act 1861, Secs. 58-59. R. v. Bourne applicable.
Scotland	X	X	X	X		X		H.M. Advocate v. Anderson [1927] Scots L.T. 651, 239. Abortion Act 1967. Abortion Regulations (Scotland) 1968, 1976 and 1980.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Legal indications for Granting an Abortion							Statutes and Cases in Force as of 1 March 1986
	Risk to Life	Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	
WESTERN HEMISPHERE								
Anguilla	X	X	X					Offences against the Person Act (Cap.56), Secs. 53-54, R. v. Bourne applied.
Antigua and Barbuda	X	X	X					Offences against the Person Act (Cap.58), Part IX, Secs. 53-54.
Bahamas	X	X	X	Where it may be interpreted as a risk to health.				Penal Code (Cap.48), Secs. 341, 353, 357.
Barbados	X	X	X	X	X	Where risk to health.		Offences against the Person Act, 1868 (Cap.141), Secs. 61-62, R. v. Bourne applied. The Medical Termination of Pregnancy Act, 1983. The Medical Termination of Pregnancy Regulations, 1983.
Belize	X	X	X	X		X		Criminal Code Ordinance 33/1980, Title IX, Secs. 108-110, 125.
Bermuda	X	X	X	X	X			Criminal Code, Title 8; Item 31, Secs. 194-196, R. v. Bourne applied. Criminal Code Amendment Act 1983.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Risk to Life	Legal indications for Granting an Abortion: Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	Statutes and Cases in Force as of 1 March 1986
WESTERN HEMISPHERE (con'd)								
British Virgin Islands	X	X	X					Offences against the Person Act (Cap.54), Secs. 53-54, R. v. Bourne applied.
Canada	X	X	X					Criminal Code, R.S.C. 1970 (Cap. C-34), Secs. 221, 251-252. Morgentaler v. R. [1975] 53 D.L.R. (3d) 161 (S.C.C.), R. v. Morgentaler [1976] 64 D.L.R. (3d) 718 (Quebec C.A., leave to appeal to S.C.C. refused).
Cayman Islands	X	X	X					General (Part V), Secs. 129-131; R. v. Bourne applied.
Dominica	X	X	X					Offences Against the Person Ordinance (Cap.44), Secs. 56-57; R. v. Bourne applied
Falkland Islands & Dependencies	X	X	X					Offences against the Person Act (Cap.56), Secs. 53-54; R. v. Bourne applied.
Grenada	X	X	X					Criminal Code 1958 (Cap.76), Secs. 238, 250-251, 254, 263; R. v. Bourne applied.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Legal indications for Granting an Abortion							Statutes and Cases in Force as of 1 March 1986
	Risk to Life	Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	
WESTERN HEMISPHERE (con'd)								
Guyana	X	X	X					Criminal Law (Offences) Act (Cap.8:01), Secs. 78-80, R. v. Bourne and R. v. Newton and Stungo applied.
Jamaica	X	X	X					Offences against the Person Law, 1864 (R.E. 1953, Vol. VI), Secs. 65-66, R. v. Bourne applied. Ministry of Health paper No.1, 1975 (M.P. No. H.H.490/01).
Montserrat	X	X	X	X				Penal Code No. 12 of 1983 Sec. 139.
St. Christopher -Nevis	X	X	X					Offences against the Person Act (Cap.56), Secs. 53-54, R. v. Bourne applied.
St. Lucia	X	X	X					Criminal Code, Book II, Title 24, Secs. 117-119, R. v. Bourne applied.
St. Vincent and the Grenadines	X	X	X					Indictable Offences Ordinance (Cap.6), Secs. 98-100, R. v. Bourne applied.

LEGAL INDICATIONS FOR ABORTION

Commonwealth Countries by Region	Legal indications for Granting an Abortion							Statutes and Cases in Force as of 1 March 1986
	Risk to Life	Physical Health	Mental Health	Fetal Indications	Juridical (rape, incest etc.)	Socio-Economic	On Request	
WESTERN HEMISPHERE (con'd)								
Trinidad and Tobago	X	X	X					Offences against the Person Act (Cap.11:08), Secs. 56-58, R. v. Bourne applied.
Turks and Caicos	X	X	X					Offences against the Person Act (Cap.21), Secs. 38-39, R. v. Bourne applied. Criminal Code, Book II, Title 24, Secs. 117-119, R. v. Bourne applied.

V. RESPONSES TO INFERTILITY

A. Introduction

Artificial means of human reproduction namely artifical insemination, in vitro ("test tube") fertilization (I.V.F.) and surrogate motherhood, have become focal points of ethical commentary and legal proposals particularly since the birth in England in 1978 of Louise Brown, the world's first "test tube" baby. Since then, developments particularly in England and Australia have advanced the relevant technology. These countries may have been able to take initiatives because restrictions on fetal and embryonic medical research in the United States of America, both actual and presumed, arrested developments that specialists in infertility relief were anxious to pursue there. Monash University in Melbourne, Australia and Bourn Hall Clinic in Cambridge, England, have become destinations of many in the Commonwealth, the United States and beyond who seek to acquire and develop the technical expertise through which infertility may be relieved.

Relief is distinguishable both from prevention of infertility and from its cure. Improved knowledge of the many causes of infertility (see B, below) assists the potential for individual and collective preventive measures. Infertility itself may be differently defined for medical, demographic and, for instance, social purposes, and is divisible into primary and secondary infertility; many infertile couples have already had children, together or separately in earlier relationships. Secondary infertility affects those who were once fertile, and may become fertile again, but who have suffered from an event or condition that renders them infertile. The potential to be a partner in an infertile relationship may be preventable, however, by medical treatment and by self-care regarding health preservation and choice of life style. Particularly, but not only in developed courtries of the Commonwealth, infertility may be due to avoidable reproductive impairments, such as venereal diseases. Similarly, relief of infertility may be attempted through surgical (including microsurgical) means, drug treatments and, for instance, dietary management, without recourse to the more spectacular, technology-dependent means of artifical reproduction which have in recent years become a focal point of legal and ethical concern. Even when successful in producing a child, these often leave their beneficiaries still infertile.

The adoption alternative to artifical conception has become decreasingly available in recent years, particularly in developed countries, due to increasingly successful means of pregnancy prevention through contraception and sterilization, and to a lesser extent due to abortion and single women keeping their children, including when the mothers are of school age. In an inadvertently dysfunctional way, however, legislation in

developed countries designed to prevent buying and selling of babies and other unsavoury commerce in children has prevented development of an adoption alternative to abortion. By these laws, those who offer to buy babies from mothers unable to cope with rearing them, and those who offer to sell their babies to others who want them, become liable to criminal punishments. These laws may obstruct conscientious persons and agencies who want to deter pregnant women who are considering abortion from pursuing that goal, by offering to pay their pregnancy and confinement expenses, including lost wage earning opportunities, if they will agree at birth to the babies being adopted. A market in babies, including a regulated, non-exploitive market of relatively free and equal suppliers and consumers, is thus prevented in favour of abortion.

This Chapter of the Report will outline alleged causes of infertility, which in a country such as Canada is estimated to affect one in six and perhaps as many as one in five couples of reproductive age. It will review the general approaches to the issue proposed in a number of prominent Commonwealth reports from the United Kingdom, where the Warnock Report has attracted great attention, Australian jurisdictions, notably the Waller Reports from the state of Victoria, and, for instance, from the Ontario Law Reform Commission in Canada. It will then address issues more specific to the technologies of artificial insemination by sperm and ovum donation, and in vitro fertilization, and consider the application of both artificial and natural means of reproduction in "Surrogate Motherhood" transactions. These may be for so-called surrogate motherhood, by which a woman has her own ovum fertilized, and more authentic surrogacy by which a woman bears an embryo created from another's ovum, in both cases in order to surrender the child on birth. Finally, it will consider the often contentious but inescapable issue of embryo and fetal research. The Table of Reproductive Options at the end of this Introduction illustrates 22 alternatives to normal conception employing artifical means.

Issues will be presented primarily from a legal perspective, but in practice much public discussion concerns ethical issues. It is proper that these be raised, of course, both in relation to and separately from legal issues. It is interesting to observe, however, that ethical deliberation about artifical reproduction is rarely matched by ethical deliberation about natural reproduction. Both may appear in some cases to be irresponsible and hazardous to potential children and to societies themselves, but the reproductive initiatives that have come to bear the burden of ethical accountability tend to be the artificial. For instance, proposed in vitro fertilization (I.V.F.) programmes raise issues of marital status of patients and their likelihood to offer children good homes. When natural fertility can be

TABLE OF REPRODUCTIVE OPTIONS

Key:
- H = Husband (legal or Common law)
- W = Wife (legal or Common law)
- D = Donor of sperm, ovum or uterine service
- AI = Artificial insemination
- ET = Embryo transplantation
- "SM" = So-called surrogate motherhood
- SM = Surrogate motherhood
- F = Single father
- M = Single genetic mother
- SPA = Step-parent adoption
- IVF = In vitro fertilization
- IV+F = In vivo fertilization (by AI) and flushing
- Any = Natural conception, AI, IVF or IV+F

	Sperm	Ovum	Uterus	Means of Conception	Intended Child Custody	Explanation
1.	H	W	W	Natural	H & W	Normal conception
2.	H	W	W	AI	H & W	AI by husband
3.	H	W	W	IVF	H & W	IVF
4.	D	W	W	AI/IVF	H & W	Conception by sperm donor
5.	H	D	W	IVF or IV+F & ET	H & W	Conception by ovum donor
6.	H	D1	D1	AI	H & W	"SM" & SPA by W
7.	H	W	D	Any & ET	H & W	SM & SPA by W
8.	H	D1	D2	Any & ET	H & W	Ovum donation, SM & SPA by W
9.	D	W	D	Any & ET	H & W	SM of W's ovum & adoption
10.	D	D	W	Any & ET	H & W	W bears (unrelated) child & SPA by H
11.	D	D1	D1	Any	H & W	Adoption
12.	D	D1	D2	Any & ET	H & W	Adoption
13.	F	M	M	Any	F & M	Child of the union
14.	F	D1	D1	Any	F	Father has child
15.	D	M	M	Any	M	Mother has child
16.	F	D1	D2	Any & ET	F	Father has true surrogate child
17.	D	M	D	Any & ET	M	Mother has true surrogate child
18.	D	D1	D2	Any & ET	D2	True surrogate has child
19.	D	D1	D1	Any	Third party	Adoption
20.	D	D1	D2	Any & ET	Third party	Adoption
21.	H	W	W	Posthumous AI/IVF	W	Widow has child
22.	H	W	D	Posthumous IVF/IV+F & ET	W	Widow has true surrogate child
23.	H	W	D	Posthumous IVF & ET	H	Widower has true surrogate child

achieved or restored by, for instance, hormone treatments or microsurgery, which may be no less expensive than I.V.F., physicians and others are rarely asked to ensure that their patients will conceive only in marriage, or that they will make good parents. By its preoccupation with the artificial, ethical discourse raises problems not only of the ethics of reproductive biotechnology, but also of the ethics of ethics.

B. Causes of Infertility

While it is ubiquitous, infertility is not a uniform phenomenon in the world. The Task Force on Diagnosis and Treatment of Infertility of the World Health Organization Special Programme of Research in Human Reproduction conducted studies in 25 countries including many in the Commonwealth between 1979 and 1984, and identified different combinations of factors contributing to individual countries' and regions' experience of infertility (see W. Cates, T. Arley and P. Rowe, "Worldwide Patterns of Infertility: Is Africa Different?" The Lancet, 14 Sept, 1985, 596). Nevertheless, without being specific to any individual Commonwealth country or region, a number of causes can be proposed to explain the infertiltiy rates in many populations.

An important cause is the fact of biology that natural fertility, perhaps in both females and males, declines with age: younger people are more fertile than those who are of advanced years for reproduction. Where, as may be increasingly the case in developed countries, women postpone marriage, perhaps to pursue education or careers, they may seek children at an age when pregnancy is less likely to occur. Reduced likelihood may be because of reproductive failure due to embryonic or fetal genetic abnormality, or, for instance, to failure of ovulation or poor sperm quality. Seeking children relatively late in life may be related not only to postponed marriage, however, but also to second marriage following divorce. Divorce rates in developing countries may not be as high as in the developed world, but where males' average life-span is shorter that that of women and women first marry in their early teenage years, they are liable to suffer widowhood, and later seek children in a second marriage when natural fertility has declined. Infertility may itself precipitate divorce in some cultures, and be both stigmatizing and socioeconomically disadvantageous, so that pressure arises in almost all countries to relieve its effects. Pressure to conceive may be felt, of course, without regard to age. In the W.H.O. Task Force study, it was found that, in Africa, 42 percent of women seeking infertility services were aged 24 years or younger, whereas in Asia only 22 percent were in that cataegory (see ibid. p. 597).

Infection is a major pathological cause of infertility, and perhaps the major cause in women. The W.H.O. Task Force study found that "Over 85% of the African women have diagnoses which could be attributed to infection" (see ibid.). Although venereal diseases are popularly held to account for rising levels of infertility, the study found that frequency of a history in women of such sexually transmitted diseases (S.T.D.) was actually quite low. Indeed in Asia, it was found that a history of pregnancy complications in women who were infertile was twice as high as a history of S.T.D., that in Africa the rates were comparable, and that in the developed world, pregnancy complications were associated with infertility in a proportion of two-thirds the number of cases in which S.T.D. occurred (see ibid.) Infertility following pregnancy complications may be a result, of course, of poor maternal and post-natal care, and of inadequate family planning programmes to reduce abortion rates, and unskilled management of spontaneous and induced abortion.

Chemical and mechanical contraception (that is, contraceptive drugs and devices) are associated with a consequent rate of infertility in given populations. An intrauterine device may be a source of infection when it is fitted or removed, or while it is in place, and a calculable incidence of pelvic inflammatory disease which may result in infertility is associated with use of some devices in studied populations, primarily in developed countries. Drugs other than contraceptive drugs are associated with infertility, including illicit, non-prescription and also prescription drugs. The level of infertility that results from medical care, regarding both contraceptive and general health care, may make it highly appropriate that medicine should devote itself to developing means to relieve infertiltiy. Similarly, societies might justifiably give resources to treatment because other causes of infertility are associated with tolerated social life styles, such as consumption of alcohol and tobacco, and with environmental and industrial pollution which societies do not effectively control by legal, economic or other initiatives (see generally "Infertility and Sexually Transmitted Disease: A Public Health Challenge" Population Reports, The Johns Hopkins University, Population Information Program, Series L, No.4 (1983)).

Fertile couples may conscientiously decide not to have a child of both partners, because of unacceptable risk to them of transmitting a harmful genetic or other congenital condition to their child. Improved methods of genetic prognosis and diagnosis have resulted in individuals coming to know of their harmful reproductive potential, and seeking means to reduce the risk. Formerly, they had alternatives of celibacy, married voluntary childlessness and adoption. More recently, the alternative of artifical insemination by sperm donor became available when a husband presented an unacceptable risk of dysgenic reproduction. Now, further alternatives include both ovum and embryo donation when a wife alone or the couple jointly is dysgenic, and, where

the abortion law is accommodating, they may also conceive the child of them born. Prenatal diagnosis, for instance by amniocentesis, will reliably show whether the fetus, is harmfully affected. In many cases it will not be, and the pregnancy will continue. When prospective genetic harm is, for instance, Tay-Sachs disease, only one child in four will be affected, and if the risk is of Down's Syndrome due to advanced maternal age, 95 percent of fetuses have been found to be unaffected. If the fetus is found to be affected, the pregancy will be terminated. In many cases the pregancy will continue, however, and the couple will have a healthy child. This is the contribution an accommodating abortion law makes to the birth of genetically normal children (see R.J. Cook, "Legal Abortion: Limits and Contributions to Human Life" in Abortion: Medical Progress and Social Implications, Ciba Foundation Symposium. 115 (1985) 211).

C. Reports on Artifical Reproduction

In the United Kingdom, Australia, Canada and, for instance, New Zealand, major reports from governmental and law reform committees have recently addressed artifical reproduction. Further, government-related, professional, religious and other public and private agencies prepared submissions to those committees, and sometimes published them as independent documents. Accordingly, an influential literature of considerable size has recently been developed. Many items are of greater length than this Report, and a presentation of them must necessarily be selective and aim to be representative. The Appendix to this section lists a number of the more helpful Reports published in recent years relevant to artifical reproduction or to aspects of it, such as related research. A number of documents of both public committees and public agencies are relatively extensively reviewed in the Appendix to the Ontario Law Reform Commission's two volume Report on Human Artifical Reproductiona and Related Matters (Ontario Ministry of the Attorney General), published in 1985.

Perhaps the most visible Report in the Commonwealth has been the 1984 Report of the Committee of Inquiry into Human Fertilisation and Embryology (H.M.S.O. Cmnd. 9314), better known as the Warnock Committee after its Chairman, Dame Mary (now Lady) Warnock. The Committee did not expressly state in its Report the philosophy upon which it was drawing for development of its analysis and proposals, unlike other bodies, particularly the Ontario Law Reform Commission, which reviewed philosophical or strategic options (see Report above, ch. 4). The broadly stated options are:

1. Prohibition of practices by criminal sanctions;
2. Deterrence by frustration of objectives;

3. Control by regulatory agencies or courts; and

4. Permission of private practices to be recognized in law, in accordance with parties' intentions.

Recognizing that its conclusions could not reflect the diverse views held in society, and with various dissenting views expressed by its own members, the Warnock Committe was generally sympathetic to controlled recourse to reproductive technology, finding that "actions taken with the intention of overcoming infertiltiy can, as a rule, be regarded as acceptable substitutes for natural fertilisation" (Report, para. 2. 4, at p. 9). This view is reflected in many other reports, and in consequent legislation, almost all of which provides that A.I.D. and I.V.F. can be undertaken only in approved centres, and/or by approved personnel.

The Committee's Report made recommendations in outline, leaving their development for implementation through legislation to others, by implication meaning those in the legislature or government. The Committee emphasized that children are best placed in two-parent families based on legal marriage or a stable Common law relationship. Selection of individual patients for artifical reproduction was considered appropriately left to medical practitioners and consultants, however, who must bear the heavy responsibility to "make social judgments that go beyond the purely medical" (para. 2.13, at p. 12). Consistently with its view that parties to an artifical reproduction transaction, meaning prospective social parents of a child and donors of gametes (sperm and/or ova), should achieve their common intention of creating parental responsibilities for the former and not for the latter, the Committee recommended anonymity of all parties. Nevertheless, it opposed the view that artificial insemination by donor (A.I.D.) should be kept secret from a child born of the procedure.

The Committee's recommendation was that the A.I.D. child should be treated in law as the child of the mother who bore and gave birth to it and of her consenting husband, whose consent to A.I.D. should be rebuttably presumed. The sperm donor should accordingly not be father in law, and, correctly anticipating ovum and embryo donation, the Committee recommended that an ovum donor should not be considered as the mother. To prevent a donor from being parent to many children, a limit of ten children was recommended, with a central register to monitor the limit. Further, a move was favoured to pay donors only their expenses, rather than any payment appearing as a reward for donation.

The Committee made generally congruent recommendations for artificial reproduction by direct insemination and I.V.F followed by embryo transfer, thereby accommodating both sperm

and ovum donation. More reserve was expressed regarding embryo donation, however, when fertilization would be in vivo and the embryo would be recovered by the process called lavage, otherwise known as flushing, washing or irrigation. Because this technique is in its early stage of development and its risks are hard to calculate, it was recommended that "the technique of embryo donation by lavage should not be used at the present time" (para. 7.5, at p. 40). An ethical objection to this recommendation is that, since the Committee found that the procedure is acceptable in principle, it is wrong to provide that it not become available in the United Kingdom unless and until other populations have borne the risks of making it safer. A population prepared to receive the benefits of a procedure should also be prepared to incur the costs of developing it to a higher level of safety.

With the exception of its approach to surrogate motherhood (below), the Committee recommended the creation of a new, independent statutory licensing authority to regulate and monitor practice in specially sensitive areas. The authority would advise government, issue guidance on good practice, publish relevant data, grant licences and oversee inspection of licensed facilities. It would regulate such activites as I.V.F. and related sperm and ovum donation, embryo creation in vitro, and the preservation in freeze-storage (cryopreservation) of gametes and embryos. The storage authority, acting under and monitored by the supervising licensing authority, might acquire lawful control of gametes and embryos where persons banking them die or cannot be traced for five yearly updating of their intentions on use or preservation. The storage authority would gain responsibility for the gametes and embryos after ten years in any event. The licensing authority would also control embryo research, which the Warnock Committee was prepared to permit up to fourteen days after fertilization, on a project-by-project basis. The Committe's recommendation that the licensing authority might also regulate the sale and purchase not only of gametes but also of embryos may be difficult to express in law in view of another recommendation that "legislation be enacted to ensure there is no right of ownership in a human embryo" (para 10.11, at p. 56). Criminal punishments were recommended for breach of the licensing system.

Logic might have required that a licensing system be applicable to surrogate motherhood agreements reached through non-profit making agencies. By these agreements a woman gestates an embryo, formed of her own ovum or from another woman's, for the purpose agreed before her pregnancy of surrendering the child on birth to another person, such as the donor of the sperm or ovum. Observing however that "it is ... with the commercial exploitation of surrogacy that we have been primarily, but by no means exclusively, concerned" (para 8.17, at p. 46), the Warnock Committee recommended criminalization of agencies

arranging surrogate motherhood agrements, whether or not on a profit making basis, and that professionals or others who knowingly assist in the establishment of a surrogate pregnancy also be punishable. It was further recommended that legislation express the conclusion of widespread legal analysis that surrogacy agreements are illegal contracts and therefore unenforceable in the courts.

The Committee did not envisage that private persons entering into surrogacy arrangements be liable to prosecution, and observed that "We ... recognize that there will continue to be privately arranged surrogacy agreements" (para. 8.19, at p. 47). Since the Committee recognized that children will be born of these agreements, it had to consider provision of their legal status. Its opinion that the woman who bears such a child should be considered its mother conforms to the customary perception of the law that a woman who bears a child is its mother. The Committee considered that a more flexible adoption law should be available to regularize relationships when a child born of ovum or embryo transfer is brought up with its commissioning genetic mother or parents. This proposal may be criticized upon several grounds, such as introduction of uncertainty of status, and distinctions between genetic mothers and fathers associated with the presumption, which from United States' judicial experience is unwarranted, that a man giving sperm for artificial insemination of a woman other than his wife in a surrogate motherhood agreement is merely a "donor". In Michigan, for instance, it has been held that such a man can be a parent if that was his purpose in making his sperm available (see Syrkowski v. Appleyard (1985), 362 N.W. 2d 211 (Mich. S.C.)). The same might be held under legislation implementing the Warnock Committee's recommendations, so that the genetic father would not have to adopt his child in order to enjoy lawful custody and to bear responsibility.

It is an historic irony that, out of the Committee's many recommendations designed to benefit children born of artificial means of reproduction, the first and to date only ones to be legislated concern criminalization of surrogate motherhood agencies and of professionals and others who facilitate surrogate motherhood agreements (see F, below).

The Warnock Committee's Report serves as a marker in relation to which other Commonwealth committees' proposals are located, including those made before the Report was released, except in so far, of course, as they address issues the Warnock Committee did not consider. The 1982 Interim Report and 1983 Report on Donor Gametes in IVF of the Victoria, Australia, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, chaired by Professor Louis Waller (The Waller Committee), for instance, were largely in agreement with the Warnock recommendations on A.I.D and I.V.F.

The Interim Report favoured restricting participants in these procedures to married couples, but acknowledged the need to accommodate "de facto relationships" (Report para. 5.8.5, at p. 24). There was also opposition to physicians acting alone as gatekeepers for society concerning which persons might participate in artificial reproduction and which others might be excluded. The final Report recommended that final responsibility for admission of patients to infertility programmes should be retained by authorized hospitals accountable to the Health Commission of Victoria, and thereby to the public. Unlike Warnock, the Waller Committee recommended that buying or selling gametes be made unlawful, although donors might be repaid for costs incurred. Donor-recipient couple anonymity was favoured, but it was considered that non-identifying information should be available to both donors and recipients, and also to consequently born children. The Waller Committee urged the Health Commission to establish a central registry containing comprehensive information, including of pregnancies and abnormalities found in I.V.F. children.

The Waller Committee's Interim Report briefly addressed cryopreservation and disposition of retained embryos, favouring that "the wishes of the couple concerning handling of such excess embryos should be respected" (para. 5.8.6, at p. 25). Like Warnock, the Committee also wanted medical reasons alone to justify embryo donation, and would not permit transfer of an embryo for reasons, for instance, of the convenience or vanity of having another woman gestate one's child. The Committee's 1984 Report on the Disposition of Embryos Produced by In Vitro Fertilization addressed management options for surplus embryos on whose destiny the gamete donors can express or have expressed no wishes. The expressed wishes of donors would not necessarily prevail, but responsible prospective usages would be respected. Embryos not governed by donors' wishes, it was recommended, should be removed from storage, but not be deliberately destroyed. Like terminally ill patients removed from life-support systems, they should be allowed to die.

The Committee recommended against surrogate motherhood, even when non-commercial, by its exclusion from authorized I.V.F. programmes and by legal non-recognition. The Queensland, Australia, Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and other Related Matters, which reported in 1984, followed the restraint of this recommendation by itself holding back from recommending actual criminalization of surrogate motherhood. It felt that the sanction of legal non-recognition and unenforceability was sufficient, reinforced by illegality of advertisements to recruit surrogate mothers or to provide facilities for those wishing to commission one. The South Australian Minister of Health's Working Party on In Vitro Fertilization and Artificial Insemination by Donor, reporting

in 1984, similarly recommended that there be no change in law to enable surrogacy to be practised, and that adoption law be used to prevent it, but did not seek criminal prohibitions.

The mainstream positions on almost all issues were taken by the Warnock Committee. Other reports can be shown to differ upon points of fine tuning, important in themselves perhaps when seen in the narrow perspective of particular concerns, but they mainly reflect the same tolerance to A.I.D. and I.V.F. in themselves, and preparedness to have the intended consequences of such procedures receive the approval of law. Similarly, they express rather different proposals to reflect the same central disapproval of surrogate motherhood. The first report fundamentally to break ranks on this and recommend recognition was the 1985 Report on Human Artificial Reproduction and Related Matters of the Ontario Law Reform Commission. It has since been reported that the Victorian Law Reform Commission has also recommended legislation to make non-commercial surrogacy agreements enforceable (see 12 Commonwealth Law Bulletin (January 1986) 252).

The Ontario Law Reform Commission approached surrogate motherhood without enthusiasm, and even less in a spirit of promoting the practice. It engaged in an exercise of damage control, recognizing that the practice is now known to exist, that it has been used in the jurisdiction, and that it is available for instance in nearby centres in the United States with family law consequences Ontario legislation and Courts would recognize. Further, the terms of the Ontario Attorney General's reference to the Commission emphasized the obligation to pursue in law the best interests of children. The Warnock Committee was established and composed to examine social, ethical and legal implications of assisted reproduction, and would have done its work by finding and declaring a practice to be unethical. The Ontario Law Reform Commission, composed of lawyers alone, but with access on this project to an Advisory Board of distinguished members of the professions of medical and social work and the disciplines of philosophy and ethics, was asked to report only on legal issues. The Commission acknowledged that moral, ethical and other perspectives critically influence evaluation of legal issues, but the project's burden was to propose legal solutions to actual problems that had already arisen in the jurisdiction. In particular, the Commission was influenced by the considerations that surrogate motherhood arrangement will continue to be made, as the Warnock Committee recognized, and that penalizing participants and holding their agreements legally unenforceable does not necessarily serve the best interests of the children who are born by them and in fact surrendered to the care and control of the commissioning, and often at least in part genetic, parents. The best interests of children are not served simply by claiming that they should not have been conceived in the way they were. The legal sanction of

unenforceability is of little effect when parties voluntarily comply with their agreements.

The Commission proposed what it described as a surrogate adoption procedure, by which prospective participants in a surrogate motherhood arrangement would take all of the agreed terms before a Family Court judge and request approval. A Children's Aid Society, a quasi-public agency mandated to protect children, would receive notice of the application, and have standing to oppose it, or to call in an officer such as the provincial Official Guardian. It would be an offence deliberately to conceal or misrepresent terms, for instance as to payment. A checklist of issues is included in the Commission's Report upon which the judge would need to be satisfied before the application could be approved. On approval, the agreement could be implemented and would have the effect upon the legal status of a resulting child and the adult participants agreed beforehand by the parties and the judge, subject to a court's right to change custody of a child in its best interests on a proper application being made and for due cause.

Most contentious is the recommendation that the agreement be specifically enforceable, if need be by seizure and delivery of the child from a surrogate mother who, on birth of the child, failed or refused to surrender it. The idea at first seemed utterly repugnant to the Commission, but on further consideration it appeared the least unattractive of the options. It has the positive merit of being emphasized to any woman considering whether to become a surrogate mother. If she is not willing to have the burden of her wanting to keep the child at its birth fall upon her instead of on the commissioning parents, she will not enter the agreement at the outset. The Advisory Board to the Commission drew upon its expertise in pediatric and child psychiatry and in social work to conclude that specific enforcement would be in the best interests of the child. Further, although the Commission did not express this justification in its Report, a surrogate may refuse surrender of the child at birth not because of her sentimental or emotional bonding to the child, but because she wants a sizeable illicit payment of money. If an agreement is not enforceable, the way is opened to ransom, baby-selling and the full horrors of unrestrained commercialism, which the threat of penal sanctions may fail to deter, not least due to the parties' incentives to conceal the transaction. The Warnock and other reports reacting against commercialism in surrogacy but recommending unenforceability do not address this issue.

APPENDIX

REPORTS ON ARTIFICIAL REPRODUCTION

Australia

The Parliament of the Commonwealth of Australia - IVF and the Status of Children, Report by the Senate Standing Committee on Constitutional and Legal Affairs on National Uniformity in Laws Relating to the Status of Children Born through the use of In Vitro Fertilisation, 1985.

National Health and Medical Research Council - Report of Working Party on Ethics in Medical Research, 1983

National Health and Medical Research Council - Report on Embryo Donation by Uterine Flushing, Interim Report on Ethical Considerations, 1985

National Health and Medical Research Council - Statement on Human Experimentation and Supplementary Notes, 1985

National Perinatal Statistics Unit, Fertility Society of Australia - In Vitro Fertilization Pregnancies, Australia and New Zealand 1979-1984.

Queensland, Report of the Special Committee Appointed by the Queensland Government to Enquire into the Laws Relating to Artificial Insemination, In Vitro Fertilization and Other Related Matters, 1984 (The Denmack Report)

South Australia Report of the Working Party on In Vitro Fertilization and Artificial Insemination by Donor, 1984.

Tasmania - Government Committee to Investigate Artificial Conception and Related Matters - Interim Report, 1985.

Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization - Interim Report, 1982 (The Waller Committee)

Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization - Report on Donor Gametes in IVF, 1983 (The Waller Committee)

Victoria, Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization - Report on the Disposition of Embryos Produced by In Vitro Fertilization, 1984 (The Waller Committee)

Canada

Health and Welfare Canada - Report of the Advisory Committee on the Storage and Utilization of Human Sperm, 1981

Ontario Law Reform Commission - Report on Human Artificial Reproduction and Related Matters, 1985

Law Reform Commission of Saskatchewan - Tentative Proposals for a Human Artificial Insemination Act, 1981

New Zealand

Department of Justice, Law Reform Division - New Birth Technologies, An Issues Paper on AID, IVF, and Surrogate Motherhood, 1985

U.K.

Department of Health and Social Security - Report of the Committee of Inquiry into Human Fertilisation and Embryology, 1984 (The Warnock Committee)

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Medical Research Council, Research Related to Human Fertilisation and Embryology, 1982 (see 285 Brit. Med. J. 1480)

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D. Artificial Insemination by Donor

Artificial insemination by sperm donor has been practised for several decades in the Commonwealth, and its theoretical legal problems have not proven to be particularly troublesome in practice. The Canadian jurisdictions of Quebec and Yukon Territory have laws that aim to achieve legal parentage only in a recipient and her consenting husband, and that relieve the donor of the legal responsibilities and deny him the legal rights of fatherhood. Similarly, recent legislation in the Australian states of Victoria, New South Wales, South Australia and Western Australia has been enacted to achieve the same

effect, particularly where A.I.D. is conducted in approved centres, and the English Law Commission's 1982 Report (Family Law - Illegitimacy, Law Com. No. 118) was directed to the same general result. Perhaps because of tenacious legal presumptions of legitimacy and the circumstances in which A.I.D. is used, when married women give birth to children of A.I.D., all parties are content that their husbands be registered as fathers of the children, with all of the legal consequences. There may be an offence committed of wilful falsification of a public register when details of birth are recorded. This may also be deceptive to a testator who left bequests to a husband and the "heirs of his body", but this has not proven legally difficult nor generated significant case-law. It is no longer seriously asserted that A.I.D. without a husband's consent constitutes adultery in law.

Issues may be worthy of consideration outside the legal realm of legitimacy and inheritance rights of children. The question of legal standards by which donors should be screened and recruited has been aggravated by a tragic Australian experience in which women contracted acquired immune deficiency syndrome (A.I.D.S.) through artificial insemination by sperm donor. Legal negligence cannot be inferred simply from this consequence, since no standards of care at the time of donor recruitment or recipient insemination may have required or rendered reasonably reliable A.I.D. screening of donors or of sperm. After the event the need becomes clear, however, to screen adequately according to available knowledge.

It is more a matter of policy than of law whether a widow may be inseminated with her dead husband's sperm. The Warnock Committee disliked the idea, but recommended only that a child conceived posthumously or an embryo implanted posthumously be disregarded for the purposes of succession to and inheritance from the father (Report, para. 10.9, at p. 55). The issue of naming the deceased husband as the child's father on the birth register and birth certificate might also warrant attention, as a matter of social form and comfort, and genetic truth, even though this be of sentimental rather than legal consequence. The spirit of the 1984 French Parpalaix case (see Current Topics, "The Parpalaix Case and post-mortem insemination" (1984), 58 Australian Law J. 627), in which a widow was held entitled to her deceased husband's frozen sperm, seems to have prevailed to reinforce the widow's right to reproductive choice.

Whether a child born with A.I.D. or another congenital defect can successfully sue those involved in the insemination, notably through negligent screening of the sperm donor, depends upon the judicial approach taken to the wrongful life action (see Chapter III, E(iv), above), and whether the claim can be presented so as to preclude the conclusion that it is in substance such an action. Similarly, it may be doubted that a

child's claim for being born of a deceased father or illegitimate, a so-called dissatisfied life claim, would be systematically received by most Commonwealth courts. A little more credible may be a claim for negligence in causing avoidable harm to the child by omitting to keep genetic data of the donor relevant to the child's medical and, for instance, reproductive counselling. This claim may lack substance, however, when donors are screened to preclude transmission of more obvious and disabling genetic conditions. The claim that children's psychological health requires them to have means to know the very identity of their genetic parents is not legally accepted, and in adoption law and practice is often expressly denied.

The rights of donors are infrequently addressed in law. In the absence of an express agreement or of legislation to the contrary, it may be presumed that a donor abandons legal interest in the surrendered gametes, and has no power of subsequent recall or control. A person who stores gametes for individual use for his or her own advantage, such as a man storing semen before undergoing irradiation therapy, is not a donor, but rather a depositor. Such a person retains control of the deposit, unless through lapse of time without renewal or change of instructions the inference of abandonment can be drawn. The Warnock Committee recommended five-year reviews of depositors' intentions, their failure to respond resulting in transfer of control of the deposit to the storage authority.

Principles derived from the practice of sperm donation are applicable in principle to both ovum and embryo donation. Differences may arise, however, when either are recovered from a woman's body in the course of a medical procedure primarily intended for a different purpose. While medical law suggests that a patient who takes no initiative to control the destination of excised tissue intends to abandon it, so that it may pass into the lawful possession of another, this is not necessarily true of gametes. It may be that while these can be wasted without express approval, their use in transplantation or research while traceable to the human source requires the user to seek consent, because of issues of confidentiality or privacy.

E. In Vitro Fertilization

Because of the relative novelty of I.V.F., the practice fits into a less settled legal foundation. An initial issue is the unresolved legal status of the embryo outside the body. Sperm and ova as such can be shown to be property, even when they are genetically identifiable and in a living state. Some find it objectionable to consider embryos property, however, and prefer to speak not of owning them but of controlling them. Legal analysis in the Common law tradition shows that their deliberate wastage while outside the body is not the crime

of homicide. This requires killing of a human "in being", which means born alive out of the mother's body. Similarly it is neither abortion, which is acting with intent to procure miscarriage of a female person, nor child destruction, which is a statutory rather than Common law offence against a child in the course of birth. Theft law may be applicable, but this depends, of course, on status as property.

The approach of equating the embryo to a child and giving quasi-parental powers of control may be helpful, but is subject to the distinction that parents cannot dispose of a child by neglect and wastage, whereas an embryo can be removed from cryopreservation and abandoned to nature. A more creative approach is through contract law, after the genetic donors and storage authority have reached a comprehensive agreement selecting options for every foreseeable eventuality. Almost all Committee reports require that agreements be reached, or that controllers give instructions in default of which the storage authority acquires control.

Even if a couple's I.V.F. involves only a single ovum and embryo, it will exist for at least a short time in vitro outside the body in which it is destined to be implanted. The prospect of achieving fertilization, successful implanation, pregnancy and birth can be considerably increased, however, if several ova are available. Accordingly, practice in many centres is to induce a woman's superovulation, for instance by hormone treatments, and to recover, say, eight or nine ova by laparoscopic means. Laparoscopy requires general anesthetic, and represents a risk to the woman which has to be minimized. That is why at a single laparoscopic investigation it will be attempted to recover a relatively high number of ova.

If, say, eight or nine are recovered, only seven or so may achieve fertilization in vitro. Practice may be to implant all that are fertilized, or alternatively not to recover more ova than a woman is willing to have embryos implanted. Often, however, three or four will be implanted, and the surplus be cryopreserved in case none is successful in making the recipient pregnant. The surplus may then be available for implantation in a later menstrual cycle without repetition of the discomfort and risks of laparoscopy. Multiple implantation presents the possibility, of course, of multiple pregnancy. Among 518 I.V.F. pregnancies of at least 20 weeks' gestation in Australia and New Zealand from 1979 to 1984, 123 (23.7%) were multiple pregnancies, including 105 (20.3%) twin pregnancies, 17 (3.3%) triplet pregnancies and one quadruplet pregnancy (see National Perinatal Statistical Unit, Fertility Society of Australia, In Vitro Fertilization Pregnancies - Australia and New Zealand 1979-1984, at p. 2.)

If pregnancy is achieved at first implantation, or if the patient declines or fails to attend for repeat implantation after initial failure, the surplus embryos will remain in storage. In time, a decision will have to be made on their disposition. They can be held, be made available to another, be used for study or research, or be taken from storage and left to nature. It is desirable, of course, that the couple's or patient's wishes on the matter be known, since they will be very influential, and perhaps decisive. The ultimate destiny of the abandoned embryo, however, is wastage. This reflects the destiny of most embryos in natural reproduction. It may be emotionally challenging to achieve on purpose what nature leaves to chance. When embryos were left surplus at Monash University in Melbourne, Australia, the Waller Committee was asked to make a recommendation on their disposition. The Committee's recommendation that they be removed from cryopreservation and be allowed to die (see Report on the Disposition of Embryos Produced by In Vitro Fertilization, 1984, para. 2.12, at p. 29) was made to the Victoria legislature, but this body voted against it, and required that they be maintained in storage in the prospect of a woman being willing to have one or more implanted in her. The issue of these "orphan embryos" received widespread newsmedia attention, and many women offered to be available for implantation, although thawing for this purpose was never attempted.

Now that it is medically established that embryos can be transferred to an infertile woman (see D. Navot, N. Laufer et al. "Artificially Induced Endometrial Cycles and Establishment of Pregnancies in the Absence of Ovaries" (27 March, 1986), 314 N. Eng. J. Med. 806), the issue of acquiring embryos becomes more critical. An alternative to creating them in vitro is to create them for instance by artificial insemination in vivo and recover them for transplantation to another woman by lavage. Although the Warnock Committee felt that the procedure is not ethically objectionable, they considered it premature and insufficiently safe (see C, above). A technique and instrument to use the procedure have been proposed, however, and are now the subject of a controversial patent application in the United States. In a comparably entrepreneurial spirit, an Australian venture named I.V.F. Australia, founded by an American business woman with links to the Monash University I.V.F. team is planning to open a series of clinics in the United States (see M. Gold, "Franchising Test-Tube Babies" (April 1986) Science 86 16 (American Assn. for the Advancement of Science)). Some may fear and deplore the commercialization of relief of infertility, but others find it no less proper to achieve a baby by these techniques than by costly surgery to facilitate natural procreation.

F. Surrogate Motherhood

Probably the most contentious and least acceptable of the new reproductive alternatives is surrogate motherhood (S.M.). While facilitated by artificial insemination and I.V.F., the practice is not dependent on advanced technology. Indeed, two instances of surrogate motherhood appear in the Bible's Book of Genesis. In contrast to I.V.F., which was launched on the world through photographs of the lovely baby Louise Brown and her parents in 1978, S.M. has appeared as an outrage in itself, and as an exploitative debasement of motherhood. It may appear marginally tolerable as an expression of the altruistic dedication of friend to friend, when one bears her child for free and affectionate surrender to another. As a commercial transaction among strangers, however, arranged through the brokerage of profit-seeking agencies and well-paid lawyers, it appears to present an egregious wrong. The Warnock Committee recognized that for some it offers their only means to have a child, but the Committee found that such benefits as S.M. may offer to the desperate are overwhelmed by its symbolic threat to social and family values, and its harm to the children it produces.

When modern instances of S.M. come to the courts, however, and the very people involved appear, the parties to the transaction tend to achieve their purposes. The intended social parents, including the children's biological fathers, have gained lawful custody of their children. A case in Scarborough, Ontario in mid-1982, which led to the reference to the Ontario Law Reform Commission whose Report appeared in 1985, resulted in a man who supplied sperm for artificial insemination of a stranger proving his paternity and so gaining legal custody of his child. His wife then succeeded in her step-parent adoption application, regularizing her relationship with the child she was rearing. Similarly in England in 1985, in the much publicized Baby Cotton case, the purposes of those who entered a paid S.M. agreement were achieved. Late in 1985 in Red Deer, Alberta, it was decided not to take legal proceedings for breach of laws against paying a mother for giving consent to adoption when a man was shown to have commissioned a woman, for payment, to bear a child for him and his wife. This probably shows that such laws, the only ones apparently relevant, are inapplicable because adoption is secondary to the transaction. As the Warnock Committee expected, these agreements are being made, and, while not legally enforceable, they are being respected not only by the parties but by courts committed to achievement of the best interests of the children.

Medical developments may show S.M. in a more benign light. When S.M. came to be seen as more than a theoretical possibility in human reproduction, it seemed in principle, as indeed it still seems to many, to be outrageous. On further reflection, however, compassionate cases appeared that may have made it

tolerable. As the only means by which a worthy couple might have a child, acting in collaboration with an altruistic friend, it appeared excusable, although not necessarily justifiable. Responding to inevitability and occasional excusability of the practice, the Ontario Law Reform Commission recommended in 1985 that, under close judicial scrutiny on a case-by-case basis, S.M. be accommodated. Medical data now show, however, that in some cases it may be desirable, as the "gestation of choice". When a woman is diabetic and has difficulty controlling her condition, or when a woman survives phenylketonuria (P.K.U.) to reach a reproductive age and condition in life, it is in the best interests of any child she conceives that it be gestated in another woman. The genetic mother's reproductive system is inhospitable to the embryo and fetus, and may cause it grave injury. The same is the case, of course, regarding a woman who suffers chronic spontaneous abortion.

Legislation on S.M. has been uniformly hostile. In the United Kingdom, the Surrogacy Arrangements Act 1985 implemented the main thrust of the Warnock Committee recommendations, criminalizing the functioning of commercial surrogate motherhood agencies, any commercial or professional negotiation of such agreements and advertisements about S.M. The Act takes care not to render private S.M. agreements criminal, but makes no provision for the legal status of children so born. As children of the commissioning male parents, who gave sperm for the insemination, they may lawfully be in the custody of their fathers without court order, although fathers may adopt them, for instance to achieve birth certificates giving the children their fathers surnames. Through provisions of the general background law, parties to S.M. may therefore achieve their general objectives of placing a child in the intended family.

A number of Australian states have taken the step not primarily of criminalizing S.M., although operation of an unauthorized I.V.F. clinic may be punishable, but of frustrating attempts to make agreements that can be effective by reliance upon the background law. They provide that, when a woman is artificially inseminated, with her husband's consent if she is married, she shall be deemed mother of the child for all purposes of law, and he shall be deemed the father. Further, the man giving sperm shall not be considered the father, nor shall an ovum donor be considered mother. Thus, even when the woman bears an embryo created from another's ovum, and the sperm used for fertilization were from the man to whom she surrenders the baby on birth, no legal conseqences flow from the transaction. Only regular adoption proceedings can give the commissioning couple legal charge of the child, and that exposes them as individuals, and their relationship to each other, to very close judicial scrutiny. The legislation, such as Victoria's Status of Children (Amendment) Act 1984, the Artificial Conception Act, 1984 of New South Wales and Western

Australia's Artificial Conception Act 1985 operate by conclusive presumptions which render biological relationships of no legal consequence. Victoria's Infertility (Medical Procedures) Act 1984 goes further. It provides not only a rigorous regulatory system to govern A.I.D. and I.V.F., but also makes entry into a S.M. agreement punishable whether or not payment is involved.

Attempts to control S.M. through regulation of A.I.D. and I.V.F. raise the prospect of evasion by recourse to natural intercourse. Children of condoned adultery may enjoy a status more compatible with the goals of S.M. than those born in Australian states where S.M. is controlled when undertaken by artificial means of reproduction. Indeed, it has been noted that:

> "... medical practitioners in Australia have recently coined a new expression to describe surrogate motherhood achieved (perhaps following the biblical precedent) by sexual intercourse between the surrogate and a married man with his wife's consent. The expression is NID (natural insemination, donor)" (R. Scott, "Test tube babies, experimental medicine and allied problems", in Proceedings and Papers of the 7th Commonwealth Law Conference, 1983, 261 at p. 264).

The problem is not just of evasion of attempted control, of course, but of falsely claiming natural intercourse when in fact artificial insemination occurred without medical or other professional assistance.

An outright legislated prohibition of S.M. creates fewer legal problems than the partial ban of the United Kingdom legislation, which is aimed only at commercial transactions, although both laws leave unresolved the status of children in fact born of S.M. transactions. The U.K. Act allows altruistic S.M. agreements, for instance, but may punish lawyers who are asked by the parties to arrange their legal relationship for the purpose of minimizing the chance of friction and legal uncertainty affecting the child. If S.M. arrangements continue to be made, perhaps when medically approved in the best interests of children's survival and health, the Act may have to be reconsidered. So far, the only legislative proposal has been a Private Member's Bill aimed at further restricting the permitted scope of S.M.

Some question remains about the function of S.M. legislation. If S.M. symbolizes the decadent commercialization of motherhood, prohibitive legislation is understandable. Some critics have observed prohibition to be, however, a response based on moral panic (see The Economist, March 15, 1986 at p. 38), and an overreaction to a practice that will never be frequent in a society. Under prohibition it may be driven underground or

into other jurisdictions, where it becomes the resort of the devious or of the wealthy. Some oppose S.M. because of its potential to induce women to offer the facilities of their reproductive systems for money, so that the poor become exploitable. Here too, S.M. may be employed by the devious and the wealthy. The instinct to protect women against the seduction of gaining money through S.M. may explain support for restrictions. As against that, however, the view that women are unable to make their own decisions on S.M. and are in need of laws to protect them against their own poor judgment may be the stereotyping of women and the paternalistic intervention in their exercise of choice that the Women's Convention opposes.

G. Embryo Research

The Warnock Committee found limited research on the early embryo permissible under strict control exercised through a licensing authority. Reflecting the widespread view of many committees that have addressed the problem from a secular standpoint, the Committee found that research conducted up to 14 days from conception could be ethical. There is little philosophical cohesion in the reasoning that has brought different committees to agree on this limit, but legally it coincides with the important distinction between abortion and non-abortifacient procedures, such as contraception and contragestion (see Chapter II, D, above). Implantation is taken to have occurred at 14 days from fertilization of the ovum. No governmental licensing agency has yet been constituted in the U.K., but a Voluntary Licensing Authority has been set up by the Medical Research Council and the Royal College of Obstetricians and Gynaecologists, and they have published guidelines generally consistent with the Warnock Committee's proposals. These require that:

(i) research procedures involve no intention to transfer embryos to a uterus, and are clearly defined and scientifically sound; and

(ii) information is likely to be obtained about the process of reproduction in connection with clinical problems such as contraception and treatment of fertility and inherited diseases.

The matter remains contentious, however, and in the U.K. an unsuccessful Private Member's Bill aimed at severely restricting embryo research gained strong support (see R. Deitch, "Commentary from Westminster" The Lancet, July 20, 1985, at p. 166), and induced a governmental commitment to address the issue with further thought. The heat of the debate may have obscured the light of some important distinctions. Research aimed at advancing the viability of an individual embryo may be analogous to therapeutic research usually permitted, if not actively

encouraged, for the benefit of the individual. Research aimed at prevention of embryo and fetal loss through implantation failure and spontaneous abortion may also be permissible, as the Warnock Committee found, because of its benefit to respect for embryonic and later human life. Research on embryos to find root causes of human pathology, such as genetic and other diseases, is consistent with but more removed from this goal. Embryo research claimed to be directed to finding a cure for cancer and comparable scourges may be viewed with sympathy, but also with some caution since it may call for the sacrifice of the identifiable embryo for the sake of unidentifiable others and for more remote and less specific goals.

The proposed 14 day limit is itself problematic in research to reduce embryo loss. Much of this is due to implantation failure, but if implantation occurs at 14 days from conception, study of its subsequent failure may have to be conducted in the 14 to 17 or 14 to 21 day period. Accordingly, if studies for that purpose are permissible, the restriction on research may have to be extended for a few additional days. A broader definitional issue is whether I.V.F. is itself experimental. Clearly, there is much more to be learned about it, but insofar as it is applied to assist a couple affected by infertility, it appears to be a therapeutically indicated practice. In 1983, the Australian National Health and Medical Research Council observed that:

> "Although IVF and ET [embryo transfer] as techniques have an experimental component, the clinical indications for their use, treatment of inferility within an accepted family relationship, are well established" (Report Ethics in Medical Research (1983) 26).

Compatibly with the Warnock Committee, however, the Council in an Interim Report of May 1985 decided not to support research into recovery of ova by lavage or flushing of wombs of women whose ova had been fertilized naturally or artificially (see Report Embryo Donation by Uterine Flushing (1985)). The Council discussed the risks of the procedure, and the ethics of the procedure in itself and in light of the risks. It is interesting to speculate whether in this decision the Council was acting as a national health council or as a medical research council.

The Waller Committee in Victoria concluded that, if regularly scrutinized, embryo research is acceptable in order to improve I.V.F. procedures and to evaluate genetic research. For example, the successful development of ovum freezing would ease the ethically difficult problems arising from use of surplus embryos; that is, if instead of preserving embryos an inferility clinic could separately store ova and sperm, and combine them later with the same prospect of achieving fertilization and pregnancy, dilemmas of preserved embryos would be reduced.

To test if ova can be successfully fertilized after freezing, embryo rsearch is required.

This touches on a related issue more ethical than legal, namely whether embryos should be deliberately created in order to be used, and to be tested to destruction, in research. More conventional legal questions in embryo research concern permission of gamete donors to create embryos for research, permission of a woman from whom an embryo has been recovered, and for instance permission of a couple whose preserved embryo has been found surplus to their reproductive needs. These are matters that patients, infertility clinics, and other health facilities might resolve in advance of gametes and embryos becoming available for research use.

VI. EFFECTS OF THE "WOMEN'S CONVENTION"

The Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention) has been fully introduced above (see Chapter I, E), and has provided a pervasive reference point to this Report. Because of the Convention's wide support among both more and less populated Commonwealth Member States (see Appendix to Chapter I) and women's special interests in reproductive health care, the Report is obliged to conclude by giving further consideration to its provisions and spirit.

It may be apprehended that a legal system or an international Convention that emphasizes rights of women does so by relegating the rights of others, such as men, children or families. The competition of interests may be real; institutions claiming to be "pro-family" or "pro-child" often promote their philosophies at the cost of women's status and legal autonomy in their communities. Modern world-wide evidence shows, however, that many of the world's families are led economically, educationally and morally by women. Mothers' loss of health or of life itself through reproductive accidents or the cumulative burdens of regular childbearing endangers the welfare of their children and families. In parts of rural Africa such as Zimbabwe, over a half of households are headed by women (Women of the World: Sub-Saharan Africa (1984) U.S. Bureau of the census and U.S. Agency for International Development (A.I.D.) at p. 114). In Jamaica, for instance, about one in three housholds in both urban and rural areas is run by a woman (Women of the World: Latin America and the Caribbean (1984), ibid. at p. 123). Accordingly, protection of women's health protects their dependents and families.

The goal of the Women's Convention is to promote women's interests only to the point of equality with men. Men face relatively few hazards to health associated with reproduction. Both fertility control, through contraception or vasectomy, and fertility promotion through sperm donation place men at little risk. In contrast, the health risks women take through pregnancy and childbirth, chemical and mechanical contraception, sterilization, abortion and preparation for artificial conception are considerable. The law cannot change the biological facts of reproductive life, of course, but it can maintain hazards at no more than the purely biological, and not add to these through legal obstacles to access to safe services designed to afford the same degree of reproductive control to women that men exercise.

The Women's Convention defines the duties binding upon States Parties, and making more concrete the measures that such Parties need to take by the year 2000 to achieve equality between men and women are the lengthily named Forward Looking Strategies of Implementation for the Advancement of Women and Concrete Measures to Overcome Obstacles to the Achievement of the Goals and Objectives of the United Nations Decade for Women

for the Period 1986 to the Year 2000: Equality, Development, Peace (the Strategies), prepared by the U.N. Secretariat's Branch for the Advancement of Women. The Strategies were endorsed by the U.N. General Assembly in December 1985 and the U.N. Commission on the Status of Women is responsible for monitoring their implementation.

It has been seen above that Article 12(1) of the Women's Convention requires that States Parties act 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."

Article 14(2)(b) similarly requires that women particularly in rural areas:

> "... have access to adequate health care facilities, including information, counselling and services in family planning."

The Strategies provide the detail in paragraph 155 that:

> "Appropriate health facilities should be planned, designed, constructed and equipped to be readily accessible and acceptable. Services should be in harmony with the timing and patterns of women's work, as well as of women's needs and family planning services should be within easy reach of all women .... Considering the unacceptably high levels of maternal mortality in many developing countries, the reduction of maternal mortality from now to the year 2000 to a minimum reducible level should be a key target for Governments and non-governmental organizations including professional organizations."

Examples of practices that inhibit equal access to family planning services include permitting husbands but not wives to obtain contraceptive agents or devices without spousal consent, permitting unmarried men but not unmarried women to obtain contraceptive services, conditioning the availability of sterilization on the number of caesarian section deliveries a woman has experienced and on such rules as the rule of 80 (sometimes the rule of 100) that makes female sterilization available only when the number of a woman's living children multiplied by her age exceeds 80 (or 100).

These requirements are discriminatory on their face when they make distinctions on the basis of sex that impair women's rights to equal access to family planning services. It has been

seen that Article 1 of the Women's Convention defines discrimination 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 ... of human rights and fundamental freedoms ..." (emphasis added).

It might be argued that these provisions would be satisifed by denial of access to contraceptive means to both married and unmarried men and women. This policy may appear nondiscriminatory on its face, but it would in fact discriminate against women because it would imperil their health more than that of men. Its general denial of basic human rights recognized in general international conventions and in national constitutions of very many Commonwealth Member States would be more easily evaded by men, and in any event would leave their general health relatively unaffected.

Conditioning female sterilization on the number of prior caesarian deliveries a woman has had makes women's autonomy dependent upon surgical history in a manner not applicable to men, whose entitlement to vasectomy is not made legally or otherwise dependent upon the reproductive history of their wives or of other mothers of their children. Underlying the condition in some cases is a legal duty to satisfy a health reason for the procedure. In Ghana only medical reasons justify sterilization, and in Malaysia medical or socioeconomic reasons are needed. (See J.A. Ross, S. Hong and D.H. Huber, Voluntary Sterilization: An International Factbook (1985) at p. 19). So-called rules of 80 or 100 are more paternalistic, being based on the view that, unless a woman has a number of children, she will be more distressed if, after sterilization, she suffers loss of a child. While the intention may be benign particularly in areas with high rates of child mortality, it responds to a crude stereotype that women must be protected against the consequences of their own considered choices. Tolerance of this stereotype may violate Article 5(a) of the Women's Convention, which condemns practices based on stereotyped roles for men and women.

Another offensively stereotypical provision, with seriously adverse implications for women's reproductive health, is that permitting female marriage at an age, usually of two years, lower than that permitted for males. This may reflect physiological differences in that females mature to reproductive capacity earlier than males. It also indicates, however, that women do not require the additional time that men receive for training to earn a livelihood outside the home and to prepare for parenthood. This reinforces a vision of an inferior, dependent

and servile role for women. Further, adolescent pregnancy and childbirth pose increased risk of death and poor health with the prospect of being pregnant frequently. The harmful effects on mothers of early pregnancy and close birth spacing have been noted above (see Chpater I, B). The cost of ill health and of limited opportunities to women's "full development and advancement" (Women's Convention, Article 3) is self-evident.

Limited educational opportunities for women are also recognized by the Women's Convention to affect reproductive and infant and child health. Lower literacy rates in women impair their ability to learn through reading, and therefore to acquire knowledge in the privacy of their own homes at times of their own choosing, governed perhaps by demands of their young children. Their dependency upon attending school in their early or mid-teenage years in order to learn to read is frustrated where school policies exist that expel unmarried students found to be pregnant, and where school authorities do not expect or require married students to attend. Experience in Swaziland may be generalized that "schoolgirls who get pregnant at school now get to be expelled and usually no punishment is given to the schoolboy anymore" (V. Dlamini, "Women and The Law and Health" in R. T. Nhlapo, Women and the Law, Report of Two Seminars in Swaziland, 1983, 66 at p. 75). Article 10 of the Women's Convention requires elimination of discrimination against women in the field of education, and in paragraph (f) mandates "The reduction of female student drop-out rates and the organization of programmes for girls and women who have left school prematurely." Paragraph (h) of Article 10 expressly requires States Parties to ensure:

> "Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."

This may be taken to refer not only to negative family planning information and advice, but also to planning when to have children in order to maximize the potential for maternal and infant survival and good health. Basic data education authorities may use to fashion educational policies are presented in the Strategies, which urge governments to "develop policies to encourage delay in the commencement of child-bearing" (para. 158). Equal marriage ages for males and females and requirements for equal school attendance and for appropriateness of the school syllabus might seem to be minimum conditions of such policies.

States Parties to the Convention are obliged to submit reports for consideration by the Committee on the Elimination of Discrimination Against Women "on the legislative, judicial, administrative or other measures which they have adopted to give effect to the provisions of the ... Covenant and on the

progress made in this respect" (Article 18). A report shall be submitted within the first year after the State Party becomes bound by the Convention, and thereafter at least every four years, and further upon request of the Committee. Reports are expected to identify progress towards achievement of the Convention's goals, but may also indicate factors and difficulties affecting the degree of fulfilment of obligations the State Party has encountered. The Committee's view is that, in order for women to be equal to men in law and in fact, women must have convenient access to all methods of family planning. Of the Commonwealth countries that were required to report by May, 1986 (see Appendix, Chapter I), only Canada has submitted a report that the Committee has addressed (see Government of Canada, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW): Reference Document (1985)). The Committee asked questions on family planning, pre-natal and post-natal counselling and expressed concern about the legal provision of abortion services particularly in the case of contraceptive failure (see ibid. at pp. 189-193).

A special challenge under national anti-discrimination laws compatible with the Women's Convention that centrally affects reproductive health concerns safety in the work-place. A number of occupational health and safety laws provide that pregnant women in jobs presenting congenital risk to the unborn may be required to work elsewhere, and some employers may screen out women from positions believed to present teratogenic and mutagenic risks, or dangers to infants workers are breast-feeding. Evidence increasingly shows men also to be at risk from employment hazards to reproduction. The inspiration to protect unborn and unconceived children often results in women being denied employment opportunities, promotions and employment in better paid work. The best approach, of course, is to make the work-place safe for both sexes and their future children. It appears that, in order to maintain jobs and enhance employment prospects, some women have undertaken voluntary sterilization. A just balance between competing interests of employed women and unborn children may be to ensure that, when a woman is denied an employment opening due to reproduction risk, or is given a "protective re-assignment", she is offered an alternative position with equivalent status, pay and prospects (see K. Swinton, "Regulating Reproductive Hazards in the Workplace: Balancing Equality and Health" (1983), 33 Univ. Toronto Law J. 45). How fairly this balance operates can be monitored under the Women's Convention, particularly when the Committee is perceptive in its reading and questioning of States Parties' reports.

As a Convention governed by principles of international treaty law, and as an instrument of councils of the United Nation's Organization, the Women's Convention is to be interpreted and applied in light of settled principles of law and practice.

Many of its problems are not specific to its subject-matter. Its purpose fashions a number of its problems, however, because it is designed to affect quite fundamental and deeply felt values in many jurisdictions. Where discrimination against women is intuitive in a country and/or rationalized in terms of divine revelation or of custom basic to survival of an historic and treasured culture, effects of the Convention are likely at best to be postponed. In order to accommodate national peculiarities, international treaties often invoke the legal feature of permitting ratifying or acceding States to make explicit reservations. That is, they may agree to be bound by the general provisions and purpose of a Convention, but add the reservation that their agreement excludes a particular obligation otherwise arising under the Convention.

Many Conventions expressly permit reservations to be made when new member States purport to join them. Article 28 of the Women's Convention provides that the U.N. Secretary-General shall receive and circulate reservations made at the time of ratification or accession, and, compatibly with the general law of treaties, sub-section 2 of the Article provides that:

> "A reservation incompatible with the object and purpose of the present Convention shall not be permitted."

One State Party may make a reservation to which another objects, thereby riasing difficult issues to be legally resolved according to principles of both settled and evolving jurispurdence. A difficulty in operation of the Women's Convention lies in determining whether a reservation that excludes a State Party's obligation to apply the Convention in the area of family law or, for instance, reproductive health, is compatible or incompatible with the Convention. In the absence of an authoritative judicial ruling or recognized custom, no reliable answer can be given in the abstract. Evolving practice must be prospectively monitored to see how a States Party proposing such a reservation is regarded and treated by other States Parties. The future operation of the Convention will in due course define its elasticity.

The Commonwealth Secretariat's commitment to the terms, machinery and spirit of the Women's Convention is evidenced in its preparation of an accession kit. This is designed to assist Member States which have not already ratified, acceded to or signed the Convention to learn its provisions, and to make their sovereign legal commitment to the Convention, and thereby to the equal rights of women with men in their own populations. Further, the kit will serve as an educational instrument through which interested groups in Commonwealth countries may learn of the Convention's goals and procedures. Written in non-legal language, the kit offers an introduction to the Women's Convention's procedures by which Commonwealth

Member States may make and show their dedication to women's welfare, and thereby to welfare of children and families dependent on women.

ISBN 978-1-84859-412-8